Washington State Department of Social & Health Services

CA Children's Administration

Child Fatality Review

C.T.

February 2015
Date of Child's Birth

May 25, 2015
Date of Fatality

September 24, 2015
Child Fatality Review Date

Committee Members
Patrick Dowd, Director, Office of the Family and Children's Ombuds
Mary Pagni-Leavitt, Child and Family Welfare Services Program Manager, Children's Administration
Shea Hopfauf, Social and Health Program Consultant Region 2, Children's Administration
Ericka Thompson, Foster Parent, Foster Parent Liaison and Recruiter
Rebecca Taylor, Supervisor, Division of Licensed Resources, Children's Administration
Yolanda Marzest, MSW, Manager of Program Operations, The Alliance for Child Welfare

Observer
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Executive Summary

On September 24, 2015, 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 3-month-old C.T., his family and his foster family.[2] The child will be referenced by his initials, C.T., in this report. At the time of his death, C.T. and RCW 13.50.100 lived with a licensed foster family. The incident initiating this review occurred on May 25, 2015, when C.T. was found unresponsive after being placed on a couch in the foster family's living room. C.T., RCW 13.50.100 and one other foster child were being cared for by the foster father while the foster mother and their RCW 13.50.100 were out of the house. The cause of death was classified as Sudden Unknown Infant Death with an undetermined manner of death, per the Thurston County Sheriff's Office investigator's report.

The Review Committee included members selected from diverse disciplines within the community with relevant expertise including a licensed foster parent who is also a liaison between DSHS and other foster parents and a manager with The Alliance for Child Welfare who supervises trainers providing training to new and established foster parents. Other Committee participants included the Office of the Family and Children's Ombuds, a Child and Family Welfare Services program manager with CA, a Division of Licensed Resources supervisor and Social and Health Program Consultant with CA. Also present was an observer who is a Family Assessment and Response worker with CA. Neither CA staff nor any other Committee members 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, home study 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, law

[1] Given its limited purpose, a 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 near 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] No criminal charges have been filed relating to the incident and therefore no names are identified. The name of C.T. and his sibling is subject to privacy laws. [Source: RCW 74.13.500(1)(a)].

enforcement reports, DLR Minimum Licensing Requirements handbook, timeline of foster care placements, relevant state laws and CA policies.

During the course of this review, the Committee interviewed the assigned licensor for the foster family, her supervisor, the placement desk coordinator with CA, the DLR/CPS investigator and his supervisor regarding the fatality, the previously assigned courtesy social worker, the worker who completed the home study for the foster family and the CFWS supervisor assigned to C.T.'s case.

Family Case Summary

The biological family came to the attention of CA on April 29, 2014, when an intake was received indicating that 2-month old [redacted]. was alleged to have RCW 70.02.020 [redacted] while in the care of the parents. [redacted] was placed in out-of-home care and a dependency petition was filed. [redacted]. required RCW 70.02.020 based on RCW 13.50.100 [redacted] case was assigned in Mason County.

On February 11, 2015, an intake was received from a Lewis County hospital stating C.T. had been born. C.T.'s mother told hospital staff she had no prenatal care RCW 13.50.100 [redacted]. This intake was assigned to the Centralia office for a Risk Only investigation.[3] A decision was made during a staffing between two Area Administrators and a Program Consultant to override the assignment made by intake. The Centralia office did not conduct a new investigation but did file a dependency petition. The petition was based on the parent's failure to correct the deficiencies that led to the RCW 13.50.100

C.T. was discharged to a foster family in Thurston County. That same foster family took placement of [redacted] 5 days later. A relative home study was in process. The children were placed in Thurston County but the case assignments were in Lewis and Mason Counties. A courtesy supervision worker out of Thurston County was assigned to conduct the monthly health and safety visits. On April 21, 2015, the courtesy supervision worker questioned the number of children in the home. The foster family was licensed for two children under the age of 2 years. However,

[3] Risk Only Intakes :CA will screen in a CPS Risk Only intake when information collected gives reasonable cause to believe that risk or safety factors exist that place the child at imminent risk of serious harm. In assessing imminent risk of serious harm, the overriding concern is a child's immediate safety. Imminent is defined as having the potential to occur at any moment, or that there is a substantial likelihood that harm will be experienced. Risk of Serious harm is defined as: A high likelihood of a child being abused or experiencing negligent treatment or maltreatment that could result in one or more of the following outcomes: death; life endangering illness; injury requiring medical attention; substantial risk of injury to the physical, emotional, and/or cognitive development of a child. [Source: CA Practices and Procedures Guide 2220]

there were four children under the age of 2 years in the home. Of the four children, three were RCW 13.50.100 and one was the RCW 13.50.100 of the foster parents. The courtesy supervision worker who observed this overcapacity discussed it with the placement desk coordinator and noted it in her monthly health and safety visit case note. All of the health and safety visits were conducted with the foster mother only.

Foster Family Summary

The home study regarding the foster family was approved on March 20, 2013. The home study was approved for one child under the age of 2 years. Basic training requirements had been met for that specific age range. On December 27, 2013, the foster care license was increased to two children under the age of 2 years. There were multiple incidents of overcapacity prior to and after the increase to the foster license.

