Children's Administration

Executive Review Child Fatality Review

N. N. Case

June 25, 2008

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Executive Summary

In June 2008, the Children's Administration (CA) convened an Executive Child Fatality Review[1] committee to review the practice and service delivery in the case involving four-month old N. N. and his family. (DOB: October , 2007)

The incident initiating this review occurred on March 10, 2008, when Pierce County Sheriff's Department notified Child Protective Services (CPS) of the death of a four-month old infant. The referrer told CPS the infant had been seen at St. Claire Hospital on March 7, 2008 due to an unexplained eye injury. The child was treated and released to his mother, Ms. Domenique Conway[2]. On March 9, 2008, despite checking on him periodically while he slept, Ms. Conway told law enforcement she contacted 911 when she noticed her son was not breathing. Preliminary cause of death at the hospital was noted as a possible skull fracture and brain bleed.

A review of the family's history with Children's Administration notes five previous referrals referencing this child, his twin brother and two other siblings. The first referral, received on June 6, 2006, referenced an older sibling of the decedent having unsupervised contact with her father, a registered sex offender. A subsequent investigation into supervision allegations resulted in a finding of unfounded.

Four other referrals were received beginning on October 18, 2007 shortly after the birth of this child and his twin brother. The October 18, 2007 and a subsequent December 3, 2007 referral were screened as Information Only; a December 28, 2007 referral was referred to an Alternative Response System and the final report received on January 7, 2008 was accepted for investigation. As a result of the January 7, 2008 referral the family agreed to and accepted services in their home. At the time of this child's death Family Voluntary Services were being provided in the home with several providers working with the family.

Committee members included a diverse group of individuals from Children's Administration (CA) staff along with representatives from several private and public

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[1] 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.

[2] The full name of Ms. Domenique Conway is being used in this report as she has been charged in connection to the incident and her name is a part of the public record.

agencies from regions across Washington. Review committee members had no involvement in the N.N. case. Team members were provided case documents consisting of the following: referral information, medical information, summary information from in home providers and coroner's information and findings. Following a teleconference with committee members on June 20, 2008 members recommended several staff and providers be interviewed during the fatality review:

- Region 5 Child Protective Services (CPS) Supervisor
- Region 5 CPS Investigator
- Intensive Family Preservation Services (IFPS) worker
- Foster parent of the child's surviving twin brother

These individuals were interviewed by committee members on June 25, 2008.

Following review of the documents, case history, interviews with staff members and providers the review committee made findings and recommendations which are detailed at the end of this report.

Case Overview

RCW 74.13.500

On October 18, 2007 shortly after the birth of N. N. and his twin brother, CA received a referral referencing the twins' pre-mature birth and lack of pre-natal care. Though the twins tested negative for drugs; the referral noted their medically fragile state. The referral screened as Information Only as both infants remained hospitalized. Over the course of the next six weeks, medical staff expressed concerns to CA regarding difficulty in contacting the parents of the children and inconsistency in their visiting. Though N. N.'s medical status was stable in early November 2007, his twin needed emergency surgery for a life-threatening condition, and the parents could not be reached. The referrer further reported lapses in contact between the parents and the children to as much as no contact in eleven (11) days.

On December 3, 2007 an Information Only referral was received noting the twins remained in the Intensive Care Unit and despite the hospital's efforts to encourage increased visitation between the children and their parents they had not yet engaged. Hospital staff expressed concern regarding attachment and bonding with the twins as well as questioning the parents' ability to care for N. N. as his discharge was approaching. On December 6, 2007, a Public Health Nurse (PHN) contacted CPS stating they were recommending a nurse be assigned to work with the family regarding the specialized care the twins would need upon discharge from the hospital. The PHN stated a referral to the Early Intervention Program (EIP) with the Public Health Department would be made and a PHN assigned. An addendum was added to the December 3, 2007 Information Only referral noting referrals initiated by a PHN to two community service agencies, Mary

Bridge Parenting Partnership Program and Pierce County Public Health. A Service Episode Record (SER) notes on December 10, 2007 the December 3, 2007 Information Only referral was staffed with the Region 5 CPS Program Manager. It was recommended at this time to leave the referral as Information Only until additional information was provided by the health care providers assigned to the family.

N.N. was subsequently discharged to his parents on December 11, 2007. In addition to the EIP referral, Mary Bridge Hospital's Parenting Partnership Program (PPP) provided nursing and social work support to the family. N. N.'s twin, S. N. remained hospitalized for additional surgery and monitoring.

On December 28, 2007 after speaking with the PHN, the CPS Intake social worker generated a referral regarding the nurse's observations of the care of N. N. by his mother. Allegations included concerns the child had on a wet bib and cold hands while sitting in front of a window. The PHN spoke to the mother about the importance of keeping a premature infant warm.

RCW 74.13.500

The CPS Supervisor told the review committee the basis for the Consensus Team's decision was based on the fact that no information was provided to indicate the infant was being neglected other than noting his cold hands. The Consensus Team also noted the information in this referral was observed by the PHN during a visit ten (10) days prior to the actual referral date.

