Children's Administration

Executive Child Fatality Review

C.V. Case

Date of Birth: 05-[redacted]-2007
Date of Death: 12-28-2008
Date of Review: 02-09-2010

Committee Members:
Don Ashley, MD, Regional Medical Consultant, Region 1
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Observers:
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Executive Summary

On December 28, 2008, Children's Administration (CA) Central Intake (CI) accepted an intake from Sunnyside Community Hospital reporting the death of 19-month old C.V. The referent stated that at approximately 8 a.m. a couple identifying themselves as C.V.'s foster parents brought him into the emergency room not breathing and non-responsive. C.V. was in the custody of the Department of Social and Health Services pursuant to a juvenile court dependency proceeding at the time of his death.

It was reported to emergency room personnel by the foster parents that C.V. often cried excessively at night and struggled with going to sleep. The foster mother stated they would wrap C.V. in a blanket, swaddling him, and lay him on his stomach as this was the best method to help him fall asleep. When they went to check on him the morning of December 28, 2008 at approximately 7 a.m., they found C.V. not breathing and non-responsive. The foster parents transported C.V. to the hospital themselves as they indicated that waiting for the ambulance would have taken longer than driving him themselves. Despite resuscitative efforts C.V. was declared dead at approximately 8:25 a.m. in the hospital emergency room.

The Yakima County Coroner requested an autopsy be completed which resulted in an undetermined cause and manner of death (dated December 28, 2008). It was subsequently determined that information regarding C.V.'s internal body temperature, which was 105 degrees at the time of admission into the emergency room, was not made available to the first medical examiner. Given this and the undetermined cause and manner determination at the initial autopsy, a second medical examiner opinion was requested. This was done by the King County Medical Examiner's Office. The opinion of the second medical examiner is as follows:

"…it would be reasonable to certify the death as 'systematic hyperthermia due to unknown etiology, with contributing conditions of chronic upper respiratory infection, swaddling, and prone sleeping position. The manner of death would depend on the contribution of external factors. In this case swaddling and the prone position appear significant enough to certify the death other than natural. While an undetermined manner may be appropriate, without signs of abuse or neglect, a manner of accident would be acceptable." Date: November 22, 2009, King County Medical Examiner

Following consultation with both medical examiners and a review of the autopsy results, the Yakima County Coroner certified the cause and manner of death as '*undetermined*.' CA records reflect this was the first intake referencing this foster family. The foster home license was effective May 2008 and C.V. and his two older siblings were the family's first placement.

Prior to the completion of the Division of Licensed Resources Child Protective Services (DLR/CPS) investigation[1] and in accordance with CA Operations Manual[2] and the Revised

[1] Requests for an additional medical examiner review delayed completion of the DLR/CPS investigation within the required 45 day time frame. Supervisory extension was approved.
[2] CA Operations Manual 5160

Code of Washington[3] (RCW), a Regional Child Fatality Review was convened in June 2009.

Upon completion of the DLR/CPS investigation and given the finding of the second medical examiner, CA convened an Executive Child Fatality Review [4] (ECFR) in February 2010 to review the practice and service delivery in this case.

Committee members included a diverse group of CA staff and community representatives from various disciplines and programs. Review committee members had no involvement in the C.V. case. Team members were provided case documents consisting of family history/chronology[5], police reports, a summary of the autopsy results prepared by Dr. Roy Simms, CA Region 2 Medical Consultant and a summary of C.V.'s medical history prepared by Dr. Don Ashley, Regional Medical Consultant, Region 1. Additional information included both medical examiners and coroner's information and findings. In addition, the social work supervisor overseeing C.V.'s case was available for questions by review team members.

During the course of the review team members discussed cross-cultural training for foster parents, safe sleep practices and the use of swaddling and/or restraining of foster children, communications with foster families regarding special needs children, and ensuring follow through when specialized services for foster children are identified.

Following review of the documents, case history and consultation with the social work supervisor the review committee made findings and recommendations which are detailed at the end of this report.

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[3] RCW 74.13.640 (2) states: "Upon conclusion of a child fatality review required pursuant to subsection (1) of this section, the department shall within **one hundred eighty days** following the fatality issue a report on the results of the review, unless an extension has been granted by the governor."

[4] Given its limited purpose, a Child Fatality Review by Children's Administration should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. A review is generally limited to documents in the possession of or obtained by DSHS or its contracted service providers and the panel may be precluded from receiving some documents that may be relevant to the issues in a case because of federal or state confidentiality laws and regulations. A review panel has no subpoena power or authority to compel attendance and generally will only hear from DSHS employees and service providers. The panel may not hear the points of view of a child's parents and relatives, or those of other individuals associated with a deceased child's life or fatality. 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, medical examiners or other entities with legal responsibility to investigate or review some or all of the circumstances of a child's death. Nor is it the function or purpose of a Child Fatality Review to take personnel action or recommend such action against DSHS employees or other individuals.

[5] Case chronologies regarding both the foster family and C.V.'s family were prepared and made available to committee members.

