Washington State Department of Social & Health Services

CA Children's Administration

Child Fatality Review

E.G.

January 2014
Date of Child's Birth

March 21, 2014
Date of Fatality

June 19, 2014
Child Fatality Review Date

Committee Members
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Executive Summary

On June 19, 2014, the Department of Social and Health Services (DSHS), Children's Administration (CA) convened a Child Fatality Review (CFR)[1] to assess the department's practice and service delivery to seventy-two-day-old E.G. and his family. In this report, E.G. is referred to by his initials. The incident initiating this review occurred on March 21, 2014 when E.G. was found non-responsive in bed with his mother and maternal great-grandmother. E.G. was in the care of his mother at the time of his death. E.G. and his mother lived with the maternal great-grandparents at the time of his death. The medical examiner determined E.G's death to be unexplained infant death with parental co-sleeping and the manner of death was classified as undetermined. CA had an open Family Voluntary Services (FVS) case with the family at the time of E.G.'s death; CA opened a case the previous month after E.G.'s twin brother passed away while sleeping in bed with their mother.

The Review Committee included members selected from diverse disciplines within the community with relevant expertise including a Department of Health Child Death Review Coordinator, Children's Administration Statewide QA/CQI Manager, Child Protective Services (CPS) Program Manager, FVS Supervisor and the Ombuds Office. An Assistant Attorney General was also present to consult regarding any legal questions. Another community professional with expertise in fatality investigations was unable to attend due to an emergency. Neither CA staff nor any other Committee members had previous direct involvement with this family.

Prior to the review, each Committee member received a case chronology, a summary of CA involvement with the family and unredacted CA case file documents (e.g., intakes, investigative assessments, investigative assessment tools, case notes and medical records). Supplemental sources of information and resource materials were available to the Committee at the time of the review. These included the medical examiner's report, a law enforcement report, the mother's CPS history as a child, relevant state laws and CA policies.

[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 near fatal injury. Nor is it the function or purpose of a Child Fatality Review to recommend personnel action against DSHS employees or other individuals.

During the time this case was open to CA, E.G. and his mother moved to three different familial locations. Staff from each of the three offices that had jurisdiction of the case were interviewed by the Committee. The case started in Everett then moved to Bellingham and ended in the Smokey Point office in Arlington.

Family Case Summary

This family came to the attention of CA on February 2, 2014 when an intake was received regarding the death of E.G's twin brother. The caller reported concerns for possible neglect related to co-sleeping[2]/bed sharing[3] on a deflating air mattress. E.G., his brother and their mother were sleeping on the mattress. The mother's significant other was sleeping in the same room but not on the mattress when E.G.'s twin brother was found unresponsive. E.G.'s brother was taken to a hospital. On February 7, 2014, E.G.'s sibling was taken off life support and he passed away that same day. At the time of the first intake, E.G. and his brother were one-month-old.

At the time of E.G.'s brother's death, E.G., their mother and mother's significant other were living with E.G.'s maternal aunt and her family. The aunt's family is comprised of a toddler and two parents. The two families were sharing a two bedroom apartment.

The intake received on February 2, 2014 was assigned for a risk only CPS investigation.[4] Based on the family's address, the investigation was assigned to the Everett office. The CPS worker contacted the family at the hospital and learned of the mother's plan to move in with her own mother, E.G.'s maternal grandmother, in Bellingham. The CPS worker continued to assess the safety of E.G. and the circumstances surrounding E.G.'s sibling's medical situation.

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[2] Co-Sleeping: A sleep arrangement in which the parent (or another person) and infant sleep in close proximity (on the same surface or different surfaces) so as to be able to see, hear, and/or touch each other. Co-sleeping arrangements can include room sharing or bed sharing. The terms "bed sharing" and "co-sleeping" are often used interchangeably, but they have different meanings. [Source: National Institute of Health]

[3] Bed Sharing: A sleep arrangement in which an infant sleeps on the same surface, such as a bed, couch, or chair, with another person. Sleeping with a baby in an adult bed increases the risk of suffocation and other sleep-related causes of infant death. [Source: National Institute of Health]

[4] Risk Only Intakes: CA will screen in a CPS Risk Only intake when information collected gives reasonable cause to believe that risk or safety factors exist that place the child at imminent risk of serious harm. In assessing imminent risk of serious harm, the overriding concern is a child's immediate safety. Imminent is defined as having the potential to occur at any moment, or that there is a substantial likelihood that harm will be experienced. Risk of Serious Harm is defined as: A high likelihood of a child being abused or experiencing negligent treatment or maltreatment that could result in one or more of the following outcomes: death; life endangering illness; injury requiring medical attention; substantial risk of injury to the physical, emotional, and/or cognitive development of a child. [Source: CA Practices and Procedures Guide 2220(D)]

The mother and her family members agreed to a safety plan. The safety plan directed the mother to no longer co-sleep with E.G. and the mother was not to be left alone with E.G. The CPS worker educated the mother on the risks of co-sleeping in conjunction with the other identified concerns present with this family. The mother told the CPS worker she has a prescription for muscle relaxants and pain medications. After the safety plan was completed, family members expressed concern for the mother's inability to wake to care for the children while she was taking the medications.

