Report to the Legislature

Quarterly Child Fatality Report

RCW 74.13.640

July – September 2015

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Executive Summary

This is the Quarterly Child Fatality Report for July through September 2015 provided by the Department of Social and Health Services (DSHS) to the Washington state Legislature. RCW 74.13.640 requires DSHS to report on each child fatality review conducted by the department and provide a copy to the appropriate committees of the legislature:

Child Fatality Review — Report

(1)(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.

(c) The department shall ensure that the fatality review team is made up of individuals who had no previous involvement in the case, including individuals whose professional expertise is pertinent to the dynamics of the case.

(d) Upon conclusion of a child fatality review required pursuant to this section, the department shall within one hundred eighty days following the fatality issue a report on the results of the review, unless an extension has been granted by the governor. A child fatality review report completed pursuant to this section is subject to public disclosure and must be posted on the public web site, except that confidential information may be redacted by the department consistent with the requirements of RCW 13.50.100, 68.50.105, 74.13.500 through 74.13.525, chapter 42.56 RCW, and other applicable state and federal laws.

(2) In the event of a near fatality of a child who is in the care of or receiving services described in this chapter from the department or a supervising agency or who has been in the care of or received services described in this chapter from the department or a supervising agency within one year preceding the near fatality, the department shall promptly notify the office of the family and children's ombuds. The department may

conduct a review of the near fatality at its discretion or at the request of the office of the family and children's ombuds.

In April 2011, SHB 1105 was passed by the legislature and signed into law by Governor Gregoire. The revised child fatality statute (RCW 74.13) became effective July 22, 2011 and requires the department to conduct fatality reviews in cases where a child death is suspected to be caused by abuse or neglect. This eliminated conducting formal reviews of accidental or natural deaths unrelated to abuse or neglect. The revised statute requires the department to consult with the Office of Family and Children's Ombuds (OFCO) if it is not clear that the fatality was caused by abuse or neglect. The department can conduct reviews of near-fatalities or serious injury cases at the discretion of the department or by recommendation of OFCO. The statutory revision allows the department access to autopsy and post mortem reports for the purpose of conducting child fatality reviews.

This report summarizes information from completed reviews of five (5) child fatalities and three (3) near-fatalities that occurred in the third quarter of 2015. All prior child fatality review reports can be found on the DSHS website: https://www.dshs.wa.gov/ca/publications/childrens-administration-child-fatality-reports

The reviews in this quarterly report include child fatalities from three regions.

Region	Number of Reports
1	2
2	1
3	5
Total Fatalities and Near-Fatalities Reviewed During 3rd Quarter 2015	8

This report includes Child Fatality Reviews conducted following a child's death that was suspicious for abuse and neglect and the child had an open case or received services from the Children's Administration (CA) within 12 months of his/her death or injury. A critical incident review consists of a review of the case file, identification of practice, policy or system issues, recommendations and development of a work plan, if applicable, to address any identified issues. A review team consists of a larger multi-disciplinary committee including

community members whose professional expertise is relevant to the family history. The review committee members may include legislators and representatives from the Office of the Family and Children's Ombuds.

The charts below provide the number of fatalities and near-fatalities reported to CA and the number of reviews completed and those that are pending for calendar year 2015. The number of pending reviews is subject to change if CA discovers new information through reviewing the case. For example, CA may discover that the fatality or near-fatality was anticipated rather than unexpected, or there is additional CA history regarding the family under a different name or spelling.

Child Fatality Reviews for Calendar Year 2015			
Year	Total Fatalities Reported to Date Requiring a Review	Completed Fatality Reviews	Pending Fatality Reviews
2015	11	8	3

Child Near-Fatality Reviews for Calendar Year 2015			
Year	Total Near-Fatalities Reported to Date Requiring a Review	Completed Near-Fatality Reviews	Pending Near-Fatality Reviews
2015	8	3	5

The five (5) child fatality reviews referenced in this Quarterly Child Fatality Report are subject to public disclosure and are posted on the DSHS website. https://www.dshs.wa.gov/ca/publications/childrens-administration-child-fatality-reports

Near-fatality reports are not subject to public disclosure and are not posted on the public website.

Notable Third Quarter Findings

Based on the data collected and analyzed from the five (5) fatalities and three (3) near-fatalities during the 3rd quarter, the following were notable findings:

- Six (6) of the eight (8) cases referenced in this report were open at the time of the child's death or near-fatal injury.

- One (1) fatality and one (1) near-fatality occurred on an open Family Assessment Response (FAR) case; another fatality occurred shortly after the close of a FAR case.
- Seven (7) of the children referenced in this report were two (2) years or younger when the fatality or near-fatal injury occurred.
- Three (3) children suffered inflicted trauma (one resulted in the death of a child). All three (3) children were under the age of two (2) years. All three cases were open at the time of the incident. Two (2) of the cases were open or recently opened to the FAR program.
- Two (2) children deaths were coded as homicides by medical examiners.
- One (1) fatality occurred during a murder/suicide incident with a parent.
- One (1) child died drowned.
- Five (5) children were Caucasian, one (1) was Black, one (1) was Native American and another was Asian.
- Children's Administration received intake reports of abuse or neglect in all of the cases prior to the death or near-fatal injury of the child. One (1) case had six (6) prior intakes, two (2) had three (3) prior intakes, and the others had two (2) intakes before the critical incident.
- Due to the small sample of cases reviewed, no statistical analysis was conducted to determine relationships between variables.

Child Fatality Review

K.S-H.

August 2014
Date of Child's Birth

January 11, 2015
Date of Fatality

March 26, 2015
Child Fatality Review Date

Committee Members
Cristina Limpens, MSW, Office of the Family and Children's Ombuds
Chris Kerns, MSW, Permanency Planning Program Manager, Children's Administration
Kellie Rogers, BS, Program Manager for Domestic Violence Services, YWCA
Tracy Harachi, PhD, MSW, BA, Associate Professor, University of Washington School of Social Work
Anita Teeter, MA, Region 3 Program Administrator Safety and Family Assessment and Response, Children's Administration

Observer
Stephanie Long, M.Ed., Evidence Based Programs Program Specialist Children's Administration

Facilitator
Libby Stewart, Critical Incident Review Specialist, Children's Administration

Executive Summary

On March 26, 2015, 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 five-month-old K.S-H. and her family.[2] The child (K.S-H.) will be referenced by her initials throughout this report.

The incident initiating this review occurred on January 11, 2015 when K.S-H. was brought to a local hospital by her mother and her mother's boyfriend. The hospital staff observed K.S-H. to be limp and apneic. Medical intervention was attempted but failed to revive K.S-H.

At the time of the fatality, K.S-H. and her nineteen-month-old sibling were in the care of their mother. K.S-H. and her sibling previously resided with their maternal grandparents. Care of the children was shared between the maternal grandparents and the mother. However, days prior to the fatality the mother and her boyfriend moved into an apartment with another family. The father of the children was incarcerated at the time of the death.

At the time of K.S-H.'s death, there was an open Child Protective Services (CPS) investigation. The allegations stated the mother failed to adequately provide care on an on-going basis for the children, would leave the children with persons unknown to the extended family. In addition, K.S-H.'s sibling had RCW 74.13.500 unknown origin.

The review Committee included members selected from diverse disciplines within the community with relevant expertise including social work instruction with a specialization in Cambodian culture, domestic violence services, the Children's Ombuds Office, a CA program manager specializing in Safety and Family Assessment and Response (FAR) and a Child and Family Welfare Services (CFWS) program manager with CA. Neither CA staff nor any other committee members had previous involvement with this family.

