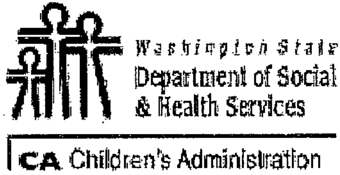
RCW 74.13.640(d)



Children's Administration

Child Fatality Review

D.M.

March 2012
Date of Child's Birth

April 26, 2012
Date of Child's Death

August 16, 2012
Child Fatality Review Date

Committee Members:
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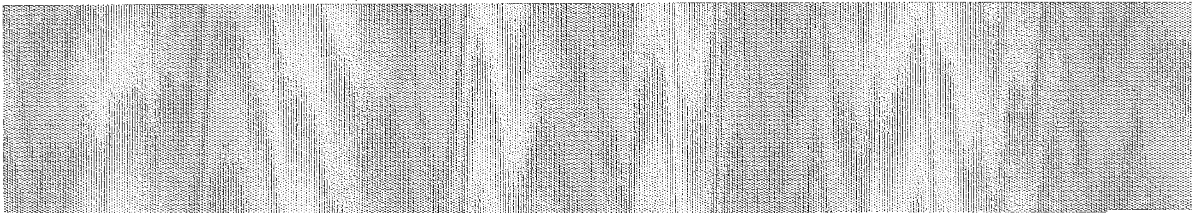
Executive Summary
On August 16, 2012, Children's Administration (CA) convened a Child Fatality Review[1] (CFR) committee to examine the practice and service delivery in the case involving a one-month-old Caucasian male infant named D.M. and his mother. The incident initiating this review occurred on April 26, 2012 when D.M. was discovered by his mother face down in a crib filled with stuffed animals and other materials. A skeletal survey ordered by the Whatcom County Medical Examiner, Gary Goldfogel, M.D. revealed remote skeletal injuries consistent with inflicted trauma. Dr. Goldfogel certified the cause of death as sudden unexpected infant death (SUID), the manner of death as "undetermined."

The CFR committee included CA staff who had no prior involvement with the family and community members selected from diverse disciplines with relevant expertise, including representatives from the fields of law enforcement, medicine, the Office of the Children and Family Ombudsman and social work. The community Committee members also had no previous involvement with the case. Prior to the review each committee member received a chronology of known information regarding the mother and child, un-redacted CA case-related documents, as well as medical records obtained shortly after the fatality incident.

Available to committee members at the review were: (1) additional case related documents (e.g., technical-based medical records such as autopsy, the CA case file on this family), (2) several CA policy and practice guides relating to Child Protective Services (CPS) investigations and assessment of risk and safety, (3) copies of relevant laws relating to CPS duties, legal definitions of child maltreatment. During the course of the review, the mother's public health nurse, the CPS investigator and CPS supervisor were made available for interview by the CFR committee members.

Following review of the case file documents, interview of the previously assigned CPS Social Worker, interview of the public health nurse, and discussion regarding social work activities and decisions, the review committee made findings and recommendations which are detailed at the end of this report.

Case Overview
D.M. is a male Caucasian child born in March 2012. D.M.'s mother is K.M. who is a 21-year-old Caucasian female. D.M.'s father was not listed on the birth certificate; however, the mother reported that the father of the baby as S.B. The mother stated to the hospital social worker that the father "won't be involved." The father was 21 years old according to the mother.



RCW 74.13.520

[1] Given its limited purpose, a Child Fatality Review should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. The CFR Committee's review is generally limited to documents in the possession of or obtained by DSHS or its contracted service providers. The Committee has no subpoena power or authority to compel attendance and generally only hears from DSHS employees and service providers. It does not hear the points of view of the child's parents and relatives, or of other individuals associated with the deceased child's life or death. A Child Fatality Review is not intended to be a fact-finding or forensic inquiry or to replace or supersede 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 recommend personnel action against DSHS employees or other individuals.

