WASHINGTON STATE
Department of
Children, Youth, and Families

Child Fatality Review

Child's Initials
A.F.

Date of Child's Birth
RCW 74.1 2017

Date of Fatality
January 2018

Child Fatality Review Date
May 31, 2018

Committee Members
Cristina Limpens, Senior Ombuds, Office of the Family and Children's Ombuds
Ashley Robillard, Sexual Assault Unit Detective, Tacoma Police Department
Erin Summa, MPH, Health Promotion Coordinator, Mary Bridge Children's Hospital and Health Network
Tarassa Froberg, Family Voluntary Services and Child Family Welfare Services Program Manager, Children's Administration
Jennifer Gaddis, MSW, Region 3 Safety Administrator, Children's Administration

Observer
Lori Gianetto Bare, Incident Management and Communications Program Manager, Developmental Disabilities Administration

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

Table of Contents

Executive Summary

On May 31, 2018, the Department of Social and Health Services (DSHS or Department), Children's Administration (CA)[1] convened a Child Fatality Review (CFR)[2] to assess the Department's practice and service delivery to A.F., RCW 74. family and out-of-home placement.[3] The child will be referenced by RCW 74. initials in this report.

On January 12, 2018, the CA received a call from RCW 74.13 County Sheriff's Office stating that A.F. had passed away. A.F. was placed in out-of-home care by CA at the time of RCW 74. death and RCW 74. case was open to Child Family Welfare Services (CFWS).

A.F. was sleeping in a Fisher Price Rock 'n Play Sleeper in front of the main floor fireplace. A.F. had been wrapped in an afghan and RCW 74. bottle had been propped when RCW 74. was put down to sleep at approximately 8:00 p.m. RCW 74.1 was found unresponsive at 11:40 a.m. the following morning. The Medical Examiner's office ruled A.F.'s cause of death as Sudden Infant Death Syndrome (SIDS) and the manner of death was natural.

The CFR Committee (Committee) included members selected from diverse disciplines within the community with relevant expertise including individuals from the Office of the Family and Children's Ombuds, law enforcement, prevention specialist and child welfare. There was an observer from the DSHS Developmental Disabilities Administration, as well. The Committee members and observer did not have any involvement or contact with this family.

Prior to the CFR, each Committee member received a summary of the CA involvement with the family, including 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 CFR. These included the Medical Examiner's report, relevant state laws and the CA policies and procedures.

The Committee interviewed the CFWS supervisor and case worker as well as the area administrator. The Child Protective Services (CPS) case workers and supervisor assigned to the A.F. case no longer worked for the CA and could not be interviewed.

1 Effective July 1, 2018, the Department of Children, Youth, and Families (DCYF) replaced the Department of Social and Health Services (DSHS) Children's Administration (CA) as the state agency responsible for child welfare (and early learning programs). The fatality happened prior to July 1, 2018, therefore CA or department is used throughout the report.

[2] Given its limited purpose, a 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 CFR 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 CFR to recommend personnel action against DSHS employees or other individuals.

[3] A.F.'s parents and the placement 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-Revised Code of Washington 74.13.500(1)(a)]

Family Case Summary

On [redacted] 13, 2017, the CA received an intake stating concerns for an unborn child (who was named A.F. after birth). The caller stated the mother did not obtain [redacted]. The mother told the caller she had [redacted] but would not provide information about them. The caller did an internet search and found a news article stating the parents were [redacted]. The intake worker did an internet search and found that the mother and alleged father of this unborn child had [redacted]. The intake worker further discovered that the National Center for Missing and Exploited Children had been involved in attempting to locate the family. This intake was closed at screening because the mother had not yet given birth.

A second intake was received on [redacted] 10, 2017, by the same caller whom called the CA [redacted] 13, 2017. The intake stated that A.F. was born at home. The caller stated the mother and child are bonding well and the mother's drug screen at delivery was [redacted] Based on the historical information out of [redacted] regarding the mother's [redacted], this intake was assigned for a 24 hour CPS Risk Only.[4]

The case was assigned to a CPS worker who attempted to contact the family at their home that same day. No one answered the door, yet the CPS worker saw blinds moving in the window. The CPS worker left her business card in the door-jam of the front door and on the fence gate. The next day the CPS worker contacted [redacted] Police Department and [redacted] Department of Health and Human Services. The CPS worker obtained police reports and CPS investigative information regarding significant [redacted] and [redacted] to the mother's [redacted]. The mother's [redacted]. The father also had a warrant for his arrest for a probation violation but the law enforcement agency indicated they would not extradite him. The CPS worker then requested assistance from the [redacted] Police Department to be present with her while attempting to make contact with the family again. When the social worker went back once again, no one answered the door. The neighbor living next door denied seeing anyone at the home for several months. The CPS worker then called the referent who provided a phone number for the mother. The CPS worker left a voice mail message requesting a call back.

