Washington State Department of Social & Health Services

CA Children's Administration

Child Fatality Review
G.C.

RCW 74.13.515 **2016**
Date of Child's Birth

May 22, 2016
Date of Child's Death

September 7, 2016
Date of the Fatality Review

Committee Members
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Brian Jones, Sergeant, Moses Lake Police Department
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Executive Summary

On September 7, 2016, 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, G.C., and [redacted] family[2]. The child is referenced by [redacted] initials, G.C., in this report. At the time of [redacted] death, G.C. resided with [redacted] mother and [redacted] older siblings in [redacted], Washington. The department had an open Family Voluntary Service case (FVS)[3] at the time of G.C.'s death. The incident initiating this review occurred on May 22, 2016, when G.C. died while co- sleeping with [redacted] mother. The county coroner later determined the child died from acute methamphetamine intoxication.

The CFR Committee included CA staff and community members selected from diverse disciplines with relevant expertise, including child welfare, chemical dependency, law enforcement, in-home service provision, the Office of the Family and Children's Ombuds and medical expertise. The participating community members had no previous direct involvement with this family.

Prior to the review, each Committee member received a case chronology, a family genogram, a summary of CA involvement with the family and 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 copies of state laws and CA policies relevant to the review, workload and case assignment data for this unit during the time that the case was open.

The Committee interviewed CA social workers and supervisors who had previously been assigned to the case. Following the review of the case file

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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 the 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. The names of G.C.'s siblings are subject to privacy law. [Source: RCW 74.13.500(1)(a)]

[3] Family Voluntary Services (FVS) support families' early engagement in services, including working with the family to create Voluntary Service Agreements or Voluntary Placement Agreements and 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 safety. [Source: CA Practices and Procedures Guide]

documents, review of case assignment and workload report information taken from FamLink[4] for the staff involved, completion of staff interviews and discussion regarding department activities and decisions, the Committee made findings and recommendations that are presented at the end of this report.

Case Overview

On May 23, 2016, the assigned Social Worker to the case received information from a contracted provider stating that [redacted] week-old G.C. had died in [redacted] mother's care. The mother had called the contracted provider to notify them that she would not be participating in services due to her child's death. G.C.'s mother reported to law enforcement that she had awakened at approximately 1:00 a.m. and found G.C. unconscious and unresponsive. Based upon the mother's report, the child appears to have been sleeping in the bed with her. She contacted emergency responders who transported the infant to a nearby hospital where [redacted] was pronounced dead at 3:00 a.m. on May 22, 2016. This family had an open Family Voluntary Services (FVS) case at the time of G.C.'s death. The mother has two surviving children, age 11 years and 2 years, respectively.

The [redacted] County Coroner ruled on the official cause of death weeks following the fatality review. The preliminary cause of death of co-sleeping with an adult was changed to acute methamphetamine intoxication. This information was not available to the Committee at the time of the review.

Background

Children's Administration (CA) first became involved with this family in 2009 when an intake report was called in by a neighbor concerning the [redacted]. That child was [redacted] at the time. The referent stated concerns surrounding [redacted] as well as suspicion of methamphetamine and marijuana use by the mother. After failed attempts to locate the family, CA closed the case on February 19, 2009.

On February 10, 2014, CA received an intake alleging [redacted]. The concerns reported were [redacted]. The mother [redacted]. She disclosed to the department social worker that she would not be having any more children as she recognized

[4] FamLink is the case management information system that CA implemented on February 1, 2009. It replaced CAMIS, which was the case management system used by the agency since the 1990s.

[5] "Negligent treatment or maltreatment" means an act or omission that evidences a serious disregard of consequences of such magnitude as to constitute a clear and present danger to the child's health, welfare, and safety. The fact that siblings share a bedroom is not, in and of itself, "negligent treatment or maltreatment. [Source: RCW 26.44.020; CA Case Services Policy Manual Appendix A: Definitions]

she could not care for any more children. The allegations were determined to be unfounded[6] and the case was closed on November 13, 2014.

