Washington State Department of Social and Health Services

Transforming Lives

REPORT TO THE LEGISLATURE

Quarterly Child Fatality Report

RCW 74.13.640

October – December 2016

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

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Executive Summary

This is the Quarterly Child Fatality Report for October through December 2016 provided by the Department of Social and Health Services (DSHS) to the Washington state Legislature. RCW 74.13.640 requires DSHS to report on each child fatality review conducted by the department and provide a copy to the appropriate committees of the legislature:

Child Fatality Review — Report

(1)(a) The department shall conduct a child fatality review in the event of a fatality suspected to be caused by child abuse or neglect of any minor who is in the care of the department or a supervising agency or receiving services described in this chapter or who has been in the care of the department or a supervising agency or received services described in this chapter within one year preceding the minor's death.

(b) The department shall consult with the office of the family and children's ombudsman to determine if a child fatality review should be conducted in any case in which it cannot be determined whether the child's death is the result of suspected child abuse or neglect.

(c) The department shall ensure that the fatality review team is made up of individuals who had no previous involvement in the case, including individuals whose professional expertise is pertinent to the dynamics of the case.

(d) Upon conclusion of a child fatality review required pursuant to this section, the department shall within one hundred eighty days following the fatality issue a report on the results of the review, unless an extension has been granted by the governor. A child fatality review report completed pursuant to this section is subject to public disclosure and must be posted on the public web site, except that confidential information may be redacted by the department consistent with the requirements of RCW 13.50.100, 68.50.105, 74.13.500 through 74.13.525, chapter 42.56 RCW, and other applicable state and federal laws.

(2) In the event of a near fatality of a child who is in the care of or receiving services described in this chapter from the department or a supervising agency or who has been in the care of or received services described in this chapter from the department or a supervising agency within one year preceding the near fatality, the department shall promptly notify the office of the family and children's ombuds. The department may

conduct a review of the near fatality at its discretion or at the request of the office of the family and children's ombuds.

In April 2011, SHB 1105 was passed by the legislature and signed into law by Governor Gregoire. The revised child fatality statute (RCW 74.13) became effective October 22, 2011 and requires the department to conduct fatality reviews in cases where a child death is suspected to be caused by abuse or neglect. This eliminated conducting formal reviews of accidental or natural deaths unrelated to abuse or neglect. The revised statute requires the department to consult with the Office of Family and Children's Ombuds (OFCO) if it is not clear that the fatality was caused by abuse or neglect. The department can conduct reviews of near-fatalities or serious injury cases at the discretion of the department or by recommendation of OFCO. The statutory revision allows the department access to autopsy and post mortem reports for the purpose of conducting child fatality reviews.

This report summarizes information from completed reviews of three (3) fatality and five (5) near-fatality that occurred in the fourth quarter of 2016. All child fatality review reports can be found on the DSHS website: https://www.dshs.wa.gov/ca/publications/childrens-administration-child-fatality-reports

The reviews referenced in this quarterly report include child fatalities and near fatalities from three regions.

Region	Number of Reports
1	4
2	2
3	2
Total Fatalities and Near-Fatalities Reviewed During 4th Quarter 2016	8

This report includes Child Fatality Reviews conducted following a child's death that was suspicious for abuse and neglect and the child had an open case or received services from the Children's Administration (CA) within 12 months of his/her death or injury. A critical incident review consists of a review of the case file, identification of practice, policy or system issues, recommendations and development of a work plan, if applicable, to address any identified issues. A

review team consists of a larger multi-disciplinary committee including community members whose professional expertise is relevant to the family history. The review committee members may include legislators and representatives from the Office of the Family and Children's Ombuds.

The charts below provide the number of fatalities and near-fatalities reported to CA and the number of reviews completed and those that are pending for calendar year 2016. The number of pending reviews is subject to change if CA discovers new information through reviewing the case. For example, CA may discover that the fatality or near-fatality was anticipated rather than unexpected, or there is additional CA history regarding the family under a different name or spelling.

Child Fatality Reviews for Calendar Year 2016			
Year	Total Fatalities Reported to Date Requiring a Review	Completed Fatality Reviews	Pending Fatality Reviews
2016	11	11	0

Child Near-Fatality Reviews for Calendar Year 2016			
Year	Total Near-Fatalities Reported to Date Requiring a Review	Completed Near-Fatality Reviews	Pending Near-Fatality Reviews
2016	7	7	0

The child fatality review referenced in this Quarterly Child Fatality Report is subject to public disclosure and is posted on the DSHS website. https://www.dshs.wa.gov/ca/publications/childrens-administration-child-fatality-reports

Near-fatality reports are not subject to public disclosure and are not posted on the public website or included in this quarterly report.

Notable Fourth Quarter Findings

Based on the data collected and analyzed from the three (3) fatalities and five (5) near-fatalities during the 4th quarter, the following were notable findings:

- Three (3) of the eight (8) cases referenced in this report were open at the time of the child's death or near-fatal injury.
- Four (4) of the eight (8) cases referenced in this report document children dying or suffering near fatal injury from ingesting toxic substances including methamphetamine and methadone.
- Six (6) of the eight (8) children referenced in this report were under three (3) years of age when the fatality or near fatality incident occurred.
- Seven (7) of the eight (8) cases referenced in this report were the result of abuse or neglect by the children's parents.
- Four (4) children in this report were Caucasian, two (2) were Hispanic and two (2) were African-American.
- Children's Administration received intake reports of abuse or neglect in the each of the cases in the report prior to the death or near-fatal injury of the child. In four (4) cases, there were two (2) intakes reported to CA prior to the critical incident; in one (1) case there were four (4) prior intakes and in another there were five (5) intakes prior to the child's death. In one (1) near fatality case, there were 30 intakes on the family prior to the near fatal incident.
- In 2016, of the fatality and near fatality cases reviewed by Children's Administration, five (5) were due to children ingesting toxic substances such as methadone and methamphetamine.
- In 2016, of the fatality cases reviewed by Children's Administration, five (5) died in unsafe sleep environments. All five children were under 8 months of age. One (1) infant died in an unsafe sleep environment of the fatalities reviewed during the 4th quarter 2016.
- Due to the small sample of cases reviewed, no statistical analysis was conducted to determine relationships between variables.