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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 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] No criminal charges have been filed relating to the incident and therefore neither the mother nor father's names are identified. The name of K.S-H.'s sibling is subject to privacy laws. [Source: RCW 74.13.500(1)(a)].

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, 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 worker and CPS supervisor. Following the review of the case file documents, completion of interviews and discussion regarding department activities and decision, the Committee identified areas where practice could improve and made one recommendation. The findings and recommendation are at the end of this report.

Family Case Summary

This family came to the attention of CA on December 17, 2014, when two intakes were generated regarding allegations of neglect by the mother and RCW 74.13.500 the older child's cheek. Both intakes were initially screened out. However, upon an intake supervisory review, the supervisor changed the screening decision to be assigned for CPS investigation based on neglect RCW 74.13.500 nineteen-month-old's RCW 74.13.500. Contact was made with the children and maternal grandmother by the assigned CPS worker. The CPS worker also spoke with the maternal aunt by phone. The maternal aunt assisted the CPS worker with translating for the grandmother. The grandmother did not want a Cambodian interpreter and requested the worker utilize the maternal aunt for interpreting.

The children appeared well cared for during the initial face-to-face contact. The CPS worker did not observe a bruise on the sibling's face. The grandmother and aunt stated the children were often cared for by the maternal grandparents while the mother worked or left for extended periods. It was reported that the mother would often not communicate with the grandparents about her plans to return. The family was also concerned that when the mother did take the children she would leave them with unknown persons and this appeared to cause the oldest child to have anxiety upon her return to the maternal grandparents. The CPS worker provided the maternal grandmother with information regarding third party custody. The case was staffed during the course of a regular monthly staffing review on January 6, 2015 between the CPS worker and her supervisor. The case note indicated the case was ready for closure.

On January 11, 2015, an intake was received stating K.S-H. was brought to the hospital by her mother and mother's boyfriend. The medical staff was unable to

revive K.S-H. Law enforcement was notified and a criminal investigation was initiated. The medical examiner's report ruled the death a homicide.

Committee Discussion

For purposes of this review, the Committee focused on case activity starting with the December 17, 2014 intake up to the fatality. There was discussion regarding the fatality, the criminal investigation, and status of the case.

A significant portion of discussion surrounded third party custody. Third party custody may be utilized by families or fictive kin to obtain custody of children without DSHS intervention. However, within the department some staff believe that if DSHS recommends or even educates a family member on this option, it is in a way indicating that the department endorses the placement and has not done due diligence in investigating the safety of the possible petitioner. Further, this practice may be questioned when the information is provided to a family in English instead of their first language and a discussion has not occurred as to whether the family's culture is supportive of the process.

In this particular case, the Committee was educated that in the opinion of the consultant, traditional Cambodian families would not utilize this legal process. The Committee was also concerned that the information was provided in English. The CPS worker stated the maternal grandmother was struggling to understand the conversation. The Committee discussed that a follow up conversation including a certified interpreter, even by phone, would have been appropriate to further discuss this option with the family.

The Committee was confused by the completion of two separate Investigative Assessments.[3] During the interviews with the CPS worker and supervisor, they both stated it is office practice to complete separate Investigative Assessments unless the allegations in each new referral are the same type of alleged abuse. In this particular case, the CPS worker and supervisor did not feel the allegations correlated closely enough to combine the two assessments. However, the Committee noted the documents were completed on the same day with inconsistent information. The Committee also noted it would have been easier to read one document that identified differences based on information gathered by the CPS worker before the fatality and after it. It was also debated as to whether there had been adequate gathering of information to complete an assessment on the December 17, 2014 intake.

[3] CA investigators complete the investigative assessment (IA) for all CPS and DLR/CPS investigations. The IA contains all the tools (i.e. assessments and screens) and documentation related to the investigation. The IA is a shell that houses all the components of the investigation. [Source: CA Practice Guide to Intake and Investigative Assessments; CA Practices and Procedures Guide, Chapter 2540]

The CPS worker also documented that she did not see any bruising on K.S-H.'s older sister. However, when asked about this during her interview, she stated she did not observe her entire body. The Committee noted the child was not potty trained and could have been fully observed during a diaper change.

Caseloads and employee staffing were discussed during the staff interviews. The staff in Kent stated they regularly receive the highest case assignments and have higher caseloads than other offices. While it is accurate to state the office has struggled to maintain regularly staffed units, there is progress being made to stabilize the office. A caseload report was gathered for the CPS worker for the day of the fatality. The report indicated the worker's caseload was similar to those of other CPS workers across the state.

The CPS worker and supervisor were asked if the initial screening decision to screen out the December 17, 2014 intake, which was then screened up to a CPS investigation, created a bias as to the legitimacy of the assignment. The CPS worker stated she discussed the decision with her supervisor but did not feel it created a bias and therefore did not impact her ability to complete the investigation. The CPS supervisor provided a similar statement to the Committee.

Findings

The Committee noted based on their review of the case documents and interviews with staff, that there were no critical errors made by department staff. However, there were areas where practice could be improved.

The Committee believed policy requires staff to utilize a certified interpreter once the CPS worker realized the maternal grandmother did not readily speak English.[4]

The Committee pointed out that the intake supervisor who changed the screening decision on the December 17, 2014 intake from screened out, to screened in for CPS investigation, made a good decision. However, the Committee also felt it would have been prudent for the allegations to then include physical abuse since there were unanswered questions as to RCW 74.13.500 one-year-old child mentioned in the decision notes.

The Committee noted the supervisory case note dated January 6, 2015, indicated the case was ready for closure. However, there had not been an adequate gathering of information based on the documentation to support this decision. The Committee believed the supervisor should have directed the CPS worker to contact the parents and to make collateral contacts beyond the maternal grandmother and aunt who were also the referral sources. The CPS worker had

[4] CA Operations Manual 4320 - Limited English Proficiency and CA Practices and Procedures Manual 2210 - Eligibility, 11

been given a phone number for the mother but the grandmother said it may not work. The CPS worker could have attempted contact through that number. The grandmother also identified the mother's employer. Some other collaterals that may have been beneficial and meaningful would have included the children's pediatrician and paternal relatives.

The CPS worker did not discuss items included in the Practices and Procedures Guide, Chapter 1135, Infant Safety Education[5] and Intervention to include safe sleep and Period of Purple Crying with the maternal grandmother.

It was unclear by reading the case notes and during the interview as to when the actual face-to-face contact occurred between the CPS worker and the children. There had been a request for an extension of the initial face-to-face but the CPS worker's case note appears to document it occurred within the appropriate timeframes. The Committee noted the date of the initial contact was vital because a fading bruise could have easily resolved within the small amount of time between intake and when the child was observed by the CPS worker.

Recommendations

Clarification and guidance should be provided from CA leadership regarding informal and formal placements and third party custody to the field. The Committee also suggested that CA should consider providing field staff with a uniform position by CA regarding third party custody.

[5] CA Practices and Procedures Guide, Chapter 1135

Washington State Department of Social & Health Services
CA Children's Administration

Child Fatality Review

S.C.

