Washington State Department of Social & Health Services

CA Children's Administration

Child Fatality Review

J.H.

May 2008
Date of Child's Birth

January 8, 2014
Date of Fatality

June 10, 2014
Child Fatality Review Date

Committee Members
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RCW 74.13.640

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Executive Summary

On June 10, 2014, the Department of Social and Health Services, Children's Administration convened a Child Fatality Review[1] to examine the department's practice and service delivery to a five-year-old and his family. In this report the initials J.H. reference the child.

The incident initiating this review occurred on January 8, 2014, when emergency medical responders were unable to resuscitate J.H. following a 911 call regarding an unresponsive child at the family home. First responders described the conditions of the residence as "deplorable" with an overwhelming smell of animal feces. CPS investigated similar home conditions a year earlier. According to the Thurston County Coroner, the child died from acute streptococcal pneumonia of the lungs,[2] with Prader-Willi Syndrome[3] (PWS) as a contributory cause. The manner of death was determined to be natural.

The CFR Committee included CA staff and community members selected from disciplines with relevant expertise including child and family counseling, domestic violence, child and family advocacy, public child welfare and child abuse investigation. None of the participating Committee members had any prior involvement with the family. Although unable to be present during the review, a physician provided written consultation to the Committee regarding the noted medical issues the child had at the time of the death.

Prior to the review, each Committee member received a summary of the mother's CA history as a child, the father's prior CPS involvement regarding his other children from previous relationships, a chronology of CA involvement (2008-2014) with J.H. and his family,[4] and relevant unredacted CA case

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[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 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 child. A CFR 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 death. Nor is it the function or purpose of a CFR to recommend personnel action against DSHS employees or other individuals.

[2] Streptococcus pneumonia is a bacterium commonly found in the nose and throat. The bacteria can sometimes cause severe illness in children, the elderly and other people with weakened immune systems. It spreads person to person by inhaling or direct exposure to the bacteria droplets through coughing or sneezing from an infected person. Symptoms can include an abrupt onset of fever or chills, headache, cough, chest pain, disorientation, shortness of breath, and weakness. [Source: The Center for Acute Disease Epidemiology]

[3] Prader-Willi Syndrome (PWS) is a rare genetic (chromosomal) disorder present at birth. A key feature is the constant feeling of hunger that usually begins after the first year of life. There is no cure for PWS. Growth hormone, exercise, and dietary supervision can help build muscle mass and control weight. Other treatments may include sex hormones and behavior therapy. Most people with PWS will need specialized care and supervision throughout their lives.

[4] The names of J.H.'s parents are not included in this report as no criminal charges emerged from the investigation of the death of their son. The names of J.H.'s siblings are subject to privacy laws. [Source: RCW 74.13.500(1)(a)]

documents (e.g., intakes, case notes, safety assessments, investigative assessments).

Supplemental sources of information and resource materials were available to the Committee at the time of the review, including information provided by the Committee medical consultant, medical articles on PWS and strep pneumonia, the contracted Family Preservation Service provider's summary of services (2013), and the deceased child's medical records.

During the course of the review, the Committee interviewed the Tumwater Child Protective Services supervisor and the Family Voluntary Services worker involved in the case prior to the fatality. Following review of the case file documents, completion of the staff interviews, and discussion regarding department activities and decisions, the Committee made findings presented at the end of this report. The Committee made no recommendations.

Case Overview

CA first became aware of the family in November 2008, six months after the birth of J.H. and his twin sister when the father alleged his partner had been neglecting their two children prior to her leaving the home following a domestic violence incident. Lacking specific allegations that met legal definitions of abuse or neglect, the intake screened out. Similarly, a report of lack of prenatal care by the mother in May 2009 also screened out.

In October 2009, CA received information from an anonymous source regarding significant health hazards in the home, parental failure to meet the children's basic needs (feeding, changing, supervising), and failing to meet the needs of a special needs child. The intake screened in for CPS investigation of allegations of negligent treatment. Investigative activities did not confirm the allegations made by the anonymous referrer and the case closed late December 2009.

