

## 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: 76J7NZRJBS

**Date of critical incident:** October 23, 2025

**Date Department became aware of fatality:** October 23, 2025

**Date Department caused an investigation to be made:** October 23, 2025

**Date of CPS assessment disposition:** January 16, 2026

**Date CIRT assigned:** October 28, 2025

**Date Final Report submitted:** February 5, 2026

**Date(s) of CIRT meeting(s):** November 14, 2025; January 6, 2026

**Number of participants:** 20; 24

**Members of the public?** 0 ; 0

## Critical incident description

**Date of report:** October 23, 2025

**Assignment decision:** Within 24 hours

**Allegation(s):** Threat of Harm; Neglect

**Disposition(s):** Founded

On October 23, 2025, ODHS received an allegation of neglect to the 2-month-old child and an allegation of threat of harm to the child's 2-year-old half-sibling by the parents. The child was brought to the hospital around 8 a.m. by the parents due to their unresponsiveness. The child was pronounced deceased at 8:38 a.m.

The child showed signs of lividity that would indicate the child was sleeping on their stomach rather than the back as what was described by the parents. The parents had been living with a family that recently had their children removed due to substance use and concerns of neglect. The report indicated concerns of bed-sharing, substance use by the parents, unsanitary living conditions and neglect in general. There were posts on social media where the father was awake at 4 a.m. or 5 a.m. taking pictures of the child, but for some reason when he found the child unresponsive, the parents did not call 911. It was unclear if the parents had a vehicle to transport the child to the hospital. This was assigned with a 24-hour response.

The CPS caseworker made announced contact with the family on October 24, 2025. The parents were in the home along with some relatives at the time of contact. The half-sibling was also observed during this contact. They were seen with scratches on their face that appeared consistent with the explanation of getting scratched from falling while pushing a toy. The CPS caseworker made note of observing sleeping areas of the children and the parents. The children had separate sleeping areas: a bassinette sitting within about a foot from the parents' bed and a pack and play at the foot of the bed. There were no dirty diapers, rotting food observed or other concerns that had been previously mentioned in the parents' home.

Although there were no noted safety concerns with the condition of the home, the roommates had their own child welfare case that created a concern for exposure of substance use to the half-sibling. The CPS caseworker also requested a urine analysis from the parents. These results later confirmed marijuana use by the mother and alcohol use by the father. The CPS caseworker and family agreed to stay at a hotel due to the concern of the sibling being in the home. When the CPS caseworker attempted to follow up with the family by phone, each call to the parents went directly to voicemail.

On October 27, 2025, the CPS caseworker received information from a relative the child might have passed away from sudden infant death syndrome (SIDS). This concerned the relative because both parents use marijuana and bed shared. An additional concern disclosed by the relative was the mother knew she would sleep through the children crying. Even though the parents had a bassinet for the child, they would still often share their bed with them. When the CPS caseworker followed up with the local law enforcement detective, it was shared they did not believe anything criminal occurred but did believe the father may have bed shared. The relative shared similar information that was reported to ODHS the previous month.

On October 28, 2025, ODHS received a report the parents would drink and drive while they were heavily intoxicated. The half-sibling was often seen wearing only a diaper and was not fed often. On this same day, the parents contacted the CPS caseworker to inquire about any results from the autopsy or drug screens for the child. The mother had indicated information was shared with her that the child tested positive for SARS-COVID 2 and passed away from SIDS. When the CPS caseworker followed up with medical professionals, they shared they did not know where this information came from. ODHS learned that it would be a minimum of two to three months before knowing a cause of death. It was confirmed that the child had no internal or external signs of injuries or abuse.

On October 29, 2025, ODHS received new allegations of neglect to the half-sibling by the mother and father as well as the roommates in the home where they lived prior to the child passing away. There was also an allegation of a threat of harm to the half-sibling by one of the roommates. It was reported the parents did not call 911 when they found the child unresponsive because they were residing where they were not supposed to, per ODHS. The roommates had a history of child welfare involvement due to exposing their own children to methamphetamine and fentanyl. One of the roommates is believed to have overdosed on fentanyl a year prior and all the residents in the apartment complex knew about this. The

parents did not know the roommates prior to moving in with them and left the half-sibling with the roommates when the child was taken to the hospital. This report was assigned with a 24-hour response.

