Critical Incident Review Team
Final Report

A Critical Incident Review Team (CIRT) 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 service 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 posting of the report. Versions of all final reports are posted on the ODHS website.

CIRT information

CIRT ID: SWCUQ8OMVY

Date of critical incident: May 16, 2025

Date Department became aware of fatality: May 16, 2025

Date Department caused an investigation to be made: May 20, 2025

Date of CPS assessment disposition: August 27, 2025

Date CIRT assigned: May 23, 2025

Date Final Report submitted: August 29, 2025

Date(s) of CIRT meeting(s): June 12, 2025, July 28, 2025

Number of participants: 18, 26

Members of the public? No, Yes

Critical incident description

Date of report: May 16, 2025

Assignment decision: Within 72 hours

Allegation(s): Neglect by Resource Parent

Disposition(s): August 27, 2025

On May 16, 2025, ODHS received a report that a resource parent found a 4-month-old child face down in the bassinet and not breathing around 7:30 a.m. The resource parent contacted 911 and child was transported to the hospital where the child was declared deceased at 8:10 a.m. The resource parent reported waking up earlier that morning at 3 a.m. to change the child's diaper. The child was fed later at approximately 6 a.m. The child historically did not feed well, and that morning was coughing and choking during meals and only taking partial bottles. The resource parent put the child back to sleep in the bassinette at approximately 7 a.m. then took a shower before finding the child face down and not breathing. The child's bassinet was said to have a foam pad on the bottom and bumpers on the side. There was no blanket, but a sock and a baby wipe were found inside. No evidence of substance use was found in the home. There was an outward facing camera outside the bedroom door, and the resource parent said they would provide police with access to the video. The deceased child's 8-year-old sibling was placed in the same resource home but was at school at the time of the incident. It was further reported the deceased child had significant health problems. The deceased child was diagnosed with a virus that can cause short- and long-term health complications especially in children exposed prenatally to the virus. On the day prior to the death, the deceased child had a two-hour supervised visit with the mother. The mother was reported to have a past history of fentanyl use. During the visits, the mother would have skin-to-skin contact with the deceased child. This report was initially closed at screening, however on May 20, 2025, it was determined to be a report of abuse and an allegation of neglect to the deceased child by the resource parent was assigned for CPS assessment with a 72-hour response time.

On May 20, 2025, the CPS caseworker attended a case staffing attended by district and local office leadership, the local safety consultant, the child safety program manager, as well as the permanency caseworkers and supervisors for the children placed in the resource parent's home. The CPS caseworker then contacted the resource parent to schedule a home visit. The CPS caseworker spoke with the permanency caseworker for the two siblings of the deceased child.

On May 21, 2025, the CPS caseworker met with the resource parent at the home. The resource parent provided detailed information regarding the deceased child's medical care, sleeping and feeding positions, routines, and the events leading up to the death. The resource parent advised the child was always placed on their back to sleep and was laid in a bassinet located in the bedroom at approximately 7 a.m. on the morning of the critical incident. The resource parent reported they showered, checked on the child who remained on their back, and observed the child to be making familiar sounds common to them when sleeping. The resource parent went downstairs briefly and returned upstairs where the child was found lying face down and not breathing. The child was immediately picked up by the resource parent who took them downstairs and requested 911 be called. The resource parent reported starting CPR immediately.

The resource parent described the child as being unwell with an ear infection, persistent congestion, coughing, wheezing, and grunting in the days prior to the critical incident. The resource parent sought medical care for the child approximately two weeks prior and was given antibiotics, which were administered as prescribed. By May 11, 2025, the child was reported to be needing to be suctioned daily with thick mucus coming from their nose. The resource parent advised they were planning to contact the child's pediatrician because of concerns of worsening respiratory illness. The resource parent advised the child was fed in an upright position and held in that position for several minutes. The child was also sometimes held in an upright position to sleep while held by the resource parent. The resource parent noted the child would demonstrate breathing issues when laid down on their back during this period of time.