On RCW 74.13.515 2016, CA received an intake from a registered nurse (RN) alleging that newborn G.C. was at risk due to the mother's drug use and her lack of prenatal care. The hospital reported that the mother tested positive for marijuana and methamphetamine. G.C.'s cord sample was compromised and no drug screening results were obtained that may have helped to determine prenatal exposure to an illegal substance. The RN reported the mother to be minimally engaged and that she would leave the child often to go outside to smoke. A CPS investigator was assigned and responded to the hospital. The mother admitted to the assigned social worker that she used methamphetamine prior to her eldest child's birth; however, she denied current use. She informed the assigned social worker that she currently used marijuana and believed some of it to have been inadvertently laced with methamphetamine resulting in her positive drug test. The social worker had conversations with the mother about safe sleep[7] guidelines, advised against co-sleeping with G.C. and ensured that she watched the Period of Purple Crying[8] video. Ongoing services for the family, including transportation and basic needs, were discussed between the mother and social worker.

On April 14, 2016, CA received a new intake alleging that G.C. RCW 13.50.100 were neglected in their mother's care. The concerns reported were in regard to RCW 13.50.100 the sleeping arrangements for G.C. Further concern surrounded the RCW 13.50.100 . The CPS investigator visited the family home and discussed the allegations with the mother. The mother stated that she laid G.C.

[6] 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. 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 26.44.020]

[7] Safe Sleep is a nationwide campaign to promote safe sleeping habits for children. Safe sleep practice can reduce the risk of SIDS. According to the National Institute of Child Health and Human Development the top 10 safe sleep guidelines are: 1) Always place your baby on his or her back to sleep, for naps and at night. 2) Place your baby on a firm sleep surface, such as on a safety-approved crib mattress, covered by a fitted sheet. 3) Keep soft objects, toys, and loose bedding out of your baby's sleep area. 4) Do not allow smoking around your baby. 5) Keep your baby's sleep area close to, but separate from, where you and others sleep. 6) Think about using a clean, dry pacifier when placing the infant down to sleep, 7) Do not let your baby overheat during sleep. 8) Avoid products that claim to reduce the risk of SIDS because most have not been tested for effectiveness or safety. 9) Do not use home monitors to reduce the risk of SIDS. 10) Reduce the chance that flat spots will develop on your baby's head: provide "Tummy Time" when your baby is awake and someone is watching; change the direction that your baby lies in the crib from one week to the next; and avoid too much time in car seats, carriers, and bouncers. [Source: A Parent's Guide to Safe Sleep]

[8] The Period of Purple Crying is a method of helping parents understand the time in their baby's life where there may be significant periods of crying. During this phase of a baby's life they can cry for hours and still be healthy and normal. The Period of Purple Crying begins at about 2 weeks of age and continues until about 3-4 months of age. [Source: What is the Period of Purple Crying?]

on the bed rather than [redacted] sleeping basket after [redacted] woke up. She finally got [redacted] back to sleep after 3 hours and laid [redacted] on the bed hoping not to wake [redacted] The social worker discussed the risks of co-sleeping and suffocation and advised the mother to take the risk of waking the baby up by putting [redacted] in the basket for safe sleep. The social worker observed the rest of the home [redacted]. The family identified as possible [redacted] ancestry and a request to the inquiry unit was sent on April 14, 2016.

With the agreement of the mother, the investigation was transferred to the Family Voluntary Services (FVS) social worker on April 29, 2016. The identified needs for services were [redacted] parental education and chemical dependency assessment. The assigned CA social worker referred the family for Family Preservation Services (FPS),[9] a home-based service offered by the department. The FPS worker and department explored sleeping arrangements and basic infant care [redacted]. The service provider continued to encourage the mother not to co-sleep and to instead use the infant sleeping basket. The FPS provider did not suspect any current use of drugs by the mother, but reported that her appearance did correlate with a methamphetamine user. On May 10, 2016, the department completed a safety assessment that identified no safety threats. The assigned social worker spoke with collateral contacts who continued to express concern that the mother was using methamphetamines [redacted]. The department discovered through a collateral contact that a [redacted]. The mother cancelled chemical dependency assessments and FPS appointments on May 17, 2016 and May 24, 2016.

On May 23, 2016, the mother notified the Family Preservation Service provider of G.C.'s death, reporting she would not be doing any services that week. The FPS provider contacted the assigned social worker who reported the fatality to the CA intake reporting line. The mother admitted to authorities that G.C. had been sleeping with her on her adult-sized bed. She woke up at approximately 1:30 a.m. and found [redacted] unconscious and unresponsive. She stated she ran next door to her mother's residence for help. Her brother was said to have started CPR.