Washington State Department of Social & Health Services

CA Children's Administration

RCW 13.50.100

[redacted].

Child Fatality Review

June 1999
Date of Child's Birth

January 4, 2016
Date of Fatality

June 13, 2016
Child Fatality Review Date

Committee Members
Randy Maynard, Sergeant, Criminal Investigations Divisions, Kennewick Police Department
Kimberlee Abe-Gunter, Quality Assurance Program Manager, Developmental Disabilities Administration
Rebecca Wilson, Child and Family Services Supervisor, Children's Administration, Yakima
Patrick Dowd, Director, Office of the Family and Children's Ombuds
Michele Leifheit, Licensed Mental Health Counselor

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

Executive Summary RCW 13.50.100

On June 13, 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 sixteen-year-old [redacted] and [redacted] family.[2] The child is referenced by [redacted] initials, [redacted] in this report. At the time of [redacted] death [redacted] resided with his adoptive parents, his four adoptive siblings and [redacted] two biological siblings. The incident precipitating this review occurred on January 4, 2016 when [redacted] died of acute intoxication due to sodium nitrite ingestion. [redacted] mother reported to police that she had given [redacted] this substance, which is commonly referred to as saltpeter, because she believed it would curb [redacted] sexualized behavior. The family had a Child Protective Services (CPS) case open during the preceding 12 months. RCW 13.50.100

The CFR committee consisted of community members and CA staff with relevant expertise in child development, mental health, law enforcement and child welfare as well as a representative from the Office of the Family and Children's Ombuds. No committee members had previous involvement with family.

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 a family home study, mental health evaluations, law enforcement reports and the medical examiner's report. 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 investigator who had most recently been assigned to the case, the CA social worker who conducted the adoptive home study in 2008 and the current CPS Supervisor who provided an overview of case load and workload issues that impacted this office during the time the case was open. The Committee spoke briefly with a caseworker from the Developmental Disabilities Administration (DDA) who provided an overview of the services DDA provided to the family. Following a review of the case file documents, interviews with CA staff and discussion regarding department activities and decisions, the Committee made

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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 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] [redacted] family is 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 management information system. [Source: RCW 74.13.500(1)(a) RCW 13.50.100

several recommendations for purposes of practice improvement that are detailed at the end of this report.

Case Summary RCW 13.50.100

Children's Administration first became involved with this family in 2007 when they contacted CA stating they were interested in adoption. In February 2008, Utah State Department of Human Services requested that CA conduct a home study of the family because they were interested in adoption [redacted]. and [redacted] two siblings. At that time, [redacted] and [redacted] siblings were residing in foster care in Utah and were eligible for adoption. The CA home study was approved and the Utah Department of Human Services placed the children with the family in July 2008 through guidelines established in the Inter Interstate Compact on the Placement of Children (ICPC).[3] After their placement in Washington state, the CA case remained open until the children's adoption was finalized in February 2009.

RCW 13.50.100

In January 2010, CA received an intake that alleged [redacted] Because [redacted] was a licensed child care provider, the intake was assigned to a CPS investigator with the Division of Licensed Resources (DLR).[4] The parents denied the allegations of [redacted], but acknowledged that they were struggling to deal with behaviors exhibited by their adopted children and often used physical exercise as a method of discipline. The investigation was unfounded for [redacted][5] and the case was closed after the family reported they were participating in family therapy and a support services. Concurrent with the DLR investigation, the Department of Early Learning (DEL),[6] reviewed the family child care license to evaluate the care of the children in licensed child care. The DEL complaint was closed with no restrictions on her license. In November 2011, the family applied for a foster care license through Children's Administration but withdrew their application prior to completion of the application process. RCW 13.50.100

[3] Interstate Compact on the Placement of Children (ICPC) is a uniform reciprocal law enacted in every state that governs the interstate placement of foster children. The Compact prohibits states from sending a dependent child to live with an out-of-state caregiver without first obtaining approval from the receiving state's child welfare agency following a home study and other assessments of the caregiver. [RCW 26.34.010]

[4] The Division of Licensed Resources/Child Protective Services Investigation takes place when a child is believed to have been abused or neglected in a facility licensed to care for children.

[5] Unfounded means the determination following an investigation by the department that available information indicates that, more likely than not, child abuse or neglect did not occur, or that there is insufficient evidence for the department to determine whether the alleged child abuse did or did not occur. Founded mean the determination following an investigation by the department that. Based on available information, it is more likely than not that child abuse or neglect did occur." [Source: RCW 26.44.020]

[6] The Department of Early Learning is a state agency that oversees licensing and monitoring of day care homes and centers.

