# 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: VTEGJV6MJK** | | |
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| **Date of critical incident:**<br><br>11/29/2019 | **Date Department became aware of the fatality:**<br><br>11/29/2019 | |
| **Date Department caused and investigation to be made:**<br><br>12/02/2019 | **Date of child protective services (CPS) assessment disposition:**<br><br>02/27/2020 | |
| **Date CIRT assigned**:<br><br>12/04/2019 | **Date Final Report submitted:**<br><br>03/10/2020 | |
| **Date of CIRT meetings:**<br><br>12/20/2019 (Initial)<br>02/07/20 (Follow-up) | **Number of participants:**<br>14<br>14 | **Members of the public?**<br>0<br>0 |

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

| **Date of report:**<br>11/29/2019<br><br>**Assignment decision:**<br>Assign- 72 hours | **Allegation(s):**<br>Neglect by Mother & Mother's significant other | **Disposition:**<br>Unfounded |
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On 11/29/19, the Department received a report that Law Enforcement (LEA) responded to the hospital due to a report of a fatality of a six-month-old infant who was pronounced deceased upon arrival. Per the report, the infant was living with the mother, mother's boyfriend, and the boyfriend's six-year-old child in a fifth-wheel trailer. The infant had been put to bed in a play pen on the floor while the six-year-old slept in a sofa bed. The mother's boyfriend reportedly checked on the infant around 1:30 AM and found one of the family's dogs inside the playpen lying on the infant. The boyfriend immediately removed the dog and noticed the infant was blue and cold to the touch. He began CPR and woke the mother. A neighbor came to the trailer to assist with CPR while emergency personnel were called. An ambulance arrived within approximately 15-20 minutes and transported the infant to the hospital where the infant was pronounced deceased. The Department assigned the report as a 72-hour response to assess the safety of the surviving six-year old child.

On 12/04/2019 the caseworker attempted initial contact with the six-year-old child at school as well as at the home with the mother and her boyfriend but was unsuccessful. On 12/06/2019, the CPS worker was able to contact the child at school and later that day conducted a home visit and had contact with the entire family. The home environment which is a 20 ft. travel trailer, was observed to be clean and organized. At the home, the caseworker once again had contact with the six-year-old child who was well groomed and appeared healthy. In describing the circumstances surrounding the fatality, the family reported the infant was placed on their back to sleep in the play pen without additional bedding, blankets or other items. Per LEA's initial response, the playpen was placed on the floor in front of the couch. The family reported the playpen was usually placed on the couch/table that was converted into a flat bed, raised off the floor. While this was the normal routine due to the boyfriend doing nighttime care for the infant and being unable to bend down due to a physical disability, this routine was altered that night because the six-year old child was sleeping on the couch. The dog had reportedly never gone into the playpen prior to their knowledge and they had no reason to believe the dog would try and sleep with the infant. Mother's boyfriend woke to use the restroom in the middle of the night and noticed the infant had not woken up, which was reportedly odd as the child was usually fed during the middle of the night. The boyfriend checked on the infant and noticed the dog in the playpen and that the infant was unresponsive. He woke the mother, called 911 and performed CPR on the infant.

After the infant's death, the parents initially removed the dog, but the dog was later brought back to the home. The Department provided counseling resources to the family. No additional concerns related to the child's death were found and allegations were determined to be unfounded.

## Description of relevant prior Department reports:

*The infant who died was living with his biological mother, her significant other (who was not the infant's father) and his child. The following reports are regarding this surviving child who was present at the time of the infant's death.*

| **Date of report:**<br>12/06/2014<br><br>**Assignment decision:**<br>Closed at Screening | **Allegation(s):**<br>Threat of Harm by father | **Disposition:**<br>Not Applicable |
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On 12/06/2014, the Department received a report that the child's legal guardian, a maternal grandmother, was killed in a car accident and the child did not have a safe caregiver. No further action was taken as the Department determined there was insufficient information to assign the report for a CPS assessment.

| **Date of report:**<br>06/22/2016<br><br>**Assignment decision:**<br>Assign- 24 Hours | **Allegation(s):**<br>Threat of Harm by mother<br><br>Threat of Harm by father | **Disposition:**<br>Founded<br><br>Unfounded |
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On 6/22/2019, the Department received a report that the father contacted LEA to report domestic violence perpetrated by the mother. The father stated the mother was throwing things at him and breaking items in the home. He attempted to leave the home with their child and the mother began throwing knives.