On [redacted] 14, 2017, the CPS worker again attempted to make contact with the family at their residence. She left another business card in the door-jam. On [redacted] 17, 2017, the CPS worker contacted law enforcement to once again accompany her to the home. The CPS worker first contacted a neighbor who stated she had just met the father and verified the recent birth of a baby [redacted] A.F. The CPS worker saw a mailman delivering mail, and that one piece of mail was addressed to A.F. When law enforcement arrived, the CPS worker discussed the historical familial [redacted], the father's current warrant for a probation violation, and current concerns for A.F.'s welfare based on the [redacted] incidents out of [redacted]

[4] CPS Risk Only is when a child is at imminent risk of serious harm and there are no child abuse or neglect allegations. https://www.dshs.wa.gov/ca/practices-and-procedures-guide/2200-intake-process-and-response

The mother answered the door and was holding a cell phone in her hand recording the interaction. The mother was holding a baby [redacted] The CPS worker requested that A.F. be placed in protective custody (PC). Law enforcement did not feel they had adequate cause to PC the child. There was considerable documentation by the CPS worker in case notes regarding the disagreement between the CA and law enforcement with how to proceed.

The CPS worker asked the mother to provide a urinalysis. The worker observed the home, a bassinet in the front of the home and a crib in a bedroom. The mother was requested to take A.F. to the hospital for a well-child exam and then to make an appointment with a pediatrician and provide all of this information by the following morning to the CPS worker.

The mother called the CPS worker the next morning. The mother stated she took A.F. to the hospital and was provided with discharge paperwork indicating the child was healthy. She had a pediatrician's appointment set for [redacted] 24th. The CPS worker reiterated the need for a urinalysis from both parents and the mother agreed. A home visit was set for the following day to review safe sleep and Period of Purple Crying. There was a discussion regarding services that were not completed in [redacted] and the mother did not agree with the information obtained from [redacted] CA obtained a pick-up order for A.F. the following day, [redacted] 18, 2017. The assigned CPS worker requested law enforcement to accompany her to the home to remove A.F., but no one answered the door when the CPS worker and law enforcement arrived.

The next day, [redacted] 19, 2017, CPS workers and law enforcement again attempted contact with the mother and A.F. The mother answered the door and was video recording the interactions. The mother was served with the paperwork to place A.F. in protective custody as well as a schedule of hearings regarding the child's dependency action. The mother was later notified of a Family Team Decision Meeting (FTDM) to discuss placement of A.F. The parents failed to show for the meeting. The CA received a call from the [redacted] who indicated the mother wanted A.F. to be placed with her. This was later confirmed by the mother.

On [redacted] 28, 2017, A.F.'s placement was changed from foster care to suitable other, the [redacted], who is the midwife that delivered A.F. This decision was made by the CFWS supervisor in consultation with an area administrator and after an FTDM occurred. The CFWS supervisor took A.F. to [redacted] new placement. The CFWS supervisor stated to the Committee that she did a walk-through of the placement and observed as well as discussed safe sleep and Period of Purple Crying with the placement, though this was not documented in a case note.

