WASHINGTON STATE
Department of
Children, Youth, and Families

CHILD FATALITY REVIEW

March 2019

www.dcyf.wa.gov

FULL REPORT

CHILD

- C.T.

DATE OF CHILD'S BIRTH

- [redacted] 2017

DATE OF FATALITY

- April 26, 2018

CHILD FATALITY REVIEW DATE

- October 18, 2018

COMMITTEE MEMBERS

- Erin Summa, MPH, Health Promotion Coordinator, Center for Childhood Safety, Mary Bridge Children's Hospital and Health Network
- Patrick Dowd, JD, Director, Office of Family and Children's Ombuds
- Ly Dinh, MSW, Region 5 Quality Practice Specialist, Department of Children, Youth, and Families
- Kristie Deese, CPS/FAR Supervisor, Department of Children, Youth, and Families

OBSERVER

- Amanda Sutherland, MSW Practicum Student, Child Welfare Training and Advancement Program (CWTAP), University of Washington School of Social Work

FACILITATOR

- Bob Palmer, Critical Incident Case Review Specialist, Department of Children, Youth, and Families

CONTENTS

EXECUTIVE SUMMARY

On October 18, 2018, the Department of Children, Youth, and Families (DCYF or Department)[1] convened a Child Fatality Review (CFR) to examine DCYF's practice and service delivery to C.T. and RCW 7 family.[2] Beginning in mid-January 2018, C.T.'s family was receiving Family Assessment Response (FAR)[3] services. The basis for this CFR occurred on April 26, 2018, when, during an unannounced visit to the home, the assigned FAR worker and his supervisor were informed by family members that C.T. had passed away earlier in the day while bed sharing with the father.[4] First responders, law enforcement, and the County Coroner's office finished processing the death scene and departed the home before the arrival of the FAR worker and supervisor. The circumstances of C.T.'s death are similar to those occurring RCW 74. months earlier when C.T.'s RCW 74.1 died.

The CFR Committee (Committee) included DCYF staff, a representative from the Office of Family and Children's Ombuds, and a child safety educator with expertise in infant safe sleep. None of the participating Committee members had any direct knowledge of the family prior to C.T.'s death. Prior to the review, each Committee member received a chronology summarizing the child welfare involvement with the family, un-redacted DCYF documents (e.g., intakes, risk and safety assessments, and case notes), and law enforcement reports. Supplemental information was also available to Committee members during the review, including death scene photos and the autopsy report involving C.T.'s RCW 74.13. The assigned DCYF worker and supervisor provided verbal information during the Committee's in-person interview process.

PURPOSE OF A REVIEW

A child fatality or near-fatality review completed pursuant to RCW 74.13.640 is subject to discovery in a civil or administrative proceeding, but may not be admitted into evidence or otherwise used in a civil or administrative proceeding except pursuant to RCW 74.13.640(4). Given its limited purpose, a child fatality or near-fatality review (CFR/CNFR) 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 DCYF or its contracted service providers.

The committee has no subpoena power or authority to compel attendance and generally only hears from DCYF 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 CFR/CNFR 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 CFR/CNFR to recommend personnel action against DCYF employees or other individuals. Information discovered through the review may be used in DCYF disciplinary actions such as revocation or suspension of a child care license.

[1] Effective July 1, 2018, the Department of Children, Youth, and Families (DCYF) is the state agency responsible for child welfare and early learning programs (the Department of Social and Health Services Children's Administration was the prior authority). The fatality occurred prior to July 1, 2018, and therefore CA or DSHS may be referenced in this report.
[2] As there are no known criminal charges filed related to the incident, the parents involved are not identified by name in this report. The names of the children are also subject to privacy laws. See RCW 74.13.500.
[3] FAR is a voluntary Child Protective Services (CPS) alternative response to a screened in allegation of abuse or neglect that focuses on the integrity and preservation of the family when less severe allegations of child maltreatment are reported. FAR cases do not require a finding.
[4] Broadly defined, bed sharing is a co-sleeping arrangement in which an infant sleeps on the same surface with another person (e.g., bed, couch, or chair). Due to increased risk for Sudden Unexpected Infant Death (SUID), both the American Academy of Pediatrics (AAP) and the U.S. Consumer Product Safety Commission (CPSC) advise against bed sharing.

CASE SUMMARY

C.T. was born in RCW 74.1 2017. Department-related child welfare history for this family includes two Child Protective Services (CPS) investigations that predated C.T.'s birth. The first investigation occurred in 2013 when CPS initiated an investigation involving allegations RCW 13.50.100 . These allegations were determined to be "unfounded."[5] In September 2014, CPS initiated a second investigation based on RCW 13.50.100 concerns. This investigation originated from a notification that a third party in the home had RCW 13.50.100 . The CPS investigation resulted in a RCW 13.50.100 finding based on the determination RCW 13.50.100 .

