CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

June 2019

Washington State Department of
CHILDREN, YOUTH & FAMILIES

Contents

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The Department of Children, Youth, and Families (DCYF) does not discriminate and provides equal access to its programs and services for all persons without regard to race, color, gender, religion, creed, marital status, national origin, sexual orientation, age, veteran's status, or the presence of any physical, sensory, or mental disability.

Full Report

Child

- H.D.

Date of Child's Birth

- 74.13.515 2018

Date of Near-Fatality

- November 24, 2018

Child Near-Fatality Review Date

- May 8, 2019

Committee Members

- Erin Summa, MPH, Health Promotion Coordinator, Mary Bridge Children's Hospital and Health Network
- Cristina Limpens, MSW, Office of Family and Children's Ombuds
- Nicole Muller, Region 6 Quality Assurance and Programs Administrator, Department of Children, Youth, and Families
- Amy Scanlon, Coordinator, Child Advocacy Center of Pierce County

Facilitator

- Bob Palmer, Critical Incident Review Specialist, DCYF

Executive Summary

On May 8, 2019, the Department of Children, Youth, and Families (DCYF or Department) convened a Child Fatality Review (CFR)[1] to examine the Department's practice and service delivery to H.D. and [redacted] family. This review originated from an incident occurring on November 24, 2018, on an open Child Protective Services (CPS) case. On that date, paramedics and police responded to a 911 call of an unresponsive infant subsequently pronounced dead at the scene. The incident initially appeared to be an infant sleep-related death. Subsequently police became skeptical about the mother's explanation of events and arrested Amelia Day four months later, charging her with suspicion of second-degree murder.[2] Reportedly, the autopsy determined the cause of death to be "undetermined suffocation."

The CFR Committee (Committee) included a DCYF quality assurance administrator, a representative from the Office of Family and Children's Ombuds, a child safety educator with expertise in infant safe sleep and the coordinator of a local Child Advocacy Center. A detective originally scheduled to participate on the Committee was unexpectedly unable to attend the CFR. None of the Committee members had any previous direct knowledge of or involvement with H.D. or [redacted] family.

Prior to the review, each Committee member received a chronology summarizing the CPS involvement with the family, un-redacted DCYF documents (e.g., intakes, assessments and case notes), initial law enforcement response reports and a brief news article regarding Amelia Day's arrest in March 2019. At the time of the review, supplemental sources of information and other reference materials were available to the Committee, including H.D.'s medical records, materials regarding infant safe sleep and the legal definition of Murder in the second degree (RCW 9A32.050).

The primary assigned CPS worker provided additional information during the Committee's in-person interview process. The CPS supervisor and a co-assigned CPS worker were unavailable for Committee interview. However, Committee members were briefed with regard to responses to questions posed during an earlier interview conducted by the CFR facilitator with those workers. This included written responses from the co-assigned worker regarding recollections from the initial (pre-critical incident) home visit. After the review of case documents, consideration of interview responses by DCYF staff and discussion regarding Department activities and decisions, the Committee made findings and recommendations that are included at the end of this report.

[1] "A child fatality or near fatality review completed pursuant to [RCW 74.13.640] is subject to discovery in a civil or administrative proceeding, but may not be admitted into evidence or otherwise used in a civil or administrative proceeding except pursuant to [RCW 74.13.640(4)]." Given its limited purpose, a child fatality review (CFR) or child near fatality review (CNFR) should not be construed to be a final or comprehensive review of all circumstances surrounding the death or near death of a child. The CFR Committee's review is generally limited to documents in the possession of or obtained by DCYF or its contracted service providers. The Committee has no subpoena power or authority to compel attendance and generally only hears from DCYF 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 child. A CFR or CNFR is not intended to be a fact-finding or forensic inquiry to replace or supersede investigations by courts, law enforcement agencies, or other entities with legal respons bility to investigate or review some or all the circumstances of a child's fatal injury or near fatality. Nor is it the function or purpose of a CFR or CNFR to recommend personnel action against DCYF employees or other individuals. "The restrictions [described in this paragraph, and the paragraph immediately above,] do not apply in a licensing or disciplinary proceeding arising from an agency's effort to revoke or suspend the license of any licensed professional based in whole or in part upon allegations of wrongdoing in connection with a minor's death or near fatality reviewed by a child fatality or near fatality review team." RCW 74.13.640(4)(d).

