

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 Review¹ committee to review the practice and service delivery in the case involving four-month old N. N. and his family. (DOB: October [REDACTED], 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. Dominique Conway². 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

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. Dominique 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. [REDACTED]

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.

