Report to the Legislature

Quarterly Child Fatality Report

RCW 74.13.640

January – March 2013

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Executive Summary

This is the Quarterly Child Fatality Report for January through March 2013 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 ombudsman. 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 ombudsman.

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 July 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 six (6) child fatalities and 1 near-fatality that occurred in the first quarter of 2013. All of these fatality and near-fatality reviews are conducted as executive child fatality reviews. All prior child fatality review reports can be found on the DSHS website: http://www.dshs.wa.gov/ca/pubs/fatalityreports.asp.

The reviews in this quarterly report include fatalities and near-fatalities from all three regions.[1]

Region	Number of Reports
1	2
2	4
3	1
Total Fatalities and Near Fatalities Reviewed During 1st Quarter, 2013	7

This report includes Child Fatality Reviews and Near-Fatality reviews conducted following a child's death or near-fatal incident 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,

[1] DSHS implemented a reconfiguration of the regional boundaries in May 2011. The existing six regions were consolidated into three.

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 2013. 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 2013			
Year	Total Fatalities Reported to Date Requiring a Review	Completed Fatality Reviews	Pending Fatality Reviews
2013	0	0	0

Child Near-Fatality Reviews for Calendar Year 2013			
Year	Total Near Fatalities Reported to Date Requiring a Review	Completed Near-Fatality Reviews	Pending Near-Fatality Reviews
2013	7	0	7

Four of the five fatality reviews referred to in this Quarterly Child Fatality Report are posted on the DSHS website. One of the fatalities was not required by statute and is therefore not subject to public disclosure.

Notable Findings

Based on the data collected and analyzed from the seven (7) fatalities and one (1) near-fatality reviewed between January and March 2013, the following were notable findings:

- One fatality occurred in Arizona. The family moved from Washington following the closure of a CPS case. A fatality review was also conducted in Arizona.
- Five (5) of the seven (7) cases involved children under three years of age.

- Four (4) of the six (6) fatalities occurred while the family had an open case with CA.
- Two (2) of the fatalities occurred with infants in unsafe sleep environments.
- The child victims were male in five of the cases, female in two cases.
- Four (4) children were Caucasian, one (1) was Pacific Islander, and two (2) were Native American.
- Children's Administration received intake reports of abuse or neglect in all of the child fatality and near-fatality cases prior to the death or near-fatal injury of the child. None of the cases had more than five (5) intakes prior to the critical incident.
- Due to the small sample of cases reviewed, no statistical analysis was conducted to determine relationships between variables.

RCW 74.13.640(d)

Child Fatality Review

A.F.

March 2012
Date of child's birth

July 6, 2012
Date of child's death

September 20, 2012
Review Date

Committee Members
Yen Lawlor, Deputy Regional Administrator, Children's Administration
Kara Rozeboom, Regional Safety Program Manager, Children's Administration
Deborah A. Robinson, Infant Death Investigation Specialist
Alan Kelley, Detective, King County Sheriff's Office
Sean Davis, Chemical Dependency Professional, King County Mental Health, Chemical Abuse and Dependency Services Division
Mary Meinig, Director, Office of the Family and Children's Ombuds

Facilitator
Ronda Haun, Critical Incident Case Review Specialist, Children's Administration

Executive Summary

On September 20, 2012, Children's Administration (CA) convened a Child Fatality Review[2] (CFR) Committee to examine the practice and service delivery in the case involving a 13-week-old Caucasian male infant named A.F. and his parents. The incident initiating this review occurred on July 6, 2012 when A.F.'s parents found their infant son not breathing and called 911. Emergency personnel responded to the home but were unable to revive A.F. The medical examiner later certified A.F.'s cause of death as sudden unexplained infant death. Bed sharing was noted by the medical examiner as a contributing factor.

The CFR Committee included CA staff and community members selected from diverse disciplines with relevant expertise, including law enforcement, child welfare, sudden infant death, and chemical dependency. Committee members had no previous involvement with the case. Prior to the review, each committee member received a case chronology of known information regarding the parents and child, and un-redacted CA case-related documents.

Available to committee members at the review were:

- Additional case related documents
- CA policy and practice guides relating to intake and Child Protective Services(CPS)
- Safe to Sleep Publications[3]

During the course of the review, the CPS supervisor and social worker working with A.F.'s family at the time of his death were interviewed by the CFR committee members.

Following review of the case file documents, interviews, and discussion regarding social work activities and decisions, the Committee made findings and recommendations which are detailed at the end of this report.

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[2] Given its limited purpose, a Child Fatality Review should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. The 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 deceased child's life or death. A Child Fatality Review is not intended to be a fact-finding or forensic inquiry or to replace or supersede investigations by courts, law enforcement agencies, medical examiners or other entities with legal responsibility to investigate or review some or all of the circumstances of a child's death. Nor is it the function or purpose of a Child Fatality Review to recommend personnel action against DSHS employees or other individuals.

[3] Safe to Sleep Campaign seeks to inform parents and caregivers of the American Academy of Pediatrics' recommendations for reducing SIDS as well as other sleep-related causes of infant death. [Source: National Institutes of Health http://www.nichd.nih.gov/sts/Pages/default.aspx]

RCW 74.13.520
RCW 70.02.020

Case Overview

[redacted]

On June 29, 2012, CA received a police report by fax. The report concerned the safety of A.F. Police responded to A.F.'s home on June 28, 2012 in response to a call made to 911. The 911 caller reported looking into the window of the locked family home and observing A.F.'s mother asleep while holding her infant son. The 911 caller tried unsuccessfully to awaken A.F.'s mother prior to calling for police assistance. The responding officer was also unable to awaken A.F's mother so the officer took emergency measures to enter the home. During the event, A.F's crying was audible from outside of the family home. A.F.'s mother awoke after the police officer entered the home. A.F.'s mother told the police officer she takes prescribed medication [redacted] and it caused her to fall asleep while holding A.F. The police officer informed A.F.'s mother that CPS would be contacted. An intake report relating to this incident was screened in for non-emergent response and assigned for a CPS investigation.[5]

On July 2, 2012, a CPS social worker attempted a home visit with A.F. and his parents. Finding no one at home, the social worker left a business card. A few hours later, A.F.'s father called the social worker and arrangements were made for the social worker to return to the family home later that same day. The social worker then met with the father, A.F., and his older half-sibling. A.F's mother was at work at the time of the social worker's home visit. The social worker noted no concerns for A.F. or his half-sibling during that initial face-to-face contact. On July 3, 2012, the social worker spoke by telephone with A.F.'s mother and arranged to visit the mother early the following week. Before that meeting took place, CA was

[4] Intake screens anonymous reports of Child Abuse and Neglect (CA/N) when any of the following criteria have been met: there is a reported serious threat of substantial harm to a child; reported conduct involving a criminal offense that has occurred, or is about to occur, in which the child is the victim; or a there has been a founded CA/N report on a household member within the past three years.[Source: Children's Administration Practice Guide to Intake and Investigative Assessment]

[5] A non-emergent response requires CA social workers to have face-to-face contact with all alleged child abuse or neglect victims within 72 hours from the date and time CA receives the intake.[Source: Children's Administration Practice and Procedures Guide 2310]

notified of A.F.'s death on July 6, 2012. An intake was accepted for risk only[6] and assigned a 24-hour response time.

A law enforcement officer and an investigator from the medical examiner's office reported to CPS that A.F.'s parents called 911 after finding their infant son not breathing. Emergency personnel responded to the home but were unable to revive A.F.

