

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: MHSMVDU48T		
Date of critical incident: 10/04/2019	Date Department became aware of the fatality: 10/04/2019	
Date Department caused an investigation to be made: 10/04/2019	Date of child protective services (CPS) assessment disposition: 12/6/2019	
Date CIRT assigned: 10/11/2019	Date Final Report submitted: 12/12/2019	
Date of CIRT meetings: 11/04/2019	Number of participants: 12	Members of the public? No

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

Date of report:	Allegation(s):	Disposition:
10/04/2019	Neglect by Mother	Unfounded
Assignment decision: Assign-10 Days		

The Department received a report the child was found deceased on the morning of 10/4/2019. The case was assigned as a 10-day response because the child was deceased and the mother did not have other children in her care. During the previous night, the mother had taken the child from the basinet to feed the child and fell asleep with the child in her bed. The child was later found wedged and unresponsive between the bed and wall. Emergency responders transported the child to the hospital where the child was pronounced deceased.

Description of relevant prior Department reports:

Date of report:	Allegation(s):	Disposition:
09/07/2019	Neglect by Mother	Unfounded
Assignment decision: Assign- 72 Hours	Threat of Harm by Alleged Biological Father	Unfounded

The Department received a report that the mother recently gave birth and self-reported historical drug use early in the pregnancy. Additionally, the mother separated from the child's biological father due to domestic violence.

Initial contact occurred at the hospital and the Department documented that the mother was receiving adequate services to address her previous substance use. The infant's drug screen was negative and the child was not experiencing withdrawals. The mother was observed providing good care for her infant and bonding appropriately.

Unsuccessful attempts were made to contact alleged biological father. The mother was no longer in a relationship with the child's father and was in safe housing away

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from any domestic violence. No safety concerns were noted and the allegations were unfounded. The report concerning the child's death came in at the conclusion of this assessment and a new assessment was opened.

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 concerns regarding Department interactions with this family. The mother was engaged in services and living in stable housing at the time the child died. No additional actions were suggested by the CIRT.

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:

In light of the age of the child, the Department had limited contact with the family and the CIRT did not identify any systemic issues related to the death of the child. No additional recommendations were provided by the team.