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

Child Fatality Review

G.R-H.

November 2013
Date of Child's Birth

December 15, 2013
Date of Child's Death

January 30, 2014
Child Fatality Review Date

Committee Members
Colleen Hinton, MSW, Office of the Family and Children's Ombuds
Yolanda Duralde, MD, Medical Director of the Child Abuse Intervention Department at Mary Bridge Children's Hospital and the Pierce County Child Advocacy Center
Amy Scanlon, MA, Social Worker Coordinator, Pierce County Child Advocacy Center
Hae-Man Song, Social Service Program Specialist 3, Pierce County Community Connections
James Manley, PhD, Director, Pacific Psychology Services
Bonnie Basile, Detective, Bellevue Police Department
Karen Erickson, Supervisor, Family Voluntary Services, Department of Social and Health Services, Children's Administration
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RCW 74.13.640

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Executive Summary

On March 13, 2014, the Department of Social and Health Services (DSHS) Children's Administration (CA) convened a Child Fatality Review (CFR)[1] to assess the department's practice and service delivery to a 29 day old female and her biological family.[2] The child will be referenced by her initials, G.R-H., in this report. At the time of her death, G.R-H. lived with her mother and two-year-old sibling. The incident initiating this review occurred on December 15, 2013 when G.R-H.'s mother woke to find her non-responsive. The mother and child had fallen asleep together on the couch.

The review committee included members selected from disciplines within the community with relevant expertise from diverse disciplines. Neither CA staff nor any other committee members had previous direct involvement with this family.

Prior to the review, each committee member received a case chronology, a summary of CA involvement with the family and un-redacted CA case documents (e.g., intakes, investigative assessments, investigative assessment tools, case notes and medical records). Supplemental sources of information and resource materials were available to the Committee at the time of the review. These included the current case files, relevant state laws, contracts related to a specific CA contracted provider, family genogram and CA policies.

The Committee interviewed the previous Family Voluntary Services (FVS) worker, the FVS supervisor, two of the previous Child Protective Services workers (CPS) and those workers' supervisor. The current child welfare social worker for G.R-H.'s biological family was available for consultation and provided a brief update which was shared with the committee.

