Child Fatality Review

K.R.

June 2015
Date of Child's Birth

August 25, 2015
Date of Fatality

January 21, 2016
Child Fatality Review Date

Committee Members
Patrick Dowd, Director, Office of the Family and Children's Ombuds
Meg Gallagher, RN, Whitman County Health Department
Molly Rice, Child Protective Services Program Manager, Region One
Cameron Norton, CPS Supervisor, Children's Administration, Spokane
Lori Eastep, MSW, LICSW, Grassroots Therapy Group
Pete Martin, Whitman County Coroner

Observer
Paul Smith, Critical Incident Practice Consultant, Children's Administration

Facilitator
Susan Danielson, Critical Incident Review Specialist, Children's Administration

Table of Contents

Executive Summary 1
Case Overview 2
Committee Discussion 4
Findings 5
Recommendations 6

Executive Summary

On January 20, 2016, the Department of Social and Health Services Children's Administration (CA) convened a Child Fatality Review[1] (CFR) to examine the Department's practice and service delivery to eleven-week-old K.R.[2] and her family. The event precipitating this review occurred on August 26, 2015 when K.R.'s mother, [RCW 13.50], found K.R. unconscious and unresponsive in her bed. Emergency personnel who responded to the parents' 911 call were unable to resuscitate the child. [RCW 13.50] and her partner [RCW 13.50.10] reported they had placed K.R. in an infant bouncer chair on their bed the night before and during the night she had fallen out of the chair landing face-down on the bed. The cause of death was listed as Sudden Unexpected Infant Death (SUID),[3] with risk factors related to sleeping conditions. At the time of K.R.'s death the family had an open Family Voluntary Services (FVS)[4] case. There are four older surviving children in the home.

The CFR committee was comprised of Children's Administration staff, a representative from the Office of the Family and Children's Ombuds and community members with expertise in public health and family therapy. Neither CA staff nor any committee members had direct involvement with the family prior to the critical incident.

---

[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] K.R.'s parents are not identified by name in this report because they have not been charged in an accusatory instrument with committing a crime related to a report maintained by the department in its case management and information system. The names of K.R.'s siblings are subject to privacy law. [Source: RCW 74.13.500(1)(a)].

[3] SUID: The United States 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 ASSB (accidental suffocation and strangulation in bed). [Source: Centers for Disease Control and Prevention]

[4] 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 mange child safety. Continuous assessment of child safety occurs throughout the case. [Source: CA Practices and Procedures Guild 2440]

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 intakes, case notes and assessments, police reports and evaluations. Supplemental sources of information and resource material regarding caseload data and CA policies were available to the Committee at the time of the review.

The Committee interviewed the CPS supervisor and social worker who were assigned to the case at the time of the fatality. Following a review of the case file documents, interviews with CA staff and discussion regarding department activities and decisions, the Committee found no critical errors by the department but made findings and recommendations which are detailed at the end of this report for purposes of practice improvement.

Case Overview

This family has an extensive history with Children's Administration dating back to 2006 when RCW 13.50.100 oldest child, RCW 13.50 ., was born. Between 2006 and 2009, CA investigated three intakes alleging substance abuse, domestic violence and negligent treatment by RCW 13.50 None of these investigations resulted in founded findings. In 2013, the department screened in four intakes alleging abuse and neglect of RCW 13.50.100 children centering on lack of supervision, substance abuse in the home, lack of stability and negligent treatment. These investigations were unfounded.

In July 2014, CA received an intake from law enforcement alleging that RCW 13.50 was in a conflict RCW 13.50.100 and was so inebriated she was unable to take care of her children. A second intake received the next day alleged that RCW 13.50 had assaulted her oldest daughter, RCW 13.50.1, causing her to "see stars." A CPS investigator made a determination that the children were not safe and developed a safety plan with the family. The family was referred for Family Preservation Services (FPS) to address family conflict and safety concerns in the home. During August, September and October 2014, CA received four more intakes alleging lack of supervision, substance abuse and domestic violence between RCW 13.50 and her partner RCW 13.5 Though these intakes were not accepted for investigation, the investigator met with RCW 13.50.10 to discuss the allegations and try to engage the family in services. The investigator was not able to engage the family in services and the investigation closed in November 2014 after the case was reviewed by the Child Protection Team.[5] RCW 13.50 was given a founded finding for negligent treatment of all

