RCW 74.13.515

Children's Administration

Executive Child Fatality Review

A.R. Case

Date of Birth: 06/ 2011
Date of Death: 09/10/2011
Date of Review: 01/27/2012

Committee Members:
Pat Shaw, Program Manager, Clark County Public Health
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Kathy Shirlla, Clark County Court Appointed Special Advocate (CASA)

Observers:
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Executive Summary

On September 10, 2011, the Skamania County Sheriff's Department received a report that two-month-old A.R. was found not breathing. Law enforcement arrived at the home of the child's grandparents. A.R.'s mother (A.S.) also lived in the grandparents' home. A.S. told first responders that she woke up at about 5:30 a.m. and fed her daughter about four ounces of formula. A.R. fell back asleep on her back next to her mother in the same bed. There was no bedding on top of them as the temperature was warm outside. The child was wearing only a diaper. The child fell back asleep and about an hour later A.S. woke to go to the bathroom. When she returned from the bathroom, she checked on her daughter who was non-responsive. A.S. called for her father who came to the room and started CPR. A 911 call was made at or around the same time.

Police officers responded and performed CPR until paramedics arrived. Paramedics continued CPR for an additional 30 minutes. Paramedics transported A.R. to Skyline Hospital in White Salmon and continued CPR. Resuscitative efforts were continued at the hospital; however, she was nonresponsive the entire time and was finally pronounced dead at 8:53 in the morning.

The emergency room doctor reported no obvious indicators that A.R.'s death was the result of abuse or neglect. The child's grandfather reported A.R. had a stuffy nose and a slight temperature of about 100 degrees.

It was reported to the team that the weather had been warm on and around the day of A.R.'s death. The air quality in the area was poor due to heavy smoke in the area from a forest fire that lasted several days.

A.R. was removed from her mother's care on June 28, 2011. She was initially placed in foster care but was later moved to her grandparents' care on July 5, 2011. She was still in the care of her grandparents when she died. Her mother also lived in the home. An initial safety plan was put in place that required the grandparents to provide all of the supervision of A.R. On August 10, 2011, the safety plan was nullified by a court order. The court lifted the requirement that A.S. could not have unsupervised contact with her daughter. The court order stipulated that the grandparents monitor A.S.'s contact with her daughter. A.R. was allowed to sleep in the same room with her mother in a bassinet.

There were no other children placed in the home at the time of A.R's death. The only persons in the home at the time of A.R.'s death were A.R., her mother, and maternal grandparents.

A.S. had an open case in the Stevenson Division of Children and Family Services (DCFS) office when A.R. was born. the department was providing court-ordered services to A.S.

A Child Protective Service (CPS) intake was screened in for investigation on circumstances of A.R.'s death. Her death was also investigated by the Skamania County Sheriff's Department.

The autopsy was completed by the Klickitat County Coroner. The coroner reported the autopsy showed no signs of trauma. The toxicology report indicated no drugs or alcohol in A.R's system. The official cause of death is listed as Sudden Infant Death Syndrome. The CPS

investigation was closed with an unfounded finding for negligent treatment or maltreatment. Skamania County Sheriff's closed their case without filing charges.[1]

On January 27, 2012, Children's Administration (CA) convened a multi-disciplinary committee to review adherence to policy and the social work practice in this family's case.[2] The fatality review team was represented by disciplines associated with the case and had no involvement or limited involvement with this family. The fatality review team members included court appointed special advocates, a member from the Clark County Children Justice Center and the Clark County Public Health Department. The team also included CA staff who had no direct connection to the case. The director of the Office of the Children and Family Ombudsman was present at the review.

Relevant case documents were made available to the fatality review team. These documents included: law enforcement reports, family history including intake information, Individual Social Service Plan, a chronology of the case upon assignment of the case and a summary of the incident the morning of A.R.'s death.

Following review of the case history, case records and law enforcement records, the review team discussed the case history, system collaboration, and service delivery regarding this child and her mother. The team discussed the department's efforts to address the issues that interfered with A.S.'s ability to parent her children —including mental health and her substance abuse issues. The team addressed safe sleep issues and efforts to educate communities and clients on safe sleep issues. The findings, issues and recommendations were discussed by the review team and this discussion is detailed at the end of this report.

