Child Fatality Review

C.R-M.

RCW 74.13.515 **2016**
Date of Child's Birth

December 21, 2017
Date of Child's Death

May 8, 2018
Date of the Fatality Review

Committee Members
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Executive Summary

On May 8, 2018, the Department of Social and Health Services (DSHS), Children's Administration (CA), convened a Child Fatality Review (CFR)[1] to assess the department's practice and service delivery to C.R-M. and RCW 74 family.[2] The incident initiating this review occurred on December 22, 2017, when C.R-M. was taken to a local hospital by RCW 74 father. At the hospital, the child was pronounced dead. The local coroner ruled that C.R-M.'s death was due to natural causes and cited RCW 74 health issues (RCW 74.13.520 from birth, RCW 74.13.520, RCW 74.13.520 and RCW 74.13.520) as contributing factors. Medical experts from RCW 74.13.515 Hospital reviewed the coroner's report and disagreed with the findings, noting that the child's death is suspicious for abuse or neglect in part due to the parents' inconsistent statements to police, medical staff and CA regarding where C.R-M. was sleeping leading up to RCW 74 death and how they found RCW 74.13.5 At the time of RCW 74 death, C.R-M. was residing with RCW 74 mother, RCW 74 father and RCW 74 twin sibling.

The Review Committee included members selected from diverse disciplines within the community with relevant expertise including the Office of the Family and Children's Ombuds, a pediatric and child abuse medical expert, a CA program manager and a Child Protective Services (CPS) supervisor with CA. Neither CA staff nor any other Committee members had previous direct involvement with this family.

Prior to the review, each Committee member received a family genogram, a case chronology, a summary of CA involvement with the family and un-redacted CA case documents (e.g., intakes, investigative assessments and case notes). Supplemental sources of information and resource materials were available to the Committee at the time of the review. These included medical reports, relevant state laws and CA policies.

During the course of this review, the Committee interviewed the CPS investigator, supervisor and area administrator. Following the review of the case

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[1]Given its limited purpose, a CFR should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of the 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 child. A CFR is not intended to be a fact-finding or forensic inquiry or to replace or supersede investigations by courts, law enforcement agencies or other entities with legal responsibility to investigate or review some or all of the circumstances of a child's fatal injury, nor is it the function or purpose of a CFR to recommend personnel action against DSHS employees or other individuals.

[2] Family members are not named in this report because they have not been charged in an accusatory instrument with committing a crime related to a report maintained by the department in its case and management information system. [Source: RCW 74.13.500(1)(a)]

file documents, completion of interviews and discussion regarding department activities and decisions, the Committee discussed possible areas for practice improvement while recognizing the limited time CA was involved prior to the incident. The Committee did not make any findings or recommendations related to CA's response or CA systems.

Family Case Summary

Prior to C.R-M.'s death, CA received three intake[3] reports regarding the child, two of which screened in[4] for investigation on June 3, 2017 and September 8, 2017. The first report included allegations of physical abuse and negligent treatment. C.R-M. was reported to have had multiple injuries to vulnerable areas of RCW 74 body at different stages of healing. CA received a confirming report that C.R-M. had verified fractures with no explanation by the parents for the cause of the injury. C.R-M. parents were named as alleged perpetrators of physical abuse and negligent treatment. A CA investigator was assigned and learned that C.R-M. was RCW 74.13.520 RC at birth, causing numerous health issues including RCW 74.13.520, RCW 74.13.520, RCW 74.13.520 and needing RCW 74.13.520. Additionally, C.R-M. has been diagnosed with RCW 74.13.520. Some of the medical professionals involved with C.R-M. believed the injuries reported in the first intake were concerning for abuse, especially the injuries to RCW 74 ribs. However, the medical professionals could not reach consensus about how the child's injuries likely occurred. C.R-M.'s primary care physician believed the injuries might have been inflicted by physical therapy (performed by various providers as well as the parents) while other medical professionals disagreed, believing C.R-M. would have had previous injuries identified from x-rays that were completed prior to June 2017. The CA investigator collaborated with all of the professionals involved with the family and ultimately was unable to find that the parents were responsible for C.R-M.'s injuries. The investigator referred the family for in-home services and helped the family find licensed daycare.

