Washington State Department of Social & Health Services

CA Children's Administration

Child Fatality Review

K.A.

February 2011
Date of Child's Birth

May 1, 2014
Date of Fatality

August 14, 2014
Child Fatality Review Date

Committee Members

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Dawn Cooper, MSW, Family Assessment Response (FAR) Project Manager, Children's Administration, Department of Social and Health Services

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Executive Summary

On August 14, 2014 the Department of Social and Health Services (DSHS), Children's Administration (CA) convened a Child Fatality Review (CFR) to assess the department's practice and service delivery to three-year-old K.A. and his family.[1] K.A. will be referenced by his initials throughout this report.

The incident initiating this review occurred on May 1, 2014 when K.A. was brought to the emergency department by his mother. K.A. was pronounced deceased at the hospital. A medical examiner's report stated K.A.'s manner of death is certified undetermined and the cause of death is acute Methadone[2] and Alprazolam[3] intoxication. Renton Police Department investigated the circumstances surrounding the death of K.A. and the case is currently under review by the King County Prosecutor's Office. At the time of his death K.A. lived with his mother and her boyfriend. Children's Administration (CA) had an open Child Protective Services (CPS) investigation at the time of the fatality.

The Review Committee included members selected from diverse disciplines within the community with relevant expertise including a Public Health Nurse (PHN), a law enforcement sergeant specializing in child related crimes, a Family Assessment Response (FAR)[4] program manager and the Ombuds Office. A representative from the chemical dependency field was originally invited to be a member of the Committee but was sick and unable to participate. 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 documents (e.g., intakes, investigative assessments, case notes and a law enforcement report). Supplemental sources of information and resource materials were

[1] Given its limited purpose, a Fatality Review (CFR) should not be construed to be a final or comprehensive review of all of the circumstances surrounding the near 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.

[2] Methadone is a very strong painkiller. It is also used to treat heroin addiction. [Source: MedlinePlus http://www.nlm.nih.gov/medlineplus/ency/article/002679.htm]

[3] Alprazolam is used to treat anxiety disorders and panic disorder (sudden, unexpected attacks of extreme fear and worry about these attacks). Alprazolam is in a class of medications called benzodiazepines. It works by decreasing abnormal excitement in the brain. [Source: Medline Plus http://www.nlm.nih.gov/medlineplus/druginfo/meds/a684001.html]

[4] Family Assessment Response: a Child Protective Services alternative to investigations of low to moderate risk screened-in reports of child maltreatment. [Source: http://www.dshs.wa.gov/ca/about/far.asp]

available to the Committee at the time of the review. These included the current case files, medical examiner's reports, the father's CPS history as a child, material regarding medications referenced in the Medical Examiner's report, relevant state laws and CA policies.

During the course of this review, the Committee interviewed the initial CPS worker, subsequent CPS workers, a Child and Family Welfare Services worker (CFWS) and two CPS supervisors involved in this case. Following the review of the case documents, completion of staff interviews and discussion regarding department activities and decisions, the Committee made findings and recommendations presented at the end of this report.

Family Case Summary

This family came to the attention of CA on February 25, 2011, when an intake was received regarding the birth of K.A. The information reported did not allege abuse or neglect and therefore it did not meet the legal definitions for abuse or neglect. This referral was screened out. A second intake was received on February 28, 2011, alleging concerns of marijuana use by the father and the mother's refusal to disclose her chemical dependency history. The caller reported the mother fell asleep in a chair while holding K.A. and was counseled regarding the risks of co-sleeping while using medications. This intake was assigned for a CPS investigation.

The CPS worker met the family at the hospital and the family agreed to a Public Health Nurse (PHN) referral. Per CA case notes, the PHN was challenged at times to maintain communication with the family due to the parents not making themselves available or returning phone calls. The PHN provided positive remarks regarding the family to the CPS worker after she did make contact and interacted with the family. The CPS investigation resulted in an unfounded finding and closed on June 30, 2011.[5]

On February 15, 2013, CA received an intake alleging drug use by the mother and drug sales out of her home. The caller also reported that the mother's drug paraphernalia was within reach of K.A. The caller reported the paternal grandparents conducted a drug test on K.A.'s diaper and it was positive for heroin. This intake was assigned for a CPS investigation. The assigned CPS worker made contact that same day with K.A. and his mother at their home. The allegations were not substantiated at that time. However, due to workload issues

[5] Unfounded: 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. WAC 388-15-005

the CPS worker did not complete the investigation. Due to high caseload counts a CFWS worker was assigned to complete this investigation. A CFWS worker completed the investigation and the Investigative Assessment (IA).[6] Before the completion of that CPS investigation another intake was received on March 1, 2013. The allegations were reportedly documented in the February 15, 2013 intake and therefore the March 1st intake was not assigned for an investigation.