The CPS worker contacted collateral sources which included law enforcement and medical personnel related to this investigation. On February 10, 2014, the CPS worker and the CPS supervisor called the Bellingham DSHS/CA office and spoke with a CPS supervisor. The Everett office requested the Bellingham office to do a preliminary assessment of the maternal grandmother's home to assess whether it was a safe environment for E.G.

On February 14, 2014, a new intake was received from a mental health professional. The caller reported the mother was brought in by law enforcement the previous night. She was intoxicated and had been in "shoving match" with her mother and others at the home. According to the caller, the mother wanted to take E.G. to bed and lay down with him, thus violating the safety plan put in place by the Everett CPS worker. This intake initially screened out. A CPS supervisor in Bellingham changed that screening decision but then after staffing the case with the Everett Area Administrator, a decision was made to screen out the intake. Since the intake was screened out, a formal investigative assessment was not completed.[5]

On February 14, 2014, a CPS supervisor from the Bellingham office conducted an unannounced visit at the maternal grandmother's home. The mother admitted to consuming too much alcohol the previous night. Although the mother denied having a drinking problem, she admitted that she cannot stop drinking once she starts. The supervisor discussed with the mother what a safe sleep environment would be for E.G. The Bellingham office determined it would be appropriate to

[5] The Investigative Assessment (IA) must be completed in FamLink within 60 calendar days of Children's Administration receiving the intake. A complete Investigative Assessment will contain the following information: A narrative description of: History of CA/N (prior to the current allegations, includes victimization of any child in the family and the injuries, dangerous acts, neglectful conditions, sexual abuse and extent of developmental/emotional harm). Description of the most recent CA/N (including severity, frequency and effects on child). Protective factors and family strengths. Structured Decision Making Risk Assessment (SDMRA) tool. Documentation that a determination has been made as to whether it is probable that the use of alcohol or controlled substances is a contributing factor to the alleged abuse or neglect. Disposition; e.g., a description of DCFS case status. Documentation of Findings regarding alleged abuse or neglect.[Source: CA Practices and Procedures Guide 2540]

open a Family Voluntary Services (FVS) case with the family. The mother agreed to voluntary services through CA.

Earlier that day, the maternal grandmother told the CPS worker in Everett she failed to maintain the safety plan and had allowed the mother to be alone with E.G. The grandmother was reminded of the importance of the safety plan and the possible outcome of legal intervention by the department if the safety plan is not followed. This information was documented in a case note.

On February 21, 2014, an intake was received stating the mother arrived at a medical appointment for E.G. smelling of cigarettes and marijuana. The medical professional informed the mother about the dangers of exposing a child to secondhand smoke. The caller also expressed concern because E.G. appeared agitated and irritated. This intake was assigned to a Bellingham CPS worker. That same day, a referral for Project Safe Care services was made by the FVS worker in Bellingham.[6] On February 22, 2014, an afterhours CPS worker conducted a home visit to assess the intake received the prior night. The CPS worker did not detect any smoke smell and observed E.G.'s sleeping arrangements. During the CPS investigation regarding the February 21, 2014 intake, the Bellingham CPS worker discussed the safety plan, appropriate care for a newborn and the mother was provided a list of community resources regarding grief and parenting. The CPS investigation resulted in an unfounded finding.[7]

On February 28, 2014, the FVS worker, along with the Project SafeCare® worker, visited the mother and E.G. The grandmother confirmed E.G. is never left alone with the mother and the mother denied co-sleeping with E.G. The mother reported she stopped taking her prescribed pain medications. On March 4, 2014, Project SafeCare® conducted a double session with the mother.

On March 11, 2014, the Project SafeCare® provider notified the Bellingham FVS worker that the mother and E.G. were kicked out of the maternal grandmother's home on March 6, 2014 and moved to the maternal great-grandparents' home in Arlington (Smokey Point CA office jurisdiction). The mother reportedly had a fight with the maternal grandmother which resulted in the move. The FVS worker called the grandmother who said E.G.'s mother appeared to struggle with

[6] Project SafeCare® is a weekly home based service lasting 18-20 sessions for families with a child from age birth to 5 years. The expected outcome is to increase parents' understanding and management of child illness and injuries; increase home safety; and improve and enhance safe parenting skills. The provider reviews the safety plan each week. There is no afterhours support for the family. [Source: CA Evidence Based Practices Description and Directory]

[7] Unfounded means: The determination following an investigation by CPS that, 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 as defined in WAC 388-15-009. RCW 26.44.020 [Source: CA Practices and Procedures Guide 2540(A)(5)(b)]

maintaining a calm demeanor and would often yell and scream. The grandmother was concerned by the mother's choice to not engage in mental health counseling.

