Washington State Department of Social & Health Services
CA Children's Administration

Child Fatality Review

S.R.

July 2013
Date of Child's Birth

February 24, 2015
Date of Fatality

July 8, 2015
Child Fatality Review Date

Committee Members
Cristina Limpens, Office of the Family and Children's Ombuds
Erin Summa, Child Safety Educator, Mary Bridge Children's Hospital
Anna Facio, Quality Assurance Program Manager, Developmental Disabilities Administration
Stephanie Frazier, Child Protective Services Program Manager, Children's Administration
Billie Reed-Lyyski, Child Protective Services Supervisor, Children's Administration

Observer
Ann Radcliffe, Licensing Analyst Southwest Region, Department of Early Learning
Deanna Sundby, Licensing Analyst, Department of Early Learning

Facilitator
Libby Stewart, Critical Incident Review Specialist

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Executive Summary

On July 8, 2015, 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 18-month-old S.R. and his family.[2] The child will be referenced by his initials S.R. in this report.

The incident initiating this review occurred on February 24, 2015 when S.R. was found by his father in his crib with his tracheostomy tube dislodged and no pulse. Law enforcement was called to the home; they were unable to revive S.R.

At the time of the fatality, S.R. lived with his parents, RCW 74.13.500 and RCW 74.13.500f-RCW 74.13.500. S.R. and his RCW 74.13.500 were born prematurely with multiple medical conditions. S.R. had a tracheostomy tube due to tracheal paralysis. He also had a monitor attached to his leg to register his breathing. S.R. had a history of pulling out or attempting to pull his tracheostomy tube. The purpose of the monitor was to alert his care providers if the tube became dislodged.

The mother had RCW 74.13.500 and CA investigated two intakes in 2013 and 2014 regarding the mother, father and all three children prior to the fatality. However, at the time of the fatality, there was not an open case or investigation.

The review Committee included members selected from diverse disciplines within the community with relevant expertise including a Quality Assurance Program Manager with Developmental Disabilities Administration (DDA) who conducts mortality reviews within DDA. The Manager previously worked for CA conducting Child Protective Services (CPS) investigations. The Committee also included a CPS supervisor, a hospital-based child safety educator, the Office of the Family and Children's Ombuds and a CPS program manager. There were two observers from Department of Early Learning. Neither CA staff nor any Committee members or observers had previous involvement with this family.

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[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] No criminal charges have been filed relating to the incident and therefore neither the mother nor father's names are identified. The name of S.R.'s siblings is subject to privacy laws. [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, and case notes). Supplemental sources of information and resource materials were available to the Committee at the time of the review. These included medical reports, S.R.'s autopsy, relevant state laws, and CA policies.

During the course of this review, the Committee interviewed the CPS supervisor. The CPS worker was not available. Following the review of the case file documents completion of interview and discussion regarding department activities and decisions, the Committee identified areas where practice could improve. The findings and recommendation are at the end of this report.

Family Case Summary

RCW 74.13.500 [redacted][3].

On October 28, 2013, a hospital social worker called CA with concerns that the parents did not regularly visit their newborn premature twins and were not participating in necessary medical education in order to care for one of the twins who was medically fragile. The caller reported the parents did not use the transportation assistance that was provided. This intake was assigned for CPS investigation.

The allegations in the October 28, 2013 intake were determined to be unfounded. There was conflicting information from hospital staff on the perception of the parents' involvement. One child was placed in the Pediatric Intensive Care Unit and the other twin was in the Neonatal Intensive Care Unit. The parents did agree they struggled with transportation. The CPS investigator conducted a home visit prior to S.R.'s discharge from the hospital at the closure of the investigation. The investigation was approved for closure by the CPS supervisor on December 30, 2013.

On November 20, 2014, CA received a third intake on this family from a pediatrician alleging S.R. missed his 6, 9, 12, and 15-month well-child appointments. S.R. had a gastrostomy tube, tracheostomy tube and was diagnosed with Failure to Thrive. The allegations included that S.R. missed

[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]

numerous other appointments with specialists who treated his medical conditions related to his congenital birth defects. This intake was screened in and was assigned for CPS investigation.