According to the police, the mother reported feeding A.F. at 6:00 a.m. before returning to bed and positioning A.F. face-up in the bed between her and A.F's father. The family dog was also in the bed. About an hour later, A.F.'s half-sibling crawled into the bed to watch television. Around 9:15 a.m., the mother awoke and found A.F. unconscious. She ran to summon help from a nurse living nearby. A.F.'s father called 911 and administered cardiopulmonary resuscitation (CPR) to A.F. The emergency response personnel continued lifesaving measures until 10:10 a.m. No obvious signs of trauma or neglect of A.F. were noted. Following the autopsy performed on July 7, 2012, the medical examiner certified A.F.'s cause of death as sudden unexplained infant death. Bed sharing was noted by the medical examiner as a contributing factor.

Committee Discussion

The Committee discussion began with an acknowledgement of the short time span between the assignment of the intake dated June 29, 2012 and A.F's death on July 6, 2012 and questioned if the July 4th holiday created a disruption in service delivery to A.F. and his family. The Committee learned about the staffing resources available from CA social workers scheduled to work on holidays, weekends, and evenings.

The Committee discussed the intake screening decision and response time and noted no concerns. Elements of a comprehensive CPS investigation were examined by the Committee. In particular, the importance of contact with collateral sources of information, verification of information presented by the subject of an investigation, recognition of the vulnerability of infants, pursuing further assessment when parental substance abuse or mental illness is identified, evaluation of potential safety hazards in the home, and the urgency of safety assessment and planning were discussed.

Also discussed was the importance of CA staff receiving sufficient and ongoing training to inform their social work practice and work with families. Emphasized were two areas of training: Infant Safe Sleeping and Methadone use. The

[6] CA will screen in a CPS Risk Only intake when information collected gives reasonable cause to believe that risk or safety factors exist that place the child at imminent risk of serious harm. [Source: Children's Administration Practice and Procedures Guide 2220]

Committee was concerned to learn neither the supervisor nor social worker assigned to this case reported receiving training in these two subject areas. The Committee discussed ways to provide training to staff in an accessible manner within budgetary restrictions. The Committee encouraged CA to utilize community partners to provide training to staff in local CA offices in addition to developing standardized statewide training.

The Committee acknowledged the likely impact of critical events on CA staff. The Committee endorsed the use of compassionate and confidential support for both social workers and supervisors. The Committee questioned why CA does not automatically reassign staff when a critical event occurs and how some staff may feel pressure to deny the need for support or reassignment to avoid appearing emotionally compromised or unprofessional to their peers or CA management.

Findings and Recommendations

The Committee made the following findings and recommendations based on interviews, review of the case records, department policy and procedures, Revised Code of Washington (RCW), Washington Administrative Code (WAC), and medical documents.

Findings

1. The CPS investigation of the intake dated June 29, 2012 would have been more comprehensive had it included collateral contacts with relatives, law enforcement professionals, treatment specialists, and health care providers involved with A.F and his family.
2. Planning for the safety of A.F. was inadequate. An immediate plan to address safety was warranted based on A.F.'s vulnerability and the reported safety concerns.
3. The social worker did not address unsafe infant sleeping practices during the initial home visit conducted on July 2, 2012. The Committee believes a review of Infant Safe Sleeping practices with A.F.'s caregivers and a visual inspection of A.F's sleeping environment was warranted due to the concerns reported in the June 29, 2012 intake. The social worker and her supervisor reported to the Committee they never received formalized training on the topic of Infant Safe Sleeping. The Committee believes the social worker was more likely to address these issues; crucial in this case, had training been available to the social worker and supervisor.
4. The full impact of A.F.'s mother's use of prescription medication and methadone was not fully assessed. Of particular concern was the potential lethality of the combination of the medication used by A.F's mother along with the recent examples of parental impairment resulting from drug use. Neither the supervisor nor social worker could recall receiving training on

Methadone use. The Committee supports ongoing social worker and supervisor training on the current topics relating to substance abuse.

5. CA management should be aware that staff experience challenging emotions following a critical event. Those emotions understandably may impair case planning and decision making abilities.

Recommendations

1. Formal training on infant safe sleeping should be available to CA staff. The training curriculum should be standardized and include information on how to evaluate an infant's sleep environment, how to engage caregivers in a discussion about safe sleep, and risk factors known to increase the risk of Sudden Unexpected Infant Death (SUID) and Sudden Infant Death Syndrome (SIDS). Curriculum should also address the distinction between SUID and SIDS, and the implications for CPS investigations.
2. Management in the CA office where A.F.'s case was assigned should provide a reminder to staff about the support available following a critical event.
3. CA should consider implementing policy mandating reassignment of staff following a critical event on an assigned case. The Committee recommends the establishment of a policy rather than allowing for individual choice of reassignment following a critical incident.
4. CA should consider reestablishing the funding for Chemical Dependency Professionals contracted to work directly in CA offices. The increased accessibility to specialized consultation would be beneficial to CA social workers working with families impacted by substance abuse.
5. CA will review the existing substance abuse training curriculum to ensure staff is receiving current and sufficient information about methadone. CA will consider offering additional substance abuse training.

RCW 74.13.640(d)

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

Child Fatality Review

W. R-F.

November 2003
Date of child's birth

July 22, 2012
Date of Fatality

November 29, 2012
Date of Child Fatality Review

Committee Members
Debra S. Hatton, Director, Working Choices
Thomas Hug, Program Manager, Region 3, Children's Administration
Kristin Winkel, Senior Director, Homeless Housing Initiatives-King County Housing Authority
Tonya Fox, Social Work Supervisor, Pierce South Office, Children's Administration
Cristina Limpens, Ombuds, Office of the Family and Children's Ombuds

Legal Consultant
Mary Li, Senior Assistant Attorney General, Office of the Attorney General

Observer
Sharon Gilbert, Deputy Director of Field Operations, Children's Administration

Facilitator
Ronda Haun, Critical Incident Case Review Specialist, Children's Administration

[redacted]

Executive Summary

On November 29, 2012, Children's Administration (CA) convened a Child Fatality Review[7] (CFR) Committee to examine the practice and service delivery in the case involving an eight-year-old boy named W.R-F. and his family. The incident initiating this review occurred on July 22, 2012 when W.R-F. was struck and killed by a moving vehicle. The accident occurred in the early evening while W.R-F. and several friends were riding bikes in the neighborhood. Failing to stop at an intersection, W.R-F. rode his bike into an oncoming sports utility vehicle. W. R-F. was transported to a regional trauma center where he died. The King County Medical Examiner determined blunt force injury of the torso resulting from a traffic accident caused W.F-R's death.

The CFR Committee included CA staff and community members selected from diverse disciplines with relevant expertise, including child welfare, housing programs, in-home family counseling services, and the Office of the Family and Children's Ombuds. A representative from the Office of the Attorney General participated in the review by providing a summary of Washington state laws pertaining to child abuse and neglect and answering the Committee's legal questions. Neither CA staff nor committee members had previous direct involvement with the case.

Prior to the review, each committee member received a case chronology of known information regarding the parents and child, and un-redacted CA case-related documents. Additional documents were made available to the Committee at the time of the review. These included an autopsy report from the King County Medical Examiner's Office, a map of the accident site, law enforcement reports, a graph highlighting case activities and copies of relevant CA policies and practice guides.

During the course of the review, the CFR Committee members interviewed the Child Protective Services supervisor, the Family Voluntary Services supervisor, and the Family Voluntary Services social worker involved with the case.

[7] Given its limited purpose, a Child Fatality Review should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. The 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 deceased child's life or death. A Child Fatality Review is not intended to be a fact-finding or forensic inquiry or to replace or supersede investigations by courts, law enforcement agencies, medical examiners or other entities with legal responsibility to investigate or review some or all of the circumstances of a child's death. Nor is it the function or purpose of a Child Fatality Review to recommend personnel action against DSHS employees or other individuals.

Following review of the case file documents, interviews, and discussion regarding social work activities and decisions, the Review Committee made findings and recommendations, which are detailed at the end of this report.

