

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. 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 DHS’ website.

CIRT ID: W2RDD9RWZF		
Date of critical incident: 03/29/2020	Date Department became aware of the fatality: 03/29/2020	
Date Department caused an investigation to be made: 03/30/2020	Date of child protective services (CPS) assessment disposition: 06/30/2020	
Date CIRT assigned: 03/31/2020	Date Final Report submitted: 07/01/2020	
Date of CIRT meetings: 04/20/2020 06/01/2020	Number of participants: 16 16	Members of the public? None None

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

Date of report: March 30, 2020	Allegation(s): Physical abuse by an unknown perpetrator	Disposition(s): Unfounded
Assignment decision: Assign-24 Hours	Threat of Harm by the infant's father	Founded

On 03/30/2020 the Department received a report that a two-week-old infant died unexpectedly the day prior. The mother reportedly found the infant not breathing shortly before 8:00 a.m. on 03/29/2020. She began chest compressions and called 911. The reporter expressed no concerns regarding the fatality and reported the infant's death may have been related to medical issues. There were reported concerns for domestic violence perpetrated by the infant's father. The father was described as verbally and emotionally abusive and previously making statements that he wanted the mother and infant to die. It was further reported that the father struggled with substance use.

The CPS caseworker met with the mother and the 4-year-old sibling. The mother reported that on 03/28/2020 the infant had an abnormal schedule, as they took a four-hour nap. The infant had diarrhea and the mother reported that she consulted with the infant's pediatrician's office, who reportedly encouraged the mother to let the infant sleep. In the evening, the mother placed the infant swaddled in a bassinet to sleep. At 3:00 a.m. on 03/29/2020 the mother awoke to nurse the infant, then returned the infant to the bassinet, swaddled and on their back. The mother reported that when she woke up next around 8:00 a.m. she found the infant unresponsive. The mother called 911 and began CPR.

Law enforcement records supported the mother's narrative and confirmed that the infant's sleep area was observed to be appropriate. Based on medical reports, the infant was determined to have had pneumonia. The infant was born with a cyst on their brain, first found in utero, which was being monitored by medical professionals. After the infant was born, they spent a little over a week in the NICU due to prematurity. The infant was discharged from the hospital on 03/20/2020. On 03/24/2020 the infant had an appointment with their pediatrician. The mother reported that everything went well at that appointment. Medical records confirmed that the appointment was attended on 03/24/2020 and that the provider had no concerns. A follow up appointment was scheduled for 04/07/2020 and the infant was expected to be seen every two weeks to measure their weight gain.

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The infant's father was reported to have moved out of the family home two days prior to the fatality which was confirmed by both parents. Between the infant's NICU stay and the father leaving the home, the father and the infant lived together for about six days. While the father was reported to have aggressive and threatening behaviors, the mother denied any physical violence. The mother reported the father had made threatening statements to her in the past and had gone through her mail and phone before. The CPS caseworker spoke with multiple collateral sources who also reported that the father had been verbally aggressive with the mother, and no collateral contacts reported knowledge of physical violence by the father toward the mother. The mother expressed an awareness of the father's substance use, though during their relationship she believed he only used marijuana. The CPS caseworker met with the four-year-old sibling and observed no concerns.

The CPS caseworker spoke with the father during the assessment. He said that he did not believe he was the father of the infant. The father reported that he struggled with mental health symptoms and self-medicated with marijuana. He reported a history of other substance use and unsuccessful attempts at treatment.

The CPS caseworker found no evidence of neglect or abuse. The allegation of physical abuse was unfounded. The allegation of threat of harm was based on reported coercive behaviors, which were substantiated during the assessment. Therefore, the allegation of threat of harm was founded.

Description of relevant prior Department reports:

Date of report: February 12, 2017	Allegation(s): Neglect by the Maternal Grandmother	Disposition(s): Not Applicable
Assignment decision: Closed at Screening		

On 02/12/2017 the Department received a report that the mother and maternal grandmother had a physical argument where the maternal grandmother hit the mother and pulled her hair. It was unclear whether the 9-month-old sibling witnessed the event. There were no further details regarding the alleged incident.

The Screener determined that the report did not rise to the level of a CPS assessment. The report was closed at screening.

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Date of report: August 13, 2019	Allegation(s): Physical Abuse by the mother's significant other	Disposition(s): Not Applicable
Assignment decision: Closed at Screening		

On 08/13/2019 the Department received a report that the 3-year-old sibling was present when the mother's significant other became violent towards her. The reporter did not have any identifying information for the significant other. It was reported that the mother's significant other pushed the sibling down and punched the mother in the back of the head. According to the reporter, the mother kicked the significant other out of the home. The reporter indicated that the mother had a history of abusive relationships, but that this was the first physical altercation with this significant other.

The Screener determined that the information was concerning, but that the mother took protective steps to end the relationship and had her significant other leave the home. Therefore, the report was closed at screening.

Date of report: March 13, 2020	Allegation(s): Threat of Harm by the infant's father	Disposition(s): Not Applicable
Assignment decision: Closed at Screening		

On 03/13/2020 the Department received a report that the infant and their 3-year-old sibling were at risk of harm due to the infant's father's behaviors. It was reported that the mother disclosed being in an on-again/off-again relationship with him. The relationship reportedly started well but the father drank alcohol and used methamphetamine and was verbally aggressive toward the mother. It was reported that the mother attempted to get a restraining order, but it was denied because she had not been physically harmed by the father. In January 2020 the mother reportedly ended her relationship with the father because of his increased verbal threats and substance use. Some of the father's friends, who were also suspected of using substances, threatened the mother and told the mother she should terminate the pregnancy. It was reported that in February 2020 the mother reunited with the father as he was no longer abusing substances, though he was not reported to be in any treatment program. Additionally, there was information that the newborn infant had a cyst on their brain which would need follow up care.

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The Screener determined that the report would be closed at screening. It was determined that the report did describe behaviors by the father that could pose a risk to the children but did not meet criteria 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:

While it has been determined the fatality was not the result of abuse or neglect and that the child died of natural causes, the CIRT recognized there may have been opportunities to further assess the family at the time of the reports that were closed at screening in August 2019 and March 2020. Any additional opportunities may have involved the assessment of any power and control dynamics by the infant's father towards the mother as well as the level of support for the mother after the infant's birth.

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 did not identify any new recommendations. In May 2020 the Oregon Child Abuse Hotline (ORCAH) implemented a comprehensive training for screeners regarding domestic violence and coercive control behaviors. This training was completed by every screener in May 2020. Screeners have been provided with additional tools to gather information regarding domestic violence. ORCAH management will monitor the implementation of these changes through monthly reviews with each screener and provide coaching for screeners as needed.