RCW 74.13.500

Children's Administration
Executive Child Fatality Review

S.R.

November [redacted] 2010
Date of Child's Birth

June 18, 2011
Date of Child's Death

September 23, 2011
Executive Review Date

Committee Members
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Executive Summary

On September 23, 2011, the Department of Social and Health Services (DSHS), Children's Administration (CA) convened an Executive Child Fatality Review (ECFR[1]) of a case involving the death of six-month old, S.R. (DOB: 11[redacted]2010) in her family home. At the time of S.R.'s death the family had an open child protective services (CPS) case and an open child and family welfare services case (CFWS) with CA. A committee that included community professionals and CA staff reviewed the case documents and interviewed staff in an effort to examine child welfare practices, system collaboration, and service delivery regarding this child and her family.

On June 18, 2011 at approximately 2:30 pm Snohomish County deputies contacted the department notifying CA of S.R.'s death earlier in the day. The deputy stated neither law enforcement nor first responders noted any concerns in the home upon arrival. Law enforcement reported that the Snohomish County medical examiner was responding to the scene and would provide additional follow-up after completing an examination and autopsy. After completion of an autopsy[2] the Snohomish County medical examiner listed S.R.'s death as *'Unexpected Infant Death of Undetermined Cause and Manner.'*

[redacted]

[redacted] S.R. was the youngest child born in a family of seven children.

[redacted]

A case summary relating to S.R. was prepared and provided to the ECFR committee. A copy of the family's case file was also available to the committee. During the course of the review the committee discussed issues related to service delivery, the significance of patterns in the case including allegations reported to the department, domestic violence, prescription drug use, and parental avoidance of contact with the department.

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[1] Given its limited purpose, a Child Fatality Review by Children's Administration should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. A review is generally limited to documents in the possession of or obtained by DSHS or its contracted service providers and the panel may be precluded from receiving some documents that may be relevant to the issues in a case because of federal or state confidentiality laws and regulations. A review panel has no subpoena power or authority to compel attendance and generally will only hear from DSHS employees and service providers. The panel may not hear the points of view of a child's parents and relatives, or those of other individuals associated with a deceased child's life or fatality. A Child Fatality Review is not intended to be a fact-finding or forensic inquiry or to replace or supersede investigations by courts, law enforcement agencies, medical examiners or other entities with legal responsibility to investigate or review some or all of the circumstances of a child's death. Nor is it the function or purpose of a Child Fatality Review to take personnel action or recommend such action against DSHS employees or other individuals.

[2] Complete autopsy includes toxicology results which often take as much as 12-16 weeks to receive post fatality.

Following review of the family's history, case records and discussion, the review committee made findings and recommendations that are detailed at the end of this report.

Case Overview

[redacted]

[3] Screening decision is based on the absence of allegations of child abuse or neglect as defined by WAC 388-15-009 What is Child Abuse and Neglect?

[redacted]

CA received four intakes[6] regarding this family beginning in December 2010 following the premature birth of S.R. Issues related to possible substance use and unsafe living conditions in the home prompted CA to be diligent in monitoring the living conditions and the parents' ability to ensure their children's safety. Referrers expressed concern that family living conditions and inconsistent parental behavior would place S.R. at risk of harm once she was released from the hospital. Monthly home visits by the CFWS social worker assigned to the case continued. CPS investigations began in December 2010 after an intake was received reporting the birth of S.R. She was premature and the caller, a medical professional, expressed concerns regarding H. J. and her ability to care for the child. An intake received in February 2011 reported similar concerns and in May 2011 another intake was received and assigned for alternative response.[7] The CPS social worker attempted home visits in May and early June to address issues related to possible drug seeking behaviors on behalf of S.R.'s mother and deteriorating conditions in the home. The family was difficult to contact[8]. When contacted by CA, the mother and father were unwilling to engage with the social worker. The CPS and CFWS cases remained open.

On June 18, 2011, the department received the report of the death of six-month-old S.R. Intake information received stated that S.R. was placed in her bassinet by her mother after being fed. S.R.'s mother reported that she had showered and, afterward, when checking on S.R. she noticed the child had pulled a blanket closer to her and was not breathing. Despite attempts by first responders to revive S.R. she was pronounced dead in the family home at 10:40 am. On June 23, 2011 shortly after S.R.'s death[9] and in collaboration with law enforcement, S.R.'s surviving siblings were placed into protective custody due to ongoing concerns of alleged domestic violence, unsanitary living conditions and their mother's untreated mental health issues. Following a brief stay in foster care the children were placed with a relative and dependency was established in August 2011. At the time of this report the children remain out of home in relative placement and the family continues to be involved in services.

Review Committee Discussion and Findings

To develop a thorough understanding of the family and case, the review committee identified dynamics that appeared to influence decision-making by the department, e.g.) intake screening decisions, placement decisions . The committee requested to meet with the CPS investigator and the CFWS social worker assigned to the case at the time of S.R.'s death. The CPS and CFWS supervisors joined the social workers for their meeting with the ECFR committee.

Patterns: The committee found that a pattern of child abuse and neglect reports to the department had occurred , the presence of multiple risk factors[10] and safety threats are found consistently, creating the need to thoroughly assess the family in order to gain an understanding of the parent's ability to safely parent their children. Diligent efforts in locating, accessing and utilizing information from other sources assists in keeping children safe, identifying family patterns, and influences decision making[11] and case planning.

