

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. The CIRT report is created at a specific time as required by statute and does not account for events occurring after the posting of the report. Versions of all final reports are posted on DHS’ website.

CIRT ID: KVRHCUQ7FQ		
Date of critical incident: February 9, 2020	Date Department became aware of the fatality: February 10, 2020	
Date Department caused an investigation to be made: February 9, 2020	Date of child protective services (CPS) assessment disposition: April 13, 2020	
Date CIRT assigned: February 11, 2020	Date Final Report submitted: May 13, 2020	
Date of CIRT meetings: February 27, 2020 April 6, 2020	Number of participants: 19 19	Members of the public? No No

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

Date of report: 02/09/2020 Assignment decision: 24-hour response	Allegation(s): Neglect by Mother and Father 2	Disposition: Unfounded
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On February 9, 2020, the Department received a report about the death of a four-month-old child while in the care of the child's father. The father reported he put the child to sleep between 8:00 p.m. and 9:00 p.m. on the evening of February 8, 2020. The child woke at approximately 10:00 p.m. and 2:30 a.m., was given a bottle and went back to sleep. When put to sleep at 2:30 a.m. the child was placed in a rocking bassinet. The father stated he swaddled the child with one blanket, laid the child on their left side placing a second blanket over the child's feet. The father checked on the child around 5:30 a.m. and found the child unresponsive and cold to the touch. The paternal grandmother attempted life-saving measures while the father called 9-1-1. The child was taken by ambulance to the local hospital and pronounced deceased. The report stated that law enforcement initial findings did not note any observable signs of abuse in the death of the child and no concerns were noted regarding the condition of the residence.

During the course of the assessment the father informed the CPS caseworker that he had placed a blanket near the sleeping child to stop the child from rolling onto the stomach. The father and the mother confirmed receiving safe sleep education from medical providers, however they also said that a medical provider told them that the child would be safe sleeping on their side with a blanket.

As part of an assessment of a report of abuse received by the department prior to the report of the fatality, an in-home safety plan had been developed, which restricted contact between the child's mother and the child and the child's sibling, both of whom were residing with the child's father. It was unclear if the mother was at the father's residence at the time of the fatality. The CPS caseworker learned from law enforcement that the father disclosed the mother was living in the home with the children and the mother was found in the residence by law enforcement personnel after the child had been taken to the hospital. The mother subsequently reported to law enforcement she was in and out of the home the night of the fatality and had returned to the father's residence at approximately 4:00 a.m.

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The mother and the father were minimally cooperative with the CPS caseworker during the assessment. The mother provided the CPS caseworker inconsistent information regarding where she was living or staying. She denied living with the children despite having reported to law enforcement she was staying with the children and the father. While concerning that the safety plan was not followed by the parents, information gathered during the assessment did not indicate the child's death was the result of neglect or abuse as the child's death was attributed to Sudden Unexplained Infant Death and the CPS assessment was determined to be unfounded.

Description of relevant prior Department reports:

Date of report:	Allegation(s):	Disposition:
08/22/2016	Sexual Abuse by Father 1	Opened in Error
Assignment decision: 24-hour response	Threat of Harm by Father 1	Unfounded
	Physical Abuse by Father 1	Unable to Determine

On August 22, 2016, the Department received a report with concerns of physical abuse and threat of harm for sexual abuse to the child's three-month old half-sibling by the sibling's father. The report stated there was a video in which the father picked up the crying sibling, left the view of the camera and then two noises could be heard followed by an increase in crying by the sibling. The report also stated that the father was accessing pornographic material involving pubescent females.

During the CPS assessment, the father reported that the noises in the video were caused by dropping cans of formula which scared the sibling. Other individuals contacted during the assessment expressed belief that the sibling had been struck by the father, although this had not been witnessed. The sibling had no visible injuries.

DHS received conflicting information about the pornography issue between what the parents reported, and information learned from collateral contacts. The CPS worker noted that the father and the mother, who have a three-year age difference, began a romantic relationship and had a child together when the mother was a minor. A collateral contact expressed concern regarding the mother's decision-making skills and mental health. The mother was offered, but declined, services.

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The Department determined that there was insufficient information gathered to identify the sibling was placed at threat of harm by the father and this allegation was coded as unfounded.

Due to conflicting information obtained regarding the incident, the Department concluded the allegation of physical abuse to the sibling by the father was unable to determine.

The sexual abuse allegation regarding the mother and her relationship with the father was determined to have been opened in error.

