Children's Administration

Executive Child Fatality Review

I. D-H. Case

June 24, 2008

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Executive Summary

In June 2008, Children's Administration (CA) convened an Executive Child Fatality Review[1] committee to review the practice and service delivery in the case involving 23-month I.D-H (DOB 3- -06) and her family. RCW 74.13.500

The incident initiating this review occurred on February 23, 2008, when CA Central Intake (CI) accepted a referral reporting the death of the child. The referrer told CI the mother and her boyfriend[2] brought the child to the Emergency Room on February 22, 2008 after indicating she had been vomiting for several hours and had been in an "altered state of consciousness".

A review of the family's history with CA notes one previous referral dated February 7, 2008 regarding bruising to the child's ears. The February 7, 2008 report was assigned for investigation, and the case was open at the time of the child's death. Information in the February 7, 2008 referral noted no other children were living in the home.

Committee members included a diverse group of CA staff representing four regions. Review committee members had no involvement in the I.D-H. case. Team members were provided case documents consisting of the following: referral information, medical information from several providers, a summary of medical care prepared by Dr. Frances Chalmers, CA Region 3 Medical Consultant, and coroner's information and findings. Following a teleconference with the committee on June 20, 2008 members recommended several staff be interviewed during the fatality review:

- Region 5 Intake Supervisor,
- Region 5 Child Protective Services Supervisor and the
- Attending physician of Lakewood Medical Clinic

These individuals were interviewed by the committee on June 24, 2008.

Following review of the documents, case history and interviews with staff members and medical provider the review committee made findings and recommendations which are detailed at the end of this report.

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[1] 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.

[2] The full names of the child's mother and boyfriend are not used in this report as the criminal investigation remains open and no charges have been brought to date against any party.

Case Overview

Child Protective Services (CPS) history for this family began with a February 7, 2008 referral reporting the child was seen by a physician as a result of concerns her mother expressed was re-occurring bruising to her ears. The report was called into CPS on February 7, 2008.

The referrer said the child was brought to the Lakewood Medical Clinic to determine the origin of what appeared to be bruising on both ears. The mother said she first noticed the bruises on the morning of February 5, 2008 and the child was subsequently seen Thursday, February 7, 2008. The referrer reported the mother was not aware of any recent trauma that could have caused such injuries. The medical provider noted the mother said this was the second time in as little as two weeks that the child had bruising to her ears. She told the medical provider she was the child's sole care giver, and she watched the child exclusively during the day and night.

The medical examination determined the child had marked bruising on the upper portion of both her ear lobes. The rest of the physical exam was not remarkable except it was noted the child was small for her age and had not been gaining weight. In fact, she had lost a little weight. The referent said that according to medical records, the child was growing at the 10th percentile at a normal steady pace until January 2008 when she had recently dropped off the graph. The child appeared thin and pale at the examination. The child's mother did not offer an explanation for the child's weight loss.

At the time of the referral on February 7, 2008, the referent told CPS that blood work and a full skeletal survey to rule out any possible underlying medical issues for the injury would be conducted. The referrer said the mother wanted to find out what happened to her child and was open and forthright with the doctor. The mother's story did not change, and she appeared to be concerned about her child's health and safety. When contacting CPS on February 7, 2008, the referrer could not say if the child had suffered a non-accidental trauma or had a medical condition. He noted he would call back the next day with results of medical tests and x-rays.

At the request of the review committee the attending physician from Lakewood Medical Clinic shared the following information regarding his examination of the child. He noted the bruising on the child's ears and given the mother's statement that this was a re-occurring issue he recommended a full skeletal exam and blood work to note any clotting issues. He stated he ordered the tests to rule out any underlying medical causes for the apparent bruising. Reporting the bruising to CPS on February 7, 2008 was completed with the understanding that CPS would conduct an investigation and make a determination despite any possible medical causes.

The intake social worker who received the information from the referrer consulted with the Region 5 Intake supervisor who told the review committee she approved leaving the referral in pending status (no screening decision) on February 7, 2008 until the physician ruled out possible medical causes for the bruising. This preliminary screening decision was based on the referrer stating he did not feel the child was at risk of imminent harm at the time of the referral. It was

based on this preliminary information that the Intake supervisor said she approved an extension to the 4-Hour Intake Process Completion Policy[3].

On February 8, 2008 results of medical tests conducted the previous day were provided to CA. The tests indicated there were no underlying medical reasons for the unilateral ear bruising nor was there any other evidence of internal injuries (healing or otherwise) to the child. The only medical finding identified during this visit was the child had an ear infection in which an antibiotic was prescribed. With the medical information provided, the referral was screened in with a risk tag of 5 (non-emergent) and assigned for investigation.

