RCW 74.13.640
RCW 74.13.640(d)

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

Children's Administration
Child Fatality Review

C.M.

August 2012
Date of child's birth

September 1, 2012
Date of fatality

November 14, 2012
Date of Child Fatality Review

Committee Members
Rebecca Benson, Referral Coordinator for CPS Projects, Public Health-Seattle & King County
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Executive Summary

On November 14, 2012, Children's Administration (CA) convened a Child Fatality Review[1] (CFR) Committee to examine the practice and service delivery in the case involving an eight-day-old male newborn named C.M. and his family. The incident initiating this review occurred on September 1, 2012 when the Des Moines Police Department received a 911 call from C.M.'s mother reporting her son was not breathing. The responding police officers and emergency medical technicians were unsuccessful in their attempts to revive C.M. The King County Medical Examiner later certified C.M.'s cause of death as Sudden Unexplained Neonatal Death. Premature birth, bed sharing with an adult on chronic opioid therapy and soft bedding were identified by the Medical Examiner as contributing factors to C.M.'s death.

The CFR Committee included CA staff and community members selected from diverse disciplines with relevant expertise, including social work, child welfare, chemical dependency, maternal-infant public health and the Office of the Family and Children's Ombudsman. Neither CA staff nor committee members had previous direct involvement with the case. A CA supervisor contacted one member of the committee at the time of the fatality to determine if C.M. and his mother had received community-based maternal and nutritional services. This committee member responded to the supervisor's questions but had no direct contact with the family. Prior to the review, each committee member received a case chronology of known information regarding the parents and child, and un-redacted CA case-related documents. Additional documents were made available to the committee at the time of the review. These included medical and law enforcement records, Safe to Sleep[2] guidelines, and relevant CA policies and practice guides.

During the course of the review, the CFR Committee members interviewed the Child Protective Services Supervisor assigned to C.M.'s case at the time of the fatality. The assigned social worker was not available for an interview.

Following review of the case file documents, interviews, and discussion regarding social work activities and decisions, the review committee made findings and recommendations, which are detailed at the end of this report.

RCW 74.13.515

Case Overview

C.M. was the only child of his mother, R.S. and his father, T.M. Children's Administration (CA) had no involvement with C.M's mother prior to C.M.'s birth in August of 2012.

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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 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 deceased child's life or death. 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] Safe to Sleep Campaign seeks to inform parents and caregivers of the American Academy of Pediatrics' recommendations for reducing SIDS as well as other sleep-related causes of infant death. Source: National Institutes of Health website; www.nih.gov

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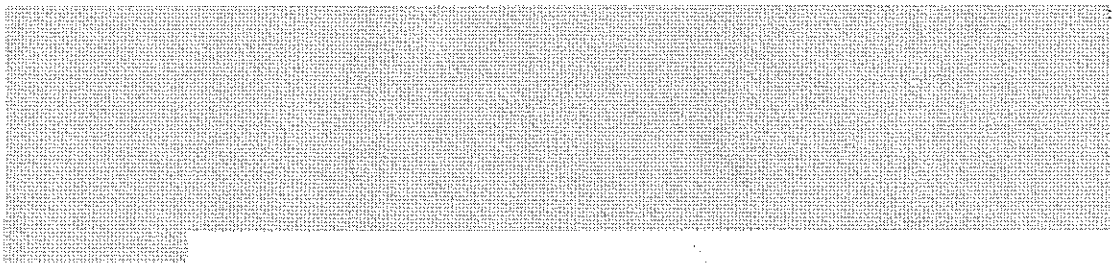

A CPS intake was received from a hospital social worker shortly after C.M. was born. The social worker reported C.M. had a presumptive positive[5] test result for prenatal exposure to opiates. C.M. was born at 36.5 weeks gestation; showed no signs of drug withdrawal; and a discharge from the hospital was expected on August 27, 2012. C.M.'s mother indicated to hospital staff she had used methadone and Oxycodone prescribed to her and marijuana during her pregnancy. The hospital social worker reported concerns about C.M.'s mother using medication in amounts beyond the prescribed dosages, possibly using controlled medications obtained without prescriptions, and the impact of the medications on the mother's ability to care for a premature infant.

The intake was screened-in for a non-emergent response.[6] On August 26, 2012, when CA learned C.M. was being discharged earlier than initially planned, a CA social worker was dispatched to the hospital. The CA social worker documented contact with C.M., his parents, and extended family members and made plans to follow-up with the family to schedule a home visit. The social worker documented contacting the family by phone on August 30, 2012 and scheduled a home visit following the social worker's return to work after a planned vacation. The social worker scheduled the home visit for either September 11 or 12.

Before that visit could take place however, CA received notification from the King County Medical Examiner's office of C.M.'s death on September 1, 2012. According to the investigator, C.M.'s mother reported she woke at 6:00 a.m. to take care of C.M. She soon returned to bed and placed C.M. beside her. R.S. positioned C.M. next to one of her legs. She slept until 11:00 a.m.when she found C.M. was unresponsive. R.S. was the

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3 CA intake social workers receive, gather, and assess information about a child's need for protection or request for service. Intake social workers determine program response type and response times(emergent or non-emergent) for an investigation.CA intakes fall into three categories: CPS – Involves a child who is allegedly abused, neglected, or abandoned and includes child abuse allegations. CPS Risk Only – Involves a child whose circumstances places him or her at imminent risk of serious harm but does not include child abuse allegations. Non-CPS – Involves a request for services for a family or child. The caregiver, child, community member, or agent of another state can make the service request. Programs include DLR Rule Infraction, Family Voluntary Services , Family Reconciliation Services , Child and Family Welfare Services , IV-E and non-IV-E Tribal/Band Placement/Payment Only, Interstate Compact on the Placement of Children , Adoption and Private Adoption.

