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

Child Fatality Review

A.M.

RCW 74.13.515 **2015**
Date of Child's Birth

November 2, 2016
Date of Child's Death

March 1, 2017
Date of the Fatality Review

Committee Members
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Executive Summary

On March 01, 2017, the Department of Social and Health Services, Children's Administration (CA) convened a Child Fatality Review (CFR)[1] to assess the department's practice and service delivery to an infant child, A.M., and [redacted] family. The child is referenced by [redacted] initials, A.M., in this report. At the time of [redacted] death, A.M. had been residing with [redacted] parents and extended family.[2] The incident initiating this review occurred on November 2, 2016, when A.M. died while co-sleeping with [redacted] father.

The CFR Committee included CA and community professionals with relevant expertise in child advocacy, child abuse and child safety, law enforcement and pediatric medicine. None of the Committee members had any previous direct involvement with this family.

Prior to the review, each Committee member received a detailed case summary, a family genogram, un-redacted case documents including case notes, referrals for services, assessments and medical records. The hard copy of the file was available at the time of the review. Supplemental sources of information and resource materials were also available to the Committee, including state laws and CA policies relevant to the review.

The Committee interviewed the local CA area administrator. Previously assigned CA caseworkers and supervisors were not interviewed due to unavailability. Following the review of the case file documents, completion of staff interviews, and discussion regarding CA activities and decisions, the Committee made findings and recommendations that are presented at the end of this report.

Case Summary

CA received seven reports on A.M.'s family between February 10, 2012 and March 21, 2016, three of which resulted in investigations with unfounded[3]

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[1] Given its limited purpose, a Child 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 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] The parents are not identified by name in this report as no criminal charges were filed relating to the incident. [Source: RCW 74.13.500(1)(a)].

[3] Unfounded means the determination following an investigation by the department that available information indicates that, more likely than not, child abuse or neglect did not occur, or that there is insufficient evidence for the department to determine whether the alleged child abuse did or did not occur

findings in 2014, 2015 and 2016. The allegations noted in the intakes were RCW 13.50.100 [redacted], RCW 13.50.100, RCW 13.50.100 [redacted], RCW 13.50.100 [redacted]. The March 2016 investigation was closed on April 19, 2016.

On November 07, 2016, a federal law enforcement agent contacted the RCW 74.13.515 CA supervisor to notify her that A.M. died on November 2, 2016 while in the care of RCW 74 father. A.M.'s father was reported to have returned home between 4:00 a.m. and 6:00 a.m. on November 2, 2016. Once the father arrived home he removed A.M. from the paternal grandmother's bed and into his own bed. Local law enforcement was dispatched to the home on the same date at approximately 7:30 a.m. for a welfare check on an older child in the home due to RCW 13.50.100. While local law enforcement was at the home, A.M. was observed face up in the bed with RCW 74 father and appeared to be alive. Later that same day, the family called 911 at approximately 1:00 p.m. requesting assistance as A.M. was unresponsive. When local law enforcement responded to the home for the second time on November 2, 2016, A.M. was found face down on the father's bed. The father stated to law enforcement that he had been drinking alcohol until around 4:00 a.m. that morning. The cause of death was documented as Sudden Infant Death Syndrome (SIDS).

Additionally, the federal law enforcement agent informed CA that another child died a few years earlier in the family home. The CA investigator assigned discovered that RCW 13.50.100 [redacted]. CA found information about RCW 13.50.100 death in law enforcement reports and medical records. SIDS was the documented cause of death. CA had not previously been aware of the birth or the death of RCW 13.50.100.

Discussion

For purposes of this review, the Committee primarily focused on case activity that occurred prior to A.M.'s death; however, the Committee did discuss the medical examiner and law enforcement activities related to A.M.'s death.

The Committee spent considerable time discussing the 2014 investigation of RCW 13.50.100, RCW 13.50.100 [redacted]. The Committee did not connect the 2014 investigation to A.M.'s death but believed discussion was important for the purpose of practice improvement. The Committee discussed the necessity of collateral contacts in conducting a comprehensive investigation and in assessing risk and safety. The Committee noted missed

Founded means the determination following an investigation by the department that. Based on available information, it is more likely than not that child abuse or neglect did occur. [Source: RCW 26.44.010]

opportunities to gather additional clarifying information from the medical providers, from law enforcement, from the school, from DSHS databases and from other sources within the family's community, including the tribal members and neighbors. The Committee discussed the importance of teaming with tribal social and health services to gather information from the tribal community noting cultural intricacies that CA may not be aware of or understand.

Although the CA social worker identified that the children were "unsafe" on the safety assessment[4] and a safety plan[5] was developed, the Committee noted that the safety plan lacked specific safety tasks that would protect the children from the identified safety threat[6]. The tasks in the plan relied on the parents to keep their children safe from harm and included a task for a referral for an in-home service. The Committee acknowledged that had the department better understood the day-to-day functioning of the caregivers, their substance use, and when the safety threat became active, a more functional and successful safety plan could have been developed to manage the identified safety issues in the home. The Committee strongly believed that a CA medical consultation and a medical assessment should have occurred [redacted] RCW 13.50.100 [redacted].

