Critical Incident Review Team Final Report

Oregon Department of Human Services
CHILD WELFARE

A Critical Incident Review Team is convened by the Department Director when the Department becomes aware of a critical incident resulting in a child fatality that was reasonably believed to be the result of abuse and the child, child's sibling or another child living in the household with the child has had contact with the Department (ODHS). The reviews are called by the Department Director to quickly analyze ODHS actions in relation to the critical incident and to ensure the safety and well-being of all children within the custody of ODHS or during a child protective services assessment. The CIRT must complete a final report which serves to provide an overview of the critical incident, relevant Department history, and may include recommendations regarding actions that should be implemented to increase child safety. Reports must not contain any confidential information or records that may not be disclosed to members of the public. *The CIRT report is created at a specific time as required by statute and does not account for events occurring after the posting of the report*. Versions of all final reports are posted on the ODHS website.

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<tr><td>Date Department caused an investigation to be made:
July 15, 2024</td><td colspan="2">Date of child protective services (CPS) assessment disposition:
Child Welfare September 24, 2024
OTIS September 23, 2024</td></tr>
<tr><td>Date CIRT assigned:
July 22, 2024</td><td colspan="2">Date Final Report Due:
October 30, 2024</td></tr>
<tr><td>Date of CIRT meetings:

August 13, 2024
September 26, 2024</td><td>Number of participants:
19
23</td><td>Members of the public?
0
4</td></tr>
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Description of the critical incident and Department contacts regarding the critical incident: Child Welfare's assessment regarding neglect by unknown perpetrator.

Date of report: July 15, 2024 **Assignment decision:** Within 10 Days	**Allegation(s):** Neglect by Unknown Perpetrator	**Disposition(s):** Unfounded

On July 14, 2024, ODHS received a report alleging neglect to the child (12) by an unknown perpetrator. It was reported the child passed away in the home of their mother. The mother had stepped away to work in the garden and left the child in the care of a personal support worker. After 15 minutes, the mother heard the personal support worker yelling for help and she rushed in and found the child lying on the floor and their lips were blue. The personal care worker was beside the child, and the child was lying on their back on a mat in front of the fireplace. Emergency medical services came to the home but were unsuccessful in reviving the child. The mother did not want to talk about the details after the child passed and was extremely upset about their death.

It was unclear what the personal care worker was doing in the moments prior to the child's death, but they would normally stay in the home for three to six hours on the days they provided care. The reporter stated there were a lot of questions remaining surrounding the child's death because there were no specifics on what happened.

The child was diagnosed with cerebral palsy and was unable to communicate verbally. They were hard of hearing and had blindness. They also received all their food and fluids through a G-Tube and took several supplements.

It was reported this was the second death in the past month in the mother's home. A foster child (11) who the mother provided foster care to passed away on June 15, 2024. The foster child was being cared for by the same personal care worker at the time of their death and both Child Welfare and Office of Training, Investigations, and Safety, (OTIS) had open investigations with allegations against the mother.

The screener reached out to law enforcement, and they stated an officer responded to home after the child died and found there to be no obvious signs of foul play. The officer stated they read their colleague's notes, and they indicated the child had a lot of medical issues and the death may have been connected to their diagnosis.

On July 16, 2024, a supervisor from the Oregon Child Abuse Hotline reached out to a Child Welfare supervisor who was investigating threat of harm to the child by the mother after the foster child passed away. The supervisor said the child received a medically involved level of care, but the mother was unable to clearly explain the child's cause of death. There was information the child may have suffocated. The supervisor said there had been past concerns about the personal support worker not having appropriate training. There was also concern someone was supposed to be awake with the child and this did not seem to be occurring. The supervisor stated after the foster child's death there was no information there was an immediate safety concern for the child.

This report was assigned as a 10-day response to Child Welfare to assess neglect by an unknown perpetrator. OTIS was assigned an assessment at the same time with allegations of neglect to the child by the personal support worker. OTIS and Child Welfare utilized a trauma-informed approach when completing these two assessments and shared information about interviews together since the circumstances were the same. The documentation is reflected in the OTIS assessment.

At the conclusion of the CPS assessment. the allegation of threat of harm to the child by an unknown perpetrator is unfounded. The child was a highly medically fragile child who required intensive care and support and was diagnosed with several developmental delays. Also present in the home was a personal support worker, hired through the Office of Developmental Disabilities Services (ODDS). This person and the circumstances are being assessed through The Office of Training, Investigation, and Safety (OTIS) as a third-party perpetrator.

Description of the critical incident and Department contacts regarding the critical incident: OTIS investigating neglect (In Care) by third party.