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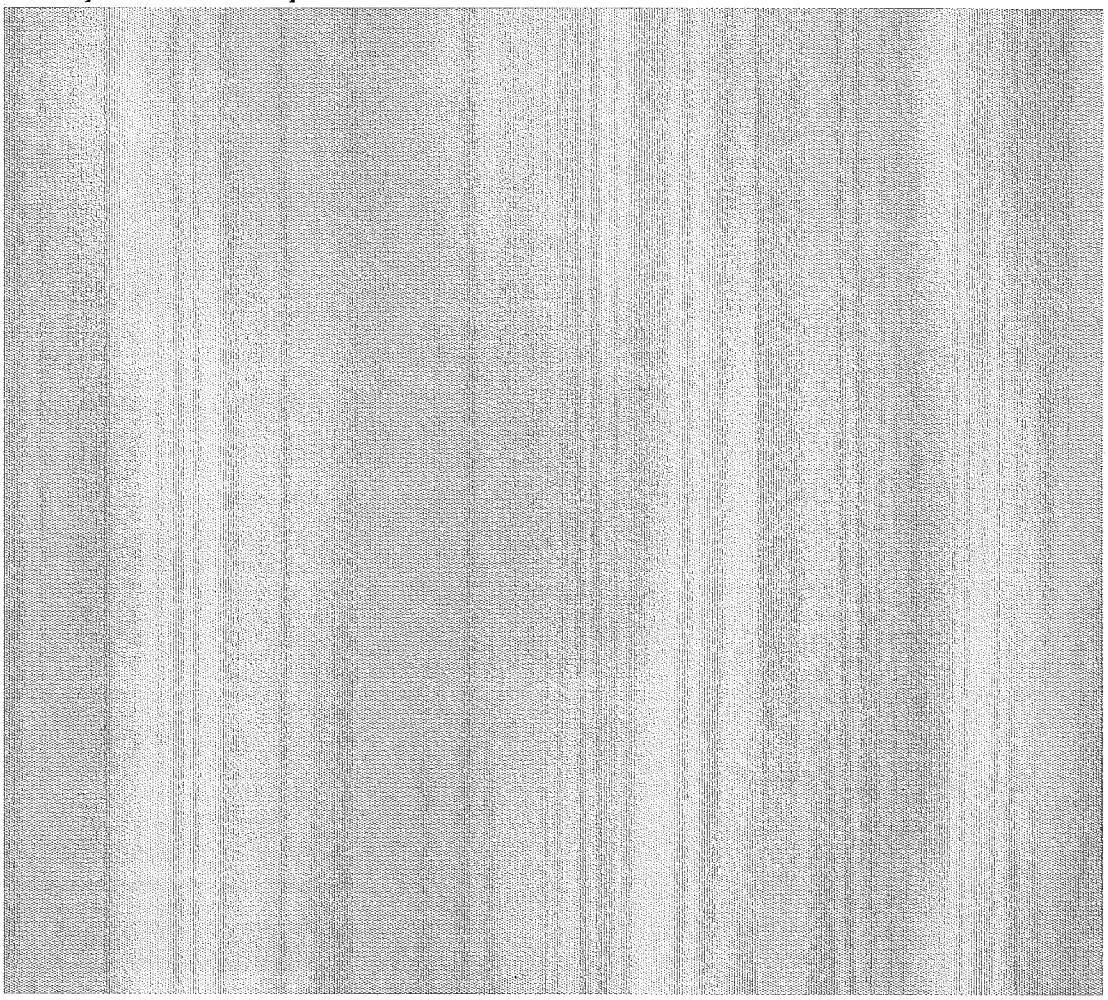
[1] Given its limited purpose, a Child Fatality Review should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. The Child Fatality Review Committee's review is generally limited to documents in the possession of or obtained by DSHS or its contracted service providers. The Committee has no subpoena power or authority to compel attendance and generally will only hear from DSHS employees and service providers. It does 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 recommend personnel action against DSHS employees or other individuals.

[2] G.R.H.'s family members are not named in this report because they have not been charged in an accusatory instrument with committing a crime related to a report maintained by the department in its case and management information system.[Source: RCW 74.13.500(1)(a)]

Following a review of the case file documents, interviews with the CA staff and discussion regarding department activities and decisions, the Committee made findings and recommendations which are detailed at the end of this report.