During the February 15, 2013 investigation the CFWS worker made three unannounced home visits and two phone calls in an attempt to meet and speak with the mother and K.A. in person. The mother would not make herself or K.A. available to the CFWS worker. The CFWS worker completed the IA as unfounded for the February 2013 intake.

On April 26, 2014, two law enforcement officers were dispatched to a call alleging that a passerby observed the mother smoking something off tinfoil while K.A. was in the backseat of the vehicle. The vehicle was parked on the side of the road with a male passenger in the front seat. When law enforcement arrived they found the mother and K.A. in the car. The responding officers did not find any drugs or drug paraphernalia in the car and were unable to re-contact the reporting party. The officers contacted the mother's boyfriend who came and took the mother and K.A. home. This report was mailed to CA intake and received on April 30, 2014. This intake was assigned for a CPS investigation on the same day it was received.

On May 1, 2014, the CPS worker arrived at K.A.'s home. She was met by law enforcement officers who were outside the residence. K.A. had been taken to an emergency department by his mother only hours before the CPS worker's arrival. K.A. was pronounced dead upon medical examination at the hospital. When K.A. arrived at the hospital, he had visible physical trauma. Law enforcement asked the CPS worker to not speak with the mother or others related to this case until further notice.

[6] 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]

Committee Discussion

The Committee discussion focused on CA policy, practice and system responses in an effort to evaluate the reasonableness of decisions made and actions taken by the department. Discussions occurring as to the family involvement with non-CA agencies was considered outside the purpose and scope of the CFR but served to generate discussion on interagency collaboration as well as collateral resource gathering.

The Committee noted the department did not obtain collateral information in order to conduct a thorough CPS investigation. The Committee noted there were many opportunities for the assigned department staff to obtain and verify allegations if the department had conducted collateral contacts during investigations. The department staff did not seek out or request medical records, criminal history, court records or contact extended family members. The lack of collateral information was noted by the Committee to have negatively impacted the accurate completion of the Structured Decision Making® tool, which informs the department when services may or must be offered.[7]

On the day before the review the department received medical records from the investigating law enforcement agency. The medical records indicated K.A. had been evaluated and treated by a local hospital for ingesting Suboxone[8] on February 7, 2012. K.A. had also been treated on March 9, 2014 for a head injury which required sutures. Neither medical intervention was reported to either law enforcement or CPS.

Staff interviews informed the Committee there were many changes to this local office starting shortly before the department received referrals regarding K.A. and his family. There have been three Area Administrators, significant turnover of senior CPS staff and a Central Case Review which recommended practice improvements regarding child safety.

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[7] Actuarial risk assessment is a statistical procedure for estimating the probability that a critical event will occur at some future time. Structured Decision Making® (SDM®) uses factors associated with higher rates of abuse and neglect to identify families who are most likely to experience a future event of child abuse or neglect. SDM® supports Children's Administration staff in making decisions about the highest risk families who should receive intervention. [Source: http://www.dshs.wa.gov/ca/pubs/sdm.asp] The Structured Decision Making Risk Assessment® (SDMRA®) is a household-based assessment focused on the characteristics of the caregivers and children living in that household. By completing the SDMRA® following the Safety Assessment, the worker obtains an objective appraisal of the risk to a child. The SDMRA informs when services may or must be offered. [Source: CA, Practices and Procedures Guide 2541]

[8] Subutex (buprenorphine hydrochloride) and Suboxone tablets (buprenorphine hydrochloride and naloxone hydrochloride) are approved for the treatment of opiate dependence. Subutex and Suboxone treat opiate addiction by preventing symptoms of withdrawal from heroin and other opiates. [Source: U.S. Food and Drug Administration http://www.fda.gov/drugs/drugsafety/postmarketdrugsafetyinformationforpatientsandproviders/ucm191520.htm]