Date of report: 07/31/2018 Assignment decision: 24-hour response	Allegation(s): Neglect by Mother	Disposition: Unable to Determine
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On July 31, 2018, the Department received a report that five days prior, while under the influence of alcohol, the mother was involved in a single vehicle crash while driving the child's sibling and an unknown male. The crash resulted in damage to forty feet of guardrail however the mother did not request assistance from emergency services. It was reported that the mother was seen driving with the sibling and unknown males in the late evening/early morning on multiple occasions. It was also reported the mother was using duct tape to keep the diaper on the sibling's body.

The CPS caseworker received a law enforcement report with detailed information about the car accident. A 9-1-1 call was placed stating a vehicle had hit the guardrail. Upon arrival the officer found an abandoned, severely damaged vehicle. Evidence on the highway indicated the damaged vehicle had been traveling at a high rate of speed when the driver lost control around a sharp corner and struck the guardrail. Blood was found in and outside of the damaged vehicle, but the officer was unable to identify a driver or any occupants at the scene.

Law enforcement contacted the 9-1-1 caller who described a female driver matching the mother's description. The witness also reported seeing a young child and a male in the vehicle. At the conclusion of the investigation, law enforcement determined that the mother was driving the vehicle, although she denied this and reported her vehicle had been stolen, despite making no prior report of a stolen vehicle. Collateral contacts informed law enforcement that the mother disclosed she had been drinking prior to the accident. While the male involved in the crash was unwilling to speak to law enforcement, through collateral contacts law enforcement learned that the man had

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been injured and required medical attention. The mother was ultimately cited and released for failing to perform the duties of a driver, reckless endangerment of another person and careless driving.

The CPS caseworker contacted the mother and the sibling at their residence. Neither the mother nor the sibling had visible injuries. The mother denied being involved in an accident and reported her car had been stolen. The worker found evidence of marijuana and alcohol use at the residence though the mother denied any current substance use. In response to the allegation of duct-taping the diaper to the sibling, the mother admitted to previously using tape to secure the sibling's diaper as the sibling had smeared feces on the walls.

Due to the inconsistent information received regarding the car crash, the Department concluded the assessment was unable to determine for neglect.

Date of report: 10/31/2018	Allegation(s): Neglect by Mother	Disposition: Unable to Determine
Assignment decision: 24-hour response		

On October 31, 2018, the Department received a report that the mother left the two-year-old sibling home alone while she drove her significant other to work. The mother was reportedly gone for a minimum of ten minutes during which time the windows to the residence were open creating at risk the sibling could fall. The report stated that the mother left the sibling unattended at the residence on previous occasions.

The CPS caseworker had difficulty contacting the mother. The mother failed to appear for an appointment with the worker and despite additional attempts made by phone and at their residence, the worker was unable to contact the mother or the child's sibling. Attempts to contact the sibling's father and grandmother were also unsuccessful.

Approximately one month after the assessment opened, the mother contacted the CPS caseworker and allowed an interview to occur at her residence. During that contact, the sibling was noted to be healthy and clean. The CPS caseworker learned the mother and the sibling were residing with the mother's significant other (the child's father) and the significant other's adult sibling. The mother denied leaving the sibling unattended, however an adult in the home reported having found the sibling unattended on multiple occasions. During one instance the adult found the sibling unattended and when the mother arrived ten minutes later, she reported she had been at the store.

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Due to conflicting information regarding the sibling being left unsupervised, the Department concluded that the allegation of neglect by the mother was unable to determine and that the sibling was safe in the mother's care.

Date of report: 10/15/2019 Assignment decision: 24-hour response	Allegation(s): Neglect by Mother	Disposition: Founded
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On October 15, 2019, the Department received a report of concern for the safety of the one-month old child and the child's 3-year old sibling. The Department was informed that the previous evening the mother and the child's father were involved in a physical altercation while driving with the children. The mother reportedly punched the father in the face and threw food at him while he was driving. She also reportedly grabbed the steering wheel causing the father to drive off the road. The father stopped the car and exited the vehicle taking the keys. The mother then took the keys from the father and with the children in the vehicle, drove away at a high rate of speed nearly striking the father. Shortly after leaving, the mother returned. When the father refused to get into the vehicle she again drove away. The father contacted law enforcement who subsequently arrested the mother for reckless endangerment.

When interviewed by the CPS caseworker, the father confirmed the information provided in the screening report including that the mother threw food, hit him and grabbed the steering wheel while he was driving. The father reported that the altercation began when he bumped an existing injury on the mother's hand. The father reported concerns regarding the mother's mental health stating that since having her second child she was experiencing mood swings and possible postpartum depression. The CPS caseworker observed the home environment and did not identify any safety concerns. The 1-month-old child was at the residence however, the 3-year-old sibling was with extended family members.

