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: 7EYWTLOIFC		
Date of critical incident: December 19, 2019	**Date Department became aware of the fatality:** December 24, 2019	
Date Department caused and investigation to be made: January 11, 2020	**Date of child protective services (CPS) assessment disposition:** March 18, 2020	
Date CIRT assigned: January 16, 2020	**Date Final Report submitted:** April 7, 2020	
Date of CIRT meetings: February 2, 2020 (Initial) March 17, 2020 (Follow-Up)	**Number of participants:** 13 16	**Members of the public?** No No

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

Date of report:	Allegation(s):	Disposition:
12/24/2019 **Assignment decision:** 24-hour response	Neglect by the Mother & the Mother's Live-In Companion	Unfounded

The Department received a report on 12/24/2019 documenting law enforcement's response to the mother's home on 12/19/2019 to assist in performing CPR on the four-month-old child. When first responders arrived at the home, the child was slightly blue and unresponsive. Responders performed life-saving efforts but were unsuccessful. The child was declared deceased at the mother's home. The mother informed law enforcement the child had been sleeping downstairs with her live-in companion, who is the father of one of the child's half siblings. The report was assigned for assessment on 1/11/2020. The delay in assignment was due to attempts to gather additional information to determine if the report met criteria for a CPS assignment.

Law enforcement interviewed the mother's live-in companion on the day of the incident. He reported he fed the child a bottle of formula and then laid the child on the back in the swing with a blanket, where the child normally slept. He then went to sleep and woke up around 9:30 AM. He smoked a cigarette and made the child's one-year-old half-sibling a bottle. He then checked on the child because he noticed the child was not yet awake, which was unusual. He found the child in the swing, with the blanket on the child's face. The mother's live-in companion reported last seeing the child alive at about 1:00 AM. According to those on site at the time, it appeared the child had passed away shortly after being placed in the swing. There was no indication of abuse and preliminary findings concluded the child's death was consistent with the mother's live-in companion's explanation.

The mother informed law enforcement her live-in companion resided in the home mainly at night to help with the children. Other members residing in the home included the maternal grandmother, two of the child's half-siblings ages one and seven and 7, and the child's twin. The mother reported the maternal grandmother and the seven-year-old half-sibling slept in the bedroom upstairs, while she and the child's twin slept in the living room. The mother's live-in companion slept downstairs with the one-year-old half-sibling and the child. The mother reported this sleeping arrangement was in place due to the children being on different sleeping schedules. The mother reported on the morning of the child's death, she had gotten the seven-year old off to school and then went back to bed. She was woken up by her live-in companion, who was holding the

child, and stated the child was dead. The maternal grandmother was not in the home at the time of the incident.

Information gathered about the examination of the child noted a possible underlying heart condition as well as other risk factors, such as the sleeping environment and exposure to nicotine smoke. No information gathered indicated abuse was a factor in the death of the child.

The Department was able to make initial contact on 1/28/2020 with the mother, the child's twin, and the one-year-old half-sibling. The mother reported she and her live-in companion were not in a romantic relationship at the time and he was no longer coming to the home after the critical incident. The mother reported he was not the biological father of the child, only the father to the one-year-old half-sibling. He did act as a caregiver for all the children at times. The mother disclosed a history of domestic violence with her live-in companion, however denied any physical assaults since the birth of the child and the child's twin. The mother indicated she had been fearful of reporting this violence. The mother further reported a history of substance use, though had been in recovery for over a year. The mother reported the biological father of the child and the child's twin did not wish to be involved on any level with the children. This lack of support led to the mother accepting support from her live-in companion.

The Department did not identify any safety concerns in the home. The mother was able to meet the children's needs and had a good support system in place through community resources and the maternal grandmother. The maternal grandmother expressed that although the mother was going through significant distress due to the loss of the child, the mother was doing well in her response to the trauma and her sobriety. Considering the domestic violence concerns by the mother's live-in companion, the maternal grandmother was taking on the responsibility of visitation arrangements between the father and his one-year-old child.

The Department attempted several times to contact the mother's live-in companion, however those contacts were unsuccessful. Throughout conversations with law enforcement, the Department learned there were no indications the mother's live-in companion was under the influence of any substances the morning of the critical incident. He was able to provide clear and consistent information throughout several reenactments and interviews.

