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: LGUA06TIP4		
Date of critical incident: 05/24/2019	**Date Department became aware of the fatality:** 05/28/2019	
Date Department caused and investigation to be made: 05/28/2019	**Date of child protective services (CPS) assessment disposition:** 01/16/2020	
Date CIRT assigned: 10/29/2019	**Date Final Report submitted:** 01/17/2020	
Date of CIRT meetings: 11/15/2019 01/06/2020	**Number of participants:** 12 14	**Members of the public?** No No

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

Date of report: 05/28/2019 **Assignment decision:** Assign- 10 Days	**Allegation(s):** Neglect by Mother	**Disposition:** Founded

On 5/28/2019, the Department received a report that an 8-week-old child passed away on 5/23/2019. The reporter stated the father alleged the child's mother may have been intoxicated and rolled over on child while bed-sharing.

Prior to the death, Oregon Child Welfare had an open CPS investigation due to a domestic violence incident between the parents. During the initial assessment, the Department learned the family often visited Oregon, but their residence was in Washington State. The child's death occurred in Oregon, and a report was made to Washington State DSHS to aid in both states conducting concurrent investigations.

The Department's CPS worker interviewed the mother who reported feeding the child at 4:00 AM on 05/23/2019. Four hours later at 08:00 AM, the child was found cold and not breathing by a friend of the mother. This friend said the child was propped up on a pillow with the child's chin forward, and nothing was near child's face. The mother was asleep in the bed with her head near the headboard. The child was perpendicular to mother with the child's feet near mother and head toward the edge of the bed. No other concerns were initially reported.

Medical records identified an enlarged mass on the right side of the child's neck. It was believed this mass, along with the positioning of the child's chin, may have cut off blood flow to the child's vein or artery. This led investigators to initially believe that the death was due to the mass. However, on 10/24/2019, the Department received the results from a toxicology screen noting cocaine metabolites detected in both the blood and urine of the child. The degree to which the cocaine and its metabolites contributed to the death could not be determined. Additionally, upon further examination, the mass on the right side of the child's neck was ruled as unlikely to have caused the death.

Subsequent interviews with the mother were documented in medical records and confirmed that she and friends were drinking on the evening before the death of the child. The mother also admitted to regular marijuana use and occasional cocaine use. Furthermore, Washington state Child Welfare records noted the father believed mother was intoxicated the morning of the death. Based on the toxicology reports and the mother's admission of substance use, it was determined the child's fatality was a result of neglect.

At the end of this assessment, neither parent would engage with the Department. Collateral contacts report the parents are still in a relationship and residing in Washington State. The assessment was closed with a founded disposition against the mother and there were no other children in the home.

Description of relevant prior Department reports:

Date of report: 04/26/2019 **Assignment decision:** Assign-24 Hours	**Allegation(s):** Threat of Harm by Father	**Disposition:** Founded

The Department received a report of domestic violence that occurred on 4/21/2019. The father had assaulted the mother and threatened her with a gun. The mother had extensive injuries and was transported to the hospital. This incident occurred in front of their four-week-old infant.

The CPS worker met with the mother who confirmed the details of the report. The child was in a nearby room during the altercation. Collateral contacts and previous police reports described a history of domestic violence by the father. The father claimed this conflict was mutual.

The father reported that he and the mother have problems with alcohol and was open to referrals for treatment. The mother admitted she and the father were drinking the night of the incident but denied that she had a problem with alcohol use. The Department learned the mother was living in Washington and reported the concerns to Child Welfare in Washington State. Washington State DSHS workers contacted mother and child and noted no safety concerns.

The child's death was reported while this assessment was pending.

Description of relevant prior Department reports for Father:
The father of the deceased child had two other children with two additional women. The reports detailed below reference those women and children as: Mother 2, who is the mother of Child 2; and Mother 3, who is the mother of Child 3.

Description of relevant prior Department reports between father and Mother 3:

Date of report: 05/09/2019 **Assignment decision:** Closed at Screening	**Allegation(s):** Neglect by Father & Mother 3	**Disposition:** Not Applicable

The Department received a report that the father is gang involved and selling drugs in front of Child 3 as well as leaving the child unsupervised in order to sell drugs. The father is violent with his current partner who is allegedly prostituting (not Mother 3 or mother of the deceased child). The Department determined there was insufficient information to assign the report for a CPS investigation.

Date of report: 09/19/2019 **Assignment decision:** Closed at Screening	**Allegation(s):** Neglect by Unknown Perpetrator – Child 3	**Disposition:** Not Applicable

The Department received a report that Child 3 was deceased. The Department contacted Washington State where the family resided and verified this information was incorrect. The caller likely confused Child 3 for the father's other infant (deceased child).

Description of relevant prior Department reports between father and Mother 2:

Date of report: 12/05/2011 **Assignment decision:** Assign- 24 Hours	**Allegation(s):** Neglect by Mother 2	**Disposition:** Founded

The Department received a report that Mother 2 recently gave birth to Child 2. Mother 2 had a history of sexual exploitation, drug use, and mental health concerns.

The CPS worker learned Mother 2 attempted to end her pregnancy via self-injurious behavior. Additionally, she engaged in dangerous sexual activities and possibly used crack cocaine while pregnant.

The Department spoke with father, a minor at the time, who denied knowledge of the concerns about the mother. He also denied any drug use, gang, or criminal involvement. He did not have a permanent residence.

The Department offered the mother services, including structured and supportive housing with a focus on education and parenting skills for teenage mother.

Date of report: 02/22/2012 **Assignment decision:** Assign- 24 Hours	**Allegation(s):** Neglect by Mother 2 Neglect by Father Threat of Harm by Mother 2	**Disposition:** Founded Unfounded Unfounded

The Department received a report that Mother 2 assaulted father while he was holding Child 2, concerns about ongoing violence between the parents, and observations the father recently smelled heavily of marijuana.

The Department received two more reports during this assessment: one on 03/12/2012 alleging the parents were “high” from using ‘Spice’; a second on 03/15/2012 reporting that Mother 2 abdicated care of Child 2 to another adult after a domestic violence incident between the parents.

The Department spoke with Mother 2 who described father as violent. Collateral sources reported Mother 2 was also violent with father and neither parent recognized how the violence placed their child at risk. The assessment was concluded as founded as to the mother, and the parents were offered services. Father discussed co-sleeping with child 2 and was cautioned against this. Both parents reported continued drug use, impulsivity, and violence.

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 discussed the Department records which highlighted historical concerns of domestic violence and substance use by the father. Further engagement with the parents may have offered additional insight into parental functioning, however the Department’s contact was limited due to the parents living in Washington State. The CIRT noted this case illustrated barriers to effective, comprehensive and timely communication with families and other state agencies when multiple states are involved in CPS investigations.

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:

In light of the number of families that move between Oregon and its neighboring states, the CIRT recommended the creation of an interstate agreement to establish uniform guidelines, standards, and procedures when CPS investigations are active in multiple states. This agreement will serve as a useful tool to help Oregon address common problems that arise with transient families and further assure child safety. This project will be assigned to the newly formed Child Fatality Review & Prevention Program. A coordinator will be tasked with developing a workgroup to address gaps in communication and resolve barriers when other state statutes differ from Oregon's. Oregon anticipates this work to be ongoing through Spring 2020 with completion by Fall of 2020.