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.

<table>
<tr><td colspan="3">CIRT ID: 2QIUOKQMFO</td></tr>
<tr><td>Date of critical incident:

October 2, 2024</td><td colspan="2">Date Department became aware of the fatality:

December 6, 2024</td></tr>
<tr><td>Date Department caused an investigation to be made:

December 6, 2024</td><td colspan="2">Date of child protective services (CPS) assessment disposition:

February 14, 2025</td></tr>
<tr><td>Date CIRT assigned:

December 11, 2024</td><td colspan="2">Date Final Report submitted:

March 21, 2025</td></tr>
<tr><td>Date of CIRT meetings:

January 3, 2025
February 10, 2025</td><td>Number of participants:
14
21</td><td>Members of the public?
No
No</td></tr>
</table>

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

Date of report:	Allegation(s):	Disposition(s):
December 6, 2024	Neglect by the mother	Founded
Assignment decision:	Neglect by the father	Founded
Within 24 Hours		

On December 6, 2024, the Oregon Department of Human Services (ODHS) received a report alleging neglect to the infant child and the older siblings, who were ages 10, 3, and 1, by the parents. Law enforcement (LEA) responded to concerns about the family and learned the infant child was born and delivered in a tent on the family's rural property on July 27, 2024, without any medical oversight or follow-up. The father stated at birth, the infant's tongue was fused to the bottom of the mouth and the infant was unable to keep down formula. The father further stated the infant was born thin and was unresponsive to sight and sound. The father was concerned for the child but didn't feel the concerns warranted medical attention. The mother also shared that she was concerned for the child's health after birth. The parents provided various accounts of the child's health and well-being, at one time reporting the infant was a stillborn and another time stating they survived until October 2, 2024. Both parents provided several reasons why they did not obtain medical attention, such as lack of transportation and needing to charge a cell phone. The mother eventually stated she should have put her foot down and obtained medical attention, but there was physical abuse to her by the father and she was afraid to argue with him. According to the parents, the infant child was sharing a sleep surface with the parents the night of October 2, 2024, and the father woke to find the infant deceased. The parents reported the infant's grave was about 30 feet from the home under a burn pile. The parents were arrested and charged with crimes related to the conditions the surviving siblings were found in. This included but was not limited to significant hygiene concerns,

malnourishment and dental decay. The home environment did not have running water, nor a hygienic way of toileting. This report was assigned to CPS for assessment.

Though the screening report was dated December 6, 2024, LEA had contacted the local ODHS office and coordinated an afterhours response to the family's residence with the on-call CPS caseworker on December 5, 2024. At the time of contact, the CPS caseworker spoke with the parents and children with LEA present. The state of the home and the condition of the children was significantly concerning. ODHS sought protective custody of the children, and the parents were taken into custody by LEA. While in custody, statements were made that indicated the infant child was cremated by the father.

During the CPS assessment, out-of-state child welfare records were obtained from three different states that showed a history of houselessness and transient lifestyles by the parents. The family was consistently found to be lacking basic living necessities such as shelter, food and transportation. Safety supplies and clothing supplies for the children were often provided by child welfare agencies. Records showed the 10-year-old and 1-year-old siblings were birthed without medical oversight or follow-up. The 3-year-old sibling was born in a hospital and was positive for methamphetamine at birth. Records showed concerns for domestic violence by the father and substance use by the parents. Additionally, it was learned the father had a history of biting and harming infant children, including a child from a previous relationship for which he was criminally prosecuted.

Throughout the assessment, the assigned CPS caseworker attempted to contact relatives of the parents, however, it seemed the parents were quite isolated from their natural supports. Other collaterals who were known to the family were contacted, however, these individuals declined to speak on their knowledge of the condition and state of the family and children. One relative, who was in contact with the mother, stated the mother reported while delivering the infant, the father broke the baby's leg, then suffocated and cremated the infant. The mother also told this relative the child was born in a house setting, and when the father broke the child's leg during delivery, he stuck a gun in the mother's mouth and told her not to call 911.

Based on the information provided by the parents, the children, relatives, it appeared the siblings had minimal exposure to education as well as minimal medical and dental attention.

The allegations of neglect to the children, including the infant child, by their parents, were coded as founded and an ongoing safety plan was developed for the surviving children.

Description of relevant prior Department reports:

Date of report:	**Allegation(s):**	**Disposition(s):**
January 1, 2024 **Assignment decision:** Closed as Screening	Not Applicable	Not Applicable

On January 1, 2024, ODHS received a report with concerns that parents were living in an older style RV with their children who were ages 9, 2, and 11 months. It was reported the family recently moved to Oregon from another state when their motorhome broke down. The father reported he was heating the motorhome using a combination of propane and a wood pellet stove. It appeared the father was burning trash and had the windows open to prevent carbon dioxide poisoning. The children were observed in the RV by the reporting party; however, the father would not allow the reporting party to speak with the children.

It was determined this report did not meet criteria for a CPS assessment and was closed at screening.