[5] Child Protection Teams provide confidential, multi-disciplinary consultation and recommendations to the department on cases where there will be an FTDM and there is a risk of serious or imminent harm to child under the age of 6 as to whether an out-of-home placement is appropriate. [Source: CA Practices and Procedures Guide 1740]

four of her children based on the July 2014 intake. Shortly after the case was closed, an anonymous source reported concerns that RCW 13.50 was pregnant, using RCW 70.02.020 and leaving her children with a variety of caregivers. This was not accepted for investigation.

The case was reopened in January 2015 after CA received two intakes alleging physical abuse and negligent treatment of her older two children. The intakes also alleged substance abuse in the home and domestic violence between RCW 13.50 and RCW 13.5 A new CPS investigator was assigned and held a Family Team Decision-Making Meeting[6] (FTDM) to discuss the allegations and assess the need for out-of-home placement. The FTDM was attended by RCW 13. and RCW 13.5 as well as members of the extended family, CA staff and service providers. At the FTDM, RCW 13. and RCW 13. agreed to participate in RCW 70.02.020 and Intensive Family Preservation Services (IFPS);[7] they agreed to cooperate with ongoing, regular monitoring by the department. Both parents RCW 13.50.100 use and indicated they were not willing to change this habit.

In March 2015, the investigator authorized Family Preservation Services (FPS)[8] to provide ongoing services in the home. In April 2015, RCW 13.50.100 . Though RCW 13.50 did not perceive herself as a RCW 13.50.100, the social worker referred her to a domestic violence advocacy center so that she could gain insight into the dynamics of domestic violence and the impact it could have on her family. The social worker met regularly with the family between March and May 2015 and attended several of their family sessions with their FPS provider. Though both parents were authorized to have regular RCW 70.02.020, RCW 13.50. participated minimally and RCW 13.5 did not participate at all. The results of RCW 13.50.100 RCW 70.02.020 were positive RCW 70.02.020.

In May 2015, CA received an intake alleging that RCW 13.50 had missed several scheduled prenatal appointments. This intake was not accepted for investigation though the investigator addressed the allegations with RCW 13.50. who explained that

[6] Family Team Decision Making (FTDM) meetings bring people together who are involved with the family to make critical decisions regarding the removal of a child from their home, changes in out-of-home placement, and reunification or placement into a permanent home. [Source: CA Practices and Procedures Guide 1720]
[7] Intensive Family Preservation Services (IFPS) are short-term, family-based services designed to assist families in crisis by improving parenting and family functioning while keeping children safe. IFPS is generally authorized for 30 days. [Source: CA Practices and Procedures Guide 4502]
[8] Family Preservation Services (FPS) are short-term, family-based services designed to assist families in crisis by improving parenting and family functioning while keeping children safe. FPS is aimed at preventing out of home placements for children and is generally authorized for a limited period. [Source: CA Practices and Procedures Guide 4502]

lack of transportation impacted her ability to attend the appointments. In preparation for the new baby's birth, the social worker and family therapists met with RCW 13.50 to prepare for the new baby's birth. The social worker collaborated with RCW 42.56.230(5) for the home. Th RCW 42.56.230(5) worker agreed to meet regularly with the family to monitor the situation and assist the family in accessing services.

When K.R. was born in June 2015, hospital staff contacted CA to report concerns about RCW 13.50.100 daily use of RCW 70.02.020 and her admission that she had used RCW 70.02.020 early in her pregnancy. A RCW 70.02.020 test done at K.R.'s birth was positive RCW 70.02.020 RCW 70.02.020 but released her on June 12, 2015, noting that K.R. was in good health. Following K.R.'s release from the hospital, the family continued to work with their FPS provider, the DSHS RCW 42.56.230(5) worker and CA staff. The investigator visited the family home weekly and spoke with the family at each visit about the importance of a safe sleep environment for the baby. In August 2015, the family completed FPS. The social worker notified the family that their case would close noting that their situation had stabilized and that they were engaged in ongoing case management with DSHS financial workers.

