Washington State Department of Social & Health Services
CA Children's Administration

Child Fatality Review

J.V.

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

October 2, 2017
Date of Child's Death

February 26, 2018
Date of the Fatality Review

Committee Members
Patrick Dowd, Director, Office of the Family & Children's Ombuds
Amy Serrano, Registered Nurse, Confluence Health Clinic
Paula Gormon, Licensed Chemical Dependency Professional (CDP), Social Service Specialist, Children's Administration
Steven Bryant, CPS Quality Assurance Program Manager, Children's Administration

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

Table of Contents

Executive Summary

On February 26, 2017, the Department of Social and Health Services, Children's Administration (CA) convened a child fatality review (CFR)[1] to assess the department's practice and service delivery to an infant child, J.V., and [redacted] family.[2] At the time of [redacted] death, J.V. resided with [redacted] mother, father, uncle, the uncle's girlfriend and J.V.'s older sibling. The department had an open Child Protective Services (CPS) investigation at the time of J.V.'s death. On October 2, 2017, J.V. died while in [redacted] parent's care. Law enforcement reports indicate J.V. died in an unsafe sleep environment.

The CFR Committee included CA staff and community members selected from diverse disciplines with relevant expertise, including child welfare, chemical dependency, the Office of the Family and Children's Ombuds and medical expertise. The participating community members had no previous direct involvement with this family.

Prior to the review, each Committee member received a case chronology, a family genogram, a summary of CA involvement with the family and un-redacted case documents including case notes, referrals for services, assessments and medical records. The hard copy of the file was available to Committee members at the time of the review. Supplemental sources of information and resource materials were also available to the Committee, including copies of state laws and CA policies relevant to the review.

The Committee interviewed CA social workers and supervisors who had previously been assigned to the case. Following the review of the case file documents, review of case assignment and workload report information taken from FamLink[3] for the staff involved, completion of staff interviews and discussion regarding department activities and decisions, the Committee made findings and recommendations that are presented at the end of this report. 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 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 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] The parents are not identified by name in this report as no criminal charges were filed relating to the incident. The names of J.V.'s sibling are subject to privacy law. [Source: RCW 74.13.500(1)(a)]

[3] FamLink is the case management information system that CA implemented on February 1, 2009; it replaced CAMIS, which was the case management system used by the agency since the 1990s.

Committee did not find any critical errors but recommended practice improvements for future cases.

Case Overview

On RCW 74.13.515 2017, CA received a report from RCW 74.13.515 Community Hospital stating that J.V. and RCW 74.1 mother both tested RCW 13.50.100 at the child's birth. When hospital staff discussed this with the mother, she admitted to RCW 13.50.100 use but did not reveal any additional substance usage. The mother had not realized that she tested RCW 13.50.100, as the hospital had not informed her of the results prior to her response. The mother also denied the use of cigarettes, though hospital staff observed her smoking. Hospital staff stated that J.V. showed RCW 74.13.520 and was being monitored for a possible RCW 74.13.520.

CA opened an investigation and responded to the hospital on RCW 74.13.515, 2017; the investigation was assigned to an investigator the same day. This investigator made initial contact with the family at the hospital, discussed safe sleep[4] and the Period of Purple Crying[5] with the mother, and scheduled an Family Team Decision Making Meeting (FTDM)[6] the following day on RCW 74.13.515, 2017. Because this

[4] CA caseworkers must complete a "Plan of Safe Care" as required by the Child Abuse Prevention and Treatment Act (CAPTA) when a newborn has been identified as substance affected by a medical practitioner. Substances are defined as alcohol, marijuana and all drugs with abuse potential; including prescription medications. [Source: CA Practice and Procedures Guide 1135. Infant Safety Education and Intervention]

[4]Current CA policy requires CA staff to conduct a safe sleep assessment when placing a child in a new placement setting or when completing a CPS intervention involving a child aged birth to one year, even if the child is not identified as an alleged victim. [Source: CA Practice and Procedures Guide 1135. Infant Safety Education and Intervention] * Safe to 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. 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. [Safe to Sleep]

[5] The Period of Purple Crying is a method of helping parents understand the time in their baby's life where there may be significant periods of crying. During this phase of a baby's life they can cry for hours and still be healthy and normal. The Period of Purple Crying begins at about 2 weeks of age and continues until about 3-4 months of age. [Source: The Period of Purple Crying]

[6] Family Team Decision Making meeting (FTDM) is a facilitated team process, which can include birth/adoptive parents, guardians, extended family members, youth (as appropriate), community members, service providers, child welfare staff and/or caregivers. These meeting are held to make critical decisions regarding the placement of children following and emergent removal of child(ren) from their home,

investigator was transitioning out of her position with CA, the FTDM was attended by another social worker who reported to the Committee that she had limited knowledge about the case at the time and was not aware that the mother and infant tested RCW 13.50.100, in the hospital. This newly assigned social worker was not aware of the mother's discrepancy in her reported use versus what was in the medical record. The FTDM was attended by the mother, the CA FTDM facilitator and the newly assigned social worker. The mother informed CA staff at the FTDM that J.V.'s father was disabled and could not get to the meeting. The facilitator attempted to have the father attend the FTDM telephonically, however he did not answer or respond to the calls.

