

E.B. CIRT Public Report

Date	11.15.19
Date of Initial Report	2.1.19
Purpose of Final Report	<p>Critical incident reports are used as tools for reviewing 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 DHS' website.</p>
Executive Summary	<p>On 4.25.18, two-year-old E.B. died after experiencing a closed head injury. On 12.6.18 the Department determined there was reasonable cause to believe E.B. died as a result of abuse.</p> <p>On 12.10.18, the Department Director declared a CIRT be convened. This is a mandatory CIRT as E.B. had been the subject of a child protective services assessment in the 12 months prior to the critical incident.</p> <p>Department history regarding this family was limited to one prior assessment, which was unfounded.</p>

<p>Summary of Critical Incident</p>	<p>On 4.7.18, two-year-old E.B. was injured in an automobile accident after the mother was driving under the influence of multiple substances. Although E.B. was properly restrained, the speed and impact resulted in bruises and scratches to the child's head and a subdural hematoma. The child was hospitalized and closely monitored for several days. When it was determined E.B. was stable, the child was sent home with relatives. The Department dismissed the protective action as the relatives had filed for guardianship and were able to safely care for the child.</p> <p>On 4.23.18, E.B. was brought to the emergency department by ambulance after the child's relatives became concerned about crying and fussiness throughout the night prior. E.B. was hospitalized with seizures and bleeding in the brain. A new CPS assessment was assigned and linked to the 4.7.18 report. On 4.25.18, E.B. died as a result of a closed head injury. There was significant delay in determination due to the nature of the law enforcement investigation and pending medical examiner's report, however on 12.6.18 the Department's assessment was closed with a determination that E.B.'s death was the result of abuse.</p> <p>An additional delay in publication of this report occurred due to pending prosecution of the criminal case. That case is now resolved, and the mother has been convicted of Assault II, DUI and Reckless Endangerment.</p>
<p>Evaluation of Department Actions</p>	<ul style="list-style-type: none"> • No systemic issues were identified
<p>Recommendations for improvements and associated tasks</p>	<p>There are no recommendations resulting from this review.</p>

Methods of evaluating expected outcomes	Not Applicable
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