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

Child Fatality Review

B.Z.

RCW 74.13.515**2016**
Date of Child's Birth

June 17, 2016
Date of Fatality

October 19, 2016
Child Fatality Review Date

Committee Members
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Table of Contents

Executive Summary

On October 19, 2016, 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, B.Z., and RCW 74 family.[2] The child is referenced by RCW 74 initials, B.Z., in this report. At the time of his death, B.Z. had been residing with RCW 74 mother. The incident initiating this review occurred on June 17, 2016 when B.Z. died while in the home of RCW 74 RCW 74.13.515 grandmother.

The Review Committee included CA staff and community members selected from diverse disciplines with relevant expertise, including an in-home service provider, child welfare professionals, mental health and the Office of the Family and Children's Ombuds. 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 at the time of the review. Supplemental sources of information and resource materials were also available to the Committee, including 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, 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.

Case Summary

On June 17, 2016, CA received an intake from the local medical examiner reporting that RCW 74.13. month old B.Z. was pronounced dead due to Sudden Infant

[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. [Source: RCW 74.13.500(1)(a)].

Death Syndrome (SIDS)[3] with unsafe sleeping practices as a contributing factor. B.Z. was under the care and supervision of RCW 74 maternal grandmother at the time of the fatality. RCW 74. mother had left B.Z. with the maternal grandmother while she was at work. B.Z. was found unresponsive and face down in a sleeping basket that also contained pillows and blankets. CA had recently closed a Family Voluntary Services (FVS)[4] case with the family in May of 2016.

Background

As a child, B.Z.'s mother was in RCW 13.50.100 and later RCW 13.50.100 by her RCW 13.50.100 . While in her RCW 13.50.100 care, B.Z.'s mother was RCW 13.50.100 and RCW 13.50.100 resulting in her RCW 13.50.100 into the RCW 13.50.100 . Early in 2015 she RCW 13.50.100 the RCW 13.50.100 as an adult.

The first report related to B.Z.'s mother as a parent came into CA on RCW 74.13.515, 2016. The local hospital called to report that B.Z. had been delivered. The mother's RCW 13.50.100 history and status, RCW 13.50.100 , RCW 13.50.100 , and RCW 13.50.100 were the reported concerns. Medical staff reported that the mother was handling and caring for B.Z. appropriately while at the hospital from RCW 74.13.515, 2016 to RCW 74.13.515, 2016. The mother was involved with a multitude of in-home and community services prior to B.Z.'s birth. Upon initial contact with B.Z.'s mother, the CPS worker was briefly informed that she was RCW 13.50.100 in her RCW 13.50.100 and maintained contact with her RCW 13.50.100 .

As time went on during the CPS assignment, an in-home service provider mentioned a concern for potential RCW 13.50.100 evolving between the mother and her partner. The CPS worker provided the mother information on RCW 13.50.100 and had a discussion with the mother about RCW 13.50.100 . The case was transferred to FVS for ongoing safety assessment and service provision and monitoring. The in-home service and community providers reported no concerns for the infant's safety in the care of the mother. There were no blatant safety or risk issues identified from the information that had

[3] Sudden Infant Death Syndrome (SIDS) is defined as the sudden death of an infant less than one year of age that cannot be explained after a thorough investigation is conducted, including an autopsy, examination of the death scene and a review of the clinical history. SIDS is a type of SUID. [Source: Centers for Disease Control and Prevention]

[4] Family Voluntary Services (FVS) support families' early engagement in services, including working with the family to create Voluntary Service Agreements or Voluntary Placement Agreements and providing ongoing case management services and assessment of safety and risk to children. Voluntary case plans are used to engage families willing to participate in services intended to reduce current and future abuse or neglect issues that do not require court intervention. Voluntary services are short-term to help increase parents' protective capacity and manage child safety. [Source: CA Practices and Procedures Guide, Chapter 3000]

been gathered by CA and the case was closed on May 19, 2016, one month prior to B.Z.'s death.

Discussion

The Committee discussion focused on CA policy, practice and system responses in an effort to evaluate the reasonableness of decisions and actions taken by the department prior to the critical incident. There was limited discussion of the critical incident and the ensuing investigation.

A majority of the Committee members were impressed with multiple areas of practice conducted by the CPS worker and the FVS worker. However, this opinion was not shared by all Committee members. The Committee appreciated the CPS worker's comprehensive summary of the case. The worker clearly identified areas of concern and what the next steps should have been for the family and the case. A majority of Committee members felt the CPS worker went above and beyond practice standards to meet with the family immediately and on a weekend to assess the safety of the B.Z. In particular, the Committee noted the CPS worker screened for RCW 13.50.100 [5] in the home and again for identifying culturally appropriate resources for the mother when she did not appear to understand the specifics and dynamics of RCW 13.50.100 and RCW 13.50.100 and how they might relate to her own relationship. Additionally, the Committee felt the family was best served by the FVS worker and CPS worker teaming together to ensure contact with the family was made frequently and efficiently. Both CPS and FVS workers provided information to the mother on safe sleep[6] for the infant as well as observed the sleeping arrangement for the infant in the mother's home. Finally, the Committee wanted to recognize the FVS worker for completing health and safety visitations dutifully and timely during his assignment.