During the FTDM, the mother denied that she had intentionally used RCW 13.50.100 and that the RCW 13.50.100, which she later found out was RCW 13.50.100. According to the social worker, the mother did not appear under the influence during the FTDM and the mother noted her lack of prior CPS involvement with her eldest child. She also identified multiple supportive family members living in her home. A consensus was reached that J.V. would remain in the care of RCW 74. parents while the mother agreed to complete chemical dependency assessments and a mental health assessment, participate with in-home parenting supports and programs, take the older sibling to dental appointments and attend and report all cardiologist and medical appointments for J.V. to CA. Though the father was not present, the mother stated that he would participate in the same services and take the children to the agreed-upon appointments. After the FTDM, and prior to the child's release from the hospital, the newly assigned social worker assessed the family home, observed the older sibling and determined that the home appeared safe. The social worker reviewed safety guidelines with the mother and observed the children's sleep environment. The social worker did not report seeing any concerns with the sleeping environment.

On September 8, 2016, the investigation was transferred to another worker, who was primarily assigned to FAR[7] cases, to continue working with the mother and

changes in out-of-home placement, and reunification or placement into a permanent home. There may be instances when a FTDM can be held prior to placement if there is not an immediate safety threat such as a child who is on a hospital hold and a FTDM could provide placement options. Permanency planning starts the moment children are placed out of their homes and are discussed during a Family Team Decision Making meeting. Am FTDM will take place in all placement decisions to achieve the least restrictive, safest placement in the best interests of the child. By utilizing this inclusive process, a network of support for the child(ren) and adults who care for them are assured. [Source: Washington State Family Team Decision Making Meeting Practice Guide]

[7] Family Assessment Response (FAR), is a Child Protective Services alternative response to a screened in allegation of abuse or neglect that focuses on the integrity and preservation of the family when less severe

J.V. The worker had been with the department for five months and J.V.'s case was his first CPS investigation. Prior to J.V.'s case, he was assigned to CPS-FAR cases. The social worker made contact with the mother on September 15, 2017 and conducted a home visit on September 16, 2017. The social worker reported that he observed the sleeping areas and noted that the parents stated that J.V. was sleeping in a bassinette. During this home visit, the social worker observed the father and the approximately one-and-a-half-year-old sibling napping in the same bed. The worker reportedly discussed co-sleeping and the dangers of overlay, but the mother stated the sibling was only taking a short nap and did not believe it to be an issue. The following week, the worker assisted the parents in obtaining necessary medical appointments and purchased some infant items for the family. The worker attended a medical appointment with the mother and J.V. on September 27, 2017 and did not note concerning behaviors by the mother. The worker completed collateral contacts with medical providers and referred the family for Intensive Family Preservation Services (IFPS)[8] on September 28, 2017.

On October 2, 2017, CA was notified by law enforcement that J.V. had died while in the care of [redacted] parents. Upon initial assessment, the coroner reported there were no obvious concerns or signs of injuries to J.V. Additionally, there was some speculation to the child having a [redacted] that may have contributed to J.V.'s death.

Both parents were interviewed by law enforcement and CPS about the sequence of events prior to the infant's death. Both parents denied having anything to do with the death of their infant. The mother stated that she woke up and fed J.V. the morning of October 2, 2017 at 6:00 a.m. and put [redacted] back to bed in the crib, facing up, at about 7:15 a.m. The mother reported she was woken up by a family member at about 10:30 a.m. and prepared a bottle for J.V. When she went to feed J.V., she found that the child was not breathing. She called 911 and attempted C.P.R. J.V. was transported by ambulance to the local hospital where [redacted] was declared dead.