In October 2010, CA intake received information regarding lack of adequate supervision in the home and frequent use of alcohol and marijuana by the parents. Assessed at intake to be low-level neglect allegations, case assignment went to alternate response.[5]

In late 2011, CA received allegations that the father had been drinking alcohol while driving two of his other children back to their custodial parent following

[5] In 2010, Alternate Intervention Policy required CPS to respond within 10 calendar days to an alternate intervention intake. The CA social worker could send a letter, make a phone call to the caretakers(s), or make a brief home visit. CA could also send such an intake to an Early Family Support Service or other community agencies willing to accept the intake for services and/or monitoring.

visitation. The assigned CPS investigator was unable to gather sufficient evidence to verify the allegation and the case closed January 2012 with an unfounded finding.

A year later in March 2013, CA intake received information regarding significant health hazards in the home, such as animal feces and garbage throughout the home. Having verified the reported conditions of the home, the CPS investigator founded the allegations of negligent treatment by the parents to J.H. and his three siblings.[6] The mother agreed to participate in Family Voluntary Services[7] and Family Preservation Services[8] were initiated to help improve the home conditions, to provide concrete services (e.g., funds for utilities, clothing, and cleaning supplies), and to support the mother and children in connecting with services in the community. The father moved out of the home under a No Contact Order stemming from a domestic violence incident and did not make himself available to services. The case closed July 30, 2013.

On January 9, 2014, local law enforcement notified CA that J.H. had died a day earlier, when, following a 911, emergency medical responders were unable to resuscitate J.H. First responders described the conditions of the residence to be "deplorable" with an overwhelming smell of animal feces, similar to the home conditions a year earlier that CPS had investigated. At the time of the fatality it was unknown if the health hazards observed in the home had contributed to the child's death. The department filed dependency petitions on the surviving siblings who were court ordered into out-of-home care. When completed, the CPS investigation supported a founded finding as to the allegation of negligent treatment based on the clear and present neglectful conditions found at the home.

As later determined by the Thurston County Coroner, J.H.'s cause of death was acute streptococcal pneumonia of the lungs, with Prader-Willi Syndrome as a contributory cause. The manner of death was determined to be natural. There

[6] CPS findings in Washington state follow a preponderance of evidence standard rather than "clear and convincing evidence" or "reasonable doubt" standards of proof. In this way "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." [Source: RCW 26.44.020(9)]

[7] Families involved in CPS investigative cases that need in-home services, transfer to Family Voluntary Services (FVS). A Voluntary Case Plan seeks 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 parent's protective capacity and manage child safety. Continued assessment of child safety occurs throughout the case.

[8] Family Preservation Services means in-home or community-based services that draw on the strengths of the family and its individual members, while addressing family needs to strengthen and keep the family together where possible. FPS services may focus on services designed to improve parenting skills, to promote a safe, stable, and supportive family environment, and to foster the well-being of the children and their adult caregivers. [Source: RCW 74.14C.010]

are no criminal charges pending regarding the circumstances surrounding the child's death.

CFR Committee Discussion

While some discussion occurred as to earlier public child welfare involvement with the family (2008-2012), the major focus centered on the written and worker verbal accounts regarding CA case activities and decisions during the CPS and FVS involvement in 2013. No in-depth discussions occurred as to the CPS investigation of the fatality with the exception of reviewing initial concerns that the child's illness (streptococcal pneumonia) may have been impacted by neglectful care and the subsequent opinion of the Committee medical consultant that the concerns were not supported by medical science.

In the process of evaluating CA intervention efforts with the family, some generalized discussion occurred regarding intergenerational child abuse and neglect, patterns of chronic neglect, and the impact of consistent environmental chaos and dysfunction in the face of persistent multiple risk factors (e.g., domestic violence, drug and alcohol issues, poverty). The Committee noted numerous barriers to family engagement, including rural isolation that made access to services difficult.