Date of report: July 15, 2024 Assignment decision: Within 72 Hours	Allegation(s): Neglect (In Care) by Third Party	Disposition(s): Unable to be Determined

On July 15, 2024, ODHS received a report alleging neglect to the child (12) by a personal support worker. It was reported the personal support worker began their shift with the child at approximately 2 p.m. on July 14, 2024. The mother had fed the child at 1 p.m. that day, and they seemed fine and did not show any signs of distress. When the personal support worker arrived at the home, the mother tended to an adult who was receiving adult foster care services and then went out to work in her garden. After 15 minutes, the mother heard the personal support worker yelling for help and she rushed in and found the child lying on the floor and their lips were blue. The personal support worker was beside the child, and they were lying on their back on a mat in front of the fireplace. Emergency medical services came to the home but were unsuccessful in reviving the child. The mother did not want to talk about the details of the after the child passed and was extremely upset about their death.

It was unclear what the personal support worker was doing in the moments prior to the child's death, but they usually stayed in the home for three to six hours on the days they provided care. The personal support worker was trained to use a Hoyer lift and had been working with the child since February 2024. It was reported there were other personal support workers who also provided care in the home.

This was assigned to OTIS for assessment as a 72-hour response.

The OTIS investigator reviewed the emergency medical services report. The mother told emergency medical services when the personal support worker called for help, she came in the home and saw the child laying supine on the ground. The mother explained the child was given time to stretch daily due to their congenital defects and this was sometimes done in the prone position. The personal support worker told emergency medical services the child was prone for approximately 10 to 15 minutes while they were reading a magazine and when they looked up from the magazine, they noticed the child was blue. They immediately turned the child over and

called for help. The mother came in and performed CPR until emergency medical services arrived. The mother said the child has multiple congenital issues and has extensive cardiac history.

When emergency medical services arrived, the child did not have a pulse and was apneic. They attempted to use life-saving measures but were unsuccessful. A doctor advised to cease any resuscitative efforts and law enforcement took over the scene.

The OTIS investigator reviewed the law enforcement report. Law enforcement arrived at the scene when emergency medical services were attempting life saving measures on the child. They observed the home and indicated there was no signs of forced entry and nothing looked out of place. Law enforcement was able to obtain information about the child's medical needs and learned they were found unconscious leaning forward on a wedge in the living room before the personal support worker called 911. The personal support worker stated after feeding the child, they placed them on the wedge, leaning forward, due to them having GERD. They indicated sitting in the same room with the child and reading the paper for approximately 10 minutes. The personal care worker checked on the child and noticed they were blue in the face and had regurgitated some of their breakfast fluids. They then yelled outside to the mother for help, and the mother called 911.

Law enforcement talked to a death investigator and advised them of the child's medical conditions. The child was released to the family and transport to the funeral home was arranged. There was no autopsy completed on the child.

An OTIS investigator interviewed the mother. She reported on the day of the child's death, a personal care worker was scheduled to come over at 2:30 pm and have one-on-one time with the child, while the mother had one-on-one time with the adult client in the home. The mother had been taking care of both the child and the adult client prior to the personal support worker's arrival and had placed the adult client at the table to watch television. The mother had planned to do some painting on a bench in the backyard but came back inside the home for a minute to check on the other client and get a bowl to put paint into. While in the home she saw the personal care worker had a wedge, along with the child's physical therapy mat on the floor, which was normal and what usually occurred. The mother

went back outside after finding a bowl, was outside painting for about 15 to 20 minutes, and was 10 yards away from the back door to the home.

While the mother was painting, she heard the back door fly open and the personal care worker was calling for help. She ran into the house and the child was on their back on the floor by the wedge. The personal support worker told the mother the child was not breathing, and the mother said several times “why are they not breathing? Call 911!” The mother checked a for pulse and could not tell if there was one but started CPR because it was clear the child was not breathing. The mother did CPR until emergency medical services arrived, and then emergency medical services continued lifesaving efforts for 45 minutes until the child passed.

The mother said she was unclear how the personal support worker had transferred the child to the wedge, but they would have used either straps or a Hoyer and was trained to use both. The mother said she was outside and did not see the transfer. She indicated it was best practice for all the personal support workers to be on the floor right next to the child to observe them on the mat and wedge. She explained this happened so the child did not slide down the wedge and cause breathing to be restricted. She indicated there being no written training on this, and the stretching exercises are something she developed and trained in her home. She described the stretching as normal daily activity and when she had come in earlier to get the bowl, she did not observe anything concerning about the child’s position or any signs they were hurt, and the personal support worker was right next to them at the time. The mother was unclear if the child had a heart attack or if they were too far down on their mat and unable to breathe. She said the only time being on the wedge would be dangerous was if the child was not being observed constantly by the personal support worker. The mother did speak with a relative, who spoke with the personal support worker on the phone right after the child was found not breathing. The relative said the personal support worker had told them they were on their laptop while sitting on the couch and the mother said she had always observed the personal support worker to be on the floor supervising, the way she had taught them.