Case Overview

C.V. Family Case History

C.V. and his family first came to the attention of Children's Administration on May 21, 2008, after an intake was received alleging physical abuse of C.V.'s 7-year old brother. Law enforcement was dispatched to do a well child check and due to the nature of the sibling's injuries, law enforcement placed the 7-year-old, C.V. and their 4-year-old sister into protective custody. The children were placed together in foster care. A CPS investigation was completed and a finding of founded for physical abuse was made against C.V.'s mother. In addition, criminal charges were filed against her by the County Prosecuting Attorney. C.V.'s mother subsequently pled guilty to one count of Assault of a Child 2nd Degree and completed all sentencing requirements.

Dependency petitions were filed as to all three children by the department in juvenile court and dependency was established for the children in June 2008. They were placed in the same foster home until C.V.'s death on December 28, 2008. In September 2008, while the children were in foster care, reports alleging possible sexual abuse of C.V.'s sister while in her mother's care were received by CA. Following a CPS investigation in which no disclosures of sexual abuse were made by the children, the report was determined to be unfounded. The birth family presents with no other child abuse or neglect allegations or history.

On April 17, 2009, the department returned C.V.'s siblings to their birth parent with Family Preservation Services (FPS) in place to support the return home. In October 2009, the dependency was dismissed by juvenile court as all services had been completed and the children were doing well with no new safety concerns identified. The CA case was closed in November 2009. CA has received no other reports of concern to date regarding this family.

Foster Home History

The foster family obtained their foster home license through Children's Administration DLR on May 9, 2008. Their initial license capacity was for 2 children, ages 2 thru 5. However, their license was later amended to change their capacity to 3 children, ages 0 thru 17.

C.V. and his two siblings, ages 7 and 4, were the first placements for this foster home. C.V. and his sister were placed in the home on May 28, 2008; their older brother joined them on June 12, 2008 once school was out for the summer. The decision not to move the oldest child in May 2008 with C.V. and his sister from the children's initial foster home placement[6] was based on the oldest child's need to finish the school year.

No licensing violations or child abuse/neglect issues were reported to CA prior to the December 28, 2008 intake noting C.V.'s death. Upon C.V.'s death, his siblings were removed from the foster home and a stop placement was issued by DLR while an investigation was completed.

[6] Original date of placement was May 21, 2008.

On December 28, 2008, when the foster parents found C.V. in his bed non-responsive and not breathing they did not contact 911 for assistance. They stated they opted to transport him to the hospital themselves stating it would be faster than waiting for emergency medical services to come to their home. Hospital staff did not notify law enforcement of C.V.'s death resulting in a delay in conducting a death scene investigation. Given the delay in contacting the authorities it was not until the following day investigators went to the home and were told all the bedding from C.V.'s room had been removed and cleaned. CA did not notify C.V.'s mother of his death until late in the afternoon on December 28, 2008.

During the course of the investigation, information regarding the foster family's method of placing C.V. in bed was detailed. The foster mother stated she had reported to C.V.'s primary care physician and the assigned social worker he often cried inconsolably at night. She stated the only way C.V. would go to sleep and stay in bed was "*if he was wrapped lightly in a blanket*." On the night of December 27, 2008 C.V. was wrapped in a large blanket and then laid on his stomach at approximately 7:30 pm. Investigators learned the family did not check on him until the following morning at approximately 7 a.m. when he was found non-responsive.

Autopsy information indicated that based on the lividity pattern C.V. was lying in a prone position, his arms/hands against his abdomen, and there was a dark red-purple lividity band just below the hairline at the back of his neck. This information lead investigators to believe C.V. was wrapped to restrict his movements and his ability to get out of bed. The DLR/CPS Investigation resulted in a *founded* finding as to the foster parents for neglect/negligent treatment. Proceedings have been initiated by DLR to revoke the family's foster home license.

Review committee members discussed the foster family's practice to wrap C.V. in a blanket to support his falling asleep and citations from the Washington Administrative Code (WAC) regarding restraints and children in licensed facilities.

- WAC 388-148-0485 (3)* states foster parents must not: *"Use physical restraint techniques that restrict breathing inflict pain as a strategy for behavior control, or that is likely to cause injury that is more than transient to a child."* The particular danger to securely wrapping a child may be the child has no control over their limbs restricting their movements.
- WAC 388-148-0480 (1)* states *"You must use efforts other than physical restraint to re-direct or de-escalate a situation unless the child's behavior poses an immediate risk to physical safety."* Investigators did not find any evidence to indicate C.V. was a physical threat to himself, others or his environment.
- WAC 388-14-0270 (9) "*You must follow the recommendation of the American Academy of Pediatrics, placing infants on their backs each time for sleep, unless advised differently by the child's physician."* The foster family did seek medical attention regarding C.V.'s excessive crying. However, there is nothing in the child's medical records which indicates a physician told the foster parents he should be swaddled/restrained or placed on his stomach to sleep. Medical records did state a need to rule out adjustment disorder in reference to the excessive crying.