On January 2, 2014, CA received an intake that alleged [redacted] of the oldest adopted child, [redacted] A CPS investigator made initial contact with the child at the family home and [redacted]. When the child was interviewed two weeks later by a different CPS investigator, [redacted] denied the allegations of [redacted]. The case remained open with no documented activity until October 5, 2014 when CA received another intake alleging [redacted] was [redacted] to the children. A new social worker was assigned who was also given the task of completing the prior investigation. The social worker interviewed all the children, who all denied that they were [redacted]. The parents denied using [redacted] but acknowledged that they use physical exercise as a form of discipline. The investigator did not observe any marks or injuries on the children and closed the investigation as unfounded. The case was closed on January 22, 2015. On January 30, 2015, CA received an intake alleging neglect of the youngest adopted child. This was screened out and not assigned for investigation[7].

The department had no further involvement with this family until January 11, 2016 when CA received information that [redacted] had died on January 4, 2016 under suspicious circumstances. The intake reported that [redacted] had apparently died from something [redacted] had ingested and that there were no overt signs of abuse or neglect. The autopsy revealed that [redacted] had died of acute intoxication due to sodium nitrite ingestion. [redacted] mother admitted to giving [redacted] to curb his behavior and did not know that this was not appropriate for consumption. This intake was accepted for investigation and the mother was given a founded finding of neglect. RCW 13.50.100

Committee Discussion

Committee members reviewed and discussed CA documentation spanning the history of CA involvement with the family from 2007 through 2014. The considered additional verbal accounts presented by staff to gain an understanding of CA policy and practice regarding investigative standards, the home study process and ICPC practice guidelines. In addition, the ICPC program manager was consulted telephonically and helped to provide the Committee with an understanding of the extent of CA's responsibility in the placement of children who are the legal dependents of another state.

In reviewing CA's more recent activity with this family during the 2014-2015 CPS investigations, the Committee was concerned about the gap in CA activity that occurred from January 2014 to October 2014. The Committee reviewed caseload data from that period which indicated that this office had a backlog of over 450 CPS

[7] CA will generally screen out the following intakes: 1)Abuse of dependent adults; 2) Allegations where the alleged perpetrator is not acting in loco parentis; 3) Child abuse and neglect that is reported after the victim has reached age 18, except that alleged to have occurred in a licensed facility; 4) Child custody determinations in conflictual family proceedings or marital dissolution, where there are no allegations of CA/N; 5) Cases in which no abuse or neglect is alleged to have occurred; and 6) Alleged violations of the school system's statutory code or administrative code.

investigations that were overdue for closure. The social worker assigned to the January 2014 investigation had over 50 open investigations, which was the average for this CPS unit. The Committee recognized that this high caseload significantly impacted the worker's ability to provide services and complete investigations in a timely manner.[8] Noting also that the CPS supervisor at that time had not documented any supervisory reviews on this case, the Committee acknowledged that high caseload would have necessarily impacted a supervisor's ability to conduct regular clinical supervision as is required by policy.[9]

The Committee expressed concern about the impact that high caseloads have on CA's ability to assess safety and risk, particularly in cases like this one where there was little case activity for an extended period of time. The Committee spoke with the current CPS supervisor about these concerns and he described how the local office worked with regional CA staff on several strategies to effectively address this backlog. The strategies included the use of data and practice consultants to prioritize cases and the deployment of workers from other CA offices and other programs who had the necessary training to complete investigations.

The Committee appreciated the participation of the staff who were interviewed, including staff who are no longer employed by CA but were willing to participate in order to assist the Committee in gaining an understanding of the case history. The Committee also wished to acknowledge the thorough and timely documentation done by the social worker assigned to the October 2014 investigation, acknowledging that this investigation was done while she was assigned to a different program and carried a full caseload.

[8] Per CA policy, the Investigative Assessment is to be completed following conclusion of a CPS investigation within 60 calendar days of CA having received an intake. [Source: CA Practices and Procedures Guide-2540 Investigative Assessment]

[9] CA policy requires that social work supervisors conduct monthly supervisory case reviews with each assigned social worker and document each case review in the client electronic case file. [Source: CA Practices and Procedures Guide 46100 Monthly Supervisor Case Reviews]

Findings

At the 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 found two areas identified as opportunities for improved practice.

- The January 2014 CPS investigation was incident-focused and could have included more information regarding child safety and parental functioning. The assessments were not completed in a timely manner and there were no ongoing efforts to monitor child safety as is required when the case had been open for more than 90 days.
- There were no supervisory reviews documented from January 2014 through November 2014.

Action taken: When interviewed by the Committee, the CPS Supervisor outlined the progress made to eliminate the backlog as well as ongoing efforts to provide regular supervisory oversight and monitoring. The elimination of the backlog has addressed both of the issues above.

Recommendations

The Committee noted that throughout CA's involvement with this family, there was little documentation of collaboration with staff from the Developmental Disabilities Administration, though the family was receiving services from that administration, including assessments and in-home care. Though the Committee did not make a finding about this, they did believe there were missed opportunities for collaboration and corroboration and chose to make recommendations for the purpose of improving practice.

- The Committee recommended that CA train staff, either through memo or a "Practice Tip," about how to use the FamLink system to recognize when their clients are receiving services from the Developmental Disabilities Administration (DDA).
- The Committee recommended that CA provide guidance to staff about best practice guidelines for collaboration with DDA, including accessing client assessments and services and the importance of including DDA workers in Family Team Decision Making Meetings (FTDM)[10] and permanency planning hearings.

[10] Family Team Decision Making 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]

Child Fatality Review
G.C.

