

Critical Incident Review Team Final Report



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 (DHS). The reviews are called by the Department Director to quickly analyze DHS actions in relation to the critical incident and to ensure the safety and well-being of all children within the custody of DHS 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. Versions of all final reports are posted on DHS’ website.

CIRT ID: 0C4TGS6SN2		
Date of critical incident: 12/29/2019	Date Department became aware of the fatality: 12/30/2019	
Date Department caused and investigation to be made: 12/30/2019	Date of child protective services (CPS) assessment disposition: 09/18/2020	
Date CIRT assigned: 01/03/2020	Date Final Report submitted: 04/10/2020	
Date of CIRT meetings: 1/17/2020 (Initial) 03/05/2020 (Follow-Up)	Number of participants: No Yes	Members of the public? 12 21

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

Date of report: 12/30/2019 Assignment decision: Assign: 10 Days	Allegation(s): Neglect by Father	Disposition: <i>PENDING</i> <i>Unable to Determine</i>
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The Department received a report of an infant fatality that occurred on 12/29/2019. The reporter was concerned the infant's death may have been a result of neglect and indicated there was a pending criminal investigation. The reporter stated the mother has a medical condition causing significant physical limitations, including immobility and the need for a communication aid. The father is believed to be mother's caregiver.

Due to the criminal investigation, initial contact with the family was delayed at the request of law enforcement. When the CPS worker was authorized to interview the father, he was unwilling to participate in the CPS assessment. The CPS worker reviewed medical and law enforcement records to provide a summary of the events leading up to the infant's death.

Records indicate the father reported feeding the infant around 6:00 PM on 12/29/2019. He put the infant to sleep on their back in a basinet located in the living room. The father said he was exhausted from being the only caretaker for the infant and the mother and went to his room to sleep. He awoke less than two hours later and went to check on the infant who was lying face down and not breathing. The father called 911 and emergency responders took the infant to the hospital. Life-saving measures were attempted but unsuccessful and the infant was pronounced dead from cardiopulmonary arrest. During later interviews with law enforcement, the father said he was unsure if he put the infant to sleep face down or on their back. The parents were provided safe sleep information at the time of the infant's birth.

Prior to the infant's death, the parents had several lactation appointments due to the mother's physical limitations which required the father to assist during breast feeding. Medical providers became concerned the infant was not gaining enough weight and a feeding plan was established with the parents. The child had only seen the pediatrician immediately after the birth despite the parents being encouraged to make additional appointments. The parents also declined referrals for maternal and infant nurse home visiting services. On 12/4/19, the parents were asked to make another lactation appointment, however they expressed they were not willing to schedule a follow-up visit. Medical professionals reiterated their concern that the infant was not gaining

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enough weight and told the parents they needed to see a pediatrician. By this point, the infant was approximately six weeks old and had gained just a little over a pound.

Through collateral contacts, the worker learned that there were other agencies involved that provided support and assistance to the mother. Collateral contacts shared several concerns about the mother's well-being while being cared for by father. Those concerns included father's refusal to allow a service provider in the home to help with the care of the infant and father's appearance of control over the mother. Father refused to allow professionals to speak to mother without his presence and would communicate for her. After the child's death, law enforcement completed a welfare check on the mother after receiving a report that the father was yelling from a car at the mother who was outside the car and that the mother had communicated by shaking her head, when asked, that she was not okay. Upon contact with law enforcement, father admitted an argument but stated it was not a physical argument. Law enforcement spoke to mother alone and interpreted her responses to indicate she felt safe with the father.

At the conclusion of the CPS assessment, the father continued to refuse to meet with the CPS worker. Though there were some indications of neglect specific to the infant's feeding, medical care and safe sleep positioning, there was insufficient information to conclude child abuse occurred. Subsequently, the allegations were coded as unable to be determined. The parents were offered additional community resources but declined any referrals.

Description of relevant prior Department reports:

Date of report:	Allegation(s):	Disposition:
11/06/2019	Neglect by Mother and Father	Not Applicable
Assignment decision: Closed at Screening		

The Department received a report the mother and father missed scheduled well-child exams with the pediatrician. The family had been unresponsive to requests to set up further appointments. The reporter said that the mother has significant physical limitations thus making it impossible for her to hold and feed the child. The father was reported to hold the child up to the mother for breastfeeding, however it was unknown if the child was receiving enough breastmilk. Additionally, the family's housing is unstable, and they were residing in a hotel. The father is described as verbally explosive at times. The Department determined there was insufficient information to warrant a CPS assessment.

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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:

The family's history with the Department was limited to one prior report which was closed at screening. The CIRT concluded this report met the requirements for a CPS assignment.

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:

With the formation of the centralized Oregon Child Abuse Hotline (ORCAH), the department will continue to closely monitor screening decisions and adjust training for screeners and supervisors as needed. ORCAH continues to monitor improved adherence to Department policy and consistency in screening decisions through continuous quality improvement efforts.