Case Overview

[redacted]

[redacted]

[8] There is a high co-occurrence of domestic violence in cases of child abuse and neglect. However, a child's exposure to domestic violence, in and of itself, does not constitute child abuse and neglect. Domestic violence, which physically harms a child or puts a child in clear and present danger, would constitute an allegation of child abuse. [Source: Children's Administration Practice and Procedures Guide 2220]

[9] CA findings are based on a preponderance of the evidence. Child Abuse or Neglect is defined in RCW 26.44.020, WAC 388-15-009, and WAC 388-15-011. Findings are determined when the investigation is complete. Founded means the determination that, following an investigation by CPS, based on available information: it is more likely than not that child abuse or neglect did occur. Unfounded means the determination that, following an investigation by CPS, based on available information: it is more likely than not that child abuse or neglect did not occur, or there is insufficient evidence for the Department to determine whether the alleged child abuse did or did not occur

[10] A Voluntary Case Plan is 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 parent's protective capacity and manage child safety. Continued assessment of child safety occurs throughout the case. [Source: Children's Administration Practice and Procedures Guide 2442]

[redacted]

On July 26, 2012, CA learned from local media coverage about W.R-F's accidental death on July 22, 2012. An intake was accepted for CPS investigation based on risk.[11] A CPS social worker, assigned to investigate the intake, delayed contact with the family out of deference for their grief. Before contact was made with the family, the social worker's supervisor and a statewide program manager decided to override the intake screening decision and close the case without further investigation in the absence of a clear allegation of child abuse or neglect. The case closed on August 2, 2012.

Committee Discussion

While recognizing the tragic death of W.R-F. was a result of an accident and not an act of child abuse or neglect, the Committee identified a number of areas of in-depth discussion and review of CA practice. The Committee focused on information gathering, family violence, low-income housing, intake screening decisions investigative findings, case transfers between CA programs, case documentation, social worker contact with the family, and collaboration between CA staff and contracted providers. The Committee discussed the impact of overcrowded living conditions on [redacted]. Committee members learned families in need of low-income housing face long waiting lists to obtain affordable housing. The Committee was aware CA does not provide clients with housing but can assist clients by referring them to community housing resources. In this case, both the CA social worker and the contracted provider assisted the family with a housing voucher program. The Committee examined CA's efforts to assess for possible safety threats and identified a few areas of practice for further consideration. The Committee felt the history of [redacted] were indicators of a possible unsafe environment and warranted further assessment by the CA social worker. The Committee determined there were a number of missed opportunities to obtain information

[11] CA will screen in a CPS Risk Only intake when information collected gives reasonable cause to believe that risk or safety factors exist that place the child at imminent risk of serious harm. [Source: Children's Administration Practice and Procedures Guide 2220]

important for assessing safety, identification of family needs, and monitoring family progress.

The Committee reviewed the various programs available to families served by CA and the transfer of cases transferred between programs to best address the needs of the family. Related to this topic of discussion was a review of how a social worker and supervisor determine when to close a case.

Findings

1. Comprehensive information gathering for case assessment and planning was not evident to the Committee. [redacted]
2. The Committee felt the monthly visits[12] between the social worker, children, and parents were inconsistent with existing CA policies. Visits did not occur on a monthly basis. The children did not have an opportunity to talk privately with their social worker and the visits were not conducted inside the family home. Contact between the father and social worker did not occur for many months. When the social worker encountered difficulties in scheduling visits in the family home, the Committee wondered why visits between the social worker and the children did not occur in alternative locations such as the children's school
3. The Committee believes a complete assessment of safety in this family's home should have included assessment of all six adults living in the family home. The Committee questioned how the social worker, without actually entering the home, monitored family compliance with maintaining a home free of health and safety hazards.
4. The Committee believes the decision to close the case was based primarily on the expiration of the voluntary services plan signed by the family and the decision to close should have occurred after a complete assessment of progress.[13]

[12] Monthly visits are face-to-face visits conducted by the assigned social worker that provide ongoing assessment of the health, safety, permanency and wellbeing of children and promote achievement of case goals. The visits are well-planned and involve the child, and all known parents in all cases of children in CA custody and cases that are open for in-home voluntary services. [Source: Children's Administration Practice and Procedures Guide 4420]

[13] 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. A Safety Assessment is completed at key decision points in a case to identify impending danger and to inform and implement safety plans with families to control or manage those threats. [Source: Children's Administration Practice and Procedures Guide 1120]

[redacted]

5. The Committee believes a case transfer should have been facilitated by the social worker instead of closing the case and directing the family to request their case be reopened to obtain family counseling services from a different CA program.
6. [redacted]
7. [redacted]
9. Noting the contracted in-home family counselor and paraprofessionals successfully gained ongoing access into the family home and positively engaged the family, the Committee believes it would have been beneficial if the CA social worker collaborated with the contracted provider by scheduling joint meetings or home visits with the family inside their home.
10. The Committee believes there was an absence of thorough documentation of case activities, supervisory reviews, and significant family events in the course of the case.

Recommendations

1. Children's Administration staff complete comprehensive in-person training about domestic violence. Training should include information about the impact of domestic violence on children and assessing for violence perpetrated by extended family members.
2. Children's Administration should provide training to staff about lessons learned from Child Near-Fatality and Fatality Reviews. The training should include an emphasis on collateral contacts, accurate documentation, verifying information, and collaboration with contracted providers.

RCW 74.13.640

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

Child Fatality Review

H.P.

November 2009
Date of Child's Birth

July 27, 2012
Date of Child's Death

November 2, 2012
Child Fatality Review Date

Committee Members
Joan Chase, ARNP, CS, Individual Counselor
Loren Erdman, Sergeant, Stevens County Sheriff's Department
Mikki Hill, RN, Public Health Nurse, Spokane Regional Health District
Sarah Foley, MSW, Domestic Violence Advocate, Alternatives to Domestic Violence Program
Cheryl Hotchkiss, Supervisor, DSHS, Children's Administration
Mary Meinig, MSW, Director, Office of Family and Children's Ombuds

Facilitator
Robert Larson, Critical Incident Case Review Specialist, DSHS, Children's Administration

Executive Summary

On November 2, 2012, the Department of Social and Health Services (DSHS), Children's Administration (CA) convened a Child Fatality Review[14] (CFR) to review the department's practice and service delivery to 2-year-old H.P. and his family. On the day of his death the mother's boyfriend, J.K., called 911 and reported H.P. had fallen down two steps and needed medical attention. Spokane County Sheriff officers and Emergency Medical Services (EMS) responded and H.P. was transported to Sacred Heart Medical Center where he was pronounced dead. The Spokane County Medical Examiner later determined the manner of death to be undetermined.

The CFR Committee included community members selected from diverse disciplines with relevant expertise, including representatives from public health, domestic violence advocacy, mental health, law enforcement, Children's Administration, and the Office of the Family and Children's Ombuds. Committee members, including CA staff, had no prior involvement with the family.

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

Supplemental sources of information and resource materials were made available to the Committee at the time of the review. These included (1) additional documents obtained post-fatality (e.g., H.P.'s medical records, police reports), (2) CA practice guides relating to Child Protective Services (CPS) investigations, (3) Safety Framework (a practice model centered on safety that informs and guides all decisions made during a case), and (4) copies of state laws and CA policies relevant to the review.

During the course of the review both CPS investigators and the CPS supervisor were interviewed by the Committee.