The resource parent advised that they received safe sleep literature and information from the hospital at the time of the child's NICU discharge as well as from the child's pediatrician and ODHS contracted nursing staff. They advised the bassinet observed in the home at the time of the CPS interview was the same as had been in the home throughout the child's placement.

The resource parent advised that both the bassinet and pad with attached bumper (commonly known as a Dock-a-tot) had been purchased through Facebook Marketplace just prior to the child's hospital discharge and placement in the home. It was observed to have a gray fabric mattress with short round bumpers; the mattress was the same shape as the bassinet, and the mattress had a slight upward slope near the area where the upper torso would be placed for sleep.

The resource parent advised the child began rolling over approximately two weeks prior and expressed there were concerns due to the child having difficulties pushing themselves up when their arms were at their sides. The child was able to lift their head and turn side to side, and if their arms were upward, could lift themselves up. The resource parent indicated they spoke with the child's pediatrician about this on May 9, 2025, and a referral was made for the child to have an EEG and MRI in June 2025 to rule out any neurological concerns.

The CPS caseworker reviewed police reports regarding the death before returning to the resource parent's home later in the afternoon to have face-to-face contact with the other adult and the other children in the home. No safety concerns were observed. The CPS caseworker requested the deceased child's medical records from multiple providers.

On May 22, 2025, the CPS caseworker requested photos and security camera footage of the resource parent's home from law enforcement then requested the medical examiner records regarding the death. On May 23, 2025, the CPS caseworker attended the 3-day fatality staffing on the case. On May 28, 2025, the CPS caseworker attended a sibling group supervision meeting.

The CPS caseworker reviewed case file documents including a Safe Sleep Checklist completed on March 3, 2025, and a Nursing Intake Assessment completed on March 3, 2025, which noted the child was born premature at 30 weeks and 3 days, with a birthweight at 3 lbs. 12 oz. The child was substance affected and tested positive for methamphetamines. The Personal Care Assessment completed on March 13, 2025, noted in the section titled Mobility, Transfer, Repositioning, two sections were checked indicating the child required special positioning, monitoring or attention during the day, due to a medical condition and child requires frequent positioning, monitoring or attention during night-time hours. Also noted by the resource parent, the child has reflux and has had a couple of apnea evens while sleeping. The Safe Sleep Checklist noted the resource parent is skilled and aware of safe sleep practices and has cared

for multiple infants. The sleep surfaces were noted to be free of concerns in the above documents. Follow-up inquiries to the involved professionals yielded a lack of recall of any concerning sleep surfaces or recalled observation of the second bassinet in the upstairs bedroom.

The CPS caseworker consulted with a local Medical Director/Designated Medical Provider who advised the child experienced a younger developmental age due to their prematurity at birth. The DMP indicated that the virus the child was diagnosed with could cause medical problems as can in-utero substance exposure. The DMP was not able to provide definitive information regarding the child's conditions as medical records were reviewed rather than direct examination. The Designated Medical Examiner did not note anything suspicious during the autopsy but deferred final conclusions to pending lab/toxicology results, which would take several months to completed.

On August 19, 2025, the DMP provided an update to the caseworker explaining that there was no evidence of viral disease based on labs or in the child's eye exams, so that virus could not solely be blamed for the child's death. The DMP noted that a Dock-A-Tot is not recommended for safe sleep practices, but many parents and caregivers utilize them despite published concerns about their use contributing to infant death. The DMP stated that the child's prematurity, known and unknown complications of fetal development due to substance use exposure in utero, diagnosis of a virus with unknown developmental and neurological impacts, and unsafe sleeping conditions, placed the child in a higher risk category of infant death.

Safety threshold criteria were examined, with conclusions being the child's vulnerability was noted to meet safety threshold criteria, but no other criteria were met. The CPS assessment was coded as unfounded for the allegations of neglect to the child by their resource parent. After reviewing hospital records, intake and personal care assessments, associated law enforcement reports including video reenactment and photographs of the residence and consultation with involved medical professionals, it was determined the unsafe sleeping item could have contributed to the child's death, but no indication of neglectful actions were present. The resource parent believed the item was appropriate and did not appear to understand the danger presented by the presence of the Dock-a-Tot.