Family Case Summary

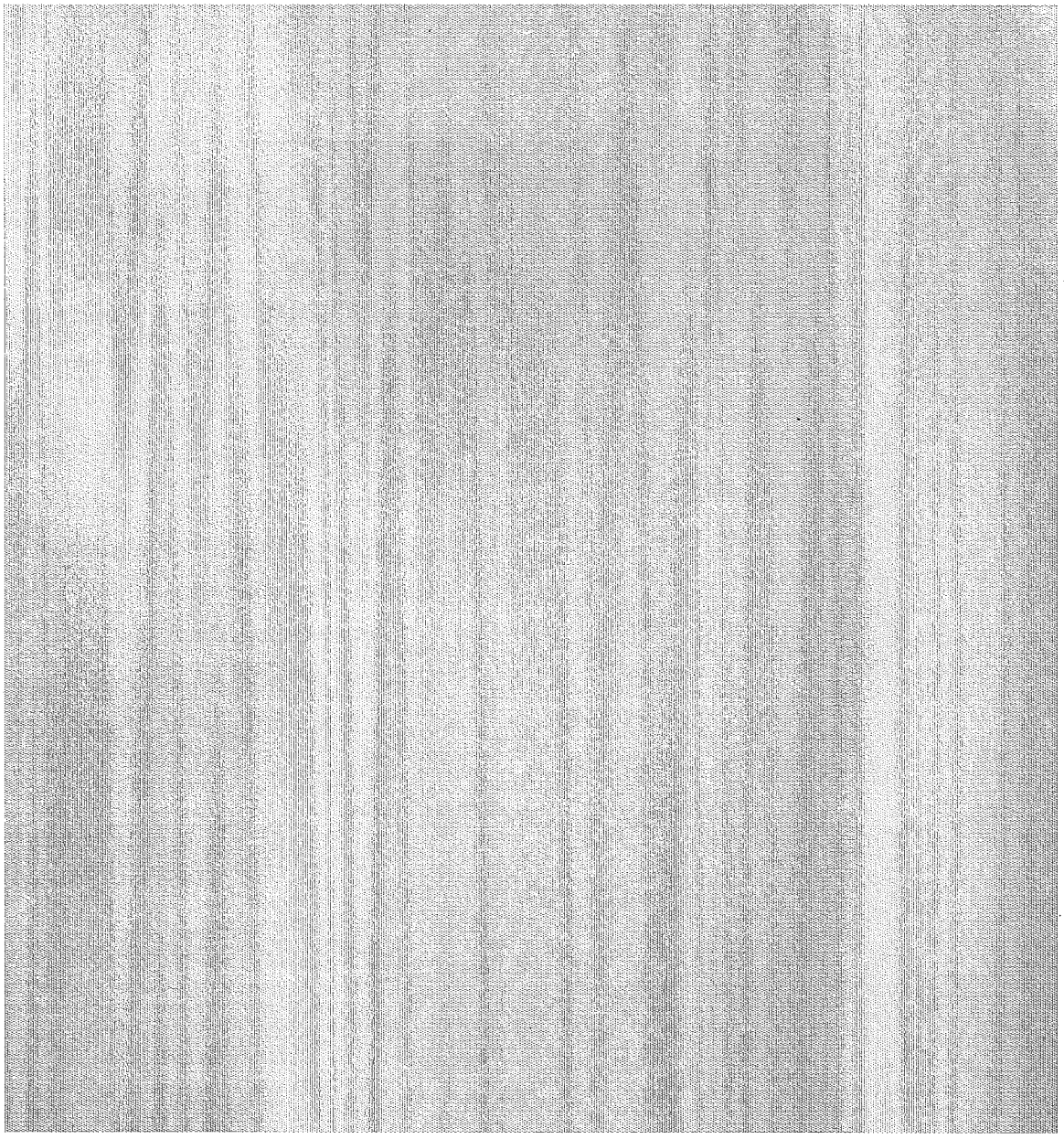


[3] CA Practice and Procedures Guide 2552: Intakes on Substance Abuse during Pregnancy - Intake Screening Decision: The intake worker will document a pregnant woman's alleged abuse of substance(s) (not medically prescribed by the woman's medical practitioner) in an intake as "Information Only." Retrieved from http://www.dshs.wa.gov/ca/pubs/mnl_pnpg/chapter2_2500.asp