October 2014
Date of Child's Birth

January 25, 2015
Date of Child's Death

June 18, 2015
Child Fatality Review Date

Committee Members
Erin Summa, MPH, CPST-I, Child Safety Educator, Mary Bridge Center for Childhood Safety
Mary Balmer-Bromberg, Pierce East Adoptions Supervisor, Children's Administration
Sheri Novak, Licensed Foster Parent, Pierce County, Washington
Cristina Limpens, MSW, Ombuds, Office of Family and Children's Ombuds (OFCO)
Rebecca Taylor, MSW, Home Study/Assessment Supervisor, Division of Licensed Resources

Observer
Mary Moskowitz, J.D., Office of Family and Children's Ombuds

Facilitator
Bob Palmer, Critical Incident Case Review Specialist Children's Administration

Executive Summary

On June 18, 2015, the Department of Social and Health Services Children's Administration (CA) convened a Child Fatality Review[6] (CFR) in Pierce County to examine the department's practice and service delivery to 3-month-old S.C., a dependent child from Clark County who was in licensed foster placement at the time of his death. The infant was found unresponsive the morning of January 25, 2015. Medics responding to the 911 call were unable to resuscitate the child. First responders noted several concerns as to the sleep environment that the child had been placed in prior to his death. Neither law enforcement nor the Clark County Medical Examiner was able to conclude with any certainty if the sleep environment contributed to the death. The Medical Examiner subsequently determined the cause of death to be Sudden Unexpected Infant Death (SUID) and the manner of death as undetermined.[7]

The CFR Committee was comprised of Children's Administration staff from both the Division of Licensed Resources[8] (DLR) and the Division of Children and Family Services[9] (DCFS) and community members with pertinent expertise from a variety of fields and systems, including child safety, public child welfare, and child advocacy. None of the Committee members had any previous direct involvement with the family.

Prior to the review each Committee member received a summary of the Division of Licensed Resources' licensing activities involving the foster home (2005-2015),

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[7] The United States Centers for Disease Control and Prevention (CDC) defines SUID as "Deaths in infants less than 1 year of age that occur suddenly and unexpectedly, and whose cause of death are not immediately obvious prior to investigation." According to the CDC, the 3 most frequently reported causes for SUID are SIDS, Unknown, and ASSB (accidental suffocation and strangulation in bed).

[8] DSHS Division of Licensed Resources (DLR) licenses, supports, and monitors foster homes/out-of-home care facilities for children, and conducts CPS investigations regarding allegations of child abuse and neglect to children in licensed, certified and DSHS-operated facilities. DLR also licenses child placing agencies, and provides assistance to those agencies that certify private agency foster homes. Licensing staff are charged with ensuring the health, safety, and quality of care for children in high quality foster family homes, group care facilities, and child placing agencies.

[9] In Washington, Children's Administration DCFS provides client services through 46 statewide offices in four primary areas: Child Protective Services (CPS), Family Voluntary Services (FVS), Child and Family Welfare Services (CFWS), and Family Reconciliation Services (FRS). DCFS also provides services and supports to families at the request of the family or as directed by the courts.

a chronology of Child and Family Welfare Services[10] involvement with the child, and un-redacted case file documents relating to the DLR/CPS investigation of the child fatality incident including photos taken by the DLR/CPS investigator of the infant's sleep environment. Other relevant documents were made available to Committee members at the time of the CFR. These included autopsy results, law enforcement reports, foster home licensing records, and a copy of CA Infant Safety Education and Intervention policy effective October 31, 2014.[11]

Several CA staff involved with the case were made available to the Committee for interview. These included the DLR foster home licensor and a CFWS worker who had visited the foster home on numerous occasions. As the CFWS worker assigned to S.C. was not available for interview due to an unexpected situation, her immediate supervisor was interviewed by the Committee. The Committee, finding the documentation of the fatality investigation to be detailed and clear, chose not to interview the DLR/CPS investigator. Following review of the case file documents, completion of the staff interviews, and discussion regarding department activities and decisions, the Committee made findings and recommendations which are presented at the end of this report.

Case Overview

S.C. first came to the attention of CA at his birth in October 2014 RCW 74.13.500 RCW 74.13.500. There was an open CFWS case at the time of his birth RCW 74.13.500 Shortly after his birth, a dependency petition was filed by the department and S.C. was discharged into the care of the licensed foster parents who were caring for his sibling as well as another foster child and three adopted children. The foster home had no prior CPS or DLR/CPS investigations.

Multiple contacts were made with S.C. and his caregivers during the 12 weeks of his life. These contacts included health and safety visits by CFWS workers, contact by a Child Health & Education Track (CHET) worker,[12] and phone contact with the caregiver by the DLR licensor. None reported any concerns with the foster home environment or the care of any of the children in the home.

[10] Both permanency planning and court-ordered services are provided by Children's Administration's CFWS to children and families to mitigate the risk of abuse or neglect so that children are able to safely return to their home of origin. CFWS oversees the health and well-being of children in out-of-home placements and provides ongoing assessments of child safety and risk factors. Children served by CFWS are dependents of the state (in-home services or out-of-home care) or legally free for adoption.

[11] CA Practices and Procedures Guide 1135 Infant Safety Education and Intervention

[12] Child Health and Education Tracking (CHET) is designed to identify and organize essential and appropriate information about the well-being of all children in the care or custody of Children's Administration (CA). The purpose is to assess the current well-being, and identify long-term needs of children in CA's care or custody. Well-being factors include physical health; development; social, family and community connections; education and emotional/behavioral health.

On January 25, 2015, CA was notified by Vancouver Police of the death of S.C. It was reported at that time that the licensed caregiver had found the infant unresponsive and called 911. Responding medics were unable to resuscitate the child and he was pronounced deceased at 6:40 a.m. at the foster home. The investigations by both law enforcement and DLR/CPS raised concerns about the sleep environment in which the child had reportedly been sleeping for several weeks. Although variously described as a "crib," "portable crib," and "playpen," the child had been placed in a pack-n-play.[13] Photos taken by law enforcement and DLR/CPS showed the infant had been placed to sleep on top of multiple layers of toys, blankets, and a covered beanbag.

Neither law enforcement nor the Clark County Medical Examiner was able to conclude with any certainty if or how such sleeping environments may have contributed to the death and there was insufficient evidence to pursue any criminal charges.

The remaining two foster children were removed from the foster home and the DLR/CPS investigation resulted in a founded finding of negligent treatment or maltreatment based upon evidence that the foster parents had placed S.C. in an unsafe sleeping environment for a period of several weeks.

Committee Discussion

Committee members briefly reviewed and discussed the licensing record of the foster parents which did not include any previous concerns. The Committee looked at the brief phone contacts with the foster parents by the DLR licensor around the time of S.C.'s placement, which primarily involved communications as to the modification of the license to accommodate an additional child under the age of two years placed in the home.

The Committee also looked at CFWS documentation regarding S.C.'s placement shortly after his birth, including that the foster parents had received infant safe sleep instruction at the hospital prior to S.C. being discharged into their care. In addition to the documented pre-incident contacts by CFWS staff with S.C. and his foster family, the Committee considered worker perceptions of the foster parents that were shared with the Committee during the worker interviews. The Committee explored the possibility that workers focused on the numerous positive qualities of the foster parents but did not fully recognize indicators of stress in the home, such as foster parent comments as to being tired,

[13] The Consumer Product Safety Commission has approved new safety standards that will protect children as they play and sleep in mesh, portable play yards. Also known as pack-n-plays**,** these products are used in homes, for travel, and in child care homes. The CPSC said that there were more than 2,100 incidents with play yards reported to the agency between November 2007 and December 2011, including 60 fatalities and 170 injuries.

experiencing sleep interruption, and having to help care for a relative with Alzheimer's while caring for 4 children under the age of four.

