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 determined 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 the DHS' website.

CIRT ID: ISBLEKXAKG		
Date of critical incident: September 19th, 2019	**Date Department became aware of the fatality:** October 8th, 2019	
Date Department caused an investigation to be made: October 8th, 2019	**Date of Child Protective Services assessment disposition:** December 5th, 2019	
Date CIRT assigned: October 11th, 2019	**Date Final Report submitted:**	
Date of CIRT meetings: November 4th, 2019 December 3rd, 2019	**Number of participants:** 17 14	**Members of the public?** No No

Critical Incident Review Team Final Report

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

Date of report: 10/08/2019 **Assignment decision:** Assign-10 Days	**Allegation(s):** Neglect by Mother to Child	**Disposition:** Unfounded
On 10/8/2019, the Department received a report regarding the death of a one-year-old child which occurred several weeks prior. After the child's death, it was learned the mother used methamphetamine while caring for the child. The CPS worker interviewed the mother who stated her child was born with extensive medical issues requiring ongoing specialized care. The child was previously in a bed car seat, but medical providers recently approved the use of an upright seat. On the day the child died, she and the child were running errands with another person. Both adults were in the front seat of the car and the mother gave the child some cookies before driving. At the end of the approximate eight-minute drive, the child was found to be unresponsive and slumped over. Emergency responders transported the child to the hospital where the child died. The mother was asked about her substance use, however she declined to respond. The mother was unwilling to disclose the identity of the biological father of the child. The child's death was attributed to the child's pre-existing medical conditions and the case was closed as no further intervention was required since there were no surviving children in the home.		

Description of relevant prior Department reports:

Date of report: 07/03/2018 **Assignment decision:** Assign-24 Hours	**Allegation(s):** Threat of Harm to Child by alleged Father 1 Neglect by Mother to Child	**Disposition:** Unfounded Unable to Determine
The Department was notified about the birth of a newborn and concerns of substance use by mother during her pregnancy and potential domestic violence by alleged Father 1. At the time of the child's birth, two men presented themselves as possible fathers. The mother reported she was referring to a previous relationship, not alleged father 1 or 2, when disclosing domestic violence to nurse staff. Alleged father 1 was interviewed and did not believe the mother was using any drugs. He disclosed marijuana use and participated in a urinalysis which confirmed his admission. Alleged father 2 was asked to leave the hospital by hospital staff because of his		

disruptive behavior and no additional information was gathered from him.

The mother denied drug use, despite being overheard by hospital staff that her UA would be positive for methamphetamine. The lab was unsure if the mother's UA results were positive for amphetamines or methamphetamine. The child's meconium sample came back positive for amphetamines and THC. The child presented with significant medical issues and a medical hold was placed on the child on 7/10/18.

The Department offered services to the mother. The Department later received confirmation that the mother's initial UA was positive for methamphetamine, however no further action was taken as the mother resolved any concerns regarding substance abuse. The child was determined to be safe and the case closed.

Date of report: 12/14/2018 **Assignment decision:** Closed at Screening	**Allegation(s):** Neglect by Mother to Child.	**Disposition:** Not Applicable
The Department received a report that a motorcycle gang was threatening to hurt the mother. Mother was provided information on resources. This was closed at screening as no child abuse was identified.		

Date of report: 02/10/2019 **Assignment decision:** Closed at Screening	**Allegation(s):** Neglect to Child by Mother	**Disposition:** Not applicable
The Department received a concern the child was admitted for a medical procedure. Alleged father 1 was not allowing mother access to the home to retrieve necessary medical equipment for the child. The medical provider was contacted by the on-call worker and they confirmed the child would not be discharged without the necessary medical equipment. This was closed at screening as the child was 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 agreed the Department's interventions with the family were adequate and did not identify additional actions necessary to assure child safety. The child's death was determined to be the result of ongoing medical conditions and not attributed to child abuse. Though later reports suggested the mother may have been using drugs while caring for the child, records indicate she provided good care of her child and advocated for services regarding his special needs.

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 had no additional recommendations because services were provided to the family which improved the family condition and the child's death was not attributed to child abuse, but rather pre-existing medical conditions that were being monitored by medical providers.