Washington State Department of Social and Health Services

Transforming Lives

REPORT TO THE LEGISLATURE

Quarterly Child Fatality Report

RCW 74.13.640

October –December 2017

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Washington State Department of Social & Health Services
Transforming lives

TABLE OF CONTENTS

Executive Summary

This is the Quarterly Child Fatality Report for October through December 2017 provided by the Department of Social and Health Services (DSHS) to the Washington state Legislature. RCW 74.13.640 requires DSHS to report on each child fatality review conducted by the department and provide a copy to the appropriate committees of the legislature:

> ***Child Fatality Review — Report***
>
> *(1)(a) The department shall conduct a child fatality review in the event of a fatality suspected to be caused by child abuse or neglect of any minor who is in the care of the department or a supervising agency or receiving services described in this chapter or who has been in the care of the department or a supervising agency or received services described in this chapter within one year preceding the minor's death.*
>
> *(b) The department shall consult with the office of the family and children's ombudsman to determine if a child fatality review should be conducted in any case in which it cannot be determined whether the child's death is the result of suspected child abuse or neglect.*
>
> *(c) The department shall ensure that the fatality review team is made up of individuals who had no previous involvement in the case, including individuals whose professional expertise is pertinent to the dynamics of the case.*
>
> *(d) Upon conclusion of a child fatality review required pursuant to this section, the department shall within one hundred eighty days following the fatality issue a report on the results of the review, unless an extension has been granted by the governor. A child fatality review report completed pursuant to this section is subject to public disclosure and must be posted on the public web site, except that confidential information may be redacted by the department consistent with the requirements of RCW 13.50.100, 68.50.105, 74.13.500 through 74.13.525, chapter 42.56 RCW, and other applicable state and federal laws.*
>
> *(2) In the event of a near fatality of a child who is in the care of or receiving services described in this chapter from the department or a supervising agency or who has been in the care of or received services described in this chapter from the department or a supervising agency within one year preceding the near fatality, the department shall promptly notify the office of the family and children's ombuds. The department may*

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

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

This report summarizes information from completed reviews of three (3) child fatalities and one (1) near-fatality that occurred in the fourth quarter of 2017. All child fatality review reports can be found on the DSHS website: https://www.dshs.wa.gov/ca/publications/childrens-administration-child-fatality-reports

The reviews in this quarterly report include child fatalities and a near-fatality from two of the three regions.

Region	Number of Reports
1	1
2	3
3	0
Total Fatalities and Near-Fatalities Reviewed During 4th Quarter 2017	4

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

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

The charts below provide the number of fatalities and near-fatalities reported to CA and the number of reviews completed and those that are pending for calendar year 2017. 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 2017			
Year	Total Fatalities Reported to Date Requiring a Review	Completed Fatality Reviews	Pending Fatality Reviews
2017	13	5	7

Child Near-Fatality Reviews for Calendar Year 2017			
Year	Total Near-Fatalities Reported to Date Requiring a Review	Completed Near-Fatality Reviews	Pending Near-Fatality Reviews
2017	8	2	6

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

Near-fatality reports are not subject to public disclosure and are not posted on the public website.

Notable Fourth Quarter Findings

Based on the data collected and analyzed from the three (3) fatalities and one (1) near-fatality during the 4th quarter, the following were notable findings:

- Two (2) of the four (4) cases referenced in this report were open at the time of the child's death or near-fatal injury.
- Two (2) of the four (4) cases resulted from infants dying in unsafe sleep environments.
- Safe sleep was discussed with the parents in cases involving infants who died in unsafe sleep environments prior to the death of their children.
- In two (2) of the three (3) fatality cases, medical examiners were unable to determine the cause of death. However, in both cases the child's death was highly suspicious for abuse or neglect. In both cases, the children died in unsafe sleep environments.
- In one (1) child fatality the child died from what doctors believe were injuries inflicted by the mother's boyfriend.
- The near-fatality case involved a five-month-old child who fell down a flight of stairs.
- In three (3) of the four (4) cases referenced in this report, the children were two years old or younger when the fatality or near-fatal incident occurred.
- Three (3) of the four (4) cases referenced in this report were the result of abuse or neglect by the children's parents or caregivers.
- Two (2) children in this report were Caucasian, one (1) was African-American, and one (1) was Native American.
- Children's Administration received intake reports of abuse or neglect in the each of the cases in this report prior to the death or near-fatal injury of the child. In one (1) of the fatality cases, there were 11 prior intakes reported to CA prior to the fatality; in the other fatality cases, there were seven (7) and five (5) intakes prior to the children's deaths. In the one (1) near-fatality case, there were five (5) intakes on the family prior to the near-fatal injury incident.
- Due to the small sample of cases reviewed, no statistical analysis was conducted to determine relationships between variables.

Child Fatality Review

S.W.

