Washington State Department of Social & Health Services

CA Children's Administration

Child Fatality Review

J.B-D.

December 2012
Date of Child's Birth

January 19, 2014
Date of Fatality

May 8, 2014
Child Fatality Review Date

Committee Members

Mary Meinig, MSW, Director of the Office of the Family and Children's Ombuds
Keli Drake, MSW, Children and Family Welfare Services Program Manager, Department of Social and Health Services, Children's Administration
Thom Young, Department of Social and Health Services, Children's Administration
Yolanda Duralde, MD, Medical Director of the Child Abuse Intervention Department, Mary Bridge Children's Hospital and the Pierce County Child Advocacy Center

Observer

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Executive Summary

On May 1, 2014, the Department of Social and Health Services (DSHS), Children's Administration (CA) convened a Fatality Review (CFR)[1] to assess the department's practice and service delivery to thirteen-month-old J.B-D.[2] and his family. The incident initiating this review occurred on January 19, 2014, when J.B-D. was found non-response in his portable crib while in the care of his father and the father's girlfriend. At the time of the fatality CA had an open Child Protective Services (CPS) investigation and the CPS worker had been attempting to locate the family.

The review Committee included members selected from disciplines within the community with relevant expertise from diverse disciplines. Neither CA staff nor any other Committee members had previous direct involvement with this family or licensed providers.

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

The Committee interviewed the current CPS supervisor. The CPS investigator ended her employment with the department before this investigation was completed and she was unavailable to participate in this process.

Family Case Summary

There was an intake made at the birth of J.B-D. and another two days after his birth. Both intakes were screened out for lack of a specific child abuse or neglect allegation.[3] On January 4, 2014, DSHS received an intake regarding alleged

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[1] Given its limited purpose, a Fatality Review (CFR) should not be construed to be a final or comprehensive review of all of the circumstances surrounding the near 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 child. 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 or other entities with legal responsibility to investigate or review some or all of the circumstances of a child's near fatal injury. Nor is it the function or purpose of a Child Fatality Review to recommend personnel action against DSHS employees or other individuals.

[2] J.B-D.'s 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)]

[3] CA will generally screen-out intakes the following intakes: 1) Abuse of dependent adults or persons 18 years of age or older. Such services are provided by the Adult Protective Services (APS) section. 2) Third-party abuse committed by persons other than those responsible for the child's welfare. 3) CA/N that is reported after the victim has reached age

physical abuse to J.B-D. while in the care of his father and the father's girlfriend. There were allegations of domestic violence between the father and his girlfriend and alleged medical neglect of J.B-D. Five days after the January 4, 2014 intake, a subsequent intake was screened in for neglect. A physician called and stated J.B-D. presented at the emergency department with diarrhea and vomiting. J.B-D. was brought to the hospital by a family friend who told the physician that the father's girlfriend could not deal with J.B-D. any longer and left him with sour milk. The physician called CA to find out if CA approved of the hospital releasing J.B-D. to this woman's care. CA did not see a reason to stop J.B-D. from being discharged to the woman who brought him. The intake was assigned for a CPS investigation.

During the CPS investigation, the assigned CPS worker was informed by the father's girlfriend that J.B-D.'s mother had been arrested in the recent past. At that time the mother gave J.B-D. to a relative or friend and eventually J.B-D. ended up in his father's care. At that time the father's girlfriend assumed primary care of J.B-D due to the father's incarceration. The family did not have stable housing and would stay with friends in order to have a place to sleep.

During the investigation, the social worker was alerted that the father had been released from jail and planned on returning to live with his girlfriend and J.B-D. which would violate the criminal no contact order that had been put in place by the court after the domestic violence charges had been filed. The CPS social worker requested law enforcement conduct a welfare check on J.B-D. When law enforcement arrived, the officer was told by the resident that the father, his girlfriend, and J.B-D. were not there and were not allowed to return. The social worker attempted to locate J.B-D. but was unable to do so before his death.

The circumstances surrounding J.B-D.'s death remain unknown. He did not have signs of trauma and the cause and manner of death are unknown. The law enforcement investigation remains open at this time. Based on the short length of time between the intake on January 4, 2014 and J.B-D.'s death on January 19, 2014, the investigation of the two screened in intakes was not concluded. Therefore the CPS investigative findings were made post-fatality.

18, except that alleged to have occurred in a licensed facility. 4) Child custody determinations in conflictual family proceedings or marital dissolution, where there are no allegations of CA/N. 5) Cases in which no abuse or neglect is alleged to have occurred. 6) Alleged violations of the school system's Statutory Code, Administrative Code, statements regarding discipline policies.

Committee Discussion

The Committee struggled with how J.B-D. could have passed away and that the cause or manner of death remains unknown. J.B-D. had been observed as an active child who could pull himself up and easily maneuver his body. There were acknowledged risks to his care but the risks did not rise to a level of imminent or present danger as is necessary for CA to request removal from a parent's care and custody. All collateral information received was positive as it pertained to J.B-D.'s care during the investigations. The allegations were not proven to be accurate at the time of the investigations. J.B-D. was sleeping in a broken portable crib with a significant amount of bedding and items in this crib. The Committee was concerned regarding J.B-D.'s sleeping arrangement and whether this contributed to his death.

There was considerable discussion surrounding why a nonrelative was caring for J.B-D. and his mother's ability to have cared for him. J.B-D.'s mother attended one of his medical appointments with the father's girlfriend, yet the mother did not attempt to take J.B-D. back with her after this appointment. The girlfriend was able to obtain medical care and welfare benefits and these supportive services were verified by the social worker.

The Committee discussed how the CPS social worker diligently requested collateral information from the daycare and medical facilities where J.B-D. had contact. Appropriate collateral contacts were made to assess the care provider's, the father's girlfriend, ability to safely provide care for J.B-D. Per policy, the worker referred the intake to the appropriate law enforcement agency, requested criminal history checks on both the mother, father and the father's girlfriend and was timely with contacts with the child and care provider.

There were no findings or recommendations made during this review process. The Committee concurred the case was appropriately investigated by the CPS social worker.