The mother stated since the child passed, she had not spoken with the personal support worker and had no plans to do so. The mother indicated being traumatized by both the foster child and the child passing away and does not know if anything else occurred while the personal support worker

was caring for the child. She had thought about the possibility the personal support worker was not supervising and the child slid down and suffocated. Ultimately the mother believed the death of the foster child and the child were due to unfortunate circumstances and coincidentally the same personal support worker was caring for them at the time. The mother stated the child's doctors had been telling her the child's death was imminent due to their conditions and did not believe the personal support worker did anything that would result in the child's death.

The OTIS investigator interviewed the personal support worker as part of the investigation. The personal support worker was not willing to speak to ODHS initially and indicated retaining an attorney but changed their mind.

The personal support worker said they arrived at the home on July 14, 2024, sometime after 2 p.m., and the child was on the couch and the adult client was sitting at a table. They did not see the mother until a few minutes later, when she came from the back of the house. The personal support worker sat down and started playing a game with the adult client, and the mother came in from the back yard and let them know the schedules and what was needed for the child and adult client that day. The mother said she would be out back working if the personal support worker needed anything.

The personal support worker decided to put the child on their mat as they had been in the home a few days prior and had not been able to provide stretching time for the child. They put the mat and wedge out at approximately 3 p.m., changed the child's diaper and used the strap system to put the child on their back. The personal support worker sat watching the child while they were folding laundry and at 3:17 p.m. they moved the child onto their stomach on the wedge to stretch for 15 more minutes. The personal support worker reported the child's chin and arms were extended past the bump on the wedge and at no time did their face appear to be near the wedge. They explained the child was placed on the flat long side of the wedge with their arms and chin extended past the bump and dropped off the wedge. The personal support worker said when the child was on their stomach they looked and acted like they normally would, and the personal support worker sat on the couch and started scrolling on their laptop. This was while being within arm's reach to keep on eye on the child. They said that during this time the child did scoot down and they corrected the child on the wedge into the appropriate position.

After another three minutes, the personal support worker noticed the child had slid off to the left side, but their arms and face were still positioned past the bump on the wedge. When they went to correct this, they saw the child's tongue was sticking out, their lips were blue, and they appeared to not be breathing. The personal support worker said they did not know what to do and went and called the mother for help. The mother came in and began CPR until emergency medical services arrived.

While emergency medical services were performing life saving measures on the child, the mother asked the personal support worker to call the mother's significant other. The personal support worker did not have the significant other's phone number, so they called the mother's relative, who then called the mother's significant other.

The personal support worker said they talked to emergency medical services while they were working on the child, and they said the medication to get their heart started was not working and there was nothing further they could do. The personal support worker was very upset because they wanted to see them take the child to the hospital to get help. The personal support worker reported not understanding what happened to the child as they had cared for them many times and they had been fine.

The personal support worker answered some follow-up questions for the OTIS investigator. They were asked about how they typically moved the child and they said with either a strap or Hoyer lift, but the choice was theirs. They had been trained on both but preferred to use the strap system because the child's arms would flair out and with the Hoyer it was difficult to navigate through the home. The strap system supported the child's hips better as they had hip dysplasia. The personal support worker said they used the straps the entire time they were employed by the mother.

The personal support worker said when they put the child on the wedge they would sometimes slide down, but the personal support worker always made sure when on their stomach their chest extended past the hump of the wedge to allow them to clear their lungs. They would be able to cough out any congestion in this position. The personal support worker said they would always put the child on their back first, and they would start congesting, signaled by gurgling, and then they would move them to their stomach. The personal support worker did not believe they suffocated on the wedge as their face and mouth were never on the wedge.

The personal support worker was asked about being on the floor with the child when they were on the wedge. They stated they normally did not do this, and the mother had seen them many times supervising from the couch without correcting them. The mother told them to do what was best for them, regarding their location during supervision.

The personal care worker said the child was sick in May and more congested at the time. They indicated the child had not been more congested than normal at the time of their death.

The personal care worker said they were in therapy and took two weeks off work after the foster child passed away. They indicated feeling ready to care for the child after the break and did not feel the foster child's passing impacted their ability to care for the child.

