Washington State Department of Social & Health Services

CA Children's Administration

Child Fatality Review

M.Y.

July 2013
Date of Child's Birth

July 25, 2013
Date of Child's Death

December 4, 2013
Child Fatality Review Date

Committee Members
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Executive Summary

On December 4, 2013, the Department of Social and Health Services (DSHS), Children's Administration (CA) convened a Child Fatality Review (CFR)[1] to review the department's practice and service delivery to a two-week-old male child and his family. The child will be referenced by his initials, M.Y., in this report. At the time of his death, M.Y. was staying in a motel with his father and mother. The incident initiating this review occurred on July 25, 2013, when M.Y. died from probable suffocation related to unsafe sleep practices.

The review is conducted by a team of CA staff and community members with relevant expertise from diverse disciplines. Neither CA staff nor any other committee members had previous direct involvement with the case.

Prior to the review each committee member received a case chronology, a summary of CA involvement with the family and non-redacted CA case documents (e.g., intakes, safety assessments, investigative assessments, provider records, law enforcement records, and Child Protective Services investigative reports).

Supplemental sources of information and resource materials were available to the committee at the time of the review. These included copies of the complete case file and relevant state laws and CA policies.

The Committee interviewed the two CA social workers previously assigned to the case.

Following a review of the casefile documents, interviews with the CA social workers and supervisor, and discussion regarding department activities and decisions, the Committee made findings and recommendations, which are detailed at the end of this report.

[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 Child Fatality Review 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 will only hear from DSHS employees and service providers. It does not hear the points of view of a child's parents and relatives, or those of other individuals associated with a deceased child's life or fatality. 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.

Case Summary

M.Y.'s family first came to CA's attention on December 11, 2012, when an intake was received alleging M.Y.'s mother was pregnant and using heroin.[2] M.Y. is his mother's only child. The intake was identified as information only and screened out.[3] On July 11, 2013, CA received an intake reporting the birth of M.Y. The mother told the referrer that she started using drugs when she was 13-years-old, and she reported to the referrer that she tested positive for methamphetamine on June 12, 2013. The mother told the referrer that she has the ability to "dupe the system" and hide her drug use. She also stated, "I always want to use, no matter the consequences."

On July 11, 2013, a safety plan was developed to ensure M.Y.'s safety after his discharge from the hospital. The social worker, mother, father, and maternal grandmother all participated in the development of the safety plan. The safety plan required M.Y. and his mother to reside at the maternal grandmother's residence while the mother engaged in chemical dependency treatment, parent education, and public health nursing services. The mother agreed not to reside at her previous residence due to drug use in the home by M.Y.'s father and the maternal grandfather; however, this agreement was not specified in the safety plan.

On July 16, 2013, the maternal grandmother informed the assigned social worker that the mother was in compliance with the safety plan. However, the maternal grandmother expressed concern about the mother relapsing as the maternal grandmother was scheduled to return to work in the next couple of days. The grandmother reported friends and relatives would help check on M.Y. and his mother while she was at work.

On July 19, 2013, the social worker attempted an unannounced home visit at the maternal grandmother's residence. The family was not home at the time of the home visit.

On July 22, 2013, the maternal grandmother reported the mother spent the last several nights at the residence of the father and the maternal grandfather. The maternal grandmother also stated that the maternal step-grandmother smelled

[2] CA Practice and Procedures Guide 2552: Intakes on Substance Abuse during Pregnancy - Intake Screening Decision: The intake worker will document a pregnant woman's alleged abuse of substance(s) (not medically prescribed by the woman's medical practitioner) in an intake as "Information Only." Retrieved from http://www.dshs.wa.gov/ca/pubs/mnl_pnpg/chapter2_2500.asp

[3] Washington state law does not authorize Children's Administration (CA) to screen in intakes for a CPS response or initiate court action on an unborn child.[Source: Department of Social and Health Services Children's Administration Practice Guide to Intake and Investigative Assessment]

alcohol on the mother's breath the previous weekend. The mother returned to the home on July 22, 2013, and then violated the safety plan again by leaving the home and spending the night at another location.