Two days later, another report was received stating that the father, who had an active restraining order against the mother, pushed the mother and broke her arm while their child was present.

A CPS worker met with the family and learned the mother had episodes of rage accompanied by periods of blacking out. She was unable to articulate where her two children were or how they were being cared for or their reactions during these incidents.

The couple's three-year-old son disclosed being fearful of his father's discipline method which included using a belt for spankings.

The Department determined there were concerns of untreated mental health, anger and impulse control issues by the mother. The Department completed a substance abuse treatment referral, however the mother reported that she was already working with a counselor. There was no further information regarding the status of these services. No information was found to substantiate the concerns of domestic violence by the father. Father reported that he had previously completed anger management classes due to his probationary requirements. The father participated in parenting services to learn appropriate disciplinary techniques. At the end of the assessment, the father remained the primary care provider of the child.

| **Date of report:**<br>10/23/2018<br><br>**Assignment decision:**<br>Closed at Screening | **Allegation(s):**<br>Threat of Harm by father | **Disposition:**<br>Not Applicable |
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On 10/23/2018, the Department received a report that the father arrived at the school to pick up his child and began yelling that the child was in "deep shit." This caused the child to begin crying hysterically. It was believed the father was angry because the child had a disruptive behavior report from school. The Department determined there was insufficient information to assign the report for a CPS assessment.

| **Date of report:**<br>04/16/2019<br><br>**Assignment decision:**<br>Closed at Screening | **Allegation(s):**<br>Physical Abuse by father | **Disposition:**<br>Not Applicable |
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On 04/16/2019, the Department received a report regarding the father's history of being domestically violent with the child's mother and significantly physically and verbally abusive to his child and the child's half-sibling. The violence included backhanding the child's mother and using a belt on the children's backs and thighs which resulted in bruising.

The Department determined the information was not current and closed the report without further action.

| **Date of report:**<br>04/30/2019 | **Allegation(s):**<br>Threat of Harm by father | **Disposition:**<br>Not Applicable |
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| **Assignment decision:**<br>Closed at Screening | | |
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On 04/30/2019, the Department received a report that the father was transient and caring for his child. Additionally, the father and his previous partner (not the mother of the deceased infant or the mother of the child in this report) engaged in domestic violence in front of his child and this was a pattern of behavior for the father. The Department determined there was insufficient information to assign the report for a CPS assessment.

| **Date of report:**<br><br>06/26/2019<br><br>**Assignment decision:**<br>Closed at Screening | **Allegation(s):**<br><br>Neglect by Third Party | **Disposition:**<br><br>Not Applicable |
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On 06/26/2019, the Department received a report that the father and his child were residing on property owned by the father's parents and the child disclosed that his grandmother took off her clothing in front of the child, however no additional contextual information was provided. It was also reported the grandmother would use the restroom while the child was bathing and play with the child in the bathtub. The father confronted the grandmother about this information, and she obtained a restraining order and forced them to leave the property.

The report was closed at screening as there was insufficient information to assign the report for 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 Department had some prior involvement with the mother's live-in companion, however the circumstances regarding that involvement were unrelated to the death of this infant. No information provided in the review suggested that the Department or law enforcement could have taken additional action to prevent the death or impact the outcome for the deceased child.

## 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 discussed some inconsistency in the screening decisions noting some of the reports closed at screening may have warranted a CPS assessment. These inconsistencies occurred prior to the entire state being merged into the Oregon Child Abuse Hotline (ORCAH). ORCAH is working on a variety of quality assurance efforts including ensuring consistency in screening decisions.