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: L8V5954CT7		
Date of critical incident: April 25, 2020	**Date Department became aware of the fatality:** April 25, 2020	
Date Department caused an investigation to be made: April 25, 2020	**Date of child protective services (CPS) assessment disposition:** July 31, 2020	
Date CIRT assigned: April 29, 2020	**Date Final Report submitted:** August 3, 2020	
Date of CIRT meetings: May 18, 2020 (Initial) June 29, 2020 (Follow-up)	**Number of participants:** 14 19	**Members of the public?** 0 1

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

Date of report: 4/25/2020 **Assignment decision:** Assign: 10-day response	**Allegation(s):** Neglect to the infant by the mother	**Disposition(s):** Unfounded

On April 25, 2020 the Department received a report regarding the death of a three-month-old infant. It was reported the mother was home alone with the infant and put the infant down for a nap in a bouncy seat with a blanket. The mother reportedly took a nap during this time and when she woke up, she found the infant unresponsive, with the blanket over the infant's head. The blanket was described to be of heavy fleece and the temperature of the room was reported to be very warm. The mother called for emergency services and the infant was transported to the hospital while life saving measures were performed. The infant was pronounced deceased at the hospital. The maternal grandmother also lived in the home with the mother and the infant but was not home during the time of the critical incident. The father of the infant did not reside in the home and was not reported to be present at the time of the incident.

The CPS caseworker spoke with one of the mother's providers who worked closely with the family. There were no concerns noted and the maternal grandmother was reported to have taken protective measures to ensure the mother's mental health needs were being addressed due to the death of her infant. The provider reported contact with the mother and the infant in the hospital after the birth and in the family home, with no safety concerns identified on either occasion.

After several unsuccessful attempts the CPS caseworker contacted the maternal grandmother, who reported the mother was coping with the death of her infant and the maternal grandmother was off work to help ensure the mother's well-being. The maternal grandmother reported she had a plan in place upon her return to work to ensure the mother was not left alone. She expressed wanting the mother to engage in services but was unsure if she would. The CPS caseworker continued to assess the concern about the father's violent behavior towards the mother which was relayed to the Department in the January 2020 report which is outlined below. The maternal grandmother denied any violent behavior by the father and reported the father was only allowed at the home when she was present to prevent arguments from occurring. The CPS caseworker offered several resources to the family.

The mother engaged minimally through phone contact with the CPS caseworker and did not avail herself of any services provided through the Department. She also denied any physical violence by the father and reported verbal arguments had occurred prior to the death of the child. The mother also denied any substance use, including marijuana.

The CPS caseworker was able to reach the father after several attempts. He informed the CPS caseworker he and the mother had arguments but denied physically assaulting the mother. He denied the need for services through the Department and reported he was coping with the death of his child without the Department's assistance.

Abuse was not determined to have been a factor in the child's death which was determined to be accidental. The Department determined the allegation of neglect by the mother was unfounded.

Description of relevant prior Department reports:

Case History: Parents of the Deceased Infant

Date of report: 1/9/2020 **Assignment decision:** Assign: 72-hour response	**Allegation(s):** Threat of Harm to the infant by the father	**Disposition(s):** Unfounded

On January 9, 2020 the Department received a report of concern for the safety and wellbeing of the infant. There were concerns with lack of bonding between the infant and parents. In addition, concerns were reported that the father was physically violent with the mother. The infant who tested positive for a very small amount of marijuana upon birth was expected to remain in the hospital for an additional week after birth. The mother denied any substance use during her pregnancy. The reporting party stated the father arrived at the hospital on the day of the infant's birth and had what was described as a loud argument with the mother. The reporting party indicated there had been previous instances of violence by the father including, slapping, pushing, and hitting; however, there were no specific timeframes for when this occurred. The mother resided with the maternal grandmother who reportedly intervened during the physical assaults.

In addition, the reporting party indicated the mother had a reported history of mental health symptoms, including self-harm. The mother was described by the reporting party as depressed, disengaged, and had a decreased appetite. The father reportedly used marijuana and other substances historically. Both parents were said to be present at the hospital each day; however, for very short periods of time and the reporting party stated

the father had shown no motivation towards parenting the infant. Both parents were offered services but refused the referrals.