[2] As a criminal charge was filed relating to the incident, the mother is identified by name in this report. The name of the child is subject to privacy laws. See RCW 74.13.500.

Case Overview

Initial DCYF involvement with the family occurred on Thursday, November 15, 2018, in response to a report from law enforcement regarding a child welfare check conducted the day before. According to 74.13.515 Police, an officer responded to a 911 call from Amelia Day's roommate regarding a possible RCW 13.50.100 of 74.13.515 old H.D. The roommate and her boyfriend had the infant with them in a parking lot. The officer saw the child and then went to the apartment to contact the mother, Amelia Day. While denying any RCW 13.50.100 Ms. Day admitted being overwhelmed with her baby whom she described as having purple crying.[3] The roommate returned the child to the mother in the presence of the officer and a more detailed examination of the child ensued. There were no observed marks or bruising, 74.13.520 . The officer found sufficient baby formula, diapers and other infant necessities at the residence. After informing the mother that he would be notifying CPS, the office cleared the field contact without taking the child into protective custody.[4]

In response to the police report sent to CPS, two DCYF staff conducted an unannounced home visit within hours of the CPS Risk Only intake.[5] Present at the residence was Amelia Day and H.D who was asleep in an infant swing. Neither the roommate nor the roommate's boyfriend were home at the time of the CPS contact. When asked about the recent police response to her residence, Amelia Day indicated that H.D. was crying so often that night that she got exhausted and overwhelmed. Her roommate offered to take the baby for a while. She denied RCW 13 50.100 or otherwise RCW 13.50.100 H.D.

A brief walk through of the residence by the CPS workers did not reveal any obvious safety concerns, with the exception of the sleep environments for mother and child. Mother slept on a pullout sofa bed in the living room area of the apartment and admitted bed-sharing[6] to help H.D. calm down at night. The CPS workers reviewed infant safe sleep issues with the mother, including safer options than relying on use of the infant swing during the day and bed-sharing at night.

During the home visit, the workers observed the mother's interactions with H.D. Although appearing relatively appropriate when holding, feeding, burping and diapering the baby, the mother's non-verbal behavior presented as awkward, being flustered, indecisive, overwhelmed and inexperience in caring for an infant. She admitted the pregnancy had been unexpected, that the alleged father indicated no desire to be involved with the baby and her "toxic" family of origin resided in 74.13.515 . Some brief discussion occurred with the mother about the stress of being a young, single, first-time mother, dealing with a fussy baby with limited support and possibly experiencing 74.13.520 .[7]

The workers saw no marks or signs of abuse on H.D. 74.13.520 74.13.520 [8] Amelia Day provided some information

[3] Purple Crying refers to a time in a baby's life where there may be significant periods of crying. The Period of Purple Crying begins at about 2-weeks of age and continues until about 3-4 months of age. [Source: What is the Period of Purple Crying?]
[4] RCW 26.44.0450: "A law enforcement officer may take, or cause to be taken, a child into custody without a court order if there is probable cause to believe that the child is abused or neglected and that the child would be injured or could not be taken into custody if it were necessary to first obtain a court order pursuant to RCW 13.34.050."
[5] DCYF will screen in a CPS Risk Only intake when information collected lacks specific allegations of child maltreatment, but provides reasonable cause to believe that risk or safety factors exist that place the child at imminent risk of serious harm.
[6] **Bed-Sharing**: A sleep arrangement in which an infant sleeps on the same surface with another person (e.g., bed, couch or chair). Sleeping with a baby in an adult bed increases the risk of suffocation and other sleep-related causes of infant death.
[7] For more information about sign and symptoms 74.13.520 , see: 74.13.520
[8] 74.13.520

regarding H.D.'s daily routine (sleep, feeding, crying) and medical/health history. This included her admission of frequently changing H.D.'s formula without consulting the Primary Care Physician (PCP).