The Committee considered numerous relevant CA policy and practice standards including infant safe sleep assessment policy for DLR[14] and DLR monitoring requirements for licensed foster homes.[15] The Committee looked at the DCFS health and safety monitoring requirements for children in out-of-home care,[16] and discussed the infant safe sleep assessment policy for CFWS cases.[17] The Committee was interested in what the CFWS workers, in the process of conducting health and safety visits, knew about the sleep arrangements in the home for S.C. and the other children. This included looking at the CFWS workers' routine of inquiry and observations during health and safety monitoring visits specifically as to sleep environments.

Findings

While neither law enforcement nor the Clark County Medical Examiner was able to conclude with any certainty that the sleep environment contributed to S.C.'s death, the foster parents' lack of judgment regarding infant safe sleep was apparent by their decision to frequently place S.C. in a dangerous sleep environment. Two aspects of WAC 388-148-1470 appeared to have been violated by the foster parents; the use of a living room as a bedroom for the child and the presence of stuffed toys and pillows with a sleeping infant.

The Committee was unable to identify any critical errors by CA that were directly associated with the critical incident outcome. However, the Committee did find instances where additional or alternative social work activity may have been considered, and these issues, identified below, serve as noted opportunities where improved practice may have been beneficial to the child's wellbeing.

- The CFWS workers who conducted health and safety visits with S.C. and his caregivers may have normalized or underestimated how overwhelmed

[14] Current DLR licensing requirements (effective October 2014) state that when licensing or approving a home study with families accepting placements for infants, the home study workers will assess the sleeping environments and educate the family on safe sleep practices. This requirement applies to new home studies and licensing.

[15] RCW 74.13.260 requires onsite monitoring of foster homes to assure quality care to children in family foster care. Monitoring shall be done by the department on a random sample basis of no less than ten percent of the total licensed family foster homes licensed by the department on July 1 of each year. Since DLR realignment in August 2014, such monitoring visits are no longer conducted by foster home licensors, but rather by Safety and Monitoring unit workers.

[16] CA social workers are required to visit with all children in person on a monthly basis if the case is open for services. The goal of these visits is to ensure the child is safe and the child's basic needs are met. Per policy, the majority of these contacts must take place in the home. [Source: CA Practices and Procedures Guide 4420]

[17] Current CA policy requires CA staff to conduct a safe sleep assessment when placing a child in a new placement setting or when completing a CPS intervention involving a child aged birth to one year, even if the child is not identified as an alleged victim.

the foster parents were in meeting the needs of three adopted children and three dependent children. Had such been recognized, conversations may have occurred that could have resulted in exploring additional support options for the foster parents.

- The DLR licensor appears to have had a conversation with the foster parents about infant safe sleep at the time of S.C.'s placement. However, the inquiry appeared limited with the worker accepting of generalized and unexacting responses when more inquisitiveness may have been beneficial.
- CFWS appeared unaware until after S.C.'s death that, due to foster parent sleep disruption because of S.C.'s neighing/grunting at night, he had been moved to the living room at night and placed in a pack-n-play. That the December 2014 health and safety visit did not occur at the foster home and the January 2015 health and safety visit was overdue, may have compromised worker awareness of the change in sleeping arrangements.
- Several health and safety visit activities appeared inconsistent with CA policy. There was no home visit within 7 days of S.C.'s initial placement, the December 2014 monitoring visit was not documented in a timely manner, and at the time of death, a health and safety monitoring visit was overdue.[18]
- Two CFWS workers with children placed in the foster home alternated conducting health and safety monitoring visits on those children. Such "teaming up" appeared to be a workload reduction strategy and, in this case, was limited and did not violate policy.[19] However, information presented at the review indicated such practice of alternating health and safety visits with other workers may be regularly occurring in the Vancouver offices and more than four times annually on individual cases, which would be a violation of policy and contrary to best practice.

Recommendations

The following Committee recommendations are intended to support CA's continuing efforts to promote Infant Safe Sleep in CA policy and practice.

- CA should consider reviewing what is contained in packets given to foster caregivers for when infants are placed and evaluate if additional or modified materials regarding safe sleep could be incorporated. This might

[18] Children in CA custody must receive private, individual face-to-face health and safety visits by the assigned CA worker every calendar month, not to exceed 40 days between visits and all visits must be documented in a case note within 3 calendar days of the visit occurring [Source: CA Practices and Procedures Guide 4420]

[19] All health and safety visits and monthly visits must be conducted by the assigned CA worker or another qualified CA staff. The number of visits conducted by another qualified CA staff is not to exceed four (4) times per year with no two (2) visits occurring in consecutive months.

include suggestions for licensors and DCFS workers to explain to caregivers why safe sleep is important and suggest ways of offering help to foster parents if needed.

- Consider changing CA policy which currently does not require workers to observe sleep environments (rooms, beds, cribs, bedding materials) during all health and safety visits in both in-home and out-of-home placements. Minimally such change in policy would require such activity for any child under age one.
- Consider expanding the recently revised "CA Worker Health & Safety Visits with Child - Required Information for Documentation (04-09-15)" guidelines to include, in the section on observations of non-verbal children, specific documentation of infant sleep environment during monthly health and safety visits.
- Consider expanding the recently revised "CA Worker Monthly Visit with Caregiver - Required Information for Documentation (04-09-15)" guidelines to include suggestions for specific conversations with caregivers as to infant safe sleep environment.

Washington State Department of Social & Health Services

CA Children's Administration

Child Fatality Review

S.R.

July, 2013
Date of Child's Birth

February 24, 2015
Date of Fatality

July 8, 2015
Child Fatality Review Date

Committee Members
Cristina Limpens, Office of the Family and Children's Ombuds
Erin Summa, Child Safety Educator, Mary Bridge Children's Hospital
Anna Facio, Quality Assurance Program Manager, Developmental Disabilities Administration
Stephanie Frazier, Child Protective Services Program Manager, Children's Administration
Billie Reed-Lyyski, Child Protective Services Supervisor, Children's Administration

Observer
Ann Radcliffe, Licensing Analyst Southwest Region, Department of Early Learning
Deanna Sundby, Licensing Analyst, Department of Early Learning

Facilitator
Libby Stewart, Critical Incident Review Specialist, Children's Administration

Executive Summary

On July 8, 2015, the Department of Social and Health Services (DSHS), Children's Administration (CA) convened a Child Fatality Review (CFR)[20] to assess the department's practice and service delivery to 18-month-old S.R. and his family.[21] The child will be referenced by his initials S.R. in this report.

The incident initiating this review occurred on February 24, 2015 when S.R. was found by his father in his crib with his tracheostomy tube dislodged and no pulse. Law enforcement was called to the home; they were unable to revive S.R.

At the time of the fatality, S.R. lived with his parents, RCW 74.13.500, and RCW 74.13.500. S.R. and his RCW 74.13.500 were born prematurely with multiple medical conditions. S.R. had a tracheostomy tube due to tracheal paralysis. He also had a monitor attached to his leg to register his breathing. S.R. had a history of pulling out or attempting to pull his tracheostomy tube. The purpose of the monitor was to alert his care providers if the tube became dislodged.

The mother had RCW 74.13.500 and CA investigated two intakes in 2013 and 2014 regarding the mother, father and all three children prior to the fatality. However, at the time of the fatality, there was not an open case or investigation.

The review Committee included members selected from diverse disciplines within the community with relevant expertise including a Quality Assurance Program Manager with Developmental Disabilities Administration (DDA) who conducts mortality reviews within DDA. The Manager previously worked for CA conducting Child Protective Services (CPS) investigations. The Committee also included a CPS supervisor, a hospital-based child safety educator, the Office of the Family and Children's Ombuds and a CPS program manager. There were two observers from Department of Early Learning. Neither CA staff nor any Committee members or observers had previous involvement with this family.