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[1] Revisions to RCW 74.13.640 went into effect in July 2011. RCW 74.13.640 reads: (a) The department shall conduct a child fatality review in the event of a fatality suspected to be caused by child abuse or neglect of any minor who is in the care of the department or a supervising agency or receiving services described in this chapter or who has been in the care of the department or a supervising agency or received services described in this chapter within one year preceding the minor's death. (b) The department shall consult with the office of the family and children's ombudsman to determine if a child fatality review should be conducted in any case in which it cannot be determined whether the child's death is the result of suspected child abuse or neglect. Although it was eventually determined by Child Protective Services, law enforcement, and the county coroner that A.R. did not die from suspected abuse or neglect, the department consulted with the office of the family and children's ombudsman and the decision was made to conduct a child fatality review of this case.

[2] 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. A 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 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 take personnel action or recommend such action against DSHS employees or other individuals. 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 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 take personnel action or recommend such action against DSHS employees or other individuals.

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Case Overview

A.S. is the mother of four children M.G., 6 years old; J.M., 3 years old; M.M., 22 months old; and A.R, who was six months old at the time of her death.

In June 2011, A.S. gave birth to A.R. at an Oregon hospital (she was a resident of Washington state at the time). The department received a report from hospital staff that A.S. had delivered a substance exposed baby girl. A meconium test for A.R. was positive for opiates. The department filed a dependency petition on A.R. two days later. She was briefly placed in foster care following her discharge from the hospital. A Family Team Decision Meeting (FTDM) was conducted and the maternal grandparents to A.R. were identified as a relative placement. The family's plan arranged during the FTDM allowed for to A.S. live with her parents, but all contact with her daughter was to be

supervised. The grandparents agreed that A.R. would sleep in a crib in their room at night. An aunt would provide supervision during the day when the grandparents were at work.

Services were offered to A.S. immediately after the dependency petition filing in June 2011. A.S. participated in a psychological evaluation with a parenting assessment, and drug/alcohol evaluation. A.S. completed a drug/alcohol education course.

She was referred to the Skamania County Early Support for Infants and Toddlers program, and a mental health assessment, but had not participated in these services prior to her daughter's death.

On August 10, 2011, a Shelter Care review hearing was held in Skamania County Superior Court. The court ordered that A.S. could have liberal unsupervised contact, monitored only by the grandparents. The easing of the supervision requirement was due to A.S.'s cooperation and participation in services. A.S. was allowed to have her daughter's crib moved to her bedroom and was allowed liberal unsupervised contact. The court order was still in effect when A.R. died one month later.

Paternity on A.R. was not established at the time of her death.

Issues Identified by the Review Team

The review team discussed actions taken by law enforcement and Children's Administration's after hours staff regarding the November 20, 2010 intake. The team acknowledged the excellent social work practice evidenced in the case file after the case was assigned to a local CPS social worker. Case staffings were frequently conducted to discuss A.S's progress, additional service needs and any other recommendations. The fatality review team's findings include the following:

- The team discussed the remote area of the state where the family lived and the limited access to resources and services, including the availability of a public health nurse and mental health services. DCFS staff from the Stevenson office and the GAL commented on the lack of available services to the families in Skamania County. This is a hardship on most families who often have to drive to Clark County to accessing appropriate services.

Findings

- The review team identified co-sleeping between the mother and her daughter as a potential factor in the child's death. The potential risks of co-sleeping were repeatedly discussed with A.S. and the maternal grandparents by her social worker. The team recognized that the worker made reasonable efforts to ensure that A.R. had a safe sleep environment. The team identified good practice in this case and suggested that best practice on open CPS cases involving infants is for social workers to discuss safe sleep education with the parents.
- The team acknowledged that A.S. lived in a small close knit community. She and her family are well known and closely watched in the community. Children's

Administration staff have a long standing relationship with her and her children. A.R.'s death has had a tremendous impact on CA staff, the GAL, and the service providers who worked with this family.

- The team commended the supervisor and social worker on the very thorough casework done by the staff in the Stevenson DCFS office and the level of support provided to A.S.

Recommendation

- The fatality review team made no specific recommendations.