Critical Incident Review Team Final Report

Oregon Department of Human Services
CHILD WELFARE

A Critical Incident Review Team is convened by the Department Director when the Department becomes aware of a critical incident resulting in a child fatality that was reasonably believed to be the result of abuse and the child, child's sibling or another child living in the household with the child has had contact with the Department (ODHS). The reviews are called by the Department Director to quickly analyze ODHS actions in relation to the critical incident and to ensure the safety and well-being of all children within the custody of ODHS or during a child protective services assessment. The CIRT must complete a final report which serves to provide an overview of the critical incident, relevant Department history, and may include recommendations regarding actions that should be implemented to increase child safety. Reports must not contain any confidential information or records that may not be disclosed to members of the public. *The CIRT report is created at a specific time as required by statute and does not account for events occurring after the posting of the report*. Versions of all final reports are posted on the ODHS website.

<table>
<tr><td colspan="3">CIRT ID: X7YIT75SA9</td></tr>
<tr><td>Date of critical incident:

March 15, 2025</td><td colspan="2">Date Department became aware of the fatality:
March 15, 2025</td></tr>
<tr><td>Date Department caused an investigation to be made:
March 15, 2025</td><td colspan="2">Date of child protective services (CPS) assessment disposition:
May 20, 2025</td></tr>
<tr><td>Date CIRT assigned:
March 19, 2025</td><td colspan="2">Date Final Report submitted:
June 27, 2025</td></tr>
<tr><td>Date of CIRT meetings:

April 17, 2025
May 19, 2025</td><td>Number of participants:
11
18</td><td>Members of the public?
No
No</td></tr>
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Level 3 - Restricted

Description of the critical incident and Department contacts regarding the critical incident:

Date of report: March 15, 2025 **Assignment decision:** Within 10 Days	**Allegation(s):** Neglect by the mother and father	**Disposition(s):** Unfounded

On March 15, 2025, the Oregon Department of Human Services (ODHS) received a report of neglect to the child by the parents. ODHS had learned from the reporting party that law enforcement (LEA) responded to a 911 call made by the parents after discovering their 5-month-old child unresponsive. At the time of this call, neither the parents nor LEA had a clear indication as to why the child became unresponsive. When LEA arrived at the home, the child was reported to be observed with blood coming from the nose and there was some concern this might have been an unsafe sleep scenario. LEA conducted CPR on the child until EMTs arrived. While the EMTs continued CPR, LEA spoke with the parents who speculated several different potential causes for this critical incident. The parents reported the night prior, the family was in a car accident after hydroplaning during a storm and the air bags deployed as a result. The child was reported to be buckled in the car seat appropriately and did not seem injured. Though the child seemed fussy at bedtime, the parents observed and monitored the child for several hours before laying the child down to sleep and ultimately did not seek medical attention. It was reported the parents woke sometime the next morning to find the child in the pack and play but it was unclear if the child was unresponsive at this time. The parents called emergency services at 12:41 p.m. Lifesaving efforts by medical providers were unsuccessful.

It was of concern to LEA that the parents' timelines were not clear and consistent. Additionally, the parents were reported to have concerning criminal and substance use history in another state, had absconded their probation and had warrants for their arrest. The parents recently moved to Oregon and had a newly opened CPS assessment at the time of this report.

This new report was assigned to CPS for assessment. Of note, the child's biological father was unknown; the individual referred to as "father" in this case assumed a parenting role for this child and acted as the psychological father/father figure to the child.

The assigned CPS caseworker reviewed medical records, requested details from the 911 call, and contacted LEA. It was learned an autopsy had been completed and there was no information discovered to indicate criminality in the child's death. Diligent efforts by the caseworker to collaborate and collect information from LEA were noted throughout the CPS assessment.