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[20] 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.

[21] No criminal charges have been filed relating to the incident and therefore neither the mother nor father's names are identified. The name of S.R.'s siblings is subject to privacy laws. [Source: RCW 74.13.500(1)(a)].

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, 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, S.R.'s autopsy, relevant state laws, and CA policies.

During the course of this review, the Committee interviewed the CPS supervisor. The CPS worker was not available. Following the review of the case file documents completion of interview and discussion regarding department activities and decisions, the Committee identified areas where practice could improve. The findings and recommendation are at the end of this report.

Family Case Summary

RCW74.13.500 [redacted].[22]

On October 28, 2013, a hospital social worker called CA with concerns that the parents did not regularly visit their newborn premature twins and were not participating in necessary medical education in order to care for one of the twins who was medically fragile. The caller reported the parents did not use the transportation assistance that was provided. This intake was assigned for CPS investigation.

The allegations in the October 28, 2013 intake were determined to be unfounded. There was conflicting information from hospital staff on the perception of the parents' involvement. One child was placed in the Pediatric Intensive Care Unit and the other twin was in the Neonatal Intensive Care Unit. The parents did agree they struggled with transportation. The CPS investigator conducted a home visit prior to S.R.'s discharge from the hospital at the closure of the investigation. The investigation was approved for closure by the CPS supervisor on December 30, 2013.

On November 20, 2014, CA received a third intake on this family from a pediatrician alleging S.R. missed his 6, 9, 12, and 15-month well-child appointments. S.R. had a gastrostomy tube, tracheostomy tube and was diagnosed with Failure to Thrive. The allegations included that S.R. missed numerous other appointments with specialists who treated his medical

[22] Washington state law does not authorize Children's Administration (CA) to screen in intakes for a CPS response or initiate court action on an unborn child.[Source: CA Practice Guide to Intake and Investigative Assessment]

conditions related to his congenital birth defects. This intake was screened in and was assigned for CPS investigation.

An initial face-to-face contact occurred on November 21, 2014 with S.R. The case note indicates S.R. and his father were present. The Investigative Assessment (IA) was submitted for review on November 24, 2014. There were other follow up actions conducted by the CPS investigator after he determined the IA to be unfounded. The Structured Decision Making Risk Assessment®[23] (SDM) scored at moderately high. There was no documentation of services being offered during or at the end of this investigation. However, per CA policy, if the SDM® score is moderately high, the caseworker may offer services to the family. During this investigation, the CPS investigator requested medical records for S.R. and those were contained in the case file. This investigation was approved for closure by the CPS supervisor on December 30, 2014.

On February 24, 2015, CA received the fourth intake from the Shelton DCFS Office CPS supervisor. The CPS supervisor received a text from the Mason County Sheriff's Office stating S.R. had been found deceased at his family home. Medics attempted intervention but they were unable to revive S.R. This intake was assigned for CPS investigation and founded as to both parents for negligent treatment or maltreatment regarding S.R.'s death. The finding was made due to the monitor not being placed on S.R.'s foot before the mother fell asleep and after the home health nurse left the home. A case note indicated a physician called the CPS investigator post fatality and informed him that the parents had been counseled on the possible ramifications if the monitor was not properly used. All three investigations were conducted by the same CPS investigator.

Committee Discussion

The Committee appreciated the CPS supervisor's input utilizing hindsight regarding areas where the worker's investigation could have improved. The supervisor stated CA should have known about the in-home nursing aid due to the assignment to the children at birth. Had there been more curiosity leading to further in-depth collateral contacts, the investigations may have provided more clarity as to the functioning of the household and the wellbeing of all three of the children. The supervisor said she has been working to change her staff's practice and to work on asking questions that are hard and uncomfortable and being more curious about situations surrounding the children they are required to assess for abuse or neglect.

[23] The Structured Decision Making® (SDM) risk assessment is a household-based assessment. It estimates the likelihood that a child will experience abuse or neglect in a given household based on the characteristics of the caregivers and children living in that household. To accurately complete the SDM® risk assessment, it is critical to accurately identify the household being assessed. [Source: CA Practices and Procedures Guide 2541]

The supervisor also stated it is regular practice to interview all of the children in a home. She acknowledged this did not occur during the three investigations regarding this family. S.R and his twin were 18 months old at the time of S.R.'s death; their sister was 6 years old at that time. She also stated that the SDM® rated moderately high and per policy services should have been offered to this family. She was not sure if services were offered but acknowledged there was no documentation of efforts to offer services to the family.

The Committee discussed the possibility of a shared decision meeting or a Family Team Decision Making Meeting (FTDM) for this family. The supervisor stated that recently the FTDM facilitators in the Shelton office have been more open to conducting the meetings for safety planning purposes and she is hopeful this will continue. The Committee noted the supervisory review notes contained in the case file were well written and detailed.

Findings

The Committee noted based on their review of the case documents and interviews with staff, that there were no critical errors made by DSHS staff. However, there were areas where practice may be improved.

The CPS investigator failed to conduct adequate collateral contacts to assess the wellbeing of all three children in the home. Collateral contacts that could have assisted with the assessment include medical providers for S.R.'s siblings and requesting medical records from those providers, interviewing S.R.'s older sister and speaking with her school she was attending, speaking with the in-home nursing aid (prior to the fatality) and speaking with relatives and/or friends.[24]

S.R. had complex medical issues. CA staff are not medical experts; however, they do have access to the Medical Consultation Network for any case. A consultation with a physician through the network may have assisted the CPS investigator with a better understanding of S.R.'s medical needs and what providers were involved with his care. There was communication with S.R.'s Gastroenterology hospital social worker but not with his pediatrician or other specialists involved in his care.

The worker failed to comply with Practices and Procedures Policy 2331 requiring the social worker to refer a child between the ages of birth to 3, identified with a

[24] Interview, in-person or by telephone, professionals and other persons (physician, nurse, school personnel, child day care, relatives, etc.) who are reported to have or, the social worker believes, may have first-hand knowledge of the incident, the injury, or the family's circumstances. [Source: CA Practices and Procedures Guide 2331]

developmental delay to a Family Resources Coordinator with the Early Support for Infants and Toddlers.[25]

Recommendations

CA should provide training to all staff regarding the utilization of the Medical Consultation Network highlighting that the consultations can also include medically complex cases.

[25] Source: CA Practices and Procedures Guide 2331]

Washington State Department of Social & Health Services
CA Children's Administration

Child Fatality Review

J.C.

February 1999
Date of Child's Birth

February 27, 2015
Date of Child's Death

May 21, 2015
Child Fatality Review Date

Committee Members
Lorien J. Newsome, Ph.D., Licensed Clinical Psychologist, Pacific Psychology Services
Melinda Murphy-Jones, Social Worker, Developmental Disabilities Administration
Tara Benson, Family Assessment Response Supervisor, Children's Administration, Aberdeen
Patrick Dowd, J.D., Director, Office of Family and Children's Ombuds (OFCO)
Jeanne McShane, MSW, Family Assessment Response Practice Consultant, Children's Administration

Observer
Elizabeth Bokan, J.D., Office of Family and Children's Ombuds

Facilitator
Bob Palmer, Critical Incident Case Review Specialist Children's Administration

Executive Summary

On May 21, 2015, the Department of Social and Health Services Children's Administration convened a Child Fatality Review[26] (CFR) to examine the department's practice and service delivery to 16-year-old J.C. and her family. On February 27, 2015, the teen was shot and killed by her mother who subsequently shot herself after leaving a suicide note. The family was receiving Family Assessment Response (FAR) services from Children's Administration Pierce East office at the time of the incident.[27]

The CFR Committee was comprised of CA staff and community members with pertinent expertise from a variety of fields and systems, including clinical psychology, developmental disabilities, public child welfare, and child advocacy. None of the Committee members had any previous direct involvement with the family.