An initial face-to-face contact occurred on November 21, 2014 with S.R. The case note indicates S.R. and his father were present. The Investigative Assessment (IA) was submitted for review on November 24, 2014. There were other follow up actions conducted by the CPS investigator after he determined the IA to be unfounded. The Structured Decision Making Risk Assessment®[4] (SDM) scored at moderately high. There was no documentation of services being offered during or at the end of this investigation. However, per CA policy, if the SDM® score is moderately high, the caseworker may offer services to the family. During this investigation, the CPS investigator requested medical records for S.R. and those were contained in the case file. This investigation was approved for closure by the CPS supervisor on December 30, 2014.

On February 24, 2015, CA received the fourth intake from the Shelton DCFS Office CPS supervisor. The CPS supervisor received a text from the Mason County Sheriff's Office stating S.R. had been found deceased at his family home. Medics attempted intervention but they were unable to revive S.R. This intake was assigned for CPS investigation and founded as to both parents for negligent treatment or maltreatment regarding S.R.'s death. The finding was made due to the monitor not being placed on S.R.'s foot before the mother fell asleep and after the home health nurse left the home. A case note indicated a physician called the CPS investigator post fatality and informed him that the parents had been counseled on the possible ramifications if the monitor was not properly used. All three investigations were conducted by the same CPS investigator.

Committee Discussion

The Committee appreciated the CPS supervisor's input utilizing hindsight regarding areas where the worker's investigation could have improved. The supervisor stated CA should have known about the in-home nursing aid due to the assignment to the children at birth. Had there been more curiosity leading to further in-depth collateral contacts, the investigations may have provided more clarity as to the functioning of the household and the wellbeing of all three of the children. The supervisor said she has been working to change her staff's practice

[4] The Structured Decision Making® (SDM) risk assessment is a household-based assessment. It estimates the likelihood that a child will experience abuse or neglect in a given household based on the characteristics of the caregivers and children living in that household. To accurately complete the SDM® risk assessment, it is critical to accurately identify the household being assessed. [Source: CA Practices and Procedures Guide 2541]

and to work on asking questions that are hard and uncomfortable and being more curious about situations surrounding the children they are required to assess for abuse or neglect.

The supervisor also stated it is regular practice to interview all of the children in a home. She acknowledged this did not occur during the three investigations regarding this family. S.R and his twin were 18 months old at the time of S.R.'s death; their sister was 6 years old at that time. She also stated that the SDM® rated moderately high and per policy services should have been offered to this family. She was not sure if services were offered but acknowledged there was no documentation of efforts to offer services to the family.

The Committee discussed the possibility of a shared decision meeting or a Family Team Decision Making Meeting (FTDM) for this family. The supervisor stated that recently the FTDM facilitators in the Shelton office have been more open to conducting the meetings for safety planning purposes and she is hopeful this will continue. The Committee noted the supervisory review notes contained in the case file were well written and detailed.

Findings

The Committee noted based on their review of the case documents and interviews with staff, that there were no critical errors made by DSHS staff. However, there were areas where practice may be improved.

The CPS investigator failed to conduct adequate collateral contacts to assess the wellbeing of all three children in the home. Collateral contacts that could have assisted with the assessment include medical providers for S.R.'s siblings and requesting medical records from those providers, interviewing S.R.'s older sister and speaking with her school she was attending, speaking with the in-home nursing aid (prior to the fatality) and speaking with relatives and/or friends.[5]

S.R. had complex medical issues. CA staff are not medical experts; however, they do have access to the Medical Consultation Network for any case. A consultation with a physician through the network may have assisted the CPS investigator with a better understanding of S.R.'s medical needs and what providers were involved with his care. There was communication with S.R.'s Gastroenterology hospital social worker but not with his pediatrician or other specialists involved in his care.

[5] Interview, in-person or by telephone, professionals and other persons (physician, nurse, school personnel, child day care, relatives, etc.) who are reported to have or, the social worker believes, may have first-hand knowledge of the incident, the injury, or the family's circumstances. [Source: CA Practices and Procedures Guide 2331]

The worker failed to comply with Practices and Procedures Policy 2331 requiring the social worker to refer a child between the ages of birth to 3, identified with a developmental delay to a Family Resources Coordinator with the Early Support for Infants and Toddlers.[6]

Recommendations

CA should provide training to all staff regarding the utilization of the Medical Consultation Network highlighting that the consultations can also include medically complex cases.

[6] Source: CA Practices and Procedures Guide 2331]