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: HXA64P1R3Y		
Date of critical incident: October 8, 2019	**Date Department became aware of the fatality:** October 8, 2019	
Date Department caused an investigation to be made: October 8, 2019	**Date of child protective services (CPS) assessment disposition:** January 13, 2020	
Date CIRT assigned: October 10, 2019	**Date Final Report submitted:** January 17, 2020	
Date of CIRT meetings: October 29, 2019 December 2, 2019	**Number of participants:** 10 14	**Members of the public?** No No

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

Date of report:	Allegation(s):	Disposition:
10/08/2019 **Assignment decision:** Assign- 24 Hours	Neglect by Mother & Father	Founded

On October 8, 2019, the Department received a report that a one-month old infant was found unresponsive at the family home. The father reported he checked on the infant around 3:00 AM and the infant did not look normal. The father woke the mother, who found the child stiff and unresponsive and called 911. The father administered CPR under the guidance of the dispatcher, however the child did not survive. The child was reported to be a healthy infant with no obvious signs of injury at the time of death.

There was an open CPS assessment at the time of the critical incident due to concerns about parental substance use and mental health. There was an initial safety plan in place, with the child in the care of the mother and father. The child was not in the custody of the Department.

The caseworker who had previously been assigned to assess the family at the time of the child's birth gathered information about the events leading to the child's death. The mother and father reported they put the infant to bed at about 09:30 PM and both adults went to bed at the same time. The infant was sleeping in a basket which was placed on the parents' bed between the mother and the wall. The father slept on the outside of the full-size bed. Inside of the basket was a standard size pillow with a blanket on top of the pillow. The child was sleeping on top of the blanket and pillow and was covered by another blanket. The mother reported the child had been sleeping in the basket for a few weeks to avoid a parent rolling over on the child. The mother stated the child did not sleep well in the bassinette.

Prior to the death of the child, the family had been referred for services to address substance use, mental health and parenting. These services included a voluntary home visiting program to address parenting and infant care. The family received safe sleep education at the hospital prior to discharge and the caseworker who visited the home shortly after the child's birth observed the bassinette and had spoken with the family about safe sleep. The father told the caseworker the family would be using the bassinette for the child to sleep in. Two weeks preceding the child's death, a home visitor spoke with the mother about the danger of putting the child down to sleep on a pillow. The service provider explained to the mother it was not safe for the child, which

the mother acknowledged and agreed to remove the pillow from the basket. The Department was unaware of the change in sleeping arrangements from the bassinette to the basket prior to the critical incident.

Both the mother and father reported near daily marijuana and tobacco use prior to the death of the child, with the mother acknowledging she smoked approximately five bowls a day of marijuana in a previous interview. The parents also reported using dabs on a regular basis. It is highly likely the mother and father were under the influence the evening prior to the death of the child. The father reported smoking that evening with mother, however the mother denied any use for several days. The caseworker asked the mother and father to provide urinalyses after the death of the child. The mother initially agreed but later refused after the father also refused. The mother and father explained they had used substances the morning following the child's death.

Collateral contacts indicated ongoing conversations about the mother's marijuana use and breast feeding and the risk to the child. The mother and father continued their use in spite of concerns expressed by CPS and other professionals. Both parents presented with significant substance abuse history and it is likely cessation would have been difficult without treatment.

The CPS assessment related to the critical incident was linked to the open assessment in the child welfare database and details of the assessment activities prior to the fatality are included in the description of the report dated 09/06/2019. The allegation of neglect resulting in the death of the child is founded for both the mother and father.

Description of relevant prior Department reports:

Date of report: 03/01/2019 **Assignment decision:** Closed at Screening	**Allegation(s):** Neglect by Mother	**Disposition:** Not Applicable

The Department received a report regarding the mother using methamphetamine while pregnant. It was reported the father was also using substances. No additional detail was provided.

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: 09/04/2019 **Assignment decision:** Closed at Screening	**Allegation(s):** Neglect by Mother	**Disposition:** Not Applicable

The Department received a report of concern the mother did not have a place to live and was in labor. The mother sought medical care to determine if her water had broken. When informed it had, the mother declined further medical testing and became upset. The maternal grandmother was present at the time and attempted to calm the mother down, however the mother left the medical center and did not return. The mother's toxicology screen was positive for marijuana.