On January 7, 2008 the PHN contacted CPS regarding concerns for N. N. and his mother's ability to care for him and her other children. The referrer said N. N. was not gaining weight, had missed a scheduled appointment with the pediatrician, and did not appear healthy. Furthermore, the referent observed what she believed to be excessive discipline (extended time outs exceeding 30 minutes in duration) of an older child (age 6) and opined the two-year-old in the family was out of control and a danger to the infant. The referral screened in with a risk tag of 4 and assigned for investigation.

During the investigation, the investigator noted the family missed several medical appointments and all children were behind on immunizations including N. N. who required a Respiratory Syncytial Virus (RSV) immunization. Further information found the family had a history of not attending medical appointments, and had difficulty feeding the child; later verified by limited weight gain. In addition, the investigation revealed continued inconsistency of visitation at the hospital with N. N.'s twin brother, S. N.

The CPS investigator reported to the review committee that given the twins' health issues concerns were addressed with the family about repeated missed medical appointments and the importance they follow through with appointments for all the children including their hospitalized son.

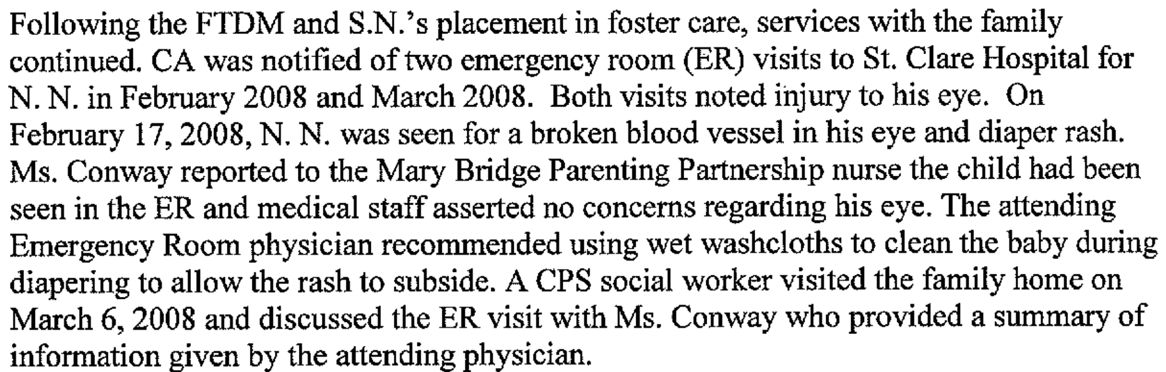
Several contacts with the family along with the older children were shared with the review committee. The CPS investigator stated she spoke with the PHN on several occasions regarding the child's weight gain and medical follow up. Following review with her supervisor, she stated she told Ms. Conway N.N. must go to the doctor by a certain date or she would recommend he be placed in out of home care. With considerable coaching and direction from CPS, Ms. Conway took the children to the family physician. CPS verified the visit with the family's primary care physician on January 25, 2008. The attending medical staff indicated the children appeared fine noting no medical concerns. N.N.'s noted weight loss was one ounce.

The January 7, 2008 referral alleging negligent treatment closed with an inconclusive finding. However, based on the identified risk factors (housing instability, a medically fragile infant, poor parenting skills, financial stressors and inconsistency in following through with tasks) the investigator recommended and offered services to the family. Intensive Family Preservation Services (IFPS) were provided with the family's agreement to participate. The case transferred to a CPS Family Voluntary Services social worker.

The IFPS provider met with the review committee and stated she met with the family at least twice weekly to address issues related to transportation, housing, parenting, discipline, and financial assistance. The provider said the child's mother presented as distracted during visits; often on the computer or engaged in other activities, preventing her from gaining Ms. Conway's full attention or engagement in services. She stated she was aware of other providers in the home, however, had not been in contact with them and obtained information from Ms. Conway regarding their interventions.

Over the course of several weeks service providers were in the home providing support and assistance to Ms. Conway in caring for her children while preparing for S. N.'s release from the hospital. The case record reflects during the three (3) months prior to N. N.'s death as many as twenty-six (26) service provider visits were made to the home. Provider notes indicate a lack of progress in reducing identified risk factors within the family related to parenting; housing stability, follow through on medical appointments, bonding with N. N., and inconsistent contact with S. N. and the medical staff at the hospital. The review committee did note despite several service providers involved with this family, communication between service providers as a means to address family stressors and dynamics was limited and lacked collaboration.

