Washington State Department of Social & Health Services

CA Children's Administration

Child Fatality Review

P.S.

RCW 74.13.5 **2016**
Date of Child's Birth

June 10, 2016
Date of Fatality

October 6, 2016
Child Fatality Review Date

Committee Members
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Jerry Sells, M.D., Retired Pediatric Physician
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Table of Contents

Executive Summary

On October 6, 2016, 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 RCW 74.13.515-old P.S. and RCW 74.1 family.[2] The child will be referenced by RCW 74.1 initials, P.S., in this report.

P.S. was born in RCW 74.13.5 2016. At the time of RCW 74.1 birth, CA received an intake with concerns of RCW 13.50.100. A Child Protective Services (CPS) worker was assigned to investigate. P.S. had been born RCW 74.13.520 and it was the understanding of the CPS worker that RCW 74.1 would remain in the hospital for a couple of weeks. The CPS worker requested notification before RCW 74.1 was to be discharged.

On RCW 74.13.515, 2016, the CPS worker was notified by the mother that P.S. had been discharged from the hospital. The worker made contact that day with the father of P.S. and both half-sisters but the mother and P.S. were not present. On June 10, 2016, law enforcement notified CA that P.S. had passed away while in the bathtub with RCW 74.1 mother. The medical examiner's office determined the cause and manner of death were both undetermined. However, within the undetermined cause of death, the report suggests the cause of death to be asphyxia mechanism, either positional or related to drowning. The autopsy also identified an unsafe environment within the diagnosis; in addition to the mother's RCW 74.13.520 the infant was held against the morbidly obese, sleeping, naked mother in a bathtub containing water.

At the time of RCW 74.1 death, P.S. lived with RCW 74.1 mother, father and two half-siblings. Additionally, the mother has two other children who live with their father out of state.

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 retired pediatric physician who also participates on the

[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] P.S.'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)]

local child protection team for CA, a co-occurring treatment provider and a Child Protective Services supervisor 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, and case notes). Supplemental sources of information and resource materials were available to the Committee at the time of the review. These included the autopsy report, medical records, relevant state laws and CA policies.

The Committee interviewed the previously assigned family voluntary services (FVS) worker, the CPS investigator and CPS supervisor for the intake related to the birth of P.S. The area administrator was available by phone; however, the Committee did not identify any questions to ask her.

Family Case Summary

There were a total of 16 intakes prior to the birth of P.S. between June 2, 2010 and March 31, 2014, related to P.S.'s mother and RCW 13.50.100. The intakes included allegations relating to RCW 13.50.100 RCW 13.50.100 , RCW 13.50.100 , RCW 13.50.100 and the mother RCW 13.50.100 . The majority of intakes related to the mother's RCW 13.50.100 and RCW 13.50.100 . In September 2013, there was a founded finding for RCW 13.50.100 related to the mother RCW 13.50.100 . The other five assessments were unfounded.

CA opened a Family Voluntary Services case with the Bellingham office. That case remained open from March 31, 2014 until January 12, 2015. The family engaged in, and completed a majority of services referred by CA staff; however, the mother RCW 13.50.100 .

On RCW 74.13.515, 2016, an intake was received alleging P.S. had been born RCW 74.13.520 , that the mother obtained RCW 13.50.100 and she admitted to RCW 13.50.100 throughout her pregnancy. The mother stated sometimes she RCW 13.50.100 . The mother also stated she RCW 74.13.520 . The referrer of the intake stated the mother was bonding well with the child and she is breastfeeding. The baby was expected to stay in the RCW 74.13.515 care unit for one to three weeks.

The CPS investigator met with the mother and child at the hospital the next day. The mother engaged in a lengthy conversation with the CPS investigator. The CPS investigator asked the mother to call her the following week to set up a time to allow the CPS investigator to see the family home before P.S. was discharged from the hospital. The CPS investigator followed up with the hospital social worker and reiterated the request to be notified when P.S. was discharged before it actually occurred.

On RCW 74.13.515, 2016, the CPS investigator called the mother to check in. The mother notified her that P.S. had already been discharged home. The investigator set up a time to meet them at the home within two hours from the time of the phone call. When the investigator arrived at the home only the father and two half-sisters were present. The mother then cancelled the next scheduled home visit for the following day.

On June 10, 2016, an intake was received stating RCW 74.13.515 old P.S. had passed away while in the bathtub with RCW 74.1 mother. The mother admitted to law enforcement she had been drinking prior to the father placing the baby with her in the bathtub. Law enforcement also stated the home was in awful condition and not fit for children to live in. The two surviving RCW 13.50.100 were placed with their RCW 13.50.100 . CA filed RCW 13.50.100 regarding those children.

