Child Fatality Review

RCW 13.50.

July 2015
Date of Child's Birth

December 3, 2015
Date of Fatality

March 3, 2016
Child Fatality Review Date

Committee Members
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Executive Summary

On March 3, 2016, 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 four-month-old RCW 13.50 and RCW 13 family.[2] The child will be referenced by RCW 13 initials, RCW 13.50, in this report.

On November 4, 2015, CA was notified that RCW 13.50 had been admitted to RCW 13.50.100 RCW 13.50.100 Hospital. RCW 13 was diagnosed with RCW 13.50.100 related to RCW 13.50.100 RCW 13.50.100. RCW RCW remained RCW 13.50.100 until RCW 13 death on December 3, 2015. Prior to RCW 13.50.100 lived with RCW 13 father, mother and 13-year-old RCW 13.50.1 The King County Medical Examiners Officer declined to conduct an autopsy stating RCW 13 death was considered to be due to natural causes RCW 13.50.100

The review Committee included members selected from the community with relevant expertise including the Office of the Family and Children's Ombuds and an executive director of a social service agency supporting the RCW 13.50.100 community within Washington state. The Committee also included a child protective services supervisor and child protective services program manager with CA. A contracted medical consultant with CA was consulted by telephone. There were two DSHS employees who observed the review. Neither DSHS/CA staff nor any other Committee members had previous involvement with this family.

Prior to the review, each Committee member received a case chronology, a summary of CA involvement with the family and un-redacted CA case documents (e.g., intakes, investigative assessments and case notes). Supplemental sources of information and resource materials were available to the Committee at the time of the review. These included the RCW 13.50.100 Hospital autopsy report, medical records, relevant state laws and CA policies.

[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 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 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] RCW 13.50.1 family members are not named 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 and management information system.[Source: RCW 74.13.500(1)(a)]

The Committee interviewed the assigned CPS worker and her supervisor, the family team decision meeting facilitator and the area administrator.

Family Case Summary

On July 31, 2015, CA received a call from a physician treating RCW 13.50 Also present with the physician during the call was a public health nurse assigned to work with the family. At the time of the intake RCW 13.50 was one week old. The physician alleged RCW 13.50.100 of RCW 13.50 by RCW 13 parents. The physician stated the RCW 13.50.100 has an RCW 13.50.100. The mother was advised to RCW 13.50. RCW 13.50.100 and have a RCW 13.50.100 during the RCW 13.50.100. The mother refused to follow medical advice. RCW 13.50.100 mother and father refused the RCW 13.50.100 for RCW 13.50 until they were informed Child Protective Services would be contacted. Another reported concern was the parents failure to attend two follow-up RCW 13.50.100 The physician was concerned that the parents may not be adequately RCW 13.50.100 RCW 13.50 to prevent RCW 13.50.100 This intake was assigned for a 24-hour CPS investigation.

The CPS investigation included interviews with both parents and collateral contacts. On September 29, 2015, the investigative assessment was completed as unfounded for negligent treatment or maltreatment. Before the closure of the investigation, CA had been informed that RCW 13.50.100 for the RCW 13.50.100 RCW 13.50.100 mother.

On November 4, 2015, a second intake was received from a local hospital. The hospital social worker reported medical neglect of three-month-old RCW 13.50 It was reported that RCW 13.50 needed to have RCW 13.50.100 within two days or RCW 1 would RCW 13.5 but the parents were not cooperating with the hospital. RCW 13 presented at the hospital with RCW 13.50.100 and was RCW 13.50.100 with RCW 13.50.100 The type of RCW 13.50.100 is directly related to RCW 13.50.100. The social worker stated the family does not believe in the RCW 13.50.100 and that the RCW 13.50.100 are too RCW 13.50.100 According to the caller, the parents appear to be bonded and providing for their RCW 13.5 other than related to this RCW 13.50.100 issue. The social worker reported that the hospital has provided all of its recommendations in a RCW 13.50.100 and RCW 13.50.100 appropriate manner; however, the parents continue to refuse the recommended RCW 13.50.100 This intake was assigned as a 24-hour CPS investigation.

On November 4, 2015, the investigation was assigned to the CPS worker who had conducted the prior CPS investigation. She contacted the public health nurse and the hospital. The CPS supervisor contacted the Child Protection Team at RCW 13.50.100

RCW 13.50.100 Hospital to discuss the case. On November 5, 2015, RCW 13.50 was placed on life support.