At the request of the review team the CPS supervisor met with them to discuss case assignment and workload issues in the Bremerton office at the time this family was referred to the department. The social work supervisor stated to the review committee when this referral was received by the office, ten (10) CPS investigator positions were assigned to the office. However, he noted five of those positions could not receive referral assignments because three (3) were vacant and two (2) social workers were attending Academy (training) and were unable to be assigned investigations. This resulted in a reduced workforce of 50% for the office in February 2008. In addition to the reduced workforce, the social work supervisor said based on the unit's workload and given the number of referrals requiring assignment (22 referrals)[4] during the week of February 3 – 9, 2008, he assigned four investigations to himself. The supervisor said vacancies and an unusually high volume of referrals in February 2008 necessitated the assignment of several referrals to himself for investigation. CA's Case and Management Information System (CAMIS) also notes of the four investigators receiving assignments the week of February 3 – 9, 2008 all had received at least four new investigations for the week and eleven investigations during the month of February 2008.[5]

On February 11, 2008, within the 72-hour requirement, a home visit and interview was completed with the mother and child. Case documentation notes the visit and a description of the bruising. The bruising on the child consisted of two unilateral bruises to her ears fading in color. It was noted that given the pale coloring, the bruises would not have been detectable in photographs, therefore no pictures were taken. The investigating supervisor noted the child was non-verbal, did not appear with any other overt signs of injury and was responsive to her mother. Brief contact was made with the mother's boyfriend at this time; however, a full interview was not conducted. The supervisor noted a plan for an ongoing investigation that would include a full interview with the mother's boyfriend, collateral contacts with family members along with follow up with the examining physician and contact with the CA Regional Medical Consultant.

On February 11, 2008 the child was seen in the Lakewood Medical Clinic as a follow up to the February 7, 2008 visit regarding bruising to her ears. During this visit the child was observed to have a bruise/scratch to the interior of her left eye. The attending physician noted the condition of the eye was "compatible with self-inflicted injury, though concerning in light of recent

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[3] Children's Administration Practice and Procedures Guide Section 2310 Response Time: Section A (1): Intake Responses.
[4] CAMIS Production Data Dated February 3-9, 2008.
[5] CAMIS Production Data Dated February 2008.

findings"[6]. The examining physician summary notes indicate he discussed with the child's mother that "she [the child] should never be left alone with the boyfriend unattended." Given the nature of the injury and the reason for the follow up visit, the physician recommended the child be seen by an ophthalmologist to discern origin of the bleeding.

The child was seen on February 13, 2008 by an ophthalmologist who diagnosed a minor scratch to the left eye with no need for medical follow up. The child was also seen in the Mary Bridge Emergency Room on February 15, 2008. She presented with redness around the eye and signs of mucus. The diagnosis was mild conjunctivitis (pink eye) with eye drops prescribed to relieve the symptoms.

The next contact received by CA regarding the child was on February 23, 2008 from Harrison Hospital in Bremerton reporting her death. The referrer reported that while examining the child on February 22, 2008 several bruises were found on her body. Specifically, it was reported the child had a bruise to her head, "above the eyebrow, on the right side, the size of a thumb print and it was older looking." Other bruising noted by the referrer included bruising to the left side of the child's rib cage, leading to her back and additional bruising on her back. The appearance of the bruises indicated they were several days old. The medical staff further reported the child was non-responsive and would lie still despite the invasive and uncomfortable exams and procedures prior to her death. The child subsequently suffered a heart attack and died despite lengthy attempts (1 ½ hours of Cardio Pulmonary Resuscitation) to revive her.

The referrer reported the mother and her boyfriend were unable to give a clear explanation for the child's injuries or illness except to say she had recently been seen by a pediatrician due to lack of weight gain. The mother's boyfriend also said he had held the child up on the previous evening inferring the bruising was caused by this action. However, the referrer stated the examining physician noted the bruises were older than what could have occurred on the previous evening.

Given the condition of the child and the multiple bruises on her body at the time of admission and death, law enforcement was contacted and an autopsy ordered. The autopsy results were received in June 2008 and note the cause of death "*...a result of blunt force injuries to the abdomen, resulting in abdominal hemorrhaging due to perforation of her large intestine. The manner of death was classified as a homicide.*"

Law enforcement has not been able to discern what or who caused the injuries and the investigation remains open with no arrests to date.

Findings and Recommendations

The committee made the following findings and recommendations based on interviews, review of the case records, department policy and protocol, Revised Code of Washington (RCW) and Washington Administrative Code (WAC), and medical documents.

