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: AR84612OB4		
Date of critical incident: 10/09/2019	**Date Department became aware of the fatality:** 10/11/2019	
Date Department caused and investigation to be made: 10/11/2019	**Date of child protective services (CPS) assessment disposition:** 12/13/2019	
Date CIRT assigned: 10/16/2019	**Date Final Report submitted:** 1/17/2020	
Date of CIRT meetings: 11/08/2019 12/13/2019	**Number of participants:** 14 12	**Members of the public?** 0 0

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

Date of report: 10/11/2019 **Assignment decision:** Assign- 24 Hours	**Allegation(s):** Neglect by Mother & Father	**Disposition:** Unfounded

On 10/09/2019, the Department received a report that a five-month-old infant was found deceased.

The parents lived in a home with their four children and an adult roommate and that roommate's girlfriend. The CPS worker interviewed the parents who reported putting the infant in the bed with 2 of the child's siblings, in the master bedroom. Normally the infant slept in a bassinet, but that bedding was soiled. The parents reported a 3rd sibling, was put into that child's own bed. The parents reported watching TV in the master bedroom, and both consuming two beers. The father later fell asleep in the 3rd sibling's room while attempting to get that child to sleep. Mother reported checking on the children throughout the night. She noted one sibling left the bed and had fallen asleep on the master bedroom floor. The mother woke up when father was leaving for work. She reported seeing a blanket over the infant's head and discovered the child was not breathing. The father, the roommate and the roommate's girlfriend called 911 and performed CPR. LEA and the medical examiner arrived at the home and the child was pronounced deceased.

Law enforcement concluded their investigation and ruled the death to be accidental likely due to an unsafe sleep environment and smothering/asphyxiation.

Collateral contacts were made with relatives and the roommates and no concerns about the parents' ability to provide a safe home were reported. The worker determined both parents had the skills and knowledge necessary to protect the children and this was an isolated incident of putting the child in a bed with siblings. No further action was taken by the Department as the surviving children were determined to be safe.

Description of relevant prior Department reports:

Date of report:	Allegation(s):	Disposition:
06/26/2019	Neglect by Mother	Unable to Determine
Assignment decision: Assign- 24 Hours	Threat of Harm by Mother	Opened in Error
	Neglect by Father	Unfounded

The Department received a report that a one and two-year-old child were found about a block from their home and had likely been outside for approximately twenty minutes. The children were returned home but there were concerns the mother may have been using drugs because she appeared disheveled and confused.

The CPS worker met with the mother and the paternal grandparents. The grandparents own the home the family live in and visit frequently. Mother confirmed the concerns in the report. Despite reportedly checking on her children every five minutes, a similar incident occurred the day prior and her two-year-old child was returned to the home by a mailman. Upon contacting the family, the CPS worker noted several concerns in the home, including improper storage of firearms; several beer bottles and cans in the parents' bedroom; a strong smell of animal excrement; clutter throughout the home; and an unsafe sleeping area (a bouncing chair) for the two-month-old. In addition, the two-month-old was observed to be small and the one-year-old had a significant diaper rash. The worker made recommendations to resolve the immediate safety concerns including storing the firearms in a safe and cleaning up some clutter. The following day, the worker returned to the house and noted that the parents had installed alarms on the doors leading outside and a bassinet had been bought for the two-month-old child. The firearms were placed out of the children's reach and the home was cleaner.

During the follow-up visit, the parents reported their relationship was strained from disagreements about child caring responsibilities. The case worker observed elements of power and control demonstrated by the father, however both parents denied any physical violence. The mother expressed concerns regarding father's alcohol use. She denied any substance abuse herself but admitted using marijuana when the children were asleep. Parents were offered and participated in in-home Family Skill Builder services. The father participated initially in another service but did not follow through.

The worker continued to follow-up with the family and communicated with Family Skill Builder for updates regarding noted safety issues. At the conclusion of the CPS assessment, the mother reported the father was drinking less. Medical providers

confirmed the two-month-old was gaining adequate weight. Additional services were offered and declined. The case was closed as the children were determined to be safe.

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 any actions taken or not taken by LEA or the Department.

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 noted the parents were offered in-home services during the prior CPS assessment. The parents expressed a desire to continue working with contracted providers, however the Department was unable to extend these contracts as the CPS assessment ended because the identified safety concerns had been addressed. Though not directly connected to the outcomes of this case, the CIRT noted further services might have continued to benefit the family.

The CIRT noted a continued need for additional safe sleep education for families, specifically, discussions with parents about alternative safe sleep environments if the primary safe sleep environment is unavailable as it was in this case. This will be included in the Department's safe sleep training which will begin before spring of 2020.