The OTIS investigator spoke with three collaterals identified as relatives and friends via a group call. All three had been on vacation together at the time of the child's passing. The personal support worker told the relative the mother had left the home, and they had left the room to fold laundry. The relative came to understand later the mother had been in the backyard and had not left and was unsure if the personal support worker folded the laundry while on the couch or in another room. The personal support worker told the collateral when they came back the child had flipped themselves over off the mat and was not breathing, and when they turned the child over, they were blue. The relative indicated being a caretaker for the child and what the personal support worker told them did not make sense as the child did not have the capability to turn themselves over.

The relative said they talked to the mother a week after the child passed and she explained she had never left the house and the personal support worker was folding laundry in the living room and not in another room.

The collateral was asked about the wedge used for the child and they said when they were on their back, they could be left alone in the room for up to five minutes. When the child was on their stomach, the personal support workers were required to be in the room, providing line of sight supervision. If the child was in distress, they would flail their head around and make gasping noise if congested or having a hard time breathing.

The OTIS investigator spoke with four other caretakers who worked in the home, and they reported no concerns about the mother's or the personal support worker's ability to safely care for the child.

The OTIS investigator spoke to several people from the Office of Developmental Disabilities Services (ODDS) regarding the child's current medical conditions, what case management looked like and guidelines around use of the Hoyer and tummy time.

The child met criteria for Childrens Intensive In-Home Services (CIIS) through the ODDS, and this was explained to be nursing home level. The child had a case manager who had been working with the child and mother since July 2023 and there is a once-a-month check in with the family, usually over the phone. Two in-person visits are required per year to check on the status of current plan and to renew. The child had an Individual Support Plan (ISP), which included qualifying for a total of six personal support workers and the mother utilized two full-time personal support workers full time throughout the week. Two of the personal support workers were used as weekend fill-ins and two were used as a back-up, as sometimes it took two adults to move the child. It was explained the personal support workers were required to go through a background process, as any employee of the state of Oregon would. They are given basic training and sometimes more directed training depending on the client's needs. ODDS explained the child's needs were very high, and they needed someone present within earshot so they could hear for any discomfort that was audibly expressed. It was explained the child rarely slept through the night, often waking up to be changed or repositioned due to the pain they experienced. ODDS said the mother was very levelheaded, open minded and easy to work with regarding the child's needs.

Regarding the use of Hoyer in the home, the vender will train the family on how to use the lift. This is not normally a nurse delegation, and there would not be any training documentation of whom did the training. For in-home settings, the family would be responsible for ensuring a personal support worker was trained properly.

Regarding breathing and tummy time guidelines, it is the child's medical team (physician, clinic nurse, and others) who teach the family. After the family is taught then the family chooses how to provide the training to others, and it is not a nurse delegation. If the caregiving task requires a

nurse delegation training, the family and case manager identifies the needs and the case manager makes the referral to the nurse. If there is a question if a task does or does not require a delegation, it should be referred so the delegating nurse can complete an assessment, and they determine what is within their scope.

The OTIS investigator interviewed the ODDS, Children's Intensive In-Home Services nurse for the home. They explained their role is to make sure care providers can render services to the children/clients in the home. The services are the type that would be offered in a hospital setting that are being used in the home. In the mother's home, they trained on feeding and medication administration. The nurse said both the mother and personal support workers were trained to care for the child, and both did very well and there were no concerns. The nurse last signed off on the delegation log on March 26, 2024. The nurse had last seen the child on July 8, 2024, a week prior to their passing and they looked happy and well taken care of. They did not have any safety concerns for the child, and the home was neat and organized.

The primary care provider for the child was interviewed and said they had provided care to the child for many years. It was shared based on the child's high medical needs and history, they believed their passing was likely due to a cardiac event or aspiration, reporting their thoughts were prior to knowing any details about their passing. The primary care physician said they spoke with the medical examiner regarding the child's death certificate, and they reached out to law enforcement and the mother to learn about the circumstances. The involved parties did not hear anything that made them believe the child's death was suspicious. The death certificate was signed by the PCP on July 18, 2024, with the cause of death as non-suspicious.

At the conclusion of the OTIS investigation, the allegation of neglect (in care) to the child by personal support worker was unable to be determined. Based on the information gathered, it is unclear if the personal support worker was neglectful to cause the child's death. Although the personal support worker stated they correctly positioned the child on the wedge and their breathing was not obstructed, there are no other witnesses who can attest to the supervision directly before the child's death. It is possible the child slid down the wedge while the personal support worker was on their laptop, resulting in asphyxiation or aspiration. Because the child relied

solely on their caregivers for movement, they would not be able to self-rescue had they been unable to breathe. If the personal support worker was not providing the appropriate supervision and the child suffocated or aspirated, this would mean they were negligent in their duties as a personal support worker. However, without a known cause of death, there is not enough information to determine if the child asphyxiated due to sliding down on the wedge. The child was at high risk of asphyxiation, but due to the complexities of their medical conditions, the death could have occurred despite adequate supervision. The lack of information regarding their cause of death makes it impossible for OTIS to determine if the personal support worker failed to supervise their safety, directly resulting in their death.