Date of report:	**Allegation(s):**	**Disposition(s):**
July 1, 2024	Neglect by the mother Neglect by the father	Unable to Determine Unable to Determine

Assignment decision: Within 24 Hours		

On July 1, 2024, ODHS received a report alleging neglect to 10-year-old, 3-year-old, and 1-year-old children by their parents. It was reported that law enforcement responded to several calls from individuals in the community who reported concern for the state of the children, stating they smelled like feces, urine, and appeared dirty. Law enforcement contacted the family in the community and noted the children did not appear to have bathed in over a week, though the family reported they showered the day prior. The 1-year-old had mold on their shirt and the 3-year-old urinated on himself the day prior and hadn't been cleaned or changed. The children reported they had not eaten breakfast, and one child did not have the proper safety car seat. It was determined this report met criteria for an assessment and was assigned to CPS.

The family was located by the CPS caseworker in the community of a different county than their primary residence. After this initial contact, the case transferred to a CPS caseworker in the county of the family's residence. The assigned CPS caseworker in the county of residence made many attempts to engage the parents by phone, home visits, and through collateral contacts, but these attempts were unsuccessful, and contact did not occur again in this assessment.

When the first CPS caseworker was assigned this case, they contacted law enforcement, who had contact with the family in the community and had concerns for the children's size and hygiene. Documentation seems to indicate law enforcement was present when CPS contacted the family. At initial contact, it was learned the family lived a homesteading lifestyle and had experienced a flat tire while driving to their property from visiting a relative out of state. They had recently purchased and moved to a plot of land and lived in a tent until one of the three structures on the property could be cleaned up enough to reside in. The structure had electricity but did not have running water. The parents indicated they had an outhouse for a restroom and would fill up jugs from a community spring tap for drinking

water. It was learned the family either bathed at a truck stop or occasionally in a motel room.

The 10-year-old was not enrolled in school and none of the children had primary care providers established. The 10 and 1-year-old were both birthed at home. The 1-year-old had not received any routine care. The parents had access to medical insurance through OHP as well as WIC services. The mother confirmed she was pregnant but stated she did not need, nor had she obtained, any prenatal care. The parents reported marijuana use but denied other substances. Pull-ups, diapers, clothes and a car seat were secured for the family.

Child Welfare records from Washington State, where the family previously resided, were requested. The father had two other children he had not parented as he had a history of biting and harming his infant children, which resulted in criminal charges. It was additionally learned that of the three children, the 3-year-old was the only one born in a hospital. Upon birth, that child tested positive for methamphetamine. An out-of-state child welfare agency attempted to intervene and safety plan for the children, however, the intervention did not lead to a legal removal of the children. Instead, the family was assigned an ongoing caseworker to help provide services to the family.

At the conclusion of this assessment, the allegation of neglect by the parents to the children was unable to determine.

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:

Though it was acknowledged ODHS had limited opportunity to engage with this family prior to the critical incident, the CIRT discussed missed opportunities in the CPS assessment from July 2024.

Upon initial contact, which occurred while the family was traveling through a county outside of their residence, ODHS appeared to engage the family effectively and address some of their immediate and basic needs before the family left to return to their county of residence. At that time, ODHS was not aware of the father’s pattern of violent behaviors toward infant children

and out-of-state child welfare records had not yet been obtained. The CIRT noted the limitations and at times inability at the screening level to timely obtain and analyze out-of-state child welfare records to inform screening decisions. The CIRT also discussed the challenges and barriers experienced by CPS when attempting to assess child safety during initial contact without safety critical information available from out-of-state child welfare records.

During the continuation of the July CPS assessment, diligent efforts were made to obtain out-of-state child welfare records, which were received while the assessment was still open. Based on concerning information about the family's child welfare history, particularly the father's prior abuse to infants, the case was staffed with a CPS safety consultant who recommended CPS pursue a protective custody order. While attempts were made to contact the family, they were unsuccessful, and a protective custody order was not pursued prior to the CPS assessment closing.

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 recommends the Safety Program re-evaluate a current MOU (memorandum of understanding) between the Oregon and Washington child welfare agencies and explore any partnership opportunities for timely information sharing regarding families who may be in various states of transit or transitions from state to state. The CIRT supports the ongoing collaboration already in progress with Washington's child welfare agency and emphasizes the urgency to prioritize timely sharing of information.

The CIRT additionally recommends the Safety Program explore a process for developing a standardized documentation framework and follow-up process when providing guidance and direction on time-sensitive child safety decisions, particularly at critical junctures involving immediate safety planning and legal intervention. The exploration should begin immediately with guidance completed and disseminated no later than July 2025.

Furthermore, it is recommended that the local district develop and implement a case staffing process when Child Safety consultants and the local branch do not agree on whether legal intervention is required or

necessary. This case staffing process will require an immediate staffing with a program and/or a district manager, and child safety program representative to ensure that all parties are informed, and all potential concerns are addressed. Additionally, any decisions resulting from the staffing with the program and/or district manager should be documented in a case note and should include reasons and justification for decision making. The development of this case staffing process should begin immediately with the process in place and implemented no later than May 2025.