Washington State Department of Social & Health Services

CA Children's Administration

Child Fatality Review

C.B.

November 2014
Date of Child's Birth

April 5, 2015
Date of Child's Death

June 30, 2015
Child Fatality Review Date

Committee Members
Brett Myers, Sheriff, Whitman County
Meg Gallagher, RN, Whitman County Health Department
Patrick Dowd, Director, Office of the Family and Children's Ombuds
Emilie McLarnan, Associate Director, Alternatives to Violence in the Palouse
Lyn Andrews, MSW, Supervisor, Children's Administration, Spokane
Lacretia Warnstaff, RN, Early Head Start Director, Okanogan County Child Development Association
Deborah Ray, LMSW, The Alliance for Child Welfare Excellence

Observer
Maggie Stewart, MSW, Supervisor, Children's Administration, Spokane

Facilitator
Susan Danielson, Critical Incident Review Specialist, Children's Administration

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Executive Summary

On June 30, 2015, the Department of Social and Health Services (DSHS), Children's Administration (CA) convened a Child Fatality Review (CFR)[1] to review the department's practice and service delivery to a four-month-old male child and his family. The child will be referenced by his initials C.B. in this report. At the time of his death, C.B. resided with his parents and older siblings in [redacted], Washington. The incident initiating this review occurred on April 5, 2015 when C.B. was found unconscious and unresponsive on the floor of an upstairs bedroom. The medical examiner later determined that he had asphyxiated on a plastic bag. This case had been open for investigation in the months prior to the child's death and was pending case closure when C.B. died. At the time of the child's death, the household consisted of C.B., his older siblings [redacted]., age three and [redacted]. age 15 months; their mother, [redacted] and [redacted], the father of C.B. and [redacted] biological father was not part of the household.

The CFR Committee included CA staff and community members from disciplines with relevant expertise including child welfare, law enforcement, domestic violence advocacy, public health, early childhood education and the Office of the Family and Children's Ombuds. None of the committee members had any prior 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 intakes, case notes, assessments, provider reports and law enforcement reports. A hard copy of the file was available to the Committee at the time of the review. Supplemental sources of information and resource materials were also available to the Committee for reference including copies of state laws and CA policies relevant to the review and workload and case assignment date for this office during the time that the case was open.

[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 it is the function or purpose of a Child Fatality Review to recommend personnel action against DSHS employees or other individuals.

The Committee interviewed the assigned investigator, the supervisor and the Area Administrator who were able to provide additional information about the case as well as information about the context of the Colfax office, including workload, caseload and staff turnover.

RCW 74.13.500 [redacted][3]

The Colfax CA office became involved with this family in November 2014 when RCW 74.13 gave birth to C.B. RCW 74.13.500 [redacted]. The parents reported that RCW 74. was a full time student at WSU studying child development and the father was the primary caregiver for the children. The father admitted to being frustrated with his daughter when his wife was in the hospital but denied using physical discipline with her. The investigator observed that the family home was cluttered and that the parents seemed overwhelmed by multiple stressors including lack of transportation, conflict between the children, social isolation and lack of social and financial supports.

RCW 74.13.500 [redacted]
RCW 74.13.500 [redacted]e
[redacted]. Prior to leaving the home, the investigator provided the parents

[2] RCW 9A.44.079
[3] CA does not accept for investigation allegations where the alleged perpetrator is a third party who is not legally responsible for the alleged victim. In this instance, the alleged perpetrator was identified as the mother's then-boyfriend, and the matter was referred to law enforcement for investigation of third degree rape of a child.

with written information about Infant Safe Sleep[4] and the Period of Purple Crying.[5] RCW 74.13.500 .

RCW 74.13.500 , RCW 74.13.500 n in [7]

RCW 74.13.500 , RCW 74.13.500

The investigator visited the family home on March 9, 2015 and attempted to see the children and re-engage the parents in services. The father explained that he and his wife did not want to participate in the program because his wife's schedule prevented her from attending sessions in their home and they would prefer to attend classes together. The worker offered to schedule the classes in

[4] Safe Sleep is a nationwide campaign to promote safe sleeping habits for children. Safe sleep practice can reduce the risk of SIDS. In October 2014, CA instituted a policy that requires social workers to discuss Safe Sleep guidelines with all families caring for children under the age of one year. [Source: CA Practices and Procedures Guide 1135]

[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] Safe Care is an evidenced-based home visitation program aimed at reducing child maltreatment among families with a history of maltreatment or risk-factors for maltreatment.