[14] Given its limited purpose, a Child Fatality Review should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. The Child Fatality Review Committee's review is generally limited to documents in the possession of or obtained by DSHS or its contracted service providers. The Committee has no subpoena power or authority to compel attendance and generally will only hear from DSHS employees and service providers. It does not hear the points of view of a child's parents and relatives, or those of other individuals associated with a deceased child's life or fatality. A Child Fatality Review is not intended to be a fact-finding or forensic inquiry or to replace or supersede investigations by courts, law enforcement agencies, medical examiners or other entities with legal responsibility to investigate or review some or all of the circumstances of a child's death. Nor is it the function or purpose of a Child Fatality Review to recommend personnel action against DSHS employees or other individuals.

RCW 74.13.520

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

Case Overview

H.P. is a Caucasian male who was born in November 2009. H.P.'s household at the time of his death consisted of his mother, mother's boyfriend, and two siblings. H.P.'s mother is E.W. who is a 29-year-old Caucasian female. The mother's boyfriend is J.K., a 31-year-old male with Native American ancestry. H.P.'s father is M.P., a 26-year-old Caucasian male. M.P. resided in Alaska at the time of H.P.'s death. H.P. has two siblings named B.R. and B.K. B.R. is a male, who was born in April, 2003. B.K. is a female, who was born in February, 2012.

On December 4, 2010, Children's Administration (CA) received a telephone call alleging E.W. was using alcohol to put H.P. to sleep. [redacted] The mother and B.R. were both interviewed about the allegations and they both denied the allegations. [redacted][15] The referrer recanted the allegation when contacted by the social worker. The CPS social worker in Washington informed the Committee that he found insufficient evidence to support a founded[16] finding. The mother was offered a urinalysis (UA)[17] on December 6, 2010 resulting in a positive for marijuana. At the time of case closure, the social worker recommended the mother follow-up with a chemical dependency screening, maintain a clean and sober home environment and obtain counseling services for B.R. due to a history of domestic violence in the home.

[15] [redacted]

[16] Founded--The determination that, following an investigation by CPS, based on available information: it is more likely than not that child abuse or neglect did occur. [WAC 388-15-005]

[17] Urinalysis--The testing of urine for illegal drugs, alcohol or other controlled substances.

J.K. and E.W. began their relationship in March 2011. On September 11, 2011, CPS received a telephone call regarding suspected physical abuse. H.P. presented at Sacred Heart Medical Center emergency room with a buckle fracture[18] to his left proximal radius,[19] fractures through his left radius and through his left ulna.[20] The referrer, the treating emergency room doctor, expressed concerns about the age of the injury. E.W. reported H.P.'s left wrist was bruised and swollen when she checked on him in his room on September 6, 2011. She gave H.P. a Motrin and the symptoms reportedly decreased for a few days. On September 11, 2011, the mother brought H.P. to the emergency room as the symptoms had returned.

On September 16, 2011, the social worker met with J.K. to discuss the broken arm. J.K. reported he was at work on September 6, 2011 when the mother called and told him H.P. had hurt his arm. J.K. told the social worker that H.P. babied his arm for a couple of days and then acted fine. H.P. was reportedly always falling down and had fallen down a few days prior to going to the emergency room.

J.K. told the social worker H.P. had had fallen off a porch earlier in the summer. H.P.'s lip was cut as a result of this fall. Medical records show H.P. was seen by a doctor on June 25, 2011 for his injuries related to falling off a porch.

On September 19, 2011, B.R. was interviewed by the social worker. He stated that he didn't know what had happened to H.P.'s arm and he reported feeling safe in his home. B.R. stated J.K. does nice things for his mom and he reported liking J.K. [redacted]

[redacted]

[18] A fracture in which one side of the bone bends, but does not actually break. This occurs when compressive force is placed on a tubular bone's long axis; the axial stress on the bone causes a buckling reaction. (www.medical-definitions.com/fracture/buckle-fracture.htm)

[19] A fracture of the proximal radius (radial head and/or neck) can occur with indirect or direct injury to the elbow joint or forearm. The elbow is a hinge joint composed of three bones: 2 in the forearm (radius, ulna) and 1 in the upper arm (humerus). These bones work together to allow movement and dexterity of the elbow, forearm, and wrist. The radius is the smaller of the two forearm bones, and it articulates with the ulna (radioulnar joint) to allow forearm rotation (supination, pronation). (www.mdguidelines.com/fracture-radius-proximal/definition)

[20] The ulna is one of two long bones in the forearm. The ulna is located at the side of the forearm closest to the body when a person's palms are facing forward.

[21] Child Abuse Consultants are a team of physicians who provide statewide consultation and training regarding medical findings in cases of alleged child abuse and neglect.

H.P. was last seen by a physician on July 24, 2012. Medical records indicate H.P. was not scheduled to see a doctor on July 24, 2012, however, he was seen by a doctor during his sister's well-child appointment. The treating physician ordered an x-ray on H.P.'s arm due to reported forearm pain. Medical records indicated

H.P. had a “non-displaced fracture of his radius” on his left forearm. E.W. reported H.P. had injured his arm when he fell next to the pool two days earlier.

On July 24, 2012, a screened out intake was received alleging J.K. reportedly threatened his daughter. He also allegedly pinned his daughter against a bunk bed and was screaming at her. J.K.’s daughter reportedly kicked and hit her father. J.K.’s daughter reported that J.K. does not act on his threats.

On July 27, 2012, at 7:42 p.m. H.P. died of unknown causes. J.K. reported the family was playing in the swimming pool area. H.P. got wet and J.K. took him back to the apartment to change his clothes. J.K. let go of H.P.’s hand to unlock the door. H.P. then fell down two steps. H.P. was taken into the apartment where he started to show signs of a seizure. J.K. called 911 and screamed for help. A neighbor and emergency response arrived and attempted to revive H.P. The names of the parents are not being used in this report as neither has been charged in connection to the fatality incident.

Committee Discussion

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

The Committee reviewed the investigation related to the December 2010 intake. The Committee noted the investigation was thorough and complete. The Committee believes all of the areas of concern were investigated and appropriately addressed. The Committee spent considerable time discussing the specific allegation regarding the mother giving her infant alcohol. The social worker was interviewed by the Committee and he explained that he looked for alcohol in the family’s cupboards, refrigerator and trash. The social worker had asked for and received permission prior to checking the aforementioned areas of the home. The home visit was unannounced so the social worker believed he was able to get an accurate assessment of the home environment.

The investigative assessment (IA)[22] associated with the December 2010 intake was completed approximately four months after case assignment. Per policy, IAs should be completed within 45 days. The Committee also noted the investigator did not contact the referrer for several months after receiving the assignment. The Committee believes referrers should be contacted shortly after receiving a new intake in an effort to verify the information in the intake and to determine if additional information is available.

In September 2011, a second intake was screened in for investigation. This intake was assigned to a different investigative social worker. The social worker actively investigated the allegation from September 2011 through November 2011. After November 2011, the social worker ceased to actively work on the case until after the fatality in July 2012. The supervisor and social worker did staff the case on a monthly basis from September 2011 through the fatality.

The Committee believes the social worker should have concluded her investigation in November 2011. The social worker informed the Committee that the case remained open due to the need for additional collateral contacts. The social worker informed the Committee that she needed to contact the primary care physician, dentist, and a character reference. She further reported receiving nine or more intakes per month during the time the case was open. The social worker believed the high volume of intakes caused a need to triage her cases. The Committee understood the need to prioritize workload, but believed the strategy implemented by the social worker was unproductive. Maintaining an open case is time intensive for social workers and supervisors regardless of the level of activity by the social worker. The Committee believes all necessary collateral contacts need to be completed timely as they should be linked to the safety concerns in the case. Waiting 10 months to complete a collateral contact implies they are not critical to the outcome of the case and are not directly related to a safety concern. Collateral contacts are important to the investigative process, however any relevant collateral contacts cannot wait ten months for completion.