On March 22, 2012, D.M. was born at St. Joseph Hospital in Whatcom County. The attending physician expressed concerns about the mother's ability to care for D.M. A hospital social worker was assigned by D.M.'s doctor to assess the mother's ability to care for her child. Hospital records reflect the following information: the mother does "not get" the basic baby care and needs and requires frequent cueing by nurses. D.M. was found with a blanket over his face. K.M. was asked about the blanket and she stated "I didn't do that, he did that himself." The hospital staff provided the mother with information regarding "Safe Sleep" practices for infants. The hospital social worker wrote that the doctor has "grave concerns" regarding mother's ability to care for her baby. The doctor further reported that the mother had no-showed four to five times for every pre-natal appointment she kept. K.M. denied a history of domestic violence (DV); She also self reported three years of sobriety and no history of drug use. The hospital social worker determined that "there is not adequate concern for a medical hold." The hospital notes reflect that "CPS was called and planned to follow-up with the mother at home." Before the mother and baby were discharged, the hospital social worker reviewed her notes and spoke to the nurse and doctor to determine whether another CPS report should be made and a medical hold placed on the baby or whether the baby could discharge home with the mother with CPS follow up to be expected. On March 24, 2012, D.M. and his mother were discharged from the hospital.

On March 26, 2012, an intake was received by CA and screened in for investigation. The referrer alleged that K.M. might be slightly mentally delayed. It was also reported that K.M. failed to respond to D.M. when he was screaming and crying and she left the room and went outside to smoke leaving her baby to cry. The doctor expressed concerns that the mother missed multiple appointments during her pregnancy. The mother stated that the baby's father has drug issues and she was not planning to have him involved in her baby's life at the time. According to the referrer the mother sent her baby to the hospital nursery for an entire day prior to discharge. The mother was referred to a Public Health Nurse by hospital staff prior to discharge.

The assigned social worker attempted to contact the family at their residence on March 27, 2012. The family was not home and a second attempt was made on March 28, 2012 when the assigned social worker and another social worker were able to complete an initial face-to-face contact with the family. The mother was reminded to remove items from D.M.'s bassinet to increase child safety related to sleeping. The social worker noted the home was clean and well picked up. K.M. stated that the maternal aunt, grandfather, great grandfather and friends are all available supports. The social worker noted that the mother appeared to have some developmental delays. The mother was offered Family Preservation Services (FPS) and parenting instruction, but refused both services. The mother refused to sign a release for medical records.

On March 29, 2012, the Public Health Nurse (PHN)[2] contacted the mother. She noted that D.M.'s hood was "up around the baby's face." K.M. reported that the baby does not nurse well.

On April 2, 2012, a letter and pamphlet about Sudden Infant Death Syndrome (SIDS)[3] and Safe Sleep[4] was mailed to the mother by the assigned social worker.

[2] Public Health Nurse (PHN) are nurses who provide individuals and families with health guidance. In this case, the PHN provided the mother with guidance related to the basic needs of herself and her child.

[3] Sudden infant death syndrome (SIDS) is the unexpected, sudden death of a child under age 1 in which an autopsy does not show an explainable cause of death.

The PHN attempted to meet the mother at her home on April 3, 2012, as scheduled, but the mother was not home. The PHN attempted further contacts by phone on April 4, 2012 and April 17, 2012. The PHN did not receive a return call from the mother. The PHN was able to make phone contact on April 25, 2012 and scheduled an appointment for May 2, 2012.

The PHN spoke to the Children's Administration's (CA) Early Intervention Program (EIP)[5] coordinator on April 18, 2012 and notified the coordinator of K.M.'s inability to track and understand the baby's needs and the baby's hood being located around his face.

Due to the PHN's concerns the social worker attempted to make contact at the family's residence on April 23rd, April 24th, and April 25th, 2012. The mother and baby were not home during any of these attempted contacts.

On April 26, 2012, D.M. was found unresponsive in a crib. D.M.'s listed time of death was 11:58 a.m. K.M. reported last seeing D.M. alive at 6:30 a.m. D.M.'s mother gave him pediatric Tylenol for a cough and runny nose. D.M. was also fed a bottle of formula by his mother and was placed into a crib that "barely [had] room for the child" according to Dr. Goldfogel. Dr. Goldfogel also noted that the mother "made an appointment [for] the day prior to death for the child's cold but failed to show for the appointment. She also failed to appear for a well-baby check and scheduled circumcision appointments."