[7] Failure to thrive is a term used to describe a child who seems to be gaining weight or height more slowly than other children if his or her age and sex. A baby who is failure to thrive may seem slow to develop physical skills. Slow growth can also lead to delays in mental and social skills.

the evenings or on the weekends but he declined those options as well. During the visit the father stated that the younger children were napping and [redacted] was at preschool. The mother was not home during this visit. The worker did not enter the house during this home visit and did not see the children. RCW 74.13.500 [redacted]

On April 5, 2015, four weeks after the last family contact documented by the CPS investigator, CA was notified by staff at RCW 74.13.500 [redacted]) that four-month-old C.B. had died after being brought to the Emergency Room that morning by ambulance. When interviewed about the sequence of events, the parents stated that they had put the baby to sleep on a queen sized bed the night before at about 12:30 a.m. They reported that the baby slept in a bedroom on the second floor of the apartment adjacent to another bedroom where the older children slept. The parents stated that they slept on couches in the living room on the first floor of the apartment. The father reported he and the younger children woke up at about 8 a.m. and [redacted] woke up at about 10 a.m. At about 11 a.m. the mother went to check on the baby and found him on the floor next to the bed. The parents attempted CPR and called emergency responders. The baby was taken to [redacted] by ambulance where he was pronounced dead at 11:39 a.m. The medical examiner later determined that the baby had asphyxiated on a plastic bag sometime during the night. The investigating officer from WSU Police described the home as filthy and cluttered with health and safety hazards including dirty diapers, soiled clothing, old food and numerous small choking hazards within reach of the children. C.B. had been laid to sleep on two queen sized adult mattresses stacked on the floor of the bedroom. The mattresses were bare without sheets or other linen. They were dirty and smelled strongly of urine. The officer noted several deflated latex balloons on the bed adjacent to where C.B. had been placed to sleep. The department initiated dependency actions on the older children to place them in out-of-home care. Following the CPS investigation of the fatality, the department issued founded findings for negligent treatment against both parents.

Committee Discussion

The primary focus of Committee discussion centered on documentation regarding observations, actions and decisions made during CA involvement in the five months prior to C.B.'s death. The Committee considered the verbal accounts

presented by the investigator, including undocumented observations of the home environment. The Committee also reviewed information gathered during the fatality investigation that provided a description of the circumstances surrounding the baby's death and conditions in the home.

The majority of the Committee discussion focused on CA policies and practice expectations for timely and thorough investigations. The Committee noted that though assessments were completed timely, the investigator seemed to focus primarily on the alleged physical abuse of RCW 74.13.51 and when she felt this had been addressed, did not gather sufficient information to assess the parents. Specifically, subject interviews were not comprehensive, the physical condition of the children was not assessed and no attempt was made to observe or fully evaluate the home for safety concerns. They noted multiple missed opportunities to gather additional available information that could have broadened the understanding of the family's situation and lead to a more comprehensive view of the family functioning. Specifically, the Committee noted that the family was involved with several service providers in the community, but the worker did not corroborate the parent's statements about their involvement or seek additional collateral contacts that could have provided important information about their parental capacity and commitment to child rearing. The investigator took at face value that they were engaged in these services without critically assessing the extent and level of involvement by corroborating the parent's assertions. The Committee felt that the parents' inconsistent attendance at appointments and their lack of cooperation with services should have been indicators of struggles, not protective factors. Similar to this, though the worker made an effort to gather the children's medical records the Committee could not find any indication that the content of the medical records was incorporated into the evaluation of the child and family functioning.

There were several points throughout the case where the Committee noted a lack of curiosity on the part of the investigator that significantly limited the information available to evaluate the allegations. They noted that although the investigator made three separate home visits, she did not go upstairs to see where the children slept. It was unclear to the Committee what factors prevented the worker from observing the home during the third home visit in March and they considered whether a different investigative approach could have been used by the social worker to gain access to the home. Even in the absence of parental permission to enter the home, the Committee noted that the worker could have seen RCW 74.13 at her preschool. The Committee also felt that the Safe Care provider

who had visited the family home in late January could have provided substantive information about the conditions in the home and her observations of the parent/child interaction.