During the CA and law enforcement investigations, the parents admitted that the mother drank throughout the day, that P.S. had been a fussy and difficult baby and the parents had been struggling to care for her. CA founded the allegation for negligent treatment or maltreatment as to both parents regarding the death of P.S. and the living conditions for all three children.

Committee Discussion

For purposes of this review, the Committee mainly focused on case activity at the birth of P.S. up until the fatality. The FVS case out of Bellingham and CPS investigation regarding the fatality were also briefly discussed.

The Committee discussed the closure of the FVS case by the Bellingham office. There was no indication to the Committee that CA should have taken any different steps regarding the case at that time. The Committee agreed with the FVS worker's assessment that there remained risk due to the mother's RCW 13.50.100 while acknowledging the parents did successfully complete other supportive in-home services. The risk was mitigated by the ages of the children in the home at that time.

It did not seem as though there was a sense of urgency regarding the assessment at the time P.S. was born. The Committee identified the history of the mother's RCW 13.50.100 RCW 13.50.100 and prior RCW 13.50.100 of her other children, coupled with the father's RCW 13.50.100 as areas that necessitated more in-depth assessment.

The Committee appreciated that the Mt. Vernon area does not have a robust public health nurse program, which presents a barrier to strong collaboration with CA staff and other social service agencies and engagement of a large number of families. The Committee did discuss a desire to have a more collaborative relationship with CA staff in order to support families such as P.S.'s family in providing a decrease to risk of future abuse or maltreatment.

An area of concern discussed by the Committee was the caseload size for the assigned CPS investigator at the time of the fatality. The Committee discussed ways other offices have handled such high workload and caseloads, such as reliance upon other CPS-trained staff in other positions within the office taking on lower level CPS investigations to help alleviate the workload.

Findings

The Committee did not find any critical errors that directly correlated with the fatality. However, the Committee identified areas where practice could improve.

The assessment of the RCW 74.13.515, 2016 intake could have been more comprehensive. The Committee identified that there was a lack of collateral contacts and corroboration of the information provided by the mother. The mother appeared to present well to the CPS investigator and provided a lot of positive information regarding her prior services and sobriety. The Committee believed that contact with the prior Family Voluntary Services worker would have benefitted the CPS investigator and provided a clearer understanding of the risk posed to P.S. A couple of areas that support this finding include the inaccuracy of the Structured Decision Making Risk Assessment®[3] and the Safety Assessment[4] both of which were completed after the fatality.

[3] Actuarial risk assessment is a statistical procedure for estimating the probability that a critical event will occur at some future time. SDMRA® uses factors associated with higher rates of abuse and neglect to identify families who are most likely to experience a future event of child abuse or neglect. SDMRA® supports Children's Administration staff in making decisions about the highest risk families who should receive intervention. [Source: CA Practices and Procedures Guide Chapter 2451]

[4] A complete Safety Assessment must be completed on all CPS and DLR/CPS intakes (including new intakes on active cases) no later than 30 calendar days from date of intake. DLR/CPS follows additional requirements per DLR/CPS Use of Safety Assessment and Safety Planning Tools Policy. [Source: CA Practices and Procedures Guide Chapter 1120]

Another area the Committee identified as needing improvement was the caseload for the assigned CPS investigator. This particular worker was identified by the office as one of their most senior and strongest investigators. She had a caseload total of 37 cases at the time of the fatality. Between the time of the initial intake on RCW 74.13.515, 2016 and the time of the fatality on June 10, 2016, the worker received 14 new intakes to include high risk intakes of life threatening injuries to infants, which often cause an increase in workload due to the complexity of such cases. Workload and caseload increases, such as the ones identified in this case, often inhibit a worker's ability to complete timely and appropriate assessments.

Another identified area of concern was what appeared to be a lack of a comprehensive understanding of the mother's co-occurring condition as opposed to only RCW 13.50.100 issues. It appeared as though CA focused mainly on the mother's RCW 13.50.100 and did not request specific co-occurring treatment.

The Committee also identified a positive finding. The finding related to the CPS investigators discussion of safe sleep with P.S.'s mother and father as well as her quick response when she learned of the newborn's discharge home. The Committee commended the worker for her diligence on these two areas.

Recommendations

The area administrator in Bellingham should reach out to the hospital where P.S. was born to discuss communication between the hospital and CA. Specific to this case was the issue of notification to CA prior to the discharge of P.S.

All CA offices should obtain training from Sterling Reference Laboratories regarding understanding, interpreting and utilization of urinalysis reports. The area administrator from Mt. Vernon was already working on obtaining a similar training and will incorporate this recommendation.