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: YH6EYJI108		
Date of critical incident: February 8, 2020	**Date Department became aware of the fatality:** February 10, 2020	
Date Department caused and investigation to be made: February 8, 2020	**Date of child protective services (CPS) assessment disposition:** April 13, 2020	
Date CIRT assigned: February 11, 2020	**Date Final Report submitted:** May 18, 2020	
Date of CIRT meetings: February 28, 2020 (Initial) April 10, 2020 (Follow-Up)	**Number of participants:** 14 17	**Members of the public?** No No

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

Date of report:	Allegation(s):	Disposition:
02/08/2020 **Assignment decision:** Assign: 24 Hours	Neglect	Unfounded

On February 8, 2020 the Department received a report that the six-year-old child was taken to the hospital after the child's caregiver called for emergency services due to the child being unresponsive. The report indicated the child lived with the mother, the child's four-year-old sibling and five-month old twin half-siblings. The child's caregiver was the mother's ex-significant other and reportedly the father of the twins. The ex-significant other reportedly cared for all the children while the mother worked. The ex-significant other told law enforcement he had left the child on the bed for a few minutes while he went outside to smoke a cigarette. When he returned, he found the child unresponsive and began life-saving measures and called for emergency services. The child was taken to the hospital by emergency responders and was declared to have no brain activity. Additional concerns were reported about the condition of the home including a strong odor of pet urine and feces in the carpet.

A CPS caseworker contacted law enforcement who gave an update on the child's condition. The child was reported to be septic, which may have been caused by a combination of the child's recent illness, disability, and diminished immune system. The detective had not spoken to the other children in the home but reported both the mother and her ex-significant other's recollection of the event were consistent. There were concerns for the home environment, specifically the strong odor of urine and feces in the room where the child was found. Based on preliminary conclusions, law enforcement determined there was no evidence of abuse.

The CPS caseworker spoke with the local hospital who explained the child had a very high white blood cell count and was being treated for sepsis. Medical providers presumed the child had likely been sick but was unable to communicate about the illness due to being non-verbal as a result of a disability. The child was transferred to another hospital and doctors there were still unclear about what caused the child's condition. The child was on life support but not expected to survive. There were no signs of abuse and the child's drug test results were negative, which ruled out the possibility the child had ingested any substances. Because the child had been moved to a different hospital, a courtesy CPS caseworker was assigned to make face-to-face contact with the child who was unconscious.

On February 10, 2020 the CPS caseworker received notification that after several tests, the child did not show any brain activity and was declared deceased. A physician at the hospital informed the caseworker that when the child arrived at the hospital, the child presented with swelling of the brain, which doctors presumed was from oxygen deprivation. Additionally, the child's heart and lungs were not functioning correctly, and the child went into cardiorespiratory arrest. The child showed no signs of abuse. The physician was unable to identify a medical reason for the child's condition and concluded the only explanation for the child's cardiorespiratory arrest could be suffocation. Further, the physician felt there were no signs of infection which contradicted the earlier concern that the child was septic.

The CPS caseworker spoke with a community provider for the family who reported no concerns of abuse but did have concerns the child was left alone by the ex-significant other, despite requiring constant supervision due to the child's disability. The CPS caseworker also spoke with the child's primary care physician (PCP). The PCP reviewed the child's hospital reports and reported the child's body temperature was 93.9 degrees upon arrival to the emergency room. The PCP felt this suggested the child was unresponsive for longer than the family had reported.

The CPS caseworker had contact with the child's half-siblings, the mother, and the mother's ex-significant other. The half-siblings were observed to be well-groomed, happy and bonded with both the mother and the ex-significant other. No safety concerns were noted with the general condition of the home. However, safe sleep practices were discussed, and the CPS caseworker recommended the parents remove blankets from the area in which the five-month old twins slept. The mother self-reported marijuana and prescription medication use but denied sharing a sleeping space with the children due to the risk it posed to their safety.