This new report was assessed along with the current report. On October 30, 2025, the CPS caseworker conducted an unannounced visit to the local motel where the family was reportedly staying; however, the family was not present. It was learned that they had recently left in a vehicle with an unidentified individual. The caseworker then proceeded to the family's previous address after being informed the mother might return there, despite the agency advising her that the location was unsafe for children. The former roommates answered the door and confirmed that the family no longer resided there. They provided the CPS caseworker with the motel information where the family had been staying.

On October 31, 2025, the CPS caseworker attempted another unannounced contact at the local motel. This time the motel staff informed the caseworker the family had checked out earlier in the morning. The CPS caseworker was able to schedule a contact at the former residence and see both the half-sibling and the mother. The CPS caseworker observed the half-sibling to be dressed appropriately for the weather and healthy. They did not observe any concerns for the of the half-sibling's safety or well-being during this contact.

On November 3, 2025, ODHS received test results back from the half-sibling's hair strand test. It confirmed the sibling had been exposed to cannabinoids and methamphetamine. The local designated medical professional confirmed the test results were consistent with environmental exposure. Both parents were unable to say how the half-sibling tested positive for cannabinoids and methamphetamine. The mother was described as having a history of allowing the children around unsafe people and exposed them to environments where substances were used. There were also allegations in ODHS records of the roommates using these substances.

Throughout the course of this CPS assessment, collateral contacts confirmed the parents struggled with parenting and functioning that could have impaired their ability to choose an appropriate living arrangement that would keep both children safe. They also struggled with the use of marijuana and alcohol that may have impacted their parenting and functioning further. The father provided a urine analysis in October that resulted with alcohol being present in the test. The mother also provided a urine analysis that resulted in a presence of marijuana metabolite. ODHS continued to monitor the care of the half-sibling with a safety plan

implemented in the home with the parents monitored by relative safety services providers. On November 25, 2025, ODHS took protective custody of the half-sibling and continued to monitor their safety while in the care of the parents with the support of safety service providers.

At the conclusion of the CPS assessment, the allegation of neglect to the child by both parents was founded. There was indication that the child was placed face down at the time of their passing and was in a high-risk sleep environment, despite the parents being given prior education.

The allegation of neglect to the half-sibling by the mother and the child's father was founded. The half-sibling tested positive for methamphetamines and marijuana, was left with unsafe caregivers and neither adult was able to explain how the half-sibling was exposed to the substances. Further, the mother and child's father lack impulse control, and this has impacted their parenting behaviors, which have impacted the half-sibling's safety.

The allegation of threat of harm to the half-sibling by the mother and the child's father was unable to be determined. There was no information provided during the assessment that domestic violence was occurring in the home.

The allegation of neglect and threat of harm by the roommates is unable to be determined. While the half-sibling was exposed to substances in the home where the roommates resided and used substances, there is not definitive evidence this is where the half-sibling was exposed.

## Relevant case history

**Date of report: October 10, 2025**

**Assignment decision: Closed at screening**

**Allegation(s): N/A**

**Disposition(s): N/A**

On October 10, 2025, ODHS received a report the parents moved into a home with the 1-month-old child and 2-year-old half-sibling, where there were previous safety concerns due to violence between other adults in the home. The roommate's children were removed due to this violence. ODHS determined the report did not meet the criteria to assign for CPS assessment and was closed at screening.

**Date of report: September 30, 2025**

**Assignment decision: Within 24 hours**

**Allegation(s): Neglect/ Physical Abuse**

**Disposition(s): Unable to Determine**

On September 30, 2025, ODHS received an allegation of neglect to the 1-month-old child and their 2-year-old half-sibling by both parents. There was also an allegation of physical abuse to the half-sibling by the mother. It was reported both children wore diapers, and their bottoms were red and blistered. The child would cry for at least 30 minutes waiting for the mother to wake up. The children were not able to eat until the mother woke up, which was usually around 10 or 11 a.m. The child had fallen off the bed twice when they were left unattended on the parents' bed. The parents did not seem concerned with this level of supervision for an infant and would tell people to keep a listen for the child. The mother would flick the half-sibling's chest as a form of discipline. This has left a red mark for at least a couple of hours. This report was assigned with a 24-hour response.

