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Children's Administration

Child Fatality Review

S.R.

December [redacted] 2010
Date of Child's Birth

December 2, 2011
Date of Child's Death

April 23, 2012
Fatality Review Date

Committee Members:
Deborah Robinson, Infant Death Investigation Specialist, Criminal Justice Center
Mary Meinig, MSW, Director of the Office of Family and Children's Ombudsman
Rebecca Benson, Public Health Nurse, King County Public Health
Marschell Baker, Child Protective Services Supervisor (CPS), Children's Administration
Randy Hart, Area Administrator, Children's Administration

Observer:
Paul Smith, Critical Incident Program Manager, Children's Administration

Facilitator:
Jeff Norman, Children's Administration Program Manager, Region 2

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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 11-month-old S.R. On November 27, 2011, S.R. was put into a bathtub with her three-year-old sister. Her mother, C.R. [2], later found her unresponsive in the bathtub. There are multiple conflicting accounts of the circumstances leading up to that moment. The mother told police officers that S.R. was bathing with her three-year-old sister and she took S.R. out of the tub and left to get a towel for S.R. She returned and found S.R. face down in the tub. The mother also told staff at Seattle Children's Hospital that she left S.R. in the tub while she went to get a towel. When she returned from being gone momentarily she found S.R. face down in the tub.

The mother told law enforcement that she performed CPR and tried to call 911, but got a busy signal, so she went to a neighbor's home and had them call 911. S.R. was unresponsive, but still alive when police and medics arrived on the scene.

S.R.'s siblings were interviewed and contradicted their mother's account.[3] One of the siblings reported she and S.R. were bathing alone while their mother watched television. In the tub, S.R. reached for a rubber duck toy and went under water and was unable to pull herself up. The three-year-old sister never mentioned that her mother was in the bathroom while she and S.R. took a bath. A relative who used to live in the home was interviewed and said it was common practice for the mother to bathe all of her children at the same time without adult supervision.

Police who responded to the scene reported they believe the mother was watching a movie as the volume on the television was very loud when they first entered the home. Police searched the home and found no evidence of drug or alcohol use. There are reports that the tub was full of water, deep enough for an adult to bathe.[4]

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[1] Given its limited purpose, 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 enquiry 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 name of S.R.'s mother is not used in this report as she was not charged criminally for her actions related to her daughter's death. The child's putative father lives in California and has had no contact with his daughter.

[3] The three-year-old male twin was not in the tub with his sisters, but may have been in the bathroom at some point after mother left the room.

[4] The mother reported that water level was below S.R.'s chest when she was sitting in the tub.

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First responders were unable to fully revive S.R. She was still alive when she left the house via ambulance and was transported to Seattle Children's Hospital. Doctors who treated S.R. reported there was no evidence of physical abuse trauma. Doctors also reported that the CPR performed by the mother and neighbors was non-functional.

After several days on life support a determination was made that S.R. had no brain activity and she was removed from life support. She died on December 2, 2011. The King County Medical Examiner determined that the cause of death is anoxic encephalopathy (brain damage due to lack of oxygen) and near-drowning in a bathtub. The manner of death is accidental.

At the time of the incident, law enforcement did not place the other children in the home into protective custody. The mother had a family friend care for them while she was at the hospital with S.R. The department filed dependency petitions on the surviving siblings. The CPS investigation into S.R.'s death was founded for negligent treatment or maltreatment.

Living in the family home at the time of the incident were the mother and five of her children, two daughters, ages 8 and 5, twins (boy and girl) age three and S.R. The mother has another son, 14 years old, who resides with his father and was not present when his sister was found unresponsive in the bath tub.

CA did not have an open case on the family at the time of this incident on November 27.

The fatality review committee included CA staff and community professionals selected from diverse disciplines with expertise in infant death investigations and public health. The committee also included a representative from 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 other offices. The community members were selected to participate as their professional expertise is germane to the nature of the case.