RCW 74.15.515 2016
Date of Child's Birth

March 12, 2017
Date of Fatality

June 1, 2017
Child Fatality Review Date

Committee Members
Mary Moskowitz, J.D., Ombuds, Office of the Family and Children's Ombuds
Karen Irish, MA, Victim Advocate, Seattle City Prosecutors Office
Jenna Kiser, MSW, Intake/Safety and Domestic Violence Program Manager, Children's Administration
Deborah Robinson, Infant Death Investigation Specialist, Criminal Justice Training Center
Ly Dinh, Quality Practice Specialist, Children's Administration

Observer
Jessica Hatch, Child Protective Services Supervisor, Children's Administration

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

Executive Summary

On February 16, 2017, the Department of Social and Health Services (DSHS) Children's Administration (CA) convened a Child Fatality Review (CFR)[1] to assess the department's practice and service delivery to S.W. and RCW 74.15.515 family.[2] The child will be referenced by RCW 74.15.515 initials in this report.

On March 12, 2017, CA received a call from law enforcement stating RCW 74.15.515 -month-old S.W. had passed away. It was reported that S.W. had been bed-sharing with RCW 74.15.515 mother on a deflating air mattress. At the time of RCW 74.15.515 death, S.W. was living with RCW 74.15.515 mother and two older half-sisters; there was an open child protective services (CPS) investigation regarding the family. The Medical Examiner's report states the cause of death is Sudden Unexplained Infant Death and the manner of death is undetermined, but the child was found prone and bed-sharing with one adult (the mother) on an air mattress.

The CFR Committee included members selected from diverse disciplines within the community with relevant expertise including the Office of the Family and Children's Ombuds, domestic violence victims' advocacy, infant safe sleep expertise, child abuse and child safety. One CA staff member observed the review. None of the Committee members, nor the observer, had previous involvement with this family.

Prior to the review, each Committee member received a case chronology, a summary of CA's involvement with the family and un-redacted CA case documents (e.g., intakes, investigative assessments and case notes) as well as one law enforcement report. Supplemental sources of information and resource materials were available to the Committee at the time of the review. These included relevant state laws and CA policies.

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

[2] S.W.'s family members are not named in this report because they have not been charged in an accusatory instrument with committing a crime related to a report maintained by the department in its case and management information system. [Source: RCW 74.13.500(1)(a)]

The Committee interviewed the prior CPS investigator and his supervisor as well as the current CPS investigator and her supervisor.

Family Case Summary

S.W.'s mother initially came to the attention of CA as a parent on February 25, 2014. The mother RCW 13.50.100. Between February 25, 2014 and until S.W. was born in RCW 74.15.515 of 2016, CA received a total of nine intakes regarding the mother and her children. The intakes alleged the mother RCW 13.50.100, RCW 13.50.100, had RCW 13.50.100 and . Of those nine intakes, five were assigned for a CPS investigation. All five investigations resulted in unfounded findings. The CPS workers cited the mother's statements of denial regarding the allegations and the lack of physical injuries to justify the unfounded findings. The mother denied offers of voluntary services but was accessing community services such as RCW 13.50.100and RCW 13.50.100shelter assistance and as a result, all investigations were closed without further services. When the fifth CPS investigation closed, the mother was RCW 13.50.100 .

On February 14, 2017, CA received an intake stating the mother left all three children alone at the RCW 13.50.100shelter where the family was residing and was gone for at least 15 minutes, possibly as long as an hour and a half. The intake alleged that her two eldest children RCW 13.50.100 and the shelter staff found two-month-old S.W. lying face down on the bed. The intake further alleged that the staff confronted the mother, who stated she made plans for another resident to watch her children. The intake caller reported the mother planned on leaving the shelter soon and they were worried about ongoing supervision for the children. This intake was assigned for a CPS investigation.

The assigned CPS worker attempted contact on February 17, 2017, but the shelter would not allow her access to the mother nor would they cooperate with the investigation even though they reported the allegations. On February 22, 2017, the worker again attempted to make contact with the mother and children. She was eventually allowed to meet with the mother and children but not allowed to observe their sleeping environment. The mother denied the allegations of leaving her children alone unsupervised, but the shelter would not allow the mother to name the individual she alleged had agreed to care for her children in her absence. The mother denied any mental health or chemical dependency issues. She stated her children's fathers are involved with their children RCW 13.50.100 . The mother

reported she placed RCW 74.15.515 infant on her stomach because the child already knows how to roll over. The CPS investigator discussed Period of Purple Crying[3] and safe sleep, which the mother stated she already knew about.[4] The CPS investigator advised the mother to notify the infant's primary care physician about rolling over so that it would be documented in RCW 74.15.515 medical file if anything were to happen. The mother also disclosed RCW 13.50.100 The CPS investigator asked the mother to contact her when she moved so that the worker could observe the new living environment before closing the case.

On March 12, 2017, CA received a call from the RCW 74.15.515 County Sheriff's detective assigned to investigate the death of S.W. He stated the RCW 74.15.515 -month-old child was found by the mother to be unresponsive that morning. The mother reported she was bed-sharing with the infant on an air mattress. The mother was aware that the air mattress would not stay inflated throughout the night. That morning, at around 4 am, the mother had to "recharge the mattress" and then went back to sleep with her infant, who was lying on RCW 74.15.515 stomach in the same bed. The two other children were sleeping on another air mattress in the home. This intake was screened in for a CPS investigation.