On July 23, 2013, the mother returned to the maternal grandmother's home. At the request of the social worker, the maternal grandmother informed the mother that she was in violation of the safety plan and needed to comply with the safety plan by staying in her home. The mother again chose to leave the the maternal grandmother's residence.

On July 24, 2013, the social worker engaged in joint efforts with law enforcement to locate the mother without success. A dependency petition was filed and the social worker obtained an order to place M.Y. into foster care. The social worker continued efforts to locate the mother throughout the day.

On July 25, 2013, the mother brought M.Y. to the hospital. M.Y. was not breathing, was cool to the touch, and ashen upon arrival. The mother told investigators that she had relapsed on methamphetamine and was attempting to evade Child Protective Services (CPS) by staying in a hotel room in a neighboring county with M.Y.'s father. The mother reported waking-up and noticed that M.Y. was aspirating blood and not breathing. M.Y. was sleeping in the bed between the parents at the time of the fatality. CA or law enforcement personnel did not interview the father, as he did not make himself available. The father did not stay at the hospital after dropping off M.Y. and the mother.

Discussion

While the Committee found that there were no apparent critical errors in terms of decisions and actions taken during the involvement by the CPS social worker, the committee did find instances where additional/different social work activity or decisions may have been considered. However, the absence of these additional activities/decisions was found to have no reasonable discernible connection to the child's death. Thus, the identified issues below serve as noted opportunities where improved practice may have been beneficial to the assessment of the family situation but were not found to be critical oversights that could have prevented the child fatality.

The incident initiating this review occurred on July 25, 2013, when M.Y. died from probable suffocation related to unsafe sleep practices. The Committee noted the social worker had taken the appropriate steps to address unsafe sleep practices

by speaking with the parents about safe sleep[4] during their initial meeting at the hospital. The Committee also noted the social worker addressed other areas of high-risk to infants including the "Period of Purple Crying."[5] The Committee found the social worker's action regarding safe sleep was proactive and appropriate.

Safety Planning: The Committee discussion noted several areas for system improvements around safety planning that are reflected in the discussion section of this report. The Committee also recommended improved ongoing training regarding safety planning that is reflected in the recommendation section of this report.

Safety Plan Participants

1) The social worker's role in the safety plan was not specified. The Committee believed the safety plan may have been enhanced by the social worker being listed as an active participant in the safety plan and her role in the monitoring of the safety plan clearly specified.
2) The father's role in the safety plan was not specified. The Committee noted all services and safety plan items were specific to the mother. The Committee noted the safety plan failed to address the father's alleged substance abuse or role in the care of M.Y.
3) The Committee noted the grandmother was listed as a participant on the safety plan. The social worker never initiated the background check process on the grandmother as required by CA Practice and Procedure Policy 5512.[6]

Safety Plan Modifications Recommended by the Committee

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[4] 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.

[5] 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. Retrieved from: http://www.purplecrying.info/what-is-the-period-of-purple-crying.php

[6] CA Practice and Procedures Guide 5512: CA staff must complete the required background check, as defined in this section, of out-of-home caregivers and other adults who will have unsupervised access to a child in their home, including: Complete for safety plan participants per Safety Plan Policy. Retrieved from: http://www.dshs.wa.gov/CA/pubs/mnl_ops/chapter5_5500.asp

1) The safety plan may have been enhanced through the timely establishment and monitoring of drug testing for both parents.
2) The safety plan may have benefitted from a relapse plan for the mother due to her lengthy drug use history going back to the age of 13. The Committee suggested the use of language such as: "In the case of a relapse, the mother will leave M.Y. in the care and custody of the maternal grandmother. The mother will not provide care or supervision while under the influence of drugs or alcohol."
3) The Committee suggested the plan may have included language to address the father's care and supervision of M.Y. such as: "The maternal grandmother agrees to supervise all contact between the father and his son until he has demonstrated a 30-day period of sobriety. The social worker agrees to measure the father's sobriety through the immediate initiation of drug testing."
4) The safety plan may have been enhanced through specifying timeframes and defining terms within the safety plan. The safety plan stated, "M.Y. and the [mother] will live with the maternal grandmother upon discharge from the hospital. The maternal grandmother will help ensure the safety of M.Y. to include calling CPS, law enforcement or taking custody if necessary." The Committee noted the mother spent three or four nights at another residence prior to the maternal grandmother contacting the assigned social worker. The Committee believed the safety plan should have specified that the grandmother would immediately call CA upon violation of the safety plan or if she observed any signs of relapse. The Committee believed the term "live with" was insufficiently descriptive and allowed the mother to leave the maternal grandmother's residence and visit the maternal grandfather's residence without restriction. The Committee noted the social worker was aware that the maternal grandfather's residence was a significant risk factor due to the alleged drug use in the home.

