

# 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 inciincident, relevantartment 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.

<b>CIRT ID: QBUPT50J0</b>		
<b>Date of critical incident:</b> October 19, 2019	<b>Date Department became aware of the fatality:</b> October 21, 2019	
<b>Date Department caused and investigation to be made:</b> October 21, 2019	<b>Date of child protective services (CPS) assessment disposition:</b> January 14, 2020	
<b>Date CIRT assigned:</b> October 25, 2019	<b>Date Final Report submitted:</b> January 31, 2020	
<b>Date of CIRT meetings:</b> December 20, 2019	<b>Number of participants:</b> 11	<b>Members of the public?</b> No

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

<b>Date of report:</b> 10/21/19	<b>Allegation(s):</b> Neglect, Threat of Harm	<b>Disposition:</b> Unfounded
<b>Assignment decision:</b> 24-hour response		

On October 21, 2019 the Department received a report that a four-month-old infant had died while sleeping in bed with the parents. According to the report, the child had a congenital heart condition and had undergone multiple surgeries since birth. There was additional information the parents had used marijuana the night prior to the child's death. The report was assigned with an allegation of neglect to the child and threat of harm to the child's siblings.

The Department learned law enforcement had responded to the family home after emergency services were called when the parents found the child unresponsive on the morning of October 19, 2019. The parents reported they smoked marijuana at about 9:30 p.m. and stayed up until about 3:00 a.m. in the living room of the home. The child was with them in the living room until they went to bed at 3:00 a.m. The mother and the father slept together in the bed, with the child between them. The mother reported the child woke three times during the night and was fed from a different bottle each time. When the father awoke in the morning, he rolled over to snuggle with the child and found the child cold. There was no indication anyone had rolled over onto the child and there had been no blankets or pillows observed over the child's nose and mouth. The child did not have any injuries or other signs of abuse.

Although the parents both acknowledged use of marijuana, there was no indication their use was a factor in the death of the child, and it is believed the child died as a result of the congenital heart condition. The child was on medication which required frequent dose changes and the child was scheduled to be seen by the prescribing physician just days after the death. It was noted the parents had been diligent in meeting the medical needs of the child.

A comprehensive assessment was completed to include interviews with both parents, contact with medical providers and law enforcement, as well as review of medical records and a prior unsubstantiated report in Washington state. The child's siblings were determined to be safe and the disposition was unfounded for neglect to the child and unfounded for threat of harm to the child's siblings.

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### Description of relevant prior Department reports:

<b>Date of report:</b> May 23, 2019	<b>Allegation(s):</b> Neglect	<b>Disposition:</b> Not applicable
<b>Assignment decision:</b> Closed at Screening		

On May 23, 2019, the Department received a call of concern for the child's two siblings, ages 3 and 1. The caller stated the home was filthy, with clothes and objects on the floor and dirty dishes in the sink. Additionally, the caller stated there was no electricity in the home at the time of the call and there were areas of the home that were unfinished, and the children were not allowed to go into those areas. The caller was concerned the father yelled at the 3-year-old child.

The report was closed at screening as there was no information provided to describe the impact to the children based on the circumstances in the home.

### 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. The Department had no prior contact with this family.

### 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.