Washington State Department of Social & Health Services

CA Children's Administration

Child Fatality Review

S.J.

RCW 74.13.515 **2016**
Date of Child's Birth

August 9, 2016
Date of Fatality

December 1, 2016
Child Fatality Review Date

Committee Members
Cristina Limpens, Senior Ombuds, Office of the Family and Children's Ombuds
Melanie Robinson, Detective, Kent Police Department
Ruth Wolbert-Neff, Chemical Dependency Professional/Opioid replacement therapist, Tacoma Pierce County Health Department
Tracey Czar, J.D. Guardian Ad Litem, Pierce County Juvenile Court
Zee Triplett, Safety Administrator, Children's Administration

Facilitator
Libby Stewart, Critical Incident Review Specialist, Children's Administration

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Executive Summary

On December 1, 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 [redacted] month-old S.J. and [redacted] family.[2] The child will be referenced by [redacted] initials in this report.

On August 9, 2016, S.J.'s mother called her assigned child and family welfare services (CFWS) social worker and stated S.J. had passed away. The CFWS worker reported the incident to CA. Local law enforcement as well as CPS conducted an investigation. There were no criminal charges and the child protective services (CPS) investigation was unfounded. The medical examiner's report stated the cause of death was compressional asphyxia and the manner of death was accidental. The report also stated the mother reported overlying on her child's abdomen and legs. She was sharing the bed with S.J. and another one of her children.

At the time of the fatality, there was an open CFWS case involving [redacted]. A [redacted] had [redacted]. There was not an open case involving S.J. at the time of [redacted] death. S.J. lived with [redacted] mother, two older sisters and the children's great grandmother. S.J.'s alleged father is reportedly deceased.

The Review Committee included members selected from diverse disciplines within the community with relevant expertise including the Office of the Family and Children's Ombuds, a guardian ad litem for child dependency matters, a chemical dependency professional who specializes in opiate replacement therapies for pregnant and parenting mothers, a child abuse detective and CA's Region 2 Safety Administrator. The Children's Administration CPS program manager was unable to attend the review. No Committee member had previous involvement with this family.

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[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 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 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] S.J.'s 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)]

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, law enforcement report, medical examiners report and case notes). Supplemental sources of information and resource materials were available to the Committee at the time of the review. These included the last two volumes of the case, relevant state laws and CA policies.

The Committee interviewed the CFWS supervisor who completed the risk only assessment at the time of S.J.'s birth, the currently assigned CFWS social worker and his supervisor as well as the area administrator.

Family Case Summary

The first intake regarding S.J.'s mother as a parent was in January 2000. There was a total of 26 intakes before S.J.'s birth, regarding RCW 13.50.100. The intakes included allegations of RCW 13.50.100 and RCW 13.50.100 the majority of issues surrounded RCW 13.50.100. There were also reports of the children RCW 13.50.100 by adults and the children, RCW 13.50.100 and RCW 13.50.100. The RCW 13.50.100 were RCW 13.50.100 between 2000 and 2005 and were RCW 13.50.100 . Then in June 2013, RCW 13.50.100 were RCW 13.50.100 and RCW 13.50.100 .

During the second RCW 13.50.100 in 2013, the mother did not engage in services until September 2015. At that time, she began to address her RCW 13.50.100 . The mother was pregnant with S.J. at that time and RCW 13.50.100 . The mother remained engaged in her RCW 13.50.100 and gave birth to S.J. in RCW 74.13.515 2016.

Prior to the birth, CA consulted with the Assistant Attorney General assigned to the mother's case and decided RCW 13.50.100 regarding S.J. A risk only CPS investigation occurred at S.J.'s birth. While the investigation involving S.J. was closed, the mother's case remained open with RCW 13.50.100 .

S.J. remained RCW 74.13.520 for two months after birth. Upon discharge from the hospital, S.J. and RCW 74.1 mother moved in with the mother's grandmother. The mother also RCW 13.50.100 at the same time as S.J.'s discharge from the hospital. S.J.'s great grandmother had RCW 13.50.100 . CA was aware of, and in agreement with, the family's plan.

During regular health and safety visits pertaining to the RCW 13.50.100 , the mother reported she was engaged in RCW 13.50.100 . The CFWS worker observed S.J. during some of his health and safety visits. He briefly discussed that the baby should sleep by RCW 74.1 self in RCW 74.1 own bed. During the CFWS worker's first contact with S.J. he observed an unsafe sleep environment. That same day the CFWS worker provided the mother with a pack-n-play to remedy the unsafe sleeping conditions.

On August 9, 2016, the assigned CFWS worker received a call from the mother stating that S.J. had passed away earlier that morning. The mother stated the death was a SIDS related death and she contacted the police and the coroner.[3] In total, S.J. was observed three times by the assigned CFWS worker prior to RCW 74.1 death.

Committee Discussion

For purposes of this review, the Committee mainly focused on case activity from the time S.J. was born until RCW 74.1 passed away. There was some discussion regarding the family's history prior to RCW 74.1 birth and regarding the death investigation.

There was significant discussion surrounding the stability of the office at the time this case transferred to the currently assigned worker in March 2016. The current CFWS worker had an extremely high case load and was assisting in coverage of health and safety visits on other workers' caseloads. The office had undergone substantial turnover and had almost a 50 percent vacancy rate within the CFWS units. The Committee discussed how it would be a challenge for the staff under these conditions to comply with best case practices.