Committee Discussion

For purposes of this review, the Committee mainly focused on case activity from the time S.W. was born until RCW 74.15.515 passed away. The Committee did discuss the content prior to S.W.'s birth but the focus of the review was to evaluation the contact and service delivery to the family between the birth and passing of S.W.

The Committee did discuss a pattern of allegations from numerous sources about the mother failing to properly supervise her children and RCW 13.50.100 . It appeared that the mother's denials of the allegations were taken at face value. The Committee noted that CA could have made a stronger effort to corroborate and assess the allegations more thoroughly. The Committee also discussed missed opportunities to speak with collaterals such as the fathers, daycare providers, relatives and law enforcement to assist in fully assessing the mother's ability to safely care for the children. A comprehensive assessment would have included these collaterals and further conversations with the referral sources of the intakes regarding the details they provided.

The last two CPS workers both indicated they did not contact the fathers of the children because they did not want to place the mother in any danger due to the

[3] What is the Period of Purple Crying?

[4] Infant Safety Education and Intervention [CA Practices and Procedures Guide Chapter 1135]

history of RCW 13.50.100 . The Committee appreciated the desire to protect the mother and children from RCW 13.50.100 . However, they also discussed that it is the responsibility of CA to conduct thorough investigations and include assessment for RCW 13.50.100 and contact with all parents involved. CA staff who investigate cases that include allegations of RCW 13.50.100 must be trained about conducting safe interviews with the alleged perpetrators of RCW 13.50.100 and to assess for the safety of the children. The CPS investigators and their supervisors had not attended the two-day RCW 13.50.100 training offered through the Alliance for Child Welfare (Alliance), nor had they attended the Safety Boot Camp training. Had the staff attended these trainings, they may have been more comfortable with how to conduct those contacts with the fathers in a safe and comprehensive manner.

Findings

The Committee did not identify any critical errors that contributed to the death of S.W. However, there were areas within case practice that could be improved. The fathers were not contacted during the last four investigations prior to S.W.'s death.[5]

The subject interview case note and three other case notes regarding the February 14, 2017 investigation were entered after S.W.'s passing. The subject interview case note should have been entered within ten days per policy.

The Structured Decision Making Risk Assessment® (SDMRA) completed during the 2016 and 2017 investigations were completed inaccurately and did not correctly reflect the risk posed to the children for future neglect or abuse.[6] While the SDM does not have a direct correlation to findings of abuse or neglect, the tool has the ability to identify future risk for abuse or neglect, which should be considered during the investigation process. During the review, it was shared that CA is currently working on an updated Safety Framework training to include updated training on completion and utilization of the SDMRA.

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[5] RCW 13.50.100 CA Practices and Procedures Guide Chapter 1700. Domestic Violence]
Child Protective Services (CPS) Investigation [CA Practices and Procedures Guide Chapter 2331. CPS Investigation]

[6] The Structured Decision Making Risk Assessment® (SDMRA) is a household-based assessment. It estimates the likelihood that a child will experience abuse or neglect in a given household based on the characteristics of the caregivers and children living in that household. To accurately complete the SDMRA®, it is critical to accurately identify the household being assessed. A household includes all persons living in the house 50% or more of the time, excluding employees. Includes persons who consider the household their primary residence but may not be currently living in the home 50% of the time. [Source: CA Practices and Procedures Guide Chapter 2541. Structured Decision Making Assessment]

There were consistently missed opportunities by both CPS workers to identify other collateral contacts and corroborate the mother's reports. It may have been beneficial for the workers to seek out further information regarding the RCW 13.50.100 history by obtaining law enforcement reports and inquiring as to any restraining orders between the mother and the children's fathers. While both investigators stated they reviewed the mother's history with CA as a parent and RCW 13.50.100, it did not appear that the chronicity and patterns were taken into consideration when assessing the safety of the children and completion of the SDMRA.

Recommendations

The CA RCW 13.50.100 program manager will contact the Alliance for Child Welfare Excellence about adding a training section to the two-day RCW 13.50.100 training and specifically address how to speak with perpetrators of RCW 13.50.100 during CPS investigations.[7]

CA should consider collaborating with the Alliance on creating a one-page resource for staff that they would receive during the two-day RCW 13.50.100 training and attach that tip sheet to a "Quick Tip" for CA staff.[8]

CA should consider a "Quick Tip" to remind staff to discuss the risks associated with bed-sharing with children on air mattresses.

The area administrators for RCW 74.15.515 South and RCW 74.15.515 Southeast should meet with the director of the RCW 74.15.515 Shelter to discuss collaboration and cooperation for cases involving families residing at the shelter. It is also recommended that a discussion occur with the RCW 74.15.515 Shelter about safe sleep practices within the shelter and the use of air mattresses and bed-sharing.

