Washington State Department of Social & Health Services

CA Children's Administration

Child Fatality Review

E.R.

RCW 74.13.52 **2017**
Date of Child's Birth

January 10, 2018
Date of Child's Death

May 11, 2018
Date of the Fatality Review

Committee Members
Patrick Dowd, Director, Office of the Family & Children's Ombuds
Annabelle Payne, Director, Pend Oreille County Counseling Services
FaLeisha Wright, Supervisor, Children's Administration
Sharon Ostheimer, CPS Program Consultant, Children's Administration

Facilitator
Cheryl Hotchkiss, Critical Incident Review Specialist, Children's Administration

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Executive Summary

On May 11, 2018, 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 E.R. and [redacted] family.[2] The incident initiating this review occurred on January 10, 2017 when E.R. was found by [redacted] parents not breathing around 6:00 p.m. The mother called 911 when E.R. was found not breathing; the father reportedly began chest compressions. At the hospital, the child was pronounced dead. E.R. reportedly had been napping since 2:00 p.m. that day and was checked on by [redacted] parents around 5:15 p.m. The parents reported E.R. to have been breathing at 5:15 p.m. but not at 6:00 p.m. At the time of the CFR, the local coroner had not made a ruling regarding the cause of E.R.'s death. E.R. was residing with [redacted] mother, [redacted] father and sibling.

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 CA program manager, a Child Family Welfare Services (CFWS) supervisor and mental health/chemical dependency specialist. 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 CPS supervisors for the 2013 and 2015 investigations regarding E.R.'s siblings, an intake area administrator and the Family Assessment Response[3] (FAR) CPS worker who was

[1]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 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 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.

[2] 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)]

[3] Family Assessment Response (FAR) is a CPS alternative response to an investigation of a screened-in allegation of child abuse or neglect. FAR focuses on child safety along with the integrity and preservation

assigned in 2018. The CA investigator who was previously assigned to the case is no longer employed with CA and was not present during the review. Following the review of the case file 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 make any findings or recommendations related to CA's response or CA systems.

Family Case Summary

CA had opened a CPS/FAR case on Friday January 5, 2018, five days before E.R.'s death. A FAR worker was assigned when the case was opened, however, the case was transferred to a different FAR unit and worker on January 8, 2018 due to the location of the family's residence and an internal jurisdiction policy. The newly assigned FAR worker responded within 72 hours, per policy requirements,[4] making the initial home visit on January 8, 2018. The FAR worker did not observe any obvious signs of neglect (based on the physical observation of the children, parents and household) or household hazards (accessible drug paraphernalia) during the home visit.

Prior reports involving this family include 11 intake[5] reports, nine of which screened out and two that screened in[6] for investigation. Of the two that screened in for investigation in December 2013 and December 2015, the allegations included RCW 13.50.100, RCW 13.50.100, RCW 13.50.100 [redacted], RCW 13.50.100, RCW 13.50.100 and RCW 13.50.100 as to both of E.R.'s parents and/or E.R.'s siblings' fathers. The allegations were determined to be unfounded[7] and no safety threats were identified by the CA social worker in both circumstances.

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of the family when lower risk allegations of child maltreatment have been reported. [Source: CA Practices and Procedures Guide 2332. Family Assessment Response]

[4] Initial Face-to-face (IFF): When conducting an IFF contact with the child, the DCFS caseworker, afterhours worker and the DLR/CPS investigator must: Meet in-person with the victim or identified child in the following timeframes from the date and time CA receives the intake: 24-hours for an emergent response and 72-hours for a non-emergent response. [Source CA Practice and Procedures Guide 2310. Child Protection Services Initial Face-to-Face Response]

[5] An "intake" is a report received by CA in which a person or persons have reasonable cause to believe or suspect that a child has been abused or neglected. A decision to screen out an intake is based on the absence of allegations of child abuse or neglect as defined by WAC 388-15-009.

[6] 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.

