Critical Incident Review Team Final Report

Oregon Department of Human Services
CHILD WELFARE

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 (ODHS). The reviews are called by the Department Director to quickly analyze ODHS actions in relation to the critical incident and to ensure the safety and well-being of all children within the custody of ODHS 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 the ODHS website.

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<tr><td colspan="3">CIRT ID: 0ML6UA6Q67</td></tr>
<tr><td>Date of critical incident:

April 16, 2025</td><td colspan="2">Date Department became aware of the fatality:
April 24, 2025</td></tr>
<tr><td>Date Department caused an investigation to be made:

April 20, 2025</td><td colspan="2">Date of child protective services (CPS) assessment disposition:

July 15, 2025</td></tr>
<tr><td>Date CIRT assigned:

April 28, 2025</td><td colspan="2">Date Final Report submitted:

Due August 6, 2025</td></tr>
<tr><td>Date of CIRT meetings:

May 20, 2025
July 3, 2025</td><td>Number of participants:
13
16</td><td>Members of the public?
No
Yes</td></tr>
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Description of the critical incident and Department contacts regarding the critical incident:

Date of report:	Allegation(s):	Disposition(s):
April 18, 2025		
Assignment decision:	No Allegation	Not Applicable
Closed at Screening		

On April 18, 2025, ODHS received a report the child, who was one month old, had been trampled by a dog two days earlier while at a park with their mother, father and other family members. The child reportedly sustained serious injuries as a result of this incident, which would have lifetime impacts if they survived. It was reported that on the day of the incident the child was laying on a blanket at the park when the maternal grandmother noticed a frisbee flying toward the family and a dog chasing it. The dog ran across the child then a person picked the dog up and quickly left the scene. The child reportedly cried immediately after the incident then settled down, was given a bottle, and fell asleep. Since the child settled down quickly and had no observable injuries, the family returned home. Around 8 p.m., the grandmother went to wake the child to feed them and noticed some discoloration, but it did not seem to be a bruise or injury. The child appeared to be minimally responsive and did not fully wake, so the family decided to closely monitor them. By 3 a.m., the child's condition began to decline, and the family brought them to the hospital. The child was admitted to intensive care experiencing seizures and was diagnosed with extensive brain injuries. The screener noted due to most of the child's injuries being internal, their demeanor being described as calm after the incident and their willingness to feed and sleep, there was little the family could have observed that would have indicated they needed to be brought in earlier. The reporter said it was unknown whether bringing the child into the hospital earlier would have made a difference. Both parents were reported to be persons with intellectual disabilities. The mother was said to have learning disabilities, anxiety and a limited ability to comprehend. She reportedly required support from family members and service providers to get through her day. The father was also reported to have intellectual disabilities but was not receiving services for those disabilities. The reporter

did not know why law enforcement was not contacted regarding this incident or why the family would report the child was trampled by a dog when it appeared to be a much more serious concern. The report was closed at screening as it did not include an allegation of abuse. This incident was assigned for assessment on April 20, 2025, after further information was received.

Date of report: April 20, 2025	**Allegation(s):** Physical Abuse by the father Neglect by the mother	**Disposition(s):** Founded Unable to Determine
Assignment decision: Within 24 hours	Neglect by the grandmother and step-grandfather	Founded

On April 20, 2025, ODHS received a report stating the parents and a relative were lying to the hospital when they stated the child's injuries were caused by being trampled by a dog. The reporter said they believed the maternal grandmother was responsible for concocting the story. They stated on April 15, 2025, the father became upset, took the mother's phone away and threw it, striking the child in the head. On the following day, the child was left in the father's care for the first time. When the mother and the grandmother returned home, they found the child unresponsive, and the father told them they had been trampled by the mother's service dog in the home. The grandmother attempted to revive the child by placing them in cold water. After an unknown period of time, another relative arrived at the home and stated the child needed to be taken to the hospital. The child was said to have a lump on their head where they were hit by the phone, as well as injuries to the arteries in their neck and to their liver. The child did not have any claw or bite marks that would indicate being injured by a dog. There were concerns reported the father was using substances and several months prior he had said he had used methamphetamine. The father was reported to storm out of the room during arguments and slam

chairs when he was angry, but it was unknown whether he had ever been physically aggressive with the mother. The mother's relatives allowed the father to stay with the family to prevent the mother from leaving the child to be in an unhealthy relationship with the father. The reporter said the mother had a learning disability and tended to believe things that were not true. An allegation of physical abuse to the child by the father was assigned for CPS assessment with a 24-hour response time. The allegation in this report was assessed along with allegations made later on the same day, and the results are documented in a single report.

