QUARTERLY CHILD FATALITY REPORT
RCW 74.13.640 APRIL – JUNE 2019

Washington State Department of
CHILDREN, YOUTH & FAMILIES

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CHILDREN, YOUTH & FAMILIES

Contents

Executive Summary

This is the Quarterly Child Fatality Report for April through June 2019, provided by the Department of Children, Youth, and Families (DCYF) to the Washington State Legislature. RCW 74.13.640 requires DCYF 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 receiving services described in this chapter or who has been in the care of the department 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 who has been in the care of or received services described in this chapter from the department 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 April 22, 2011, and requires the department to conduct fatality reviews in cases where a child's 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.

On July 1, 2018, the Department of Social and Health Services (DSHS) Children's Administration (CA) transitioned from DSHS to DCYF.

Quarter Two Roll-up

This report summarizes information from completed reviews of one (1) child fatality and four (4) near-fatalities[1] that occurred in the second quarter of 2019. All child fatality review reports can be found on the Child Fatality & Serious Injury Reports page of the DCYF website.

The reviews in this quarterly report include child fatalities and a near fatality from four of the six regions (DCYF divides Washington State into six regions). Previous quarterly fatality reports reflect three regions when child welfare was administered within DSHS under CA.

DCYF Region	Number of Reports
Region 1	1
Region 2	1
Region 3	0
Region 4	1
Region 5	0
Region 6	2
Total Fatalities and Near Fatalities Reviewed During Second Quarter 2019	**5**

This report includes information from reviews of child fatalities and near fatalities conducted following a child's death or near-fatal injury that was suspicious for abuse and neglect and the child had an open case or received services from the DCYF within the 12 months prior to the child's death or injury. A child fatality or near fatality 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 multidisciplinary committee including community members whose professional expertise is relevant to the family history. The review committee members may include legislators and representatives from OFCO.

The following charts provide the number of fatalities and near-fatalities reported to DCYF and the number of reviews completed and those that are pending for the calendar year 2019. The number of pending reviews is subject to change if DCYF discovers new information by reviewing the case. For example, DCYF may discover that the fatality or near-fatality was anticipated rather than unexpected, or there is additional DCYF history regarding the family under a different name or spelling.

[1] Near-fatality reports are not subject to public disclosure and not posted on the public website nor are the reports included in this report.

Child Fatality Reports for Calendar Year 2019			
Year	**Total Fatalities Reported to Date Requiring a Review**	**Completed Fatality Reviews**	**Pending Fatality Reviews**
2019	8	3	5

Child Near-Fatality Reports for Calendar Year 2019			
Year	**Total Near-Fatalities Reported to Date Requiring a Review**	**Completed Near-Fatality Reviews**	**Pending Near-Fatality Reviews**
2019	8	2	6

The child fatality review referenced in this Quarterly Child Fatality Report is subject to public disclosure and posted on the DCYF website.

Near-fatality reviews are not subject to public disclosure and are not posted on the public website nor submitted to the legislature.

Notable Second Quarter Findings

Based on the data collected and analyzed from the reviews of one (1) fatality and four (4) near-fatalities during the second quarter, the following were notable findings:

- Four (4) of the five (5) cases referenced in this report were open at the time of the child's death or near-fatal injury.
- In four (4) of the five (5) cases, the child was under the age of 12 months at the time of death or near-fatal injury.
- One (1) child fatality occurred in an unsafe sleep environment. One (1) near fatality occurred when a parent was bed-sharing with her infant son resulting in near-fatal asphyxiation of the child.
- Two (2) of the near-fatality cases were the result of an infant and toddler overdosing on narcotics.
- One (1) near fatality was a closed case to DCYF for six months. All other cases were open to DCYF for services or investigation at the time of the critical incident.
- Safe sleep was discussed with the caregivers prior to the near fatality of the child in the case involving a parent who was bed-sharing with their infant.
- Three (3) children referenced in this report were Caucasian, one (1) was Native American and one (1) was Hispanic.
- Substance abuse was an identified risk factor in three (3) of the five (5) cases. Domestic violence and homelessness were other significant risk factors identified in several of the cases in this report.
- In two cases involving medically complex children, lack of proper medical care was a concern in both cases.

- DCYF received intake reports of abuse or neglect in each of the cases in this report prior to the death or near-fatal injury of the child. In two (2) of the cases, there was only one (1) prior report made regarding the family. In one (1) near fatality case, there was one (1) prior report made regarding the family. In one (1) near fatality case, the department received 12 prior reports; in another near fatality case there were 11 prior reports.
- Due to the small sample of cases reviewed, no statistical analysis was conducted to determine relationships between variables.