The Committee was concerned to learn that training on interviewing children with disabilities or developmental delays has not been available to staff outside of a brief session in Regional Core Training (RCT)[7]. The Committee discussed the

[4] Safety Assessment is used throughout the life of the case to identify impending danger and determine whether a child is safe or unsafe. It is based on comprehensive information gathered about the family at the time the safety assessment is completed. [Source: CA Practices and Procedures Guide, Chapter 1120]

[5] The Safety Plan is a written agreement between a family and CA that identifies how safety threats to a child will be immediately controlled and managed. The Safely Plan is implemented and active as long as threats to child safety exist and caregiver protective capacities are insufficient to protect the child. A Safety Plan is required for all children where there is a safety threat(s) indicated on the Safety Assessment. Note: when creating an in-home Safety Plan, the following criteria must be met: 1) there is at least one parent/caregiver or adult in the home; 2) the home is calm enough to allow safety providers to function in the home; 3) the adults in the home agree to cooperate with and allow an in-home safety plan; 4) sufficient, appropriate and reliable resources are available and willing to provide safety services/tasks. [Source: CA Practices and Procedures Guide, Chapter 1130

[6] A threat of danger is a specific family situation or behavior, emotion, motive, perception or capacity of a family member that threatens child safety. The danger threshold is the point at which family functioning and associated caregiver performance becomes perilous enough to be perceived as a threat or produce a threat to child safety. The safety threshold determines impending danger. Safety threats are essentially risk influences that are active at a heighten degree and greater level of intensity. Safety threats are risk influences that have crossed a threshold in terms of controllability that has implications for dangerousness. Therefore, the safety threshold includes only those family conditions that are judged to be out of a caregiver's control. [Source: Safety Threshold Handout]

[7] RCT is the initial, intensive, task-oriented training that prepares newly hired Social Service Specialists to assume job responsibilities. RCT starts on the first day of employment and lasts for 60 days, or the first two months of employment. Competencies are used to assess learning needs and to identify a developmental plan for the new workers.

importance of child interview training to include all levels of child development. The Committee discussed that CA's ability to effectively interview children with disabilities without training is limited and would likely vary by caseworker depending on previous education, training and practice.

The Committee discussed the death of RCW 13.50.100 . The Committee wondered why the medical examiner or law enforcement bypassed notifying CA of this child's death. Some Committee members discussed mandatory reporting[8] and that unlike law enforcement, medical examiners aren't required by law to report child deaths to CA even if there is concern for child abuse or neglect[9]. The statute requires medical examiners to make a report to law enforcement or CA if they feel the death is suspicious or criminal in nature. Other Committee members opined, understanding CA's inability to mandate or enforce reporting by community professionals, that they would have liked CA to have been notified of the death of RCW 13.50.100 based the Committee's RCW 13.50.100 . The Committee heard from the local area administrator that CA usually receives information from the medical examiner or law enforcement in such instances of a child death and that this particular situation was unusual. The Committee noted that local law enforcement did not notify CPS of the death of RCW 13.50.100 nor did they report A.M.'s death. The Committee further noted that a federal agent contacted CA about A.M.'s death almost a week past the death. Some Committee members questioned why the case workers that were assigned in subsequent investigations might not have come across the information of the birth and death of RCW 13.50.100 in the Department of Health (DOH) records. Discussion centered on lack of training for

[8] RCW 26.44.030(1)(a) defines mandated reporter as: "…any practitioner, county coroner or medical examiner, law enforcement officer, professional school personnel, registered or licensed nurse, social service counselor, psychologist, pharmacist, employee of the department of early learning, licensed or certified child care providers or their employees, employee of the department, juvenile probation officer, placement and liaison specialist, responsible living skills program staff, HOPE center staff, or state family and children's ombuds or any volunteer in the ombuds office has reasonable cause to believe that a child has suffered abuse or neglect, he or she shall report such incident, or cause a report to be made, to the proper law enforcement agency or to the department…"

[9] Any law enforcement agency receiving a report of an incident of alleged abuse or neglect pursuant to this chapter, involving a child who has died or has had physical injury or injuries inflicted upon him or her other than by accidental means, or who has been subjected to alleged sexual abuse, shall report such incident in writing as provided in RCW 26.44.040 to the proper county prosecutor or city attorney for appropriate action whenever the law enforcement agency's investigation reveals that a crime may have been committed. The law enforcement agency shall also notify the department of all reports received and the law enforcement agency's disposition of them. In emergency cases, where the child's welfare is endangered, the law enforcement agency shall notify the department within twenty-four hours. In all other cases, the law enforcement agency shall notify the department within seventy-two hours after a report is received by the law enforcement agency. [Source: RCW 26.44.030(5)]

staff on DOH programs as well as other state agency computer information systems. The Committee considered the importance of case consultation, multi-disciplinary team staffings and shared decision-making when dealing with complex cases like this one and that the consultation should include a medical consultation, connections with Developmental Disabilities Administration (DDA) services as well as program experts and CA staff at all levels in the chain of command.