Description of relevant prior Department reports: OTIS reports assessing the mother as a foster care provider.

Date of report: November 16, 2023 **Assignment decision:** Closed at Screening	**Allegation(s):** Not Applicable	**Disposition(s):** Not Applicable

On November 16, 2023, ODHS received a report with concerns about the foster child (10.) It was reported the foster child was at school and had a high fever which reached 103.1 degrees. The foster child did not communicate verbally but through a special device was able to say they were hot, and their head, stomach and throat hurt. The school attempted to contact the mother, and she was not responding. The school was unable to provide the foster child with any medications and had concerns they may have a seizure due to the high temperature. It was reported the mother had not provided the school with any emergency contact info so there was nobody to call.

It was reported the mother came to the school at 2 p.m. and brought a thermometer, because she did not believe the school the last time this had happened in October 2023. In October the school had taken pictures of the thermometer and sent them to the mother, but she refused to accept the school's information that the child had a temperature.

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

Date of report: June 20, 2024 **Assignment decision:** Within 24 Hours	**Allegation(s):** Neglect (In Care) by the foster parent	**Disposition(s):** Unfounded

On June 20, 2024, ODHS received a report alleging neglect (In Care) to the foster child (11) by their mother. It was reported on June 15, 2024, the foster child passed away from a medical issue and there was concern the mother may have not sought appropriate medical treatment or provided appropriate supervision. It was reported the foster child had a diagnosis of thrombocytopenia, which means they had low blood platelets, and this put them at high risk of internal bleeding and bruising. The foster child was diagnosed with cerebral palsy, quadriplegia, and portal hypertension with esophageal, gastric, and rectal varices. They were fed through a gastronomy tube, were hard of hearing and were non-verbal. The foster child communicated through sounds, facial expressions, and Picture Exchange Communication using an iPad.

It was reported on June 14, 2024, the personal support worker was caring for the foster child. The personal care worker was preparing to do a tube feeding for the foster child and observed blood coming from the G-tube and from the foster child's nose. The personal support worker was alone in the home with the foster child and called 911, as the mother was out at the time. Emergency medical services came to the home and the mother also came home during that time. Emergency medical services determined the foster child's vital signs were OK and there was no emergency medical need. The reporter was not aware if emergency medical services was aware of the foster child's medical history or if there was a recommendation to seek further medical care.

After emergency medical services left, the mother left the home again and the personal support worker put the foster child to bed for the night. It was unclear if the foster child was checked on during the night, but it appeared

they were not. The reporter was concerned ODDS had poorly written bleeding protocols and said the protocols do not appear to address if the foster child was bleeding from their G-tube. The reporter believed the most prudent course of action would have been to seek medical care to best determine how to care for the foster child after emergency medical services responded.

The next morning, the personal support worker prepared to do another G-tube feeding for the foster child. They went to the foster's child's room and found them deceased. The personal support worker contacted 911 and was instructed to begin chest compressions. When the medical examiner came to the home, they determined the foster child had been deceased for several hours. The reporter was unaware if an autopsy had been conducted or if a cause of death was determined.

This report was assigned as a 24-hour response to OTIS. A case was also assigned to Child Welfare to assess threat of harm to the child.

The OTIS investigator reviewed the emergency medical services report from June 14, 2024, from the night before the foster child died. It was reported the bleeding had stopped before emergency medical services arrived. The mother said the foster child's vital signs were stable, and they were acting normal. The mother told emergency medical services there was concern the foster child had esophageal varices and had surgery in the past but believed currently they were experiencing a nosebleed. The mother refused transport to a hospital and said the child would either be in her care or a facility's care. The mother also expressed the foster child had a history of nosebleeds and this often happened after spending time with their biological mother, which had occurred on that day. Emergency medical services observed the foster child sitting on the mother's lap, conscious and alert. Their skin was warm, dry and of a normal color and their mouth clear of blood. The foster child was tracking and following commands. Emergency medical services did not see evidence of esophageal varices. The mother stated she understood the risk of refusal, had the capacity to refuse and signed the formal refusal paperwork.

The OTIS investigator reviewed the emergency medical services report from June 15, 2024, when they were responding to a call that the foster child was in cardiac arrest. Emergency medical services learned from the personal support worker that the foster child had surgery for esophageal varices a week prior and had been found deceased that morning at 9:45 a.m. Emergency medical services observed the foster child's bed to be covered in blood that had come from their mouth. They were pale and had dried blood around their mouth and nostrils. Emergency medical services continued to assess and found the foster child did not have a pulse, was apneic, cold to the touch and rigor mortis had set in. It was stated in the report due to previous findings, resuscitative efforts were not attempted, and the scene was turned over to law enforcement.