Exhibit A

Child Fatality Reviews

The child fatality reviews referenced in this Quarterly Child Fatality Report are subject to public disclosure and are posted on the DCYF website.

Exhibit A contains the following child fatality reviews from the second quarter of 2019:

- A.G. Child Fatality Review

CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

June 2019

Washington State Department of
CHILDREN, YOUTH & FAMILIES

Contents

Full Report

Child

- A.G.

Date of Child's Birth

- RCW 74.13.515 2017

Date of Fatality

- August, 2018

Child Fatality Review Date

- April 10, 2019

Committee Members

- Kathy Jennings, BSN, RN, Tacoma-Pierce County Health Department
- Cristina Limpens, MSW, Office of Family and Children's Ombuds
- Ly Dinh, MSW, Region 5 Quality Practice Specialist, Department of Children, Youth, and Families
- Lisa Caudle, MSW, LSWAIC, Social Service Specialist III, Department of Children, Youth, and Families

Facilitator

- Bob Palmer, Critical Incident Review Specialist, DCYF

Executive Summary

On April 10, 2019, the Washington State Department of Children, Youth & Families (DCYF or Department) convened a Child Fatality Review (CFR)[1] to examine the Department's practice and service delivery to A.G. and [redacted] family.[2] This review was commenced due to an incident that occurred on August 12, 2018. On the date of the incident there was an open Family Assessment Response (FAR) case.[3] A.G. was tracheotomy-tube (T-tube) dependent and gastrostormy-tube (G-tube) fed since birth.[4] On August 12, 2018, the Department received notification that A.G. was admitted to the hospital due to possible respiratory interruption and subsequent cardiac arrest. These conditions occurred while being cared for at [redacted] home. Life support was withdrawn four days after A.G. had been hospitalized. The manner of death is described as natural, and the cause of death is described as respiratory failure due to subglottal stenosis.[5]

The CFR Committee (Committee) included a DCYF quality practices staff person and a Child Protective Services (CPS) social services specialist, a representative from the Office of Family and Children's Ombuds, and a Public Health Nurse with expertise in working with Children with Special Health Care Needs (CSHCN). None of the Committee members had any previous direct knowledge of or involvement with A.G. or [redacted] family.

Prior to the review each Committee member received a chronology summarizing the FAR involvement with the family, un-redacted DCYF documents (e.g., intakes, assessments, and case notes), a summary table of A.G.'s medical appointment history, and law enforcement reports about the critical incident. At the time of the review supplemental sources of information and other reference materials were available to the Committee, including A.G.'s expansive medical records and the cause and manner of death listed with the Department of Health. The assigned DCYF worker and supervisor provided additional information during the Committee's in-person interview process.

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[1] A child fatality or near fatality review completed pursuant to [RCW 74.13.640] is subject to discovery in a civil or administrative proceeding, but may not be admitted into evidence or otherwise used in a civil or administrative proceeding except pursuant to [RCW 74.13.640(4)]." Given its limited purpose, a child fatality review (CFR) or child near fatality review (CNFR) should not be construed to be a final or comprehensive review of all circumstances surrounding the death or near death of a child.

The CFR Committee's review is generally limited to documents in the possession of or obtained by DCYF or its contracted service providers. The Committee has no subpoena power or authority to compel attendance and generally only hears from DCYF 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 CFR or CNFR is not intended to be a fact-finding or forensic inquiry to replace or supersede investigations by courts, law enforcement agencies, or other entities with legal responsibility to investigate or review some or all the circumstances of a child's fatal injury or near fatality. Nor is it the function or purpose of a CFR or CNFR to recommend personnel action against DCYF employees or other individuals.

The restrictions do not apply in a licensing or disciplinary proceeding arising from an agency's effort to revoke or suspend the license of any licensed professional based in whole or in part upon allegations of wrongdoing in connection with a minor's death or near fatality reviewed by a child fatality or near fatality review team. RCW 74.13.640(4)(d).

[2] There are no known criminal charges filed against the parents that are related to this incident. Accordingly, the parents involved are not identified by name in this report. The names of the children are also subject to privacy laws. See RCW 74.13.500.

[3] FAR is a voluntary Child Protective Services (CPS) alternative response to a screened in allegation of abuse or neglect that focuses on the integrity and preservation of the family when less severe allegations of child maltreatment are reported. FAR cases do not require a finding.

[4] Tracheotomy dependence is the state of needing to breathe through a trach tube. A gastrostomy tube is a tube inserted through the abdomen that delivers nutrition directly to the stomach.

[5] Tracheal stenosis is a narrowing of the trachea, or windpipe, due to the formation of scar tissue of malformation of the cartilage in the trachea.

After the review of case documents, consideration of the interview responses by DCYF staff, and discussion regarding Department activities and decisions, the Committee made various findings that are included at the end of this report. The Committee forwarded no recommendations.