On March 20, 2025, the CPS caseworker attempted to contact the parents at their residence and by phone. A home visit was scheduled for later in the day. The parents were described to be engaged and cooperative in the CPS assessment process. As the parents spoke about funeral/burial plans, they reported they had poor cell service at their rural residence. The parents also spoke about information provided to them by the medical examiner, indicating the child's death was not due to the car accident nor was there evidence the child was smothered or rolled on. The parents provided a description of the car accident that took place the night before and reported after they returned home, the child cried some and was fed a formula bottle. They reported they placed the child in the pack 'n play for bed. The father woke at 9 a.m. and though the child was not yet awake, the father made a bottle and picked up the child and held the child on his chest. At 10 a.m., he tried to wake the child and noted the child was making some moaning sounds and their body seemed limp. The mother stated they needed to take the child to the hospital and as they ran to seek help from a relative on the property, the child stopped breathing and 911 was called.

On March 25, 2025, the CPS caseworker contacted the paternal relatives who lived on the same property with the parents and child. They reported they had an estranged relationship with the father for several years and were grateful at the opportunity to start building their relationship again.

On March 27, 2025, the CPS caseworker had further contact with the parents while both were incarcerated to discuss helping arrange funeral/burial arrangements. The CPS caseworker spoke with the probation officer for the father and requested out-of-state child welfare records from

the parents' home state. The CPS caseworker was in contact with each of the parents' probations officers throughout the CPS assessment. The parents had warrants for their arrest and were extradited out of state during the course of this assessment.

The CPS caseworker reviewed emergency room documentation from this critical incident and spoke with the attending physician, who reported the child presented with cardiac arrest and was noted to be hypoglycemic. Life-saving efforts were implemented by hospital staff, including CPR, glucose, and Narcan (to help with the hypoglycemic event). Previous medical records from March 6, 2025, showed the child was seen for a rash and was diagnosed with impetigo. The parents were provided a topical prescription and appeared to be appropriately managing and administering the medication. The CPS caseworker requested and received birth records for the child, which indicated a full-term birth.

The CPS caseworker contacted the medical examiner, who interviewed the parents. The medical examiner reported the parents stated they were up at 3 a.m. to feed the child. The father told the medical examiner that around 9 a.m. he got up and picked up the child, noting the child seemed cold. The father tried to feed the child, but the child wouldn't take a bottle. The father laid down on his back with the baby on his chest and the mother awoke. The father also noted he did not fall asleep during this time. The mother could see the child was limp and she wanted the child seen by medical staff.

The CPS caseworker requested but was not provided access to the police report detailing LEA's response to this critical incident, however, they allowed the CPS caseworker to review the bodycam footage.

At the beginning of the video, the father brings the child to the responding officer, and they all go inside. The officer began CPR. There was no blood observed on the child in the bodycam footage. EMTs arrived and brought the child to the ambulance. The officer did not allow the parents to follow and proceeded to interview them. The father began talking about the car accident from the night prior and stated the child was in the back seat. He asked if the powder from airbags was toxic and speculated if this could be a factor in the critical incident.

The mother then told the officer the car accident took place around 9 p.m. and they went to bed at roughly midnight, indicating they were monitoring and watching the child. The child woke in the middle of the night to eat, and the parents noted the child seemed cold. The bottle and snuggles seemed to help, and the child was returned to the pack n' play for the remainder of the night. At 9 a.m. when the father woke, he noted the child was still sleeping and attributed this to being up late the night prior. The child was offered a bottle at this time but refused it. The parents reported the child woke back up around 10:30-11 a.m. and noted the child felt cold again. The mother stated at this time, the child was acting odd and making groaning sounds. They were going to give the child a bath to help with warmth and arousal, and if that didn't seem to help, they would seek medical attention. At this time, the child stopped breathing, and 911 was called.

The bodycam footage showed the parents asking multiple times if the child was ok and if they could go be with their child; this request was denied. The officer inquired again about the car accident and events leading up to the child's passing. The father appeared to do his best to provide details, but was visibly upset and seemed preoccupied with the life-saving efforts that were happening in the ambulance, so much so that he could not recite his cell phone number to LEA. The father was interviewed by a second officer and the remainder of the bodycam footage was muted.

Regarding some of the discrepancies in the timeframes provided by the parents, the father reported the family was residing in a trailer on the rural property of relatives and there were no clocks in the trailer. The parents had bad cell reception and no wifi access, so they usually turned their phones off when they were in their home. They didn't know the exact times of the events that took place the morning of this critical incident. Additionally, documentation reflects that the parents placed the child on the stomach for sleep and fed the child by bottle propping.