Prior to the review each Committee member received a chronology of CA involvement and un-redacted case file documents. Other relevant documents were made available to Committee members at the time of the CFR. These included investigative and post-mortem findings from the Pierce County Medical Examiner's Office, and both medical and medication records for the child. Also made available to Committee members were relevant Children's Administration policy and practice guidelines.

During the course of the review several Pierce East Division of Children and Family Services staff were interviewed by the Committee, including workers from Child Protective Services (CPS), Family Voluntary Services (FVS), and Family Assessment Response (FAR). Following review of the case file documents, completion of the staff interviews, and discussion regarding department activities and decisions, the Committee made findings and recommendations which are presented at the end of this report.

[26] Given its limited purpose, a Child Fatality Review should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. The Child Fatality Review 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 will only hear from DSHS employees and service providers. It does 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 recommend personnel action against DSHS employees or other individuals.

[27] Family Assessment Response (FAR) is a Child Protective Services alternative to investigations of low to moderate risk screened-in reports of child maltreatment.

Case Overview

RCW 74.13.500. [redacted].

Eight years later a CPS investigation was initiated following allegations that J.C. had been bruised by an object thrown by her mother. Information gathered at that time indicated that the then 12-year-old had significant behavioral and other special needs, including Asperger Syndrome.[28] The two-month investigation resulted in the allegations being unfounded and the case closed in late October 2011.[29]

In November 2013, CPS investigated an alleged non-accidental facial bruise on J.C. The mother's partner admitted to having struck the child and was founded for physical abuse. The mother was founded for negligent treatment for having been aware of the incident and continuing to allow her partner unsupervised access to the child who was taking multiple medications to control behavior and mental health issues. Based on an assessment of risk, the case was transferred to Family Voluntary Services.[30] A state contracted provider was engaged to provide FAST services in the home.[31] Due to J.C.'s demonstrated serious emotional symptoms, self-destructive behavior, and lack of behavioral control that resulted

[28] Asperger syndrome (AS) is an autism spectrum disorder (ASD), one of a distinct group of complex neurodevelopment disorders characterized by social impairment, communication difficulties, and restrictive, repetitive, and stereotyped patterns of behavior. Other ASDs include autistic disorder, childhood disintegrative disorder, and pervasive developmental disorder not otherwise specified (usually referred to as PDD-NOS). ASDs are considered neurodevelopmental disorders and are present from infancy or early childhood. Although early diagnosis using standardized screening by age 2 is the goal, many with ASD are not detected until later because of limited social demands and support from parents and caregivers in early life. [Source: National Institute of Neurological Disorders and Stroke]

[29] CA findings are based on a preponderance of the evidence. Child abuse and neglect are defined in RCW 26.44, WAC 388-15-009, and WAC 388-15-011. Findings are determined when the investigation is complete. Founded means the determination that, following an investigation by CPS, based on available information, it is more likely than not that child abuse or neglect did occur. Unfounded means the determination that, following an investigation by CPS, based on available information, it is more likely than not that child abuse or neglect did not occur, or there is insufficient evidence for the department to determine whether the alleged child abuse did or did not occur.

[30] Family Voluntary Services (FVS) support early engagement in services, including providing ongoing case management services and assessment of safety and risk to children. Voluntary Case Plans are used to engage families willing to participate in services intended to reduce current and future abuse or neglect issues that do not require court intervention. Voluntary services are short-term to help increase parents' protective capacity and manage child.

[31] Family Access Stabilization Team (FAST) is now referred to as Intensive Stabilization Services. These support services are provided to families with children at risk of out of home placement. This is a short-term (up to 90 days) community-based alternative to psychiatric hospitalization or foster care placement. Intended outcomes are increased safety, stabilization, and ensuring children have a permanent family resource.

in provoking dangerous reactions in caregivers, a Safety and Supervision Plan was initiated with regard to controlling access to J.C. by the mother's partner.

On January 21, 2014, while the case was still open with FVS, the contracted provider reported that the mother's partner had been left unsupervised with J.C. in violation of the Safety and Supervision Plan. CPS again became involved and the mother admitted to having left her daughter unsupervised with the partner. The mother was founded for negligent treatment. The partner reportedly moved out of the residence and both the CPS and FVS cases closed in mid-April 2014.

On April 28, 2014, a report was received by CPS intake alleging that J.C. had been hit (no injuries) by a book thrown by the mother's partner who was staying at the home for a few days. Based upon information gathered during the CPS investigation, there was no evidence that abuse or neglect occurred to J.C. and the allegations were determined to be unfounded; the case was closed in July 2014.

In January 2015, concerns of possible maltreatment were reported by a medical facility regarding the mother's lack of follow through with recommended psychiatric services for J.C., and that the mother's partner may have, at some undefined time, held J.C. by her neck. The case was assigned for differential response (FAR) and the mother signed a Family Participation Agreement. As J.C.'s biological father was in the military, a referral was made to the Family Advocacy Program (FAP) at Joint Base Lewis-McChord (JBLM). On March 18, 2015, the JBLM FAP Committee Review Board reviewed the case and determined it did not meet the criteria for neglect or abuse services per the military protocol.[32]

Ten days later local media reported the deaths of a 16-year-old and her mother from a likely homicide/suicide incident occurring on March 27, 2015. The identification of the two individuals came to the attention of CPS on April 2, 2015. Subsequently records from the Pierce County Medical Examiner's Office confirmed J.C. died from multiple gunshot wounds perpetrated by her mother.

CFR Committee Discussion

Committee members reviewed and discussed the CA documentation and the additional verbal accounts presented by the CA workers who were interviewed during the review. The Committee considered relevant CA practice and

[32] For FAP to be involved in reports of child abuse, alleged victims must be under age eighteen or incapable of self-support due to physical or mental incapacity, and in the legal care of a service member or military family member. FAP staff members are trained to respond to incidents of abuse and neglect, support victims, and offer prevention and treatment. For the purposes of military family services, the Department of Defense defines child abuse and neglect as injury, maltreatment, or neglect to a child that harms or threatens the child's welfare.

procedural standards for intervention and service response. The Committee also acknowledged the challenge for CA workers to be knowledgeable and responsive to complex issues such as mental health, chemical dependency, and domestic violence. The Committee also discussed the impact of the caseloads and workloads of the CPS and FVS workers involved in the case.[33]

In an effort to evaluate the reasonableness of decisions made and actions taken by the department, and as a balance to simply reviewing defined minimal practice measures, the Committee spent considerable time discussing the qualitative nature of the information gathering, assessment, and service delivery by the workers assigned to the case. This included reviewing and discussing the quality of the critical thinking, curiosity, collateral contacts, corroboration of information, collaboration with outside agencies, communication (internal and external), and comprehensiveness of the understanding of the family by the workers who were involved.[34]

Thus the Committee discussed whether the workers, in the process of conducting safety and family assessments, sufficiently gathered, probed, and understood the family members individually and collectively. The Committee looked at workers' understanding of the nature of the relationships within the family system (mother-child, mother-partner, partner-child, and biological father-child), the mother's situation (psychological health, physical health, coping strategies and social support network), and aspects of stability and dysfunction that each family member contributed to the family unit. Such discussions were important in evaluating whether the services offered by CA were the most appropriate to meet the needs of the family.