Immediately after J.V.'s death, law enforcement inspected the family home and noted that the crib had blankets and a small pillow used for propping J.V.'s head and upper back. The father had also reported this but the mother denied it. The

allegations of child maltreatment have been reported. [Source: CA Practices and Procedures Guide 2332. Child Protective Services Family Assessment Response]

[8]Intensive Family Preservation Services (IFPS) are short-term, family-based services designed to assist families in crisis by improving parenting and family functioning while keeping children safe. IFPS is generally authorized for 30 days. [Source: CA Practices and Procedures Guide 4502. Intensive Family Preservation Services, Family Preservation Services]

final Coroner's report received by CA on January 16, 2018 revealed that the cause of death was "unexplained infant death" and that "unsafe sleep environment with soft bedding was a significant condition."

Committee Discussion

The Committee acknowledged the legal barriers CA faces when trying to remove children from their parents' care when a child or parent tests positive for substances at the child's birth. The Committee wondered what CA or the legislature might do in response to the challenges CA faces when responding to hospital reports of children who have been exposed to or affected by drugs in utero. Some Committee members discussed the possibility of the legislature amending the current laws to allow CA the authority place children into care where an infant has been exposed to or affected by substances in utero.

Considerable Committee discussion focused on CA's assessment of the mother's alleged substance abuse. Conversation developed around CA making possible changes to procedures related to response to high risk infant cases when substance use is identified at the child's birth. Some Committee members would like to see CA develop a system to ensure the parents' drug issues are fully explored, corroborated and consulted on prior to the child being released from the hospital. The Committee questioned whether the assigned social workers and supervisors fully considered the impacts of the mother's self-reported RCW 13.50.100 [redacted] use in correlation to her ability to safely care for her children. The Committee was concerned that the workers may have taken the mother's statements about her drug use at face value and that further corroboration and collateral contacts may have improved the worker's assessment of the mother's ability to care for her children. Considering the mother's denial of intentional use of RCW 13.50.100 in the face of contradictory evidence, the Committee agreed it would have been appropriate to request subsequent and ongoing urinalysis of the mother starting at the initial contact. Urinalysis would also have possibly given CA a clearer picture as to the amount of RCW 13.50.100 and/or other drug use post-delivery. The Committee speculated that it could have been beneficial to consult with medical and chemical dependency providers for their expert opinions on issues surrounding medical conditions and treatment options. The Committee noted that the investigators accepted the majority of the mother's statements regarding substance use at face value and did not seek out collateral sources to corroborate her statements, which led to an incomplete assessment of risk and safety. The Committee discussed whether or not there had been an active safety

threat[9] and acknowledged that the limited collateral information made this difficult to ascertain. The Committee speculated that additional information may have been available to CA to evaluate whether or not the mother's substance abuse and father's disabilities impacted their ability to safely care for their children. Overall, the Committee believed there was a lack of curiosity, verification, corroboration and consultation while assessing safety and completing the investigation. There were missed opportunities to understand the daily functioning in the home and the caregivers' ability to care for the children. The Committee noted that there was limited information gathered on the father in the home and in regard to his ability to safely care for or protect the children. The Committee discussed the importance of collateral contacts in conducting a comprehensive assessment of risk and safety and noted missed opportunities to gather additional clarifying information from the hospital and medical providers, relatives, from DSHS databases and from other sources within the family's community, including the landlord and neighbors.

The Committee discussed that best practice guidelines would suggest that the social workers complete a "Plan of Safe Care"[10] when children have been exposed to substances in utero regardless of whether it can be determined if the child has been affected from substances. The supervisors should verify that a Plan of Safe Care has been completed in a case note in all circumstances. It was unclear if a Plan of Safe care was completed by the originally assigned investigator.

The Committee believed that CA demonstrated good practice by holding an FTDM prior to the child's release from the hospital but believed that the FTDM could have been more productive if the attending worker or supervisor had been more familiar with the case. The Committee noted that there was about a month of inactivity after the FTDM and the services identified as a need were not initiated until the end of September 2017. The Committee recognized that the supervisor of the unit was significantly understaffed and had limited resources to

[9] A threat of danger is a specific family situation or behavior, emotion, motive, perception or capacity of a family member that threatens child safety. The danger threshold is the point at which family functioning and associated caregiver performance becomes perilous enough to be perceived as a threat or produce a threat to child safety. The safety threshold determines impending danger. Safety threats are essentially risk influences that are active at a heighten degree and greater level of intensity. Safety threats are risk influences that have crossed a threshold in terms of controllability that has implications for dangerousness. Therefore, the safety threshold includes only those family conditions that are judged to be out of a caregiver's control. [Source: Safety Threshold Handout]

[10] CA caseworkers must complete a "Plan of Safe Care" as required by the Child Abuse Prevention and Treatment Act (CAPTA) when a newborn has been identified as substance affected by a medical practitioner. Substances are defined as alcohol, marijuana and all drugs with abuse potential; including prescription medications. [Source: CA Practice and **Procedures** Guide 1135. Infant Safety Education and Intervention]

achieve the required tasks on multiple cases. However, the Committee maintained that it is the responsibility of a supervisor to attend an FTDM in high-risk cases and with such staffing limitations to ensure effective and thorough measures are taken to ensure child safety.