On March 12, 2014, the Bellingham CA office notified the Smokey Point CA office of the change in circumstances and residence for E.G. and his mother. The Smokey Point office immediately sent out a CPS worker to the maternal great-grandparents' home. During that home visit, the great-grandmother answered a phone call from the mother who was at a medical appointment for E.G. The phone was on speaker and the mother was overheard telling her grandmother to not inform the CPS worker she had been co-sleeping with E.G. The great grandmother told her the CPS worker already had learned that information before the phone call. The family was notified that a Family Team Decision Making Meeting (FTDM) was scheduled for the following day at the Smokey Point office.[8] The mother was requested to provide a urinalysis (UA) the following morning before the FTDM.

There was an internal discussion between the two CPS supervisors and the FVS supervisor in the Smokey Point Office the day before the FTDM was held. A dependency petition was drafted the day before the meeting based on the discussion and majority opinion that there was a need to request removal of E.G. from his mother's care based on the mother's failure to maintain the safety plans and unaddressed or unassessed mental health and substance abuse issues. The CPS supervisor who was drafting the petition also attended the FTDM. The Area Administrator was not part of this meeting.

On March 13, 2014, the mother, her family and supports were present for the FTDM. The Smokey Point CPS worker and her supervisor were also present. CA and the family agreed to a safety plan which included the great-grandmother sleeping in the same bed with the mother to prevent her from further bed sharing with E.G. The mother had failed to provide a UA that morning and was once again asked to submit a sample. The Area Administrator, who participated in the second half of the FTDM, directed the FVS supervisor to devise a safety plan with the mother and her family after the FTDM had concluded. The mother agreed to a chemical dependency assessment, attendance at sober support groups, ongoing random UAs, continued participation in Project SafeCare® services and to live in her current location (with the maternal great grandparents).

[8]Family Team Decision Making (FTDM) meetings bring people together who are involved with the family to make critical decisions regarding the removal of child(ren) from their home, changes in out-of-home placement, and reunification or placement into a permanent home. [Source: CA Practices and Procedures Guide 1720 Purpose Statement]

On March 18 and 20, 2014, the assigned Smokey Point FVS social worker made two unannounced home visits. On the first visit, the mother appeared impaired. The mother stated if E.G. is going to die she wants him to die in her arms. The mother also told the FVS worker she had to make appointments with her as opposed to showing up unannounced. The FVS worker informed the mother that while she is assessing the safety of E.G. and getting to know the family better her practice is to make unannounced home visits. The FVS worker was thorough in her documentation regarding her discussions of grief, safe care for an infant and safe sleep. On the second unannounced visit, the FVS worker found the mother not impaired but remained concerned about the mother's ability to maintain the safety plan parameters. However, based on both of the unannounced visits, the FVS worker remained concerned for the safety of E.G. The FVS worker spoke with her supervisor about possibly filing a dependency petition if the situation continued.

On March 21, 2014, an intake was received stating E.G. was found unresponsive and brought to the hospital. The mother later admitted to bed sharing with E.G. at the time of his death. That same day the UA results from March 13 were received by the CA office. The UA was positive for a number of differing substances and it is unknown if they were prescribed.

Committee Discussion

The Committee interviewed nine staff members in person and four staff members by phone. The Committee's discussion focused on safety planning, identification of risk factors in conjunction with co-sleeping and/or bed sharing, service delivery to ameliorate risk factors and staff communication.

There was an overarching theme throughout the review of timely and thorough communication between the three offices and appropriate response times in relation to learning of the residential changes by the family.

The Committee acknowledged this case was open for only thirty-four business days. During that time, E.G. and his mother moved three times, thus involving contact and services with three CA offices. Collateral contacts shared both supportive and concerning details regarding the mother's ability to safely care for E.G. During the death investigation in February, law enforcement and the hospital provided supportive comments regarding the mother and her ability to care for E.G. as did the Bellingham Project SafeCare® worker. However, other medical providers who called in intakes, expressed concerns regarding the mother's ability to safely care for E.G.

It was clear based on a majority of the staff interviews that it was difficult for the involved CA workers to distinguish between the mother's grief over the loss of E.G.'s twin and other possible contributing factors for her behaviors.

