RCW 74.13.500

Children's Administration

Executive Child Fatality Review

C.C.-W.

July 2011
Date of Child's Birth

November 28, 2011
Date of Child's Death

April 23, 2012
Executive Fatality Review Date

Committee Members:
Deborah Robinson, Infant Death Investigation Specialist
Mary Meinig, MSW, Director of the Office of Family and Children's Ombudsman
Megan Sweeney, Domestic Violence Advocate, Lynnwood Police Department
Marschell Baker, Child Protective Services Supervisor (CPS), Children's Administration
Randy Hart, Area Administrator, Children's Administration

Observer:
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Executive Summary

On April 23, 2012 Children's Administration (CA) convened a Child Fatality Review[1] (CFR) committee to examine the practice and service delivery in the case involving 4-month-old C.C.-W. and his mother. The incident initiating this review occurred on November 28, 2011. The Snohomish County Medical Examiner's Office contacted CPS intake to report the death of C.C.-W at the home of his mother's friend in the Arlington area. C.C.-W.'s mother, J.C., found her son in his bassinet in the morning with a plastic grocery bag and a pillowcase over his face.[2] Emergency medical technicians were dispatched to the home and performed CPR.

At 11:45 a.m. J.C. placed her son C.C.-W. in his bassinet for a nap. She reported that his head was turned to left and a pillowcase was tucked over and underneath the bassinet pad which acted as a sheet or cover. When C.C.-W. was placed down, a plastic grocery bag was underneath him. The mother reported that she did not see the bag, but thought there may have been a bag in the bassinet as she heard the sound of a plastic bag rustling when she put him down for a nap. The bedroom was dark.

At 1:45 p.m. J.C. checked on C.C.-W. in the darkened bedroom and he was okay. At 1:55 p.m. she checked on C.C.-W. again and then found him unresponsive with his face covered by a plastic bag and the pillowcase. J.C. was alone in the home with C.C.-W. when the fatality occurred.

C.C.-W. was taken to Cascade Valley Hospital where he was later pronounced dead.

The assigned detective noted that there were no clear signs of any abuse when C.C.-W. was taken to the hospital. J.C. disclosed that two weeks prior, C.C.-W. was taken to the same hospital after experiencing seizures. This information was not reported to CPS Intake.

The medical examiner completed an autopsy and did not find anything of significance internally and externally concerning C.C.-W.'s body. However, there are concerns about how J.C. initially described the events leading up to C.C.-W.'s death. During the

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[1] Given its limited purpose under RCW 74.13.640, a Child Fatality Review by Children's Administration should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. Review is generally limited to documents in the possession of or obtained by DSHS or its contracted service providers and the panel may be precluded from receiving some documents that may be relevant to the issues in a case because of federal or state confidentiality laws and regulations. A review panel has no subpoena power or authority to compel attendance and generally will only hear from DSHS employees and service providers. The panel may not hear the points of view of a child's parents and relatives, or those of other individuals associated with a deceased child's life or fatality. A Child Fatality Review is not intended to be a fact-finding or forensic inquiry or to replace or supercede investigations by courts, law enforcement agencies, medical examiners or other entities with legal responsibility to investigate or review some or all of the circumstances of a child's death. Nor is it the function or purpose of a Child Fatality Review to take personnel action or recommend such action against DSHS employees or other individuals.

[2] The child's mother is not identified by name in this report as she was not charged with a crime related to her action or inaction in her son's death. The CPS investigation finding was still pending at the time of this report.

reenactment of C.C.-W.'s death, there were discrepancies in the mother's story about whether she knew if a plastic bag was present in the bassinet or not. Her reconstruction account includes a baggie or plastic bag being in front of C.C.-W.'s face and the pillowcase over the top of his head. C.C.-W.'s face was exposed as he was lying on his stomach on top of the pillowcase.

During J.C.'s first recounted version, she said that she heard a crinkle sound when she put her son down in the bassinet and thought it was a zip lock bag underneath the mattress which she cleaned during the previous night. However, after the medical examiner entered the home and J.C. reenacted the events with a doll, she later said that she knew a grocery bag was in the bassinet with the pillowcase that was wrapped around the mattress. J.C. was reportedly alone in her friend's home at the time of the fatality and called 911 at 1:58 p.m.

The detective reported that J.C. has a history of lying in court in addition to lying to law enforcement. She made several inconsistent or false reports to law enforcement about her actions leading up to her son's death. She claimed that C.C.-W. was sick for one month prior to his death. She maintained that she took him to the hospital two weeks prior for febrile seizures, however, the records from the hospital revealed that a spinal tap was conducted and C.C.-W. presented with "nothing remarkable."

C.C.-W.'s putative father, Z.W., describes J.C. as a liar. He had supervised visitation with his son in the weeks before his death and denied that his son had been ill, as the mother previously claimed.

The Snohomish County Medical Examiner has determined the cause of death as sudden and unexpected infant death with risk factors of the sleeping environment. The examiner found the manner of death – whether the death was natural, an accident, or homicide – to be undetermined. Additional testing is being conducted on the bag found in the bassinet. The decision to pursue criminal charges against the mother by law enforcement and the prosecuting attorney are pending the outcome of these tests. The finding of the CPS investigation into C.C.-W.'s death is also pending.

The family's case history with CA was reviewed in preparation for this fatality review. The history included two previous intakes from September 2011 and November 2011. Neither of the two prior intakes were accepted for investigation by CPS. The first intake alleged domestic violence between C.C.-W.'s parents and the second alleged that C.C.W. came home from a visit with his father with suspicious scratches on his body and with poor hygiene. The most recent report (November 3, 2011) was screened in for Alternate Intervention. A letter was sent to the mother and the case was closed 10 days before the child's death.