The OTIS investigator reviewed the law enforcement report. Law enforcement was able to observe the environment, obtain pictures and establish the foster child was deceased. They obtained a statement from the personal support worker who indicated at 8 p.m. the previous evening, the foster child had coughed up blood and emergency medical services responded. They said it had been determined transportation to the hospital was not needed at that time. The personal support worker said the following morning they checked on the foster child at 8 a.m. and they were under the blankets, did not respond, and they assumed the foster child was sleeping. At approximately 9 a.m., the personal support worker checked on the foster child again, and they observed them to be unconscious, not breathing, there was blood on the sheets, and blood coming from their mouth. Law enforcement spoke to a medical death investigator, who had investigated and did not take jurisdiction of the case. An autopsy was not performed, and there was no criminal investigation opened.

The OTIS investigator spoke with the foster child's primary care physician who stated the mother was one of the best foster parents in the state of Oregon. She was always on top of the foster child's medical care and educated about their diagnosis. The primary care physician had no concerns about the mother's ability to care for the foster child. The primary care physician stated the foster child had low counts of blood platelets, which assist in forming blood clots if they were to bleed. The primary care

physician said the foster child was prone to nose bleeds, which can drain down their throat causing them to vomit. The foster child's conditions placed them at high risk of death due to bleeding out. It was an expected outcome they would bleed out and pass away and it was just a matter of time. When the primary care physician received the death certificate to sign for the foster child, they signed it as they had no concerns about how the foster child passed, as it was expected. The death certificate was signed by the primary care physician with the manner of death as natural by thrombocytopenia.

The OTIS investigator interviewed the delegation nurse who was managing the foster child's case. The nurse's role is to make sure care providers can render services to the children in the home. The services in the home are the type that would be offered in a hospital-like setting, and in the mother's home the nurse trains on feeding and medication administration. The nurse indicated both the mother and personal support worker are trained to provide care for the child and did not have concerns about the care provided. The nurse signed off on the delegation log on March 26, 2024, for the mother and personal support worker.

The OTIS investigator spoke to a services coordinator who managed the foster child's case. They reported the mother is on top of the foster child's medical care and worked hard to care for them. The service coordinator had some questions around the mother not seeking further medical care the evening prior to their death, as the bleeding protocol stated if they vomit blood to take them to the emergency room. There was also a note in their system stating the foster child needed to be checked on three times per night, and the coordinator was unsure if that was occurring.

On June 27, 2024, the OTIS investigator interviewed the mother. Also present was an adult protective service case worker, the foster child's biological mother and a personal support worker. The mother said she has been providing foster care for eight years and she recently hired four personal support workers who had to go through the background process through CIIS. She had two other personal support workers who were rolled

over and had done background checks through the county system, where they resided. The mother said she logs into a county system to check on the personal support worker's training status and they also get a certificate when they are cleared to work in a home. The mother said the personal support worker who was with the foster child when they died is one of her most active personal support workers, and they had been working in the home since February 2024. The mother indicated they did hands-on training with the personal support worker, and they were trained on all the foster child's protocols. When the mother would hire someone like the personal support worker to care for the foster child overnight, she would stay two full weekends with them to do hands on training. This meant teaching the personal support worker to do lifts, transfers, food preparation, G-tube procedures, and how to meet medical needs. The mother stated she would not leave the foster child with a personal support worker she did not trust completely and had confidence in this personal support worker's ability to care for the foster child.

When asked about routine and schedule, the mother stated her time in the home depended on her respite days, her travel, and the personal support worker being with other clients due to their significant medical needs while she is out with the other clients on various appointments and activities.

The mother was asked about the events beginning on June 14, 2024, to when the foster child passed away. She said the evening before the foster child passed, she was out listening to music in a nearby town. The mother received a call from the personal support worker who told her the foster child had been spitting up blood. The mother directed the personal support worker to call 911, and she immediately left the music venue to come home. The mother also called the foster child's biological mother who came to the home. The mother told emergency medical services the foster child frequently gets bloody noses, and they were seen by medical providers a week prior to get varices banded due to their low platelets. Emergency medical services stated the foster child's vitals were stable, with the exception of their heart rate which was slightly elevated. The mother asked emergency medical services what they would be seeing if the foster child

was experiencing complications with their varices and was told if the varices had burst, they would have known, and the foster child would have continued to bleed out and their blood pressure would be very low. Emergency medical services offered transport the foster child to the hospital and the mother declined, even though the bleeding protocols said if they vomited blood to take them to the emergency room. The mother explained she believed they had only spit up blood and it did not involve the varices. The mother and foster child's biological mother both expressed they had taken the foster child to the emergency room in the past and sat for six hours to find they had vomited blood from a bloody nose. The mother said the foster child acted normally after emergency medical services left the home and she left the home shortly after. The mother was asked about the protocol for the foster child to be checked on three times per night and she said this was an old note from when the foster child first came to stay and was scared and awake through the night. She said for the last several years, the foster child slept through the night and did not need to be checked on.