On October 1, 2025, the CPS caseworker attempted contact with the family at the last known location, which was a local motel. The family had already checked out and initially the mother did not answer her phone. However, the CPS caseworker was able to see the mother and children at the local business where both children were observed but too young to be interviewed. The father was still at work at the time of this contact. The family was staying with friends at a local Airbnb. The children appeared healthy at the time of contact, and the mother was provided pack n plays for both children. The Safe Sleep Checklist was completed with the mother and CPS caseworker.

On October 13, 2025, ODHS contacted the family at the residence of two individuals known to the agency relating to unsafe behavior. The CPS caseworker did not note any concerns for the children, and there were no observed injuries. During this contact, both parents demonstrated an understanding of safe sleep practices, the Safe Sleep Checklist was completed, and both parents were provided education. The mother described both children as healthy, and the CPS caseworker observed the child placed on their tummy, actively kicking and moving their arms. Relatives described the child as a very active infant. The child's half-sibling was described as a

hearty eater, and they were born with a condition that could cause development concerns in the future.

The parents denied any type of physical discipline including flicking the half-sibling in the chest or hitting them in the back of the head. They indicated using time-outs. The mother denied she ever dropped the child and said she would have sought medical attention if that were true. Relative collaterals were spoken to, and they indicated never observing the child being dropped, only hearing something that sounded like they were dropped. The mother denied calling the half-sibling any names. Relatives confirmed that she did call the half-sibling chunky because of their larger size.

The parents denied that they feed the children unsafe milk in a dirty bottle, but a relative collateral said the parents would sometimes prepare a bottle for the child and feed it to them throughout the day without refrigerating it and using the same bottle multiple days in a row without washing it. The same relative collateral said the children did have diaper rashes in which the mother used corn starch to treat, but they were never to the point of bleeding.

There were no foul smells indicating substance use or any paraphernalia observed in the home. The mother indicated that she was not allowing the children to be unsupervised with roommates whom the agency identified as being unsafe.

The parents described struggling with stable housing and had previously lived with relatives and then moved into a motel. On about October 1, 2025, they moved in with the current roommates. The father said he worked full time nearby. He reported he drank alcohol socially and typically drank one per day. The mother denied using any substances other than marijuana and did state she drank alcohol occasionally.

On October 23, 2025, while this current CPS assessment was open, ODHS received a report that the child was deceased. That report would be assigned separately from the open CPS assessment. There were also two closed at screenings on October 27 and October 28 and another CPS assessment assigned on October 29 regarding concerns about the parent's substance use and substance use by the roommates.

On October 24, 2025, a CPS caseworker had contact with the half-sibling at the home. They were observed with a scrape under their right eye and on the side of the nose. The mother said this happened when law enforcement was at the home, and the half-sibling fell while pushing a

toy in the driveway. Other than this injury, the half-sibling appeared healthy, was active and running between adults in the home. The caseworker observed the sleeping area and there were no concerning items that would jeopardize the half-sibling's safety. There was a decision made at this time that the half-sibling could not remain in this home due to the roommate's history of substance use and possibly active substance use occurring. At this time, an in-home safety plan with a relative was made.

Following the child's passing, the half-sibling was given a hair strand panel test for substances. The results were positive for marijuana and methamphetamine, and a designated medical professional (DMP) indicated this was indicative of environmental exposure. Neither parent could explain how the test returned positive for these substances; however, they have a history of allowing the children to be around unsafe individuals as evidenced in past assessments.