CA should consider providing a death investigation training for seasoned CPS staff so they are aware of what to look for, correct terminology, and how to professionally challenge law enforcement to discuss investigative details during a death investigation.

[7] The Alliance for Child Welfare Excellence is a statewide training resource through the University of Washington dedicated to developing professional expertise for individuals working with vulnerable children.

[8] A quick tip is a pop up box that appears each time a CA employee logs onto their work computer. The box contains a tip or reminder regarding practice and/or policy related matters.

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

Child Fatality Review

M.F.

RCW 74.15.515 **2017**
Date of Child's Birth

February 5, 2017
Date of Fatality

May 11, 2017
Child Fatality Review Date

Committee Members
Mary Moskowitz, J.D., Ombuds, Office of the Family and Children's Ombuds
Zee Triplett, Safety Administrator, Children's Administration
Mary Mills, Chemical Dependency Professional, Therapeutic Health Services
Diane Toy, LMHC, Therapist, Institute for Family Development

Observer
Heather Lofgren, MSW, Quality Practice Specialist, Children's Administration

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

Executive Summary

On February 16, 2017, the Department of Social and Health Services (DSHS), Children's Administration (CA) convened a Child Fatality Review (CFR)[9] to assess the department's practice and service delivery to M.F. and RCW 74.15.515 family.[10] The child will be referenced by RCW 74.15.515 initials in this report.

On February 5, 2017, the medical examiner's office contacted CA to notify the department that M.F. had passed away. At the time of RCW 74.15.515 death, M.F. was living with RCW 74.15.515 mother, maternal grandfather and maternal aunt. M.F.'s father did not reside with him. There was an open child protective services (CPS) investigation and the case was transferring to family voluntary services (FVS) due to the mother's RCW 13.50.100 , the father's alleged RCW 13.50.100 . The mother had completed RCW 13.50.100 and was referred for RCW 13.50.100

The medical examiner's report states the cause of death was unexpected infant death associated with co-sleeping with one adult and the manner of death was undetermined. The CPS investigation regarding the death was closed as founded for negligent treatment by M.F.'s mother. The case is currently closed.

The CFR Committee included members selected from diverse disciplines within the community with relevant expertise including the Office of the Family and Children's Ombuds, chemical dependency, child abuse and child safety. Another Committee member was an in-home service provider with expertise in infant mental health and parenting assistance. No Committee member, nor the observer, had previous involvement with this family.

Prior to the review, each Committee member received a case chronology, a summary of CA involvement with the family and un-redacted CA case documents (e.g., intakes, investigative assessments and case notes). Supplemental sources of information and resource materials were available to the Committee at the time of the review. These included the most recent volumes of the case, the medical

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

[10] M.F.'s family members are not named in this report because they have not been charged in an accusatory instrument with committing a crime related to a report maintained by the department in its case and management information system. [Source: RCW 74.13.500(1)(a)]

examiner's report, the law enforcement report, relevant state laws and CA policies.

The Committee interviewed the CPS supervisor who also supervised the FVS worker who was slated to receive the case and the Family Team Decision Making[11] (FTDM) meeting facilitator. The original CPS worker no longer works for CA and was not available for this review.

Family Case Summary

On November 29, 2016, CA received a report from law enforcement stating that they contacted a woman who was RCW 13.50.100 (M.F.'s mother) and she admitted to RCW 13.50.100 . Law enforcement arrested M.F.'s mother on a felony warrant. This intake was screened out.[12]

On RCW 74.15.515 2017, CA received a report stating that M.F. had been born the previous day. RCW 74.15.515 was RCW 74.13.520 and would remain at RCW 74.15.515 Hospital. The mother's chart indicated she had a history of methamphetamine and opiate use and that she had had only RCW 13.50.100 The hospital also reported the father has a history of RCW 13.50.100, the family is homeless and moving their motor home from one place to another. This intake was assigned for a CPS investigation. The mother was engaged in the RCW 13.50.100 program for mothers at RCW 74.15.515 Hospital.

The CPS worker made contact with the hospital staff and mother and also observed M.F. The CPS worker then made contact with the maternal grandfather and scheduled a Family Team Decision Making meeting to discuss M.F.'s safety and plans for discharge.

The FTDM occurred on January 11, 2017. The father was invited but did not attend the meeting. The mother attended by phone along with a RCW 13.50.100 professional from RCW 74.15.515 Hospital. The grandfather attended in person as did CA staff. A decision was made to allow M.F. to discharge to RCW 74.15.515 mother, but then for mother and M.F. to live with the maternal grandfather and maternal aunt. The safety plan called for the relatives to keep M.F. within line-of-sight supervision at all times. The mother was not to be unsupervised with M.F. The mother agreed to ongoing voluntary services through CA to support her bonding

[11] Family Team Decision Making (FTDM) meetings bring people together who are involved with the family to make critical decisions regarding the removal of child(ren) from their home, changes in out-of-home placement, and reunification or placement into a permanent home.