Findings

[6] Lakewood Medical Clinic Patient Chart entry dated February 11, 2008 at 5:03pm.

- Cited as a challenge to casework and a barrier to quality practice is the influence of workload and vacancies within an office. The ability of social workers and supervisors to adequately staff cases to ensure child safety and follow through on investigative elements (i.e. collateral contacts) is greatly impacted by the workload of the social worker and their respective supervisor. Workload issues prevalent in the Bremerton Division of Children and Family Services (DCFS) office noted a 50% vacancy rate of available CPS investigative staff along with an unusually high intake workload during the first full week of February 2008. Workload necessitated the assignment of several referrals to the CPS supervisor impacting his availability to adequately staff cases with workers and complete investigative elements on his own assigned cases. The committee noted a review of previous task force findings and recommendations made by the Joint Task Force on Administration and Service Delivery to Families and the Joint Task Force on Child Safety for Children in Child Protective Services or Child Welfare Services Custody in 2007[7] may be beneficial in addressing this issue.

- Due to workload in the Bremerton DCFS office assignment of investigations to the CPS Supervisor was noted. Social worker vacancies, staff not yet having completed Academy and the intake workload at the time resulted in the need for supervisory assignment of some referrals.

- The February 7, 2008 referral decision was pended approximately 24 hours (February 8, 2008) awaiting medical information. Given the allegations in the referral - lack of weight gain and unilateral bruising to the ears of a non-verbal child, the referral should have screened in and been assigned for investigation at time of the initial report to CA.

- Given the circumstances of the child's injuries noted in the February 7, 2008 referral, best practice requires the assigned investigator (in this case the CPS Supervisor) ensure collateral contacts are made in a timely manner as a means to discern what may have or may not have happened. One of those collateral contacts could be to the referrer for the purpose of gaining clarification of information provided and as a means to develop next steps.

Recommendations

- The Joint Task Force on Administration and Service Delivery to Families and the Joint Task Force on Child Safety for Children in Child Protective Services or Child Welfare Services Custody in 2007[8] noted several recommendations (among others) as a means to improve and ensure child health and safety. Several of these recommendations are noted below:

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[7] Final Report: Joint Task Force on Administration and Delivery of Services to Families, August 2007 and Final Report: Joint Task Force on Child Safety For Children in Child Protective Services or Child Welfare Services Custody, January 2007

[8] Final Report: Joint Task Force on Administration and Delivery of Services to Families, August 2007 and Final Report: Joint Task Force on Child Safety For Children in Child Protective Services or Child Welfare Services Custody, January 2007

- A review of current statutory requirements should be conducted and recommendations made to streamline or eliminate duplicative requirements to affect workload.
- The agency should establish and maintain control of its personnel system. Staffing levels must match the expectations of law and policy.
- Establish an 'over hire pool' of previously trained workers who would be available to fill temporary vacancies to assist offices exceeding workload standards.
- Develop a mechanism to adequately affect a reduction of caseload size.

Referencing caseload size; a review of and adherence to the Council on Accreditation Standards for caseload size was recommended. Council of Accreditation Standards set the standard for child protective services (CPS) investigation caseloads at no more than 15 families and for child welfare services (CFWS) caseloads at no more than 18 children.[9] A December 2004 Executive Child Fatality Review further recommended no more than eight (8) new investigations be assigned to a CPS investigating social worker per month.[10]

- When workload dictates the need to assign a referral for investigation to a supervisor, the supervisor shall staff and/or consult with the Area Administrator the assignment within 24 hours. Though time frames were not missed in this investigation; it is recommended when a plan of action is developed it should note completion timeframes for action items. Plan of action would include contact with collateral agents; medical personnel, family members etc.

- Emphasize and provide training for intake staff on physical abuse and the mechanics of injuries. Any significant injuries suspicious of abuse or that have no underlying medical cause or appear inconsistent with the explanation for the injury should be reviewed by the Child Abuse Regional or Statewide Medical Consultation Network team or another medical professional with expertise in child abuse[11].

- Social workers and their supervisors in accordance with best practice should initiate timely and regular contact with community professionals including medical providers. In addition, consideration to encourage referrals to a Public Health Nurse, Early Intervention Program, Family Support Center etc. for children under school age (5 and under) should be made.

[9] Council on Accreditation Standards 7th Edition, Child Protective Services (Section S10.7.06) and Child Welfare Services (Section S21.11).
[10] Champagne-Loop Review Dated December 21, 2004 page 8.
[11] Champagne-Loop Review Dated December 21, 2004 page 6.