

R.Y. CIRT Public Report

Date	February 11, 2019
Date of Initial Report	November 16, 2018
Purpose Statement	<p>Critical incident reports are used as tools for Department actions when the Department becomes aware of a critical incident resulting in a child fatality that was likely 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 recommends which actions should be implemented and which individuals should be responsible for evaluating the implementation. 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.</p>
Executive Summary	<p>On 9.5.18 the Department was notified of the death of the child, R.Y. A CPS assessment was conducted and determined to be founded for neglect of R.Y. by both the mother and father.</p> <p>On 10.15.18 the Department Director declared a CIRT be convened to examine the Department's practice and service delivery to R.Y. and the child's family. This is a mandatory CIRT as R.Y.'s death was determined to be the result of abuse and there had been a child protective services assessment in the 12 months prior to the critical incident.</p>
Summary of Critical Incident	<p>Early in the morning of 9.5.18, the infant, R.Y., was taken to the hospital by the parents after being found unresponsive on the floor of the van the family was sleeping in. The mother had gone to sleep in</p>

the family's van the night before with R.Y. in her lap. Older siblings were sleeping in the back seat and another sibling was staying elsewhere. The father was having trouble sleeping so left the van around 1:00 a.m. When he returned around 6 a.m. he found another child asleep in the mother's arms and could not immediately find R.Y. After some difficulty, he woke the mother up and together they found R.Y. unresponsive on the floor of the van. The father then drove the family to the hospital where he dropped off the mother and R.Y. and then took the other children to be with a friend. R.Y. did not survive and was pronounced dead shortly after arriving at the hospital.

Law Enforcement and DHS accompanied the father to view the van the family had been sleeping in and found it to be messy and cluttered. The parents did not have a clear explanation for what happened to R.Y. but surmised the child may have rolled out of the mother's arms in the night.

Further investigation revealed R.Y. died after a period of struggle on the floorboard of the van. The child had abrasions on the body consistent with that struggle, including injuries from a metal-spiked bike pedal that was near where the child fell. The ultimate cause of death was determined to be hypothermia. Toxicology revealed R.Y. tested positive for amphetamines as well. Interviews with the siblings in the van at the time of the critical incident did not reveal any additional details about what occurred.

The assessment related to the death of R.Y. was coded founded for Neglect by both parents.

Evaluation of Department Actions

- No internal or external systemic issues were identified
- Caseworkers gathered significant collateral information related to child safety, correctly identified moderate to high needs and made attempts to engage the family in supportive services during previous assessment contacts

Recommendations for improvements and associated tasks	There are no recommendations resulting from this review.
Methods of evaluating expected outcomes	Not Applicable