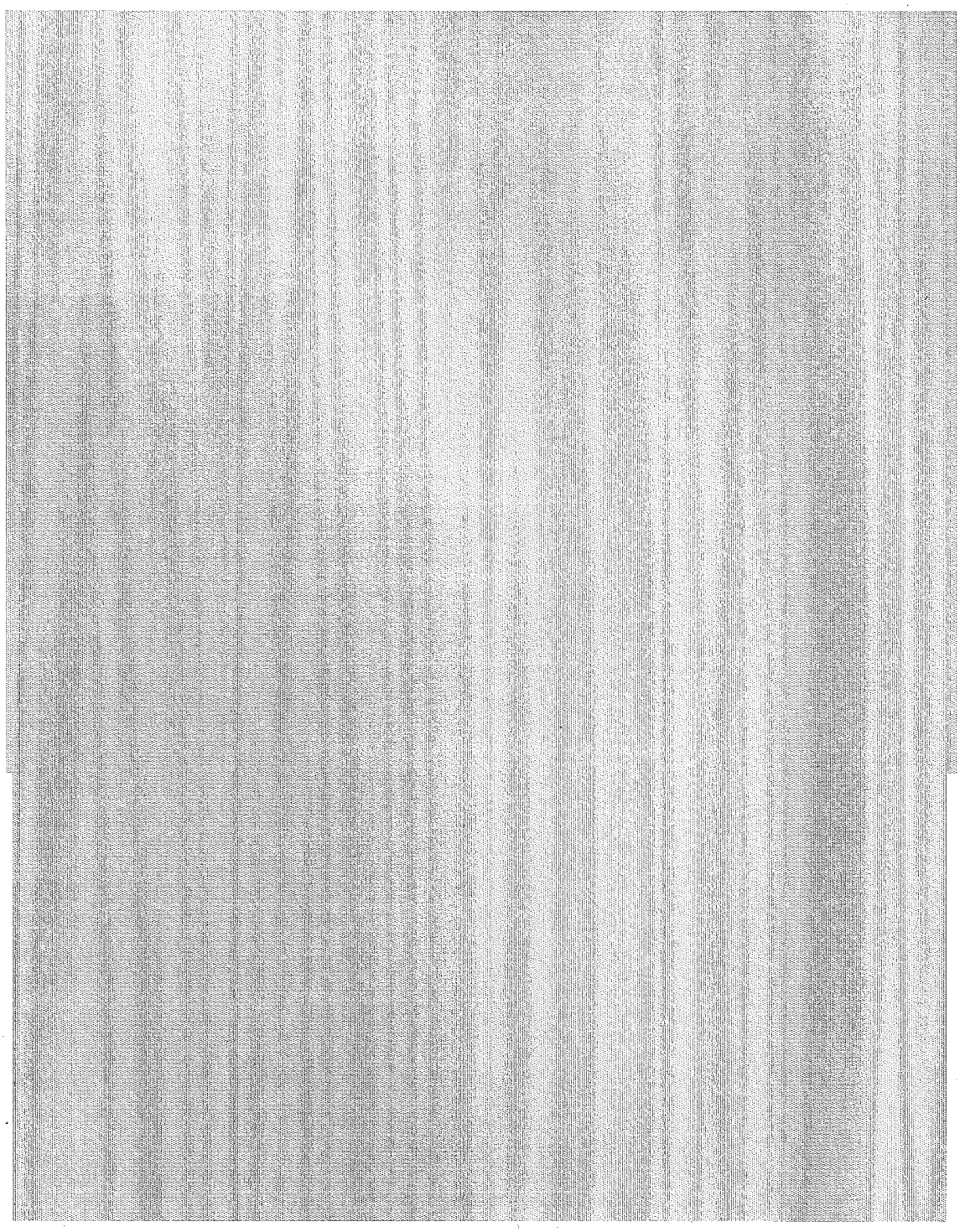
[4] Washington state law does not authorize Children's Administration (CA) to screen in intakes for a CPS response or initiate court action on an unborn child.[Source: Department of Social and Health Services Children's Administration Practice Guide to Intake and Investigative Assessment]

[5] Unfounded--The determination that, following an investigation by CPS, based on available information: it is more likely than not that child abuse or neglect did not occur, or there is insufficient evidence for the department to determine whether the alleged child abuse did or did not occur. WAC 388-15-005.