The area administrator informed the Committee that a community multidisciplinary team meets monthly and has done so for over the last twenty years to discuss local protocols and information sharing among agencies on serious physical abuse and sexual abuse cases. Further, the area administrator informed the Committee that the local CA staff use shared planning meetings[10] and the Local Indian Child Welfare Advisory Committee(LICWAC[11]) to gain information on families. The Committee recognized that the LICWAC committee may not provide much information to CA on a child that has passed away due to customary cultural traditions not to speak of those who have died.

The Committee questioned whether there is a statewide lack of consensus about CA's role in the investigation of child deaths related to unsafe sleep and ongoing misunderstandings among staff and community agency's about the meaning of the terms "SIDS"[12] and "SUID."[13] The Committee expressed concern that what appears to be a lack of consensus may be a system-wide issue with the professional entities involved regarding the SIDS determination and the potential effect it can have on CA's ability to more fully assess child safety of other children in the home. Committee members questioned the possibility of some medical

[10] All staffings engage parents in the shared planning process to develop family specific case plans focused on identified safety threats and child specific permanency goals. Working in partnership with families, natural supports and providers helps identify parents' strengths, threats to child safety, focus on everyday life events, and help parents build the skills necessary to support the safety and well-being of their children. The shared planning process integrates all CA staffings. [Source: CA Practices & Procedures Guide, Chapter 1700]

[11] A LICWAC is a body of volunteers, approved and appointed by CA who staff and consult with the department on cases of Indian children who: are members of a tribe, band or First Nations has not responded, or has chosen not to be involved, or is otherwise unavailable; or for whom the child's tribe, band, or First Nations has officially designated the LICWAC to staff the case; or are defined as a recognized Indian child.

[12] Sudden Infant Death Syndrome (SIDS) is defined as the sudden death of an infant less than one year of age that cannot be explained after a thorough investigation is conducted, including an autopsy, examination of the death scene and a review of the clinical history. SIDS is a type of SUID. [Source: Centers for Disease Control and Prevention]

[13] The Centers for Disease Control (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 of SUID are SIDS, unknown, and accidental suffocation and strangulation in bed.

examiners using the SIDS determination to eliminate further intervention from agencies such as law enforcement or CA in order to protect the family from additional hardships post child death. The Committee expressed concern that an autopsy was not completed on A.M. The Committee discussed that A.M. was a RCW 74.13.515 short of RCW 74 first birthday and wondered what the cause of death determination would have if A.M. had officially been one-year-old (the usually observed cut off for a SIDS determination). The Committee believed that education from the area administrator and/or a CA medical consultant[14] might assist the local community professionals including the local medical examiner in understanding that although not always mandated, the importance of information sharing in child death cases.

Findings

After a review of the case chronology, interviews with staff and discussion, the Committee did not identify any critical errors linked to the death of A.M. The Committee reached consensus on the findings and recommendations below:

- The Committee found that the investigations related to the April 2014 and 2015 reports were incident-focused and lacked comprehensive information gathering from collateral sources; if the information had been gathered, it may have improved the CA's assessment of risk and safety or the current law.
- The Committee found that a CA medical consultation or emergency medical care did not occur for the 2014 investigation regarding the RCW 13.50.100.[15]

Recommendations

- In an attempt to reduce possible ambiguity in CA's role in child death investigations, the Committee recommends that the local DCFS area administrator and/or a CA medical consultant communicate with the local professionals who investigate child death and child abuse (including the

[14] The tasks of the statewide Child Abuse Consultation Network include providing telephonic consultations, case staffing/case review, training, court testimony, and written consults to CA staff, law enforcement officials, prosecuting attorneys, and physicians regarding child maltreatment cases.

[15] Consultations, Evaluations and Referrals (i)Secure a prompt medical evaluation or treatment for a child:
A. If indicators of serious CA/N exist.
B. A child is three or younger with a physical abuse allegation.
C. The alleged CA/N cannot be reasonably attributed to the explanation and a diagnostic finding would clarify the assessment of risk or determine the need for medical treatment.
D. If the alleged neglect includes concerns that children are deprived of food, underweight, or are starved.
(ii.) Contact the Child Protection Medical Consultant in your region when identification or management of CA/N would be facilitated by expert medical consultation.
(iii.) Seek legal authority for the medical examination if the parent does not comply with the request.
(iv.) Contact the Washington Poison Control Center at 1-800-222-1222 if consultation is needed about prescribed or non-prescribed medications. [Source: CA Practice & Procedures Manual, Chapter 2331(4)(f)]

local medical examiner and local law enforcement), possibly at a multidisciplinary meeting, how SIDS findings, autopsy reports, and information sharing impacts CA's ability to assess the safety of the surviving children in the home and complete investigations more accurately.

- The Committee recommends that CA make training available to all CA staff on interviewing children with disabilities, safety assessment of children with disabilities, and partnering with the community for assessment and services of children with disabilities to include working with Developmental Disabilities Administration.
- The Committee recommends that CA make training regularly available to all CA staff on navigating and using Department of Health records and the Community Service Office databases.