

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: Q9OFUFHSLQ		
Date of critical incident: October 9, 2019	Date Department became aware of the fatality: October 9, 2019	
Date Department caused and investigation to be made: October 9, 2019	Date of child protective services (CPS) assessment disposition: January 7, 2020	
Date CIRT assigned: October 14, 2019	Date Final Report submitted: January 9, 2020	
Date of CIRT meetings: October 24, 2019 December 4, 2019	Number of participants: 19 14	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: 10/09/2019	Allegation(s): Neglect by Father	Disposition: Founded
Assignment decision: Assign-24 Hours		

On 10/09/2019, the Department received a report regarding an eleven month-old child who died during a nap in the family home. According to the report, the explanation given by the parents was in question due to the age of the child and the fact it is uncommon for a nearly one-year old child to die while sleeping. It was reported that an adult-sized comforter was put in the crib and the child may have suffocated. The mother was overheard by law enforcement stating she told the father not to put the blanket in the crib.

The deceased child had never been the subject of a CPS report or assessment. The mother was a child known to the Department in the twelve months preceding the fatality. At the time of the critical incident, the mother and child had been living with the child's father and the child's paternal grandmother for approximately three months.

The mother reported she had gone to work the morning of the incident and returned to the home about 2:30 PM. When entering the home, the mother reported she did not hear her child making noise, which was not typical, so she became concerned. When she checked on the child, she found the child in the crib, with a blanket over the child's face, around the neck. The mother tried to wake the child, however the child was not responsive. The mother began screaming, which alerted the father who was reportedly in the restroom. A 911 call was made, and CPR was attempted. Emergency responders arrived and transported the child to the hospital, where the child was pronounced deceased.

The father reported he put the child down for a nap in the crib, with the blanket, at about 10:00 AM. The father reported he gave the child a bottle, laid the child on the back and the child fell asleep with the bottle. The father stated the child normally naps for about two hours. The father reported he went to work on a car in the shop on the property, which was a distance from the home, and he did not use a baby monitor or other method of observing the child while he was outside of the home. The father stated no one else was in the home during this time. He reported checking on the child throughout the time the child was napping, describing this as standing in the doorway and looking into the

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room toward the crib. He stated that he last checked on the child about thirty minutes prior to the mother's screams.

When interviewed, the mother reported there was an incident a few weeks prior where the child was found with the blanket around the neck and was unable to breathe. The mother reported she informed the father to not use the blanket again. The father reported he felt the child was strong enough to get out of the blanket, therefore he put the blanket in the crib on the date of the incident.

When asked about substance use, the mother reported both she and the father regularly used marijuana, however smoked outdoors away from the child. The mother reported using a baby monitor whenever leaving the child unattended for this purpose. The father denied the use of marijuana.

The Department found the child was left unsupervised by the father for several hours while the child napped. The distance from the home to the shop, as well as the machinery noise was significant. The amount of time the child napped was atypical, as the father stated the child normally napped for about two hours, however the child would have napped for about four and half hours by the time the mother came home. The father would have been unable to properly observe the child when checking on the child due to the setup of the room. The room was cluttered, and the type of crib did not allow for a clear view of the child from the doorway of the room. The assessment was closed with a founded disposition of neglect by the father.

Description of relevant prior Department reports:

There are no prior reports regarding the child, or the parents as caregivers.

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 specific concerns regarding actions taken or not taken in response to the critical incident and there had been no reports of concern prior to the critical incident. The mother and child had been engaged with community providers regarding child development and parenting and the child had been receiving routine medical care. Information about the father's parenting was largely unavailable until after the critical incident.

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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:

While there were no concerns regarding actions or inactions of the Department in this specific case, the CIRT acknowledges working with teen parents is complicated and guidance is limited on how to aid in ensuring safety of the teen parent's child when that child is not under the formal purview of the Department. The CIRT would like to better understand how the Department can engage with teen parents in a way that incorporates the safety and well-being of their children into case planning, particularly when the teen parent is known to, and working with, DHS. The local district and the CIRT coordinator will identify opportunities to bring this question to larger conversations about the Department's work with teens and young adults formally involved with the Department.