The autopsy listed the cause of death as sudden unexpected infant death (SUID). The autopsy opinion section reads, "The decedent is a one month old Caucasian male infant discovered face down in a crib essentially filled with stuffed animals and other materials. Skeletal survey reveals remote skeletal injuries consistent with inflicted trauma. Forensic autopsy reveals no evidence of congenital anomaly, infection or other anatomical explanation of the infant's demise. Based on circumstances surrounding the death, as currently known, the manner of death is certified as undetermined."

Committee Discussion

Committee members reviewed and discussed the documented social work activities completed by Children's Administration from intake to case closure. As a means to provide structure and context to reviewing social work practice, the committee was provided a case summary and had access to D.M's case file. In this way, committee members were able to evaluate the reasonableness of actions taken and decisions made by the Children's Administration. In addition to social work practice, discussions occurred around policy issues. The discussions largely focused on the following areas: the March 26, 2012 intake, the initial face-to-face contact, social work practice related to the initial investigation, and the gathering of medical records after an intake is received from the hospital.

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[4] Safe Sleep is a nationwide campaign to promote safe sleeping habits for children. Safe sleep practice can reduce the risk of SIDS. According to the National Institute of Child Health and Human Development the top 10 safe sleep guidelines are: 1) Always place your baby on his or her back to sleep, for naps and at night. 2) Place your baby on a firm sleep surface, such as on a safety-approved crib mattress, covered by a fitted sheet. 3) Keep soft objects, toys, and loose bedding out of your baby's sleep area. 4) Do not allow smoking around your baby. 5) Keep your baby's sleep area close to, but separate from, where you and others sleep. 6) Think about using a clean, dry pacifier when placing the infant down to sleep, 7) Do not let your baby overheat during sleep. 8) Avoid products that claim to reduce the risk of SIDS because most have not been tested for effectiveness or safety. 9) Do not use home monitors to reduce the risk of SIDS. 10) Reduce the chance that flat spots will develop on your baby's head: provide "Tummy Time" when your baby is awake and someone is watching; change the direction that your baby lies in the crib from one week to the next; and avoid too much time in car seats, carriers, and bouncers.

[5] Early Intervention Program (EIP) offers services to help families build knowledge and skills to meet the developmental and health need of the child from birth to three years of age. Helps families with practical and emotional challenges related to care of their child. Helps families identify and use community resources and services.

The Committee interviewed the CPS social worker regarding her actions related to the CPS investigation. The social worker completed her initial contact with the mother and D.M. within policy time frames. The social worker observed the mother had placed too many items in the crib and asked the mother to remove the items. The Committee was informed by the social worker that she had asked the mother to demonstrate a safe sleeping arrangement. The mother was able to appropriately demonstrate that she was able to create a safe sleeping environment. The Committee determined the social worker had completed a thorough interview as the social worker was able to provide significant details about the mother's daily routine, mental health history, and general ability to care for D.M. In addition, the social worker addressed the primary areas of concern in the referral.

The Committee wanted to know how resistant the mother was to services. The social worker informed the Committee that the mother was offered Family Preservation Services (FPS)[6], but she refused. The social worker informed the mother of the benefits of FPS including the financial assistance that is offered as part of the service. The mother continued to refuse FPS. The mother was also offered parenting instruction, but she also refused this service and stated that she had completed a Love and Logic[7] class recently. The social worker asked the mother to sign a release of information for medical records in an effort to gather more information about the missed appointments. The mother refused to sign the release of information and denied no-showing for medical appointments. The mother told the social worker, "my medical information is private." The social worker told the Committee that she chose to keep the case open and she also informed the mother at the time of the initial face-to-face contact that she would be doing regular checks on her progress.

The committee asked the social worker if she had completed an NCIC[8]. The social worker stated that she did not believe the client's history indicated a need for a NCIC criminal background check. The Committee discussed how the NCIC may not have provided any additional information, but the completion of a NCIC background check has the potential to provide social worker's with additional valuable information and is an additional method of protection for the social worker as it could potentially inform the social worker of dangerous individuals.