Prior to the child's death, the mother and her ex-significant other reported the child had been sick with a cold and was more affectionate than normal on the day of the incident. The ex-significant other was the child's caregiver and was home with all four children while the mother worked. Thirty minutes prior to the child being unresponsive, the child reportedly ate breakfast, then sat on the bed and played on the iPad. The ex-significant other reported he checked on the child every five to ten minutes and on one of the checks, he found the child slumped over. He reported that he immediately called for emergency services and began life-saving measures. The child was almost completely non-verbal and relied fully upon caregivers. Both the mother and the ex-significant other were observed to be highly knowledgeable about the child's required level of care. Later in the day, the mother brought the child's four-year old sibling to the CPS caseworker's office, however the sibling refused to engage in an interview. The CPS caseworker contacted the child's biological father and set up a home visit. The father reported sporadic contact with his children, the child and the four-year-old sibling.

The CPS caseworker conducted interviews with multiple service providers for the child and no concerns of abuse or neglect were reported. The mother was described as a

good communicator and had always followed through with obtaining resources for her children, especially the child now deceased. The mother also followed through with medical appointments for the child. At the conclusion of the assessment, though the medical providers had differing theories about the child's cause of death, it was determined the child likely developed sepsis from the respiratory issue the child had from the cold and/or flu, which resulted in the child's death. There were no medical findings of abuse or neglect.

The Department determined there was no evidence that the child's death was the result of abuse. Although there were conflicting medical views about the cause of the child's death, the mother, the mother's ex-significant other, and the father were found to have been adequately providing care for the child and the child's siblings. The allegations of neglect by the mother and the mother's ex-significant other were determined to be unfounded.

Description of relevant prior Department reports:

(The deceased child had an older sibling who passed away in 2013. The following information is regarding this child who will be referred to as the sibling).

Date of report: 01/24/2013 **Assignment decision:** Closed at Screening	**Allegation(s):** Neglect	**Disposition:** Not Applicable

On January 24, 2013 the Department received a report regarding concerns of medical neglect for one of the child's siblings, who was ten months-old at the time of the report and is currently deceased. The sibling was born with medical conditions that affected the heart and lungs and required the sibling to be on oxygen and have a nasal feeding tube. The sibling needed heart surgery but needed to gain weight for the operation to occur. The mother and the father were referred to a specialized hospital to monitor the sibling's medical conditions in preparation for the surgery. Hospital staff had ongoing concerns about delays in medical care, failure to attend team meetings, and ongoing weight gain issues. Because of this, an alternative feeding tube surgery was scheduled. The parents missed the scheduled surgery because they overslept, and they missed subsequent appointments to have the surgery rescheduled. The sibling had been hospitalized twice and was diagnosed as failure to thrive. It was reported the sibling had been so ill that a common cold could be fatal. It was noted that if the parents did not make the upcoming medical appointment, medical providers would formally classify the case as medical neglect. The reporter stated the father was volatile with medical staff and difficult to communicate with. Providers also noted the father came to an

appointment where he smelled of alcohol. Additionally, the mother and father had stayed at a housing facility provided by medical providers but were asked to leave due to fighting.

Collateral contact was made with the general medical provider for the sibling who stated the family was consistent with some of the medical appointments, but not the specialized medical appointments.

The Department determined this report did not meet the criteria for a CPS assessment due to the lack of a formal medical neglect diagnosis. If the parents failed to attend the upcoming medical appointment to monitor the sibling's weight gain, the new report would be assigned.

Date of report: 01/29/2013 **Assignment decision:** Assign: 24 Hours	**Allegation(s):** Neglect	**Disposition:** Unfounded

On January 29, 2013 the Department received a follow up report regarding the ten-month-old sibling's medical care. The parents did make the scheduled appointment to monitor the sibling's weight gain in preparation for the feeding tube surgery; however, they were one hour late. The appointment occurred and it was further reported the parents failed to bring the sibling's specialized formula or sufficient oxygen, and the sibling had lost additional weight since the last appointment. As a result, the sibling's feeding tube surgery was further delayed.

The CPS caseworker made initial contact at the parents' home with law enforcement one day after the report was made. The father reported the sibling had significant and rare medical issues. He said the sibling's heart was on the wrong side of the body and had a hole in it. During the conversation, the mother had the sibling out in the cold with them, and the CPS caseworker had to tell the parents several times to take the sibling back inside the home for warmth. The father reported severe weather prevented the family from making two of the three missed appointments at the specialized medical provider. He said the third appointment was missed due to the sibling not sleeping the night before and they had not wanted to wake the sibling up in the morning. These appointments were in place to help monitor the sibling's weight gain and ability to undergo surgery.