The Department determined the allegations of neglect by both the mother and the mother's live-in companion were unfounded. There was no information provided by law enforcement or collateral sources to indicate the death of the child was caused by neglect.

Description of relevant prior Department reports:

The infant who died was living with the biological mother, the mother's live-in companion, two half-siblings, and a twin. The mother's live-in companion also had his own biological child. The following reports are regarding the half-siblings of the child and the mother's live-in companion's biological child.

Date of report:	**Allegation(s):**	**Disposition:**
08/15/2011 **Assignment decision:** Five-day response	Neglect by the Mother's Live-in Companion Neglect by the Mother's Live-in Companion's Ex-Spouse	Unfounded Unfounded

The Department received a report on 08/15/2011 that the eight-year-old child of the mother's live-in companion was found under bed covers with a cousin and there were concerns about inappropriate sexual contact. It was reported both children initially denied any sexual activity, however, the eight-year-old later disclosed sexual interaction. The cousin reportedly threatened the eight-year-old not to tell anyone, however the specifics of the threat were unknown. The cousin reportedly has had concerning sexualized behaviors for several years and mother's live-in companion and his ex-spouse were aware of them. They were not supposed to leave the two children alone together.

The Department made initial contact with the assistance of law enforcement. The mother's live-in companion reported he was aware the cousin had sexualized behaviors in the past. He reported the cousin was at his home due to behavioral issues and needing to give the parents of the cousin a break. He stated he was unable to keep his eyes on the children all the time, but suspected the incident occurred while the children were watching a movie. The mother's live-in companion's ex-spouse reported she had used the restroom during the movie, and this was when the incident occurred. She articulated she would no longer allow any contact between the two children.

The eight-year old was interviewed and reported the cousin exposed himself to the eight-year old and asked the child to touch him and the eight-year old refused. The only other concern noted was the child was hesitant to speak about any fighting in the home. The eight-year-old stated there were verbal arguments that occurred and both adults were very mean to each other.

Collateral contact was made with the cousin's parent who informed the Department that necessary precautions and steps were being taken to prevent further incidents

occurring. Law enforcement was investigating other incidents that occurred between the child and other juveniles.

At the end of the assessment, the Department was unable to determine if neglect had occurred. There was contradicting information on what happened and the level of supervision. The assessment was closed with the parents stating no further contact between the children would occur.

Date of report: 02/10/2012 **Assignment decision:** Closed at Screening	**Allegation(s):** Neglect by the Mother's Live-in Companion Neglect by the Mother's Live-in Companion's Ex-Spouse	**Disposition:** Not Applicable

On 2/10/2012, the Department received a report the eight-year-old child of the mother's live-in companion and his ex-spouse was not receiving required medication timely. Without the medication, the eight-year-old was unable to maintain in the classroom. It was reported the parents sometimes brought the medication and other times stated it was lost. At the time of the report, the child would have been without medication for about a week due to the pharmacy refusing to refill the prescription early. The eight-year-old was reported to be functioning at the level of a kindergartner and lacked appropriate hygiene. Both parents were reported to struggle with hygiene and the mother's live-in companion smelled of alcohol on multiple occasions.

The Department determined the information did not meet criteria for a CPS assessment. The information was sent to a community resource for additional services for the family.

Date of report: 10/11/2012 **Assignment decision:** Closed at Screening	**Allegation(s):** Threat of Harm by a Third Party	**Disposition:** Not Applicable

On 10/11/2012, the Department received a report the child's eldest half-sibling was residing with the mother in the maternal grandmother's home. The maternal grandmother was currently married to a man who had prior sexual abuse charges. It

was reported the mother was aware of this concerning history. Collateral contact occurred and confirmed the charges were accurate, however the maternal grandmother's spouse was no longer living in the home and moved out prior to the mother moving in.

The Department determined the information did not meet the criteria of a CPS assessment.