[9] Family Preservation Services (FPS), authorized and described in RCW 74.14C.050, are family-focused, behavior-oriented, in-home counseling and support programs. FPS may be used when youth are at substantial risk of placement or for children returning to the home from out-of-home care. FPS begins within 48 hours of referral, is available 24 hours a day, and can be up to six (6) months in duration. FPS is designed to be less intensive than IFPS/Homebuilders and interventions are focused on improving family functioning and assisting with getting connected to local community resources. FPS is provided by contracted vendors.

Paramedics arrived at the home at about 2:00 a.m. and transported the baby to the nearest hospital where [redacted] was later pronounced dead. The county coroner had yet to identify a cause or manner of death when the review took place.

Committee Discussion

For purposes of this review, the Committee focused on case activity that occurred prior to the fatality and most specifically on case activities during the 2016 involvement. The Committee discussed case assignment information that was provided in order to gain insight as to the functioning of the office from 2015 through 2016. The Committee acknowledged that the CPS response in 2014 was limited in relation to information gathering for assessment and should have closed according to the policy timeframes for investigations.[10] Though the Committee chose not to make a finding about this, they wanted their concerns included in the report for purposes of practice improvement.

The Committee discussed that during the 2016 investigations, there may have been an active safety threat[11] based on the information that was available to the department. Overall, the Committee believed there was a lack of curiosity, verification, corroboration and consultation while assessing safety, completing the investigation or during ongoing Family Voluntary Services. There were missed opportunities to truly understand the daily functioning in the home and the caregivers' ability to care for the children. The Committee spent considerable time discussing the importance of collateral contacts in conducting a comprehensive assessment of risk and safety. The Committee noted missed opportunities to gather additional clarifying information from the hospital and medical providers, from law enforcement, from the school, from DSHS databases and from other sources within the family's community, including the landlord and neighbors. The Committee believed that a Family Team Decision-Making meeting (FTDM),[12] a consultation with the Assistant Attorney General (AAG), a shared

[10] Per CA policy, a Safety Assessment is required to be completed no later than 30 calendar days from the date of an intake. The Structured Decision Making Risk Assessment® (SDMRA) is to be completed no longer than 60 days after the intake was received. Similarly, the Investigative Assessment is to be completed following conclusion of a CPS investigation, within 60 calendar days of CA having received an intake. [Source: CA Practices and Procedures Guide 1120; CA Practices and Procedures Guide 2540; CA Practices and Procedures Guide 2541]

[11] 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]

[12] A Family Team Decision-Making meeting (FTDM) is a facilitated team process, which can include birth/adoptive parents, guardians, extended family members, youth (as appropriate), community members, service providers, child welfare staff and/or caregivers. These meeting are held to make critical decisions regarding the placement of children following and emergent removal of child(ren) from their home, changes in out-of-home placement, and reunification or placement into a permanent home. There may be instances when an FTDM can be held prior to placement if there is

planning meeting[13] or case consultation may have assisted the department in obtaining additional and available information that would have promoted a thorough safety assessment.

Considerable Committee discussion focused on the department's assessment of the mother's alleged substance abuse. The Committee questioned whether the assigned social workers fully considered the impacts of the mother's current marijuana use and twice positive methamphetamine urinalyses in correlation to her ability to safely care for her children. The Committee was concerned that the workers may have taken the mother's statements about her drug use at face value and that further corroboration and collateral contacts may have improved the worker's assessment of the mother's ability to care for her children. The Committee identified that further training on how substance use impacts child safety and parental functioning would be beneficial for all staff members in CA.

The Committee considered the importance of case consultation and shared decision-making when dealing with complex cases like this one and that the consultation should include the AAG as well as program experts and CA staff at all levels in the chain of command. The Committee discussed whether this office might benefit from training with local AAGs that is focused on when to staff cases with an AAG and how to staff them productively. The Committee discussed the importance of their management team being present to support the process and staff.