[12] Washington state law does not authorize Children's Administration to screen in intakes for a CPS response or initiate court action on an unborn child. [Source: Children's Administration Practice Guide to Intake and Investigative Assessment]

and parenting as well as to monitor her RCW 13.50.100 . The grandfather also agreed to be a placement resource, if necessary, for M.F.

The CPS worker conducted a walk-through of the maternal grandfather's home. There were two contacts from the hospital social worker expressing concerns that M.F.'s mother was not visiting regularly, and when she did, it was for short periods of time. In addition, the mother was not taking an active effort to participate in RCW 74.15.515 care RCW 13.50.100 . Contact was made with the mother's RCW 13.50.100 provider who indicated the mother was RCW 13.50.100 . The CPS worker contacted the mother and referred her for RCW 13.50.100. An appointment was made for two days later to meet with the CPS and FVS workers and the mother. The RCW 13.50.100 was RCW 13.50.100.

The CPS and FVS social workers met with the mother together to discuss the hospital social workers' concerns. While the mother did not demonstrate the most appropriate decision making, the CPS and FVS workers still felt that her case could proceed at that time to voluntary services. During this meeting the Period of Purple Crying and safe sleep were also discussed.[13]

M.F. was discharged on RCW 74.15.515, 2017. On February 1, 2017, the FVS and CPS workers made a joint home visit. They met with the maternal grandfather, maternal aunt, mother and M.F. Another walk-through of the home occurred. M.F.'s sleep environment was observed. The safety plan and expectations were reviewed again between all of the adults. The workers discussed the in-home services again with the mother. The mother appeared to be fixating on wanting her own housing, even stating she would lie on a new assessment to appear as though she needed RCW 13.50.100 so she could obtain housing through that process.

On February 5, 2017, CA received an intake stating M.F. had passed away. The medical examiner stated the mother had fallen asleep in a chair with M.F. on her chest. When she woke, RCW 74.15.515 was unresponsive.

Committee Discussion

For purposes of this review, the Committee mainly focused on case activity from the time M.F. was born until RCW 74.15.515 passed away. There was minimal discussion regarding the death investigation. There were six calendar days

[13] CA is committed to improving child safety outcomes for children under one year of age through early intervention and education with parents and out-of-home caregivers. [Source: CA Practices and Procedures Guide Chapter 1135. Infant Safety Education and Intervention]

between the time that M.F. was discharged home to RCW 74.15.515 mother and the time that he passed away. During that time, the CPS and FVS workers made a health and safety visit in the home, met with the mother and spoke with the relatives and attempted to meet with the father.

After this fatality and prior to this review, the CA office obtained a training regarding RCW 13.50.100 from a local RCW 13.50.100 provider regarding current challenges presented by the RCW 13.50.100. The Committee discussed that this was a good start, but a more in-depth training for all offices and case carrying staff regarding the behavioral indicators of use or abuse as well as how to collaborate with RCW 13.50.100 providers would be a good next step. The Committee noted it would be ideal to take the next step to train caregivers and providers regarding child safety and RCW 13.50.100

There was discussion regarding the many facets to RCW 13.50.100 as it collides with child safety. Two that are of great importance to child welfare would include the collaboration and communication between CA and RCW 13.50.100. Case carrying staff should know the basic questions to ask providers such as a parent's RCW 13.50.100, what is the mother's RCW 13.50.100 after having given birth, safe storage of RCW 13.50.100 what discussions has the treatment provider had with the parent regarding safe sleep while using an RCW 13.50.100, what are behavioral indicators to be concerned about, etc.

The Committee also discussed that a referral for a Public Health Nurse either from the hospital or from CA would have been beneficial for this mother and they also supported the idea that CA was going to refer the family for Promoting First Relationships.[14] However, the Committee did not identify that either of the supports would have had a direct impact on the ultimate outcome of this case.

There was some confusion about the mother's RCW 13.50.100, including when she began RCW 13.50.100, where was she going and her RCW 13.50.100 plan. However, while that was not clear, the inclusion of a RCW 13.50.100 during the FTDM and communication between the staff at RCW 74.15.515 Hospital and CA was sufficient. It would have been ideal to have had the documentation of the mother's assessment for treatment, discharge summary and current documentation of a treatment plan if available.

The Committee supported the staff's identification that a more in-depth discussion of line-of-sight supervision and how that was to play out during the evening hours would have been appropriate. However, it appeared as though the

[14] Promoting First Relationships, an evidence based service for families with a child between the ages of 0 and 3 years of age. [Evidence Based Practices - Description and Directory]

staff did discuss on numerous occasions safe sleep and supervision issues with the mother and relatives.

All CA staff involved were concerned about the mother's RCW 13.50.100; however, they identified that the mother was willing to cooperate, that there were appropriate and supportive family and that reasonable efforts must be made prior to legal intervention. The Committee agreed with this conclusion as well.