Following the death of the child, additional information was learned about the father's substance use. He admitted to drinking to intoxication the night after the child died but self-reported he was a social drinker and rarely drinks to intoxication. One of the roommates disclosed the father used to go through an 18-pack of beer in two days. The father's UA following the child's death was positive for alcohol but no other substances.

The mother said she would often drink when she got off work with the father, but never to the point of hindering her parenting responsibilities. The mother initially denied all use of marijuana but then admitted she occasionally used marijuana from a vape pen. She did a urinalysis test, which was positive for marijuana. Both parents participated in a hair strand test, which was negative for all substances.

The parents were asked if they were aware why the roommates had their children removed from their care. They both denied knowing about ongoing substances use or domestic violence and thought it was because the roommate worked too much. They were not aware of their use of methamphetamines but did notice some behaviors after the fact such as rapid speech, pacing, and other concerns. Both parents believed the odd behavior was due to their ongoing mental health issues. ODHS learned as part of this assessment that one of the roommates had overdosed on substances the prior year.

At the end of this CPS assessment, the fatality assessment regarding the child remained in progress. Both parents agreed to take parenting classes and were trying to understand what happened to the child since the cause of death remains unknown. The family continues to work

with ODHS through an in-home safety plan with safety service providers checking in regularly with the family.

The dispositions for neglect to both children by both parents are unable to determine. The assessment addresses reports of concern related to a living situation that was unhygienic, and that the children were being insufficiently supervised. During the assessment period leading up to the death of the child, the CPS caseworker was able to observe the family living environment and interact with the children, with no significant concerns identified. The parents denied co-sleeping practices. There was no information gathered that supported the allegations under assessment during this period. Despite this lack of evidence, it is clear from the subsequent events addressed in the companion assessment that the children were likely at risk of serious harm during the assessment period. The CPS worker was not able to move forward with a finding that neglect did or did not occur.

**Date of report: September 28, 2025**

**Assignment decision: Closed at Screening**

**Allegation(s): N/A**

**Disposition(s): N/A**

On September 28, 2025, ODHS received a report of concern the mother was using a vape device in front of the 1-month-old child. Although the mother denied ever using a vape device in front of her children, she did admit to using a vape device to consume nicotine only. A relative disclosed a concern of the parents not feeding the 2-year-old half-sibling. There was also a concern the mother would flick the half-sibling as a form of discipline. When the reporter made contact, the children did not have any injuries, nor did they appear malnourished. ODHS determined the report did not meet the criteria to assign for CPS assessment and was closed at screening.

**Date of report: July 21, 2025**

**Assignment decision: Within 24 hours**

**Allegation(s): Neglect**

**Disposition(s): Unfounded**

On July 21, 2025, ODHS received an allegation of neglect to the child's 2-year-old half-sibling, by the mother. The mother had experienced housing insecurities due to low or no income. This has created a barrier for her to provide food to the half-sibling other than milk or junk food. The half-sibling had a scabbed-over diaper rash and appeared to have lost several pounds in the last few weeks.

The mother was accessing SNAP benefits and working with WIC. She was also working with a program that serves pregnant women. The mother was offered food from the local Relief Nurse. But the mother had been overwhelmed due to not having anywhere to go and said they would have to sleep on the streets if she could not find a hotel room. The mother did not have a plan for establishing housing even with the support of a few resources provided to her. The mother did not reach back out to the housing programs which might have been due to a lot of chaos and stress in her life.

The family had a car accident a few weeks prior and did not have a car or car seat for the half-sibling. The half-sibling smelled like they had not been cleaned in a while. It was also described that the mother used a marijuana vape pen around the half-sibling when she picked them up from daycare. This report was assigned as a 24-hour response.

On July 21, 2025, a CPS caseworker contacted the mother and half-sibling at a motel where they were residing. The mother's significant other was also in the room when the CPS caseworker made contact. No safety threats were identified. A few weeks later the half-sibling's pediatric records were requested as well as additional information from collaterals.

On August 13, 2025, the mother gave birth to the child and the child's father was the mother's current significant other.

On August 14, 2025, the CPS caseworker was able to locate the half-sibling's father, at a correction facility. The correction facility informed the CPS caseworker they would need to send a letter to the half-sibling's father to discuss a time to accept a phone call as they do not schedule calls for inmates.