The Committee discussed case junctures where there were missed opportunities to assess the mother's mental health and chemical dependency. However, the Committee acknowledged there were also times that the mother was provided community resources to address her grief and loss. The Everett CPS worker obtained grief support information in the Bellingham area and provided this to the mother and grandmother. When the Everett CPS worker obtained concerning information from the mother's medical provider, she immediately shared the information with the FVS worker in Bellingham. The Committee noted the mother was in the Bellingham catchment area for eighteen working days. During that time, a CPS supervisor, CPS worker, afterhours CPS worker, FVS worker and Project SafeCare® staff made contact with the mother. The FVS worker was attempting to build a trusting relationship with the mother and had planned on requesting the mother to complete a chemical dependency assessment but was unable to do so before the mother moved to Arlington (Smokey Point office).

CA staff has the ability to consult with Assistant Attorneys General (AAGs) regarding legal sufficiency to file a dependency petition to either work with an in-home or out-of-home plan for a child or children. In this particular case, consultation was not sought. The Committee noted this would have been appropriate at the time of the FTDM on March 13, 2014.

The Committee identified areas of quality practice during this review. The areas of quality practice are:

- The Committee agreed that the first intake on February 2, 2014 was comprehensive.
- The Committee agreed that the Everett CPS worker communicated effectively with the family, law enforcement, medical professionals and the Bellingham CA office. The CPS worker's communication was consistent and her documentation was thorough.
- The Smokey Point FVS worker was knowledgeable about safe sleep and spoke with a clear understanding of child safety.

Findings

- The Committee found the February 14, 2014 intake should have screened in for a CPS investigation.
- The department did not obtain a copy of the police report and mental health records from the February 13, 2014 incident. These documents

could have informed the investigation and assessment of the mother's ability to safely care for E.G.

- Chemical dependency services, including urinalyses and a mental health assessment for the mother, could have informed the investigation following the February 13, 2014 incident and could have strengthened the investigation and assessment.
- The Committee found that the Smokey Point office should have consulted with an Assistant Attorney General (AAG) on March 13, 2014, to see if there was legal sufficiency to file an out of-home dependency petition. The factors the Committee considered to be imminent safety risks were: the mother did not follow the safety plan by co-sleeping/bed sharing with E.G.; the mother's alleged substance abuse issues and the mother's inability to control her behaviors to such a degree that she was asked to leave the maternal grandmother's residence.
- Another resource available to CA staff is Practice Consultants. The Committee agreed a Practice Consultant could have been utilized to provide a chronology of this case as part of a discussion related to the safety of E.G. in his mother's care. This case included the fatality of a twin sibling, three moves to three different CA offices, five intakes and inconsistent communication from safety plan participants all within 34 business days. Those factors made assessing this case very challenging for CA staff.
- The Committee found many of the CA staff struggled with allowing the mother to grieve the loss of E.G.'s twin yet assessing for risk to E.G.'s safety at the same time. The Committee found many staff believed the mother's mannerisms or behaviors were related to grief rather than possible pre-existing or mental health or substance abuse issues. It also appeared that many staff members were incident-focused on the issue of the mother co-sleeping/bed sharing instead of identifying other safety risks.

Findings Related to Safety Planning

- The Committee questioned the use of a safety plan that requires a parent to be supervised by a third party at all hours of the day and night. The Committee found that this type of plan is not manageable and if it is necessary to consider such a plan, then a consultation with the AAG's office as to whether there is legal sufficiency to file a dependency petition should occur.
- The Committee also found there was no monitoring of the first safety plan out of the Everett CA office. The identification of a monitoring person or

persons in a safety plan, day and night, is essential to the effectiveness of a safety plan.

- The Committee also suggested that the Bellingham CA office should have conducted an FTDM and engaged the family in creating their own safety plan.
- The Committee questioned the decision by the Smokey Point office to have the FVS supervisor engage the family in creating a safety plan given that the supervisor was not present during the FTDM. The Committee believes the FVS supervisor should have either been in the meeting from the beginning or that the CPS supervisor and AA who had been a part of the FTDM should have constructed the safety plan.

Recommendations

- The Committee recommended that all staff receive updated training on a regular basis regarding assessing safety throughout the life of a case and writing effective safety plans. The Committee stated the best method to meet this recommendation would be to utilize infield mentoring by the Alliance for Child Welfare Excellence. The Committee also acknowledged that small workgroup such as in unit meetings versus large classroom education would be a second, less preferred option.
- The Committee recommended that CA remind staff about practice consultation resources available through CA Quality Improvement or Policy Divisions. The names and contact information for the Practice Consultants and Policy Program Managers should be provided to all staff on a regular basis.