

Critical Incident Review Team Final Report



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 (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 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. Versions of all final reports are posted on DHS’ website.

CIRT ID: 045TVVIMJR		
Date of critical incident: May 3, 2019	Date Department became aware of the fatality: May 3, 2019	
Date Department caused and investigation to be made: May 3, 2019	Date of child protective services (CPS) assessment disposition: September 17, 2019	
Date CIRT assigned: August 7, 2019	Date Final Report submitted: November 21, 2019	
Date of CIRT meetings: August 29, 2019 October 11, 2019	Number of participants: 11 11	Members of the public? Yes Yes

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

Date of report:	Allegation(s):	Disposition:
5.3.19	Physical Abuse and Neglect by the mother	Founded for Neglect, Unable to Determine for Physical Abuse
Assignment decision:		
Within 10 business days		

The Department received a report that an infant child died overnight while in the care of the mother. According to the information received, the mother reported blacking out after consuming alcohol the night of the fatality. Witnesses reported hearing the child and the mother crying in the hour preceding the mother's call to 911. The child was observed to have petechiae in the right eye and spots of blood were observed on a pillow and on the bed, though there were no obvious signs of injury to or blood loss from the child.

There was an open assessment at the time of the child's death and the family was receiving contracted support services through the Department.

The caseworker assigned to assess the fatality contacted law enforcement to gather information regarding the circumstances surrounding the child's death. Limited details were available, but the cause of the child's death remained unexplained.

According to the mother, she had been having a bad day and drank some beer and blacked out for a period. She originally reported leaving the child home alone to go to the store for more alcohol. The mother later changed her story and it was confirmed she did not leave the child alone, but rather took the child with her when she went to the store. It is unknown exactly how the mother found the child unresponsive or how long it took her to call emergency services. The mother denied recollection of the events leading to the child's death, stating she blacked out and when she regained consciousness the child was blue. Witnesses reported hearing the child crying in the middle of the night and later hearing the mother asking why the baby was blue. The mother was heard lightly crying but within five minutes was reported to be heard screaming hysterically. It was confirmed she ultimately called her mother, who told her to call 911. By the time first responders arrived, it had been over an hour since the witnesses first began hearing the distress in the home. The child was transported to the hospital and pronounced dead shortly after arrival.

Further assessment into the circumstances by the Department was limited due to lack of available information. The contracted service provider who had been working with

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the family reported the mother had presented just the day prior as doing well managing her mental health and care of the child. However, the mother also sent a disturbing text message to the named biological (putative) father of the child the same evening stating she and the child had been hit by a car.

The CPS assessment was founded for neglect of the child by the mother and unable to determine for physical abuse. While the exact cause of the child's death remained undetermined, there was reasonable cause to believe the mother failed to provide the child with adequate care and supervision on the night of the critical incident.

Description of relevant prior Department reports:

Date of report: 8.20.18 Assignment decision: Closed at Screening	Allegation(s): Threat of Harm by the mother	Disposition: Not Applicable
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The Department received a call with concerns for the unborn child. The mother and another woman had recently stolen a gun from the mother's ex-significant other, who was also believed to be the father of the baby. The mother was believed to have significant mental health symptoms, had previously held a knife to her own throat, had been hospitalized, and was possibly using cocaine.

The information was documented and closed at screening as the report did not meet the statutory definition of child abuse as there was no child. High risk alerts were sent to area hospitals.

Date of report: 11.5.18 Assignment decision: Closed at Screening	Allegation(s): Threat of Harm by the mother	Disposition: Not Applicable
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The Department received a report of concern for the mother's unborn child due to the mother's mental health condition and resulting behaviors. The mother was reported to

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be making threats to kill herself via text messages to the putative father. She had previously assaulted him but when police arrived, she reported he had raped her. The caller noted the mother was also smoking cigarettes and marijuana. The putative father reportedly did not want to parent the child.

The information was documented and closed at screening as the report did not meet the statutory definition of child abuse as there was no child.

Date of report: 3.3.19	Allegation(s): Threat of Harm by the mother	Disposition: Unfounded
Assignment decision: Within 24 hours		

The Department received a report alleging threat of harm to the child by the mother due to her significant mental health issues and erratic behavior reported during pregnancy. According to the report the mother was doing well with the baby and had been engaged in supportive services. The putative father was visiting the hospital and planned to visit the child daily after release.