On September 15, 2025, the CPS caseworker contacted the family at their new residence. The half-sibling was observed and described as being dressed appropriately and clean. The child was also observed, no marks or injuries were seen on their body, and safe sleep education was

completed with the child's father. It is unclear where the mother was during this contact. The CPS caseworker noted there was no present danger identified.

On September 30, 2025, a new report of neglect to the child and half-sibling by the mother and child's father was assigned. There was also an allegation of physical abuse to the half-sibling by the mother. This report was assessed in its own report dated September 30, 2025.

On October 1, 2025, the CPS caseworker contacted the mother and the children at the parking lot of a local business where they waited for the child's father to get off work. The child's father was not available due to their work schedule. It was noted that the children appeared comfortable and appropriately dressed. The CPS caseworker did not identify a safety concern during this contact.

The family was working with a parent support program in the local area that provided case managed services that included home visits. Information provided during a collateral contact described the family experiencing housing instability and living out of their car and at a local motel. The case manager was concerned with parenting practices that resembled corporal punishment. They observed the mother scream at the half-sibling instead of physically intervening and saw her hit the half-sibling in the mouth. She was also observed picking up the half-sibling by the bicep without any additional support and putting them on the hood of the car. Some of this style of parenting would occur in response to developmentally appropriate behaviors. The case manager's main concern was regarding food insecurity and the half-sibling getting enough food and nutrition.

Prior to this CPS assessment, the family had purchased a trailer and were living in it. They were going to move out of the area with the trailer, but before they could they were in an accident, resulting in no trailer or vehicle for the family. It was unclear if the half-sibling was in a car seat or if the family was trying to get a new car seat after the accident as the mother mentioned they didn't have a car seat for the half-sibling. The family has stayed with relatives during their housing insecurity and at local motels. The case manager informed the CPS caseworker that their agency would be willing to help support the family with funds, but the family would have to participate consistently with the program. This is something the mother or the child's father have not been able to do. The family was originally living with the child's father's family at the onset of the assessment. However, at the conclusion of the assessment, the family was

homeless and residing at a local Airbnb. The parents were working on buying an RV or securing affordable housing.

At the conclusion of the CPS assessment, the allegation of neglect by the mother to the half-sibling was unfounded. The CPS caseworker was able to determine the half-sibling was being provided adequate nutrition and, despite the family struggling with housing, their well-being and needs were being met. The child's pediatrician reported the half-sibling's weight had been trending upwards, and they were not under-weight.

**Date of report: October 7, 2024**

**Assignment decision: Closed at screening**

**Allegation(s): N/A**

**Disposition(s): N/A**

On October 7, 2024, ODHS received a report of concern of the mother was providing marijuana and alcohol to a 15-year-old non-relative child in the community. There was also a concern the mother or another adult gave this 15-year-old a tattoo. ODHS determined the report did not meet the criteria to assign for CPS assessment and was closed at screening.

**Date of report: August 27, 2024**

**Assignment decision: Within 72 hours**

**Allegation(s): Neglect**

**Disposition(s): Founded**

On August 27, 2024, ODHS received report of an allegation of neglect to the child's 1-year-old half-sibling by the mother. The mother was living in a home with the half-sibling that was filled with rotting food waste and other garbage items. There were open containers of alcohol and empty food cans and other items that could potentially cause harm to the half-sibling. The home had a strong odor of feces due to the toilets not working and marijuana, especially in the room where the half-sibling's crib was. The home did not have water or power. It was believed that the mother was not a legal tenant of this home and were illegally squatting.

The assigned CPS worker was contacted as a collateral who reported being in the home two weeks prior and did not observe the home to be in the described conditions.

This report was assigned as a 72-hour response and was linked to the open CPS assessment dated July 24, 2024, and they were assessed and documented together.