The CPS caseworker interviewed the mother while she was lodged in the local jail. The mother reported that the father was the aggressor in the altercation. She stated that the father became angry at her when she changed the temperature in the vehicle, so he grabbed her injured hand and hit her in the face. The mother reported that in response she threw food at the father. The mother denied grabbing the steering wheel as well as driving away in the vehicle and nearly striking the father. The mother admitted to historical depression but denied any current mental health concerns.

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When the mother was released from jail, the CPS caseworker contacted the mother where she was staying at the home of a family member. A Protective Action Plan restricting the mother's contact with the children was created. The mother agreed to the Protective Action Plan but then refused to engage with the CPS caseworker and therefore the Department was unable to offer the mother services.

The Department subsequently determined that the Protective Action Plan was not necessary as the mother was subject to a no-contact order with the children as a result of her criminal case. While the father was determined to be following the no-contact order, he allowed contact at one point stating he was informed the criminal no-contact order had been dismissed when, in fact, it had not. The father agreed to follow the no-contact order and inform the Department if the no-contact order was dismissed.

The Department concluded that the allegation of neglect by the mother was founded as the mother engaged in a pattern of erratic behavior placing her children in an unsafe situation. The Department's contact with the family continued as additional assessments were opened during this assessment.

Date of report: 11/08/2019 Assignment decision: 24-hour response	Allegation(s): Neglect by Mother and Father 2	Disposition: Unfounded
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On November 8, 2019, the Department received a report that the seven-week-old child was seen in the emergency room due to vomiting blood and having unexplained injuries. Hospital personnel did not find that the parents' report that the child scratched their own throat to be a plausible explanation for the blood. It was also reported that the parents failed to adequately follow-up with medical appointments for the child's orthopedic birth defect. The parents reportedly failed to show or call for two appointments and providers had difficulty contacting the parents. It was also reported that the quality of the parents' relationship was concerning but no further details were provided.

The CPS caseworker attempted to locate the family both at local medical facilities and at the family home without success. The CPS caseworker learned that the child had been treated and released from the hospital seven days prior.

A few days later the CPS caseworker was able to locate the children and the father. The CPS caseworker observed both children and noted no concerns. The father reported that he was following the no-contact order between the mother and the children but did not understand the safety concerns expressed by the Department.

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The father reported that he had taken the child to the emergency room after the child vomited a small amount of blood. The father could not think of a cause of the child's injury other than the child scratching their own throat. The father reported the child was under the care of a specialist and had not missed a single appointment and therefore the father did not deem it necessary for the child to also be seen by a pediatrician. The father signed releases of information for the child's medical providers who reported no concerns regarding the child's throat abrasions and believed they were caused by the child putting their own fingers down their throat. The CPS caseworker noted both the mother and the father were reportedly at the emergency room visit for the child, which was a violation of the no-contact order.

The Department concluded that the allegation of neglect to the child by the parents was unfounded. The Department determined that the information gathered indicated the child's medical needs were being met, that the child's throat injury was reported to be consistent with the parents' report and medical professionals did not express concerns for the child's care.

The Department's work with this family continued through additional assessments dated December 19, 2019, and January 5, 2020.

Date of report:	Allegation(s):	Disposition:
12/19/2019	Neglect by Father 2	Unfounded
Assignment decision: 24-hour response	Threat of Harm by Father 2	Unfounded

*Please note that the assessment activities for this report were captured under the assessment dated 11/08/2019 and separated here for clarity.

On December 19, 2019, the Department received a report of concerns for the safety of the child and the child's sibling as their mother returned to the home despite a no-contact order with the children. It was also reported that the child's father was verbally and physically abusive to the mother in the presence of the children. The mother reportedly had a black eye caused by the father who was not allowing her to leave the residence. The father also reportedly threatened the mother with a violation of the no-contact order and began monitoring her telephone use and denying her access to the internet.

When the CPS caseworker responded to the residence with the assistance of law enforcement, the father would not allow either to enter the home. The father brought the children to the porch so that they could be observed by the CPS caseworker who did not note any concerns or injuries to either child. The father denied any violence and

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acknowledged the requirements of the no-contact order but stated that he did not agree with the order.

The CPS caseworker made attempts to contact and interview the mother without success.

The Department concluded that the allegations of neglect to the children by the mother and the child's father other were unfounded. The Department found that the information gathered did not substantiate that contact between the mother and the father was occurring. Regarding the allegation of threat of harm to the children by the father, the Department concluded that the information gathered did not substantiate concerns about domestic violence or power and control dynamics.