During the CPS assessment, the CPS caseworker spoke with the mother and the maternal grandmother at the family home. The CPS caseworker discussed the report of domestic violence by the father towards the mother. The mother denied physical violence but indicated she and the father argued at times. The CPS caseworker also inquired about the infant's positive marijuana screen and the mother reported she was unaware of how the infant tested positive. She denied any substance use, including marijuana. The CPS caseworker observed the bedroom in which the infant and the mother would reside and observed a bassinet for the infant. The CPS caseworker discussed safe sleep practices with the mother. The maternal grandmother reported she had never observed domestic violence by the father but had heard several arguments between the two of them. The maternal grandmother appeared to recognize the reported concerns and indicated that she would not allow the father at the home unless she was present. A plan was made for the CPS caseworker to come back to the home when the infant was released from the hospital.

The CPS caseworker contacted the father who denied domestic violence towards the mother. The father reported he and the mother are supported in their roles as parents by their respective families.

The CPS caseworker attempted several times to contact the maternal grandmother to complete the follow-up visit to the home, however the maternal grandmother never responded. The CPS caseworker attempted to go to the home; however, the family lived in a secure complex which prevented the CPS caseworker from accessing the home. No further contact could be made with the family.

The Department determined there was no information to support domestic violence was occurring by the father therefore, the allegation of threat of harm by the father was determined to be unfounded.

During this assessment, on April 25, 2020, the Department received a notification of the infant's death. This report was assigned and generated a new CPS assessment.

Case History: Maternal Grandmother

Date of report: 1/9/2020 **Assignment decision:** Assign: 72-hour response	**Allegation(s):** Neglect to the mother by the maternal grandmother	**Disposition(s):** Unfounded

On January 9, 2020 the Department received a report which indicated the mother had recently given birth to the infant. The mother lived with the maternal grandmother, as would the infant upon discharge from the hospital. The infant was born premature and it was believed the infant would remain in the hospital for an additional week. The mother was described as isolated, withdrawn and not engaged with hospital staff, but denied being depressed or suicidal. The father did appear at the hospital after the birth of the infant and was observed to have an argument with the mother. The reporting party stated the father had previously physically assaulted the mother, which included incidents where he had slapped, pushed and hit her. The maternal grandmother was reportedly aware of the physical assaults and had intervened. The reporting party indicated the mother did not feel safe at her home, but there were no details provided as to why.

The CPS caseworker met with the mother and maternal grandmother. The maternal grandmother expressed joy in her grandchild coming to the home and stated she would not allow the father in the home unless she was present. She denied observation of any violent behavior by the father but stated she wanted to ensure there would be no arguments in her home. The mother showed the CPS caseworker a bassinet which would be the sleeping environment for the infant upon discharge from the hospital and a safe sleep practices conversation occurred between the CPS caseworker and the mother. The mother stated she and the father had multiple arguments but denied any physical assaults. The maternal grandmother indicated she would be helping the mother with the infant when not at work. There were no safety concerns and a plan was made for the CPS caseworker to return to the home when the infant was released from the hospital.

The CPS caseworker attempted several times to contact the maternal grandmother to complete the follow-up visit to the home, however the maternal grandmother never responded. The CPS caseworker attempted to go to the home; however, the family lived in a secure complex which prevented the CPS caseworker from accessing the home. No further contact could be made with the family.

On April 25, 2020 the Department was notified of the infant's death and a new CPS assessment was assigned in the mother's name. Based on the information gathered, the allegation of neglect by the maternal grandmother to the mother was determined to be 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 CIRT did not identify any specific action or inaction by the Department as directly correlated to the death of the child. The CIRT recognized the death of the infant was

determined to be accidental, however the CIRT discussed the unsafe sleeping environment which may have played a role in the death of the infant. Although the CPS caseworker spoke with the mother about the safe sleep practices, the CIRT recognized the pattern of infant deaths with unsafe sleeping environments and the need for continued and increased safe sleep training for caseworkers.

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 a critical part of the child safety community, child welfare professionals have a role in supporting families to reduce the risk of sleep related deaths through education and engaging families in conversations about their experiences and opinions related to sleep practices. The Department has implemented a training plan which consists of separate state role specific versions of self-study training and an opportunity to practice having safe sleep conversations with parents and caregivers. In addition, new requirements and procedural guidance for child welfare professionals have been developed, along with a safe sleep checklist and safe sleep resources including handouts. Phase one of this training plan began in May 2020.