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: KAEX624LSI		
Date of critical incident: January 1, 2020	**Date Department became aware of the fatality:** January 1, 2020	
Date Department caused and investigation to be made: January 1, 2020	**Date of child protective services (CPS) assessment disposition:** April 8, 2020	
Date CIRT assigned: January 6, 2020	**Date Final Report submitted:** April 9, 2020	
Date of CIRT meetings: January 23, 2020 March 6, 2020	**Number of participants:** 13 16	**Members of the public?** No Yes

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

Date of report:	Allegation(s):	Disposition(s):
1/1/20 **Assignment decision:** Assign with 24-hour response	Neglect by Mother and Father	Unfounded

On January 1, 2020, the Department received a report regarding the death of a four-month old infant. According to the report, the mother called emergency services at approximately 4:00 a.m. after the child was found unresponsive in the bassinette with a blanket around the head. The father was also on the phone and was instructed on how to perform infant CPR by the dispatcher. Emergency services arrived and transported the child to the hospital, where the child was pronounced dead.

Law enforcement requested the assistance of the Department at the hospital due to the unknown circumstances surrounding the death of the child. The initial medical observation of the child noted a possible healing fracture of the tibia as well as a red spot on the child's eye. These observations were later determined inaccurate by way of full examination.

The parents stated the family, including the child, were mixed up on sleeping schedules, with everyone up late into the night. The father said they put the child to bed between midnight and 2:00 a.m. The child was placed to bed alone and swaddled with a blanket. The father explained he and the mother began to prepare for bed about 4:00 a.m. but when they checked on the child, they noticed the child's color was not right. The mother reported observing the child on the stomach with a blanket around the head. Additional information provided in the report indicated the child had not started rolling over until the day of death, though later the mother reported the child had been rolling over recently, including from back to front. The mother stated lately the child had also been kicking out of the blanket when swaddled.

The father made some statements regarding the mother's mental health and personality changes and stated he was the primary caregiver for both the mother and child. He stated he left the child with mother for about an hour to run to the store the day prior. When the father arrived back home, the child had thrown up, but the father was not concerned as spitting up was normal behavior and there was nothing else of concern.

At the time of the fatality, the father was on probation for assaulting an unrelated adult in another city, where the couple experienced housing instability. The mother and father were married in December 2019 and had recently moved into their residence. The father was compliant with probation and had been in regular contact with his probation officer since the birth of the child.

Initial contact occurred with both parents and the maternal grandparents at the family home. The father was very upset with the Department and explained he had experienced trauma due to prior involvement with child welfare as a child. The mother was more forthcoming with information though it was noted she also had a traumatic past. The contact was short due to the somber circumstances and the caseworker explained they would follow up at a later date.

Prior to participating in comprehensive interviews, the parents hired an attorney to communicate with the Department. This was due to their past trauma and apprehension about participating in a CPS assessment. Health records for the child were gathered and there were no noted concerns with the mother's behavior or mental health. It was noted the mother reported the child slept regularly in a crib, on the back.

Based on the information gathered, there was no indication the child had been physically abused or neglected and the fatality appeared to be an unexplained infant death. The CPS assessment was closed as unfounded without further contact with the family.

Description of relevant prior Department reports:

Date of report: 11/4/19 **Assignment decision:** Closed at Screening	**Allegation(s):** Threat of Harm	**Disposition(s):** Not Applicable

On November 4, 2019 the Department received a report of concern regarding the newborn infant. According to the reporter, the father had a history of sexual offending behavior and the reporter was concerned he had not completed treatment and could be a risk to the child. There was also concern the mother was not worried about the father's past behavior. The reporter believed the father had lived on the streets in order

to avoid probation requirements. The reporter was also concerned about the family's living situation.

The screener made a collateral contact to confirm the father's status and compliance with probation. The family had housing and there were no concerns or restrictions regarding the father caring for the infant. The report was closed at screening as it did not meet criteria for assignment.

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 child and no safety concerns for the child were reported by providers having contact with the family. The allegation of abuse related to the death of the child was unfounded.

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 did not have any recommendations.