Washington State Department of Social & Health Services

CA Children's Administration

Child Fatality Review

S.W.

RCW 74.15.515 **2016**
Date of Child's Birth

March 12, 2017
Date of Fatality

June 1, 2017
Child Fatality Review Date

Committee Members

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Table of Contents

Executive Summary	3
Family Case Summary	3-5
Committee Discussion	5
Findings	5
Recommendations	6

Executive Summary

On February 16, 2017, the Department of Social and Health Services (Department or DSHS), Children's Administration (CA), convened a Child Fatality Review (CFR)[1] to assess the Department's practice and service delivery to S.W. and RCW 74.13 family.[2] The child will be referenced by RCW 74.13 initials in this report.

On March 12, 2017, CA received a call from law enforcement stating RCW 74.15.515-month-old S.W. had passed away. It was reported that S.W. had been bed-sharing with RCW 74.13 mother on a deflating air mattress. At the time of RCW 74.13 death, S.W. was living with RCW 74.13 mother and two older half-sisters and there was an open child protective services (CPS) investigation regarding the family. The Medical Examiner's report states the cause of death is Sudden Unexplained Infant Death and the manner of death is undetermined, but the child was found prone and bed-sharing with one adult (the mother) on an air mattress.

The CFR Committee included members selected from diverse disciplines within the community with relevant expertise including the Office of the Family and Children's Ombuds, domestic violence victims' advocacy, infant safe sleep expertise, child abuse and child safety. One CA staff member observed the review. None of the Committee members, nor the observer, had previous involvement with this family.

Prior to the review, each Committee member received a case chronology, a summary of CA's involvement with the family and unredacted CA case documents (e.g., intakes, investigative assessments and case notes) as well as one law enforcement report. Supplemental sources of information and resource materials were available to the Committee at the time of the review. These included relevant state laws and CA policies.

The Committee interviewed the prior CPS investigator and his supervisor as well as the current CPS investigator and her supervisor.

Family Case Summary

S.W.'s mother initially came to CA's attention, as a parent, on February 25, 2014. The mother RCW 13.50.100. Between February 25, 2014, and until S.W. was born in RCW 74.15.515 of 2016, CA received a total of nine intakes regarding the mother and her children. The intakes alleged the mother RCW 13.50.100, RCW 13.50.100, had RCW 13.50.100

[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] S.W.'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. RCW 74.13.500(1)(a).

RCW 13.50.100 , and RCW 13.50.100 . Of those nine intakes, five were assigned for a CPS investigation. All five investigations resulted in unfounded findings. The CPS workers cited the mother's statements of denial regarding the allegations and the lack of physical injuries to justify the unfounded findings. The mother denied offers of voluntary services but was accessing community services such as RCW 13.50.100 and RCW 13.50.100 shelter assistance, and as a result, all investigations were closed without further services. When the time the fifth CPS investigation closed, the mother was RCW 13.50.100

On February 14, 2017, CA received an intake stating the mother left all three children alone at the RCW 13.50.100 shelter where the family was residing and was gone for at least 15 minutes—possibly as long as an hour and a half. The intake alleged that her two eldest children RCW 13.50.100 and the shelter staff found two-month-old S.W. lying face down on the bed. The intake further alleged that the staff confronted the mother, who stated she made plans for another resident to watch her children. The intake caller reported the mother planned on leaving the shelter soon and they were worried about ongoing supervision for the children. This intake was assigned for a CPS investigation.

The assigned CPS worker attempted contact on February 17, 2017, but the shelter would not allow her access to the mother nor would they cooperate with the investigation even though they reported the allegations. On February 22, 2017, the worker again attempted to make contact with the mother and children. She was eventually allowed to meet with the mother and children but not allowed to observe their sleeping environment. The mother denied the allegations of leaving her children alone unsupervised, but the shelter would not allow the mother to name the individual she alleged had agreed to care for her children in her absence. The mother denied any mental health or chemical dependency issues. She stated her children's fathers are involved with their children RCW 13.50.100 . The mother reported she placed her infant on RCW 74.15 stomach because the child already knows how to roll over. The CPS investigator discussed Period of Purple Crying and safe sleep, which the mother stated she already knew about.[3] The CPS investigator advised the mother to notify the infant's primary care physician about rolling over so that it would be documented in RCW 74.15 medical file if anything were to happen. The mother also disclosed RCW 13.50.100 . The CPS investigator asked the mother to contact her when she moved so that the worker could observe the new living environment before closing the case.

On March 12, 2017, CA received a call from the RCW 74.15.5 County Sheriff's detective assigned to investigate the death of S.W. He stated the RCW 74.15.515 -month-old child was found by the mother to be unresponsive that morning. The mother reported she was bed-sharing with the infant on an air mattress. The mother was aware that the air mattress would not stay inflated throughout the night. Around 4am that morning, the mother had to "recharge the mattress" and then went

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

back to sleep with her infant, who was lying on [redacted] stomach in the same bed. The two other children were sleeping on another air mattress in the home. This intake was screened in for a CPS investigation.