The Committee noted that there was no contact between the social worker and family for several months. CA policy does not require a CPS social worker to

[22] A completed investigative assessment will contain the following information: A narrative description of the alleged child abuse or neglect allegation, the known prior history of child abuse or neglect. Structured Decision Making Risk Assessment Tool. Documentation regarding the probability of alcohol or controlled substances contributing to the alleged abuse or neglect. Description of the status of the case with CA. Documentation regarding the social workers findings regarding abuse or neglect.

complete a monthly health and safety[23] check. CA policy clearly states FVS[24] and CFWS[25] social workers are required to complete monthly health and safety checks. The Committee discussed how CPS social workers should be required to complete a monthly health and safety similar to the requirement for a FVS and CFWS social worker.

It is not the role or responsibility of the Committee to determine the cause of injuries or the manner of H.P.'s death. However, the Committee's objective is to review information, ask critical questions, and to make recommendations and findings that improve CA's ability to protect children in the future. For that reason, the Committee spent a significant length of time reviewing the sequence of events and injuries prior to H.P.'s death. Upon review, the Committee found H.P.'s pattern of injuries and weight loss to be concerning and noted a strong correlation between H.P.'s injuries, H.P.'s weight loss, and J.K.'s arrival in the family home.

The Committee noted J.K. and E.W. started their relationship in March 2011. Medical records indicated H.P. was a healthy 18-month-old child as of March 31, 2011. He weighed 29.04 pounds and was listed at the 91.5 percentile. Three months after J.K. arrived in the home H.P. had his first known significant injury. In June 2011, H.P. fell off a porch and cut his lip while in J.K.'s care. In July 2011, H.P. had his second injury when he fell off a trampoline and injured his leg. H.P.'s leg was x-rayed and it was determined not to be broken. In September 2011, H.P. broke his arm. This incident was of particular concern to the Committee due to the mother's failure to seek medical care for five days following the injury.

On December 19, 2011, H.P. was 24-months-old and his weight had dropped to 23.61 pounds. H.P. was down to the fourth percentile. The Committee noted the lack of a medical explanation for an 85 percentile weight drop. On May 8, 2012, H.P. was 29-months-old and his weight had increased back up to the 28 pound mark, 1.04 pounds less than 14 months earlier.

In July 2012, H.P. broke his arm for a second time. The Committee found it concerning that the mother again failed to seek medical treatment in a timely manner. The mother reported a two-day delay between the time of injury and treatment.

[23] Health and Safety--CA social workers are required to visit with all children in person on a monthly basis if the case is open for services. The goal of these visits is to ensure the child is safe and the child's basic wellbeing needs are being met.
[24] FVS social worker--Family Voluntary Services social workers offer parents services designed to reduce the safety threats while the children remain in the care and custody of their parents.
[25] CFWS social worker--Child and Family Welfare social workers assume responsibility of a child welfare care after the children have been removed from their caregivers and a dependency petition filed.

[redacted]

At the time of the fatality H.P. had facial abrasions on the left side, contusion and abrasion on his right scalp with subgaleal hemorrhage, chest contusions, lower extremity contusions, right elbow abrasions, contusion of right side of pubis and global hypoxic-ischemic brain injury.

H.P. had a total of six significant injuries between 18 and 32 months of age. He also had a significant unexplained loss of weight. Whereas the Committee acknowledged some of these injuries may have been accidental and explainable, the Committee also believed it is unlikely that any child would receive so many significant injures and weight loss without a strong possibility of abuse and/or neglect. In addition, J.K.'s documented DV history with E.W. [redacted] increased the Committee's concerns regarding J.K.

The Committee noted the significant pattern of injury did not become fully evident until after the fatality.

The CPS social worker informed the Committee that her investigation into the September 11, 2011 intake was complete and the allegation was unfounded. The Committee agreed with the unfounded finding for the September 11, 2011 investigation.

The CPS social worker further reported that her investigation into the July 27, 2012 intake was complete and the allegation was unfounded.[26] The Committee spent a significant amount of time discussing the unfounded finding related to the July 27, 2012 intake and the legal requirements for a founded finding. Upon review, the Committee believed the social worker did not gather all necessary and available information to complete her investigation and determine a finding. Specifically, the social worker had not reviewed the autopsy photographs from the time of the fatality, obtained a completed Child Abuse and Neglect consult, or interviewed J.K.'s children. In addition, the Committee believed the social worker needed to make additional inquiries to medical professionals as to the degree of probability or actual likelihood that the injuries were intentional.

At the time the social worker completed her investigation into the July 27, 2012, intake she had received a preliminary Child Abuse and Neglect Consult that was completed by Dr. Kenneth Feldman. The preliminary consult stated, "H.P.'s cause of death remains unclear. However it appears most likely that he died of an acute brain trauma with associated brain injury and mild swelling. The multiplicity of

[26] Unfounded--The determination that, following an investigation by CPS, based on available information: it is more likely than not that child abuse or neglect did not occur, or there is insufficient evidence for the Department to determine whether the alleged child abuse did or did not occur. WAC 388-15-005

scalp injuries could not be explained by a single fall onto the back of his head. Had he sustained such a fall it is much more likely he would have been immediately concussed, though he could have had a post-traumatic seizure sometime after injury. To have sustained so severe a brain injury, it would be common to also have a skull fracture from the described fall. Overall, the findings are highly concerning for an abusive cause of death."

The autopsy report found the cause of death to be "undetermined." The autopsy report indicates, "Although the external injuries do not fully correlate with the witness statement, these external injuries would not have caused death in-and-of themselves. Because of these considerations, the cause of death is undetermined after complete autopsy."

The CPS social worker used the "undetermined" cause of death as an additional justification in her unfounded determination. The Committee noted that the autopsy included other information that warranted further evaluation and consideration. Those other factors included the various unexplained injuries and the inconsistent explanation for the external injuries. The Committee believed the social worker did not look for additional information as she apparently believed the "undetermined" finding was sufficient to make a determination related to child abuse or neglect. In addition, the Committee did not find where the social worker made additional inquiries as to the degree of probability or actual likelihood that the injuries were intentional. It was the position of the Committee that while the cause of death is an important factor when determining a finding, it should not be the sole factor used when determining the probability of abuse or neglect. The Committee noted that it is not uncommon for a child to die from undetermined causes and still be a victim of physical abuse.

The Committee expressed concern that this case may have been impacted by the presence of confirmatory bias after the fatality. Confirmatory bias is present when an individual seeks information and gives greater weight to information that confirms their current beliefs. This was evident when the Committee asked the CPS social worker regarding her thoughts about the September 2011 broken arm. The social worker stated that she consulted with medical professionals about the broken arm and also reviewed the medical professional's final report. The social worker stated her phone contact and the medical report both stated the broken arm was an accident. The Committee reviewed the medical report referenced by the social worker and noted the following statement, "A child of this age certainly could have accidently fallen and injured his arm in this fashion. It is concerning, however the child's caregiver seems to have no story as to how

the injury could have occurred or awareness of when it occurred." The Committee noted that the medical provider clearly did not state the injury was accidental only that it could have been accidental.

The Committee stated that the CPS social worker would have benefitted from pictures of the various bruises, scrapes, and marks related to the fatality on July 27, 2012. H.P.'s diaper also had scuff marks that were described but not seen by the CPS social worker, supervisor or new CWFS social worker. The Committee asked the assigned CPS social worker if she had observed or obtained a copy of the photographs from law enforcement. The CPS social worker stated that she had not obtained the photographs. The Committee asked the CPS social worker if she thought these photographs would have been beneficial to her investigation. The CPS social worker did not think the pictures would have been useful as she "relies on the autopsy and medical consult when making a determination regarding abuse or neglect." The Committee felt photographs are a critical piece to any investigation and should be placed in the CA case file whenever reasonably possible and accessible. The photographs can be used to supplement the reports from other professionals. The Committee felt it was important for CA to form their own opinion regarding the presence of abuse or neglect as CA is governed by its own laws and policies that vary significantly from law enforcement and medical examiner standards and laws.