Later, on April 20, 2025, ODHS received a report the child had no brain activity and there was a plan to discontinue their life support on April 22. The reporter stated the child's condition was due to blunt force trauma to their body as well as a delay in medical care. The reporter said on April 16, 2025, the mother returned home at 3 p.m. and noticed the child, who had been in the father's care, was not eating and was not tracking her voice. The mother called the grandmother who advised her to put a wet wipe under the child's chin. The mother said this helped a little and put the child down for a nap. The grandmother arrived home at 9 p.m. to find the child almost completely unresponsive and with bruising on their head and torso. The reporter believed this bruising would have been visible prior to 9 p.m. The grandmother decided to give the child a bath to wake them then put them back to bed. The grandmother, step-grandfather and the mother then all went to bed. Another relative came home at 3 a.m. and insisted the child be taken to the hospital. The family did not call 911 and decided to drive to a children's hospital, despite there being four other hospitals that were closer. The mother and grandmother did not say why they delayed medical care for the child. The step-grandfather said they delayed care due to fear ODHS would become involved. The grandmother instructed the father, the mother and the step-grandfather to tell hospital staff the child had been trampled by a dog at the park to avoid ODHS involvement. When the child arrived at the hospital, they were hypothermic, and the child abuse pediatrician said the delay in getting them medical care was a significant factor in the child's inability to recover from their injuries. The reporter stated the mother was a person with cognitive delays, was not able to make appointments on her own, and was unable to understand information unless it was broken down into smaller pieces and explained multiple

times. The mother was said to not fully understand what happened to the child. The grandmother and step-grandfather were reported to be her guardians and made many decisions for her. The grandmother and step-grandfather were also believed to have some cognitive delays. Allegations of neglect to the child by the mother, grandmother and step-grandfather were assigned for CPS assessment with a 24-hour response time. The allegations in this report were assessed alongside the allegation of physical abuse to the child by the father that was assigned earlier in the day and the results were documented in a single report.

On April 20, 2025, the CPS caseworker received an update on the child's injuries, then interviewed the grandmother and step-grandfather. The CPS caseworker staffed the case with an on-call supervisor then interviewed the mother. On April 21, 2025, the CPS caseworker visited the child in the hospital then participated by phone in a staffing with medical providers and law enforcement before speaking with the step-grandfather by phone. On April 22, 2025, the CPS caseworker interviewed the father. He insisted the child was trampled by the mother's service dog in the home and ended the interview. Later, the CPS caseworker spoke with a detective assigned to the case. On April 23, 2025, the CPS caseworker acquired photos of the home from law enforcement. The CPS caseworker spoke with a medical provider then called a detective assigned to the case. The CPS caseworker then reviewed the family's child welfare history. On April 24, 2025, the CPS caseworker spoke by phone with the step-grandfather. The CPS caseworker staffed the case with their supervisor and later spoke by phone with law enforcement. On May 2 and May 6, 2025, the CPS caseworker received and reviewed the child's medical records. On May 9, 2025, the CPS caseworker interviewed the mother and grandmother.

Based on the interviews with family members, law enforcement, medical providers, collateral contacts, and a review of records, the CPS caseworker summarized the events leading up to and following the critical incident.

At the time of the child's birth on March 4, 2025, the mother's family requested a safety code be put on their hospital room door due to the mother being the survivor of past domestic violence perpetrated by the father. Due to feeding problems, the child's pediatrician set up weekly well child checks to monitor their weight and feeding. The mother brought the

child to two of these appointments but missed subsequent ones until the child was seen again on April 17, 2025. When the child was approximately two weeks old, the mother and child moved in with other maternal family members. The family resided in two adjoining motel rooms. The child, the mother, the grandmother, a maternal aunt and the aunt's two children stayed in one hotel suite comprised of two bedrooms and a living room. The child's step-grandfather, great grandfather and maternal uncle resided in the adjoining room. When the child was approximately one month old, the father moved into the motel room. The grandmother and step-grandfather both expressed concerns about the father's violent and aggressive behaviors and said they were fearful of him.

