C.V. CIRT Public Report

<table>
<thead>
<tr>
<th>Date</th>
<th>5.24.19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Initial Report</td>
<td>1.22.19</td>
</tr>
</tbody>
</table>

**Purpose of Final Report**

Critical incident reports are used as tools for Department actions when the Department becomes aware of a critical incident resulting in a child fatality that was likely 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 (DHS). The reviews are called by the Department Director to quickly analyze DHS actions in relation to the critical incident and to ensure the safety and well-being of all children within the custody of DHS or during a child protective services assessment. The CIRT recommends which actions should be implemented and which individuals should be responsible for evaluating the implementation. Reports must not contain any confidential information or records that may not be disclosed to members of the public. Versions of all final reports are posted on the DHS’ website.

**Executive Summary**

On 10.28.17, the child, C.V. was found deceased by the parents after reportedly being placed to sleep in a pack n’ play next to the parents’ bed the night prior. Based on information gathered, the initial assessment of the death was closed as unfounded by the Department. The law enforcement investigation was also closed, and no criminal charges were pursued.

On 4.6.18, a second report related to the death of C.V. was received after the father made statements regarding prior abuse of C.V. and opined his actions may have contributed to the child’s death. The assessment and law enforcement investigations were re-opened, and the Department determined the death was the result of abuse on 11.26.18.
On 11.28.18, the Department Director declared a CIRT be convened. This is a mandatory CIRT as C.V.'s death was determined to be the result of abuse and the child had been the subject of a child protective services assessment in the 12 months prior to the critical incident.

The report of C.V.'s death on 10.28.17 was the third call on the family and the second assessment. There were no prior founded reports.

<table>
<thead>
<tr>
<th>Summary of Critical Incident</th>
</tr>
</thead>
</table>
| On the morning of 10.28.17, law enforcement responded to the home after C.V. was found unresponsive by the mother and father. The child had reportedly been put to bed in the pack n' play the night before by the father while the mother was out of the house at an event.  

The parents presented as cooperative with the CPS assessment and law enforcement investigation and recounted the events of the night before. The mother had gone to an event while the father was home caring for C.V. The father noted C.V. had been fussy and would not fall asleep in the pack n’ play so the father put the child on his chest and they both fell asleep on the parents’ bed. The father got up and placed C.V. to sleep in the pack n’ play around 11:00 p.m. The mother arrived home around 11:15 p.m. and the parents went to bed. Both parents reported glancing at C.V. in the pack n’ play but had no reason to check closer. The next morning, the father looked at C.V. and found the child to be unusually still. The mother checked on the child, who was cold, purple and not breathing. The mother ran to a family member’s room and 9-1-1 was called. C.V. was not able to be resuscitated and was declared deceased at the scene.  

Collateral contact with relatives as well as the child’s physician revealed no concerning information regarding discipline practices or family functioning during the initial fatality assessment. The |
assessment was closed as unfounded. The law enforcement investigation was also closed, and no criminal charges were pursued.

A second assessment related to the death of C.V. was opened on 4.6.18 after information was received the father had made disclosures of abusive treatment of C.V. that may have contributed to the child’s death. The father disclosed having problems controlling his anger from the time the child was about six months old, and described instances of aggressive and abusive behavior towards C.V. that would result in bruising. The father recounted frustration with C.V. being fussy and not falling asleep on the night of C.V.’s death and his engaging in further abusive behavior towards C.V.

The father was arrested on 10.16.18 and charged with Measure 11 aggravated murder, Measure 11 murder, felony strangulation, third degree assault and first-degree criminal mistreatment.

The mother disclosed witnessing the father’s anger and his aggressive and rough handling of C.V. that led to bruising. The mother reported that she threatened to leave the father over his anger and behavior towards C.V. Regarding the night C.V. died, she expressed disbelief that the father was capable of killing C.V. and then denied earlier statements about the child having bruising as a result of the father’s actions.

The assessment dated 4.6.18 was coded founded on 12.7.18. There was reasonable cause to believe the father inflicted ongoing physical harm to C.V., ultimately resulting in the child’s death. Additionally, there was reasonable cause to believe the mother was aware of the father’s abusive behavior and failed to intervene on behalf of C.V.
### Evaluation of Department Actions

- No systemic issues were identified
- The CIRT is aware there has been ongoing work to develop guidelines for assessing safe sleep and providing education to parents of infants during CPS assessments. While not identified as a driving factor in the father’s behavior, this case brings to light the need for considerations regarding how to talk with families about sleep when sleep is scarce, and caregivers are tired or frustrated or struggling with mental health issues.
- Although not correlated to the outcome in this case, the review identified two assessment activities with the family that were not completed. First, separate interviews were not conducted with the parents when domestic violence was alleged and second, full interviews with all household members were not conducted.

### Recommendations for improvements and associated tasks

No recommendations identified specific to this case. The conversation about why activities occur on some cases and not others is ongoing and is a focus of the Director’s office and the Child Safety Program. This case supports continued exploration of the issue. It is important to identify and address barriers in order to support caseworkers in gaining clear understanding of safety for all children they assess.

### Methods of evaluating expected outcomes

Not Applicable