The mother stated the following morning, she texted the personal support worker and asked how the foster child was doing, to which they said the foster child was fine. Shortly after this, the mother received a call that the foster child had passed away. After speaking with medical professionals, the mother learned that the foster child would have gone to sleep prior to passing, which provided the mother comfort. The death was ruled as a natural cause.

The OTIS investigator spoke to the foster child's biological mother who confirmed all the information the mother had shared. She emphasized the excellent care the mother provided to the child and felt the personal support worker also provided excellent care.

The OTIS investigator spoke to personal support worker. They confirmed how long they had been working for the mother and explained the appropriate training they had to take care of the foster child. They stated providing a lot of care for the foster child when the mother was on vacation

and would do overnight and long weekend shifts. The personal support worker said they slept on the couch so they could hear if any of the children were making noises or in distress. The personal support worker confirmed the information previously obtained, that the personal support worker called emergency medical services due to the foster child's bleeding the night before the child's death, that EMS confirmed the child's vitals were stable and the child was fine, and that the child was put to bed and discovered deceased at 9:30 a.m.

The OTIS investigator interviewed four other caretakers employed in the home and they all reported having no concerns about the mother's or personal support worker's ability to take care of the foster child.

At the conclusion of the OTIS CPS assessment, the allegation of neglect (in care) to the foster child by the mother was unsubstantiated. There was no evidence the mother failed to provide the foster child with medical care or supervision required. The mother was away from the home at the time of their death, but she left the foster child in the care of a trained professional, fully aware of their needs and protocols. All the protocols were followed, and medical personnel had no concerns for the foster child's death, stating it was from natural causes.

Description of relevant prior Department reports: The mother's Child Welfare case.

Date of report: June 21, 2024 **Assignment decision:**	**Allegation(s):** Neglect by the Mother	**Disposition(s):** Unfounded

On June 21, 2024, ODHS received a report alleging threat of harm to the child (12) by the mother. It was reported a foster child, who the mother provided care for, passed away on June 15, 2024. Blood was observed leaking from their G-tube site. OTIS was assigned to investigate the allegations of neglect (in care) by the mother to the foster child. It was

determined the child had high medical needs and could have been at risk of harm.

The child was diagnosed with cerebral palsy, asthma, GERD, chronic chest congestion, dysphagia, and received multiple treatments, physical therapy and medications daily. The reporter described the child as not being able to communicate verbally but did use facial expressions such as smiling, giggling, or crying. They had significant vision and hearing loss and relied fully on multiple caregivers to complete all activities of daily living including feeding, toileting, showering, transferring and general hygiene. The child took all their food in through a G-tube, completed six to seven times daily. If positioned incorrectly there is risk for aspiration related to excess drooling. The child had a history of pulling out their G-tube and it was kept wrapped by caregivers to prevent this. They also had self-injurious behaviors due to itching and would bite themselves or would rub their face on hard surfaces. The child could not say when they were not feeling well beyond crying or grimacing. They were often sick, so caregivers had to monitor their vital signs daily. The child received Children's Intensive-In-Home Services (CIIS) through the Office of Developmental Disabilities Services.

This report is linked with another CPS referral dated July 15, 2024, regarding allegations of threat of harm to the child by an unknown perpetrator, and they are documented together. For the purposes of this summary, the information has been separated out.

On June 21, 2024, the CPS caseworker reached out to law enforcement. The officer assigned to the case was on vacation for two weeks. It was indicated the case had not been assigned to a detective and if there was more information presented regarding the need for further law enforcement involvement, a detective would be assigned.

On June 21, 2024, the CPS caseworker had face-to-face contact with the child. They appeared to be clean and was sitting in a chair in the middle of the room and was in and out of a nap. Due to being legally blind, hard of hearing and non-verbal they were unable to be interviewed. They were able to follow the caseworker with their eyes and smile, and the personal support worker noted they did not usually track and thought it was amusing. The caseworker also had face to face with an adult receiving foster care in the home.

On June 21, 2024, the CPS caseworker interviewed the personal support worker who was caring for the foster child when they died. They indicated they had been working with the family since February and were very emotional during the interview. They said it was the first time being with the child and the adult receiving foster care since the foster child had passed away.