The Committee discussed case assignment information that was provided in order to gain insight as to the functioning of the office. The Committee was informed that this office is struggling with a high level of worker turnover. During this investigation, the office experienced staffing shortages that necessitated the supervisor of the investigative unit to take on a caseload and request assistance from the other CPS unit in the office. This high turnover presented struggles for staff to complete their tasks in a timely and thorough manner. The Committee discussed how the investigative supervisor in this particular office was also asked to stretch her supervision capabilities to a level which may have led to less than ideal clinical supervision of the casework by line-staff.

The supervisors informed the Committee that the area administrator provided direction on the case prior to transfer to both the transferring supervisor and the receiving supervisor. Nonetheless, transferring cases between programs was a focus of conversation for the Committee. The Committee heard from the supervisors that in regular situations with full staffing levels, the local office generally follows a transfer process that includes an in-person staffing to ensure all parties are aware of and understand their responsibilities related to case activity and gathering subsequent information related to child safety. The Committee expressed the importance of supervision and communication in such instances of high risk cases so that newly assigned and especially inexperienced workers understand casework expectations as well as policy and procedures related to that program. The Committee speculated that it did not seem as if the receiving investigator fully understood the necessary duties and next steps for a global safety assessment. The Committee further discussed how the receiving investigator was very focused on obtaining a medical appointment for J.V. but missed opportunities to gather information for global assessment of the home and for child safety. The Committee believed that the relative inexperience of the receiving investigator pointed to a need for increased clinical guidance and supervision.

Findings

After a review of the case chronology, interviews with staff and discussion, the Committee did not identify any critical errors. Acknowledging the difficulties and challenges CA faces when there is a high rate of staff turnover and minimally

trained staff available to perform at the desired and required levels, the Committee identified possible areas for practice improvement.

Missed opportunities to gather information:

- The Committee believed that had further information been gathered to assess child safety during the investigation, there may have been an identified safety threat early on in the response. The Committee recognized that there were limited contacts with the family and the latter part of the investigation was focused primarily on J.V.'s possible [redacted]. The investigation lacked more comprehensive information from collateral sources that may have improved CA's assessment of risk and safety. The Committee believed that the CA staff should have gathered information on all of the children in the home. Had this information been sought out, it would have assisted the CA staff in completing a more comprehensive safety assessment and investigation. Sources of information or areas of corroboration that CA could have used during its assessment are:
    - Explore and gather information about all the children in the home and their functioning.
    - Obtain medical and records for all of the children in the home and communicate with providers for explanations of the records as well as consultation.
    - Consult with chemical dependency professionals, medical staff, and/or experts to analyze statements made regarding parental use of drugs in comparison to physical evidence.
    - Obtain criminal history for the caregivers in the home or people living in or who frequent the home.
    - Contact the father and relatives of the children.

Supervision:

- FTDM
  The Committee believed that the supervisor should have participated in the FTDM as J.V.'s case was high-risk and ensured all necessary information was being relayed and safety concerns were addressed.
- Case Transfer
  While acknowledging the challenges associated with staff shortages, the Committee felt that important information as to the mother's drug use was not emphasized and impressed upon to the newly assigned worker at case transfer. The receiving unit seemed to focus primarily on a possible medical need of J.V. rather than a global assessment and follow up or inquiry regarding the mother's [redacted] use as

well as assessing others in the home or individuals who have access to the children. The Committee believes that the supervisor should have worked more closely with assigned worker due to the worker's inexperience.

Recommendations

The committee recommends that CA consider utilizing a roving unit statewide or in Region 1 to assist in circumstances where staffing levels impact the office and assist with child safety assessments or completing investigations in a thorough manner.

The Committee recommends that CA consider changing its response to high risk infants exposed to or affected by substances to include a mandatory plan of safe care. A parent's statements regarding their use should not be taken at face value and should encompass collateral contacts. The CA workers and supervisors should ensure that they have consulted and verified the parent's statements in relation to the toxicology reports. Due to infant's vulnerability, CA should have a thorough understanding of the parent's drug use, the dynamics of the household and functioning within the home, verified protective factors and verified sleeping arrangements for the infant prior to discharge of the infant from the hospital.