Findings

The Committee did not identify any critical errors during the short time this case was opened to CA. The Committee identified positive practice conducted by the staff regarding their assessment and engagement of least restrictive interventions with the family. This also included the identification by the Committee that practices, such as the FVS and CPS worker meeting with the family together, showed a genuine attempt to have a successful and smooth transition from one worker to the next.

Recommendations

CA shall develop or obtain a training for staff regarding the behavioral indicators of persons using and abusing RCW 13.50.100 and RCW 13.50.100. This training should provide staff with tools on how to assess the risk to child safety for parents using or abusing RCW 13.50.100 and/or RCW 13.50.100 as well as provide guidance on what to do with that information after it was been received.

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

Child Fatality Review

R.A.

RCW 74.15.515 **2015**
Date of Child's Birth

August 3, 2017
Date of Child's Death

September 21, 2017
Date of the Fatality Review

Committee Members
Patrick Dowd, Director, Office of the Family & Children's Ombuds
Dr. Roy Simms, M.D., Acting Chief Medical Director, Coordinated Care of Washington; Primary Care Pediatrician, Yakima Pediatrics, Community Health of Central WA
Jim Weed, Detective Sergeant, Ellensburg Police Department
Angie Keith, Supervisor, Children's Administration
Jenna Kiser, Intake and Safety Program Manager, Children's Administration

Facilitator
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Executive Summary

On September 21, 2017, the Department of Social and Health Services (DSHS), Children's Administration (CA), convened a Child Fatality Review (CFR)[15] to assess the department's practice and service delivery to 2-year-old R.A and RCW 74.15.515 family.[16] The child will be referenced by the initials R.A.in this report. The incident initiating this review occurred on June 22, 2017 when RCW 74.15.515 was taken to a local hospital by paramedics after the mother called 911 stating R.A. was seizing. At the hospital, the child was found to have a subdural hematoma. Law enforcement notified CA of the injuries and R.A.'s hospitalization. The report was made with allegations of child abuse and neglect due to the mother and her newly identified paramour giving inconsistent explanations of the circumstances surrounding the incident. At the time of the incident, R.A. was residing with RCW 74.15.515 mother and sibling. Prior to the incident, R.A. would travel between RCW 74.15.515 mother and father for court ordered visitation at RCW 74.15.515 father's home.

The Review Committee included members selected from diverse disciplines within the community with relevant expertise including the Office of the Family and Children's Ombuds, a law enforcement officer, a pediatric and child abuse medical expert, a CA intake and safety program manager and a CPS supervisor with CA. Neither CA staff nor any other Committee members had previous direct involvement with this family.

Prior to the review, each Committee member received a family genogram, a case chronology, a summary of CA involvement with the family and un-redacted CA case documents (e.g., intakes, investigative assessments and case notes). Supplemental sources of information and resource materials were available to the Committee at the time of the review. These included medical reports, relevant state laws and CA policies.

During the course of this review, the Committee interviewed the Child Protective Services investigator and supervisor. Following the review of the case file

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

[16] Family members are not named in this report because they have not been charged in an accusatory instrument with committing a crime related to a report maintained by the department in its case and management information system. [Source: 74.13.500(1)(a)]

documents, completion of interviews and discussion regarding department activities and decisions, the Committee discussed possible areas for practice improvement, while recognizing the limited time CA was involved prior to the incident. The Committee did not conclude with any findings or recommendations related to CA's response or CA systems.

Family Case Summary

The CA case history for this family includes six reports since August 2016, three of which screened in for investigation. On June 8, 2017, two reports received by CA screened in[17] for investigation. The first report included allegations of physical abuse and negligent treatment. R.A. was reported to have had multiple injuries to vulnerable areas of RCW 74.15.515 body. CA later received a confirming report that R.A. had verified breaks in RCW 74.15.515 right arm (ulna and radius), with no explanation by the parents for the cause of the injury. R.A.'s parents, although separated and residing in different homes, were named as subjects of physical abuse and negligent treatment. It was determined by CA that the child was in the care of RCW 74.15.515 mother and that the mother delayed seeking medical care for the child overnight. The following day on June 9, 2017, RCW 13.50.100called in a report accusing R.A.'s father of neglect and alleging that R.A. was returned to RCW 13.50.100after visitation with injuries. This report screened out as the allegations had previously been reported twice and was under investigation. The parents were blaming each other for the condition of the child.

On June 11, 2017, another report was called into CA that was screened in for investigation. Law enforcement along with CA made initial contacts with the children, parents and collateral sources; R.A. was found to have bruising on RCW 74.15.515 right shoulder. R.A.'s sibling was found to be RCW 13.50.100 The investigator was able to find that the father to R.A.'s sibling resides in another state RCW 13.50.100 . On June 15, 2017, an orthopedic surgeon who was reviewing R.A.'s medical records called CA concerning the previously reported injuries. The orthopedic surgeon indicated that a child with such injuries would have been in great pain and crying initially out, making it apparent RCW 74.15.515 was in need of immediate medical attention. The orthopedic surgeon questioned the mother's explanation of circumstances surrounding the injury and the delay on the part of the mother in seeking medical care. The orthopedic surgeon further noted curiosity and concern when the child

[17] 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.

was verbally apologetic to medical staff about RCW 74.15.515 injuries. This report screened out[18] for investigation as it was duplicate information already under investigation.