Committee Discussion

For purposes of this review, the Committee mainly focused on case activity from the time S.W. was born until [redacted] passed away. The Committee did discuss the content prior to S.W.'s birth but the focus of the review was to evaluation the contact and service delivery to the family between the birth and passing of S.W.

The Committee did discuss a pattern of allegations, from numerous sources, about the mother failing to properly supervise her children and [redacted]. It appeared that the mother's denials of the allegations were taken at face value. The Committee noted that CA could have made a stronger effort to corroborate and assess the allegations more thoroughly. The Committee also discussed missed opportunities to speak with collaterals such as the fathers, daycare providers, relatives and law enforcement to assist in fully assessing the mother's ability to safely care for the children. A comprehensive assessment would have included these collaterals and further conversations with the referral sources of the intakes regarding the details they provided.

The last two CPS workers both indicated they did not contact the fathers of the children because they did not want to place the mother in any danger due to the history of [redacted]. The Committee appreciated the desire to protect the mother and children [redacted]. However, they also discussed that it is the responsibility of CA to conduct thorough investigations and include assessment for [redacted] and contact with all parents involved. CA staff who investigate cases that include allegations of [redacted] must be trained about conducting safe interviews with the alleged perpetrators of [redacted] and to assess for the safety of the children. The CPS investigators and their supervisors had not attended the two-day [redacted] training offered through the Alliance for Child Welfare (Alliance), nor had they attended the Safety Boot Camp training. Had the staff attended these trainings, they may have been more comfortable with how to conduct those contacts with the fathers in a safe and comprehensive manner.

FINDINGS

The Committee did not identify any critical errors that contributed to the death of S.W. However, there were areas within case practice that could be improved.

The fathers were not contacted during the last four investigations prior to S.W.'s death.[4]

[4] [redacted] [Procedures 2:a] and https://www.dshs.wa.gov/ca/2000-child-protective-services/2331-child-protective-services-cps-investigation [4:c]

The subject interview case note and three other case notes regarding the February 14, 2017, investigation were entered after S.W.'s passing. The subject interview case note should have been entered within ten days per policy.[5]

The Structured Decision Making (SDM) assessments completed during the 2016 and 2017 investigations were completed inaccurately and did not correctly reflect the risk posed to the children for future neglect or abuse.[6] While the SDM does not have a direct correlation to findings of abuse or neglect, the tool has the ability to identify future risk for abuse or neglect, which should be considered during the investigation process. During the review, it was shared that CA is currently working on an updated Safety Framework training to include updated training on completion and utilization of the SDM.

There were consistently missed opportunities by both CPS workers to identify other collateral contacts and corroborate the mother's reports. It may have been beneficial for the workers to seek out further information regarding the RCW 13.50.100 history by obtaining law enforcement reports and inquiring as to any restraining orders between the mother and the children's fathers. While both investigators stated they reviewed the mother's history with CA as a parent RCW 13.50.100, it did not appear that the chronicity and patterns were taken into consideration when assessing the safety of the children and completion of the SDM.

RECOMMENDATIONS

The CA RCW 13.50.100 program manager will contact the Alliance about adding a training section to the two-day RCW 13.50.100 training and specifically address how to speak with perpetrators of RCW 13. during CPS investigations.[7]

CA should consider collaborating with the Alliance on creating a one-page resource for staff that they would receive during the two-day RCW 13. training and attach that tip sheet to a "Quick Tip" for CA staff.[8]

CA should consider a "Quick Tip" to remind staff to discuss the risks associated with bed-sharing with children on air mattresses.

[5] https://www.dshs.wa.gov/ca/13100-records-management-and-security/13102-documentation-famlink

[6] The Structured Decision Making® (SDM) risk assessment is a household-based assessment. It estimates the likelihood that a child will experience abuse or neglect in a given household based on the characteristics of the caregivers and children living in that household. To accurately complete the SDM® risk assessment, it is critical to accurately identify the household being assessed. A household includes all persons living in the house 50% or more of the time, excluding employees. Includes persons who consider the household their primary residence but may not be currently living in the home 50% of the time. [https://www.dshs.wa.gov/ca/2500-service-delivery/2541-structured-decision-making-risk-assessment%C2%AEsdmra]

[7] The Alliance is a statewide training resource through the University of Washington dedicated to developing professional expertise for individuals working with vulnerable children. [https://allianceforchildwelfare.org/]

[8] A quick tip is a pop up box that appears each time a CA employee logs onto their work computer. The box contains a tip or reminder regarding practice and/or policy related matters.

The area administrators for [redacted] South and [redacted] Southeast should meet with the director of the [redacted] Shelter to discuss collaboration and cooperation for cases involving families residing at the shelter. It is also recommended that a discussion occur with the [redacted] Shelter about safe sleep practices within the shelter and the use of air mattresses and bed-sharing.

CA should consider providing a death investigation training for seasoned CPS staff so they are aware of what to look for, correct terminology, and how to professionally challenge law enforcement to discuss investigative details during a death investigation.