Findings

The Committee found no apparent critical errors in terms of decisions and actions taken by CA. The Committee found that the assigned CA workers appeared invested in child safety and child well-being and were actively engaged with the family. The FAR worker's connection to the family appeared particularly strong and genuine. The Committee did find instances where additional or alternative social work activity may have been considered and these issues, identified below, serve as noted opportunities where improved practice may

[33] Caseload and workload are not synonymous. While a worker's caseload generally equates to the number of assigned cases, workload involves the complexity of cases requiring intensive intervention and additional administrative requirements. [Source: U.S. Department of Health & Human Services, Administration for Children & Families, Child Welfare Information Gateway]

[34] These domains, known as The Seven Cs, have recently been incorporated into the statewide Children's Administration Lessons Learned Training to guide discussions about key areas for qualitative evaluation of practice.

have been beneficial to the assessment of the family situation and service delivery.

1. While noting instances of appropriate collateral contacts for information gathering (e.g., school staff and the child's primary care physician), the Committee found that there were also missed opportunities for additional collaterals throughout the multiple interventions by CPS, FVS, and FAR workers. This was particularly evident in the lack of information sought by CA workers regarding the mother's mental health and medical issues (including prescribed medications). The Committee found that what little information was gathered largely came from the mother's accounts without significant probing or seeking corroboration.
2. Although reasonably evident as early as 2011 that J.C. likely qualified for Social Security Income (SSI) benefits and state developmental disability services, there appeared to be missed opportunities from multiple CA staff to be more persistent in helping to connect the child with both SSI and Developmental Disabilities Administration (DDA). Such enrollments may have provided valuable support services to the family such as financial support, intensive in-home services, respite care, and parent support. Based on the interview responses, the workers involved did not appear to be aware of DDA programs and services.
3. Case file documentation showed multiple notations by CA staff regarding the contracted provider not having satisfied the expected service delivery. Comments from staff interviewed appeared to indicate a lack of awareness as to what action steps were available to them to address complaints about contracted providers.
4. The CA workers (2013-2014) largely focused on the mother's partner as the predominant issue (allegation and safety threat) to be resolved resulting in the referral to FAST as a "placement prevention service" with a goal of limiting the boyfriend's presence in the home. This incident-focused approach appeared to result in an understanding of individual and family functioning and service needs that may have been influenced by worker biases as to the boyfriend's PTSD condition and his access to weapons (including a concealed weapons permit).
5. While the FAST services were not without benefit, including safety and supervision planning, some consideration might have been made for more appropriate in-home services such as an Applied Behavior Analysis (ABA) program.[35]

[35] Applied behavior analysis (ABA), previously known as behavior modification, is a process of systematically applying interventions based upon the principles of learning theory to improve socially

6. CA workers did document numerous situations, behaviors, and comments by the mother that in isolation may reasonably have seemed marginally important but collectively had possible significance as risk factors for serious depression and suicide.[36] These included the mother having no stable employment, limited financial resources, raising a special needs child, subtle expressions of hopelessness and shame, isolating behaviors, excuses for not following through with commitments, relationship issues, limited support, sleeping all day, history of trauma, significant medical conditions, access to lethal means, and expressions of being overwhelmed at times. While the Committee found it unreasonable to expect CA staff to have expertise in the field of mental health, recognition of such risk factors may have created an opportunity for more in depth conversations with the mother.

Recommendations

- CA should consider making available to any CA staff a (non-mandatory) presentation (e.g., web-based) that provides basic information regarding both risk factors and warning signs for suicide.[37]
- CA should evaluate the need and/or benefit of cross-training opportunities with DDA that would include information as to the agency collaboration and the current interagency Memorandum of Understanding.
- In order to improve accountability of contracted providers, CA should explore continued and improved ways to message out to CA staff the agency expectations and process for forwarding concerns about contracted provider service delivery. This would include clear reminders to workers, supervisors, and administrators on how to proceed with concerns about contracted providers.

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significant behaviors to a meaningful degree, and to demonstrate that the interventions employed are responsible for the improvement of behavior. Methods in applied behavior analysis range from validated intensive behavioral interventions--most notably utilized for children with an autism spectrum disorder (ASD).

[36] Risk factors are often incorrectly confused with warning signs of suicide, as factors identified as increasing risk are not factors that cause or predict a suicide attempt. Risk factors are characteristics that make it more likely that an individual will consider, attempt, or die by suicide, but do not cause or predict a suicide attempt.[Source: Suicide Prevention Resource Center]

[37] Suicide is the eighth leading cause of death among all Washington residents and the second leading cause among youth ages 15-24. [Source: Washington State Department of Health]

Washington State Department of Social & Health Services
CA Children's Administration

Child Fatality Review

A.J.

March 2014
Date of Child's Birth

April 3, 2015
Date of Child's Death

August 13, 2015
Child Fatality Review Date

Committee Members
Christi M. Lyson, BSW, Assistant Director Institute for Family Development/Homebuilders®
Mara Campbell, Division of Children and Family Services, Pierce West
Cristina Limpens, MSW, Office of Family and Children's Ombuds (OFCO)
Lori Chavez, BSN, RN, Tacoma/Pierce County Health Department

Observers
Ann Radcliffe, Department of Early Learning, Management Analyst Lead
Deanna Sundby, Department of Early Learning, Northwest Licensing Analyst

Facilitator
Bob Palmer, Critical Incident Case Review Specialist Children's Administration

Executive Summary

On August 13, 2015, the Department of Social and Health Services Children's Administration convened a Child Fatality Review[38] (CFR) to examine the department's practice and service delivery to 1-year-old A.J. and her family.[39] On April 3, 2015, the child drowned in a bathtub at the family residence while in the care of her mother. One month prior to the fatality the Vancouver Division of Children and Family Services (DCFS) completed a Family Assessment Response (FAR) with the family.[40]

The CFR Committee was comprised of CA staff and community members with pertinent expertise from a variety of fields and systems, including public child welfare, public health nursing, parenting education, intensive family preservation services, and child advocacy. None of the Committee members had any previous direct involvement with the family.

Prior to the review each Committee member received a chronology of CA involvement and un-redacted case file documents. Available to Committee members at the time of the CFR were the parenting education records from a local community agency that had provided services to the family since July 2014. Clark County Medical Examiner's Office records regarding the child fatality (autopsy and ancillary studies) were formally requested in advance of the review but had not been received by the time the Committee convened.

During the course of the review the Vancouver DCFS Family Assessment Response (FAR) worker and his supervisor were interviewed. Following review of the case file documents, completion of the staff interviews, and discussion regarding department activities and decisions, the Committee made findings which are presented at the end of this report. The Committee forwarded no recommendations.

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[38] Given its limited purpose, a Child Fatality Review should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. The Child Fatality Review 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 will only hear from DSHS employees and service providers. It does 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 recommend personnel action against DSHS employees or other individuals.

[39] No criminal charges have been filed relating to the incident and therefore neither of the parent's names are identified. The name of the child is subject to privacy laws [Source: RCW 74.13.500(1)(a)].