Date of report:	Allegation(s):	Disposition:
01/05/2020	Physical Abuse by Father 2	Unfounded
Assignment decision: 72-hour response		

*Please note that the assessment activities for this report were captured under the assessment dated 11/08/2019 and separated here for clarity.

On January 5, 2020, the Department received a report of physical abuse to the 3-year-old sibling by the child's father. It was reported that two weeks prior, the father hit the sibling across the face leaving a bruise. Law enforcement had contact with the sibling on the day the report was received by the Department and did not observe any injuries to the child. While law enforcement was at the residence, the mother arrived and was arrested for violating the criminal no-contact order. It was noted that the mother had no injuries. A collateral contact reported that the mother had arrived at the residence because the father placed the mother's belongings outside the home and threatened to burn them if she did not retrieve the items.

The CPS caseworker contacted the mother, who was incarcerated and refused to speak to the worker. When the father was contacted, he denied concerns and stated that he was being harassed by the mother's family. He stated he had placed the mother's belongings outside the home to be retrieved, however he denied threatening to destroy the belongings. The father reported that the mother's criminal attorney informed him the no-contact order was lifted, however this was incorrect, and the CPS caseworker informed him the order was still in place. The CPS caseworker observed the home and no safety concerns were identified.

The CPS caseworker contacted the father of the 3-year-old sibling who resided out of the area. The sibling's father expressed concern regarding the mother's behaviors and

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planned to pick up the sibling immediately from the care of the child's father. The sibling's father met with the CPS caseworker and completed a Protective Action Plan agreeing he would provide care for the sibling.

The mother plead guilty to harassment and subsequently her criminal no-contact order was dismissed. At that time, the Department initiated an in-home safety plan for the child in the care of the child's father. The child's father agreed to restrict contact between the mother and the child, although both the father and the mother stated they did not understand the safety concerns posed by mother.

The Department concluded that the allegation of physical abuse to the 3-year-old sibling by the child's father was unfounded as the sibling had no injuries and medical staff did not report concerns or suspicious injuries to the sibling.

Based on the totality of the information obtained during the recent CPS assessments involving the family, the Department concluded that the mother established a pattern of erratic and unstable behaviors that directly impacted the safety of her children. The mother's failure to acknowledge this concern and the children's vulnerability based on their ages and dependence on caregivers for their basic needs, placed the children at threat of harm. Based on the information gathered during the CPS assessment, the Department added an allegation of threat of harm to both children by the mother. The allegation was founded for threat of harm to the children by their mother under the November 8, 2019 report.

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 concerns regarding actions taken or not taken by the Department or law enforcement agencies in response to the critical incident or the events that directly led to the critical incident. The child's death was determined to be Sudden Unexplained Infant Death and the allegation of neglect to the child by the parents was unfounded. The Department had current involvement with family, however the circumstances regarding that involvement were unrelated to the death of the infant.

The CIRT's analysis of the case history offered the following key observations, though not directly related to the fatality:

- Over the past two years, the CIRT has reviewed cases in which infants died while sleeping. These deaths have led to questions regarding the consistency and efficacy of safe sleep education in the community and offer an opportunity to further explore the role the Department can further play in reinforcing safe sleep practices for infants.

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- As the Department strives to keep children safely in their home, safety planning and appropriate safety decisions are critical elements in managing identified safety threats to children. The CIRT noted opportunities for additional support regarding safety decisions and safety planning.
- The CIRT recognizes that many families engaged with the Department may have past or current trauma which can influence their response to Department involvement. Understanding and interacting with families in a manner that is responsive to the impact of the trauma they have experienced is essential to effectively partnering and communicating with families to address child safety.

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 recommends the Department continue with the implementation of a safe sleep education plan for child welfare staff. This plan includes providing education and coaching to all child welfare staff who come into direct contact with families. Education will include guidance for caseworkers around engaging in thorough safe sleep conversations and providing safe sleep education as appropriate to families any time there is a child under the age of one in the home. This mandatory training is scheduled to begin in May 2020.
- The CIRT recommends the Department continue with current efforts to support best practice for safety decisions and safety planning. The Department is now generating reports on existing safety plans which supports ongoing training and coaching regarding the sufficiency of safety planning. Additionally, the Department conducts fidelity reviews every six months as well as quarterly de-briefs in order to review the accuracy and sufficiency of safety plans and decisions. These efforts support the ongoing coaching and training of staff in this practice area.
- The CIRT recommends the Department continue with recent steps towards becoming a trauma informed organization. In December of 2019, the Department created a trauma-informed organization policy which directs the Department to provide resources and training to support a trauma-informed approach to service delivery. This is a vital first step to providing casework staff the tools to effectively engage with families in a trauma informed manner.



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