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[6] Two intakes screened as CPS Risk Only, one for alternative intervention and one screened out.

[7] The committee found the information in the May 6, 2011 intake screened as an Alternative Response (10-day response time) contained information to support screening in the intake for investigation given the family's history.

[8] Case record documentation notes repeated attempts to contact the family without success.

[9] Death determined to be Sudden Unexpected Infant Death of Undetermined Cause and Manner.

[10] Mental health, substance abuse, domestic violence

[11] Decisions such as those made on new intakes or the need for out of home placement or services.

While the mother appeared cooperative with the CFWS social worker, she avoided contact with CPS social workers attempting to complete investigations. Noted in the record were the department's unsuccessful efforts to contact the family through unannounced home visits and phone calls. This pattern of behaviors and events, verifiable through collateral sources, raise questions about the mother's credibility and apparent willingness to work with the department.

Domestic Violence (DV): After closely reviewing the case information and meeting with the assigned social workers the committee identified domestic violence as a reoccurring theme in this family. The committee found that managing the domestic violence in this case was challenging given H.J. was often the single source of information.

The committee found that by utilizing historical information[13] and accessing collateral information from law enforcement , mental health professionals, and domestic violence agencies, CA can gain insight into the family dynamics to support intervention and planning. Understanding how to identify domestic violence perpetrators, how they think, how other family members respond within the home and how to effectively work with victims and perpetrators can only be gained when employing a collaborative planning effort among experts.

Critical Thinking/ Shared-Decision Making: While the committee was convened to review the death of S.R. in 2011, They found complex cases call for a gathering of information from additional sources and is essential in understanding the family's dynamics.

The committee found examples in which gathering additional information and not relying on a single source, such as H.J., would have provided a better understanding of this family's situation. For example, CA received conflicting information from two psychological evaluations on S.R.'s mother in 2010; and continued reports of unsafe and unhealthy living conditions. The committee also noted that the department did not follow-up on critical pieces of information

CA received four intakes beginning in December 2010. The committee noted the referrers making reports were all professionals within the community who had insights into this family. The review committee

found the family was evasive with CA during this time and when the opportunity to meet with the family occurred CA relied heavily on information from S.R.'s mother and did not always seek corroborating information from second sources (e.g. law enforcement reports, medical examiner, referrer, etc.) regarding allegations or present family circumstances.

The review team found fully understanding a family should result in as complete a picture of a family as possible and will come from a variety of sources[14]. Critical thinking and shared decision making helps to build an understanding of a family and can take into account several areas such as family strengths and respective challenges, which supports developing intervention strategies and case planning.

The committee noted this case could have benefitted from a critical review and analysis of all information received (e.g. clinical supervision, case staffings, child protection teams and multi-disciplinary team staffing). A multi-disciplinary team staffing in particular can provide a comprehensive review and assessment of a complex child abuse and neglect case such as in this family. The collaborative staffing opportunity can support development of case plans that serve individual family members and support child safety.

Given the dynamics in this family the review team found utilizing a multi-disciplinary team decision making approach may have resulted in increased objective recognition and understanding of the family patterns.

Recommendations

Patterns: During the review, the committee learned about CA's implementation of a new Child Safety Framework in November 2011 that supports and assists social workers in assessment, identification, and management of safety threats throughout the life of a case. The patterns of child abuse and neglect reports, domestic violence, and avoidance of department staff would be identified in the new assessment, moving the practice away from incident-focused work to a comprehensive assessment of how this family functioned. The Child Safety Framework also supports the verification of information gathered by contacting collaterals and other child welfare partners working on a case.

Domestic Violence: In February 2010 CA released a Social Worker's Practice Guide to Domestic Violence. The 88 page guide provides social workers with information regarding domestic violence which includes legal considerations, routine screening, domestic violence assessment, case decisions and case planning. The committee commended CA in this effort. However, the committee found that regardless of how valuable the guide, supporting it with a training program that includes direction for supervisor consultation can provide guidance and information to front line staff in assessing and planning around domestic violence.

Given the complexity regarding domestic violence the committee recommended on-going training and regular consultation on domestic violence. A training curriculum that addresses the broad spectrum of domestic violence and includes topics such as perpetrator assessment and accountability, treatment recommendations, understanding patterns and cycles, and safety planning is recommended. Training could be conducted in person or through on-line resources.

Critical Thinking/Shared Decision Making: It is recommended when multiple agencies and service providers over time have worked or are working with a family or have referred them for intervention,

[14] Sources include medical professionals, law enforcement, schools, community services agencies to include other state agencies, etc.

CA convene a multi-disciplinary team. While the primary purpose may typically be to help team members resolve difficult cases, MDT teams may fulfill a variety of additional functions. They can promote coordination between agencies; provide a 'checks and balances' strategy to ensure the interests and rights of all concerned parties are addressed; and identify service gaps and breakdowns in coordination or communication between agencies or individuals. MDTs can enhance the professional skills and knowledge of individual team members by providing a forum for learning more about the strategies, resources, and approaches used by various disciplines.