On July 23, 2013, the social worker requested the maternal grandmother speak with the mother about her failure to follow the safety plan. The Committee noted the maternal grandmother followed the social worker's direction and spoke with the mother. She informed the mother that she would be out of compliance if she failed to sleep every night at her residence. The Committee expressed concern about the social worker placing the maternal grandmother in the position of confronting her daughter. The Committee believed if the social worker addressed this issue personally it may have enhanced case practice.

The Committee discussed the value of the shared decision making process. In this case, the Committee believed CA practice may have benefitted from the completion of a Family Team Decision Making (FTDM) meeting.[7] The Committee believed the FTDM process may have provided the social worker with an opportunity to further explore the strengths and areas of concern regarding the family.

Workload is often cited as a challenge of casework and a barrier to quality practice. The Tumwater CA office was undergoing a period of significant staff turnover around the time of the fatality. The assigned social worker had six years experience at the time of the fatality. However, all other remaining CPS investigators in the Tumwater office had less than one year experience. Additionally, the assigned social worker had 32 open investigations at the time of the fatality and received 17 CPS investigative assignments during the month of the fatality.

Findings

1) The Committee believed the social worker should have initiated drug testing immediately as drug use by both parents was the primary concern identified on this case.
2) The Committee noted the safety plan insufficiently addressed the safety concerns around plan member participation, parental drug use, child supervision, and clearly specifying timeframes and terms.
3) The Committee believed DSHS policy 1720 required the completion of a FTDM.[8]

Recommendations

1) The Committee recommends social workers receive and demonstrate a strong understanding of the safety planning process prior to carrying of cases and completion of Regional Core Training (RCT). [9]

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[7] Family Team Decision 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 meetings are held to make critical decisions regarding the placement of children following an 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 a FTDM can be held prior to placement if there is not an immediate safety threat such as a child who is on a hospital hold and a 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. A Family Team Decision-Making meeting will take place in all placement decisions to achieve the least restrictive, safest placement, in the best interest of the child. By utilizing this inclusive process, a network of support for the child(ren) and adults who care for them is assured.
www.dshs.wa.gov/pdf/ca/FTDMPracticeGuide.pdf

[8] CA Practice and Procedures Guide 1720: The social worker shall conduct a FTDM meeting prior to removing a child and anytime out-of-home placement of a child is being considered. Retrieved from:
http://www.dshs.wa.gov/ca/pubs/mnl_pnpg/chapter1.asp#1720

2) The Committee recommends social workers receive an annual refresher training regarding safety planning.
3) The Committee noted a significant amount of documentation was entered into Famlink following the fatality. The Committee believed the documentation accurately reflected case activity and met all policy requirements; however, the Committee questioned CAs practice of destroying hand written casenotes after the information is entered into Famlink. The Committee believes CA would benefit from a policy that requires the retention of all hand written casenotes that exist at the time of the fatality. The Committee specifically stated that this recommendation should not change the requirement that hand written case notes be entered into Famlink.

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, age, veteran's status or the presence of any physical, sensory or mental disability.

[9] Regional Core Training (RCT) - The RCT is the initial, intensive, task-oriented training that prepares newly hired Social Service Specialists to assume job responsibilities. RCT starts on the first day of employment and lasts for 60 days, or the first two months of employment. Competencies are used to assess learning needs and to identify a developmental plan for the new workers. Retrieved from: http://allianceforchildwelfare.org/sites/default/files/sites/default/files/career/alliance_training_september_2013_0.pdf