The personal support worker was asked about the foster child's death, and they said they had called 911 when they found them bleeding the night before their death, because they normally did not bleed like that. They said emergency medical services came out and said it looked like a nosebleed and there was nothing irregular about the situation. The personal support worker was told to clean the foster child up and put them to bed. The personal support worker slept on the couch just in case they heard anything so they would have a better chance at waking up. They said the mother was out with her significant other since it was her first night back after a recent surgery.

The personal support worker expressed they loved their job, and the death of the foster child was traumatizing. They believed they would lose their job. They said this was the first time they had worked with children but used to work at a nursing home taking care of senior citizens. They stated they were a college graduate and had a bachelor's degree. The personal support worker said the mother had trained them, and they wanted to own something similar when they were older.

On June 22, 2024, the CPS caseworker spoke with the mother over the phone. The mother described the foster child's medical conditions and said they had been seen at a medical appointment a week prior to their death for a routine visit. She said the night of their death she had gone to listen to music with a friend and she received a call from the personal support worker that the foster child was bleeding. She rushed to the home and got there before emergency medical services. When emergency medical services evaluated the foster child, they took their vitals and said everything was fine. The mother called the foster child's biological mother to discuss with her what the next plan of action was. They discussed that the foster child had regular nose bleeds and believed that was the current issue. Emergency medical services concurred with this and said if the foster child had been bleeding due to their portal hypertension, there would have been blood in their bowels. The mother cleaned the foster child up and then went

back to spend the weekend with her significant other because if she stayed in the home, she just ended up working. The mother indicated the foster child was fine when they went to bed.

The mother stated that medical professionals had already said the foster child died of natural causes and that the foster child's doctors could explain there was nothing anyone could have done and because it happened while they were sleeping, it would have been silent.

A representative from ODDS called the caseworker and talked about the child in the mother's home. They stated the child received Children's Intensive In-Home Services (CIIS), which is nursing home level of care. The child is supposed to have a singular caregiver around the clock who tended only to them, and that the caregiver should always be awake.

On July 16, 2024, a report was called into ODHS regarding the child passing away on July 14, 2024, while in the care of the same personal support worker. There was an assessment assigned to OTIS with allegations of neglect (in care) by the person support worker and assessment assigned to Child Welfare with allegation neglect by an unknown perpetrator.

At the conclusion of the CPS, the allegation of threat of harm to the child by the mother was unfounded. There was no evidence to suggest the mother had unqualified personal support workers providing care for the foster child and no evidence the mother was unable to meet their safety and well-being needs.

Description of concerns regarding actions taken or not taken by the Department or law enforcement agencies in response to the critical incident or events that led to the critical incident:

The team acknowledged the complexities involved in investigating child abuse cases, particularly for children with severe, chronic medical conditions. It was noted that an autopsy was not pursued, which may have indicated a tendency among law enforcement and medical professionals to downplay the severity of deaths in these cases. This bias suggested that the value of the children's lives, given their medical challenges, was perceived as less significant compared to that of healthier children. Currently, the decision to conduct an autopsy rests solely with law

enforcement and medical professionals, without any collaboration with the Oregon Department of Human Services (ODHS), even when a CPS assessment is underway, and allegations of abuse related to the child's death are present. This highlights a critical gap in the system where the voices of child welfare are not integrated into vital decisions that could impact the investigation and the protection of vulnerable children.

The Child Protective Services (CPS) investigation concluded with an "unable to determine" disposition due to the unknown cause of death, despite indications neglect might have been present.

The team recognized the significant impact on families when both Child Welfare and the Office of Training, Investigations and Safety (OTIS) are investigating the same incident of abuse, especially when different alleged perpetrators are involved. This dual investigation often results in families being interviewed multiple times, which can exacerbate the trauma they are already experiencing.

In response to this challenge, both OTIS and Child Welfare collaborated effectively during the investigation, conducting interviews in tandem and sharing relevant information. This approach aimed to provide the family with a trauma-informed response, reducing the burden of repeated questioning and fostering a more supportive environment during a difficult time. This collaboration demonstrates a commitment to minimizing further trauma and ensuring that families receive cohesive support from both agencies.

Recommendations for improvement in the administration and oversight of the child welfare system that are specific to the critical incident and any historical information reviewed by the team:

The team recommends enhancing collaboration and exploration with law enforcement and medical professionals statewide to establish clearer guidelines on when medically complex or children with disabilities should undergo an autopsy. The Child Fatality Prevention Review Program will initiate this exploratory work through the State Child Death Review and Prevention Team.

These discussions aim to improve communication between agencies during investigations of child abuse, particularly when an autopsy could yield crucial information for understanding the circumstances surrounding a child's death.