On the morning of the critical incident, the mother and the grandmother both reported the mother and father were on a video call with a friend when the father became upset and threw his phone at the wall, which bounced off and struck the child in the head. The child began crying and was observed to have a red mark on their head. Shortly after that incident, the child was left in the father's care while the mother went with the grandmother's partner to make food deliveries, and the grandmother left for her job. Two other maternal relatives left the room around 1 p.m. resulting in the father being unsupervised with the child from approximately 1 p.m. to 3 p.m. At approximately 3 p.m., a relative, who was in the adjoining hotel room, called the mother to report the father had texted them saying he couldn't do this anymore and asked the relative to get him out of there. The mother returned to the hotel, then called the grandmother to say the child wasn't right. They were sleeping and refusing to feed as they normally did. The grandmother advised the mother to rub the child's cheek with a wet wipe to wake them. At approximately 7 p.m., the mother reported the child was behaving unusually, their breathing was not normal, and their eyes were not tracking her voice as they normally did. The grandmother returned to the room around 8-9 p.m. and found the child to be lethargic and not able to wake. The grandmother decided to bathe the child, and the family went to bed. At approximately 3 a.m. the next morning, a relative arrived, and after observing the child, urged the family to take them to the hospital. The grandmother drove the mother, father, step-grandfather and child to a children's hospital despite there being several other hospitals closer to their home. During the drive to the hospital, the family developed a false story as

to how the child received the injuries, saying they were trampled by a dog at the park. The grandfather later said the family developed this story due to fears ODHS would remove the child from the mother's care if the truth were to come out.

When the child was admitted to the hospital, they were hypothermic and struggling to breathe. The child was intubated and placed in a warmer. They were diagnosed with extensive brain injuries they would never be able to fully recover from. Medical staff said the child's brain injuries were consistent with a crush injury where pressure was placed on their skull resulting in diffused blunt force trauma. The child also had bruising under their jawline indicating possible strangulation. The father was arrested by police on the day of the incident. The child died on April 23, 2025, and their death was determined to be a homicide. The father was charged with two counts of murder in the second degree and one count of assault in the first degree.

When law enforcement responded to the family's motel room, they found it to have piles of dirty laundry in the bedrooms and living area, the oven door was broken with shards of glass under it, the sink was piled high with dirty dishes. Mold was found around the bathroom sink and tub, dog feces were found throughout, and the room smelled of urine.

When asked why the child had not been brought to the hospital sooner, the grandmother said she did not believe their injuries were severe enough while the step-grandfather said he was in the adjoining motel room and was not aware of the injuries prior to being woken to go to the hospital. The mother appeared to not understand the concerns the CPS caseworker was asking about and looked to the grandmother to provide answers about them.

The allegation of physical abuse to the child by their father was determined to be founded as the child was in his sole care when they were fatally injured and after which the father was arrested and charged with murder and assault. The allegations of neglect to the child by their grandmother and step-grandfather were determined to be founded as they delayed medical care for the child, exacerbating their injuries.

The allegation of neglect to the child by their mother was coded as unable to determine as while she did hesitate to access medical care for the child,

her cognitive disabilities resulted in her being unable to fully understand the situation and the impact of delaying care.

Date of report: April 20, 2025 **Assignment decision:** Closed at Screening	**Allegation(s):** No Allegation	**Disposition(s):** Not applicable

On April 20, 2025, ODHS received a report containing additional information regarding allegations of physical abuse to the child by the father. The reporter stated there were text messages from the father admitting he had become angry with the child and threw his cell phone, which bounced off of a wall and struck the child in the head. No one else was in the room with the child and the father when this occurred. The father was said to have just come into the child's life about two weeks earlier and had been left alone with them for approximately three hours when the incident occurred. The father was said to yell at the mother, was controlling of her, and would become angry when he did not get his way. The child was reported to be on a ventilator and their only brain activity was when they would have seizures. The neurosurgeon had stated they expected the family would need to make a decision about discontinuing life support in the next few days. The report was closed at screening as it was not a new report of abuse. An assessment had already been assigned earlier in the day for an allegation of physical abuse to the child by the father.

Description of relevant prior Department reports under the case name of the child's mother:

Date of report: March 7, 2025 **Assignment decision:** Closed at Screening	**Allegation(s):** No allegation	**Disposition(s):** Not applicable

On March 7, 2025, ODHS received a report the mother had given birth to the child three days earlier. The child was still admitted to the hospital due to being born prematurely and having feeding problems. The mother was said to have cognitive delays, struggled to process information and would leave her prenatal appointments early. The mother was reported to be behaving appropriately but appeared to be slow in comprehending information regarding the child's care. Staff had to repeat themselves multiple times when speaking to her about safe sleep practices. The mother's parents were present at the hospital and there were no concerns for their behaviors. The reporter stated the father was not known and no other persons were present for the birth other than the mother and her parents. The report was closed at screening as it was not a report of abuse.