[40] Family Assessment Response (FAR) is a Child Protective Services alternative response to investigations of low to moderate risk screened-in reports of child maltreatment. [Source: CA Practices and Procedures Guide 2332]

Case Overview

A.J. first came to the attention of CA on March 14, 2014, two months after her "RCW 13.50.100 [redacted],[41] when a caller contacted CA intake with generalized concerns about the birth mother. Lacking any direct knowledge of the situation by the anonymous referrer or any specific allegations, the report was screened out at intake. In early June 2014, a social worker from a local hospital reported concerns that the parents may lack resources for meeting the needs of the infant who was due to be discharged from the hospital. Without specific allegations of abuse or neglect or imminent harm the report was screened out. It was reported at that time that the family had agreed to in-home services by a community health nurse.

On January 9, 2015, a parent educator from a local community agency working with the family reported concerns for the safety of an infant in the home. The mother reportedly was ignoring voiced concerns by the parent educator about leaving the infant on the couch unattended and concerns about a 4-foot boa constrictor roaming free in the residence. The mother had reported to the parent educator that the snake had previously constricted her (the mother's) neck but did not feel her infant was at risk. The intake was assigned for differential response and the parents agreed to FAR intervention.

The assigned FAR worker discussed with the parents the concerns as reported. The parents agreed to make sure they knew where the snake was at all times, keep it away from the child, and not leave the child unsupervised around the snake. Parents were cooperative and willing to make necessary changes to ensure the child's safety. Other issues of child safety were assessed (e.g., infant safe sleep) and the FAR worker confirmed that a parent educator with a community agency was still actively working with the family. FAR services were ended on March 11, 2015.

On April 4, 2015, CA intake received a report from local law enforcement that A.J. had drowned the day before. The mother had admitted to detectives that she had placed her 1-year-old daughter in the bathtub and stepped away to throw a dirty diaper in the trash. She then got distracted when getting onto the computer and lost track of time. Ten minutes elapsed when the mother returned to the bathtub and found the child under water, not breathing, and lips having turned blue. The mother attempted CPR with no success and then called 911. Arriving

[41] The term "micro preemie" is used in the medical field to refer to the smallest and youngest preterm babies who are born before 26 weeks gestation or weighing less than 1 pound, 12 ounces (800 grams).

medics continued to attempt resuscitation. The child was transported to a local hospital where she was pronounced dead.

A CPS investigation was initiated resulting in a founded finding regarding an allegation of negligent treatment on the part of A.J.'s mother.[42] According to Vancouver area media reports the Clark County Medical Examiner's Office ruled the drowning as an accidental death. At the time of the child fatality review it is believed that law enforcement had not charged the mother with any criminal offenses.

CFR Committee Discussion

Committee members reviewed and discussed the CA documentation and the additional verbal accounts presented by the CA staff who were interviewed during the review. The Committee considered relevant CA practice and procedural standards for intervention and service response.

In an effort to evaluate the reasonableness of decisions made and actions taken by the department, and as a balance to simply reviewing defined minimal practice measures, the Committee spent considerable time discussing the qualitative nature of the information gathering, assessment, and service delivery by the worker assigned to the case. This included reviewing and discussing the quality of the critical thinking, curiosity, collateral contacts, corroboration of information, collaboration with outside agencies, communication (internal and external), and comprehensiveness of the understanding of the family by the FAR worker and supervisor who were involved.[43]

Thus the Committee discussed whether the worker, in the process of conducting safety and family assessments, sufficiently gathered, probed, and understood the family members individually and collectively. Such discussions were important in evaluating whether the services offered by CA were the most appropriate to meet the needs of the family.

The Committee briefly discussed both the workload and caseload[44] of the worker at the time of his FAR assignment as well as his breadth of experience working for

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[42] "Founded" means the determination that, following an investigation by the department, based on available information: it is more likely than not that child abuse or neglect did occur. [Source: RCW 26.44.020]

[43] These domains, known as The Seven Cs, have recently been incorporated into the statewide Children's Administration Lessons Learned Training to guide discussions about key areas for qualitative evaluation of practice.

[44] Caseload and workload are not synonymous. While a worker's caseload generally equates to the number of assigned cases, workload involves the complexity of cases requiring intensive intervention and additional administrative requirements. [Source: U.S. Department of Health & Human Services, Administration for Children & Families, Child Welfare Information Gateway]

Children's Administration for 20 years. This included consideration of the fact that the worker, after 7 years as an intake worker, had relatively recently rejoined field work following implementation of FAR in the Vancouver DCFS office in October 2014. The purpose of such discussion was to apply a context for the Committee's concerns that the supervisor may have overestimated the worker's skill level based upon previous field experience at a time in which the Vancouver office developed high caseloads in FAR as a result of the transition to the new response system. The Committee was provided information that, following an internal review of A.J.'s death and routine review of other cases, the Vancouver DCFS office utilized a Regional Safety Practice Consultant to work with Vancouver workers to improve practice in the Structured Decision Making® (SDM)[45] and Family Assessments.

The Committee also briefly discussed the service delivery by a local community agency that had worked with the family since July 2014, which predated involvement by the Children's Administration that began in January 2015. Although the agency providing services to the family is a contracted provider for CA, its engagement with the family was not through the department. Thus, any Committee considerations regarding that service delivery is deemed outside the scope and purpose of this review.

Findings

The Committee found no apparent critical errors in terms of decisions and actions taken by CA. The Committee did find instances where additional or alternative social work activity may have been considered and these issues, identified below, serve as noted opportunities where improved practice may have been beneficial to the assessment of the family situation and service delivery.

<u>Lack of Curiosity</u>

The FAR worker appeared to primarily focus on the incident involving the lack of supervision of the infant around the boa constrictor. The worker did document general aspects of child safety in the home (e.g., safe sleep practices by the parents), the home environment (cleanliness of the residence), and parent cooperation. These appeared to have been given great weight by the worker in his assessment which reflected possible confirmatory bias.[46] Such appeared to

[45] The Structured Decision Making® (SDM) Risk Assessment is an evidence-based actuarial tool from the Children's Research Center (CRC) that was implemented by Washington state Children's Administration in October 2007. It is one source of information for CPS workers and supervisors consider when making the decision to provide ongoing services to families.

[46] Confirmation biases are effects in selective collection of evidence and information processing that explain how people search through available information, interpret that information, and hence reach

result in a general lack of curiosity about more global aspects of the family which led to missed opportunities to gather comprehensive information about the family to assess child safety and the family's needs and strengths as required in RCW 26.44.260 Family Assessment Response.

Collateral Contacts

The Committee found that there were missed opportunities for additional collaterals by the FAR worker including contacting the referrer, the Primary Care Physician, the Public Health Nurse who had previously engaged the family, and relatives. The Committee found what little information was gathered by the worker largely came from the mother's accounts, without significant probing or seeking corroboration. This was particularly evident in the lack of information sought by CA workers regarding the mother's mental health situation.

Lack of Adequate Collaboration

Although brief phone contact was made by the worker with the community agency that had been providing parent education services to the family since July 2014, requesting records from that agency would have been helpful for assessment purposes, particularly in improving the accuracy of the SDM®. The records obtained post-fatality from the community agency revealed numerous documented indicators of possible parental ambivalence on the part of child's mother.[47]

Recommendations

The Committee forwards no recommendation.

conclusions. Studies of social judgment provide evidence that people tend to overweight positive confirmatory evidence or underweight negative disconfirmatory evidence.

[47] Parental ambivalence relates to the nurturing and affectionate aspects of a parent/child relationship. It is often identifiable by behavioral or verbal indicators that suggest contradictory attitudes toward the relationship, incompatible expectations and mixed emotions, and self-doubt regarding being able to handle a parent/caretaker role.