Case Overview

Born at RCW 74.13.520, gestation (micro-preemie), A.G. remained in a Neonatal Intensive Care Unit (NICU) for 5 months until RCW 74 RCW 74.13.515 2018 discharge.[6] On July 26, 2018, DCYF became involved with A.G. and RCW 74 family because of reported concerns from an out-of-county special Gastroenterology and Nutrition Clinic (GI Clinic). The clinic reported A.G. missed multiple medical appointments for respiratory, feeding, and nutrition evaluations. The on-going evaluations have been described as being important so that the infant could be transitioned to T-tube and G-tube independence.

Two DCYF staff conducted an unannounced home visit within 24 hours of the July 26, 2018 FAR intake. Present at the residence were the mother, A.G., and RCW 74 older sibling. The father was not home at the time of the visit. A.G. appeared awake, alert, breathing well, and without distress or discomfort. There were no outward signs of nutritional deficits. A brief walk through of the residence, including A.G.'s sleep environment, did not reveal any obvious safety concerns. There were no indications that either child was in present (imminent) danger.[7]

The mother told DCYF staff that A.G.'s medical needs require special training for A.G.'s caretaker, and only she and A.G.'s father provide care for A.G. at their home. The mother seemed to indicate that she was the primary parent caring for A.G., only getting a break when her partner was home. The mother admitted to having missed several recent medical appointments citing frustration and stress in dealing with so many out-of-county appointments. The mother agreed to immediately re-schedule the GI Clinic appointments.

After the home visit, the assigned FAR worker obtained Primary Care Physician (PCP) records for A.G. and RCW 74 sibling. The PCP records revealed no concerns. The FAR worker also telephonically confirmed the mother had followed through with rescheduling two GI Clinic appointments and later confirmed that on August 7, 2018, the father brought A.G. into the clinic. The medical provider reported the clinic visit went well regarding the G-tube check and dietitian consult. However, due to the length of the appointment the father declined to take A.G. for a labs blood draw, which can easily be completed back in the family's county or residence. A pulmonary evaluation was rescheduled for early September, and follow ups were recommended for physical and occupational therapy and an evaluation by a dysphagia (swallowing) expert. The FAR worker requested and received A.G.'s GI Clinic records.

On August 8, 2018, the FAR worker contacted the mother by phone to express concerns about A.G.'s rescheduled pulmonology evaluation and lab tests. The mother said that she and the father got into an argument and he left the residence with her car saying he needed to live elsewhere. She reported that she contacted local law enforcement about the incident, but they declined to intervene. The FAR worker and mother discussed options for obtaining support services. After this discussion the FAR worker and mother agreed to meet the following Monday. The worker also consulted with her supervisor and

[6] A.G. was born in RCW 74.13.515 2017.

[7] "Present danger is defined as immediate, significant, and clearly observable severe harm or threat of severe harm occurring in the present requiring immediate protective response. Present danger may be a basis to determine that 'Imminent Harm' under RCW 13.34.050(1) exists and therefore may be a basis to seek immediate removal if other less intrusive options for immediate protective actions will not assure child safety." See https://www.dcyf.wa.gov/sites/default/files/pdf/SafetyThresholdHandout.pdf

discussed the options of engaging the family in services and convening a Family Team Decision-Making Meeting.[8]

On Sunday, August 12, 2018, DCYF learned that on August 11 A.G. suffered an apparent cardiac arrest and was not likely to survive. Reportedly, an aunt had put the infant down for a nap and may have propped the child up too much, which then obstructed A.G.'s T-tube resulting in Hypoxic Ischemic Encephalopathy (HIE).[9] Several days later A.G. died after removal of life support.

The cause of death was medically determined without an autopsy. The Department of Health lists the manner of death as natural, and the cause of death as respiratory failure due to subglottal stenosis. Local law enforcement did not pursue any criminal charges against anyone. However, DCYF entered a founded[10] finding for neglect against the mother. The basis for the finding is the fact that the mother allowed a third party to lay A.G. down for a nap despite the fact the third party was not trained to meet A.G.'s special medical needs. At the time of the CPS finding, the cause and manner of death was yet to be determined.

Committee Discussion

A major area of discussion focused on the fact that the FAR intervention had only been open for 16 calendar days (12 working week days) before the fatality incident. The Committee focused on the actions and decisions made by Department staff during this relatively brief interval, including the following:

1. Conducting an unannounced home visit;
2. Making face-to-face contact with all children in the home within 24-hours of the intake;
3. Conducting an initial interview with the primary caretaker (the mother);
4. Follow up contact with the mother to confirm A.G.'s missed medical appointments had been rescheduled;
5. Requesting and obtaining PCP records for both children living in the home;
6. Multiple contacts with the referring GI Clinic to confirm A.G. was seen by the specialist; and
7. Assessing present (imminent) danger.