Relevant case history under mother's case:

Date of report: November 22, 2022

Assignment decision: Within 24 hours

Allegation(s): Threat of Harm by Mother

Disposition(s): Unfounded

On November 22, 2022, ODHS received a report alleging threat of harm to the deceased child's newborn sibling by their mother. It was reported the mother gave birth, tried to avoid testing for substances, and self-reported using marijuana, alcohol, and methamphetamine during pregnancy.

On November 23, 2022, the CPS caseworker contacted the mother, the newborn sibling and another sibling. During the CPS assessment, the CPS caseworker also contacted all the deceased child's siblings, contacted or attempted contact with the siblings' fathers, and contacted relatives. It was learned the mother was engaged in services, and the CPS caseworker documented that information gathered and observed supported the mother being able to safely parent.

At the conclusion of the CPS assessment, ODHS determined the allegation of threat of harm to the deceased child's newborn sibling by their mother was unfounded.

Date of report: January 12, 2023

Assignment decision: Closed at Screening

Allegation(s): Not Applicable

Disposition(s): Not Applicable

On January 12, 2023, ODHS received a report alleging the mother smoked marijuana in front of the children in the home. The children included the deceased child's 1-month-old, 6-year-old, 8-year-old, and 13-year-old siblings as well as 6-year-old and 9-year-old children that are not related to the deceased child. Contact with the mother and children did not support the siblings being impacted by the behavior. ODHS determined the report did not meet the criteria to assign for CPS assessment and was closed at screening.

Date of report: March 28, 2023

Assignment decision: Within 24 hours

Allegation(s): Threat of Harm, Neglect by Mother

Disposition(s): Unfounded

On March 28, 2023, ODHS received a report alleging threat of harm to the deceased child's 4-month-old, 6-year-old, and 13-year-old siblings by their mother and neglect of the same children and the 8-year-old sibling also by their mother. It was reported the family has limited food resources and, while caring for the children, the mother was exhibiting behaviors consistent with substance use, such as unable to sit still or focus, confusion, and delusional. The mother reportedly denied current substance use.

On March 29, 2023, the CPS caseworker contacted the child's 8-year-old sibling and their father. During the CPS assessment, the CPS caseworker also contacted all the children, the mother, school personnel, other caseworkers engaged with the family, relatives, and medical staff. The fathers of each child were either contacted or contact was attempted. It was learned the mother self-reported and tested positive for methamphetamine. It was also learned there was ample food, and the mother's statements that appeared delusional were based in reality. The CPS caseworker documented observing the mother for an extended period with the children and having no concerns about the mother's ability to parent and manage an unregulated emotional and behavioral state.

At the conclusion of the CPS assessment, ODHS determined the allegations of threat of harm and neglect to the deceased child's siblings by their mother were unfounded.

Date of report: June 15, 2023

Assignment decision: Within 24 hours

Allegation(s): Neglect by Mother

Disposition(s): Founded

On June 15, 2023, ODHS received a report alleging neglect of the deceased child's 13-year-old and 6-year-old siblings by the mother, who was said to be using methamphetamine, and stated wanting the 13-year-old child to be removed and placed in foster care to keep the younger

children safe. The 13-year-old had reportedly repeatedly demonstrated unsafe behaviors to the 6-year-old child. This report was assigned for CPS assessment.

ODHS received additional reports on June 20, June 21, and June 22, 2023. The information reported was assessed and documented together under the June 15, 2023, report. Each screening report is identified separately, and casework activities are summarized under this June 15, 2023, report.

On June 15, 2023, the CPS caseworker contacted the mother, and the deceased child's 13-year-old, 6-year-old, and 7-month-old siblings at the campground. The mother reported needing to imminently move a trailer out of the campground where the family had been residing. The CPS caseworker arranged for gas cards to facilitate the move. The CPS caseworker also contacted the father of the 7-month-old child and the family's permanency caseworker.