[7] CA findings are based on a preponderance of the evidence. "Child abuse or neglect" is defined in Chapter 26.44 RCW, WAC 388-15-009 and WAC 388-15-011. Findings are determined when the investigation is complete. Founded means the determination, following an investigation by CPS and based on available

Committee Discussion

The Committee briefly discussed the investigations that occurred prior to the 2018 FAR response involving E.R.'s sibling. The Committee wondered if the assigned CA worker assessed all of the allegations prior to closure as documentation was limited in the case file. The Committee noted the importance of CA staff and supervisors addressing each allegation in documentation, providing written and photographic evidence if warranted. The Committee recognized that it is difficult to know what the CA worker assessed if it is not documented and, as with this case, the worker is no longer working for CA to clarify what occurred.

Understanding CA's inability to remedy or oversee outside agencies' protocols, the Committee discussed the potential benefits of care coordination between community agencies and CA. The Committee discussed the barriers surrounding communication between mental health and chemical dependency providers with CA due to confidentiality laws. The Committee added that CA might have been able to respond to the family much earlier had CA received information regarding the mothers RCW 13.50.100 from a local RCW 13.50.100 provider in December, 2017. CA was not aware of the December RCW 13.50.100 assessment concerns and services until after E.R. had passed away. The Committee recognized that it is not regular practice for a RCW 13.50.100 provider to share assessments with CA when CA does not have an open case and there is not a signed consent to share information. The Committee wondered whether legislation could be passed to address the privacy laws and incorporate necessary communication between agencies so that CA is better able to promptly assess child safety. The Committee wondered about the possibility of a shared electronic information system for CA in accessing mental health and chemical dependency records.

The Committee noted that the newly assigned FAR worker in January 2018 responded to the home as required. However, the Committee noticed that there was a systemic delay in assignment which prevented the worker from having time to review the case history prior to responding to the family home. The Committee recognized that the worker completed the tasks in the required timeframes, however noted that global assessment of a situation and family is enhanced when workers have an opportunity to prepare prior to responding.

information, that it is more likely than not child abuse or neglect did occur. Unfounded means the determination, following an investigation by CPS and based on available information that it is more likely than not child abuse or neglect did not occur, or there is insufficient evidence for DSHS to determine whether the alleged child abuse did or did not occur.

Further, the Committee noted that the FAR worker's documentation was above standard practice.

Safe sleep[8] policy and practice was discussed. Some committee members wondered if CA staff assigned to this case or in statewide practice discuss secondary, third or fourth risks to infants associated with second hand smoke or exposure to various chemicals on clothing or in a household. The CA supervisor, program consultant as well as the staff interviewed, discussed the policy for safe sleep and that based on individual staff's experience or training, it varies as to what information is provided beyond the required information CA staff already provides families. The Committee noted that the FAR worker assigned in January 2018 covered safe sleep as required by CA policy.

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.

[8] Safe Sleep is a nationwide campaign to promote safe sleeping habits for children. Safe sleep practice can reduce the risk of SIDS. According to the National Institute of Child Health and Human Development the top 10 safe sleep guidelines are: 1) always place your baby on his or her back to sleep, for naps and at night; 2) place your baby on a firm sleep surface, such as on a safety-approved crib mattress, covered by a fitted sheet; 3) keep soft objects, toys, and loose bedding out of your baby's sleep area; 4) do not allow smoking around your baby; 5) keep your baby's sleep area close to, but separate from, where you and others sleep; 6) think about using a clean, dry pacifier when placing the infant down to sleep; 7) do not let your baby overheat during sleep; 8) avoid products that claim to reduce the risk of SIDS because most have not been tested for effectiveness or safety; 9) do not use home monitors to reduce the risk of SIDS; and 10) reduce the chance that flat spots will develop on your baby's head, provide "Tummy Time" when your baby is awake and someone is watching, change the direction that your baby lies in the crib from one week to the next and avoid too much time in car seats, carriers and bouncers.