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: 09/06/2019 **Assignment decision:** Assign-24 Hours	**Allegation(s):** Neglect & Threat of Harm by Mother	**Disposition:** Unfounded

On September 6, 2019, the Department received a report the mother had given birth to the child. According to the reporter, the mother used marijuana throughout her pregnancy and used methamphetamine until approximately five months gestation. The mother also had a history of mental health concerns. The mother was reported to be appropriate with the child and the child was healthy with no medical concerns despite being born two weeks early. There was an adult man at the hospital who was reported to be the possible father to the child.

The assigned caseworker met with the mother, father, and child. The mother reported she believed her current significant other was the child's father, but there was also

another man who could be the father. The caseworker made attempts to contact the other possible father, without success. The man who resided with the mother and provided parental care for the child is referred to as the father in this report.

The mother acknowledged intravenous use of methamphetamine for a number of years and through the first five months of pregnancy. She also acknowledged marijuana and tobacco use throughout her pregnancy. The father reported a similar history of substance use, including methamphetamine and marijuana. Both parents maintained they had ceased use of methamphetamine several months prior to the birth of the child and had only continued use of marijuana and tobacco. It is unclear how the parents were able to maintain abstinence from methamphetamine.

The family rented a room in a home where three other adults also resided. According to the mother and father, the other adults in the home did not use illegal substances. Contact at the home shortly after the child's birth noted the home and in particular the room the family was renting, was safe for the child. A bassinette was observed, and the father stated it would be used for safe sleeping. The documentation indicates the parents' room smelled of marijuana and the father explained they keep their marijuana inside a table next to the bed.

Due to the recent history of significant substance use by the parents, the caseworker devised a safety plan for the child upon release from the hospital. The plan included the maternal grandmother visiting the home daily to check on the family to assure safety of the child. Additionally, referrals were made to local providers who could assist with child safety, in particular short-term parenting support through a contracted Intensive Safety and Reunification Services provider and a local community health nurse program. The parents were cooperative with the CPS assessment and accepted referrals to the Child Welfare Addiction Recovery Team, submitted UAs (which were positive for marijuana), and accepted referrals for mental health assessments.

Early in the assessment, the Department received information about possible domestic violence in the home. One police contact in September, just days before the child's birth, occurred after the father threw coffee on the mother and pulled her hair. Both the mother and father denied any violence in their relationship and only acknowledged any incidents after confronted with information in police reports. After the death of the child, reports of violence increased, and the father was arrested. It was after the caseworker contacted the mother regarding this incident that the mother and father refused to engage any further with the Department's assessment.

The child died on October 8, 2019, during the pendency of this assessment. The allegation of neglect related to the fatality is founded and the allegations in this 9.6.19 assessment are unfounded.

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 Department had limited contact with the child in this case, having only begun assessing the family five weeks prior to the fatality. The early assessment activities resulted in identification of safety concerns and the development of an initial in-home safety plan. The mother and father presented as receptive to support and services through the Department and had participated in early referrals for screenings and assessments. The caseworker had been to the home at the beginning of the assessment and observed a safe sleep environment but had not been back to the home since and was unaware the family had begun using the basket with the pillow.

Both parents continued to use marijuana and tobacco after the birth of the child. Their use of marijuana and their decision to continue placing the child in an unsafe sleep environment likely contributed to the death of the child. The Department, though unaware of the specific sleep arrangement, did not fully understand the scope of the parents' marijuana use in relation to the safety of the child. Although legal, marijuana use presents a host of risks to children, in particular infants, who rely solely on adults to care for them. In this case, the child was exposed prenatally, in the home environment and also through breast milk. The parents were likely impaired during parenting activities.

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:

As with other similar cases reviewed by the CIRT, there is a gap in understanding the potential safety threats associated with parental marijuana use and infant care. This is especially concerning when the use is persistent and there are other risk factors present, such as parental mental health/post-traumatic stress and family violence. Even when parents are given a significant amount of information about safe sleep, as was true in this case, the family situation may be such that parents are unable to follow recommendations and children are placed in harm's way.

The CIRT recommends the Department continue efforts to educate and support caseworkers in adequately assessing parental substance use, in particular marijuana use in relation to safe care of infants and young children.

The CIRT recommends the Department continue current efforts to develop and deliver training on assessing infant sleep environments, in particular when the risk factors mentioned above are present. Additionally, the CIRT recommends continued efforts to partner with public health organizations who provide safe sleep education in order to identify families most at risk and provide education that is considerate of the unique circumstances of the family versus relying solely on a one size fits all approach.