On June 21, 2023, the mother contacted the ODHS office requesting assistance, and a caseworker met with the mother and 6-year-old and 7-month-old children in the community. The mother requested they be taken to a shelter because the family trailer was towed. The caseworker attempted to transport the family to a hotel for the night with a plan to check on the trailer. While driving to the hotel, the mother stated law enforcement intended to kill them and then requested to go to a store and went in with the children while the caseworker waited outside. After approximately 40 minutes the caseworker went in and could not find them.

Also on June 21, 2023, the CPS caseworker contacted a former caseworker for the 6-year-old child's father to acquire the father's contact information. The CPS caseworker then contacted the family's permanency caseworker who reported being with the family earlier in the day and staffing the case with their supervisor. The CPS caseworker then contacted the hospital and learned the mother was behaving as if under the influence of substances but had not been tested. The mother was reported to be displaying erratic behaviors, was treating the 6-year-old child roughly, and there was concern the mother would drop the 7-month-old child. It was confirmed the mother had tested positive for methamphetamine at the hospital on June 9, 2023. The CPS caseworker, their coworker, and a relative contacted the mother and two of the children in the hospital room. The mother was observed to have unexplained bruises and admitted poor self-care. The mother admitted using methamphetamine in the morning to keep up with the 6-year-old child. The mother also shared being diagnosed with borderline

personality disorder but reported not taking medication in 30 days. Once the mother and two children were cleared for discharge, the CPS caseworker transported them to a hotel.

On June 22, 2023, the CPS caseworker and a coworker responded to the hospital and learned the mother had called 911 from the hotel stating the 6-year-old child was coughing, had an iron deficiency, was malnourished, and was having seizures. When first responders arrived at the hotel, the 6-year-old child had no signs of experiencing a seizure. There was no record of the mother being diagnosed with a mental health condition, but a relative reported the mother was diagnosed with bipolar disorder and refused to take medication for it. Both children were examined, and no signs of abuse were found. The CPS caseworker and their coworker asked the mother what occurred since the CPS caseworker dropped them at the hotel the prior evening, the mother responded the family had no food or access to food at the hotel. The CPS caseworker reminded the mother of declining the offer to get food. The mother stated the children were sick and needed evaluation. Safety planning occurred for the 7-month-old and 6-year-old children.

On June 27, 2023, the CPS caseworker interviewed the 13-year-old child. They disclosed their mother started exhibiting erratic and paranoid behavior about a month earlier. The CPS caseworker contacted multiple other relatives, including the fathers of the child's 9-year-old and 7-month-old siblings. They all disclosed observing significant changes in the mother's behaviors since May 2023.

At the conclusion of the CPS assessment, ODHS determined the allegations of neglect by the mother to the 13-year-old and 6-year-old children assigned for CPS assessment on June 15, 2023, were determined to be founded as throughout the assessment the mother was unable or unwilling to care for the 13-year-old and had left the 6-year-old in the care of the 13-year-old despite being an unsafe arrangement. The allegations of threat of harm by the mother to the 13-year-old, 6-year-old, and 7-month-old children assigned for CPS assessment on June 21, 2023, and threat of harm by the mother to the 6-year-old and 7-month-old children assigned for CPS assessment on June 22, 2023 were determined to be founded as the mother's unstable and erratic behavior, substance use, and unmanaged mental health conditions resulted in being unable to safely care for the children placing them at threat of severe harm. The allegation of threat of harm by the mother to the 9-year-old child assigned for CPS assessment on June 21, 2023, was determined to be unfounded as the 9-year-old was residing with their father at the time of the CPS assessment and was not impacted by the mother's behaviors.

Date of report: June 20, 2023

Assignment decision: Closed at Screening

Allegation(s): Not Applicable

Disposition(s): Not Applicable

On June 20, 2023, ODHS received two reports alleging concerns for the deceased child's 6-year-old and 6-month-old siblings because of their mother's behavior. The reports concerned the mother reportedly sharing information on social media such as being in a hit and run car accident while with the 6-year-old child causing a broken windshield, and that all the children needed to be tested for a parasite. Reportedly, it was stated by the mother that someone was going to kill the mother and the children, and the 6-year-old child had cut themself with a knife. The mother reportedly had a history of substance use and appeared to have relapsed due to dark circles under eyes and losing 10-15 lbs. in the past two weeks. The mother was reported to have been diagnosed with depression, bi-polar disorder, and a personality disorder. The 6-year-old child's father was also reported to be using substances, living out of state, and had not been in touch with the child since October 2022. The 13-year-old child was said to be out of the home.