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

May 22, 2016
Date of Child's Death

September 7, 2016
Date of the Fatality Review

Committee Members
Patrick Dowd, Director, Office of the Family & Children's Ombuds
Brian Jones, Sergeant, Moses Lake Police Department
Amy Serrano, Registered Nurse, Confluence Health Clinic
Roxanne Cates, Program Manager, Children's Home Society
Chris Tippet, County Designated Mental Health Professional (CDMHP), Director, The Center for Alcohol and Drug Treatment
Jennifer Andrade, Supervisor, Children's Administration

Consultant
Jenna Kiser, Intake/Safety Program Manager, Children's Administration

Facilitators
Susan Danielson, Investigation Specialist, Children's Administration
Cheryl Hotchkiss, Critical Incident Review Specialist, Children's Administration

Executive Summary

On September 7, 2016, the Department of Social and Health Services, Children's Administration (CA) convened a Child Fatality Review (CFR)[11] to assess the department's practice and service delivery to an infant child, G.C., and RCW RCW 74.13.515 family[12]. The child is referenced by RCW 74.13.515 initials, G.C., in this report. At the time of RCW 74.13.515 death, G.C. resided with RCW 74.13.515 mother and RCW 74.13.515 older siblings in RCW 74.13.515, Washington. The department had an open Family Voluntary Service case (FVS)[13] at the time of G.C.'s death. The incident initiating this review occurred on May 22, 2016, when G.C. died while co- sleeping with RCW 74.13.515 mother. The county coroner later determined the child died from acute methamphetamine intoxication.

The CFR Committee included CA staff and community members selected from diverse disciplines with relevant expertise, including child welfare, chemical dependency, law enforcement, in-home service provision, the Office of the Family and Children's Ombuds and medical expertise. The participating community members had no previous direct involvement with this family.

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 case notes, referrals for services, assessments and medical records. The hard copy of the file was available at the time of the review. Supplemental sources of information and resource materials were also available to the Committee, including copies of state laws and CA policies relevant to the review, workload and case assignment data for this unit during the time that the case was open.

The Committee interviewed CA social workers and supervisors who had previously been assigned to the case. Following the review of the case file documents, review of

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[12] The parents are not identified by name in this report as no criminal charges were filed relating to the incident. The names of G.C.'s siblings are subject to privacy law. [Source: RCW 74.13.500(1)(a)]

[13] 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 manage child safety. [Source: CA Practices and Procedures Guide]

case assignment and workload report information taken from FamLink[14] for the staff involved, completion of staff interviews and discussion regarding department activities and decisions, the Committee made findings and recommendations that are presented at the end of this report.

Case Overview

On May 23, 2016, the assigned Social Worker to the case received information from a contracted provider stating that RCW 74.13.515 -week-old G.C. had died in RCW 74.13.515 mother's care. The mother had called the contracted provider to notify them that she would not be participating in services due to her child's death. G.C.'s mother reported to law enforcement that she had awakened at approximately 1:00 a.m. and found G.C. unconscious and unresponsive. Based upon the mother's report, the child appears to have been sleeping in the bed with her. She contacted emergency responders who transported the infant to a nearby hospital where RCW 74.13.515 was pronounced dead at 3:00 a.m. on May 22, 2016. This family had an open Family Voluntary Services (FVS) case at the time of G.C.'s death. The mother has two surviving children, age 11 years and 2 years, respectively.

The RCW 74.13.515 County Coroner ruled on the official cause of death weeks following the fatality review. The preliminary cause of death of co-sleeping with an adult was changed to acute methamphetamine intoxication. This information was not available to the Committee at the time of the review.

Background

Children's Administration (CA) first became involved with this family in 2009 when an intake report was called in by a neighbor concerning the RCW 13.50.100. That child was RCW 13.50.100 at the time. The referent stated concerns surrounding RCW 13.50.100 as well as suspicion of methamphetamine and marijuana use by the mother. After failed attempts to locate the family, CA closed the case on February 19, 2009.

On February 10, 2014, CA received an intake alleging RCW 13.50.100[15] of the RCW 13.50.100 The concerns reported were RCW 74.13.520 . The mother RCW 74.13.520 She disclosed to the department social worker that she would not be having any more children as she recognized she could not care for any more

[14] FamLink is the case management information system that CA implemented on February 1, 2009. It replaced CAMIS, which was the case management system used by the agency since the 1990s.

[15] "Negligent treatment or maltreatment" means an act or omission that evidences a serious disregard of consequences of such magnitude as to constitute a clear and present danger to the child's health, welfare, and safety. The fact that siblings share a bedroom is not, in and of itself, "negligent treatment or maltreatment. [Source: RCW 26.44.020; CA Case Services Policy Manual Appendix A: Definitions]

children. The allegations were determined to be unfounded[16] and the case was closed on November 13, 2014.

On RCW 74.13.515, 2016, CA received an intake from a registered nurse (RN) alleging that newborn G.C. was at risk due to the mother's drug use and her lack of prenatal care. The hospital reported that the mother tested positive for marijuana and methamphetamine. G.C.'s cord sample was compromised and no drug screening results were obtained that may have helped to determine prenatal exposure to an illegal substance. The RN reported the mother to be minimally engaged and that she would leave the child often to go outside to smoke. A CPS investigator was assigned and responded to the hospital. The mother admitted to the assigned social worker that she used methamphetamine prior to her eldest child's birth; however, she denied current use. She informed the assigned social worker that she currently used marijuana and believed some of it to have been inadvertently laced with methamphetamine resulting in her positive drug test. The social worker had conversations with the mother about safe sleep[17] guidelines, advised against co-sleeping with G.C. and ensured that she watched the Period of Purple Crying[18] video. Ongoing services for the family, including transportation and basic needs, were discussed between the mother and social worker.