**Date of report: July 24, 2024**

**Assignment decision: Within 72 hours**

**Allegation(s): Neglect**

**Disposition(s): Founded**

On July 24, 2024, ODHS received a report alleging neglect to the child's 11-month-old half-sibling by a roommate in the home. The roommate was using methamphetamine in the home and acting erratically, including locking the mother out of the home while the half-sibling was still in the home unattended and crying. The mother reportedly climbed through a window to get inside. It was reported there was methamphetamine paraphernalia in the roommate's room. This report was assigned as a 72-hour response.

On July 26, 2024, the assigned CPS caseworker made unscheduled contact with the mother and half-sibling at their residence. The CPS caseworker attempted phone contact with the father of half-sibling the same day but was unsuccessful. The CPS caseworker also attempted contact with other adults who lived in the home with the mother on this day.

On August 15, 2024, the CPS caseworker made another unannounced contact with the half-sibling and the mother at their home, and no concerns were observed. During this contact, the mother disclosed that she was still in the process of finding a different place to live and would move in a relative's home as a last resource. The CPS caseworker attempted to contact the other adults in the home this same day, but they were not home.

On August 26, 2024, a permanency caseworker contacted the mother at this residence when contacting a different person who lived in the home. During this contact, the permanency caseworker described the home as being deplorable and unsafe. There was no water or electricity, and the permanency worker was able to smell human feces when entering the home. There were also smells of marijuana and garbage. The outside of the home was said to have several bags of garbage outside. The mother planned to have the half-sibling go to a

relative's home. The permanency caseworker confirmed this and the relative told the permanency caseworker that the relative would not allow the half-sibling to return to the home. The relative advised the mother to clean up the home and move out since she was not paying any rent there.

On August 27, 2024, these concerns were reported to ODHS and assigned as a 72-hour response.

On August 29, 2024, the CPS caseworker attempted to make unannounced contact with the family at several locations including the last known address, an address for a relative, and a new address for where the family might be staying. When the CPS caseworker arrived at the old residence of the family, the home had garbage piled on the porch and derogatory words spray painted on the garage. The CPS worker was not able to contact the family.

On August 30, 2024, the CPS caseworker attempted to contact the family at these same locations again unannounced. When they were unsuccessful, the CPS caseworker called a relative and a family friend. On September 3, 2024, the concern was staffed between the supervisor and CPS caseworker as the worker was still unsuccessful at making contact since the recent report. More attempts of contact were made on this day, and again the following day when a business card was left at a relative's home where the half-sibling was said to be staying.

A relative confirmed the half-sibling was still in their care and requested help from the CPS caseworker to get a crib and mattress. When the relative was at work, the mother would care for the half-sibling or take them to the park or store. The mother was staying in a tent at the relative's home until a spare room was available.

At some point after the new call, the CPS caseworker was able to make an unannounced home visit at the relative's home and see the half-sibling in person. The half-sibling was seen crawling and moving around in the living room without any safety concerns. Although the relatives smoke marijuana and cigarettes, there were no concerns noted. They were able to clean the fabric of the pack and play where the half-sibling would sleep.

The CPS caseworker asked for help from the relative to get the mother to return calls and arrange a time to meet. On September 6, 2024, CPS caseworker contacted the family at a local park. During the contact, the mother shared she thought things were going well until the

landlord told everyone to vacate the old home due to rent not being paid. She shared that her and some friends decided to have parties in the home where she consumed alcohol and smoked marijuana all while the half-sibling would be placed in their pack and play in the bedroom.

During this assessment, records from out of state were received, and the CPS caseworker was able to review and discuss the concerns with the mother during a contact. The out-of-state child welfare records noted similar concerns for the home conditions. The father of the half-sibling, the half-sibling and the mother were living in a travel trailer at the back of a relative's property. Neither parent kept up on the home care and there was animal feces, garbage including dirty diapers and dirty dishware throughout the trailer. The clutter extended all over and there was no visible walkway in the home. The family was also using a space heater to heat the trailer, which caused the local law enforcement to be concerned of fire hazard. The mother explained to the worker she left that home during the child welfare assessment due to the condition. There was nothing documented about how the mother felt about the conditions of both these homes and the correlation. There was also no documentation of following up with concerns around her behavior in the assessment from out of state, which including throwing her infant on the couch when she was upset with the half-sibling.