The screener contacted the family's caseworker who said the mother had mental health problems, including paranoia, but had no concerns for the safety of the children. The windshield was said to already be broken prior to the accident and there was already awareness of the 6-year old's knife wound. It was reported the mother was currently on the way to the ODHS office.

ODHS determined the reports were closed at screening as there was no allegation of abuse and there were current open CPS assessments regarding many of the concerns in the reports. The CPS caseworker did not mention these reports in their CPS assessment. See report dated June 15, 2023, for details.

Date of report: June 21, 2023

Assignment decision: Within 24 hours

Allegation(s): Threat of Harm by Mother

Disposition(s): Unfounded

On June 21, 2023, ODHS received a report alleging threat of harm to the deceased child's 13-year-old, 9-year-old, 6-year-old, and 7-month-old siblings by the mother. Reportedly, the mother and children were transported to the hospital by ambulance and the mother was suffering from suspected methamphetamine-induced psychosis. The mother stated the children were infested with insects and had insect bites, which was determined not to be true. The mother reported being sexually assaulted and was said to have bruises on legs and buttocks but would not provide a statement to law enforcement about the assault. The mother was behaving irrationally and yelling at the children. Reportedly, the mother was seen at the hospital about 10 days earlier and had tested positive for methamphetamine at that time.

ODHS determined the report was assigned for CPS assessment. The reported information was similar to information previously reported and assigned for CPS assessment therefore it was determined the new allegations would be addressed in the open CPS assessment. See report dated June 15, 2023, for details.

Date of report: June 22, 2023

Assignment decision: Within 24 hours

Allegation(s): Threat of Harm by Mother

Disposition(s): Founded

On June 22, 2023, ODHS received a report alleging threat of harm to the deceased child's 6-year-old and 7-month-old siblings by the mother. Reportedly, the mother returned to the hospital requesting the 6-year-old and 7-month-old children be tested for everything. The mother stated the 6-year-old experienced a seizure and there was concern for the 7-month-old. The mother's behavior was described as erratic, manic, and paranoid.

ODHS determined the report was assigned for CPS assessment. The reported information was similar to information previously reported and assigned for CPS assessment therefore it was determined the new allegations would be addressed in the open CPS assessment. See report dated June 15, 2023, for details.

Date of report: December 25, 2024

Assignment decision: Closed at Screening

Allegation(s): Not applicable

Disposition(s): Not Applicable

On December 25, 2024, ODHS received a report alleging the mother was pregnant, having severe abdominal pain, and using substances to manage the pain. It was also reported the mother stated this after being told to go to the emergency room despite having gone to the emergency room already and not having the pain resolved.

ODHS determined the report did not meet the criteria to assign for CPS assessment and was closed at screening.

Date of report: January 16, 2025

Assignment decision: Within 72 hours

Allegation(s): Threat of Harm by Mother

Disposition(s): Founded

On January 16, 2025, ODHS received a report the mother gave birth on the previous day. The child, now deceased, was born premature and was expected to be in the NICU for 3-4 weeks. The mother tested positive for methamphetamine at the time of birth. The birth was via C-section and the mother was expected to be hospitalized for approximately three days. The mother's 8-year-old and 2-year-old children were under the care of the mother as part of an in-home safety plan at the time of the birth, so alternative arrangements were made for their care while the mother was hospitalized. Arrangements were also made for the 15-year-old child. The mother's 10-year-old child was said to be residing with their father. Allegations of threat of harm by the mother to the deceased child and the deceased child's 8-year-old sibling were assigned for CPS assessment with a 72-hour response time.