On April 14, 2016, CA received a new intake alleging that G.C. and RCW 13.50.100 were neglected in their mother's care. The concerns reported were in regard to RCW 13.50.100 the sleeping arrangements for G.C. Further concern surrounded the RCW 13.50.100 . The CPS investigator visited the family home and discussed the allegations with the mother. The mother stated that she laid G.C. on the bed rather than RCW 74.13.515 sleeping basket after RCW 74.13.515 woke up. She finally got RCW 74.13.515 back to sleep after 3 hours and laid RCW 74.13.515 on the bed hoping not to

[16] Unfounded means the determination, following an investigation by the department, that available information indicates that, more likely than not, child abuse or neglect did not occur, or that there is insufficient evidence for the department to determine whether the alleged child abuse did or did not occur. Founded means the determination following an investigation by the department that, based on available information, it is more likely than not that child abuse or neglect did occur." [Source: RCW 26.44.020]

[17] 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. [Source: A Parent's Guide to Safe Sleep]

[18] 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. [Source: What is the Period of Purple Crying?]

wake RCW 74.13.515. The social worker discussed the risks of co-sleeping and suffocation and advised the mother to take the risk of waking the baby up by putting him in the basket for safe sleep. The social worker observed the rest of the home RCW13.50.100 The family identified as possible RCW 74.13.515 ancestry and a request to the inquiry unit was sent on April 14, 2016.

With the agreement of the mother, the investigation was transferred to the Family Voluntary Services (FVS) social worker on April 29, 2016. The identified needs for services were RCW13.50.100, parental education and chemical dependency assessment. The assigned CA social worker referred the family for Family Preservation Services (FPS),[19] a home-based service offered by the department. The FPS worker and department explored sleeping arrangements and basic infant care RCW 13.50.100. The service provider continued to encourage the mother not to co-sleep and to instead use the infant sleeping basket. The FPS provider did not suspect any current use of drugs by the mother, but reported that her appearance did correlate with a methamphetamine user. On May 10, 2016, the department completed a safety assessment that identified no safety threats. The assigned social worker spoke with collateral contacts who continued to express concern that the mother was using methamphetamines RCW 13.50.100 The department discovered through a collateral contact that a RCW 13.50.100. The mother cancelled chemical dependency assessments and FPS appointments on May 17, 2016 and May 24, 2016.

On May 23, 2016, the mother notified the Family Preservation Service provider of G.C.'s death, reporting she would not be doing any services that week. The FPS provider contacted the assigned social worker who reported the fatality to the CA intake reporting line. The mother admitted to authorities that G.C. had been sleeping with her on her adult-sized bed. She woke up at approximately 1:30 a.m. and found RCW 74.13.515unconscious and unresponsive. She stated she ran next door to her mother's residence for help. Her brother was said to have started CPR. Paramedics arrived at the home at about 2:00 a.m. and transported the baby to the nearest hospital where RCW 74.13.515was later pronounced dead. The county coroner had yet to identify a cause or manner of death when the review took place.

[19] Family Preservation Services (FPS), authorized and described in RCW 74.14C.050, are family-focused, behavior-oriented, in-home counseling and support programs. FPS may be used when youth are at substantial risk of placement or for children returning to the home from out-of-home care. FPS begins within 48 hours of referral, is available 24 hours a day, and can be up to six (6) months in duration. FPS is designed to be less intensive than IFPS/Homebuilders and interventions are focused on improving family functioning and assisting with getting connected to local community resources. FPS is provided by contracted vendors.

Committee Discussion

For purposes of this review, the Committee focused on case activity that occurred prior to the fatality and most specifically on case activities during the 2016 involvement. The Committee discussed case assignment information that was provided in order to gain insight as to the functioning of the office from 2015 through 2016. The Committee acknowledged that the CPS response in 2014 was limited in relation to information gathering for assessment and should have closed according to the policy timeframes for investigations.[20] Though the Committee chose not to make a finding about this, they wanted their concerns included in the report for purposes of practice improvement.

The Committee discussed that during the 2016 investigations, there may have been an active safety threat[21] based on the information that was available to the department. Overall, the Committee believed there was a lack of curiosity, verification, corroboration and consultation while assessing safety, completing the investigation or during ongoing Family Voluntary Services. There were missed opportunities to truly understand the daily functioning in the home and the caregivers' ability to care for the children. The Committee spent considerable time discussing the importance of collateral contacts in conducting a comprehensive assessment of risk and safety. The Committee noted missed opportunities to gather additional clarifying information from the hospital and medical providers, from law enforcement, from the school, from DSHS databases and from other sources within the family's community, including the landlord and neighbors. The Committee believed that a Family Team Decision-Making meeting (FTDM),[22] a consultation with the Assistant Attorney General (AAG), a shared planning meeting[23] or case

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[20] Per CA policy, a Safety Assessment is required to be completed no later than 30 calendar days from the date of an intake. The Structured Decision Making Risk Assessment® (SDMRA) is to be completed no longer than 60 days after the intake was received. Similarly, the Investigative Assessment is to be completed following conclusion of a CPS investigation, within 60 calendar days of CA having received an intake. [Source: CA Practices and Procedures Guide 1120; CA Practices and Procedures Guide 2540; CA Practices and Procedures Guide 2541]