Transferring cases between programs was a focus of conversation for the Committee. It was evident that a clear process for transferring cases should be followed by the local office follows to ensure all parties are aware of and understand their responsibilities related to case activity and gathering subsequent information related to child safety. Training was discussed as a potential need when social workers taking on overflow case assignments in secondary programs to assist workers in their understanding of policy and procedures related to that program.

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not an immediate safety threat such as a child who is on a hospital hold and an FTDM could provide placement options. Permanency planning starts the moment children are placed out of their homes and are discussed during a Family Team Decision-Making meeting. An FTDM will take place in all placement decisions to achieve the least restrictive, safest placement in the best interests of the child. By utilizing this inclusive process, a network of support for the child(ren) and adults who care for them are assured. Source: Family Team Decision-Making Meeting Practice Guide]

[13] 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.

The Committee discussed CA developing a protocol in response to fatalities on open cases. In deliberation, it was relayed that social workers and supervisors should be offered best practice guidelines involving response to investigations and/or fatalities involving substance abuse in conjunction with unsafe sleep allegations. The Committee discussed noticeable ambiguity that arises when responding to a fatality that is related to unsafe sleep practices. 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 confusion among staff about the meaning of the terms "SIDS"[14] and "SUID." While acknowledging that the CFR is focused on CA's actions and decision-making prior to the child's death, the Committee expressed concern that what appears to be a lack of consensus may be a system-wide issue with the professional entities involved.

Furthermore, the Committee discussed that best practice guidelines would suggest that the social workers complete a "Plan of Safe Care"[15] when children have been exposed to substances in utero regardless of whether it can be determined that the child has been affected from substances. The supervisors should verify that a Plan of Safe Care has been completed in a case note in all circumstances.

The Committee wanted to express its appreciation to the local office staff for their participation in the review and their cooperation in helping the Committee understand the "story" of the case. The Committee also wished to note an area of strong practice related to the number of conversations CA and providers had with the mother and documentation that was completed in regard to infant safe sleep.

Findings

After a review of the case chronology, interviews with staff and discussion, the Committee did not identify any critical errors. However, the Committee identified areas for practice improvement.

The Committee recognized that the investigation related to the April 2016 reports was incident-focused and lacked more comprehensive information from collateral sources that may have improved the department's assessment of risk

[14] 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]

[15] Children's Administration caseworkers must complete a "Plan of Safe Care" as required by the Child Abuse Prevention and Treatment Act (CAPTA) when a newborn has been identified as substance affected by a medical practitioner. Substances are defined as alcohol, marijuana and all drugs with abuse potential; including prescription medications. [Source: CA Practice and Procedures Guide 2552]

and safety. The Committee recognized that had further information been gathered to assess child safety during the investigation, there may have been an identified safety threat early on in the 2016 response. Additionally, the siblings in the home were not included in the safety assessment and the Committee believed that the CA staff should have gathered information on all of the children in the home. Had this information been sought out, it would have assisted the CA staff in completing a more comprehensive safety assessment and investigation. Sources of information or areas of corroboration the department could have used during its assessment include:

- Exploring and gathering information about all children in the home and their functioning.
- Obtaining medical and educational records for all of the children in the home.
- Obtaining criminal history for the caregivers in the home or people who frequent the home.
- Collaborating with Law Enforcement.
- Contacting the fathers and paternal relatives of the children.
- Verification of and curiosity in relation to the mother's statements or explanations of all situations.

Recommendations

The Committee recommends that the local office consider holding a Family Team Decision-Making meeting immediately at the local office or hospital when an infant has been exposed to drugs in utero and the parent denies use of drugs or the impact of such drugs on the infant.

To assist in information gathering and assessment, the local CA office Area Administrator, in conjunction with the CPS and FVS supervisors in the office, should devise a more specific method for case transfer that details the roles and responsibilities of the sending and receiving social workers. The receiving unit should ensure that there is sufficient information gathered from the sending party to proceed in ongoing safety assessment and case planning. If the sending party has not investigated other persons caring for the children or frequenting the home, obtained medical records and criminal histories and verified information given by the subjects and victims, the roles and responsibilities at transfer should outline who will follow up to gather the necessary information to complete comprehensive assessments (if the case is transferred without these items completed).

Finally, any unit taking on overflow case assignment responsibilities should be crossed-trained in the program from which that unit is receiving overflow cases if those responsibilities are not their primary program function.