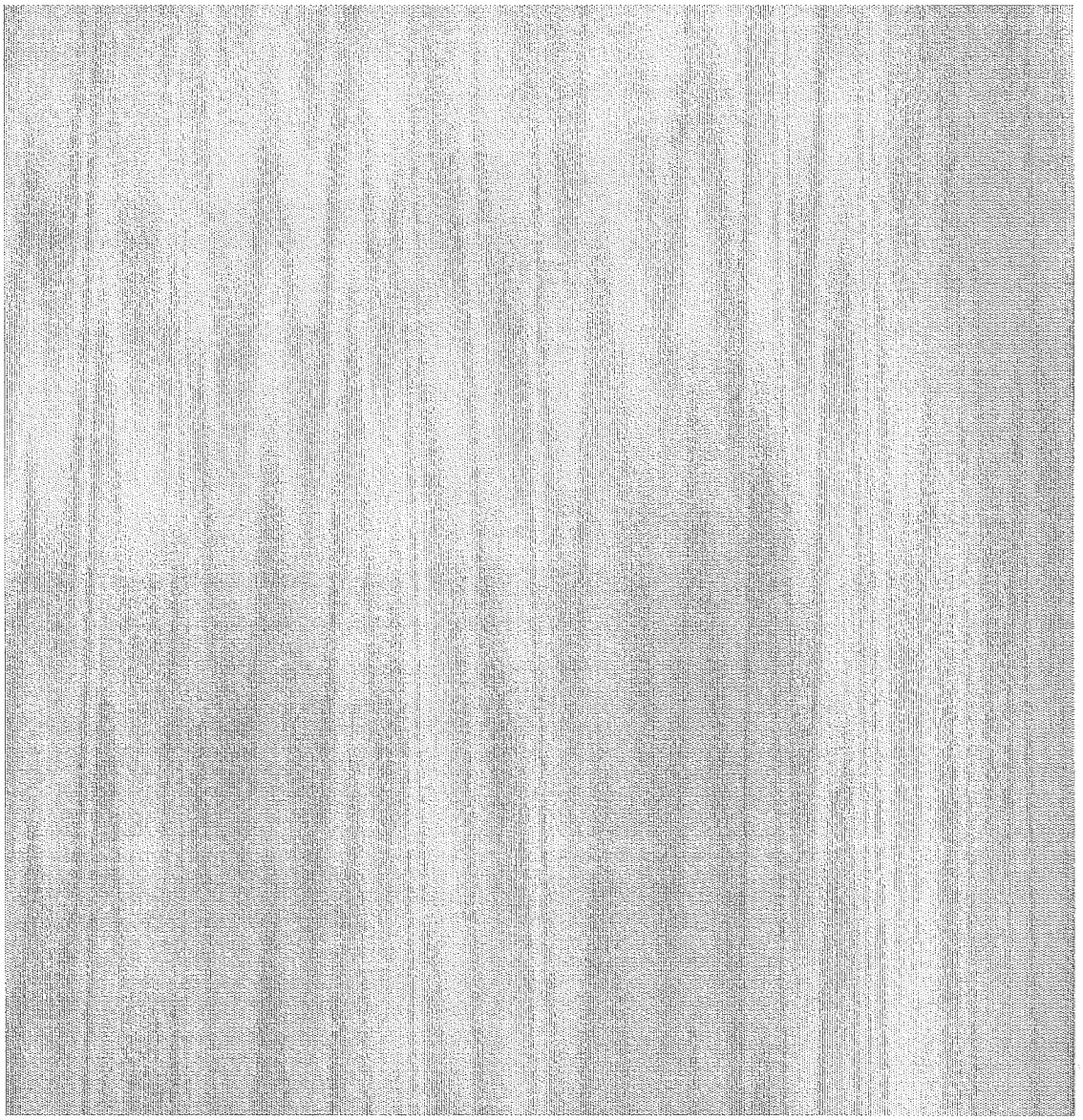
[6] Negligent Treatment or Maltreatment means an act or a failure to act, or the cumulative effects of a pattern of conduct, behavior or inaction, that evidences a serious disregard of consequences of such magnitude as to constitute a clear and present danger to a child's health, welfare, or safety including but not limited to conduct prohibited under RCW 9A.42.100.[Source: RCW 26.44.020(14)]



[7] Homebuilders is an evidence based, short term, intensive home-based service utilized to aid in placement prevention.
[8] The tasks of the statewide Child Protection Medical Consultants (CPMC) network include providing telephonic consultations, case staffing/case review, training, court testimony, and written consults to CA staff, law enforcement officials, prosecuting attorneys, and physicians regarding child maltreatment cases.
[9] FVS social worker-Family Voluntary Services social workers offer parents services designed to reduce the safety threats while the children remain in the care and custody of their parents.
[10] Family Team Decision Making meeting (FTDM) is a meeting that occurs whenever a placement decision needs to be made. Typical participants include the parents, the child (as appropriate), relatives, family friends, neighbors, caregivers, community stakeholders, service providers, and Children's Administration social workers. The purpose of the meeting is to develop an appropriate course of action to keep the child safe by creating a detailed case plan.



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 74.13.649(4).



[11] The Structured Decision Making® (SDM) risk assessment is a household-based assessment. It estimates the likelihood that a child will experience abuse or neglect in a given household based on the characteristics of the caregivers and children living in that household. To accurately complete the SDM® risk assessment, it is critical to accurately identify the household being assessed.