On November 5, 2015, an FTDM[3] occurred. The parents, RCW 13.50.100 familial support and medical professionals were present. This meeting occurred at the hospital. A dependency petition was filed on November 6, 2015 as to RCW 13.50 The petition did not include RCW 13 older RCW 13.50.1 RCW 13.50.100 RCW 13.50 remained inpatient until RCW 13 death on December 3, 2015.

Based on two suspected child abuse and neglect consultations by two differing CA medical consultants, the investigative assessment was RCW 13.50.100 for RCW 13.50.100 RCW 13.50.100 as to both parents regarding their failure to meet RCW 13.50.100 needs resulting in RCW 13 death.

Committee Discussion

For purposes of this review, the Committee focused on case activity prior to the fatality. The CPS investigation regarding the fatality was briefly discussed.

There was a suggestion that inclusion of a person from the RCW 13.50.100 RCW 13.50.100 community, who was not identified by the family, may have assisted CA with an unbiased education regarding the RCW 13.50.100 and interactions with the family. This contact may have aided CA staff with a better understanding of how this RCW 13.50.100 is viewed within the RCW 13.50.100, the lack of trust of the medical field within the community and overall interactions between Child Protective Services and the RCW 13.50.100 community. There has been recent communication between the Everett area administrator and the RCW 13.50.100 representative on the Committee to discuss collaboration between the office and local community.

The Committee also discussed that once the actual RCW 13.50.100 of the RCW 13.50.100 was made known to us, and knowing that the father had not yet been made aware, the investigation could have been extended. This extension would have allowed for CA to assess the family's willingness to maintain medically recommended care and connect with natural or community supports in light of this new information.

An overarching area identified as a challenge was the stress faced by the field offices. Those areas include turnover, increased caseloads, inability to obtain

[3]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]

and/or provide timely and comprehensive training to new staff and the inception of SB 5888 also known as Aidan's Act.

The issue of staff retention was included in the Committee's discussion regarding stress. While a litany of reasons were suggested related to staff turnover, the Committee primarily discussed the fact that staff feel overwhelmed immediately upon starting in child welfare. The CPS investigator on this case was new when she received the first intake. Within three months of that initial intake, the subsequent intake qualified for the first Aidan's Act review and a near-fatality review. Understanding that the work of child welfare will be open to scrutiny, it can have a chilling impact on staff's willingness to remain in this field unless they feel they have received adequate training and have a supporting supervisor and area administrator.

Findings
The Committee did not identify any critical errors that contributed the fatality. However, there were areas where the Committee identified possible improvements in case practice.

At the conclusion of the first investigation, the worker's last case note was regarding contact with the public health nurse. During that conversation, the public health nurse noted concerns about the parents' unwillingness to follow through with recommended RCW 13.50.100, the child had RCW 13.50.100 RCW 13.50.100 for the RCW 13.50.100 and there was a comment made that RCW 13.50.100 Hospital wanted to admit the child to the hospital. The investigator did not follow up on the identified concerns.

The Committee believed it would have been appropriate to have had a shared planning meeting or FTDM with the parents, identified familial supports and the medical professionals. The meeting would have allowed for all parties to have the same information regarding RCW 13.50.100 medical needs, RCW 13 RCW 13.50.100 result (RCW 13 father was not aware of the RCW 13.50.100 result at the closure of the case) and a plan for notification to CA if the parents failed to maintain the recommended RCW 13.50.100.

The Committee noted that it may have been beneficial for the CPS investigator to have requested the prenatal records and RCW 13.50.100 birth records. Those documents may have assisted CA in identifying and verifying what conversations occurred with the parents regarding recommended RCW 13.50.100 RCW 13.50.100 for the birth of RCW 13.50 and for RCW 13 RCW 13.50.100 care post birth.

The Committee also identified positive actions as evidence of good decision making and RCW 13.50.100 competence related to this case. When the CPS investigator

contacted RCW 13.50.100 older RCW 13.50.100 school, RCW 13.5 requested the contact list from the child's file. The investigator utilized this as a collateral resource. The Committee noted this was good practice and a way to attempt to help verify information provided by the parents.

During the second investigation, an FTDM occurred. The FTDM occurred at the hospital where RCW 13.50 was admitted. The attendees included a pastor from the family's religion who shared their RCW 13.50.100 background. This pastor was utilized as a support to the family and as a RCW 13.50.100 advisor to the department regarding this family specifically. This was not only a respectful inclusion but also was a positive way to build trust with the family and to follow the department's expectation for RCW 13.50.100 competence.

The Committee did not make any recommendations during this review.