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 inciincident, relevantartment 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.

CIRT ID: 8MHIALFEU3		
Date of critical incident: May 15, 2020	**Date Department became aware of the fatality:** May 15, 2020	
Date Department caused an investigation to be made: May 15, 2020	**Date of child protective services (CPS) assessment disposition:** July 30, 2020	
Date CIRT assigned: May 19, 2020	**Date Final Report submitted:** August 20, 2020	
Date of CIRT meetings: June 5, 2020 (Initial) July 14, 2020 (Follow-up)	**Number of participants:** 17 16	**Members of the public?** 0 0

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

Date of report:	Allegation(s):	Disposition(s):
May 15, 2020 **Assignment decision:** Assign: 24-hour response	Neglect by the mother & the father	Founded

On May 15, 2020 the Department received a report about the death of the one-month-old infant. It was reported the infant lived with the mother, the father, an eight-year-old half-sibling and a two-year-old sibling. The infant's other two half-siblings, ages eight and seven, were on an overnight visit at the family's home during the time of the incident.

Law enforcement was dispatched to the family home during the morning of May 15, 2020 due to a report of an unresponsive infant. Upon arrival, the mother informed law enforcement that she, the father, the two-year-old sibling, and the infant went to bed on May 14, 2020 around midnight. The two-year-old was reportedly asleep between the mother and father, while the infant was asleep on the mother's chest. Reportedly, at about 5:00 a.m., the mother woke up and found the infant face down on the mattress and not breathing. The mother called for emergency services and upon their arrival the infant was pronounced deceased. There were no reported concerns with the home environment, or any safety concerns observed for the other children in the home by responding officers, however the report indicated there were multiple items within the bed including pillows, blankets and a comforter. The mother reported receiving information about bedsharing from medical staff, however, she did not choose to follow the medical advice. In addition, it was reported there were empty alcohol containers within the home, however neither parent appeared impaired on the morning of the incident to the emergency responders.

The CPS caseworker met individually with all family members and conducted interviews. None of the children reported any safety concerns regarding the mother or the father. During the interviews with the half-siblings, who were at the home for an overnight visit during the critical incident, concerns arose regarding their biological mother's boyfriend. These concerns generated an additional assessment under their biological mother's case, the father's ex-wife, which was determined to be unfounded.

The CPS caseworker observed the parents' bedroom where a crib was set up, however there were numerous items inside, which prevented an infant from sleeping inside the crib. The mother reported the crib was originally set up for the two-year-old sibling, but the sibling bed-shared with the mother and father instead. The mother reported she and the father planned to use the crib for the infant but that had not occurred either.

In describing the events of the night before the infant's passing, the mother reported she had picked up a relative around 12:00 p.m. on May 14, 2020 and brought the relative to her home. The mother stated she started to consume alcohol around 5:00 p.m. with the relative and continued to drink until about 10:30 p.m. She reported she had at least four mixed drinks and once she felt intoxicated, she stopped drinking. The mother reported she was exhausted the night of May 14, 2020, but she did not feel her alcohol consumption impaired her ability to safely parent.

According to the mother, the father fed the infant a bottle around 11:30 p.m. and put the infant to bed. The infant awoke around 3:00 a.m. and the mother breastfed the infant. The mother believed the infant rolled off her and onto the mattress at some point after the 3:00 a.m. feeding. When the mother noticed the infant was not breathing, she awoke the father who attempted to revive the infant while the mother called for emergency services.

The father informed the CPS caseworker he had consumed at least six to seven beers on the evening of May 14, 2020. He reported he began to drink around 7:00 p.m. and stopped sometime between 11:00 p.m. and 11:30 p.m. The father reported he fed and changed the infant at this time. The father did not feel his alcohol consumption impaired his ability to safely parent and indicated he had stopped drinking before he became intoxicated.

The mother and father both reported they had previously discussed what their alcohol use would consist of when the children were present and had agreed that both would not be intoxicated at the same time. On May 14, 2020 the plan was for the father to drink less alcohol, while the mother would consume more. Both had also reported they discussed bed-sharing with their children when the mother was pregnant with the two-year-old sibling. The mother stated they agreed to bed-share due to this arrangement being more convenient for nursing.