On the day the report was made, the CPS caseworker staffed the case with their supervisor, other caseworkers, and spoke with a social worker at the hospital.

On January 17, 2025, the CPS caseworker met with the mother at the hospital and observed the child in the NICU. The mother reported relapsing on methamphetamine the weekend prior to the birth. The mother also reported experiencing significant pain, hemorrhaging, and seeking

help from medical providers prior to reaching out to a friend for methamphetamine. The mother explained using methamphetamine enhanced energy and productivity when caring for the children and self. The CPS caseworker then met with the 15-year-old child and a relative at the mother's home. Next, the CPS caseworker interviewed the 8-year-old child at the ODHS office. Information gathered supported the 8-year-old being threatened with a knife and hit by the 15-year-old, as well as having reasons to fear the mother's friend and fear returning home if mother's friend was there. The CPS caseworker observed the 2-year-old child and spoke with the 2-year-old child's father.

On January 22, 2025, the CPS caseworker spoke with the family's caseworker and learned the 15-year-old child started school and the mother completed an assessment for a housing program. The CPS caseworker spoke with a hospital social worker and learned the child was still being fed through a tube, no longer on a CPAP, breathing without assistance and expected to be hospitalized for at least 2-4 weeks. The CPS caseworker spoke with the mother about the relapse, the status of services, the 15-year-old child's enrollment in school, as well as housing and transportation barriers.

On January 23, 2025, the CPS caseworker learned the deceased child's meconium screening was positive for methamphetamine. On the following day, the CPS caseworker met with the mother and provided a gas card to assist in visiting at the hospital.

On January 31, 2025, the CPS caseworker spoke to the hospital and learned the mother was visiting daily and there were no concerns for the mother's behavior. The deceased child's feedings were going well.

An allegation of threat of harm by the mother to the 15-year-old was assigned on the day of the birth and during this CPS assessment an allegation of threat of harm to the 2-year-old was also added.

The allegations of threat of harm to the 15-year-old, 8-year-old, two-year-old, and the now deceased, then newborn child were determined to be founded as the mother used methamphetamine in the home while providing care. The mother was unable to provide care due to substance use.

Date of report: February 3, 2025

Assignment decision: Within 72 hours

Allegation(s): Neglect by Mother

Disposition(s): Founded

On February 3, 2025, ODHS received a report the mother had been in a car accident two days earlier. There were concerns the mother was under the influence of alcohol at the time. The mother was life flighted to the hospital after the accident. The mother was said to be unable to speak and unable to plan for the deceased child's 15-year-old sibling who was living in the mother's home at the time of the accident. It was reported there were no relatives willing to take the child; however, adults were checking in. An allegation of neglect by the mother to the 15-year-old child was assigned for CPS assessment with a 24-hour response time.

On the day the report was made, a CPS caseworker who had an open CPS assessment with the family, made contact with a social worker for the mother and learned the mother would spend at least a week in intensive care then would need to be assessed for services. It was confirmed the mother's blood alcohol content at the time of the accident was 0.127. On the following day, the CPS caseworker assigned to this report interviewed the 15-year-old child at the mother's home. It was learned the 15-year-old child was home alone since the mother's accident, but family friends had checked in and provided food. There was no plan for care while the mother was hospitalized. The CPS caseworker unsuccessfully attempted to contact the 15-year-old child's father at several phone numbers obtained through an absent parent search. The CPS caseworker then interviewed the mother at the hospital where a plan for care was developed.

On February 5, 2025, the CPS caseworker interviewed the mother at the hospital. The mother admitted driving while intoxicated and expressed interest in engaging in services. The CPS caseworker and a coworker unsuccessfully attempted to locate the father of the 15-year-old child at two addresses obtained through an absent parent search. On February 12, 2025, the mother left the hospital against medical advice and reported wanting to stay with friends while waiting on services.

On February 28, 2025, the CPS caseworker interviewed the mother. The mother reported using methamphetamines and fentanyl after leaving the hospital until services were in place. It was determined the mother used amphetamines, benzodiazepines, fentanyl, and THC. On March 25, 2025, the mother stopped engaging in services and at the conclusion of the CPS assessment the mother's whereabouts were unknown.

