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Washington State Department of Social & Health Services

CA Children's Administration

Children's Administration
Child Fatality Review

A.F.

March 2012
Date of child's birth

July 6, 2012
Date of child's death

September 20, 2012
Review Date

Committee Members

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Deborah A. Robinson, Infant Death Investigation Specialist
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Sean Davis, Chemical Dependency Professional, King County Mental Health, Chemical Abuse and Dependency Services Division
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Executive Summary

On September 20, 2012, Children's Administration (CA) convened a Child Fatality Review[1] (CFR) Committee to examine the practice and service delivery in the case involving a 13-week-old Caucasian male infant named A.F. and his parents. The incident initiating this review occurred on July 6, 2012 when A.F.'s parents found their infant son not breathing and called 911. Emergency personnel responded to the home but were unable to revive A.F. The medical examiner later certified A.F.'s cause of death as sudden unexplained infant death. Bed sharing was noted by the medical examiner as a contributing factor.

The CFR Committee included CA staff and community members selected from diverse disciplines with relevant expertise, including law enforcement, child welfare, sudden infant death, and chemical dependency. Committee members had no previous involvement with the case. Prior to the review, each committee member received a case chronology of known information regarding the parents and child, and un-redacted CA case-related documents.

Available to committee members at the review were:

- Additional case related documents
- CA policy and practice guides relating to intake and Child Protective Services(CPS)
- Safe to Sleep Publications[2]

During the course of the review, the CPS supervisor and social worker working with A.F.'s family at the time of his death were interviewed by the CFR committee members. Following review of the case file documents, interviews, and discussion regarding social work activities and decisions, the committee made findings and recommendations which are detailed at the end of this report.

Case Overview

[redacted]

[1] Given its limited purpose, a Child Fatality Review should not be construed to be a final or comprehensive review of all of the circumstances surrounding the 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 deceased child's life or death. 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 recommend personnel action against DSHS employees or other individuals.

[2] Safe to Sleep Campaign seeks to inform parents and caregivers of the American Academy of Pediatrics' recommendations for reducing SIDS as well as other sleep-related causes of infant death. [Source: National Institutes of Health website www.nih.gov]

On June 29, 2012, CA received a police report by fax. The report concerned the safety of A.F. Police responded to A.F.'s home on June 28, 2012 in response to a call made to 911. The 911 caller reported looking into the window of the locked family home and observing A.F.'s mother asleep while holding her infant son. The 911 caller tried unsuccessfully to awaken A.F.'s mother prior to calling for police assistance. The responding officer was also unable to awaken A.F's mother so the officer took emergency measures to enter the home. During the event, A.F's crying was audible from outside of the family home. A.F.'s mother awoke after the police officer entered the home. A.F.'s mother told the police officer she takes prescribed medication and it caused her to fall asleep while holding A.F. The police officer informed A.F.'s mother that CPS would be contacted. An intake report relating to this incident was screened in for non-emergent response and assigned for a CPS investigation.[4]

On July 2, 2012, a CPS social worker attempted a home visit with A.F. and his parents. Finding no one at home, the social worker left a business card. A few hours later, A.F.'s father called the social worker and arrangements were made for the social worker to return to the family home later that same day. The social worker then met with the father, A.F. and his older half-sibling. A.F's mother was at work at the time of the social worker's home visit. The social worker noted no concerns for A.F. or his half-sibling during that initial face-to-face contact. On July 3, 2012, the social worker spoke by telephone with A.F.'s mother and arranged to visit the mother early the following week. Before that meeting took place, CA was notified of A.F.'s death on July 6, 2012. An intake was accepted for risk only[5] and assigned a 24 hour response time.

A law enforcement officer and an investigator from the medical examiner's office reported to CPS that A.F.'s parents called 911 after finding their infant son not breathing. Emergency personnel responded to the home but were unable to revive A.F.

According to the police, the mother reported feeding A.F. at 6:00 a.m. before returning to bed and positioning A.F. face-up in the bed between her and A.F's father. The family dog was also in the bed. About an hour later, A.F.'s half-sibling crawled into the bed to

[3] Intake screens anonymous reports of Child Abuse and Neglect (CA/N) when any of the following criteria have been met: there is a reported serious threat of substantial harm to a child; reported conduct involving a criminal offense that has occurred, or is about to occur, in which the child is the victim; or a there has been a founded CA/N report on a household member within the past three years.[Source: Children's Administration Practice Guide to Intake and Investigative Assessment]

[4] A non-emergent response requires CA social workers to have face-to-face contact with all alleged child abuse or neglect victims within 72 hours from the date and time CA receives the intake.[Source: Children's Administration Policy 2310.]