[21] A threat of danger is a specific family situation or behavior, emotion, motive, perception or capacity of a family member that threatens child safety. The danger threshold is the point at which family functioning and associated caregiver performance becomes perilous enough to be perceived as a threat or produce a threat to child safety. The safety threshold determines impending danger. Safety threats are essentially risk influences that are active at a heighten degree and greater level of intensity. Safety threats are risk influences that have crossed a threshold in terms of controllability that has implications for dangerousness. Therefore, the safety threshold includes only those family conditions that are judged to be out of a caregiver's control. [Source: Safety Threshold]

[22] A Family Team Decision-Making 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 meeting are held to make critical decisions regarding the placement of children following and 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 an 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 an 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. An FTDM will take place in all placement decisions to achieve the least restrictive, safest placement in the best interests of the child. By utilizing this inclusive process, a network of support for the child(ren) and adults who care for them are assured. Source: Family Team Decision-Making Meeting Practice Guide]

[23] All staffings engage parents in the shared planning process to develop family specific case plans focused on identified safety threats and child specific permanency goals. Working in partnership with families, natural supports and providers helps identify

consultation may have assisted the department in obtaining additional and available information that would have promoted a thorough safety assessment.

Considerable Committee discussion focused on the department's assessment of the mother's alleged substance abuse. The Committee questioned whether the assigned social workers fully considered the impacts of the mother's current marijuana use and twice positive methamphetamine urinalyses in correlation to her ability to safely care for her children. The Committee was concerned that the workers may have taken the mother's statements about her drug use at face value and that further corroboration and collateral contacts may have improved the worker's assessment of the mother's ability to care for her children. The Committee identified that further training on how substance use impacts child safety and parental functioning would be beneficial for all staff members in CA.

The Committee considered the importance of case consultation and shared decision-making when dealing with complex cases like this one and that the consultation should include the AAG as well as program experts and CA staff at all levels in the chain of command. The Committee discussed whether this office might benefit from training with local AAGs that is focused on when to staff cases with an AAG and how to staff them productively. The Committee discussed the importance of their management team being present to support the process and staff.

Transferring cases between programs was a focus of conversation for the Committee. It was evident that a clear process for transferring cases should be followed by the local office follows to ensure all parties are aware of and understand their responsibilities related to case activity and gathering subsequent information related to child safety. Training was discussed as a potential need when social workers taking on overflow case assignments in secondary programs to assist workers in their understanding of policy and procedures related to that program.

The Committee discussed CA developing a protocol in response to fatalities on open cases. In deliberation, it was relayed that social workers and supervisors should be offered best practice guidelines involving response to investigations and/or fatalities involving substance abuse in conjunction with unsafe sleep allegations. The Committee discussed noticeable ambiguity that arises when responding to a fatality that is related to unsafe sleep practices. The Committee questioned whether there is a statewide lack of consensus about CA's role in the investigation of child deaths related to unsafe sleep and ongoing confusion among staff about the meaning of the terms "SIDS"[24] and "SUID." While acknowledging that the CFR is focused on

parents' strengths, threats to child safety, focus on everyday life events, and help parents build the skills necessary to support the safety and well-being of their children. The shared planning process integrates all CA staffings.

[24] 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]

CA's actions and decision-making prior to the child's death, the Committee expressed concern that what appears to be a lack of consensus may be a system-wide issue with the professional entities involved.

Furthermore, the Committee discussed that best practice guidelines would suggest that the social workers complete a "Plan of Safe Care"[25] when children have been exposed to substances in utero regardless of whether it can be determined that the child has been affected from substances. The supervisors should verify that a Plan of Safe Care has been completed in a case note in all circumstances.

The Committee wanted to express its appreciation to the local office staff for their participation in the review and their cooperation in helping the Committee understand the "story" of the case. The Committee also wished to note an area of strong practice related to the number of conversations CA and providers had with the mother and documentation that was completed in regard to infant safe sleep.

Findings

After a review of the case chronology, interviews with staff and discussion, the Committee did not identify any critical errors. However, the Committee identified areas for practice improvement.

The Committee recognized that the investigation related to the April 2016 reports was incident-focused and lacked more comprehensive information from collateral sources that may have improved the department's assessment of risk and safety. The Committee recognized that had further information been gathered to assess child safety during the investigation, there may have been an identified safety threat early on in the 2016 response. Additionally, the siblings in the home were not included in the safety assessment and the Committee believed that the CA staff should have gathered information on all of the children in the home. Had this information been sought out, it would have assisted the CA staff in completing a more comprehensive safety assessment and investigation. Sources of information or areas of corroboration the department could have used during its assessment include:

- Exploring and gathering information about all children in the home and their functioning.
- Obtaining medical and educational records for all of the children in the home.
- Obtaining criminal history for the caregivers in the home or people who frequent the home.
- Collaborating with Law Enforcement.
- Contacting the fathers and paternal relatives of the children.

[25] Children's Administration caseworkers must complete a "Plan of Safe Care" as required by the Child Abuse Prevention and Treatment Act (CAPTA) when a newborn has been identified as substance affected by a medical practitioner. Substances are defined as alcohol, marijuana and all drugs with abuse potential; including prescription medications. [Source: CA Practice and Procedures Guide 2552]

- Verification of and curiosity in relation to the mother's statements or explanations of all situations.

Recommendations

The Committee recommends that the local office consider holding a Family Team Decision-Making meeting immediately at the local office or hospital when an infant has been exposed to drugs in utero and the parent denies use of drugs or the impact of such drugs on the infant.