Date of report: 02/01/2015 **Assignment decision:** Closed at Screening	**Allegation(s):** Neglect by the Mother's Live-in Companion	**Disposition:** Not Applicable

On 02/01/2015, the Department received a report the mother's live-in companion and his eleven-year-old biological child like to rough house. A few years ago, in 2012, they were roughhousing when the then seven-year-old stated there was pain in the ribs. This was reportedly due to the mother's live-in companion stomping on the seven-year-old's ribs. It was unknown if there were bruises, however the mother's live-in companion's ex-spouse did not want anyone to know about the incident. It was also reported the mother's live-in companion drove while intoxicated frequently and had a gun collection. The reporter expressed concerns there were times when the live-in-companion would be intoxicated with loaded guns left within his child's reach.

The Department determined the information did not meet the criteria of a CPS assessment due to the historical nature of the report. There was no information to indicate there was current abuse or neglect occurring.

Date of report: 10/04/2017 **Assignment decision:** Five-day response	**Allegation(s):** Threat of Harm by the Mother's Live-in Companion	**Disposition:** Unable to Determine

On 10/4/2017, the Department received a report alleging threat of harm to the children. According to the report, the mother had been assaulted by her boyfriend the night prior. There were no specific details available about the assault, but the mother presented

with bruises on her legs, hips, and belly area. She was experiencing abdominal pain. The five-year-old half-sibling was not present at the time of the incident and resided with the maternal grandmother. No information was received to identify the mother's boyfriend at the time.

The screener was able to identify the mother's boyfriend as the individual who is referred to as her live-in companion throughout this report. In addition, collateral sources indicated the five-year-old half-sibling may have been residing in the home with the mother.

A CPS caseworker conducted an unannounced home visit and spoke with the mother alone, as her live-in companion had gone to the store. The mother denied the five-year-old half-sibling resided in the home but lived with the maternal grandmother instead. The mother reported that she was currently on probation and engaged in services for Driving Under the Influence of Intoxicants. The mother reported ongoing alcohol use by herself and her live-in companion. She reported he used other drugs at times. Throughout the conversation the CPS caseworker became concerned about domestic violence in the home. This was due not just to information gathered in the interview but based on observations of the home environment as well. While completing the walkthrough of the home, the caseworker observed multiple holes in doors and walls. At least two of the door frames in the home were broken and the doors were off their hinges. There were multiple shot glasses observed in the home and the entire environment was cluttered and dirty.

The fourteen-year-old child of the mother's live-in companion was in the home and interviewed. The fourteen-year-old disclosed both adults drank vodka every day and argued after drinking.

At this point in the initial contact, law enforcement was called for assistance and the CPS worker prepared to make a safety plan with the family. When law enforcement arrived, the mother said she would not cooperate with the officers. Law enforcement reported they were familiar with the mother who regularly called 911 requesting an ambulance. Every time officers arrived; the mother was intoxicated. When the mother's live-in companion returned to the home during this process, he was interviewed. He denied any incidents of physical violence towards the mother. Due to the lack of a clear disclosure by the mother, no criminal charges were filed and due to the lack of information from the fourteen-year-old, there was no ability to further intervene with a safety plan. The family was asked to clean the residence and law enforcement stated they would return to the home to ensure it was cleaned.

The following day, the CPS caseworker returned to the home and completed another walkthrough. The home was much cleaner, and the physical home environment concerns were ameliorated. The mother was on the couch during the contact and appeared to be heavily intoxicated as evidenced by her slurred speech, incoherent speech patterns, and belligerent interactions. The mother admitted to drinking, but said

she'd only had one shot. The mother's live-in companion stated he had been laid off work due to his alcoholism, but he was actively engaged with community services. Additional services were offered by the Department, but the mother's live-in companion declined. He acknowledged the concerns presented by the Department regarding the condition of the home and the alcohol use. He agreed to have a temporary roommate move into the home as a family plan however the individual was unable to move in due to criminal involvement. No subsequent plan was made as there were no other adults who could assist, and the fourteen-year old was ultimately determined to be safe.

The maternal grandmother was contacted and confirmed the five-year-old half-sibling was in her care. She agreed with the family plan and would not allow unsupervised contact between the mother and the half-sibling. The CPS caseworker conducted a walkthrough of the maternal grandmother's home and interviewed the half-sibling. The half-sibling recalled witnessing an ex-boyfriend hit the mother and force her out of the car while the half-sibling was in the backseat. The half-sibling reported being fearful and urinated due to the fear. There was no information disclosed regarding any violence between the mother and the mother's live-in companion. There were no safety concerns identified for the half-sibling while in the care of the maternal grandmother.