The mother was cooperative with the CPS assessment and was open to continuing existing services and engaging in additional mental health support services offered through the Department. She was living with the child in a studio apartment and receiving daily support from the maternal grandmother. The mother expressed a desire to bed-share with the child to make breast-feeding easier and the caseworker discussed the risks with the mother. The mother used marijuana during her pregnancy but reported she did not plan to continue use while breastfeeding.

The putative father was also interviewed during the assessment. He stated he was not certain he was the biological father of the child and would like paternity testing before engaging in a parenting role with the child. The putative father expressed concerns about the mother's emotional stability and ability to parent. He denied sexually assaulting the mother while she was pregnant. When interviewed the mother maintained the allegation but was unable to provide clarifying detail. Neither parent would elaborate on violence in their relationship and reported they were no longer together.

The maternal grandmother was interviewed and indicated she felt the mother was doing well since the birth of the child. She did not approve of the relationship with the putative father and believed it was harmful to the mother. The putative father's mother was also interviewed and said she believed the relationship was toxic and also did not approve.

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The last face to face contact with the family was on March 20, 2019. Progress reports from the DHS contracted service provider were positive, noting the mother presented as attentive to the child's needs and the child was growing and developing well.

Although this assessment was still open when the Department received the report of the child fatality, it was determined to be unfounded for threat of harm to the child and closed when the new assessment was opened.

Date of report: 4.4.19	Allegation(s): Neglect by the mother	Disposition: Not Applicable
Assignment decision: Closed at Screening		

The Department received a call of concern on an open CPS assessment. According to the report, the mother sent nude photos to the putative father and also made threats to harm herself or the child in text messages to the putative father. He went to the apartment to check on the mother and child and the pair allegedly engaged in consensual sex. The mother then reportedly beat him up, causing scratches and tearing his shirt before called police, stating the putative father had raped her. A similar incident occurred in November of 2018, while the mother was pregnant.

It was unknown if the child was present during the incident, though the caller believed it was likely. The reporter alleged the mother was drinking alcohol and using marijuana and had at times left the child with the maternal grandmother to go out drinking. The caller was concerned the mother may have been neglecting the child and not waking to feed the child frequently enough and not changing the child's diaper enough. The reporter did not have information about how often or for how long the child's needs were not met.

The caseworker received an email notification of the call and the intent to close the report at screening.

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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 CIRT identified missed opportunities for enhanced partnership with community service providers. The mother was involved in a home visiting program within the community, however there was not communication between the program and the Department. The provider was unable to contact the Department because the mother would not sign a release of information. The Department had not clearly inquired as to who the mother was involved with in the community and was therefore unaware of the service. Gaps in communication between the Department and vital community service providers limits the ability of the Department to gain a full understanding of family functioning and limits the ability of providers to engage with families in a way that may address concerns about child safety and well-being.

Closed at screening reports received on open assessments or open cases must be reviewed in consultation with a supervisor on the same day the caseworker receives notification of the new information. While there is documentation in the open assessment the local office was notified of the closed at screening report in April 2019, there was not clear documentation about how the concerns were addressed in the open assessment. The information in the report provided insight into the mother's behavior that was not being observed by the Department or providers involved with the family at the time.

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:

Partnership between the Department and community providers is critical to the safety and well-being of children and their families. When connections are made early in the life of a case, better information is gathered and the strengths and needs of families can be more fully assessed. It should be routine for any caseworker contacting a family for the first time and during future contacts to inquire about involvement with other service providers or agencies. Caseworkers must feel empowered to engage in conversations about what supports are working and where families require extra assistance. The CIRT discussed this case as just one example of how the Department could more routinely inquire about specific programs families may be involved with to support engagement and partnership and enhance child safety. CIRT Coordinators will explore avenues for reinforcing natural connections between caseworkers and providers.

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As noted in other recent CIRT reports, CIRT Coordinators are undertaking efforts to better understand what systemic factors may be influencing the work of Child Welfare. These efforts include the application of safety science and the Safe Systems Improvement Tool (SSIT). Observations regarding actions of the Department are being tracked and compared over time to inform ongoing quality improvement efforts.