The CPS caseworker spoke with the child's pediatric office from the family's state of origin and did not learn any concerning information regarding the health and well-being of this child.

The CPS caseworker also spoke with collateral contacts from out of state; these individuals were the legal guardians to the mother's oldest child. The mother and the child resided with this family prior to moving to Oregon.

These individuals reported concern that the parents were using substances and had moved to Oregon without the necessary baby supplies and equipment. They also reported some concern for the mother's cognitive functioning, stating she often appears void of facial expressions or with a flat affect.

At the conclusion of this CPS assessment, the exact cause of death was not verified and would be pending the autopsy and toxicology results. The child was born healthy, free of injury, and had been seen by medical professionals just nine days prior to passing away. The child was noted to have suffered cardiac arrest and a hypoglycemic event, but the cause of this is unknown. The allegations of neglect to the child by the parents was determined to be unfounded.

Description of the relevant case history under the mother's case name:

Date of report: March 9, 2025 **Assignment decision:** Within 24 Hours	**Allegation(s):** Threat of Harm by the mother and father	**Disposition(s):** Unfounded

On March 9, 2025, ODHS received a report alleging threat of harm to the child by the mother and her significant other, who is the father figure to this child. It was reported the parents absconded their probation from out of state and took a road trip with little to no baby supplies or equipment. It was reported the mother and father had warrants out for their arrest due to them fleeing their state of origin. It was reported the parents' criminal history was drug and theft related, and there was a no-contact order between the two of them. It was reported the mother may have had some intellectual deficits and was easily manipulated. This may have contributed to the reason for the no-contact order. Additionally, the mother was reported to use methamphetamine early in her pregnancy with the child and may have been actively using marijuana at the time of this call. The mother lived with

supports who were caring for her older child following the birth of the child. It was reported that the mother did well in this environment and the reporting party had concerns for the mother's ability to safely parent the child without supports. The reporting party had concerns that the father was a bad influence on the mother and may present safety concerns. This report was assigned to CPS for assessment.

On March 9, 2025, the assigned CPS caseworker called the reporting party and left a message. On March 10, the CPS caseworker was able to speak with the reporting party and the family who housed and supported the mother and child before they left for Oregon. Phone contact with the mother's probation officer also took place on this day and throughout the assessment. It was learned the warrants for the parents were non-extraditable at that time, but they would attempt to make them extraditable. The purpose for the no-contact order was due to the mother and father being co-dependent and on probation. The mother was doing well for herself while the father was in jail but derailed once the father was released from custody. It was also learned that the child was not likely the biological child to the father.

On March 10, 2025, the CPS caseworker went to the family home with a recovery support specialist and made contact with the parents and the child. The parents both admitted to history of using methamphetamine and current use of marijuana (the parents provided UAs that were positive for THC). The parents previously engaged in supportive services around their substance use.

The parents reported they had supplies for the child such as formula, diapers, and clothing, but they needed a sleep space for the child as they had been co-sleeping. The CPS caseworker educated the parents on safe sleep practices and emphasized the risks of co-sleeping. The CPS caseworker returned later this day to provide the family with a pack n' play, but they were not home.

On March 10, 2025, the CPS caseworker spoke with the mother's probation officer and the following day, the CPS caseworker spoke with the father's probation officer.

Contact with the family was made again on March 11, 2025, when the CPS caseworker delivered the pack n play, where they again emphasized the importance of safe sleep practices.

On March 12, 2025, the CPS caseworker participated in an infant safety staffing where the family's history, current circumstances, and safety needs were discussed.

On March 15, 2025, it was learned the child suffered cardiac arrest and a hypoglycemic event and despite lifesaving efforts, the child did not survive.

At the conclusion of this CPS assessment, the allegations of threat of harm to the child by the parents were determined to be unfounded. Though the parents had concerning criminal and substance use history, and though they had absconded probation, the parents had all necessary baby supplies and were responsive to the child and the child's needs.