On September 8, 2017, CA was notified by C.R-M.'s therapists that the parents did not seem to understand RCW 74 therapeutic needs due to missing some appointments. The parents explained to CA that C.R-M. had been ill and missed a few therapy appointments. The parents ensured C.R-M.'s attendance to all of the

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[3] An "intake" is a report received by CA in which a person or persons have reasonable cause to believe or suspect that a child has been abused or neglected. A decision to screen out an intake is based on the absence of allegations of child abuse or neglect as defined by WAC 388-15-009.

[4] Intake social workers determine program response type and response times (emergent or non-emergent) for an investigation.CA intakes fall into three categories: CPS involves a child who is allegedly abused, neglected, or abandoned and includes child abuse allegations. CPS Risk Only involves a child whose circumstances places him or her at imminent risk of serious harm but does not include child abuse allegations. Non-CPS involves a request for services for a family or child.

therapy appointments after the complaint was made. The parents agreed to communicate with the therapists in the future to have shared decision making regarding therapy cancellations. The allegations were investigated and determined to be unfounded. The case was closed October 18, 2018.

On December 21, 2018, C.R-M.'s father reportedly put C.R-M. down for a nap around 10:00 a.m. and checked on RCW 74.13 around 2:00 p.m. The father reported to hospital staff that he was caring for C.R-M. alone and the mother was not home. The father stated that he found C.R-M. unresponsive at around 2:00 pm and took RCW 74.13 to the hospital, where C.R-M. was pronounced dead. Hospital staff wondered why the father had not called 911 and why the baby reportedly had been unattended and not checked on for four hours. Law enforcement later interviewed the parents. Law enforcement informed CA that both parents stated that they were both at home during the incident and reported C.R-M. to have been put down in the crib around 10:00 am and checked on at 2:00 pm. The mother reported that C.R-M. slept more during the day than at night. Law enforcement questioned why the parents did not call 911 and why the mother did not join the father in going to the hospital with C.R-M. The mother reported that it was routine for the father to transport C.R-M. to the hospital rather than call 911. Later, the parents reported to the CA investigator that they had all fallen asleep on the bed during the day and had placed C.R-M. next to the headboard of the bed. When the parents woke up they stated C.R-M. was unresponsive.

Committee Discussion

The medical expert on the Committee agreed with the RCW 74.13.515 Hospital SCAN Team's concerns about physical abuse to C.R-M. based on the type and location of injuries. The Committee discussed the challenges CA faces working with multiple medical professionals with varying opinions and uncertainty regarding injuries and suspicion for physical abuse. The Committee noted that regardless of the challenges, the assigned CPS investigator responded appropriately and efficiently to assess child safety and sort information for assessment and services. Further, the Committee noted that the investigator swiftly secured appropriate services for the family. The Committee appreciated the investigators skills and knowledge related to the family's culture and language believing that it benefitted the investigator in sorting out information for a global assessment. The Committee agreed with the investigator's assessment of child safety based on information that was available at the time of the investigation, adding that the investigator's actions were purposeful, tenacious and well thought out.

The Committee discussed the possibility that the family's primary language being Spanish may have impacted their reports to the various professionals (outside of CA) surrounding the circumstances of C.R-M.'s death. The Committee believed that the father's response in transporting the child to the hospital without calling 911 could have been a normal response based on his culture and routine practice in seeking care for C.R-M. The Committee discussed that many cultures or persons residing in rural areas may not be accustomed to having emergency services available. The Committee did not consider the parent's response to the hospital, rather than calling 911, out of the ordinary based on the information that was available.

Understanding CA's inability to remedy or oversee protocols of outside agencies, the Committee discussed the differing opinions between the coroner's written findings on the nature of C.R-M.'s death and the RCW 74.13.515 Hospital medical experts' assessment. The medical expert on the Committee agreed with the RCW 74.13.515 Hospital medical expert's assessment concerning abuse or neglect to C.R-M. The Committee medical expert added that the coroner's report did not meet the standards necessary for a quality death investigation and agreed with the RCW 74.13.515 Hospital medical expert that some of the notations in the report were generalized and inaccurate. The Committee discussed that an autopsy was not ordered by the Coroner, which the Committee speculated might reflect a disparity in the healthcare system's treatment of children with complex medical needs such as C.R-M. The Committee believed that CA is put in a difficult position when receiving conflicting reports from community professionals while also being responsible for conducting thorough investigations and assessing surviving children's safety.

Based on a review of the case documents and interviews with staff, the Committee did not find any critical errors made by department staff directly linked to the child's death. The Committee did not have any findings or recommendations. The Committee commended the investigator for her efforts and assessment.