*WACs 388-148-0485 and 388-148-0480 address the use of restraints as a disciplinary tool or a means to control a child's behavior when it creates a risk to the child or others. The review committee did not find the use of swaddling/restraint in this case was disciplinary in nature, but used as a means to support sleep.

The foster parents stated they discussed C.V.'s sleeping pattern with both his primary care physician and social worker. Following C.V.'s Child Health and Education Tracking (CHET)[7] assessment in June 2008 he was referred to the Infant Toddler Early Intervention Program for an education evaluation. In September 2008 relatives of the foster parents who accompanied C.V. to the evaluation told staff members he tends to "*eat and eat*", and wakes nearly every evening between 1 a.m. and 2 a.m. and "*cries and cries*". Results of the education evaluation recommended C.V. receive services from an early intervention team to address cognitive issues[8]. The Children's Village evaluation indicated that "*with a consistent, supportive home environment, C.V. is expected to continue developing skills in all areas.*"

Review committee members expressed concern that given the recommendation for early intervention services in September 2008 and documentation that indicated C.V. was assessed at a level II[9] foster care rate, a referral should have been made to address the issues identified in the assessment which would include his sleep patterns and insatiable appetite. The referral had not been made prior to his death.

Review team members inquired if the foster parents had asked CA to remove C.V. from their care due to his excessive crying. The assigned CA social worker stated the foster parents did ask what would happen "*if they requested C.V. be placed*." The social worker indicated she spoke with them about maintaining the sibling placement and that if C.V. were moved; CA would then be compelled to assess removal of all three children in order to keep them together. The social worker indicated the family did not request his removal despite their inquiry as to what would happen if they did.

Review committee members stated communication between the Division of Children and Family Services (DCFS) and DLR when families are experiencing their first placement was not evident. Committee members agreed that asking about a child's removal is a 'trigger' to ensuring appropriate supports are in placed to enhance placement stability. Members stated DLR and DCFS should make efforts to ensure clear communication is occurring as a means to support foster families.

In addition to discussing details of the fatality investigation and service delivery to the foster family; the review team discussed foster parent training, and the availability of

[7] CA Practice and Procedures Guide 43092: CHET screens are to be completed on all children placed in out of home care within the first 30 days of placement. Reference: Revised Code of Washington 74.14A.050.
[8] Cognition skills evaluated were related to memory, attention, perception and concepts. C.V.'s score of -1.5 qualified him for early intervention services.
[9] Foster Care Rate Assessment (CA Form 10-261): Responses to questions by the foster parent and social worker assesses the level of care needed for a child compared to the level of care provided to a typically developing child (level I) of the same age. Based on answers additional reimbursement for care may be available.

bilingual training. Use of an interpreter experienced in child welfare practice and foster care licensing can increase the level of understanding and comprehension for monolingual foster families.

Findings and Recommendations

The committee made the following findings and recommendations based on information provided by the social work supervisor, review of the case records, department policy and procedure, the Revised Code of Washington (RCW), and Washington Administrative Code (WAC).

Findings and recommendations from the June 2009 review were discussed during the February 2010 review. Review team members agreed with the June 2009 findings and recommendations and they are incorporated below.

Findings

- Foster parents chose to transport the child in their own vehicle to the area hospital rather than calling 911 'emergency' for assistance. When contacted, emergency personnel can provide increased medical assistance and support prior to hospital arrival.
- The foster family sought support from the primary care physician and the social worker regarding night time sleep issues. Without readily available recommendations or suggestions to assist in ameliorating the issues they relied on swaddling/restraining the child as a means to ensure quality sleep. Use of restraints and placing him in a prone position did not equate to a "safe sleep" environment.
- This was the first placement experience for this foster family. In addition, the behaviors of two of the three children placed in their home supported an increased foster care rate based on supervision and care needs. On-going assessment of family skills to ensure they have the qualifications and adequate training to address the child's behavioral issues presented is warranted.
- The CHET screen and the Children's Village evaluation recommended referral for follow up services to include a hearing evaluation and cognitive skills development.

Recommendations

- WAC[10] and foster parent pre-service training requires that 911 shall be called in medical emergency situations. Foster parent written training material should reflect 911 shall be called whenever there is a medical emergency involving a foster child.
- Bilingual foster parent training is available and provided by List Certified[11] staff members well versed in child welfare competencies. Additional recommendations

[10] WAC 388-148-0275

[11] List Certified staff members have passed both and oral and written tests as a means be certified as interpreters.

regarding enhancements to foster parent pre-service, on-going training and support were made as follows:

- Ensure 'safe sleep' practices are discussed and clarify that using restraints to support or assist in sleeping is discouraged. Include education on the practice of swaddling vs. restraining and include information on the parameters of use[12].
- Encourage coordination of support efforts between DCFS and DLR as a means to increase placement stability, particularly with first time placements.

- Following completion of the CHET screening ensure any and all referrals for identified services have been completed and initiated in a timely manner.

[12] American Academy of Pediatrics - Child Care Providers Guide to Safe Sleep, Back to Sleep for Babies in Foster Care Every Time, With Every Caregiver and Healthy Children - Ages and Stages - Sleep Position - Why Back is Best