The lack of evaluation of the home situation led to a discussion about the department's Infant Safety Policy that became effective on October 31, 2014. The policy requires the worker to review the Infant Safe Sleep Guidelines with the caregivers, assess the sleep environment, engage the caregiver in creating a safe sleep environment and consult with the supervisor when there are concerns about the caregiver's ability to maintain child safety. Though the policy does not explicitly state that the worker is to observe the sleep environment, the Committee felt that observation of the sleep environment was implicit and necessary to assess the sleep environment. This understanding of the policy was supported by statements from both the Area Administrator and Supervisor who stated it is their expectation that social workers observe where the child is sleeping and document that they have done so. The Committee discussed the importance of engagement when talking to caregivers about safe sleep particularly because caregivers may be given conflicting messages in the media.

In discussing the documentation requirements for CPS investigations, the Committee noted that the Safety Assessments, Present Danger Assessments and Investigative Assessments are separate documents that do not easily lend themselves to a holistic view of the family or provide a clear understanding of the story of the case. The Committee felt that the fragmented design does not necessarily promote critical thinking and the complexity of the process may lead workers to view the forms as a series of "check boxes" rather than a guide to developing a comprehensive understanding of the case.

In reviewing the February intake, the Committee disagreed with the screening decision and felt that this should have been accepted for investigation. The Committee felt that regardless of the screening decision, the allegations warranted a home visit to assess the safety of the child and a collateral contact to insure that the child's condition had been addressed.

The Committee discussed the importance of clinical supervision to provide direction and guidance to social workers, particularly with high risk cases where the family has refused services. The Committee believed that strong clinical supervision may have provided the social worker with additional guidance and direction about collateral contacts, corroboration of the parent's statements and additional techniques for engaging the family and for accessing the home. The

Committee heard information that because of staff shortages in the Colfax office, the supervisor carried a caseload and she felt that this negatively impacted her ability to focus on clinical supervision.

Findings

1. The Committee disagreed with the decision to screen out the February 5, 2015 intake and felt that it met screening criteria for neglect and should have been assigned for investigation.
2. The Committee believed the CPS investigation did not include key elements needed to ensure a thorough assessment of child safety and family functioning. The elements include:
    a. Subject interviews/child contact: Documentation of the contacts with the parents did not contain sufficient information to assess the allegations or fully explore their functioning as parents. The parent contacts did not include comprehensive interviews regarding the specific allegations nor was it documented if the investigator observed whether or not the child had injuries.
    b. Collaterals: The Committee noted that this family was involved with multiple service providers throughout the community yet there was little direct contact documented with providers. The Committee felt that this information could have been used to develop a more comprehensive assessment of child functioning and parental capacity.
    c. Corroborating information was not sought with providers who had ongoing contact with this family. The Committee felt that the parents' statements about their participation in community services were taken at face value without a critical assessment of their level of engagement.
    d. Though information in the casefile included prior concerns about domestic violence between the parents, this was not assessed or addressed.
3. The Committee felt that the family's refusal to engage in services warranted a reassessment of risk and child safety and consideration should have been given to holding a Family Team Decision-Making Meeting or Shared Planning Meeting.
4. The CA policy on Infant Safety Education and Intervention was not followed.
5. Though supervisory reviews were done consistently and timely, the content lacked critical thinking and clinical supervision.

Recommendations

1. The Committee recommended that the Area Administrator work with Regional CPS Program staff to identify a mentor for the supervisor to partner with to improve and reinforce clinical supervision skills and to develop a plan for continued staff development and training among staff. The Committee recognized the challenges faced by supervisors in smaller offices who are required to have expertise in all programs and recommended that the mentor be a staff member who is experienced with supervision and understands the challenges of supervising multiple programs.
2. The local office will collaborate with the Alliance for Child Welfare Excellence to ensure that all staff are trained in the appropriate approach to discuss safe sleep with clients and with the local public health department on outreach and education.
3. The Committee recommended that the local office staff and Area Administrator consider cross training of staff to help with case coverage during times of staff shortages. The Committee recognized that the Colfax Office currently has some relatively new staff and this may be a long range goal but the Committee saw a benefit to this for staff.
4. The Committee recommended that CA reevaluate the tools used in the Safety Framework as they are currently designed in order to make the assessment process more cohesive.