Description of relevant prior Department reports under the case name the child's aunt, mother of the other children residing in the home at the time of the critical incident: (In the following reports the deceased child's aunt is referred to as the mother and the deceased child's uncle is referred to as the father)

Date of report: July 29, 2024 **Assignment decision:** Within 72 hours	**Allegation(s):** Threat of Harm by the father	**Disposition(s):** Unfounded

On July 29, 2024, ODHS received a report the child's cousin, who was 1 year old at the time, was being exposed to domestic violence perpetrated by the cousin's father against their mother. Their father was said to frequently accuse the mother of cheating on him and during a recent phone call to the mother, the father could be heard in the background screaming at her. He was overheard saying the mother was the leaseholder on their apartment and therefore she could not leave him. On another occasion, he was heard to say he would destroy the mother's possessions if she were to leave. The mother was asked by text if she and her child felt safe in the home with the father and she did not respond. The reporter felt someone was monitoring her text messages. The mother was said to have cognitive

disabilities that affected her decision making, and the father had isolated her from her family and friends. The reporter stated the father had a history of being physically aggressive with his own mother and had gone after her with a pair of scissors during their child's baby shower. The mother was reported to be pregnant and due in October 2024. An allegation of threat of harm to the child's cousin by their father was assigned for CPS assessment with a 72-hour response time.

On July 30, 2024, the CPS caseworker staffed the report with their supervisor then left a voicemail for the reporter asking for a return call. The CPS caseworker then made an unscheduled visit to the family's home. A relative answered the door and initially said the mother was not at home, until she came to the door. The CPS caseworker had contact with the mother, the father and the child's cousin. The mother denied any power and control issues between her and the father and said everything was fine. She reported being six months pregnant. The father said he had COVID-19 and declined to be interviewed. The parents denied the CPS caseworker access to the home as it belonged to a relative who was not at home at the time to grant access. The door was open during the CPS caseworker's interaction with the family and nothing concerning was observed. On August 2, 2024, the CPS caseworker made another effort at contacting the reporter and left another voicemail for them. A review of records documented the father was also a person with cognitive disabilities. The CPS caseworker later spoke by phone with a relative who reported both parents were persons with cognitive delays. The relative denied ever seeing any injuries to the mother though she did say the mother had become distant from relatives on her side of the family and she had concerns for the father's control over her.

The allegation of threat of harm to the child's cousin by their father was determined to be unfounded as their mother denied any abusive or controlling behaviors by the father and no collateral information was gathered that would support the allegation.

Date of report:	**Allegation(s):**	**Disposition(s):**
April 21, 2025		Unfounded

Assignment decision: Within 72 hours	Threat of Harm by the deceased child's father	

On April 21, 2025, ODHS received a report that the child's 22-month-old and 7-month-old cousins were residing in the same home as the child when the child's father caused potentially fatal injuries to them. The child was not expected to survive. The cousins' family were said to be residing in two adjacent motel rooms. Their mother, aunt and grandmother resided in one room, and their father and grandfather resided in the other room. The cousins reportedly spent time in both rooms and were in their father's room at the time the child's father assaulted the child next door. The child's father was said to have been living with the family for a few weeks prior to the incident and had never provided care to the child's cousins. Allegations of threat of harm to the child's cousins by the child's father were assigned for CPS assessment with a 72-hour response time. The allegations in this report were assessed together with allegations assigned for assessment on April 25, 2025, and the results were documented in a single report.

On April 22, 2025, the CPS caseworker visited the family outside the motel room where they were residing. The child's 22-month-old cousin presented with stitches near their eye, cuts around their mouth and scratches to their face, which the parents said were the result of a dog bite that occurred the previous day. The parents reported the child's cousin had been seen at the hospital after the incident occurred. When asked about their children's contact with the deceased child's father, the mother said he had never been alone with her children. She stated her children were always with her, their father or their grandmother. The cousins' parents said they did not trust the deceased child's father or feel safe around him. Later in the day, the CPS caseworker interviewed the deceased child's father in jail; he denied ever being alone with his child's cousins but chose not to complete a comprehensive interview.

