

# 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. 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 DHS’ website.

<b>CIRT ID: 87DK98F1DR</b>		
<b>Date of critical incident:</b> March 12, 2020	<b>Date Department became aware of the fatality:</b> March 12, 2020	
<b>Date Department caused an investigation to be made:</b> March 12, 2020	<b>Date of child protective services (CPS) assessment disposition:</b> June 1, 2020	
<b>Date CIRT assigned:</b> March 17, 2020	<b>Date Final Report submitted:</b> June 12, 2020	
<b>Date of CIRT meetings:</b> April 30, 2020	<b>Number of participants:</b> 18	<b>Members of the public?</b> No

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

<b>Date of report:</b> 03/12/2020	<b>Allegation(s):</b> Neglect by the mother	<b>Disposition:</b> Unfounded
<b>Assignment decision:</b> Assigned		

On 03/12/2020 the Department received a report that a 2-month-old infant passed away after their mother fell asleep while feeding them. The mother reported feeding the infant in a reclined position in bed and remaining in this position when she moved the infant onto her chest to burp. The mother fell asleep and believed the infant rolled off her and onto the bed. Approximately an hour later, the mother awoke and found the infant face down on the bed between her and the infant's 5-year-old sibling.

The CPS caseworker interviewed the mother, father, and two surviving siblings, aged 5 years old and 15 years old. Neither of the children made any disclosures of abuse or neglect.

The mother declined to review the events of 03/12/2020 with the CPS caseworker but referred them to the police report. The mother commented to the worker that she had no plans the day of the critical incident and was enjoying the morning, relaxing, and cuddling with the infant and sibling in bed before falling asleep.

The CPS worker reviewed the law enforcement report. The report confirmed the information originally provided to the Department and indicated the incident happened around 8:00am. It offered some additional details and explained the infant was still warm when the mother picked them up. She took off her shirt for skin-to-skin contact and ran out her front door screaming for help. Two neighbors called 911 and began CPR on the infant until police arrived. The father was at work and the 15-year-old sibling was at school, so neither were present for the critical incident.

The mother reported marijuana use during pregnancy to manage nausea. The father reported he used marijuana occasionally and stated the mother uses it regularly. Both parents denied active substance abuse. The mother reported taking one medication typically used to treat pain as well as addiction to narcotic pain relievers. Medical records indicated the mother had some history of opioid dependence; however, the caseworker was unable to gather additional information as to any history of substance use.

During the CPS assessment, the CPS caseworker learned the infant struggled to gain weight, which resulted in a multiple day hospitalization when the infant was about eight

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weeks old. During the hospital stay it was learned that the infant had acquired pneumonia and was tongue tied. The infant was discharged from the hospital with a feeding plan, which required the mother to feed the infant every two hours. The mother expressed feeling exhausted and reported getting very little sleep. According to birth records, the mother was educated on safe sleep practices and reported having a crib for the child to sleep in. During the later hospitalization, the mother reported not knowing how long the infant nursed because she sometimes fell asleep while breastfeeding. Medical records indicate that the child was successfully gaining weight on the feeding plan.

Local law enforcement ruled the child's death as accidental. The Department gathered no other information to indicate abuse or neglect and the allegation of neglect was unfounded.

### Description of relevant prior Department reports:

<b>Date of report:</b> 01/09/2012	<b>Allegation(s):</b> Threat of Harm by the mother	<b>Disposition:</b> Unfounded
<b>Assignment decision:</b> Assign- 24 Hours	Threat of Harm by the stepfather	Unfounded

***The mother and the father of the deceased child have been in a relationship for the duration of the Department's history. The deceased child's father is referred to in this report as stepfather for ease of reading, though the couple's marriage did not occur for several years.***

On 01/09/2012 the Department received a report of domestic violence occurring between the mother and stepfather. Additionally, there were concerns that the mother had threatened to harm herself. In the home was the mother's 10-year-old child and a 7-year-old relative child who was being cared for by the family pursuant to a guardianship.

The CPS caseworker interviewed the children at school individually. The children denied physical or sexual abuse. Regarding substance use, the children reported the parents drink alcohol but denied seeing them intoxicated. The 10-year-old child reported their mother and stepfather sometimes argued resulting in them throwing things, yelling, and occasionally pushing each other. The 10-year-old reported they were usually at school when the parents did these things. The 7-year-old child reported one incident where the stepfather was mad, resulting in the rest of the family sleeping in the car. Both children reported there was an argument between the parents on 01/08/2012 but denied witnessing it.

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The CPS caseworker interviewed the mother and stepfather separately at the home. The mother reported more frequent fighting over financial stress but denied threatening to hurt herself. On 01/08/2012, the mother stated the couple was arguing and she went to shower to take a time-out. When she closed the shower door, it shattered on her. She denied any domestic violence in the home but confirmed she and the children slept in the car one evening because the stepfather was intoxicated and angry. As a result of this incident, the stepfather stopped drinking. The stepfather confirmed the details of 01/08/2012 and stated he and the mother rarely argued and if they did, it was rarely in front the children.

During the assessment the CPS caseworker spoke to collateral contacts and the 10-year-old's biological father who denied any concerns for the children.

It was determined the argument did not occur in the presence of the children and that the children were not fearful in their home. The allegations of threat of harm by the mother and stepfather to the children were unfounded and the CPS assessment was closed.

<b>Date of report:</b> 03/04/2019	<b>Allegation(s):</b> Sexual Abuse	<b>Disposition:</b> Founded
<b>Assignment decision:</b> Assign- 24 Hours		

On 03/04/2019 the Department received a report that the families 4-year-old child had been sexually abused by a teenage relative who lived outside of the home. The relative admitted to sexually abusing the child approximately two years prior on one occasion.

The CPS case worker met the 4-year-old child and the mother at the family home. The mother reported she ended all contact with that relative after learning about the admission in September of 2018. The CPS worker attempted contact with the father but was unable to speak with him during the assessment. The family declined any further service referrals.

Based on the relative child's own admission to law enforcement, the allegation of sexual abuse to the 4-year-old sibling was founded.

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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 did not identify any concerns regarding actions taken or not taken by the Department or law enforcement agencies. There had been no prior Department contact with the child. The allegation of neglect related to the death of the child was unfounded.

### **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 CIRT did not have any recommendations.