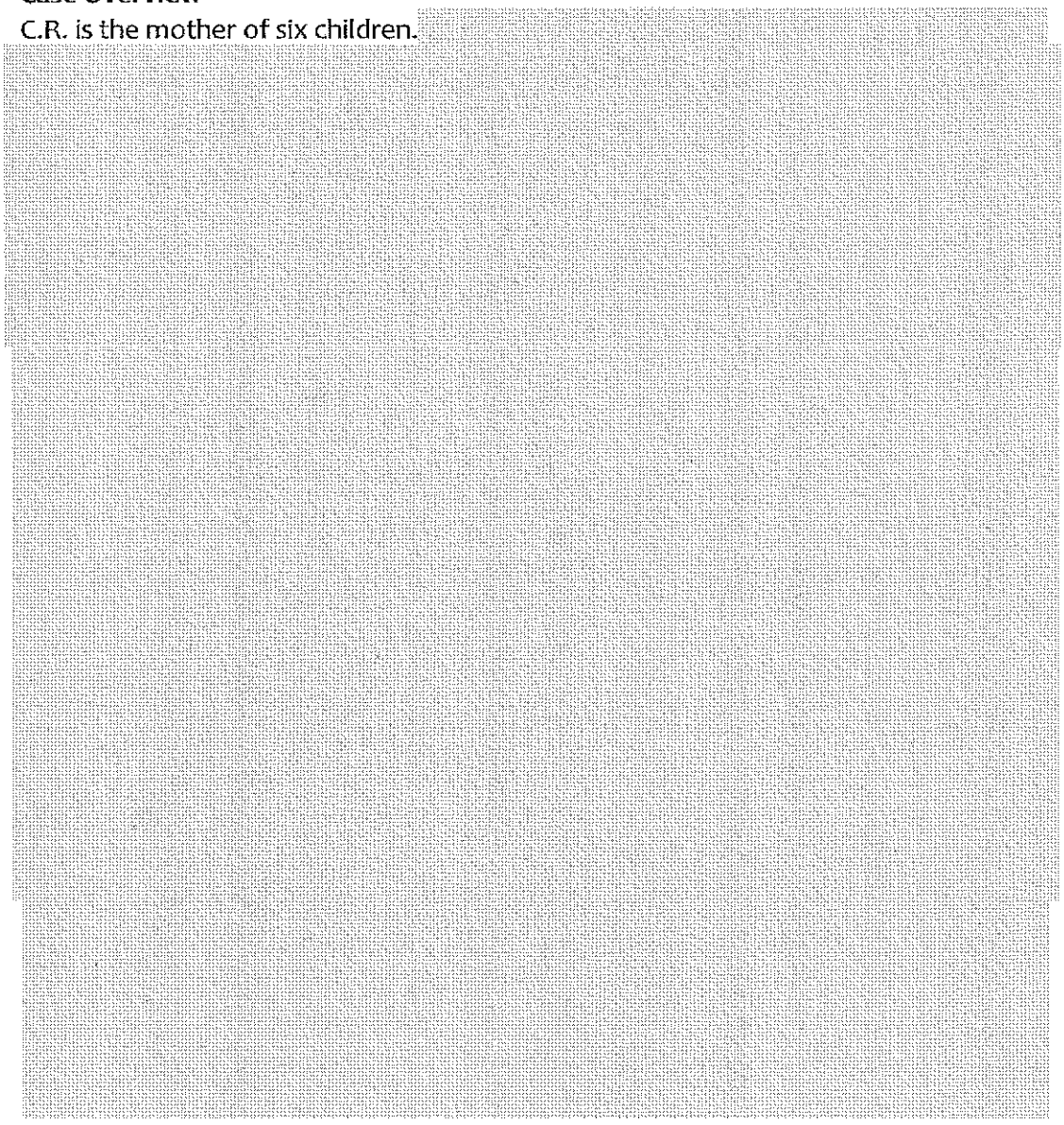
During the course of the review, each committee member had available to them CA information regarding the mother and her children, un-redacted CA case related documents, as well as medical and law enforcement records. The committee had a history of intake reports on the family and a CA incident report on S.R.'s death.

The assigned CPS investigator, CPS Supervisor, and the Area Administrator were present during the review and discussed the mother's past involvement with the department, the CPS investigation into S.R.'s death and case activity on the family following S.R.'s death.

Following review of the case file documents and discussion regarding social work activities, intake screening decisions, CA's involvement with the family, and decisions during the CPS investigation, the review committee made findings which are detailed at the end of this report. The team also discussed discrepancies in law enforcement response to children not riding in car seats or using seat belts, and how the department screens intakes alleging small children not wearing seat belts while riding in cars.

Case Overview

C.R. is the mother of six children.