J.K. has three children from a previous marriage. All three of the children were visiting the family at the time of the fatality and could provide details about the home environment preceding the fatality. CA generally follows law enforcement's direction related to the interviewing of subjects, witnesses and victims when a joint investigation is being conducted. In this case, law enforcement requested CPS to not interview these three children. The CPS social worker waited several months following the fatality and then asked the assigned detective if law enforcement would be following up with any additional contact with J.K.'s children. The detective reported he had spoken with the children's mother. He did not feel additional contact was necessary as the children were at the swimming pool at the time of the fatality and they could not provide any additional information related to the time of the fatality. [redacted]

The Committee noted the law enforcement investigation was focused on the day and time of the fatality. CA's investigation has a broader mandate that requires a more global safety assessment. For this reason, the Committee felt K.B.'s children should have been forensically interviewed by a CA social worker. In addition, J.K.'s daughter, M.K, reportedly witnessed J.K. swing H.P. by the arm. [redacted], "[J.K.] had swung H.P. by his arm and he [J.K.] didn't

seem like he was playing or happy." The Committee is concerned that this statement has not been further investigated and the timing of this incident coincides with the second broken arm in July 2012.

The Committee expressed concern that an intake was not completed by the medical professional treating H.P.'s broken arm in July 2012. In addition, H.P. had a significant and unexplained weight loss during the course of this investigation. This sudden weight loss may have warranted an intake to CPS by his treating doctors.

The allegations into H.P.'s broken arm in September 2011 warranted law enforcement's participation in the investigative process. The CPS social worker informed the Committee they routinely coordinate with law enforcement and that law enforcement was notified by fax. The Committee believes the best practice was for the CPS social worker to have contacted law enforcement by phone and asked the status of their investigation due to the concerning nature of this intake.

The Committee discussed the continued involvement of the same CPS social worker following a child fatality. Some committee members expressed that CA should consider changing social workers after a child fatality. Committee members felt that a change in social workers may help ensure an unbiased view of the case. CA social workers often have a dual role of helping a family while investigating them at the same time. This role is naturally conflicted and becomes more conflicted post-fatality. Social workers who handle a case before and after a fatality are forced to look at their own decisions and actions while determining future actions on a case. For this reason, some bias may be unavoidable.

Other committee members contend that knowledge and experience could get lost at a critical point should the social worker be changed. Many case files are very complex and it may prove challenging to change social workers due to the time it takes to review a case file and become familiar with the family and their supporting community. The Committee did not come to a consensus on this topic.

The Committee noted that additional information was gathered post-fatality via a social media website. The Committee noted CA does not have standardized guidelines for the accessing and use of information obtained from social media websites and believed CA would benefit by developing clear guidance for social workers.

Workload is often cited as a challenge of casework and a barrier to quality practice. The CPS social worker at the time of the fatality had over 40 open CPS investigations. Since this child's death, a new CPS unit has been added to the Spokane office and the amount of cases per social worker has dramatically decreased. Workload may have been a factor related to the duration this case remained open, but it should be noted that many of the open cases only needed additional collateral contacts to complete the investigations or were ready for closure following supervisory review.

Findings

1. The documentation was thorough, complete and submitted timely. Both CPS social workers completed their initial interviews and face-to-face contacts within required time frames. The case was staffed monthly.
2. H.P. had a total of six significant injuries between 18 and 32 months of age. He also had a significant unexplained loss of weight. Whereas the Committee acknowledged some of these injuries may have been accidental and explainable, the Committee also believed it is improbable that any child would receive so many significant injures and lose as much weight without a strong possibility of abuse and/or neglect. The Committee noted the significant pattern of injury did not become fully evident until after the fatality.
3. The Committee believed the social worker did not gather all necessary and available information to complete her investigation and determine a finding. Specifically, the social worker had not reviewed the autopsy photographs from the time of the fatality, obtained a completed Child Abuse and Neglect consult, or interviewed J.K.'s children. In addition, the Committee believed the social worker needed to make additional inquiries to medical professionals as to the degree of probability or actual likelihood that the injuries were intentional.

4. The mother should have been offered information about local DV victim services in November 2011.

Recommendations

1. The Committee believes CPS social workers should be required to complete a monthly health and safety check of the children similar to the policy requirement for cases in a FVS or CFWS program.
2. The CPS unit that handled this investigation should invite a representative from the local DV advocacy center to join them at a unit meeting. The advocate and social workers should participate in a discussion about the different forms and patterns of DV.
3. The Committee reviewed and agreed with the screening decision related to the July 25, 2012 intake. The intake social worker noted the subject of this intake was also related to E.W.'s case. FamLink is designed to notify social workers of any new intake associated with an open case; however, FamLink will not notify social workers when a subject is connected with a different family. In this case, the new intake was opened under K.B.'s name. For this reason the CPS social worker did not receive notice of the new screened out allegation. The Committee recommends the supervisor and social worker automatically receive notification via email any time a subject is connected to an open case.

RCW 74.13.640

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

Child Fatality Review

M.J.

March 2010
Date of Child's Birth

August 25, 2012
Date of Child's Death

December 20, 2012
Child Fatality Review Date

Committee Members
Pat Shaw, Public Health Nurse, Program Manager with Clark County Public Health
Connie Head, Family Educator, Children's Home Society (Vancouver)
David Raines, Social Work Supervisor, Children's Administration, Region 3 South (Centralia)

Co-Facilitator/Committee Member
Daphne Morrison, MSW, Clinical Supervisor-Homebuilders, Institute for Family Development

Facilitator
Bob Palmer, Critical Incident Case Review Specialist Children's Administration

Executive Summary

On December 20, 2012, the Department of Social and Health Services Children's Administration convened a Child Fatality Review[27] (CFR) to examine the department's practice and service delivery to 2-year-old M.J. and her family. On August 25, 2012, M.J. died while in the care of her mother in Mesa, Arizona. The child was found unresponsive in a trailer with no working air conditioning in 100+ degree weather. Prior to the family moving to Arizona, M.J. was alleged to be a victim of neglect by her mother in Vancouver, Washington (2011).

A CFR is required under RCW 74.13.640(1)(a) because the child and her family received services by the department within a year of her death from alleged abuse or neglect. The CFR Committee was comprised of CA staff and community members with pertinent expertise from a variety of fields and systems, including public health nursing, parenting education, clinical social work, and child advocacy. None of the Committee members had any previous direct involvement with the family. The Office of Family and Children's Ombuds was invited to participate but was unable to attend.

Prior to the review each committee member received (1) a chronology of CA involvement with the family, (2) un-redacted case file documents relating to the CPS investigation in 2011, and (3) various Arizona media reports regarding the death of M.J.

During the course of the review the CA supervisor and social worker involved in the Washington state investigation in 2011 were interviewed. Following review of the case file documents, completion of the staff interviews, and discussion regarding department activities and decisions, the Committee made findings which are presented at the end of this report. There were no recommendations regarding policy, practice or service delivery.

Case Overview

The family first came to the attention of the Children's Administration in October 2011 when CPS investigated allegations of child maltreatment in the home made by a family acquaintance. The reported concerns included poor hygiene,

[27] Given its limited purpose, a Child Fatality Review should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. The Child Fatality Review Committee's review is generally limited to documents in the possession of or obtained by DSHS or its contracted service providers. The Committee has no subpoena power or authority to compel attendance and generally will only hear from DSHS employees and service providers. It does not hear the points of view of a child's parents and relatives, or those of other individuals associated with a deceased child's life or fatality. A Child Fatality Review is not intended to be a fact-finding or forensic inquiry or to replace or supersede investigations by courts, law enforcement agencies, medical examiners or other entities with legal responsibility to investigate or review some or all of the circumstances of a child's death. Nor is it the function or purpose of a Child Fatality Review to recommend personnel action against DSHS employees or other individuals.

inappropriate discipline, and leaving M.J. in a playpen for excessive amounts of time. Following an unannounced home visit, contact with the alleged victims and subject, contact with other residents of the home, a child safety assessment, and information provided by the child's primary care physician, the allegations were determined to be unfounded[28] and the investigation was closed in November 2011.