To assist in information gathering and assessment, the local CA office Area Administrator, in conjunction with the CPS and FVS supervisors in the office, should devise a more specific method for case transfer that details the roles and responsibilities of the sending and receiving social workers. The receiving unit should ensure that there is sufficient information gathered from the sending party to proceed in ongoing safety assessment and case planning. If the sending party has not investigated other persons caring for the children or frequenting the home, obtained medical records and criminal histories and verified information given by the subjects and victims, the roles and responsibilities at transfer should outline who will follow up to gather the necessary information to complete comprehensive assessments (if the case is transferred without these items completed).

Finally, any unit taking on overflow case assignment responsibilities should be crossed-trained in the program from which that unit is receiving overflow cases if those responsibilities are not their primary program function.

Washington State Department of Social & Health Services

CA Children's Administration

Child Fatality Review

B.Z.

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

June 17, 2016
Date of Fatality

October 19, 2016
Child Fatality Review Date

Committee Members
Elizabeth Bokan, Office of the Family & Children's Ombuds
Megan Boyle, Associate Director, Children's Intensive Services, Compass Health
Elizabeth Morgan, Family Support Center Professional, Brigid Collins
Kristy Suydam, MSW, Supervisor, Children's Administration
Melissa Phillips, Continuing Education Specialist, Alliance for Child Welfare Services
Jennifer Gaddis, Quality Practice Specialist, Children's Administration

Facilitator
Cheryl Hotchkiss, Critical Incident Review Specialist, Children's Administration

Executive Summary

On October 19, 2016, the Department of Social and Health Services, Children's Administration (CA) convened a Child Fatality Review (CFR)[26] to assess the department's practice and service delivery to an infant child, B.Z., and RCW 74.13.515family.[27] The child is referenced by RCW 74.13.515initials, B.Z., in this report. At the time of RCW 74.13.515death, B.Z. had been residing with his mother. The incident initiating this review occurred on June 17, 2016 when B.Z. died while in the home of RCW 74.13.515 . RCW 74.13.515grandmother.

The Review Committee included CA staff and community members selected from diverse disciplines with relevant expertise, including an in-home service provider, child welfare professionals, mental health and the Office of the Family and Children's Ombuds. The participating community members had no previous direct involvement with this family.

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 case notes, referrals for services, assessments and medical records. The hard copy of the file was available at the time of the review. Supplemental sources of information and resource materials were also available to the Committee, including state laws and CA policies relevant to the review.

The Committee interviewed CA social workers and supervisors who had previously been assigned to the case. Following the review of the case file documents, completion of staff interviews, and discussion regarding department activities and decisions, the Committee made findings and recommendations that are presented at the end of this report.

Case Summary

On June 17, 2016, CA received an intake from the local medical examiner reporting that RCW 74.13.515month old B.Z. was pronounced dead due to Sudden Infant Death Syndrome (SIDS)[28] with unsafe sleeping practices as a contributing factor. B.Z. was under the care and supervision of RCW 74.13.515maternal grandmother at the time of the fatality. RCW 74.13.515mother had left B.Z. with the maternal grandmother while she was

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[26] 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

[27] The parents are not identified by name in this report as no criminal charges were filed relating to the incident. [Source: RCW 74.13.500(1)(a)].

[28] 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]

at work. B.Z. was found unresponsive and face down in a sleeping basket that also contained pillows and blankets. CA had recently closed a Family Voluntary Services (FVS)[29] case with the family in May of 2016.

Background

As a child, B.Z.'s mother was in RCW 13.50.100 and later RCW 13.50.100 by her RCW 13.50.100. While in her adoptive parent's care, B.Z.'s mother was abused and neglected, resulting in her re-entry into the foster care system. Early in 2015 she exited the foster care system as an adult.

The first report related to B.Z.'s mother as a parent came into CA on RCW 74.13.515, 2016. The local hospital called to report that B.Z. had been delivered. The mother's mental health history and status, cognitive/developmental capability, disclosure of past drug use, and history with CA as a child were the reported concerns. Medical staff reported that the mother was handling and caring for B.Z. appropriately while at the hospital from RCW 74.13.515, 2016 to RCW 74.13.515, 2016. The mother was involved with a multitude of in-home and community services prior to B.Z.'s birth. Upon initial contact with B.Z.'s mother, the CPS worker was briefly informed that she was RCW 13.50.100 in her RCW 13.50.100 and maintained contact with her RCW 13.50.100.

As time went on during the CPS assignment, an in-home service provider mentioned a concern for potential RCW 13.50.100 evolving between the mother and her partner. The CPS worker provided the mother information on RCW 13.50.100 and had a discussion with the mother about RCW 13.50.100. The case was transferred to FVS for ongoing safety assessment and service provision and monitoring. The in-home service and community providers reported no concerns for the infant's safety in the care of the mother. There were no blatant safety or risk issues identified from the information that had been gathered by CA and the case was closed on May 19, 2016, one month prior to B.Z.'s death.

Discussion

The Committee discussion focused on CA policy, practice and system responses in an effort to evaluate the reasonableness of decisions and actions taken by the department prior to the critical incident. There was limited discussion of the critical incident and the ensuing investigation.