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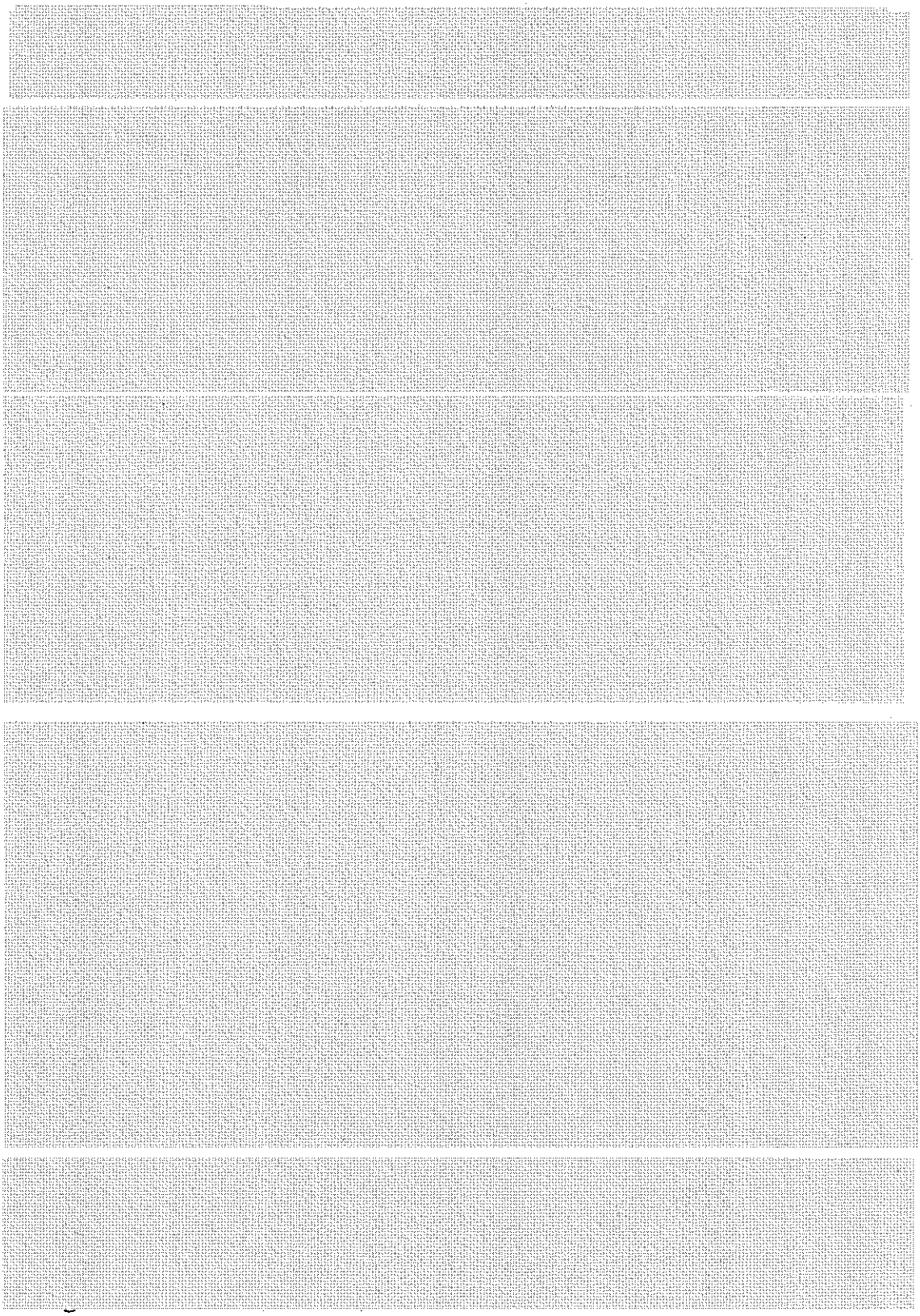

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On November 27, 2011, CPS intake received a report of negligent treatment or maltreatment from Renton Police after 11-month-old S.R. was found unresponsive in a bathtub full of water. She was transported to Seattle Children's Hospital. She was left alone in a bathtub when her mother found her. She was not expected to survive when the initial report was made.

S.R. died on December 2, 2011, from complications of the near drowning. CA filed dependency petitions as to the surviving siblings except for the oldest child who was living with his father. The children were placed in out of home care. The dependency petition was dismissed for the three-year-old twins after their father obtained legal custody. Dependency as the other two children was established on April 16, 2012.

Committee Discussion:

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Parental Engagement

The CA staff involved with this mother report she has been difficult to engage whenever CA has been involved with her family and particularly since the filing of dependency petitions. She is not participating in services, nor is she visiting her children on a consistent basis. The committee suggested offering bereavement counseling as a way to make a positive connection with her.

Recommendations:

The committee made no recommendations.

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The Bellevue Division of Children and Family Services office changed their procedure in responding to Alternate Intervention cases and is now sending out social workers on all 10 day Alternate Intervention cases in order to have more contact with the family.