On August 26, 2015, CA was notified that K.R. died at her parents' home. RCW 13.50.1 reported to law enforcement that she had placed K.R. unsecured in a baby bouncer on top of her own bed. She reported she accidentally fell asleep and RCW 13.50.1 joined her sometime in the night. She woke up at about 4:00 a.m. and found K.R. lying face down, unconscious and unresponsive on the bed. There were no signs of trauma. The cause of death is listed as Sudden Unexpected Infant Death with risk factors related to the sleeping conditions.

Committee Discussion

The Committee discussion focused on CA policy, practice and system responses to evaluate the reasonableness of decisions made and actions taken by the department. Committee members primarily focused on CA involvement during 2015 when the family engaged in voluntary services, though some discussion occurred regarding the department's prior interventions with the family in 2014.

The Committee spent considerable time discussing risk factors[9] noted throughout CA's involvement with this family. Persistent risk factors included alleged

[9] Allegations of child abuse or neglect assert specific events, incidents, patterns and conditions defined by law and policy as child abuse and neglect. Allegations always describe past events, incident and conditions.

substance abuse, domestic violence, unstable housing and struggles with parenting. The Committee noted the challenge posed by attempting to impact multiple risk factors within the relatively short intervention period that is allowed by the FVS model. The Committee noted that considerable resources were used in meeting the family's basic needs either directly by CA or through collaboration with community providers. The Committee discussed whether the parent's lack of compliance with recommended RCW 70.02.020 substance abuse evaluations was of sufficient weight to warrant legal intervention based on the chronicity of alleged abuse and neglect in the family. Though there was no consensus about whether or not the department should have intervened legally, the Committee felt that best practice would have been to consider holding another FTDM to evaluate the situation with the family.

The Committee utilized staff interviews to provide additional sources of information for consideration. This included discussions about caseload and workload size, the general makeup of the unit in terms of worker experience and staff turnover. The office has experienced a high turnover in staff due to transfers within the agency and as a result, the office experienced vacancies during this period. The Committee acknowledged the challenges faced by CA to maintain a high level of practice during a time of significant staff turnover and commended the office on managing to maintain regular, ongoing contact with this family in spite of the challenges.

The Committee noted several areas of quality practice during the 2015 intervention. The case notes were clear, thorough and timely. The social worker did an exceptional job in addressing safe sleep guidelines with the parents during every home visit. The use of regular, unannounced visits to the family home reflected strong commitment to child safety as well as good engagement with the parents. The social worker was resourceful in accessing community partners to meet the family's basic needs and in gaining their collaboration to help monitor the family's situation.

Findings

At completion of the review of the case file documents, staff interviews and discussions regarding CA activities and decisions, the Committee found no critical errors by the department. However, the Committee identified several missed opportunities in the 2014 investigations for improved practice that were determined to be worthy of inclusion in this report. Specifically, the Committee believed that the investigation conducted in 2014 could have more

---

Risk factors include all other information that lacks assertions of abuse or neglect but which are relevant to assessing the likelihood of future child abuse and neglect.

comprehensively assessed child safety and parental functioning in several key areas.

- The child interviews could have more fully assessed or explored the allegations.
- The parent interviews could have been more comprehensive with regard to either the allegations or the risk factors alleged in the intakes.
- The investigative assessment lacked collateral contacts that may have enhanced the assessment of child safety
- The safety plan developed by the social worker in 2014 did not address the specific safety threat and could have been enhanced by the inclusion of additional monitoring of the children’s well-being.

Recommendations

1. Children's Administration should consider offering training in how to effectively deal with secondary trauma or compassion fatigue to offices whose staff have experienced critical incidents.
2. The Committee recommended that the Region One Practice Consultant review with the staff in this office the benefits of conducting an FTDM when a family is not compliant with Family Voluntary Services.