January 2018 Intake

On January 19, 2018, a RCW 13.50.100 reportedly disclosed she had been left to watch her sickly RCW old RCW 74.13.515 C.T. when the mother and the baby's father got into a quarrel. The report also included information that C.T.'s RCW 74.13.515 had died RCW 74.1 month earlier (no details were provided). The report was initially screened out as the information provided at the time of intake did not appear to meet the legal definition of child abuse or neglect under WAC 110-30-0030. However, an acting regional intake administrator overrode the screening decision, and the intake was assigned for FAR services. During the FAR worker's interview of the RCW 13.50.100, no disclosures were made with regard to negligent treatment or maltreatment,[6] or feeling unsafe at home. The RCW 13.50.100 15-year old sibling declined to be interviewed. When contacted by phone, the mother denied the allegations. When interviewed in-person, she again denied neglecting any of her children. When asked about the RCW 74.13.515 2017 passing of RCW 74.13.515 , the mother became distraught and indicated the death was related to SIDS (Sudden Infant Death Syndrome). Under the January 2018 FAR case, DCYF initiated a referral for Family Preservation Services (FPS).[7]

March 2018 Intake

While the FAR case was still active, a new FAR intake was accepted on March 22, 2018. Reportedly, the 13-year old half-sibling came home from school to find that C.T. had been left unattended at the home. The assigned FAR worker and another DCYF social worker conducted a home visit. With the exception of C.T.'s father who was later interviewed by telephone, in-person contact was made with all household members. No obvious safety threats were identified other than concerns with C.T.'s sleep environment (e.g., cluttered crib area). These concerns were discussed and addressed with the mother. After meeting with the mother, the Department decided to initiate an investigation of the circumstances of the death of C.T.'s RCW 74.13. which had not been reported to CPS as suspicious.[8] Records obtained from the County Coroner revealed the RCW 74.13.51 death was attributed to Sudden Unexplained Infant Death (SUID), and the manner classified as Undetermined.[9] Law enforcement records confirmed the death occurred

---

[5] Findings are determined when the investigation is complete and are based on a preponderance of the evidence standard. **Unfounded** means "the determination following an investigation by the Department that available information indicates that more likely than not child abuse or neglect did not occur, or that there is insufficient evidence for the Department to determine whether the alleged child abuse did or did not occur." **Founded** means "the determination following an investigation by the department that, based on available information, it is more likely than not that child abuse or neglect did occur." RCW 26.44.020.

[6] Included within the definition of child abuse or neglect is the phrase "negligent treatment or maltreatment." Under WAC 110-30-0030(5), negligent treatment or maltreatment is defined as follows: "an act or a failure to act, or the cumulative effects of a pattern of conduct, behavior, or inaction, on the part of a child's parent, legal custodian, guardian, or caregiver that shows a serious disregard of the consequences to the child and creates a clear and present danger to the child's health, welfare, or safety."

[7] Family Preservation Services (FPS) are contracted short-term, family-based services designed to assist families in crisis by improving parenting and family functioning while keeping children safe. FPS is aimed at preventing out-of-home placements for children and is generally authorized for a limited period.

[8] Child fatalities are not required to be reported to CPS unless there is a reasonable basis to suspect child abuse or neglect caused the death.

[9] Sudden unexpected infant death (**SUID**) is a term used to describe the sudden and unexpected death of a baby less than 1-year old in which the cause was not obvious before investigation. These deaths often happen during sleep or in the baby's sleep area.

during bed sharing (the father and the infant), noting concerns for the sleeping environment (excessive items in the bed) and for possible contribution of alcohol consumption by the father the night of the incident. However, there was insufficient evidence to suggest the situation was anything other than an accidental death.

C.T.'s April 2018 Death

On April 26, 2018, during an unannounced visit to the home, the assigned FAR worker and his supervisor were informed by family members that C.T. had passed away earlier in the day while bed sharing with the father. The circumstances were remarkably similar to the RCW 74.13.515 2017 death of C.T.'s RCW 74.13. In both cases, the mother was not home at the time of death, there was bed sharing by the father, and an infant was in an adult bed cluttered with items. Following the CPS investigation, a neglect founded finding was issued against the father. This finding was based on C.T.'s sleep environment conditions that created "a clear and present danger to [C.T.'s] health, welfare, or safety."[10] Given the indeterminate nature of C.T.'s actual cause of death, the CPS investigator was unable to make a finding regarding parental actions or inactions causing the death. It should be noted that at the time of the CFR, law enforcement had not released the criminal investigative report and the County Coroner's report was still pending toxicology results. Notwithstanding this, the preliminary autopsy suggested the death was a SUID.