During this assessment, ODHS received police records from out of state. The family lived out of state for a short period of time. Within that short period of time, the police had made a few contacts due to concerns child welfare allegations and escalating violence at the relative's home. On June 25, 2024, additional police records from out of state showed the father of the half-sibling had perpetrated sex abuse with a sibling close in age and was arrested on charges related to this this and charged. It is unclear if concerns from law enforcement records were discussed with the mother and how much of the information she was aware of.

At the conclusion of the CPS assessment, the allegations of neglect to the half-sibling by the mother and a roommate were substantiated. During the period of comprehensive assessment, the residence was found to be in a condition that presented as a health and safety hazard to the half-sibling. There was no running water or electricity, which contributed to the overflow of human feces in the bathroom. That created a strong odor throughout the home and garbage was strewn throughout the home. The mother acknowledged the home was unsanitary and not a place for the half-sibling but only planned for them to stay with a relative after child welfare intervention. The CPS caseworker was also able to confirm that the roommate locked the

mother out of the home while the half-sibling was crying in the home unattended until the mother could get inside of the home.

**Date of report: June 9, 2024**

**Assignment decision: Closed at screening**

**Allegation(s): N/A**

**Disposition(s): N/A**

On June 9, 2024, ODHS received a report the mother moved back in with relatives after the child's half-sibling was born. The adults are often heard cussing at each other from outside, and the police are often called to the home due to the fighting. When the police arrive, no one shares any violence is occurring. The reporter believed the mother smoked marijuana in the bedroom with the half-sibling. ODHS determined the report did not meet the criteria to assign for CPS assessment and was closed at screening.

**Date of report: May 14, 2024**

**Assignment decision: Closed at screening**

**Allegation(s): N/A**

**Disposition(s): N/A**

On May 14, 2024, ODHS received a report about the mother and the child's 9-month-old half-sibling living with relatives. The relatives fight often, and one was knocked out by the other one in the front yard before the half sibling was born. One of the relatives is larger in size and has anger issues; they do not appear to be appropriate around babies due to this. The relatives also smoked marijuana and cigarettes.

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

**Date of report: May 9, 2024**

**Assignment decision: Closed at screening**

**Allegation(s): N/A**

**Disposition(s): N/A**

On May 9, 2024, ODHS received a report of concern the mother using marijuana while caring for the child's 9-month-old half-sibling. The mother was previously living with the half-sibling's father out of state but moved back with her relatives after child welfare had a concern with the home. The relatives' home was said to be unsanitary with trash throughout the home. Concern was also expressed of the relatives' use of crack in the home on a weekly basis, however there was no knowledge of this happening while they were caring for the half-sibling.

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

**Relevant case history—(Relative case)****Date of report: November 29, 2023****Assignment decision: Closed at Screening****Allegation(s): N/A****Disposition(s): N/A**

On November 29, 2023, ODHS received a report of concern due to the mother and the half sibling's father being responsible for care of a relative's children. One of the children has a diagnosis of Down's Syndrome and their needs are at a higher level of care due to their development. The parents called the relative child names and used profanities and physical acts for punishment. The home was filthy according to the reporter and the child did not appear to have their diaper changed appropriately as they developed a rash in the diaper area.

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

**Concerns regarding actions taken or not taken**

According to the Center for Disease Control and Prevention, there are approximately 3,500 sleep-related infant deaths in the United States each year. This is the leading cause of death for children under the age of 12 months, and it is believed most are preventable when caregivers are provided consistent education on safe infant sleep practices. ODHS Child Welfare

caseworkers utilize a Safe Sleep Checklist as a guide to educate families on safe sleep practice at each contact. This CIRT recognized the use of this tool during the CPS assessment open prior to the fatality, which included the deceased child.

