Child Fatality Review

J.S.

RCW 74.13.515 **2017**
Date of Child's Birth

December 2017
Date of Fatality

March 29, 2018
Child Fatality Review Date

Committee Members
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Executive Summary

On March 29, 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 J.S. and RCW 74 family.[2] The child will be referenced by RCW 74 initials in this report.

On December 13, 2017, CA received an intake from the RCW 74.13. County Medical Examiner's Office stating RCW 74.13.515 month-old J.S. passed away. J.S.'s mother put RCW 74.13 face down on her bed which had clothes and blankets on it. She later checked on RCW 74.13 and RCW 7 was not breathing.

Law enforcement placed J.S.'s sister in protective custody. The Medical Examiner found no outward signs of trauma at the scene. The cause of death was determined to be Sudden Infant Death Syndrome (SIDS) and the manner of death was deemed natural. After the child's death, CA learned that J.S. was living with RCW 74 mother and sister. CA had closed the most recent Child Protective Services (CPS) investigation seven days prior to J.S.'s death with the understanding that J.S. and RCW 74 sister were living with their maternal grandmother.

The 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, domestic violence and crime victims advocate as well as child welfare. There were two observers from CA and one observer from another DSHS administration. None of the Committee members or observers had any involvement or contact with this family.

Prior to the review, each Committee member received 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

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[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 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.

[2] J.S. mother is not named in this report because she has 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)]

review. These included the law enforcement report, relevant state laws and CA policies.

The Committee interviewed one CPS worker and two CPS supervisors. The CPS worker assigned to the case, which closed on December 6, 2017, was not available to be interviewed by the Committee.

Family Case Summary

On September 12, 2016, CA received an intake regarding J.S.'s then four-year-old sister. Between September 12, 2016 and August of 2017, there were six intakes received alleging RCW 13.50.100 to J.S.'s sister, RCW 13.50.100 and RCW 13.50.100 by the mother. Three of the six intakes were screened in for CPS/Family Assessment Response (FAR)[3] and one intake was screened in for a CPS Risk Only[4] assessment.

CA was made aware that the mother and daughter had moved to western Washington in August of 2017 during a FAR assessment that was open in eastern Washington. On September 1, 2017, an intake was received providing historical allegations of RCW 13.50.100 as well as stating that the mother RCW 13.50.100 . The intake further alleged that RCW 13.50.100 . That intake was assigned for a CPS investigation.

On RCW 74.13.515, 2017, while CPS was investigating the September 1, 2017 intake, another intake was received stating the mother had given birth to J.S. The intake stated that J.S. RCW 74.13.520 and that RCW 7 had been RCW 74.13.520 in the first few months of the pregnancy. This intake was screened in for a Risk Only CPS assessment. On October 12, 2017, an intake was received stating that J.S.'s sister was RCW 13.50.100. This intake was screened out. The decision to close this intake was stated as not having met the sufficiency guidelines for a CPS investigation. The case was closed on December 6, 2017. At the time of the case closure, CA believed that J.S. and RCW 74 sister were in the physical care of their maternal grandmother. At the time of the case

[3] Family Assessment Response (FAR) is a Child Protective Services (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 of the family when lower risk allegations of child maltreatment have been reported. [Source: CA Practice and Procedures Guide 2310. Child Protection Services Initial Face-to-Face Response]

[4] CPS Risk Only reports when a child is at imminent risk of serious harm and there are no CA/N allegations. [Source: CA Practices and Procedures Guide2200. Intake Process and Response]

closing, CA believed that the mother had obtained RCW 13.50.100 treatment for herself and RCW 13.50.100 services for her daughter.

On December 13, 2017, J.S. passed away. RCW 74 was found by RCW 74 mother not breathing on her bed, after she laid RCW 74.13 down on RCW 74 stomach for a nap. According to the Medical Examiner, the bed had clothing and blankets on top of it. Based on the repeated education on safe sleep environments provided to J.S.'s mother by CA staff and the hospital staff where J.S. was born, a founded finding for neglect was given to the mother regarding the death of J.S. A criminal investigation regarding J.S.'s death was initiated based on the education provided to the mother regarding safe sleep and statements that the maternal grandmother made about prior incidents where J.S.'s ability to breathe were interrupted. After J.S.'s death, CA RCW 13.50.100 as to J.S.'s sister and she was briefly placed in out-of-home care. However, the court shortly thereafter chose to return the child to the mother, against the department's objection and while the criminal investigation continued.