Potential resources and services were discussed during the home visit, including the Department providing a Rock 'n Play Sleeper[9] and other baby items, referring the family to SafeCare[10] or for Public Health Nurse (PHN) services. The workers also suggested the mother schedule an appointment for a consult with the PCP in 74.13.515 and seek a local medical provider for H.D. if her plan was to permanently reside in 74.13.515 County.

After departing from the home visit, the two workers discussed their observations, identified risk factors and areas where safety threats could eventually emerge (e.g., safe sleep). They discussed next steps in the case, including the need to conduct another home visit soon, to contact collateral sources of information and to put intervention services and support resources into motion. Following the home visit, the primary assigned worker inquired with a local WIC office as to the availability of soy formula.[11] The co-assigned worker briefed the supervisor on the home visit observations.

The following day (Friday), the primary worker contacted the County Public Health District regarding a PHN referral and requested H.D.'s PCP medical records. After further discussion between the two co-assigned CPS workers, the decision was made to conduct another home visit that day, before the weekend. That evening, the primary worker conducted a second home visit. The worker again discussed the baby's routine for feeding, sleeping and bowel movement and urination. The worker delivered numerous baby items (pacifiers, diaper rash cream, diapers, sleeper outfits and a Fisher-Price Rock 'n Play sleeper). Materials regarding Infant Safe Sleep[12] and the Period of Purple Crying[13] were provided to Amelia Day, as well as information regarding Use of Force on Children (RCW 9A.16.100), a list of county medical providers and information about contacting WIC. During the home visit, the CPS worker overheard a heated discussion between Amelia Day and the PCP's Clinic in 74.13.515 that resulted in an appointment scheduled two weeks out. The CPS worker strongly encouraged Amelia Day to have H.D. seen at an Urgent Care for the possible 74.13.520 situation.

On November 19, 2018, the worker text-messaged Amelia Day to follow up on the 74.13.520 situation and viewing of the Period of Purple Crying video. The following day, the worker got confirmation of a PHN to work with the mother and infant.

On November 21. 2018, the eve of the 4-day Thanksgiving Holiday weekend, afterhours intake received information from H.D.'s PCP in 74.13.515 County. H.D. had been seen for a well-child check on October 31, 2018, but efforts to get Amelia Day to bring H.D. in for routine follow up had been unsuccessful.

74.13.520

[9] *The U.S. Consumer Product Safety Commission (CPSC) and Fisher-Price took the advice of the American Academy of Pediatrics and issued a recall of the Rock 'n Play Sleeper in April 2019 due to concerns for infant safety for those infants able to rollover (typically 3 months of age).*

[10] SafeCare is an in-home parent training for at-risk families to improve parenting skills and address health and safety issues.

[11] The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) provides federal grants to states for supplemental foods, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and non-breastfeeding postpartum women, and to infants and children up to age five who are found to be at nutritional risk. https://www.fns.usda.gov/wic

[12] NIH Pub No 17-HD-7040

[13] *The Period of Purple Crying is a method of helping parents understand the time in their baby's life where there may be significant periods of crying. During this phase of a baby's life they can cry for hours and still be healthy and normal. The Period of Purple Crying begins at about 2 weeks of age and continues until about 3-4 months of age.

According to the PCP, Amelia Day had recently contacted her to request [redacted] medication for the baby and became verbally abusive to clinic staff when the request was denied due to not having examined the infant. It was at that time the PCP apparently became aware that the mother and child had moved to [redacted] County. While not having any current information regarding the family's specific living situation, the PCP had concerns about Amelia Day's ability to meet the needs of the baby, largely due to the mother's history [redacted]. The intake was accepted for CPS investigation of neglect, with a designated 72-hour response time.