The Department continued to work towards reunification with the parents to include supervised visitations, health and safety visits and communication regarding recommended services. On January 12, 2018, the CA was notified of A.F.'s death. At that time, the mother was the only parent actively involved in the case. The father had left Washington State. The CFWS worker spoke with the investigating detective who provided the following details surrounding the event precipitating A.F.'s death. There were three adults living in the home, the placement (husband and wife) and a male adult relative. The husband put A.F. to sleep in the Rock 'n Play

Sleeper around 8:00 p.m. He had wrapped A.F. in a knitted afghan blanked that was about five and a half feet long. It wrapped around A.F.'s body about three and a half to four times. A.F. was placed in the rock n' play and the husband put another quilt on top of [redacted] and then propped a bottle for [redacted] to eat. The husband indicated [redacted] was too long for the rock n' play chair and [redacted] bottom was not in the correct spot. He then watched a movie with his children and then they went to bed. At 8:00 the next morning, A.F. appeared to still be asleep so the wife asked the other male adult (her brother) in the home to keep an eye on the child. At 9:45 a.m. when she returned home, the wife noticed A.F. was still in the chair but assumed [redacted] had woken up and was already down for [redacted] morning nap. The wife herself laid down for a nap. Around 11:00 a.m. she texted her brother to check on A.F., and he noticed there was a bubble coming out of [redacted] nose. The family then contacted emergency services and started cardiopulmonary resuscitation which was continued by responding emergency personnel. They were not able to revive A.F.

Committee Discussion

The Committee noted concerns about lack of mandatory, ongoing trainings for the CA staff regarding safe sleep. The Committee was aware of some trainings that are offered (Safety Boot Camp) as well as Regional Core Trainings for new staff through the University of Washington Alliance for Child Welfare Excellence. However, the Committee discussed how unsafe sleep-related deaths remain a significant percentage of fatality review cases. The Committee believed that the CA's Infant Safety Education and Intervention policy provides clear guidance regarding the sleeping environment and guidelines to follow but that some of the language could be more consistent. There was also some discussion that safe sleep may be more strongly emphasized in early service areas (CPS and Family Voluntary Services) in CA's involvement with a family and not as emphasized in CFWS.

When the CA staff were interviewed, they were asked if they believed they had a bias regarding the placement provider's employment as a midwife and how that may have impacted their belief that she would know what safe sleep is. The staff agreed that they may have been biased in believing this. This may also have led to a less thorough discussion regarding what safe sleep looked like. However, the CFWS supervisor did state she believed it was safe for A.F. to sleep in the rock n' play based on her own parenting experience. There was discussion regarding how this is not congruent with the CA's safe sleep policy.[5]

The Committee was also concerned by some of the details surrounding the relationship between A.F.'s parents and the placement. The Committee was aware that the placement was cautioned regarding the father's history of [redacted] when discussing interactions and the placement facilitating visits between A.F. and [redacted] parents. The placement told the CA that they were allowing the father to build or rebuild a deck at their residence to pay back the placement for the delivery fees related to A.F.'s birth as well as allowing the parents in their home for supervised visitation. The placement also indicated they wanted to adopt a baby. The

[5] https://www.dshs.wa.gov/ca/1100-child-safety/1135-infant-safety-education-and-intervention

placement had attempted to adopt a baby through a private agency on two previous occasions but for unknown reasons those adoptions did not take place. This, coupled with the fact that the placement was also RCW 13.50.100, was noted by the Committee as concerning for a possible conflict of interest.

There was some discussion by the Committee regarding systemic barriers to CA staff completing all of the expectations on all cases, the turnover of staff throughout the state, and the lack of seasoned staff to mentor newer staff. Another Committee member discussed how challenging the work is and the difficult circumstances staff are expected to navigate on a daily basis.

The Committee discussed the documented frustrations of CA staff regarding law enforcement's refusal to place A.F. in protective custody. The CA asked law enforcement to place A.F. in protective custody seven days after the intake was screened in. However, at that time, the baby appeared to be well cared for by the parents, the home did not present any imminent danger and CA had been aware of the risks presented to A.F. for an entire week. A Committee member who is a law enforcement officer provided the Committee with education surrounding the restrictions law enforcement face for what constitutes imminent danger in order to place children in protective custody. The Committee discussed that if there was such concern from the onset of the intake assignment regarding the risk to A.F., that it would have been appropriate for CA to staff the case with an Assistant Attorney General and request a pick up order as opposed to relying on law enforcement to place RCW 74. in protective custody.

The Committee did note how the persistence by the CPS worker to make contact with the family and gather information from RCW 74.13.515 was very well done. There were three attempts to locate the family at their home, three calls to the referent and information gathered from law enforcement and child welfare in RCW 74.13.515 within a short period of time.

