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

RCW 74.13.640

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Executive Summary

On June 18, 2015, the Department of Social and Health Services Children's Administration (CA) convened a Child Fatality Review[1] (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.[2]

The CFR Committee was comprised of Children's Administration staff from both the Division of Licensed Resources[3] (DLR) and the Division of Children and Family Services[4] (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.

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[1] 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.

[2] 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).

[3] 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.

[4] 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.

Prior to the review each Committee member received a summary of the Division of Licensed Resources' licensing activities involving the foster home (2005-2015), a chronology of Child and Family Welfare Services[5] 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.[6]

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 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,[7] and phone contact with the

[5] 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.

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

[7] 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

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.

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.[8] 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

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children in CA's care or custody. Well-being factors include physical health; development; social, family and community connections; education and emotional/behavioral health.

[8] 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.

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, 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[9] and DLR monitoring requirements for licensed foster homes.[10] The Committee looked at the DCFS health and safety monitoring requirements for children in out-of-home care,[11] and discussed the infant safe sleep assessment policy for CFWS cases.[12] 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.

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[9] 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.

[10] 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.

[11] 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]

[12] 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 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 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.[13]
- 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.[14] However, information presented at the review indicated such practice of alternating health and safety visits with other workers may be regularly occurring in the

[13] 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]

[14] 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.

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 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.