Collateral contacts reported concerns for the fourteen-year-old's medical and education needs, as well as overall hygiene. The CPS caseworker attempted to contact the mother and the mother's live-in companion again several times but was unsuccessful.

The CPS assessment was closed as unable to be determined due conflicting and inconsistent information provided by all family members.

Date of report: 10/12/2017 **Assignment decision:** 24-hour response	**Allegation(s):** Threat of Harm by the Mother's Live-in Companion Neglect by the Mother & the Mother's Live-in Companion	**Disposition:** Unable to Determine Unable to Determine

On 10/12/2017, the Department received a report opening a companion case referral under the mother's live-in companion regarding the domestic violence concerns in the home. This was due to the mother's live-in companion having full custody of his fourteen-year-old child and that child residing in the home. Upon initial contact, the fourteen-year-old had disclosed both the mother and her live-in companion drank every day. It was learned that the fourteen-year-old had not gone to school due to the incident.

However, the fourteen-year-old did not make clear disclosures of any physical violence in the home.

Please see the assessment dated 10/04/2017 for specific information on these allegations.

Date of report: 02/22/2019 **Assignment decision:** Closed at Screening	**Allegation(s):** Neglect by Mother	**Disposition:** Not Applicable

On 2/22/2019, the Department received a report the six-year-old half-sibling had inappropriately touched a younger female child on the school bus. It was reported the female child disclosed the six-year-old was playing a tickling game and tickled in the vaginal area. The six-year-old wanted the female child to tickle back, but she refused. The school contacted the mother through email who responded she would follow up with the six-year-old's counselor. There had not been any concerns prior to this incident. In addition, it was reported the six-year-old was very aggressive in the classroom.

The Department determined this information did not meet the criteria of a CPS assessment.

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 CIRT did not have concerns about actions taken or not taken by the Department or law enforcement in response to the critical incident. The child did not die as a result of abuse and the CPS assessment was unfounded.

The CIRT discussed concerns about the Department's approach to domestic violence and substance use within the family in the 2017 CPS assessment. The decision to make an unannounced visit to the home was inconsistent with best case practice and led to incomplete assessment of the allegations. In cases of domestic violence, it is important and best practice to make all efforts to speak to the survivor in private, without the risk of the alleged perpetrator hearing the conversation. When best practice is not followed it can result in conflicting information being gathered and may increase the risk to survivors and children. Additionally, the assessment did not fully address the substance use by both parents in the home. Additional assessment and intervention

with regard to the substance abuse could have provided further opportunity to address the domestic violence in a safe manner. Instead, the assessment was closed with no further action. Although the mother was ultimately able to gain sobriety, the relationship with the alleged perpetrator continued for some time and the mother was compelled to rely on him for support in spite of his violent behavior.

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:

The CIRT has observed over time that while not always directly related to the death of a child, historic domestic violence is often present in cases with tragic outcomes. Concern about domestic violence in a family is not limited to the physical harm that results from a perpetrator's aggression. The trauma of being exposed to domestic violence, even indirectly, can be significant and results in lasting impact on a child's development and functioning. Similarly, survivors may be significantly impacted long after the relationship has ended. It is not uncommon for families experiencing domestic violence to have other trauma or stressors that predate the violence and increase vulnerability. We must shift the focus of our intervention from the survivor to the source of harm, the perpetrator. Care must be taken to gather comprehensive social history in order to understand caregiver functioning and partner with the survivor to ensure safety.

There are tools, resources and guidance available to child welfare staff when assessing cases of domestic violence, though it has been recognized those providing direct service to families at times struggle to understand the patterns of domestic violence and focus on the perpetrator and behavior. The Department has identified the Safe and Together Model and the associated tools as complimentary to Oregon's child welfare practice model. Continued diligent effort is required by supervisors, MAPS, and consultants to ensure incorporation into practice. Increased coordination with community partners is also essential to holding perpetrator's accountable.

The local district in this case has taken steps to bring additional Safe and Together Model training and enhanced case consultation to caseworkers when working with families experiencing domestic violence. Similar efforts are underway in other areas of the state.