The allegation of neglect by the mother to the 15-year-old child was determined to be founded as no arrangements for the child's care were made prior to the accident or following leaving the hospital.

Concerns regarding actions taken or not taken

The Critical Incident Review Team (CIRT) acknowledges the complexity of reviewing cases involving multiple vulnerabilities and a pending cause of death. The CIRT identified the potential presence of confirmation bias in this case, stemming from an overreliance on the expertise of an experienced resource parent who had previously cared for numerous infants and was reported to have a medical background. In addition, nurses are widely recognized as subject matter experts in infant safe sleep practices due to their formal education, clinical training, and ongoing professional development. This reliance may have contributed to the Department deferring to the judgment of these individuals, rather than conducting a fully independent assessment of all sleep environments. As a result, critical evaluation of the setting may have been inadvertently limited.

It is important to note that the sleep environment where the critical incident occurred was believed to be safe at the time, having been observed by a nurse and selected by the experienced resource parent. However, the widespread commercial availability of products such as the Dock-A-Tot, combined with subtle changes to the sleep surface and the infant's heightened vulnerability due to multiple medical issues, underscored the need for heightened vigilance no matter the level of experience. Consistent application of safe sleep standards must occur across all placements.

The CIRT identified several opportunities to strengthen Department practices in alignment with the broader goal of reducing and ultimately eliminating child fatalities.

Recommendations for improvement

1. Strengthen Safe Sleep Training for Resource Parents

The Foster Care Program to explore enhancements to annual or biennial certification training requirements for Resource Parents. Updates should include expanded content on safe sleep practices that incorporate discussions about commercially marketed infant products, particularly those that may not meet safe sleep standards.

Timeline:

- Exploration and development to begin no later than October 31, 2025
- Implementation of training changes by January 1, 2026

2. Enhance Staff Capacity for Safe Sleep Conversations and Evaluation

ODHS child welfare programs including CPS, Child Fatality Prevention & Review, Permanency, Training & Workforce Development, and Health & Wellness Services to review existing safe sleep training for staff and expand training for meaningful engagement with the material. This may include live discussions, role-playing scenarios, and other applied learning methods focused on how to effectively engage caregivers in conversations about the safety of infant sleep environments. Training should also emphasize how to conduct thorough in-person evaluations of all known infant sleep environments.

Timeline:

- Exploration and planning to begin no later than October 31, 2025
- Implementation of expanded opportunities to begin no later than February 2026

3. Update Documentation Tools to Improve Safe Sleep Monitoring

The *Safe Sleep Checklist* to be revised by the Child Fatality Prevention and Review Program in partnership with the CPS Program. The revision should include an additional prompt that guides staff to initiate discussions with caregivers about any known product recalls or emerging safety concerns related to commonly used sleep surfaces. This prompt should encourage staff to reference current recall databases. Additionally, the checklist should clarify when it must be completed specifically during initial and ongoing face-to-face contacts to ensure regular review of all surfaces used for infant sleep or play. This includes reassessing environments where previously observed sleep surfaces may have changed or been replaced, in order to identify potential risks introduced by new or secondhand products. An evaluation of the *Safe Sleep Checklist* should also include a review of optional considerations such as photos of all sleep areas to determine if this or others should be required.

Timeline:

- Exploration of potential revisions to begin no later than October 31, 2025
- Form revisions, if determined beneficial, submitted by January 1, 2026

4. The Permanency & Reunification Program will review current guidelines for *Confirming Safe Environments* and evaluate the inclusion of additional observation and documentation requirements when an infant is placed in a foster home. These additions would supplement and not replace the existing *Safe Sleep Checklist*. The proposed enhancements may include, but are not limited to, the following:

    - Sleep surfaces
    - Sleep positioning practice as reported by all caregivers
    - Bedding and items
    - Room sharing
    - Environmental factors

Timeline:

- Review of current guidelines to begin immediately and any proposed additions to be developed and implemented by January 2026