A majority of the Committee members were impressed with multiple areas of practice conducted by the CPS worker and the FVS worker. However, this opinion

[29] 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 manage child safety. [Source: CA Practices and Procedures Guide, Chapter 3000]

was not shared by all Committee members. The Committee appreciated the CPS worker's comprehensive summary of the case. The worker clearly identified areas of concern and what the next steps should have been for the family and the case. A majority of Committee members felt the CPS worker went above and beyond practice standards to meet with the family immediately and on a weekend to assess the safety of the B.Z. In particular, the Committee noted the CPS worker screened for RCW 13.50.100[30] in the home and again for identifying culturally appropriate resources for the mother when she did not appear to understand the specifics and dynamics of RCW 13.50.100 and RCW 13.50.100 and how they might relate to her own relationship. Additionally, the Committee felt the family was best served by the FVS worker and CPS worker teaming together to ensure contact with the family was made frequently and efficiently. Both CPS and FVS workers provided information to the mother on safe sleep[31] for the infant as well as observed the sleeping arrangement for the infant in the mother's home. Finally, the Committee wanted to recognize the FVS worker for completing health and safety visitations dutifully and timely during his assignment.

As part of the review process, the Committee discussed the mother's CA history as a child. The Committee recognized that the initial report included concerns surrounding the mother's CA history as a child as well as concerns for her RCW 13.50.100 and RCW 13.50.100. The Committee discussed that the mother's RCW 13.50.100, RCW 13.50.100, and RCW 13.50.100 could have been assessed more completely. The Committee believes that obtaining the mother's CA records via FamLink,[32] MODIS,[33] and from the mother's most recent RCW 13.50.100 could have assisted CA in acquiring a more comprehensive understanding of the mother's functioning and her ability to provide care for or make safe decisions for B.Z. The mother's historical involvement with CA was recognized by the Committee as being

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30 "RCW 13.50.100 ." [Source: Social Workers Practice Guide to RCW 13.50.100 page 33]

31 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. [Source: National Institute of Child Health and Human Development]

32 FamLink is the case management information system that CA implemented on February 1, 2009 which replaced CAMIS, the case management system used by Children's Administration since the 1990s.

33 MODIS is CA's digital case archiving system. Closed files are stored in this system so that workers are able to view the case history on their computers

a significant source of information that should have been gathered for the investigation, assessment of child safety, and use in consideration for case closure. The Committee did recognize that the CPS worker initiated gathering such information, but FVS did not follow up upon transfer by gathering information specific the mother's RCW 13.50.100, RCW 13.50.100, and RCW 13.50.100

The Committee noted that the CPS worker and the mother briefly conversed about the RCW 13.50.100 grandmother having contact with the mother. The Committee believed that this may have been a missed opportunity to inquire and explore the extent to which the RCW 13.50.100 grandmother was involved or potentially could have caretaking responsibility of B.Z. in the future. The Committee recognized that this was not a topic of concern brought forth by the multiple community service providers involved with the mother and B.Z. during the CPS or FVS case interventions.

Once the case transferred to the FVS worker, the Committee believed that there may have been a disconnect in the understanding of responsibility for ongoing assessment of the family by the FVS worker. The Committee identified that the CPS worker was clear in her understanding and documentation of the concerns for the family and the ongoing assessment needs. The Committee felt that the CPS worker's assessment for ongoing services may have been diluted or lost in translation at the case transfer. It seemed to the Committee that the FVS worker believed that his primary role was to monitor service compliance rather than gathering information that could not be reviewed or gathered prior to the case transfer in order to have a more comprehensive safety assessment.[34]

The Committee felt that it may have been beneficial for the FVS worker to have had the mother identify long term or future daily life plans prior to case closure. The Committee would have liked to have seen after care conversations with the mother about her ongoing plans once the department was no longer involved, as these may have assisted the mother with future resource and child care planning once the case was closed.

The Committee discussed the supervisor's role in the case transfer process in the local office and specifically between the CPS and FVS units. A formal case transfer and documentation process related to current concerns and next steps did not occur in this case. Further, the Committee found that at times during case transfer there was limited clinical supervision and the assigned staff only informally relayed information about the cases to each other. The Committee believed that a formal case transfer staffing facilitated by the supervisor may assist the workers in clearly

[34] Safety Assessment is used throughout the life of the case to identify impending danger and determine whether a child is safe or unsafe. It is based on comprehensive information gathered about the family at the time the safety assessment is completed. [Source: CA Practices and Procedures Guide, Chapter 1120]

transferring information, identifying gaps in information review or gathering and directing the next steps in the case.
Additionally, to enhance clinical supervision, the committee identified that the 30-day case review could have addressed some of the concerns surrounding the next steps in the case and the lack of historical CA data and RCW 13.50.100 records analysis. Furthermore, the Committee would have liked to have seen each 30-day case review address safety, permanence and well-being more thoroughly and to include updated information related to the case plan and next steps for the worker to take.

Findings

After a review of the case chronology, interviews with staff and discussion, the Committee did not identify any critical errors by CA related to the incident. As previously discussed in this report, the Committee found that the CPS investigation was thorough and comprehensive. The Committee also identified areas for practice improvement, specifically, clarifying FVS' responsibility for ongoing assessment of the family and strengthening the supervisory review process.

Recommendations

Monthly supervisory reviews were documented as having occurred regularly and timely. However, such reviews could have included clinical direction to provide guidance, critical thinking and feedback. The Committee recommends that the local office supervisor work with the regional program consultants to address clinical supervision and documentation practices. The Committee identified the following areas of practice to be considered for improvement:

- The local office CPS/FVS supervisor should verify that CA history on all caregivers and intimate partners or others who have frequent access to the child has been gathered, assessed and documented.
- The CPS/FVS supervisor should take a more active role in the transfer process by facilitating a formal transfer staffing and complete case file documentation of the concerns and dynamics of the case.
- Improve 30-day case review documentation to specifically address safety, permanency, wellbeing with updated case information or case plans.