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[5] "RCW 13.50.100 " [Source: Social Workers Practice Guide to RCW 13.50.100 , page 33]

[6] Safe 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. [Source: National Institute of Child Health and Human Development]

As part of the review process, the Committee discussed the mother's CA history as a child. The Committee recognized that the initial report included concerns surrounding the mother's CA history as a child as well as concerns for her RCW 13.50.100 and RCW 13.50.100. The Committee discussed that the mother's RCW 13.50.100 RCW 13.50.100 and RCW 13.50.100 could have been assessed more completely. The Committee believes that obtaining the mother's CA records via FamLink,[7] MODIS,[8] and from the mother's most recent RCW 13.50.100 could have assisted CA in acquiring a more comprehensive understanding of the mother's functioning and her ability to provide care for or make safe decisions for B.Z. The mother's historical involvement with CA was recognized by the Committee as being a significant source of information that should have been gathered for the investigation, assessment of child safety, and use in consideration for case closure. The Committee did recognize that the CPS worker initiated gathering such information, but FVS did not follow up upon transfer by gathering information specific the mother's RCW 13.50.100, RCW 13.50.100 and RCW 13.50.100.

The Committee noted that the CPS worker and the mother briefly conversed about the RCW 13.50.100 grandmother having contact with the mother. The Committee believed that this may have been a missed opportunity to inquire and explore the extent to which the RCW 13.50.100 grandmother was involved or potentially could have caretaking responsibility of B.Z. in the future. The Committee recognized that this was not a topic of concern brought forth by the multiple community service providers involved with the mother and B.Z. during the CPS or FVS case interventions.

Once the case transferred to the FVS worker, the Committee believed that there may have been a disconnect in the understanding of responsibility for ongoing assessment of the family by the FVS worker. The Committee identified that the CPS worker was clear in her understanding and documentation of the concerns for the family and the ongoing assessment needs. The Committee felt that the CPS worker's assessment for ongoing services may have been diluted or lost in translation at the case transfer. It seemed to the Committee that the FVS worker believed that his primary role was to monitor service compliance rather than

[7] FamLink is the case management information system that CA implemented on February 1, 2009 which replaced CAMIS, the case management system used by Children's Administration since the 1990s.
[8] MODIS is CA's digital case archiving system. Closed files are stored in this system so that workers are able to view the case history on their computers

gathering information that could not be reviewed or gathered prior to the case transfer in order to have a more comprehensive safety assessment.[9]

The Committee felt that it may have been beneficial for the FVS worker to have had the mother identify long term or future daily life plans prior to case closure. The Committee would have liked to have seen after care conversations with the mother about her ongoing plans once the department was no longer involved, as these may have assisted the mother with future resource and child care planning once the case was closed.

The Committee discussed the supervisor's role in the case transfer process in the local office and specifically between the CPS and FVS units. A formal case transfer and documentation process related to current concerns and next steps did not occur in this case. Further, the Committee found that at times during case transfer there was limited clinical supervision and the assigned staff only informally relayed information about the cases to each other. The Committee believed that a formal case transfer staffing facilitated by the supervisor may assist the workers in clearly transferring information, identifying gaps in information review or gathering and directing the next steps in the case.

Additionally, to enhance clinical supervision, the committee identified that the 30-day case review could have addressed some of the concerns surrounding the next steps in the case and the lack of historical CA data and RCW 13.50.100 records analysis. Furthermore, the Committee would have liked to have seen each 30-day case review address safety, permanence and well-being more thoroughly and to include updated information related to the case plan and next steps for the worker to take.

Findings

After a review of the case chronology, interviews with staff and discussion, the Committee did not identify any critical errors by CA related to the incident. As previously discussed in this report, the Committee found that the CPS investigation was thorough and comprehensive. The Committee also identified areas for practice improvement, specifically, clarifying FVS' responsibility for ongoing assessment of the family and strengthening the supervisory review process.

[9] Safety Assessment is used throughout the life of the case to identify impending danger and determine whether a child is safe or unsafe. It is based on comprehensive information gathered about the family at the time the safety assessment is completed. [Source: CA Practices and Procedures Guide, Chapter 1120]

Recommendations

Monthly supervisory reviews were documented as having occurred regularly and timely. However, such reviews could have included clinical direction to provide guidance, critical thinking and feedback. The Committee recommends that the local office supervisor work with the regional program consultants to address clinical supervision and documentation practices. The Committee identified the following areas of practice to be considered for improvement:

- The local office CPS/FVS supervisor should verify that CA history on all caregivers and intimate partners or others who have frequent access to the child has been gathered, assessed and documented.
- The CPS/FVS supervisor should take a more active role in the transfer process by facilitating a formal transfer staffing and complete case file documentation of the concerns and dynamics of the case.
- Improve 30-day case review documentation to specifically address safety, permanency, wellbeing with updated case information or case plans.