On June 22, 2017, R.A. was again taken to the hospital. The mother had called 911. Paramedics reported that upon arrival, R.A. was in an active seizure and paramedics intubated RCW 74.15.515. The mother reported to paramedics that R.A. had fallen the night before in the back of the house on the wooden stairs, falling backyards and hitting RCW 74.15.515 head on a concrete patio floor. R.A. was transported to the local hospital ER and was given a computerized tomography (CT)[19] scan, which came back positive for bleeding in the brain. R.A. was taken to emergency surgery to drill holes in RCW 74.15.515 skull to release cranial pressure and then later was transported RCW 74.15.515 Medical Center. R.A.'s profound injuries were inconsistent with the history RCW 74.15.515 mother provided. The medical record identified that R.A. would have been symptomatic immediately after the event. The delay in presentation and inadequate story to explain RCW 74.15.515 injury, plus the prior arm fracture of unknown cause were of concern for inflicted injury and child abuse. The mother and her paramour (who was present during the incident) changed their account on the sequence of events leading up to the injuries. CA was not aware of the identity of the mother's paramour or involvement in her life prior to the incident. R.A. died due to complications from RCW 74.15.515 injuries on August 3, 2017 while on comfort care.[20]

Committee Discussion

The Committee discussed the response to the intake that screened out on June 15, 2017. The Committee agreed with the intake worker's screening decision, as the allegations were duplicative and already being investigated. The medical expert on the Committee did not disagree with the orthopedic surgeon's concerns; however, provided an alternative assessment that the injury may have occurred from a fall, but not in all circumstances would a child respond with agonizing pain or complaints. After some discussion and recognizing that it is not required in policy, the Committee thought it would have been more helpful and

[18]Generate a new screened out intake when a CA caseworker receives a second report of child abuse or neglect already documented in an intake (excluding facility related intakes) [Source: CA Practices and Procedures Guide 2200. Intake Process and Response]

[19] A computerized tomography (CT**)** scan combines a series of X-ray images taken from different angles and uses computer processing to create cross-sectional images, or slices, of the bones, blood vessels and soft tissues inside your body. CT scan images provide more detailed information than plain X-rays do. [Source: Mayo Clinic]

[20] Comfort Care Measures refers to medical treatment of a dying person where the natural dying process is permitted to occur while assuring maximum comfort. It is in contrast to other levels of intervention such as removal of all support modalities and long-term full care (intensive care support, mechanical life-support, multiple surgeries).

better practice had the assigned worker or supervisor contacted the surgeon immediately as a collateral contact to gain further insight to the concerns and for a more comprehensive assessment of child safety.

The Committee found the staff interviews helpful in understanding how the local CA office functions and works to achieve policy measures and gather information for child safety. The Committee briefly noted systemic issues that seemed to go beyond CA's capacity to respond more fully to the demands of policy and work requirements in effort to assess for child safety. The Committee recognized the challenges CA staff have in triaging cases when there are vacancies in a unit, absenteeism, high caseloads, and/or emergent placement of a child on case(s) in the unit. Some Committee members believed CA should make provisions or additional resources for CA staff for the investigation of cases when the number of cases being assigned exceeds the capacity for CA to adequately investigate or gather information in a timely manner. Further, a portion of the Committee opined the importance of having a standardized or universal system for case assignments as well as basic competencies for all supervisors. Limited discussion occurred surrounding the CA's current Supervisor Core Training[21] (SCT) related to basic supervision competencies. Regardless of the noted systemic issues, the Committee believed to be a statewide issue for CA, there was an appreciation for the local supervisor's management of her unit and overall management skills.

Furthermore, the Committee was impressed with the partnership between the local CA investigative unit and local law enforcement agencies. It seemed to the Committee that partnership between CA and the medical communities lacked efficiency and effectiveness in comparison to partnerships with local law enforcement and medical communities statewide. The Committee did not conclude with related recommendations or findings for CA.

Understanding CA's inability to remedy or oversee outside agencies' protocols, some Committee members believed that the medical community failed to respond immediately to the child's evaluation needs at the initial June 8, 2017 visit. Recognizing the opinion regarding procedure of outside agencies is not

[21] SCT: This updated competency-based training program provides the foundation for effective supervisory practice in the child welfare system. This instructor led program will prepare new supervisors to become comfortable in assuming their new role, learning what it means to be a supervisor in the child welfare system, and to understanding the new responsibilities of this position. This program is offered for a 3-month period and covers topics such as: Becoming a Supervisor; Workload and Caseload Management; Navigating FamLink for Effective Supervision; Supervising with Data; Elements of Administrative Supervision; Talent Management; Elements of Clinical Supervision; Self Care, Secondary Trauma, Burnout Prevention and Conflict Management; Building and Facilitating Effective Teams; Role of the Supervisor in Critical Incidents and AIRS; Professional Ethics; ICW Government to Government. [Source: Alliance for Child Welfare Excellence]

within purview of this review, some Committee members voiced the importance of noting that due to the medical evidence and questions surrounding the circumstances, a skeletal survey should have been ordered immediately by medical staff at that initial hospital visit.