4 CA findings are based on a preponderance of the evidence. Child Abuse or Neglect is 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.

5 A positive screening drug test result is considered a "presumptive positive" until confirmed by gas chromatography–mass spectrometry. Source: www.ncsacw.samhsa.gov

6 A non-emergent response requires CA social workers to have face to face contact with all alleged child abuse or neglect victims within 72 hours from the date and time CA receives the intake. Source: Children's Administration Policy 2310.

only adult in the home at the time. She first called C.M.'s father before calling 911. A CPS risk-only[7] intake reporting C.M.'s death was assigned for follow-up. The CPS social worker documented contact with C.M.'s parents before closing the case on November 9, 2012.

On October 31, 2012, the King County Medical Examiner completed the autopsy report. The Medical Examiner certified C.M.'s cause of death as Sudden Unexplained Neonatal Death. The identified contributing factors included C.M.'s prematurity, bed sharing with an adult on chronic opioid therapy and soft bedding. C.M.'s toxicology report indicated a positive result for methadone.

Discussion

The committee discussed how possible parental substance abuse impacted this case. There was recognition of the challenges faced by CA social workers when trying to fully assess clients for possible chemical dependency. Some clients may intentionally minimize their drug use or need for treatment. Using validated screening tools and obtaining collateral information are essential when assessing for substance abuse. The committee learned how access to treatment for pregnant or parenting women is given the highest priority by treatment providers and is readily available in the local community.

The intake screening decisions on all the intakes associated with C.M. or his parents and subsequent investigative findings were discussed. The discussion included the distinction between risk-only intakes and intakes screened-in based on specific allegations of child abuse or neglect. Also discussed were CA guidelines for screening and investigating reported unexpected infant deaths. The committee supports CA's ongoing efforts to strengthen statewide consistency in this area of practice.

The committee reviewed the various assessment tools completed during this CPS investigation. The committee questioned how quickly the tools were completed after the investigation was initiated and noted some of the assessment information documented by the social worker was incongruent with the facts of the case. The lack of a home visit, collateral contacts and in-depth interviews with the parents prior to the completion of the safety assessment were concerning to the committee.

The committee was interested in learning how supervisors manage caseloads when social workers are on leave and how social workers communicate with their supervisors or co-workers about specific cases prior to taking leave.

Some of the committee members remarked how their participation in this review prompted them to think of ways to improve how their own organizations provide parents with information about infant safe sleeping practices.

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7 RCW 74.13.031 (3) requires Children's Administration to "investigate complaints of any recent act or failure to act on the part of a parent or caretaker that result in the death of a child…." The deceased child must be identified as a victim. The 24 hour or 72 hour response time requirements are removed when there are no other children in the home.

The committee made the following findings and recommendations based on interviews, review of the case records, department policy and procedures, Revised Code of Washington (RCW), Washington Administrative Code (WAC), and medical documents.

Findings

1. On August 25, 2012, a hospital social worker called CA to report concerns of suspected parental substance abuse presenting possible risks to C.M.'s safety and well-being. The committee believes the screening decision on the resulting CPS intake should have been based on imminent risk of serious harm[8] in the absence of a specific allegation of child abuse or neglect[9] to be consistent with CA policy. The committee acknowledges regardless of the intake screening decision, CA initiated contact with the family prior to C.M.'s discharge from the hospital.
2. According to CA's practice guide and RCW 74.13.031, intakes reporting child death resulting from alleged child abuse or neglect will be accepted for investigation. The practice guide further stipulates the deceased child will be identified on the intake as a victim. The committee believes the intake reporting C.M.'s death should have been screened in based on alleged child abuse or neglect instead of imminent risk of serious harm and C.M. should have been identified as a victim of alleged child abuse or neglect.
3. Timely completion of the Global Appraisal of Individual Needs – Short Screener (GAIN-SS)[10] may have been beneficial in assessing for possible parental substance abuse and the need for further drug and alcohol evaluation.
4. The committee believes due to the concerns of parental substance abuse, prior CPS history, and C.M.'s age and prematurity, an initial assessment of safety and possible safety planning were warranted prior to his discharge from the hospital. If that was not possible, there should have been immediate follow-up with the family in their home.
5. The committee found little documented evidence of comprehensive information gathering by the social worker. In particular, the committee was concerned with the lack of collateral contacts and postponement of the initial home visit for several weeks while the social worker was on leave from work.
6. In the view of the committee, several of the assessment tools completed by the social worker did not accurately reflect the facts of the case.

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8 CA investigates intakes that do not allege an actual incident of child abuse or neglect but have risk factors that place a child at imminent risk of serious harm.

9 Washington state law defines abuse or neglect as "sexual abuse, sexual exploitation, or injury of a child by any person under circumstances which cause harm to the child's health, welfare, or safety, or the negligent treatment or maltreatment of a child by a person responsible for or providing care to the child. Source: RCW 26.44.020

10 RCW 71.05.027 requires all DSHS Administrations to use the Global Appraisal of Individual Needs – Short Screener (GAIN-SS) to screen for substance abuse, mental health and co-occurring disorders.

Recommendations

1. Provide training on infant safe sleeping practices and infant growth and development to all CA social workers.
2. CPS social workers should complete the GAIN-SS at the time of initial investigative contact with the parent(s) identified as a subject on the intake or person(s) acting in the role of parent and living in the child's home.
3. Refer all CPS cases in King County involving infants with identified social, developmental or health needs to the Seattle-King County Public Health Department for home visiting by a public health nurse.