[12] The social worker shall complete an investigative risk assessment on all investigations of child abuse and neglect upon completion of the investigation within 45 calendar days of Children's Administration receiving the intake. [CA Practices and Procedure Guide 2520] For reports of alleged abuse or neglect that are accepted for investigation by the department, the investigation shall be conducted within time frames established by the department in rule. In no case shall the investigation extend longer than ninety days from the date the report is received, unless the investigation is being conducted under a written protocol pursuant to RCW 26.44.180 and a law enforcement agency or prosecuting attorney has determined that a longer investigation period is necessary. At the completion of the investigation, the department shall make a finding that the report of child abuse or neglect is founded or unfounded.[Source: RCW 26.44.030]

[13] Founded--The determination that, following an investigation by CPS, based on available information: it is more likely than not that child abuse or neglect did occur. WAC 388-15-005

On November 18, 2013, an intake was received stating the mother gave birth to G.R-H. The child was placed in the Neonatal Intensive Care Unit due to neonatal abstinence syndrome (NAS).[15] The intake reports the mother was engaged in treatment for pain management, has an active CPS worker and had a founded for abuse of an older child. The intake was assigned for a CPS investigation. The FVS worker saw the mother and newborn (G.R-H.) at the hospital on November 18, 2013.

On December 15, 2013, an intake was received from the King County Medical Examiner reporting the death of 29-day-old G.R-H. and suspected SUIDS[16] as the cause of death. The report also alleged neglect of the older sibling. The mother reported she put her older child in a high chair around 11:00 p.m. At about 11:30 p.m. the mother reported she placed G.R-H. on her chest, facing up and they fell asleep. The mother woke around 4:00 a.m. and found G.R-H. non responsive. The two and a half-year-old child was still in the highchair. The mother called 911 for assistance. Law enforcement responded and conducted an investigation.

Committee Discussion

During the course of the review, committee members discussed critical decision points throughout the case, initial and ongoing assessment of safety and risk, utilization of assessment tools, service referrals for assessment purposes (UAs, mental health assessments) and shared decision making. The Committee discussed how CA's Safety Framework stresses the importance of gathering information regarding child safety and risk throughout the life of a case and the importance of verifying information received through collateral contacts to ensure a thorough assessment of child health and safety.

The Committee was impressed with the FVS worker and her ability to positively interact with the mother and build a trusting, child focused relationship. After interviewing the FVS worker the Committee also commended her for working

[14] 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 Practices and Procedures Guide 2220 (D)]

[15] Neonatal abstinence syndrome (NAS) is a group of problems that occur in a newborn who was exposed to addictive illegal or prescription drugs while in the mother's womb. [Source: PubMed Health www.ncbi.nlm.nih.gov]

[16] Sudden unexpected infant deaths are defined as deaths in infants less than 1 year of age that occur suddenly and unexpectedly, and whose cause of death are not immediately obvious prior to investigation. [Source: www.cdc.gov]

hard to maintain regular health and safety visits even when the mother regularly moved. The locations included extremely remote and lengthy distance as well as a secured domestic violence residence which required prior authorization to enter. The worker also discussed that while her caseload count may not have been high, the destinations she needed to travel to were not local and travel time was extensive. The travel time negatively impacted her ability to conduct other case work duties.

During the course of the review process the Committee discussed the entire CPS history for the mother and children. The Committee believed the first investigation starting in August 2012 was not investigated thoroughly and the SDM[17] was not completed accurately. As the case progressed with additional intakes, the Committee discussed the lack of services to assess and address concerns regarding the allegations of substance abuse and mental health issues of the mother. The Committee felt social workers repeatedly failed to acknowledge concern for possible substance abuse except for one documented case note by a worker who was not assigned to the case. The Committee was concerned about the lack of verification with the [redacted] pain clinic regarding the mother's reported use of [redacted] for treatment of chronic pain. The Committee expressed concern that historical information was not being reviewed and considered in the subsequent active CPS investigations.