The Committee heard from the assigned investigator and supervisor regarding their heightened level of concern for the children based on the numerous received reports, unexplained circumstances surrounding the incidents leading to those reports and the behaviors of R.A.'s mother. The investigator and supervisor reported to the Committee how they responded and started their assessment by working with law enforcement to interview both children, relatives and R.A.'s parents. The CA staff that were interviewed further conveyed that they had constant communication and discussion of investigative evidence or lack thereof between the investigator and supervisor in the office. The investigator and supervisor identified challenges interviewing and gaining information from R.A.'s mother in comparison to R.A.'s father. Both parents equally shared negative opinions of each other; however, the investigator's and supervisor's initial contacts with R.A.'s father were more helpful in gaining information on RCW 74.15.515 daily life and care of the child when he had visitation. R.A.'s mother presented to CA and law enforcement with behavior indicative of someone under the influence of substances or possible mental health issues. The investigator and supervisor relayed that R.A.'s mother continually returned the conversations to her opinions on her ex-husband rather than her daily life and functioning. Recognizing the apparent deceptiveness or external influences prohibiting the mother from communicating effectively for safety assessment[22] of the children, the Committee wondered if further curiosity and time spent during the initial contacts may have improved the quality of information gained for a more thorough understanding of the daily life and safety of the children. The Committee discussed the concept of a supervisor or more experienced worker helping in such situations to model interviewing techniques in attempt to gain needed information.

According to the Committee, there seemed to be some ambiguity on next steps for the investigator to take even after multiple case staffings with the supervisor. The Committee discussed the possibility of collaboration and communication with a CA program consultant, a request for urinalysis of R.A.'s mother and holding a Family Team Decision Making Meeting[23] (FTDM) immediately after the

[22] Safety Assessment is used throughout the life of the case to identify impending danger and determine whether a child is safe or unsafe. It is based on comprehensive information gathered about the family at the time the safety assessment is completed. [Source: CA Practices and Procedures Guide Chapter 1120]
[23] 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,

second interview of R.A.'s mother on June 15, 2017. These approaches may have improved information gathering or have assisted with any ambiguity for investigative tasks.

The CA investigator and supervisor informed the Committee they had planned to request a CA medical consultant review, but were waiting to receive a medical report. The Committee recognized that, although the case was newly assigned and staff were within designated policy timeframes[24] for their investigation, the Committee would have preferred to see CA staff make an immediate telephone call to a CA medical consultant[25] based on the reported heightened concern for the children.

Based on a review of the case documents and interviews with staff, the Committee did not find any critical errors made by department staff directly linked to child's death. The Committee did not have any findings or recommendations.

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service providers, child welfare staff and/or caregivers. These meeting are held to make critical decisions regarding the placement of children following and emergent removal of child(ren) from their home, changes in out-of-home placement, and reunification or placement into a permanent home. There may be instances when a FTDM can be held prior to placement if there is not an immediate safety threat such as a child who is on a hospital hold and a FTDM could provide placement options. Permanency planning starts the moment children are placed out of their homes and are discussed during a Family Team Decision-Making meeting. Am FTDM will take place in all placement decisions to achieve the least restrictive, safest placement in the best interests of the child. By utilizing this inclusive process, a network of support for the child(ren) and adults who care for them are assured. [Source: CA Practices and Procedures Guide Chapter 1720]

[24] Time frames-Safety, Risk and Investigative Assessments: 4.d.i. Complete a safety assessment within 30 calendar days from the date of the intake, and at key decision points in a case. 4.d.ii If a safety threat is identified and cannot be managed with a safety plan, review the case with a supervisor to determine if the child should be placed in out-of-home care. 4.d.iii. Complete the Structured Decision Making Risk Assessment (SDRMA) within 60 calendar days from the date and time CA receives the intake. Services must be offered to family with a high SDMRA score, and may be offered to families with a moderately high score. Ongoing risk assessment continues throughout the life of a case from the initial CPS intake until the case is closed. 4.d.iv. Complete the Investigative Assessment (IA) on all investigations within 60 calendar days of date and time CA receives the intake. 4.d.v. Document and submit for supervisor approval, a FamLink timeframe extension for investigations remaining open beyond 90 calendar days from the date and time CA receives the intake due to law enforcement or prosecutor collaboration. [Source: CA Practices and Procedures Guide Chapter 2331]

[25] The tasks of the statewide Child Protection Medical Consultants (CPMC) network include providing telephonic consultations, case staffing/case review, training, court testimony, and written consults to CA staff, law enforcement officials, prosecuting attorneys, and physicians regarding child maltreatment cases.