COMMITTEE DISCUSSION

During the review process, the CFR Committee explored and discussed a number of issues potentially relevant to DCYF practice, including: intake decisions, investigative practices, infant safe sleep assessment procedures, family engagement and service delivery, and systemic barriers to meeting policy requirements and practice standards in state child welfare work. Not all of the issues discussed and documented in this section resulted in findings or conclusions by the Committee.

Intake Decisions

The Committee briefly discussed the screening decisions for the three intakes taken between mid-January 2018 and C.T.'s death in late April 2018. With regard to the January intake, the Committee was undecided about the management decision to override the initial screen-out decision. However, Committee members did agree that C.T. could have reasonably been identified as an alleged victim in that intake. With regard to the April 2018 intake, additional discussion occurred as to whether generating the intake regarding the previous SUID death of C.T.'s RCW 74.1 (RCW 74.13.515 2017) was actually necessary since information about that event had already been documented. The Committee did not reach consensus, but appreciated the fact that the decision to look into the previously unreported death of the RCW 74.1 resulted from shared decision-making.

Information Gathering/Assessment

Some discussion occurred as to the CPS family history that predated the birth of C.T. and RCW 7. The Committee was concerned the FAR worker may not have sufficiently grasped the significance of this prior history as it relates to a possible pattern of the mother's questionable ability to meet the basic health, welfare, and safety needs of her children. However, most of the Committee's focus centered on the more current involvement with CPS and the FAR activities occurring during the three months the case was open before C.T.'s death. The Committee examined worker activities pertaining to the completion of required work (e.g., timelines to conduct various tasks), and the quality of the child welfare work (e.g., sufficiency of collateral

---

The three most frequently reported causes for SUID are (1) SIDS, (2) Unknown, and (3) ASSB (accidental suffocation and strangulation in bed).

[10] See "child abuse or neglect" and "negligent treatment or maltreatment" definitions contained in WAC 110-30-0030(5)

contacts and corroboration of information, level of investigative curiosity, critical thinking/analysis). The Committee also compared the initial efforts by the worker in January 2018 to connect with the family, versus subsequent efforts to gather additional information or corroborate additional information reported by family members (e.g., the nature of the prior death of the RCW 74.1[redacted]).

The Committee also discussed that during the three months the case was open before C.T.'s death, the information gathered by the FAR worker was incident-focused instead of assessment-focused. For example, the FAR worker appeared attentive to the allegations originating from the RCW 13.50.100, but the case file did not contain substantive documented information about C.T. until C.T. was identified as an alleged victim in the March intake. Despite living in the home, very little information regarding the father surfaced until the FAR worker spoke to him by phone in early April 2018. The Committee also considered whether the worker should have explored the discrepancies between what one of the older siblings had reportedly told others about what was going on in the home, and what she disclosed to the worker when interviewed. The Committee considered how missing but obtainable information may have significantly impacted the accuracy of the assessment tools used to evaluate safety and risk and determine the service needs of the family.

Infant Safe Sleep

Taking into consideration the unusual, if not suspicious, circumstances of two apparent SUID deaths in the same family just months apart, the Committee was given statistical data related to national infant mortality rates, mortality rates for RCW 74.13.5[redacted] including SUID/SIDS deaths, and current frequency estimates for multiple infant deaths in a family. The Committee also looked at risk reduction recommendations for infant safe sleep promoted by the American Academy of Pediatrics and the National Institute of Child Health and Human Development,[11] and the DCYF infant safe sleep policy.[12] The Committee also considered the nature and extent of the infant safe sleep assessment, education, and intervention activities conducted by DCYF staff before C.T.'s death. The Committee looked at efforts by the FAR worker and his co-worker to address basic infant safe sleep with the mother during a visit to the home. There was also discussion about the "wedge" sleep positioner[13] allegedly recommended by C.T.'s doctor for reflux reduction but never verified by the worker. The Committee discussed missed opportunities for improved safe sleep education and intervention with other caregivers in the home (the father, the teen half-siblings, the grandmother). This issue seemed particularly relevant given the fact that the father was the adult involved in the bed sharing SUID of C.T.'s RCW 74.13.515. While all Committee members were familiar with DCYF's commitment to address infant safe sleep in policy and training opportunities for staff, some questioned how reasonable it is to expect DCYF staff to have anything more than basic knowledge about infant safe sleep.