This CIRT highlighted the need for increased education and partnership efforts by community partners along with Child Welfare to reach more families about high-risk sleep environments. Infant sleep practices look different across cultures, generations, and family traditions. All caregivers, regardless of gender, identity, or their role in a child's life, benefit from hearing clear, consistent guidance. When trusted community voices share aligned, culturally responsive messages about safe sleep, it strengthens relationships between educators and families, builds confidence, reduces confusion and normalizes safe sleep practices. Consistent messaging also helps address long-held habits or generational beliefs, making it easier for every caregiver to feel supported and empowered in creating a safe sleep environment.

During this review, the CIRT engaged in detailed discussions about parental substance use and identified missed opportunities to assess its complexity and impact on child safety. It was documented the parents in this case used legal substances, marijuana and alcohol, and this CIRT emphasized ongoing challenges faced by child welfare professionals in evaluating substance use that is both socially acceptable and legally available for recreational purposes. Over-reliance on parents' self-reports of substance use and the normalization of the use of the substances may contribute to bias in assessing child safety. The use of substances may have also impacted parenting behaviors for this family; for example, impulsivity in parenting choices may have been influenced by substance use.

This CIRT recognized the importance of accurate assessment of parent functioning. To fully assess functioning and identify risk factors and protective factors, it is important to understand what is driving parenting behavior. To create effective case plans with appropriate service provisions, identifying underlying mental health conditions, substance use disorders, or intellectual/developmental disabilities is crucial for child welfare caseworkers. Knowing what to ask and how to phrase questions in a trauma-informed, culturally sensitive way can ensure families are fairly assessed with minimal bias, so families feel respected, guiding child welfare to best serve children and families.

## Recommendations for improvement

Included in the current 2026 ODHS Safety Action Plan is an extensive focus on safe sleep education and determining the gaps in safe sleep education provided to caregivers across Oregon communities. This evaluation aims to increase awareness and engagement and to reduce the number of children who die in high-risk sleep environments. It is recommended these efforts continue with the goal of ensuring that accessible, consistent, and ongoing safe sleep education and training are available to parents across Oregon, particularly in communities with limited access to resources.

This CIRT recognized many of the improvement opportunities identified in this review regarding parental substance use are consistent with themes in recent CIRT reviews. This highlights the importance of maintaining focus on current recommendations in progress, some of which are also included in the Child Welfare Safety Action Plan.

Key related recommendations include:

- Required completion of five modules of substance use disorder training for child welfare professionals
- Expanding substance use disorder training within the caseworker academy model
- Implementing a standardized supervisory framework for Recovery Support Team leads to promote statewide consistency
- Improving safe sleep resources and materials, particularly focusing on impacts of cannabis use
- Developing a comprehensive plan to strengthen caseworker knowledge and capacity in initiating Plans of Care as required by the Comprehensive Addiction & Recovery Act
- Implementation of UNCOPE framework (screening tool for identifying dependence on alcohol and substance use)
- Development of substance use disorder guidelines for staff

The National Partnership for Child Safety facilitates an applied learning community “Safely to Their First Birthday.” This group focuses on upstream prevention of -and compassionate response to Sudden Unexpected Infant Death (SUID.) One of the challenges numerous

jurisdictions have shared is the role substance use plays in many SUID deaths and the community wanting to understand which substance is most prevalent nationally. In response, the National Partnership for Child Safety will be gathering data on what substances show up nationally in SUID deaths and sharing this data at the next quarterly meeting to understand patterns and to inform future interventions.

The CIRT recommends local safety consultants lead targeted coaching sessions for supervisors and coaching training specialist (CTS) to strengthen their ability to assess and analyze overall family functioning. This development should focus on building deeper more comprehensive assessment skills rather than relying on incident-based information alone, especially for families that have complex history and lived experiences. It is recommended this work start by April of 2026.

Additionally, CIRT recommends consistent use of trauma-informed and culturally sensitive questions and other assessment tools already available within the agency, paired with ongoing supports for workers in applying them effectively to further enhance practice. It is recommended this begin immediately.

---

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact ODHS at [odhs.info@odhs.oregon.gov](mailto:odhs.info@odhs.oregon.gov) or 800-282-8096. We accept all relay calls.