There were discussions regarding the SDM and Investigative Assessment tools. Specifically, there was concern regarding the lack of understanding of the definitions for the 17 safety threats embedded within the tool. A discussion occurred regarding the continuous need to refresh the workers' understanding and utilization of the assessment/investigative tools. The Committee questioned whether the tool is useful if there continues to be an ongoing need to refresh seasoned workers understanding of the tool.

The Committee was concerned at the low number of FVS workers for this specific office. It was identified by the FVS worker that before the child fatality the office had two FVS workers. The Committee was also concerned about supervision to the assigned FVS worker on this case. While committee members acknowledge turnover of staff is an ongoing issue, they were concerned by the two month period for which the FVS worker had to utilize supervision from another CPS

[17] The Structured Decision Making Risk Assessment (SDMRA) is a household-based assessment focused on the characteristics of the caregivers and children living in that household. By completing the SDMRA following the Safety Assessment, the worker obtains an objective appraisal of the risk to a child. The SDMRA informs when services may or must be offered. Source: DSHS Children's Administration Practices and Procedures Guide 2541.

supervisor within the office while a new supervisor was hired. The new FVS supervisor was hired a couple weeks before the fatality occurred. The Committee agreed the current FVS supervisor was providing positive and strong support to the FVS worker. The case load count was provided to the committee. The FVS worker had 14 cases at the time of the fatality. The case count was not determined to be unreasonable by the Committee.

The Committee discussed how regular Multi-Disciplinary Team (MDT) staffings through the Child Advocacy Centers (CAC) are beneficial to investigations for CPS and law enforcement. This is not a process currently occurring in King County according to the social workers and supervisors interviewed. The size and population of King County was discussed and the challenge it would present for all the agencies to attend a regularly scheduled MDT staffing. However, as an accredited member of the National Children's Alliance, which King County's Children's Justice Center is, it is expected that case reviews should occur no less than once a month.[18]

When discussing systems issues and investigations with law enforcement involving SUID/SIDS investigations numerous Committee members recommended a urinalysis when the situation involves a parent co-sleeping/bed sharing with a current allegation of substance abuse. A majority of committee members expressed a desire for the King County MDT to discuss this recommendation as best case practice.

There was concern for what appeared to be a lack of engagement by the investigative social workers with the father of G.R-H.'s older sibling. There was not a strong effort to communicate with the father or his family prior to the case opening for voluntary services. The paternal grandmother called in two intakes and the father of the surviving child called in one intake. The lack of integrating identified risks from the Homebuilders report into a safety plan or case plan was also discussed.

Findings

1. During the first investigation the witnesses were not interviewed. The Investigative Assessment and Structured Decision Making Tools were not accurately completed. The errors were not corrected at a supervisory review.
2. There were missed opportunities to offer voluntary services during the first investigation. A staffing with the Assistant Attorney General regarding

[18] Standards for Accredited Members Revised 2011, National Children's Alliance www.nationalchildrensalliance.org

the filing of a dependency petition would have been appropriate upon the receipt of the Medical Consultant's report in August of 2013. The investigative process could be strengthened through the use of substance abuse and mental health evaluations.

3. The intake on December 18, 2012 should have screened in for CPS investigation.
4. The safety plan developed in May 2013 did not include plan participants in the process as required by policy.
5. The Committee was concerned about the lack of timely communication by the contracted Triple P provider to the assigned FVS worker.
6. The Committee believed best practice would have been to conduct a home visit immediately after G.R-H. was discharged home and to have made collateral contact with her pediatrician to monitor her care and safety.
7. The Committee wanted to commend the FVS worker for establishing a very positive and appropriate relationship with the mother which was acknowledged by the Committee to be a difficult task. The FVS worker impressed the Committee by her clear position of safety first as opposed to placing more value on a positive relationship with the mother.
8. There were good joint investigations with law enforcement starting in May 2013. The Committee was impressed by the use of a hair follicle test when the mother was tested for substance use/abuse and the fact that the FVS worker communicated concerns to providers supervisors associated with this case regarding timely documentation.

Recommendation

1. The Committee recommended re-instating the placement of chemical dependency professionals within the DSHS offices.