Findings

The Committee was informed that the CFWS supervisor had given approval for the out-of-home placement provider to use the rock n' play for A.F. to sleep in. Based on that information coupled with the Infant Safety Education and Intervention policy, the Committee identified that a critical error had occurred. A critical error is something the Committee identifies as a factor that may have contributed to a fatality or near-fatality. Below are the areas the Committee identified as findings related to this case, which unlike critical errors are not identified as factors that may have contributed to the fatality or near-fatality.

The Committee noted that including strong, descriptive language in case notes regarding the CA's frustration with law enforcement was not appropriate. It would have been more appropriate to have the AA or supervisor meet with law enforcement to discuss this issue rather than document the frustration.

The Committee also noted that the CA did not document a review of the infant safe sleep guidelines at either of the two placements for A.F. nor at each health and safety visit, per policy 1135.

The Committee members were impressed with the CFWS worker. Her presentation was professional. The CFWS social worker was able to create a positive relationship and engaged well with the biological mother. She also did a very good job of gathering information from the placement provider regarding A.F. and documenting this in her health and safety visit case notes.

Recommendations

The CA should remove the term "pack-n-play or bedside co-sleeper" from Infant Safety Education and Intervention policy 1135, procedures 2.b. It should be replaced with "crib, bassinet, or play-yard that meets current federal safety standards. Car seats, swings and sleepers/nappers do not qualify as a safe sleep environment." Also within this policy, the safe sleep guidelines should be listed and not just on the attachment/link. A definition of safe sleep assessment should be included within the policy. This assessment should include observing and assessing all of the places that baby sleeps as well as a discussion regarding how often they sleep in those environments.

CA should remove the link to the Department of Health brochure on safe sleep in Policy 1135. The brochure link is currently not working and the brochure is not utilized by hospitals that are certified as National Safe Sleep hospitals and has been somewhat controversial in the SIDS/Safe Sleep community.

CA should discuss how to provide ongoing training for all CA staff regarding infant safety on a yearly basis. This recommendation is based on the Committee's assessment that there continue to be consistent reviews of infant deaths related to unsafe sleep.

CA should add language and a check box to the Placement Agreement form 15-281 to include discussion of policy 1135 including providing the handout Infant Safe Sleep Guidelines 22-1577. The CA Child and Family Welfare Family Voluntary Services (CFWS/FVS) Program Manager has started working on this process.

CA should include a link to policy 1135 on the Child Information and Placement Referral 15-300. This would allow placements to access the policy and Infant Safe Sleep Guideline form at their convenience.

CA should include language in the Health and Safety Visits with Children and Monthly Visits with Caregivers and Parents policy 4420 to align with the Infant Safety Education and Intervention policy 1135 stating, "DCFS caseworkers must also review the Infant Safe Sleep

Guidelines DSHS 22-1577 at each health and safety visit." The CFWS/FVS Program Manager has started working on this process.

The CFWS/FVS Program Manager also added instruction in the new placement policy rolling out on July 1, 2018, for staff to give the Infant Safe Sleep Guidelines to the caregiver at the time of placement. A link on the online CFWS Tools and Guide for "Safe Sleep for Your Baby Every Time" was removed and replaced with a link to the 22-1577 Infant Safe Sleep Guidelines. The CFWS/FVS Program Manager also added the Infant Safe Sleep Guidelines to the online placement packet.

The RCW 74.13 Southwest and RCW 74.13 Southeast offices should receive training regarding the Practices and Procedures policy 1135 Infant Safety Education and Intervention. This training should include (but not be limited to) a virtual walkthrough of assessing infant sleep, discussing developmentally appropriate care such as when to stop swaddling an infant/when to drop the crib's mattress level, intervening in unsafe sleep environments and the expectation of ongoing assessment during health and safety visits throughout the life of a case. This training should be provided to all staff.

The Committee noted the frustration by the CPS staff, as well as law enforcement, when asking law enforcement to place A.F. in protective custody. The relationship between law enforcement and the CA is integral. The RCW 74.13 Southwest area administrator should meet with the Chief of the RCW 74.13.515 Police Department to address the challenges faced by each agency during this case and to better understand each agency's responsibilities and roles in hopes to not repeat this same situation in the future.

Nondiscrimination Policy

The Department of Children, Youth, and Families does not discriminate and provides equal access to its programs and services for all persons without regard to race, color, gender, religion, creed, marital status, national origin, sexual orientation.