Early Saturday morning of November 24, 2018, a CPS worker attempted a home visit in response to this new intake. The worker knocked several times. Getting no response and hearing no noises coming from the apartment, the worker attempted to peek through a window but shades were drawn. The worker later attempted to contact the mother by phone, leaving a voice message.

The following Monday the primary assigned worker got in phone contact with Amelia Day, at which time it was revealed that H.D. had died. Amelia Day initially told the CPS worker that around 8:30 Saturday morning she put H.D. down in the Rock 'n Play sleeper after a feeding. Around 10 a.m. she went to pick [redacted] up - [redacted] was still warm. She laid [redacted] on the bed and noticed [redacted] heart was not beating. She started performing CPR on [redacted] and called 911 at about 10:05. Within about 10 minutes EMT's arrived and took H.D. out to the ambulance where [redacted] was pronounced deceased. Law enforcement and the County Coroner's Office arrived later to initiate a death scene investigation.

Detectives pursued an investigation of the death. While the initial physical findings were not suggestive of foul play, the mother's statements to detectives were inconsistent. Subsequently, Amelia Day admitted to having lied as to the circumstances surrounding the death of her infant [redacted] She indicated that she was alone with the baby the day [redacted] died, having to deal with the baby's crying by herself, as her roommate was gone that day. She became frustrated, angry and exhausted dealing with the crying and [redacted] lack of feeding and held H.D. against her chest until [redacted] stopping crying and moving. Believing [redacted] had fallen asleep, she put [redacted] down on the bed. She then went to sleep and found [redacted] unresponsive when she woke.

The CPS investigation of the death resulted in a founded neglect finding.[14] At the time of the CPS finding, the cause and manner of death was not yet determined. The County Coroner eventually identified the death as an "undetermined suffocation". On March 26, 2019, Amelia Day was arrested and booked into [redacted] County jail, charged with suspicion of second-degree murder of her [redacted] old [redacted]

Committee Discussion

A major area of discussion focused on the fact that the case had been open only 10 calendar days before the fatality incident. This included 5 working week days, 3 weekend days, and a 2-day holiday. The Committee discussed the actions and decisions made by Department staff during the brief interval preceding H.D.'s death. This included the following documented activities:

1. Conducting two home visits.
2. Making face-to-face contact with the child the same day as the intake was received.
3. Conducting an initial interview with the primary caretaker (the mother).

[14] See https://app.leg.wa.gov/RCW/default.aspx?cite=26.44.020

4. Making a Public Health Nurse referral.
5. Requesting medical records from the PCP.
6. Contacting WIC to inquire about obtaining soy formula.
7. Follow up text messaging with mother.

The Committee considered state policy and practice for CPS Risk Only interventions, discussing reasonable activities expected from DCYF staff in the initial stages of CPS, contrasted with the more expansive activities expected during a fully allotted timeframe for completing an investigation. The Committee recognized the likelihood of more detailed information being gathered by the workers during a full course of investigation, assessment and client engagement. In addition, the Committee identified and discussed specific areas of inquiry and corroboration that would have been important to eventual completion of the CPS investigative pathway but not reasonably expected to be completed during the first days of a case being opened. This included extensive collateral contacts, consulting with local child abuse medical professionals (e.g., CAID[15]) and running criminal background checks on the mother, the mother's roommate and the roommate's boyfriend.