During interviews with the assigned CFWS social worker and his supervisor, it appeared as though there was not a clear understanding of the CFWS worker's responsibility as it pertained to S.J. since there was not an open case involving RCW 74.13 The Committee contemplated the issues that may have impacted the work on this case including the CFWS worker not only covering his high caseload but also working to cover others' caseloads, the CFWS worker's status as newly hired therefore not coming with on-the-job experience to assist in decision making, and lack of clinical supervision due to the office wide need for all staff to cover unassigned caseloads.

[3] Sudden Infant Death Syndrome (SIDS) is defined as the sudden death of an infant less than one year of age that cannot be explained after a thorough investigation is conducted, including an autopsy, examination of the death scene and a review of the clinical history. SIDS is a type of SUID. [Source: Centers for Disease Control and Prevention]

The Committee appreciated the struggle this case highlighted: to have faith that a parent can change; the ability to change and RCW 13.50.100 even after a lengthy history of RCW 13.50.100; and other risk factors and how that impacts the desire to allow for consistent, safe bonding between a newborn and a parent. While not all of the Committee members agreed with the decision RCW 13.50.100 , they appreciated the inclusion of the AAG in the decision making and the thought process that was clearly discussed by the area administrator and CFWS supervisor who conducted the Risk Only assessment intake at S.J.'s birth.

There was a discussion regarding how collaboration between RCW 13.50.100 Therapy providers can help educate CA staff regarding many areas highlighted in this case. Those discussions could have included a description of the mother's demonstrated RCW 13.50.100 and positive change in behaviors, any conversations regarding safe sleep to include the fact that the mother herself stated she does not easily wake while sleeping and what signs, such as nodding off during conversations, necessitate a discussion with the prescriber, if not a RCW 13.50.100 It was also discussed that there have been numerous recent conversations regarding a need for CA staff to receive ongoing education regarding RCW 13.50.100 therapies and how those therapies pertain to assessing child safety.

Findings

The Committee did not find that a critical error occurred. The Committee identified overarching themes where CA could have bolstered collaboration and corroboration to improve case practice.

CA did not staff the case with a Child Protection Team (CPT) as required by policy. The Structured Decision Making Assessment® tool that was completed at the time of S.J.'s birth resulted in a high level of risk. Per CA policy this would also have necessitated a discussion and offer of ongoing voluntary services if it was deemed that the case was not sufficient for legal intervention.[4] A Shared Planning Meeting such as a Family Team Decision Making Meeting could have also been utilized. CA could also have included the Court Appointed Special Advocate assigned to RCW 13.50.100 during staffings and meetings regarding how CA was to proceed at the time of S.J.'s birth.

The Committee believed that there were missed opportunities by the CFWS social worker to gather information from collateral contacts that would have

[4] Cases with a high SDMRA score must be staffed with a Child Protection Team (CPT) for identified child victims aged six years or younger. [Source: CA Practices and Procedures Guide 2541. Structured Decision Making Assessment®]

provided a more comprehensive picture of the mother's ability to safely parent S.J. This would have included contacts with providers that were reportedly working with the mother, such as a public health nurse, RCW 13.50.100 support groups, parent child assessment program worker, RCW 13.50.100 providers and RCW 13.50.100 providers. The worker did not corroborate the information provided by the mother by contacting the appropriate collateral contacts.

Another area that could have provided a more comprehensive view of the mother's capabilities and functioning included a RCW 13.50.100 evaluation. Originally the mother was court ordered to complete a RCW 13.50.100 evaluation; however, after receiving concerns from the mother's RCW 13.50.100 provider regarding RCW 13.50.100, a request was made to the mother's attorney to change the service to a RCW 13.50.100 evaluation. This request was never responded to prior to the fatality.[5]

The RCW 13.50.100 program could have provided a description of the mother's demonstrated RCW 13.50.100 It would also have been appropriate to discuss the CFWS worker's observation of the mother nodding off during one home visit and if that had any bearing on the mother's RCW 13.50.100 or RCW 13.50.100.

CA did not comply with the Plan of Safe Care, Period of Purple Crying and Safe Sleep policy.[6]

CA did not conduct a new safety assessment of the household when the mother and S.J. moved in with the RCW 13.50.100 children and their relative care provider.[7]

Recommendation

CA should review the current policies regarding situations involving RCW 13.50.100 and RCW 13.50.100 children with the same parent, as occurred in this case, and consider any revision or clarification. The revision or clarification could possibly allow for the assigned social worker and supervisor to have a clearer indication of how to proceed with the responsibility of CA to complete a comprehensive, ongoing assessment of children who are not a part of an open case yet are under the care of their parent who has other RCW 13.50.100 children.

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[5] Neuropsychological evaluation (NPE) is a testing method through which a neuropsychologist can acquire data about a subject's cognitive, motor, behavioral, linguistic, and executive functioning. In the hands of a trained neuropsychologist, these data can provide information leading to the diagnosis of a cognitive deficit or to the confirmation of a diagnosis, as well as to the localization of organic abnormalities in the central nervous system (CNS). The data can also guide effective treatment methods for the rehabilitation of impaired patients. [Source: Medscape Neuropsychological Evaluation]

[6] Source: CA Practices and Procedures Guide 1135 Infant Safety Education and Intervention

[7] Source: CA Practices and Procedures Guide 1120 Safety Assessment