The CPS caseworker and law enforcement were allowed into the home. The CPS caseworker observed medical equipment, cans of formula, an oxygen tank and feeding machine. The sibling was on a continuous feeding machine throughout the night, however during the day needed to be fed every three hours. The mother reported the

sibling was about four-months-old when breathing problems began. The sibling was eventually admitted to the hospital for about a month, where they learned of the medical conditions. The family believed the sibling's general medical provider did not recognize the severity of the issues in a timely manner, thus making the conditions worse.

Collateral contact was made with the specialized medical provider who indicated the sibling was supposed to be admitted to the hospital soon to change the feeding tube in hopes the sibling would gain weight. When the sibling was previously admitted, weight gain occurred every day except for the day of discharge from the hospital. The medical provider confirmed the parents had arrived at the appointment without enough oxygen or formula and reported the parents had not known how to mix the formula correctly. The CPS caseworker later learned from the medical provider that the scheduled admittance for the feeding tube surgery did not occur due to an insurance problem. The sibling was due to be seen again in a few days to have the surgery.

The family obtained a new general medical provider on February 4, 2013 for the sibling. When the CPS caseworker contacted that medical provider, no concerns about the family were shared or noted. The medical provider planned on speaking to the parents about the importance of having formula consistently, as well as oxygen.

Several days later, the CPS caseworker learned the sibling had been admitted to have the feeding tube surgery, however had a medical crisis while at the hospital. The Department learned the sibling passed away on March 1, 2013 while still in the hospital due to medical conditions.

The Department determined the allegation of neglect by the mother and the father was unfounded. This finding was determined due to the parents reporting that two of the three medical appointments were missed due to severe weather. In addition, it was learned there was an issue with insurance which delayed the feeding tube surgery.

Date of report: 02/25/2016 **Assignment decision:** Closed at Screening	**Allegation(s):** Neglect	**Disposition:** Not Applicable

On February 25, 2016 the Department received a report of concern for the two-year-old child and another sibling of the child, who was ten months-old at the time of the report. It was reported the family had been without water for over a month, although it had just recently been turned back on. It was unknown how the children were being bathed. Additionally, the family had gone without heat for periods of time and it was unknown if there was heat in the home at the time of the report. The child was reported

to have rotted teeth and needed several of them pulled. This was reportedly due to parental neglect. The parents did not pick up antibiotics for the child in a timely manner. Finally, it was reported that the father had admitted to methamphetamine use, although there were no specifics given about this or when this occurred.

The Department determined this report did not meet the criteria for a CPS assessment.

Date of report: 08/13/2019 **Assignment decision:** Closed at Screening	**Allegation(s):** Neglect	**Disposition:** Not Applicable

On August 13, 2019 the Department received a report that the mother admitted to marijuana use during her pregnancy with the child's twin half-siblings. There was not a drug test completed at the time of the screening call. There were no concerns reported with the mother's parenting or postpartum recovery. The father of the twin siblings, the mother's ex-significant other, was reported to be present, supportive, and appropriate.

The Department determined this report did not meet the 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:

The Critical Incident Review Team recognized that the death of the child was determined to have not been caused by abuse or neglect. While there were two closed at screening reports received during the child's life, there was no direct involvement with or assessment of the child and the family prior to the child's death. The CIRT did not identify any concerns regarding the actions or lack of actions taken regarding this critical incident.

The CIRT discussed the unique history of this family with two children having passed away from complex medical issues. The CIRT noted opportunities for additional support and education regarding identification and assessment of intermittent neglect appearing in the case history.

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 Critical Incident Review Team discussed the closed at screening reports in this case. These calls were received prior to the centralization of the Oregon Child Abuse Hotline (ORCAH). 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. In addition, the Child Fatality Prevention and Review team has invited the ORCAH CQI manager to provide ongoing review of screening reports on cases that result in a CIRT. This new process will allow an objective review of screening decisions and provide an avenue to make recommendations and determine improvement opportunities when deemed necessary by the CIRT.

Enhanced training efforts for Child Welfare staff began in 2019 to further improve and strengthen casework practice when assessing for neglect, specifically chronic neglect, which is complex and can be difficult to identify. Training sessions have already been offered to and completed by line managers. Due to COVID-19, previously scheduled training sessions for caseworkers were postponed. Trainers are currently determining other modalities to provide this comprehensive training and coaching to staff.