At some unknown time after the Washington state CPS case closed, the family moved to Mesa, Arizona where on August 25, 2012 the mother called 911 to report her daughter unresponsive. When emergency responders arrived to the home they were unable to revive M.J. who was pronounced dead at the scene. The temperature in the trailer reportedly exceeded 100 degrees Fahrenheit. The mother told local police that the air conditioning unit had broken days before.

Responding officers initially found no evidence of physical abuse but both children in the home appeared malnourished and dehydrated and the mother was later arrested for child abuse based on the physical condition of the surviving child. At the time of the CFR no charging decisions had been made by the Maricopa County Attorney's Office regarding the death of M.J. as autopsy results were still pending.

Committee Discussion

Committee members reviewed and discussed the documented CA activities and decisions from the intake dated October 20, 2011 through case closure in November 2011. In an effort to evaluate the reasonableness of decisions made and actions taken by the department, the Committee considered Washington state law, CA policy, practice and system response, CA case documentation, and interview responses from CA staff that occurred during the review. No critical errors or significant practice issues were identified. Actions taken and decisions made appear to have been reasonable based on the information available at time of investigation.

The Committee also reviewed and discussed numerous Arizona news articles that contained reported statements made by the mother and others after the fatality incident. These accounts suggest long term parental ambivalence[29] and

[28] "Unfounded" is defined as "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." RCW 26.44.020(24) "Founded" is defined as "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." RCW 26.44.020(9)

[29] Parental ambivalence relates to the nurturing and affectionate aspects of a parent-child relationship. It is often identifiable by behavioral or verbal indicators that suggest contradictory attitudes toward the relationship,

depression that may have been active but undiscovered at the time of the CPS investigation in Washington. While the Committee acknowledged that such information retrospectively provided insight as to the nature of the parent-child relationship, the Committee was unable to identify any clear failure on the part of the Vancouver CPS worker to uncover evidence of child safety issues or neglect.

Findings

While the Committee found that there were no apparent critical errors in terms of decisions and actions taken during the CPS investigation in 2011, the Committee did find instances where additional social work activity may have been considered. However, the absence of these additional activities was found to have no reasonably discernible connection to the child's death. Thus the identified issues below serve as noted opportunities where improved practice may have been beneficial to the assessment of the family situation but were not found to be critical oversights that could have prevented the child fatality nearly a year later.

- The worker did not make contact with the referrer. Given the discrepancies between the referrer's and the parent's accounts regarding parenting practices, such additional inquiry with the referrer might have proven beneficial.
- When interviewed the CPS worker indicated that despite the mother's responses on the GAIN-SS[30] that indicated no depression, the worker suspected parental depression. The worker might have offered suggestions for local mental health or and/or counseling resources given her suspicions.

Recommendations

Upon review and discussion, the Child Fatality Review Committee forwards no recommendations.

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incompatible expectations and mixed emotions, and self-doubt regarding being able to handle a parent/caretaker role.

[30] RCW 71.05.027 requires all DSHS Administrations to use the same screening tool for substance abuse, mental health and co-occurring disorders. The Global Assessment of Individual Needs – Short Screen (GAIN-SS) version 2.0.1 is the identified tool. The GAIN-SS is a screening tool to identify a need for further assessment to be completed by a community professional. The GAIN-SS does not identify service needs. The goal of the screen is to increase the number of people accurately identified as needing a mental health, substance abuse or co-occurring disorder assessment.

RCW 74.13.640

Child Fatality Review

C.M.

August 2012
Date of child's birth

September 1, 2012
Date of fatality

November 14, 2012
Date of Child Fatality Review

Committee Members
Rebecca Benson, Referral Coordinator for CPS Projects, Public Health-Seattle & King County
Cynthia Blair, Social Work Supervisor, Office of Indian Child Welfare, Children's Administration
Sean Davis, Chemical Dependency Professional, King County Mental Health, Chemical Abuse and Dependency Services Division
Mary Meinig, Director, Office of the Family and Children's Ombuds
Debbie Sullivan, Social Worker, Valley Medical Center

Facilitator
Ronda Haun, Critical Incident Case Review Specialist, Children's Administration

Executive Summary

On November 14, 2012, Children's Administration (CA) convened a Child Fatality Review[31] (CFR) Committee to examine the practice and service delivery in the case involving an eight-day-old male newborn named C.M. and his family. The incident initiating this review occurred on September 1, 2012 when the Des Moines Police Department received a 911 call from C.M.'s mother reporting her son was not breathing. The responding police officers and emergency medical technicians were unsuccessful in their attempts to revive C.M. The King County Medical Examiner later certified C.M.'s cause of death as Sudden Unexplained Neonatal Death. Premature birth, bed sharing with an adult on chronic opioid therapy, and soft bedding were identified by the Medical Examiner as contributing factors to C.M.'s death.

The CFR Committee included CA staff and community members selected from diverse disciplines with relevant expertise, including social work, child welfare, chemical dependency, maternal-infant public health and the Office of the Family and Children's Ombuds. Neither CA staff nor committee members had previous direct involvement with the case. A CA supervisor contacted one member of the Committee at the time of the fatality to determine if C.M. and his mother had received community-based maternal and nutritional services. This committee member responded to the supervisor's questions but had no direct contact with the family. Prior to the review, each committee member received a case chronology of known information regarding the parents and child, and un-redacted CA case-related documents. Additional documents were made available to the Committee at the time of the review. These included medical and law enforcement records, Safe to Sleep[32] guidelines, and relevant CA policies and practice guides.

During the course of the review, the CFR Committee Members interviewed the Child Protective Services Supervisor assigned to C.M.'s case at the time of the fatality. The assigned social worker was not available for an interview.

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[31] Given its limited purpose, a Child Fatality Review should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. The 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 deceased child's life or death. A Child Fatality Review is not intended to be a fact-finding or forensic inquiry or to replace or supersede investigations by courts, law enforcement agencies, medical examiners or other entities with legal responsibility to investigate or review some or all of the circumstances of a child's death. Nor is it the function or purpose of a Child Fatality Review to recommend personnel action against DSHS employees or other individuals.

[32] Safe to Sleep Campaign seeks to inform parents and caregivers of the American Academy of Pediatrics' recommendations for reducing SIDS as well as other sleep-related causes of infant death. [Source: National Institutes of Health www.nichd.nih.gov/sts/Pages/default.aspx]

Following review of the case file documents, interviews, and discussion regarding social work activities and decisions, the review committee made findings and recommendations, which are detailed at the end of this report.

RCW 74.13.515

Case Overview

C.M. was the only child of his mother, R.S. and his father, T.M. Children's Administration (CA) had no involvement with C.M's mother prior to C.M.'s birth in August of 2012. [redacted][34]

A CPS intake was received from a hospital social worker shortly after C.M. was born. The social worker reported C.M. had a presumptive positive[35] test result for prenatal exposure to opiates. C.M. was born at 36.5 weeks gestation, showed no signs of drug withdrawal, and a discharge from the hospital was expected on August 27, 2012. C.M.'s mother indicated to hospital staff she had used methadone and Oxycodone prescribed to her and marijuana during her pregnancy. The hospital social worker reported concerns about C.M.'s mother using medication in amounts beyond the prescribed dosages, possibly using controlled medications obtained without prescriptions, and the impact of the medications on the mother's ability to care for a premature infant.