The social worker informed the Committee about her attempts at gathering additional information. She completed an ACES[9] check to confirm the mother's address and check for additional information. The social worker reported that the ACES narrative report had very limited information. The social worker also reported leaving a voicemail with the hospital social worker; however, she did not receive a call back. The social worker stated she was very busy at the time of this investigation and was unable to document every contact and action including the phone message to the hospital social worker. The social worker stated she had received 14 intakes to investigate between March 26, 2012 and April 26,

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[6] Family Preservation Services (FPS)— are short-term, family-based services designed to assist families in crisis by improving parenting and family functioning while keeping children safe.

[7] Love and Logic—according to the Love and Logic website it is a philosophy of raising and teaching children which allows adults to be happier, empowered, and more skilled in the interactions with children. Love allows children to grow through their mistakes. Logic allows children to live with the consequences of their choices. Love and Logic is a way of working with children that puts parents and teachers back in control, teaches children to be responsible, and prepares young people to live in the real world, with its many choices and consequences.

[8] NCIC-- CPS investigators may request a NCIC Purpose Code C on subjects of CPS investigations and other adults related to the CPS investigation. This information is used to assess child and worker safety. Requests for NCIC checks for CPS investigations are made in accordance with federal and state law (RCW 26.44.030 & PL109-248). Purpose Code C may only be requested during a CPS investigation for the purpose of assessing child and worker safety as it relates to the CPS investigation.

[9] ACES –is the computer system used by the community services offices of the Department of Social and Health Services to determine eligibility for public assistance.

2012. During this same time period she also placed four children in out-of-home care from three different families.

The Committee discussed the intake and medical reports with the social worker. The social worker stated, and the Committee agreed, that the referral did not rise to a level where she was concerned about imminent harm to D.M. The initial home visit went well and the mother was able to show her how to meet the babies basic needs. She stated that she would normally gather the birth records, but she was very busy at the time of this referral due to the high volume of referrals. The Committee reviewed the pre-natal and birth records that were obtained post-fatality and did not feel that they would have impacted or changed the outcome of the case; however, the Committee felt the gathering of birth records immediately after a referral from the hospital should be considered best practice and reviewed as soon as possible.

The Committee discussed the differences between the March 26, 2012 intake report and the hospital social worker's records that were received post fatality. The Committee noted that the medical notes included more details and concerns regarding the mother than the March 26, 2012 intake. The Committee was unable to determine the cause for the differences, but did note that it is not unusual for a referrer to provide an abbreviated summary of concerns. The medical records from March 23, 2012 indicated that CPS had previously been contacted; however, there are no additional records within Children's Administration that indicate CPS had been called and no knowledge about a previous contact according to Bellingham CPS staff. In addition, the Committee discussed the timing of the referral. The Committee noted that the referral was called into Children's Administration on March 26, 2012. The mother and D.M. were discharged from the hospital on March 24, 2012. The Committee determined that it would have been beneficial to both the investigator and Committee to have an audio recording of the referral as routinely done by 911. Some Committee members felt the recording of all referrals would be good practice for CA while other Committee members expressed concern that some referrers would not call if they knew the call would be recorded. The Committee did not come to a consensus on the recording of future intakes.

Findings:

1. The social worker demonstrated quality practice by initiating a complete and thorough face-to-face interview within policy timeframes. She offered the mother reasonable services and asked detailed and relevant questions. The social worker would have been within policy to close the case following the refusal of services, but the Committee felt she appropriately informed the mother that she would keep the case open and follow-up with in-home checks. The PHN appropriately communicated her concerns to CA when the mother demonstrated a pattern of failing to make herself and her child available for PHN services. The social worker then appropriately acted by attempting to make contact with the family the three days preceding D.M.'s death.
2. Two practice concerns were noted by the Committee. The Committee believes it would have been beneficial to the investigation to have completed a criminal background check, though it was not required by policy. Second, the investigative process would have benefited from the gathering of the birth records immediately after the receipt of the referral. The Committee noted that the birth records would not have been sufficient reason for further court intervention and would not have led to more services as the mother had refused all offered services.

Recommendations:

1. The Bellingham Children's Administration office should develop a plan to increase communication with the local hospital following an intake regarding abuse and/or neglect originating at a hospital.

Action Taken: The Bellingham Children's Administration office contacted the local hospital and a meeting was facilitated by a CPS Supervisor on July 8, 2011. A follow-up meeting between the Bellingham Children's Administration office and local will be scheduled by December 31, 2012.