The Committee looked closely at the information initially gathered, particularly surrounding risk factors identified by the two CPS workers as "concerning" in terms of assessing for both present (imminent) and possible impending (future) danger.[16] This included evaluating the potential impact of a young, single, first time parent, isolated with very limited support, overwhelmed and stressed, exhibiting subtle indications of parental ambivalence,[17] somewhat resistant to guidance, with a history 13.50.100 [redacted]. Given the number and types of risk factors involved, coupled with the allegation that the mother may have RCW 13.50.100, the Committee debated possible alternatives available to DCYF to prioritize and plan around the immediate care and safety of the baby. This included consideration to seek a temporary Voluntary Placement, filing for dependency, developing an emergency safety support network to ameliorate any possible crisis point or requesting local law enforcement conduct a child welfare check over the long weekend. The Committee did not reach consensus for these options.

The Committee discussed whether the workers had fully understood and followed the DCYF Infant Education and Intervention policy.[18] A major issue was the questionable providing of the Fisher-Price Rock 'n Play as an assumed safe sleep product. The Committee heard the worker's explanation that the Rock 'n Play was deemed to be an available and safer option than the mother's bed-sharing with her infant. It was noted that the Department had been messaging concerns since November 2017 about child welfare services offices providing co-sleepers, sleeper boxes and other infant sleep products not fully approved by the Consumer Product Safety Commission. It was further noted that by late 2018 efforts were being made to remove Rock 'n Play swings from DCYF concrete good supplies in all offices although the actual national recall of the product did not occur until April 2019. The Committee did not

[15] The **Child Abuse Intervention Department** at Mary Bridge offers medical treatment, psychosocial support, legal advocacy and crisis intervention services for victims of child abuse and their families. CAID also provides strategies for Pierce County parents and the community to prevent child abuse through these free programs.

[16] "Present danger is defined as immediate, significant, and clearly observable severe harm or threat of severe harm occurring in the present requiring immediate protective response. Present danger may be a basis to determine that 'Imminent Harm' under RCW 13.34.050(1) exists and therefore may be a basis to seek immediate removal if other less intrusive options for immediate protective actions will not assure child safety." See https://www.dcyf.wa.gov/sites/default/files/pdf/SafetyThresholdHandout.pdf

[17] Parental ambivalence relates to the nurturing and affectionate aspects of a parent-child relationship. It is often identifiable by behavioral or verbal indicators that suggest contradictory attitudes toward the relationship, incompatible expectations and mixed emotions, and self-doubt regarding being able to handle a parent/caretaker role.

[18] https://www.dcyf.wa.gov/1100-child-safety/1135-infant-safety-education-and-intervention

reach consensus as to whether the Rock 'n Play provided for the child actually contributed to the infant death, but a majority of Committee members called to question that decision.

Given the primary task of the Committee is to review and evaluate recent DCYF service delivery occurring prior to a suspicious child death, there was only limited Committee discussion about the CPS investigation of the fatality incident. This included looking at the information gathered largely by law enforcement over several months of criminal investigative interviews following the child's death. While such information certainly supported the initial concerns of DCYF staff, the Committee was unable to say, with any degree of certainty, that having this information prior to the death would have led the Department to preemptively legally intervene and remove the child.

Findings

The Committee reached full consensus as to the absence of any identified catastrophic errors or significant policy violations by DCYF. The Committee recognizes that when the fatality incident occurred, the case had only been open for 10 calendar days (five working week days) and was in the very early stages of the investigative and assessment process. It is the Committee's opinion, based on the information gathered by the Department in the limited time the case was open (pre-critical incident) that the subsequent fatality outcome was not clearly predictable or reasonably preventable short of removing the infant at first contact. The Committee believes there was insufficient reason to seek legal intervention (removal) at the time.

Recommendations

- DCYF should consider reinstituting specific training for child welfare workers on recognizing indicators of parental ambivalence for risk and safety assessment.
- DCYF should continue messaging the importance of assessing infant safe sleep and provide updates regarding Consumer Product Safety Commission, American Academy of Pediatrics and Centers for Disease Control and Prevention guidelines and infant care products. Consideration should be given to requiring a brief annual refresher training on infant safe sleep (on line or classroom), especially for child welfare workers who have infants on their caseloads.