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[33] CA intake social workers receive, gather, and assess information about a child's need for protection or request for service. Intake social workers determine program response type and response times (emergent or non-emergent) for an investigation.CA intakes fall into three categories: CPS – Involves a child who is allegedly abused, neglected, or abandoned and includes child abuse allegations. CPS Risk Only – Involves a child whose circumstances places him or her at imminent risk of serious harm but does not include child abuse allegations. Non-CPS – Involves a request for services for a family or child. The caregiver, child, community member, or agent of another state can make the service request. Programs include DLR Rule Infraction, Family Voluntary Services , Family Reconciliation Services , Child and Family Welfare Services , IV-E and non-IV-E Tribal/Band Placement/Payment Only, Interstate Compact on the Placement of Children , Adoption and Private Adoption.

[34] CA findings are based on a preponderance of the evidence. Child Abuse or Neglect is defined in RCW 26.44.020, WAC 388-15-009, and WAC 388-15-011. Findings are determined when the investigation is complete. Founded means the determination that, following an investigation by CPS, based on available information: it is more likely than not that child abuse or neglect did occur. Unfounded means the determination that, following an investigation by CPS, based on available information: it is more likely than not that child abuse or neglect did not occur, or there is insufficient evidence for the Department to determine whether the alleged child abuse did or did not occur.

[35] A positive screening drug test result is considered a "presumptive positive" until confirmed by gas chromatography–mass spectrometry. [Source: http://www.ncsacw.samhsa.gov/]

The intake was screened-in for a non-emergent response.[36] On August 26, 2012, when CA learned C.M. was being discharged earlier than initially planned, a CA social worker was dispatched to the hospital. The CA social worker documented contact with C.M., his parents and extended family members, and made plans to follow-up with the family to schedule a home visit. The social worker documented contacting the family by phone on August 30, 2012 and scheduled a home visit following the social worker's return to work after a planned vacation. The social worker scheduled the home visit for either September 11 or 12.

Before that visit could take place however, CA received notification from the King County Medical Examiner's office of C.M.'s death on September 1, 2012. According to the investigator, C.M.'s mother reported she woke at 6:00 a.m. to take care of C.M. She soon returned to bed and placed C.M. beside her. R.S. positioned C.M. next to one of her legs. She slept until 11:00 a.m. when she found C.M. was unresponsive. R.S. was the only adult in the home at the time. She called C.M.'s father before calling 911. A CPS risk-only[37] intake reporting C.M.'s death was assigned for follow-up. The CPS social worker documented contact with C.M.'s parents before closing the case on November 9, 2012.

On October 31, 2012, the King County Medical Examiner completed the autopsy report. The Medical Examiner certified C.M.'s cause of death as Sudden Unexplained Neonatal Death. The identified contributing factors included C.M.'s prematurity, bed sharing with an adult on chronic opioid therapy, and soft bedding. C.M.'s toxicology report indicated a positive result for methadone.

Discussion

The Committee discussed how possible parental substance abuse impacted this case. There was recognition of the challenges faced by CA social workers when trying to fully assess clients for possible chemical dependency. Some clients may intentionally minimize their drug use or need for treatment. Using validated screening tools and obtaining collateral information are essential when assessing for substance abuse. The Committee learned how access to treatment for pregnant or parenting women is given the highest priority by treatment providers and is readily available in the local community.

[36] A non-emergent response requires CA social workers to have face-to-face contact with all alleged child abuse or neglect victims within 72 hours from the date and time CA receives the intake. [Source: Children's Administration Policy 2310]

[37] RCW 74.13.031(3) requires Children's Administration to "investigate complaints of any recent act or failure to act on the part of a parent or caretaker that result in the death of a child…." The deceased child must be identified as a victim. The 24 hour or 72 hour response time requirements are removed when there are no other children in the home.

The intake screening decisions on all the intakes associated with C.M. or his parents and subsequent investigative findings were discussed. The discussion included the distinction between risk only intakes and intakes screened in based on specific allegations of child abuse or neglect. Also discussed were CA guidelines for screening and investigating reported unexpected infant deaths. The Committee supports CA's ongoing efforts to strengthen statewide consistency in this area of practice.

The Committee reviewed the various assessment tools completed during this CPS investigation. The Committee questioned how quickly the tools were completed after the investigation was initiated and noted some of the assessment information documented by the social worker was incongruent with the facts of the case. The lack of a home visit, collateral contacts, and in-depth interviews with the parents prior to the completion of the safety assessment were concerning to the Committee.

The Committee was interested in learning how supervisors manage caseloads when social workers are on leave and how social workers communicate with their supervisors or co-workers about specific cases prior to taking leave.

Some of the Committee members remarked how their participation in this review prompted them to think of ways to improve how their own organizations provide parents with information about infant safe sleeping practices.

The Committee made the following findings and recommendations based on interviews, review of the case records, department policy and procedures, Revised Code of Washington (RCW), Washington Administrative Code (WAC), and medical documents.

Findings

1. On August 25, 2012, a hospital social worker called CA to report concerns of suspected parental substance abuse presenting possible risks to C.M.'s safety and wellbeing. The Committee believes the screening decision on the resulting CPS intake should have been based on imminent risk of serious harm[38] in the absence of a specific allegation of child abuse or neglect[39] to be consistent with CA policy. The Committee acknowledges regardless of the intake screening decision, CA initiated contact with the family prior to C.M.'s discharge from the hospital.

[38] CA investigates intakes that do not allege an actual incident of child abuse or neglect but have risk factors that place a child at imminent risk of serious harm.

[39] Washington state law defines abuse or neglect as "sexual abuse, sexual exploitation, or injury of a child by any person under circumstances which cause harm to the child's health, welfare, or safety, or the negligent treatment or maltreatment of a child by a person responsible for or providing care to the child. [Source: RCW 26.44.020]

2. According to CA's practice guide and RCW 74.13.031, intakes reporting child death resulting from alleged child abuse or neglect will be accepted for investigation. The practice guide further stipulates the deceased child will be identified on the intake as a victim. The Committee believes the intake reporting C.M.'s death should have been screened in based on alleged child abuse or neglect instead of imminent risk of serious harm and C.M. should have been identified as a victim of alleged child abuse or neglect.
3. Timely completion of the Global Appraisal of Individual Needs – Short Screener (GAIN-SS)[40] may have been beneficial in assessing for possible parental substance abuse and the need for further drug and alcohol evaluation.
4. The Committee believes due to the concerns of parental substance abuse, prior CPS history, and C.M.'s age and prematurity, an initial assessment of safety and possible safety planning were warranted prior to his discharge from the hospital. If that was not possible, there should have been immediate follow-up with the family in their home.
5. The Committee found little documented evidence of comprehensive information gathering by the social worker. In particular, the Committee was concerned with the lack of collateral contacts and postponement of the initial home visit for several weeks while the social worker was on leave from work.
6. In the view of the Committee, several of the assessment tools completed by the social worker did not accurately reflect the facts of the case.

Recommendations

1. Provide training on infant safe sleeping practices and infant growth and development to all CA social workers.
2. CPS social workers should complete the GAIN-SS at the time of initial investigative contact with the parent(s) identified as a subject on the intake or person(s) acting in the role of parent and living in the child's home.
3. Refer all CPS cases in King County involving infants with identified social, developmental or health needs to the Seattle-King County Public Health Department for home visiting by a public health nurse.

[40] RCW 71.05.027 requires all DSHS Administrations to use the Global Appraisal of Individual Needs – Short Screener (GAIN-SS) to screen for substance abuse, mental health and co-occurring disorders.