On April 21, 2015, the assigned DLR licensor spoke with the foster mother regarding the overcapacity of four children under the age of 2 years in the home. A staffing occurred between DCFS and DLR that resulted in an agreement for a 30-day approval for an overcapacity while placement was located for C.T. and RCW 13. A supervision plan was agreed to between the foster mother and licensor. The plan stated two adults would be in the home at all times when there are more than two children under the age of 2 years in the home.

On May 25, 2015, C.T. passed away in the foster home while under the care of the foster father. That same day investigations were initiated by DLR/CPS, DCFS/CPS and law enforcement and all children were removed from the foster home. The investigations resulted in unfounded findings for abuse or neglect to all children and no criminal charges were filed.

Committee Discussion

For purposes of this review, the Committee focused on case activity from the day C.T. was born up until the day of the fatality. The investigation of C.T.'s death was briefly discussed as was the initial case plan regarding the foster family and removal of their RCW 13.50.100.

This case highlighted the struggle that foster families face in situations involving critical incidents or when a child moves from their home after a long-term placement. These situations can impact the children of the foster family as well. The Committee discussed the need for a clear, concise and consistent path for obtaining support through the department.

The Committee discussed at length areas where CA could have improved collaboration and critical thinking. These were highlighted by discussions surrounding courtesy supervision workers, their roles and expectations as well as their inclusion in case and/or safety planning. The Committee emphasized the need for collaboration with all assigned staff to include licensors, primary and courtesy supervision workers. The lack of collaboration diminishes the likelihood of comprehensive critical thinking regarding suitable placements and overall safety for children in out-of-home care.

During the staff interviews, the Committee was repeatedly informed of the shortage of available foster homes. Staff discussed the struggles they have to find timely and appropriate placements based on the specific needs of children. This was balanced with discussion regarding the need for DLR's input prior to an overcapacity placement being made due to the shortage of openings. Prior engagement of DLR was believed to allow more structured critical thinking to combat the pressures inherently present for placement coordinators and assigned social workers. Collaboration between DCFS and DLR staff was thought to strengthen safe and suitable placements. The Committee also discussed the challenges posed for recruitment and retention of appropriate licensed foster homes as well.

Findings

The Committee discussed areas where a stronger emphasis on critical thinking and collaboration may have assisted in alternative case practice and service delivery to C.T., [redacted] family and the foster family. Those discussions are highlighted in this section.

The Committee believed the intake dated February 2015 regarding the birth of C.T. warranted a new CPS investigation. The mother gave birth to C.T. in a county other than the originating case, the parents were not involved in services with DCFS due to the pending [redacted] and a new assessment of the current circumstances would have been appropriate.

The placement made on March 28, 2013 with C.T.'s foster family was not appropriate based on the foster parent's lack of training necessary to provide effective care to a child with [redacted] specific needs. This placement occurred prior to consultation with the DLR licensor. There were multiple incidents of overcapacity based on the age and number of children placed within this foster home. The record did not reflect consultation or approval from the DLR licensor regarding the majority of these incidents.

The supervision plan created in April of 2015 was inadequate and unrealistic. The plan did not provide clear details, all participants were not included in the discussion and ultimately the plan was never delivered to and signed by the licensed providers. While the Committee understood that at the time of each placement the parties involved believed they were making appropriate child centered decisions, the number of children in the home was at an unrealistic level for adequate care.

The Committee also noted several positive actions during this review. When the foster family was first licensed, the licensor utilized critical thinking and appropriately assessed that the foster parents should only handle one child under 2 years of age. The Committee also noted thorough and clearly documented critical thinking regarding the DLR/CPS investigation related to C.T.'s death.

During the health and safety visit on February 20, 2015, the CFWS supervisor for C.T. and the courtesy supervision worker for both C.T. and [redacted] conducted a joint visit at the foster home. During this visit, the CFWS supervisor not only discussed safe sleep but also took immediate actions to remediate the unsafe sleeping arrangements in the home. On May 6, 2015, the courtesy supervision worker also took immediate actions to remove a blanket the foster mother had placed over C.T.'s face while the child slept in a swing, once again educating the foster mother about safe sleep.

Recommendations

CA DLR Specific: DLR should create a form for the licensed provider to sign stating each person applying for a home study has reviewed and understands the Period of Purple Crying and safe sleep instructions. This form must be signed and dated by each person included in the home study/license. DLR should also reconsider the training hours and how they are required per license. The Committee believes each person on a license should receive training at some point during the time they are licensed.

CA DCFS: CA should identify a concise, clear path for who should share information with out-of-home care providers regarding supportive services, such as grief and loss counseling, and have a clear and consistent way for the payments to occur even if there are no children placed in the home.

The Committee identified consistent overcapacity situations occurring with this specific foster family and a failure to engage DLR prior to those decisions occurring. This led to the Committee's recommendation that if an overcapacity is

considered during business hours, DLR and all assigned social workers (i.e. primary, courtesy supervision, licensor, etc.) must be consulted prior to the placement occurring. If the placement occurs afterhours, DLR and all assigned social workers must be consulted and provide approval for ongoing placement by the end of the following business day.

When a child in an out-of-home placement is adopted, CA should have a mechanism to update the member tab. This mechanism needs to ensure that the appropriate household composition is reflected on the member page. This will aid in decreasing erroneous overcapacity situations.