The CFR committee included CA staff and community professionals selected from diverse disciplines with relevant expertise, and included an infant death specialist, a domestic violence/community advocate, and representatives with experience in

parenting and child welfare. The committee also included the Director of the Office of the Children and Family Ombudsman. The fatality review committee members had no prior direct involvement with the case. The CA staff on the committee were not affiliated with the case and were selected from offices other the one that had been assigned to work with this family. The community members were selected to participate as their professional expertise is germane to the nature of the case.

During the course of the review, each committee member had available to him or her information regarding the mother, the father and the child, un-redacted CA case related documents, as well as medical and law enforcement records. A petition for a protection order that had been drafted by C.C.-W.'s mother was also available for the committee's review. Additional documents provided to the committee included the Lynnwood Police Department's report of a domestic violence incident between the parents, the autopsy report, photographs of the child's sleeping area, and a medical assessment of C.C.-W.'s death completed by Dr. Kenneth Feldman, a child abuse and neglect medical consultant with Children's Hospital. The assigned CPS investigator, CPS Supervisor, and the Area Administrator were present during the review and discussed the family's past involvement with the department and the CPS investigation into C.C.-W.'s death.

Following review of the case file documents and discussion regarding social work activities and decisions during the CPS investigation, the review committee made findings that are detailed at the end of this report.

Case Overview

C.C.-W. was born to these parents when they were both 17 years old. The issue of C.C.-W.'s paternity was questioned, though Z.W. is listed as the father on the birth certificate.

CPS received two reports regarding C.C.-W. and his parents in the months prior to his death. An intake reporting his death was made to CPS.

The first intake was received on September 28, 2011. The intake was screened out for investigation. The regional intake unit received a protection order from District Court. C.C.-W.'s mother, J.C. sought an order of protection for herself and infant son. She alleged that on September 21, 2011, C.C.-W.'s father, Z.W. assaulted her. She asked for his help to care for C.C.-W. while she moved into her new house. He became very angry and shoved her into a wall and yelled at their infant son to "shut up." She left the residence with her son. The committee was able to review a copy of the petition C.C.-W's mother submitted to the court to obtain the petition. The District Court had previously sent CPS Intake the protection order on September 28, 2011, but it did not include the petition, which included many more details of alleged abuse of C.C.-W. by his father and domestic violence between the parents.

The restraining order was dismissed on the mother's request on November 9, 2011.

The second intake was received on November 3, 2011 and screened in for Alternate Intervention with a 10-day response. A counselor for C.C.-W.'s grandmother made a report with concerns about C.C.-W.'s condition after he had a four hour visit with his father. Upon his return to his mother's care, she changed C.C.-W.'s diaper and found hardened feces and scratches near his penis. She told the child's grandmother of her concerns. The case was assigned to a worker to provide the mother with community resource information. The worker wrote a letter to J.C. with a list of community resources she could access to assist her in the care of her child. The case was closed on November 18, 2011.

A third intake documenting the death of C.C.-W was received on November 29, 2011. The intake screened in for investigation of physical abuse and negligent treatment or maltreatment. The Snohomish County Medical Examiner reported that C.C.-W. died on November 28, 2011 while sleeping in his bassinet at the home of his mother's friend in Arlington. This sleep-related infant death resulted in a complex medical/legal investigation. The sleeping environment was unsafe due to a pillowcase and plastic bag in the bassinet and the child being placed in a prone sleep position. The mother made conflicting statements about the circumstances leading up to the discovery when she found C.C.-W. unresponsive in his bassinet. She reported that the child had recently had seizures, but they were not verified by the child's medical providers.

The finding of the CPS investigation is pending at the time of this report. The Medical Examiner has issued his conclusions regarding the child's cause and manner of death. The prosecutor has not made a decision on whether to file charges against the mother.

Findings:

Intake

The committee members discussed the screening decision of the September 28, 2011 intake and consensus was that based on the information given by the referrer and documented in the intake narrative, the screening decision was appropriate. However, the mother's petition for a protection order detailed allegations of physical abuse of C.C.-W. by his father, Z.W. There was consensus among the committee members that this information would have warranted an investigation by CPS, if it had been provided to CPS. However, the petition was not sent to CPS. The information in this petition likely would have affected the screening decision for the prior intake and presented a missed opportunity to intervene with this family.

The prior intake dated November 3, 2011 was screened for Alternate Intervention and alleged neglect and suspicious scratches on C.C.-W. The department's response to the Alternate Intervention intake was to send a letter to the child's mother as she was identified as C.C-W.'s custodial parent. The committee questioned why the letter was sent to the mother and not the father, who was the alleged subject of abuse.

The committee also discussed the screening decision of the November 3, 2011 intake and concluded that the intake should have screened in for investigation given the injury to an infant.

The committee found the documentation by the assigned social workers to be very good.

Response to Alternate Intervention Cases
The Everett DCFS office has contracted with a public health nurse to respond to most intakes screened for Alternate Intervention.

Since this event, the Everett DCFS office has changed its practice for Alternate Intervention cases. These changes are as follows:

1. Safe sleep education is given in all cases in which there is an infant in the family, regardless of the allegations in the intake.
2. Face to face contact will be made with all families for intakes that are screened in for Alternate Intervention.

Recommendations:
No recommendations were made by the committee.