The Committee utilized staff interviews to provide additional sources of information for consideration. This included inquiry and discussions about caseload size of the assigned social workers, the general makeup of the supervisory unit in terms of worker experience levels and availability of trained investigators, staff turnover, and changes in management at the Tumwater DCFS office. Brief discussion occurred regarding the expedited closure of the Family Voluntary Services in July 2013, due to the worker closing out many of her assigned cases prior to temporarily leaving her position with the department.

The Committee acknowledged the challenges faced by CA to maintain a high level of practice during a time of significant workload, staff turnover, and reliance on workers with relatively limited experiences in child protection.[9] The Committee was unable to conclude with certainty the impact of such circumstances on case practice in this case.

At completion of the review of the case file documents, staff interviews, and discussions regarding CA activities and decisions, the Committee found no critical errors by the department. However, the Committee did identify several

[9] DSHS Strategic Plan Metrics – Children's Administration (April 2014): "It takes an average of two years for an investigator to become proficient. It takes an average of 3 months to hire a new CPS investigator. The high turnover rate also impacts staff that remains. They are burdened with higher caseloads and mentoring new staff."

opportunities where additional reasonable actions by the worker might have served to enhance the assessment of the parents' ability to meet the safety and well-being needs of their children, including J.H. The inclusion of this information below serves as suggested areas where improved practice could have occurred.

Findings

Intakes

- In review of all intakes associated with J.H. and his family, the Committee found the intake decisions and assigned response times to be generally supportable. However, two intakes were identified (2008, 2010) where different decisions at intake might have also been reasonably supportable, but the Committee was unable to reach full consensus on these.
- The May 2013 intake (screen out) included information that the parents had been allowing registered sex offenders to frequent the home. While no specifics were provided at intake to indicate the identified registered sex offenders had unsupervised access to the children, a decision to screen in the report for Risk Only[10] would have been supportable.

CPS Investigations

- During the course of the 2009 CPS investigation, the worker interviewed the parents together. Given the documented intimate partner violence history involving the parents, separate interviews of the parents should have occurred, as is currently supported in the CA Social Worker's Practice Guide to Domestic Violence (February 2010).[11]
- In 2012, the worker completed a risk assessment (SDM®)[12] on the custodial parent's household rather than the household of J.H.'s father who was the identified subject of the investigation. This was not consistent with CA procedures that direct workers always assess the subject's household if the subject is a parent.

FVS (2013)

- Although the Committee noted several instances of good social work practice by the FVS worker, the worker admittedly failed to follow CA

[10] CA will screen in a CPS Risk Only intake when information collected lacks allegations but 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]

[11] DSHS/Children's Administration: Social Worker's Guide to Domestic Violence (published February 2010; revised May 2012). **www.dshs.wa.gov**/pdf/Publications/22-1314.pdf

[12] The Structured Decision Making (SDM®) risk assessment is an actuarial household-based assessment focused on the characteristics of the caregivers and children living in that household. By completing the SDM following the Safety Assessment, the worker obtains an objective appraisal of the risk to a child. The SDM® informs when services may or must be offered.

policy and practice with regard to documenting home visits and contact with the children.

- Although not reaching full consensus, there were noted opportunities where the worker might have conducted more in-depth inquiries in the process of assessing risk and safety. These included following up on an incident where one of the children fell out of a window, and following up on the nature of the reported registered sex offenders having access to the children in the home.

FPS (contracted provider)

The Committee noted two concerns regarding the contracted FPS provider.

- Pairing an inexperienced FPS therapist with a family with a substantive pattern of chronic neglect was not optimal in this case.
- The FPS Exit Summary presented by the therapist at closure of services appeared minimal and lacked details regarding interventions and accomplishment of family goals.

Recommendations

The Committee made no recommendations.