The Committee was made aware, by all of the staff interviewed, of high staff turnover within the office during both the 2011 and 2013 investigations. The Committee was told of a decision by the office to utilize workers from other program units as well as other King County Children's Administration offices to help complete open CPS investigations as a means to close out the large number of open CPS investigations. However, the decision included utilizing staff who were not trained in CPS investigations to complete this work. While considering the staff turnover issue the Committee believed it was not an appropriate decision. The Committee also discussed concerns that a majority of the CPS workers had less than one year experience and were assigned high risk cases.[9] The office also struggled with a lack of experienced CPS supervisors to help mentor and guide the new CPS investigators.

Below are the findings and recommendations made as a result of the staff interviews and discussion regarding K.A. and his family's involvement with CA.

Findings

- The Committee found the department failed to conduct a home visit after K.A. was discharged home after his birth with his parents and before the investigation was closed. This was documented as a directive by the CPS worker's supervisor but it was not completed by staff.
- The department utilized the Public Health Nurse as the only collateral contact for the February 2011 investigation. The Committee found that collateral contacts were lacking in both the 2011 and 2013 investigations. The Committee agreed best case practice would have been to contact other sources such as extended family and mother's medical provider, obtain prenatal records, follow up with K.A.'s pediatrician to verify adequate post natal care and request a urinalysis from the mother to make sure the prescribed medications were the only ones being used by the mother. Collateral contacts are a way to verify if information contained in an intake and during an investigation are accurate.
- The Committee was concerned about the inaccuracies in the SDM® and whether the lack of risk identified through proper use of this instrument negatively influenced this as well as the next investigation and subsequently led to an early closure of the case. Neither SDM® was completed in a timely manner.[10]

[9] DSHS Strategic Plan Metrics – Children's Administration (April 2014): "It takes an average of two years for an investigator to become proficient. It takes an average of 3 months to hire a new CPS investigator. The high turnover rate also impacts staff that remains. They are burdened with higher caseloads and mentoring new staff."

[10] Complete the Structured Decision Making Risk Assessment® (SDMRA®) no longer than 60 days after the intake was received and following the Safety Assessment and prior to a determination to offer ongoing services or a case

- The Committee found the department did not conduct background checks on the alleged subjects of the intakes as well as others who lived in the home with the family. During the two investigations prior to K.A.'s fatality the department did not request any background checks. The Committee considered this a worker safety issue as well as leading to an inaccurate completion of the SDM® during the February 2013 investigation.
- The Committee found there was too long of a time lapse between the assignment of the February 2013 investigation and the completion by the CFWS worker three months later.
- During the February 2013 investigation, the department did not utilize the Guidelines for Reasonable Efforts to Locate Children and/or Parents (DSHS 02-607).

Recommendations

- Children's Administration should further evaluate providing, either through funding or donations, CPS investigators with mobile electronic equipment beyond what is currently available. Specifically, the Committee noted a tablet or related item could be used to take photographs, access DSHS programs such as FamLink, ACES and other available databases which would help workers utilize their time in the field in a more cost-effective manner and could aid in worker safety and investigations.
- Children's Administration should discuss the value of continued use of the SDM®. The Committee found that the SDMs® completed on both the February 2011 and February 2013 investigations were inaccurate and not completed in the recommended time frames. They were approved by the supervisor where they should be checked for accuracy. During the Committee discussion this was identified as a statewide issue and not specific to this particular office. The Committee questions the benefits that continued use of the SDM® provides.
- An administrative representative from the Kent office will speak with the law enforcement agency regarding the decision to mail the April 26, 2014 report rather than calling CA intake. The Committee believed the report should have been called in to intake rather than mailed. An administrative representative from the Kent office should also speak with the medical facility that did not report the February 7, 2012 incident involving K.A. accessing and ingesting methadone.

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transfer to another program area. Supervisors may extend the completion date of the SDMRA® with reason. [Source: CA, Practices and Procedures Guide 2541]

Nondiscrimination Policy
The Department of Social and Health Services does not discriminate and provides equal access to its programs and services for all persons without regard to race, color, gender, religion, creed, marital status, national origin, sexual orientation.