Family Engagement/Services

The Committee reviewed and discussed the FAR worker's efforts to connect with the family and offer services beyond providing the family with a FAR brochure[14] and County Resource Guide. The Committee considered the fact that the FAR worker had very limited follow-up contact with the family for a two-month period, and no in-person interactions with the father prior to C.T.'s death. As previously noted, the Committee had concerns the worker may not have had sufficient

[11] https://safetosleep.nichd.nih.gov/
[12] https://www.dcyf.wa.gov/1100-child-safety/1135-infant-safety-education-and-intervention
[13] A sleep positioner is a readily available product used to keep babies on their backs while sleeping. Some are flat mats with side bolsters, and others are inclined (wedge) mats with side bolsters. Many types of sleep positioners claim to help reduce the risk of SIDS by keeping babies on their backs, help with food digestion and reflux, ease colic, and prevent flat head syndrome. The U.S. Consumer Product Safety Commission (CPSC) and the U.S. Food and Drug Administration (FDA) have issued warnings to consumers to stop using infant sleep positioners as they pose a suffocation risk. Similarly, the American Academy of Pediatrics (AAP) advises caregivers to avoid using commercial devices marketed to reduce the risk of SIDS. https://www.cpsc.gov/Newsroom/News-Releases/2010/Deaths-prompt-CPSC-FDA-warning-on-infant-sleep-positioners/
[14] https://www.dshs.wa.gov/sites/default/files/SESA/publications/documents/22-1534.pdf

comprehension of family functioning and individual functioning within the family to inform how to proceed with service delivery. For example, the Committee discussed whether the referral to FPS was the appropriate service given there did not appear to be a substantial risk of placement and the FPS referral was very non-specific with regard to targeted services. There was some indication the FPS referral may have been the result of the "best service available" in the family's community at the time.

Possible Systemic Barriers

The Committee looked at possible systemic barriers that may have contributed to the FAR worker not meeting some policy requirements and practice standards (e.g., timely documentation and timeframes for completion of work). The Committee considered the worker's caseload, his years of experience in the field, and, based on interview responses from the worker and supervisor, the quantity and quality of supervision provided to the worker on a regular basis. While noting the worker's caseload appeared to exceed the state average as well as the recommended standards of national child welfare organizations,[15] it was unclear to the Committee what specific impact the high caseload may have had on meeting expectations.

Post-Critical Incident Activities

Given that the task of the Committee is to review and evaluate recent DCYF service delivery occurring prior to a suspicious child death, there was only limited discussion about the post-critical incident activities and findings. With the cause and manner of C.T.'s death being undetermined at the time of the CFR, the Committee discussed the challenges with regard to making a finding that the death was the result of child maltreatment. However, because the death scene investigation showed evidence of an unsafe sleeping environment, the Committee took no issue with the CPS investigative finding that the parent failed to provide a reasonably safe sleeping environment for an infant irrespective of C.T.'s death. Finally, the Committee speculates that the worker and supervisor seemed reluctant to continue family engagement soon after C.T.'s death, possibly persuaded by the family's decline for further services.

FINDINGS

The Committee did not identify any critical errors by the Department in this case. In part, this was due to the unknown nature of what caused C.T.'s death. However, the Committee noted the following missed opportunities for reasonably improved practice – issues that may be important for consideration for statewide DCYF practice.

- Although there was documentation that the infant safe sleep assessment and safe sleep discussion occurred in the family home with the mother present, there did not appear to be any significant infant safe sleep discussions occurring with C.T.'s father, the paternal grandmother, or C.T.'s teenage half-siblings – all of whom had caretaking responsibilities for the infant. There was no follow up with C.T.'s doctor who reportedly recommended the use of a crib wedge due to reflux issues. As a part of the infant safety education process, the FAR worker may not have been aware that DCYF workers are to review materials with parents and caregivers that include the Infant Safe Sleep Guidelines (DSHS 22-1577). These guidelines contain the recommendation for caregivers to "avoid wedges, positioners or other products unless prescribed by your baby's doctor."[16]
- Information gathered by the FAR worker during the three months the case was open before C.T.'s death appeared to be limited, concrete, and incident-focused instead of assessment-focused. The worker may not have had a substantive understanding of

[15]For child protective services, the Council on Accreditation recommends that caseloads do not exceed 15 investigations or 15-30 open cases. http://coanet.org/standards/standards-overview/ The Child Welfare League of America recommends a caseload size of 12 intake reports per month per worker. See http://www.cwla.org/wp-content/uploads/2014/05/DirectServiceWEB.pdf
[16] https://www.dshs.wa.gov/sites/default/files/SESA/publications/documents/22-1577_0.pdf

family and individual functioning, resulting in flawed assessment of service needs, and missing numerous opportunities to address parental chemical dependency issues.

- The Committee believes there were missed opportunities for the supervisor to adjust his supervisory skills to meet the needs of the FAR worker, and to recognize where the worker may have needed more guidance. This includes more guidance with regard to activity completion, next steps follow-up, and identifying the need to initiate collateral contacts to corroborate information. The Committee acknowledged the significant challenges facing DCYF to maintain a high level of practice during a time of significant workload increases, significant staff turnover rates, reliance on workers with relatively limited experience in child protection, and the inability to provide an essential level of consistent supervision.

RECOMMENDATIONS

There are no specific recommendations emerging from this review. However, the Committee encourages DCYF to continue its efforts to promote infant safe sleep with families through continued policy enhancements and staff training.