The Committee considered state policy and practice expectations for FAR interventions for reported child maltreatment. The Committee discussed and debated reasonable activities expected from DCYF staff in the initial stages of FAR, as compared to more expansive activities expected during a fully allotted timeframe for completing a FAR intervention.[11]

The Committee recognizes the likelihood that more detailed information may have been gathered by the FAR worker if the Far engagement lasted between 45 and 120 days. The Committee identified and discussed numerous areas of inquiry and corroboration that would have been important to eventual

[8] 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.
[9] Hypoxic Ischemic Encephalopathy (HIE) is a type of brain damage caused by a reduction in the supply of oxygen to the brain and other organs (hypoxia), compounded by low blood flow to vital organs (ischemia). Encephalopathy refers to any condition that results from reduced blood and oxygen supply to the brain.
[10] "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." RCW 26.44.020(12). See https://app.leg.wa.gov/RCW/default.aspx?cite=26.44.020
[11] Under RCW 26.44.030(13(a FAR case must be closed within 45 calendar days from the date the intake was received unless the parent or caregiver receiving services consents to the case remaining open for up to 120 calendar days per RCW 26.44.030 (13).

completion of the FAR pathway, but would not have been reasonably expected to be accomplished during the first 2 weeks of a case being opened. This included the following:

- More detailed information from the parents as to A.G.'s daily care requirements (feeding, toileting, hygiene management, sleeping routine) and general daily routine for all family members.
- Seeking consultation with the Regional Medical Consultant (RMC)[12] to enhance understanding of A.G.'s medical and well-being needs. Such consultation would reasonably include obtaining the RMC's opinion as to the daily care requirements for a child with A.G.'s specific medical conditions, and distinguishing critical medical appointments from those that may be more therapeutic and well-being related.
- Checking with the PCP regarding any special sleep recommendation for A.G., particularly as to any medical recommendations for elevating the child during sleep. This would include corroborating the mother's later statement that A.G. required slight propping (e.g., use of a "boppy pillow" or sleep positioner[13]) to enhance trach flow and reflux reduction.
- More detailed information regarding other members of the household and/or adults with frequent access to the children, and what, if any, help caring for A.G. do they provide.
- Obtaining a a more complete understanding of the family situation, including the parent's histories of RCW 13.50.100 as children and their current relationship situation.
- Exploration with both parents about any barriers to meeting A.G.'s needs (including meeting scheduled medical appointments), and any individual or family values that may hinder them from asking for help.

Given that the primary task of the Committee is to review and evaluate recent DCYF service delivery occurring prior to a suspicious child death, there was only limited Committee discussion about the post-critical incident CPS investigation. The Committee looked at information gathered during the CPS investigation following A.G.'s death that had relevance to the FAR case. In reviewing the information gathered after the child's passing, the Committee was unable to say with any degree of certainty, that having this information prior to the death would likely have prevented the fatality outcome. The Committee understands it is not the duty of the Committee to determine the validity of CPS findings, but questioned the basis for finding A.G.'s death to be the result of negligent treatment or maltreatment by the mother.

[12] RMCs are available to DCYF staff to provide medical consultation regarding medical records of children, including children with complex health needs and chronic health conditions.

[13] A sleep positioner is a readily available product that is used to keep babies on their backs while sleeping. Some are flat mats with side bolsters, and others are inclined (wedge) mats with side bolsters. Many types of sleep positioners claim to help reduce the risk of SIDS by keeping babies on their backs, help with food digestion and reflux, ease colic, and prevent flat head syndrome. The U.S. Consumer Product Safety Commission (CPSC) and the U.S. Food and Drug Administration (FDA) have issued warnings to consumers to stop using infant sleep positioners as they pose a suffocation risk. Similarly the American Academy of Pediatrics (AAP) advises caregivers to avoid using commercial devices marketed to reduce the risk of SIDS. See https://www.cpsc.gov/Newsroom/News-Releases/2010/Deaths-prompt-CPSC-FDA-warning-on-infant-sleep-positioners/.

Findings

The Committee reached full consensus as to the absence of any identified critical errors or policy violations by DCYF. The Committee recognizes that when the fatality incident occurred, the FAR case had been open for only 16 calendar days (12 working week days), and was in the very early stages of the FAR process. It is the Committee's opinion, based on the information gathered by the Department in the limited time the case was open, that the subsequent fatality outcome was not reasonably predictable or reasonably preventable. The Committee believes there was sufficient information to support the Department's initial determination that A.G. was not in present (imminent) danger prior to the fatality.

Recommendations

There are no specific recommendations emerging from this review.