

Z.H.F. CIRT Public Report

Date	May 16, 2019
Date of Initial Report	May 16, 2019
Purpose Statement	<p>Critical incident reports are used as tools for reviewing 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 the DHS' website.</p>
Executive Summary	<p>On 11.26.18 the Department was notified the child, Z.H.F. had died after bed-sharing with the mother and father the night prior. The report outlined concerns of marijuana use in the home.</p> <p>On 3.19.19 the Department Director declared a CIRT be convened to examine the Department's practice and service delivery to Z.H.F. and the child's family. This is a mandatory CIRT as Z.H.F.'s death was determined likely the result of abuse and there was a report closed at screening within the 12 months prior to the critical incident.</p> <p>There was no history of contact with the child by the Department.</p>
Summary of Critical Incident	<p>The Department received a report on 11.26.18 regarding the death of the infant, Z.H.F. According to the report, the mother awoke in the</p>

	<p>morning to find she had rolled onto Z.H.F. Additionally, both parents and other adults in the home had used marijuana the night prior. The home smelled like marijuana and there was visible paraphernalia related to marijuana use.</p> <p>The parents called 911 when they found Z.H.F. was not breathing. Both the parents and emergency responders attempted to revive the child but were unable.</p> <p>Information gathered revealed both parents had consumed marijuana in multiple forms the night prior to Z.H.F.'s death. Both parents admitted to daily use of marijuana and acknowledged feeling the effects of marijuana when they went to bed the night before. The parents also admitted they had been provided information about safe sleep for their infant child and had safe sleep arrangements available in the home but preferred Z.H.F. sleep in their bed. This was despite a prior incident in which the mother awoke to find herself on top of the child. The CPS assessment was determined to be founded for neglect of Z.H.F. by both parents.</p>
<p>Evaluation of Department Actions</p>	<p>No systemic issues were identified that contributed to the death of Z.H.F. The Department did not have any contact with the child or family prior to the critical incident.</p> <p>The team noted the parents had been provided clear and consistent information from medical providers regarding safe sleep, yet the education was not enough to prevent the parents from making unsafe sleep decisions and bed-sharing while under the influence. The combination of substance use and the young age of the parents likely contributed to their lack of judgment about child safety. This case lends to the ongoing conversation about a holistic approach to safe sleep and opportunities for coaching and intervention with parents when significant risk factors are present. As the Department continues efforts to establish partnerships with community providers to promote safe sleep and address risk factors, this case offers an</p>

	opportunity for reflection on what role the community plays, particularly when the Department is not in the picture.
Recommendations for improvements and associated tasks	Not Applicable
Methods of evaluating expected outcomes	Not Applicable