On April 24, 2025, the CPS caseworker interviewed the grandmother who denied the children were ever left alone with the deceased child's father.

The allegations of threat of harm to the deceased child's cousins by the deceased child's father were determined to be unfounded as all persons interviewed denied the deceased child's father had ever been unsupervised

around the children, and they were not present when he physically abused the child.

Date of report: April 25, 2025 **Assignment decision:** Within 72 hours	**Allegation(s):** Neglect by the mother and father	**Disposition(s):** Founded

On April 25, 2025, ODHS received a report a dog had bitten the deceased child's 22-month-old cousin on April 21 while they were in the care of their parents. The child's cousin was taken to the emergency room, and their parents were instructed to give them antibiotics, which they failed to do. According to the parents, the child's cousin was attacked by a stranger's dog at the park, but the reporter stated the mother had told the father it was one of the family's dogs. The deceased child's 7-month-old cousin was not injured. It was reported the mother went to pick up the antibiotics on April 22, but at the time the boys were seen for medical appointments on April 24, the 22-month-old had still not received any medication and had an infection on their face due to a lack of care. Hair follicle testing was completed on both children, and both were positive for cannabis and methamphetamine. Allegations of neglect to the child's cousins by their parents were assigned for CPS assessment with a 72-hour response time. The allegations in this report were assessed together with allegations assigned for assessment on April 21, 2025, and the results were documented in a single report.

The CPS caseworker was already aware of the incident and allegations as they had been working with the family for several days and had attended the medical appointment for the children on April 24, 2025. During the medical appointment, it was learned neither child had received any medical care since their births. The family had no medical insurance for the children and the children had no primary care provider. Urine drug screens were not able to be completed due to the children being dehydrated but hair follicle testing was positive for THC and methamphetamine.

Police body camera video of the family's living environment obtained by the CPS caseworker revealed concerning conditions for child safety. Piles of dirty laundry were in the bedrooms and living area, the oven door was broken, and shards of broken glass from it were under the door. Dirty dishes were piled high in the sink. The bathroom was moldy. Dog feces were observed throughout, and the room reportedly smelled of urine. A marijuana bong, a torch, a metal spatula and a white sticky substance were on a table within reach of the children.

On May 21, 2025, the CPS caseworker spoke with a relative who stated the mother had said it was one of the family's dogs that attacked the older child.

During the course of the CPS assessment, the CPS caseworker accompanied the children to medical appointments where the younger child was found to be in the less than first percentile for height and head circumference and their weight was found to be in the 10th percentile. The younger child was diagnosed with flat head syndrome and was referred for a helmet. The older child was found to have speech delays as well as delays in gross motor skills and social interaction.

The allegations of neglect to the child's cousins by their parents were determined to be founded. The parents failed to follow through with medical care after the older child was attacked by one of the family's dogs, resulting in an infected wound. Both children had medical needs the parents were not meeting, both children tested positive for methamphetamine, and the parents failed to maintain a safe and sanitary living environment for them.

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 identify any concerns regarding actions taken or not taken by ODHS or law enforcement agencies in response to the critical incident or the events that led to it. It was determined the March 7, 2025, report made shortly after of the child's birth was not a report of abuse. The information received at that time was the father was unknown, and the mother was being supported in caring for the child by her parents, who

were reported to be behaving appropriately. The subsequent report was the report of the critical incident that led to the child's death.

The CIRT noted the child's death qualified for a mandatory CIRT review due to the fact another child in the home, the deceased child's cousin, was the subject of a report of abuse in the 12 months preceding the child's death. At the time of the fatality, the child had only been residing in the same hotel room as their cousin for a few weeks and the CPS assessment regarding the cousin was completed prior to the child's birth.

Lastly, the CIRT recognized the parents of the deceased child and of the deceased child's young cousins were reported to be persons with intellectual disabilities. The importance of appropriately providing information, services and supports to all persons with intellectual and developmental disabilities in a format that meets their individual needs was discussed by the team as was improving communication between Child Welfare staff and staff from the Office of Developmental Disabilities Services when a person with intellectual and/or developmental disabilities is receiving services from both agencies.

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 make any new 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, however a multi-phase review of identification and practice improvement needs for children and families experiencing intellectual and/or developmental disabilities is currently occurring within ODHS Child Welfare with the goal of improved safety and service delivery practice. The CIRT supports these current and future efforts.