The CPS caseworker conducted an interview with the relative who reported being picked up by the mother and arriving at the family home between 7:00 p.m. and 8:00 p.m. He reported the mother had not consumed any alcohol prior to his arrival that he was aware of, but she began to drink between 8:00 p.m. and 9:00 p.m. The relative reported he had consumed alcohol prior to his arrival and stated he had been around the mother and father several times before when they had consumed alcohol. The relative stated there was never a difference in the father's behavior and the mother would become happier when she drank. On the evening of May 14, 2020, the relative did not believe either parent's demeanor or behavior had changed nor posed any concerns. The relative reported the infant was asleep for the majority of the evening.

While reviewing the information received by law enforcement, the CPS caseworker learned the family had not informed law enforcement of the extent of their alcohol consumption on the evening of May 14, 2020. The CPS caseworker consulted with the assigned detective to provide further information on the reported activities that occurred

prior to the death of the infant, as well as identified inconsistencies in the timelines reported by the mother, the father, and the relative.

The CPS caseworker, law enforcement and an Addiction Recovery Team (ART) service worker met with the mother and the father. Individually with each parent, law enforcement inquired about the timelines associated with their alcohol use and the lack of information initially provided. Neither parent had an explanation as to why they failed to report their alcohol use, despite each parent being directly asked by law enforcement on May 15, 2020. The ART worker spoke with each parent and concluded that neither parent needed additional services related to substance use.

Throughout the CPS assessment, the CPS caseworker communicated with the mother and the father regarding the sleeping arrangements in the home. The Department assisted in providing the family with a toddler bed for the two-year-old sibling.

At the conclusion of the CPS assessment, the Department determined that although there was no risk of harm or safety threat to any of the older children in the home, the infant's death was the result of neglect due to the overconsumption of alcohol the evening of May 14, 2020 coupled with the decision to bed-share with the infant while under the influence of alcohol. Therefore, the allegations of neglect by the mother and the father to the infant were founded.

This incident also generated a screening report regarding the safety of the eight-year-old and seven-year-old half siblings while in the care of the father which was documented under the father's ex-wife's case, the mother of the half siblings. The Department determined the half siblings primarily resided with the father's ex-wife and had limited visitation at the father's home, therefore the report did not meet the criteria of a CPS assessment and was closed at screening.

Description of relevant prior Department reports:

Date of report: 9/4/2019 **Assignment decision:** Closed at screening	**Allegation(s):** Neglect by the mother and the father	**Disposition(s):** Not Applicable

On September 4, 2019 the Department received a report alleging neglect of the children and stepchildren of the mother and the father. It was reported the father had parenting time with his two biological children, who were seven and six years old. Both of the children were at an overnight visit at the father's home when the children were required

to sleep in the same bed as their seven-year-old stepsibling. It was reported there had been previous concerns of inappropriate touching and there was a concern with the amount of alcohol consumed by the mother and the father.

The Department determined this report did not meet the criteria of a CPS assessment as there was no indication of current inappropriate touching occurring nor was there any information the adult's consumption of alcohol negatively impacted the parenting or caregiving of the children. Therefore, this report was closed at screening. This information was also documented as a closed at screening report under the case belonging to the father's ex-wife.

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 have any concerns regarding actions taken or not taken by the Department or law enforcement agencies. There had been no prior Department contact with the infant.

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 discussed the prevalence of unsafe sleep environments identified in recent CIRTs and the continued need for safe sleep education for families and child welfare professionals who interact with parents/caregivers who have infants in the home. As a response to the identification of a need for safe sleep training, the Department has implemented a Safe Sleep training plan, which consists of developing specific curriculum for caseworkers, certifiers, hotline screeners and social service assistants. The training package will also provide tools for staff to practice having safe sleep conversations with parents and caregivers. In addition, a new procedure was developed for child welfare professionals along with a safe sleep checklist and a safe sleep handout for parents/caregivers. Phase one of this training plan began in May 2020, with additional phases expected to continue through 2021.