RCW 74.13.500



Following the FTDM and S.N.'s placement in foster care, services with the family continued. CA was notified of two emergency room (ER) visits to St. Clare Hospital for N. N. in February 2008 and March 2008. Both visits noted injury to his eye. On February 17, 2008, N. N. was seen for a broken blood vessel in his eye and diaper rash. Ms. Conway reported to the Mary Bridge Parenting Partnership nurse the child had been seen in the ER and medical staff asserted no concerns regarding his eye. The attending Emergency Room physician recommended using wet washcloths to clean the baby during diapering to allow the rash to subside. A CPS social worker visited the family home on March 6, 2008 and discussed the ER visit with Ms. Conway who provided a summary of information given by the attending physician.

The foster parent to the surviving twin requested to meet with the review team and share her observations of N.N. The foster parent clarified she had attempted to contact the assigned FVS social worker and supervisor on several occasions prior to a March 5, 2008 doctor appointment for S.N. to discuss her observations of N.N. She told the team during the nephrologists visit for S.N. on March 5, 2008 she observed N.N. to appear small, lethargic and non-responsive to his environment and those around him. She stated his demeanor on this date was similar to other times she had observed him when participating in family visits and doctor appointments.

When the foster parent spoke with both the assigned FVS social worker and supervisor she said she did not feel N.N. was getting sufficient nutrition or attention from his care providers. The foster parent expressed frustration to the review team in having to make several attempts to speak with a CA staff member regarding this case and was unaware if her concerns were being addressed with the family or shared with providers working with the family. The case record notes conversations between the foster parent and social worker regarding her concerns for N.N.

On March 7, 2008 N. N. was seen at the ER for a left eye injury. Medical information notes his eye appeared swollen and blackened. The attending physician noted a plausible explanation for the injury was provided by the attending parent. N. N. was released to his parents' care with no follow up to CPS on either occasion. Upon learning of the ER visits, CPS did not follow up with either ER physician referencing the visits to confirm the parents' explanation or physicians' assessment. According to medical records received following the child's death, neither visit indicated concern by the attending physicians that the injuries were the result of non-accidental trauma.

On March 10, 2008 CPS was notified by Pierce County Sherriff of N. N.'s death. The detective responding to the scene on March 9, 2008 observed a bruise on the infant's

eyelid as opposed to around the eye which would have been indicative of a punch. Autopsy results received later in the day noted cause of death "*Non-Accidental trauma resulting in old and new brain bleeds and a skull fracture.*"

During a March 11, 2008 interview with law enforcement, Ms. Conway stated prior to the March 2008 ER visit she had punched N. N. in the head twice as he continually cried and would not stop. She stated when noticing the injury to the eye she took him to the ER where she told the interviewing detective the physician asked if there were older kids in the home at which she stated 'yes.' She then told law enforcement the physician replied; "one of the children may have hit the baby in the eye with a toy." Ms. Conway admitted to going along with this explanation and offered no other information.

As a result of Ms. Conway's statement to law enforcement she was arraigned on charges of murder in the 2nd degree and remains in jail. N. N.'s siblings were placed in protective custody and are in the care and custody of the state of Washington.

Findings and Recommendations

The committee made the following findings and recommendations based on interviews, review of the case records, department policy and procedures, Revised Code of Washington (RCW), Washington Administrative Code (WAC), and medical documents.

Findings

- Multiple community service providers and medical providers were involved with this family. However, the communication between providers and CA was inconsistent and lacked coordination.

- Insufficient weight gain and lack of caregiver attachment and bonding was evident in this case. Inconsistency of visits by the parents while their infants were hospitalized, lack of follow through on medical appointments and limited weight gain are noted risk factors which cumulatively can affect child health and safety.

- An inconclusive finding was made on the January 7, 2008 referral. However, the review team believed the assigned worker did not fully pursue reported concerns and given the cumulative effects of verified parental actions and inactions there may have been sufficient information to establish a finding of founded for negligent treatment. The January 7, 2008 referral addressed child neglect issues and several high risk factors related to child health and safety. Information obtained and verified during the course of the investigation included the following:
    - Parents repeatedly missed or cancelled well child and other medical appointments for all the children.
    - The parents delayed obtaining a necessary immunization for N.N. despite repeated requests made by medical providers and CA (confirmed by physicians).

- The parents' were inconsistent in visiting the hospitalized twin thereby affecting parent/child bonding.
- The inability to reach the parents despite numerous attempts to authorize emergency surgery for the child (confirmed by hospital staff).
- The parents' inconsistency and inappropriate use of discipline methods for children's developmental stages (verified by several providers working with the family in the home).
- Repeated concerns by providers referencing the feeding of N.N. and lack of consistent weight gain.

Recommendations

- When multiple agencies and service providers are working with a family it is recommended to convene a multi-disciplinary or child protection team staffing as early as possible in the case to ensure coordination and communication of services provided and the evaluation of family compliance and progress. Participation by family members should be included to represent priorities and solutions recommended and identified by the family.

- Consult with the Regional Medical Consultant as needed, particularly in regards to children with special needs.

- In the presence of such risk factors (attachment/bonding issues, lack of weight in an infant and failure to timely follow through in accessing services) a referral for a mental health assessment of the caregiver(s) or a parent/child bonding assessment is warranted.