Committee Discussion

The Committee discussed how the mother's presentation, as described by the staff who participated in this review, led to a biased approach in CA staff's interactions with her. There were re-occurring instances of staff taking the mother's statements as fact as opposed to verifying the information through other sources. There were areas where collateral contacts, such as mental health providers and substance abuse providers, could have provided a more thorough and unbiased assessment regarding the family's safety and stability.

The Committee struggled with the ongoing issue of turnover and CA's struggle to maintain consistent staff. This issue of turnover and vacancies leaves supervisors with a substantial workload. One specific area that proves to be a struggle is the supervisor's reliance on their staff to provide accurate and comprehensive details regarding cases during monthly supervision staffings. The Committee discussed how supervisors do not have the time to read through each and every case assigned to their staff to make sure there are no gaps in the information provided to them by their staff. This can lead to supervision that lacks critical thinking and support to the families CA is involved with. There were periods of time where supervisory reviews were not documented on this case.

The Committee also thought CA could have utilized other supports and shared decision making by cross reporting the September 1, 2017 intake to law enforcement. This intake contained allegations of RCW 13.50.100 to J.S.'s sister that the mother allegedly admitted to.

One Committee member discussed that RCW 74.13. County has a Domestic Violence Best Practices Group that meets on a monthly basis. The group consists of service providers in RCW 74.13. County and CA staff. The purpose is to staff cases involving DV and for shared decision-making and next steps. Also discussed was the fact that CA did not have a DV policy at the time of the allegations in this case. Since that time, a policy has been implemented which outlines how to handle assessments of DV within the families that CA interacts with.

The Committee discussed the placement of J.S. and RCW 74 sister with their grandmother. Due to the identification of the children as unsafe with their mother and then the mother making the decision to place with the maternal grandmother, this was considered an informal placement. The Committee discussed that the issue of informal placements has been a statewide issue for some time. The Committee is hopeful that this issue will be addressed in the upcoming policy roll out July 1, 2018.

Findings

Based on the review of the case documents and interviews with staff, the Committee did not identify any critical errors made by CA that contributed to the death of J.S. The Committee did identify missed opportunities within the assessment and casework with this family as well as systemic barriers to consistent supervision and case practice.

The Committee identified there were differing points during the case where the assessment of safety was not accurately completed. There were missed opportunities to engage collateral contacts such as relatives and service providers. This included the need to adequately assess the maternal grandmother based on differing statements received regarding her suitability and stability for providing care fulltime to her grandchildren. There was also a missed opportunity to assess for the safety and well-being of J.S. and RCW 74 sister in the month of November prior to the case closing. CA did not conduct a health and safety visit during November or December 2017.

The Committee noted that the assessments of safety throughout this case were incomplete. The Committee believed that there were times where the household circumstances changed and there was not a new assessment completed. The Committee discussed that CA did not thoroughly assess the safety of J.S.'s sister regarding the mother's boyfriend and allegations of RCW 13.50.100 . The mother RCW 13.50.100 and told CA the child was safe; there was reliance upon the mother's statements as fact.

The Committee noted that the CA staff during the September 2017 assessments believed J.S. and RCW 74 sister were not safe in their mother's care. The CA staff allowed the mother to choose to have the children stay with the maternal grandmother as an informal placement. The Committee believes it would have been appropriate for CA to discuss this with an Assistant Attorney General or possibly formalize this placement decision based on the unsafe status of the children with their mother. As part of this formalized placement, CA would have conducted a thorough assessment of the maternal grandmother's suitability for placement. Instead, CA relied upon a revocable document indicating the mother was allowing the children to live with and be cared for by the maternal grandmother.

The Committee believed that the mother had unmet mental health needs based on her statements that she was RCW 13.50.100, experienced the RCW 13.50.100, was a RCW 13.50.100 and RCW 13.50.100. The Committee noted that it may have been beneficial for CA to have referred the mother to her own mental health assessment.

Recommendations

CA needs to address the issue of coverage for supervisors and line staff based on the high turnover rates within the agency.

The RCW 74.13. Southeast and Southwest offices should receive training regarding safety throughout the life of a case to include informal placements, safety framework and safety threshold.