Description of concerns regarding actions taken or not taken by the Department or law enforcement agencies in response to the critical incident or events that led to the critical incident:

In review of this case, the CIRT noted the parents were reporting to be sober but were using and tested positive for marijuana. Cannabis products can affect attention, decision making and reaction time. A caregiver under the influence may not be able to respond quickly or appropriately putting an infant at risk. The sedative effects of Cannabis can lead to excessive sleepiness or distraction. This is especially dangerous for infants who require constant attention. Cannabis use is often underestimated compared to other substances but the impact on infant safety can be significant. Caregivers under the influence of Cannabis who are bed sharing with an infant significantly increase infant sleep-related risks. It is important for caseworkers to approach Cannabis use with both awareness and objectivity. While Cannabis use is increasingly normalized, it still has potential risks, especially for individuals with co-occurring substance use disorders that further impair judgement and caregiving capacity.

The safe sleep checklist utilized as a tool to help assess infant safe sleep practices indicated the parents placed the child on the stomach for sleep and also discussed bottle propping. Though there were several efforts

documented to educate the parents on infant safe sleep practices and safe sleep equipment was provided to support this, it was unknown if the parent's marijuana use, frequency, and impacts was discussed in relationship to surface sharing dangers. It was also unclear if specific education was provided to the parents around bottle propping and placing the child on the stomach for sleep.

The CIRT noted significant challenges and barriers experienced by child welfare professionals in collaborating with law enforcement partners at the onset of the CPS assessment assigned to assess the child's fatality. The LEA report from the critical incident was not initially shared with ODHS, nor was this information provided verbally upon request. There did not appear to be a police report related to the car accident experienced by the family, which sounded severe given that air bags deployed.

During this review, the Screening Program noted that it was difficult to obtain out of state records, and they had limited information regarding the family and their circumstances in the March 9 report. The Screening Program noted that in some cases, it is even difficult to obtain basic information, such as a confirmation of child welfare history for a family. The CIRT discussed ongoing issues around gathering out of state records, this struggle is not isolated to this case and is experienced often among child welfare professionals. There is no national child welfare data base or electronic case management system available to bridge vital information sharing opportunities between different child welfare jurisdictions.

Recommendations for improvement in the administration and oversight of the child welfare system that are specific to the critical incident and any historical information reviewed by the team:

Currently, Oregon Child Welfare is a member of the National Partnership for Child Safety, a quality improvement collaborative comprised of more than 35 county, state, and tribal child and family serving jurisdictions whose mission is to improve child safety and prevent maltreatment and fatalities by strengthening families and promoting innovations in child protection. The CIRT recommends the Department approach and collaborate with the partnership around the challenges and barriers experienced in cross-jurisdictional information sharing to explore potential solutions.

Efforts to build upon existing infant safe sleep education for Oregon Child Welfare caseworkers are underway, particularly focusing on the impacts of cannabis use. In the summer of 2024, the Safe Sleep Training for all child welfare caseworkers was updated to a computer-based format. Caseworkers who previously completed the initial version are encouraged to take the new training to refresh their learning and engage with the content in a more interactive manner. To supplement the foundational knowledge provided by the training, spaced education curriculum is being developed specific around case and safety management when a caregiver is using cannabis.

Critical incident reviews and historical data indicate that Child Welfare is not always notified by law enforcement when a child dies unexpectedly. Strengthening timely notification practices is essential to support appropriate response, inform risk assessment, and enhance prevention efforts across the state.

To address this gap, Child Welfare is engaging partners to explore collaboration on the following:

- **Updating Statewide Protocols**: Child Welfare will propose updates to the state's Multi-Disciplinary Team (MDT) and/or Child Fatality Review protocols to more clearly direct law enforcement to report all unexpected child deaths to Child Welfare.
  Estimated completion: December 2025
- **Strengthening Training for MDTs**: A new training or alternative educational format for MDTs, including specific content on death reporting expectations.
  Training launch: Spring 2026
- **Outreach to Law Enforcement**: A statewide memo is being prepared to explain the reporting requirements and any protocol changes.
  Planned release: February 2026
- **Long-Term Collaboration with Police Training Programs**: Child Welfare is reaching out to Oregon's Department of Public Safety Standards and Training to promote the inclusion of child death reporting in foundational and continuing law enforcement education.
  Initial outreach milestone: Fall 2025