[5] CA will screen in a CPS Risk Only intake when information collected gives reasonable cause to believe that risk or safety factors exist that place the child at imminent risk of serious harm. [Source: Children's Administration Policy 2220.]

watch television. Around 9:15 a.m., the mother awoke and found A.F. unconscious. She ran to summon help from a nurse living nearby. A.F.'s father called 911 and administered cardiopulmonary resuscitation (CPR) to A.F. The emergency response personnel continued lifesaving measures until 10:10 a.m. No obvious signs of trauma or neglect of A.F. were noted. Following the autopsy performed on July 7, 2012, the medical examiner certified A.F.'s cause of death as sudden unexplained infant death. Bed sharing was noted by the medical examiner as a contributing factor.

Committee Discussion

The committee discussion began with an acknowledgement of the short time span between the assignment of the intake dated June 29, 2012 and A.F's death on July 6, 2012 and questioned if the July 4th holiday created a disruption in service delivery to A.F. and his family. The committee learned about the staffing resources available from CA social workers scheduled to work on holidays, weekends and evenings.

The committee discussed the intake screening decision and response time and noted no concerns. Elements of a comprehensive CPS investigation were examined by the committee. In particular, the importance of contact with collateral sources of information, verification of information presented by the subject of an investigation, recognition of the vulnerability of infants, pursuing further assessment when parental substance abuse or mental illness is identified, evaluation of potential safety hazards in the home, and the urgency of safety assessment and planning were discussed.

Also discussed was the importance of CA staff receiving sufficient and ongoing training to inform their social work practice and work with families. Emphasized were two areas of training: Infant Safe Sleeping and Methadone use. The committee was concerned to learn neither the supervisor nor social worker assigned to this case reported receiving training in these two subject areas. The committee discussed ways to provide training to staff in an accessible manner within budgetary restrictions. The committee encouraged CA to utilize community partners to provide training to staff in local CA offices in addition to developing standardized statewide training.

The committee acknowledged the likely impact of critical events on CA staff. The committee endorsed the use of compassionate and confidential support for both social workers and supervisors. The committee questioned why CA does not automatically reassign staff when a critical event occurs and how some staff may feel pressure to deny the need for support or reassignment to avoid appearing emotionally compromised or unprofessional to their peers or CA management.

Findings and Recommendations

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

Findings

1. The CPS investigation of the intake dated June 29, 2012 would have been more comprehensive had it included collateral contacts with relatives, law enforcement professionals, treatment specialists, and health care providers involved with A.F and his family.

2. Planning for the safety of A.F. was inadequate. An immediate plan to address safety was warranted based on A.F.'s vulnerability and the reported safety concerns.

3. The social worker did not address unsafe infant sleeping practices during the initial home visit conducted on July 2, 2012. The committee believes a review of Infant Safe Sleeping practices with A.F.'s caregivers and a visual inspection of A.F's sleeping environment was warranted due to the concerns reported in the June 29, 2012 intake. The social worker and her supervisor reported to the committee they never received formalized training on the topic of Infant Safe Sleeping. The committee believes the social worker was more likely to address these issues; crucial in this case, had training been available to the social worker and supervisor.

4. The full impact of A.F.'s mother's use of prescription medication and methadone was not fully assessed. Of particular concern was the potential lethality of the combination of the medication used by A.F's mother along with the recent examples of parental impairment resulting from drug use. Neither the supervisor nor social worker could recall receiving training on Methadone use. The committee supports ongoing social worker and supervisor training on the current topics relating to substance abuse.

5. CA management should be aware that staff experience challenging emotions following a critical event. Those emotions understandably may impair case planning and decision making abilities.

Recommendations

1. Formal training on infant safe sleeping should be available to CA staff. The training curriculum should be standardized and include information on how to evaluate an infant's sleep environment, how to engage caregivers in a discussion about safe sleep, and risk factors known to increase the risk of Sudden Unexpected Infant Death (SUID) and Sudden Infant Death Syndrome (SIDS). Curriculum should also address the distinction between SUID and SIDS and the implications for CPS investigations.

2. Management in the CA office where A.F.'s case was assigned should provide a reminder to staff about the support available following a critical event.

3. CA should consider implementing policy mandating reassignment of staff following a critical event on an assigned case. The committee recommends the establishment of a policy rather than allowing for individual choice of reassignment following a critical incident.

4. CA should consider re-establishing the funding for Chemical Dependency Professionals contracted to work directly in CA offices. The increased accessibility to specialized consultation would be beneficial to CA social workers working with families impacted by substance abuse.
5. CA will review the existing substance abuse training curriculum to ensure staff is receiving current and sufficient information about methadone. CA will consider offering additional substance abuse training.