Washington State Department of Social & Health Services

CA Children's Administration

Child Fatality Review

L.H.

June 2015
Date of Child's Birth

September 21, 2015
Date of Fatality

December 3, 2015
Child Fatality Review Date

Committee Members

Mary Moskowitz, J.D., Office of the Family and Children's Ombuds

Robert Welch, MSW, MHP LSWAIC, CDPT, Behavioral Health Specialist, Metropolitan Development Council

Stephanie Frazier, Child Protective Services and Family Voluntary Services Program Manager, Department of Social and Health Services, Children's Administration

Tim Kelly, Program Manager, Department of Social and Health Services, Children's Administration

Chad Harty, Family Voluntary Services Supervisor and Child and Family Welfare Services, Department of Social and Health Services, Children's Administration

Observer

J. Christopher Graham, Ph.D., Senior Reports and Data Developer/Designer, Children's Administration Data Management and Reporting Section

Consultant

Shea Hopfauf, Social and Health Program Consultant Region 2, Department of Social and Health Services, Children's Administration

Facilitator

Libby Stewart, Critical Incident Review Specialist, Department of Social and Health Services, Children's Administration

Table of Contents

Executive Summary

On December 3, 2015, 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 three-month old L.H. and his family.[2] The child will be referenced by his initials, L.H., in this report.

At the time of his death, L.H. lived with his mother and a roommate. L.H.'s father lived in a separate residence. On September 21, 2015, L.H. was found to be unresponsive after taking a nap. The circumstances surrounding where L.H was sleeping or if he co-slept with anyone remains unclear. Kent Police responded to the home as did an investigator from the King County Medical Examiner's Office. There were no observable signs of injury. At the time of the fatality, the family had an open Family Voluntary Services case with Children's Administration. There was also a visiting public health nurse working with the family.

The review Committee included members selected from diverse disciplines within the community with relevant expertise including, the Office of the Family and Children's Ombuds, a Child Protective and Family Voluntary Services program manager with CA, an Evidence Based Services program manager with CA, a co-occurring therapist[3] with a community chemical dependency agency and a FVS/Child and Family Welfare Services supervisor with CA. There was a consultant and one observer from CA. Neither CA staff nor any other Committee members had previous involvement with this family.

Prior to the review, each Committee member received a case chronology, a summary of CA involvement with the family and unredacted CA case documents (e.g., intakes, investigative assessments, and case notes). Supplemental sources of information and resource materials were available to the Committee at the time of the review. These included medical reports, law enforcement reports, relevant state laws, and CA policies.

[1] Given its limited purpose, a Fatality Review (CFR) should not be construed to be a final or comprehensive review of all of the circumstances surrounding the near 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 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 near 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] No criminal charges have been filed relating to the incident and therefore no names are identified. [Source: RCW 74.13.500(1) (a)].

[3] Formerly known as dual diagnosis or dual disorder, co-occurring disorders describe the presence of two or more disorders at the same time. For example, a person may suffer substance abuse as well as bipolar disorder. [https://www.psychologytoday.com/conditions/co-occurring-disorders]

During the course of this review the Committee interviewed the public health nurse, FVS worker and supervisor and CPS investigator of the fatality.

Family Case Summary

The mother first came to the attention of CA on June 18, 2015, when an intake was received stating L.H. was born. Both mother and child tested positive for opiates. The mother told the hospital staff she used leftover pain medication from a prior automobile accident during her pregnancy when she started to feel bad. The report included that the mother did not start prenatal care until she was twenty-four weeks pregnant and the baby was born prematurely at 35.6 weeks. The report stated the baby was showing signs of withdrawal and was being monitored.

The CPS worker contacted the mother and maternal grandmother as part of the assessment. At the time of his birth, there were two alleged fathers. One of the alleged fathers contacted the CPS worker and reported that the other alleged father was an intravenous drug user. The hospital referred the family for a public health nurse. The case was accepted for FVS services and a transfer staffing was held on July 1, 2015.

On July 2, 2015, a safety plan was written and agreed to between CA, the mother and maternal grandmother. The grandmother agreed to make daily, in-person contact with the child and mother. The mother agreed to voluntary services including random urinalysis, a parenting class and a public health nurse referral. It is unclear how many times the mother and alleged father were requested to provide random UA's. There were only two urinalyses submitted by the mother. The first urinalysis was shortly after the birth of the child. The second urinalysis was on September 2, 2015. The second urinalysis was diluted. The mother failed to regularly engage with the FVS worker. The public health nurse reported to CA that the mother and baby were doing well and she did not see any signs of drug use.

Committee Discussion

For purposes of this review, the Committee focused on case activity from the day L.H. was born up until the day of the fatality. The CPS investigation regarding the fatality was briefly discussed; however the focus of the review was CA's involvement prior to the fatality.

The Committee discussed actions CA could have taken to provide a more comprehensive assessment of this family. Based on the mother and child's positive urinalyses and the mother's admission to improper use of prescribed medications, an immediate chemical dependency assessment would have offered CA a clearer picture as to the mother's chemical dependency needs. There was discussion regarding the term "pseudo addiction". This term relates to inadequate pain management, which can lead to addiction of pain medication. This could also have been assessed through a chemical dependency assessment.

Another action CA could have taken was to conduct a family team decision meeting. This meeting would have allowed the parents, family supports, service providers and CA to come

together and discuss the families strengths, needs and barriers to ameliorating the circumstances which brought the family to the attention of CA.

The mother stated that she was prescribed pain medication due to an injury as a result of an automobile accident. The consensus was that it would have been appropriate for the CPS investigator to verify the mother's statement. Verifying her statement could have included a two-pronged approach: First, the worker could have requested NCIC to see if the automobile accident was listed and if not, attempted to track down a police report, if there was one, of the accident to verify its occurrence. Second, the CPS investigator could have reached out to the prescriber to speak with him or her and to verify the mother's prescription.

The Committee noted CA missed an opportunity to comprehensively assess the mother through a chemical dependency assessment, an immediate referral for random UAs, and timely follow-up regarding the mother's diluted UA. It also felt that CA missed an opportunity to comprehensively assess the child's alleged fathers for suitability and child safety.

FINDINGS

The Committee identified positive case practice during this case. Those positive actions included having a meet-and-greet between the CPS investigator, FVS worker and the mother and the referral for the PHN through the Early Intervention Program at the CA office.

The Committee did not find any critical errors and did not make any recommendations. The Committee identified an area where case practice could improve. There was a lack of comprehensive assessment related to substance abuse regarding the mother and the alleged fathers. This lack of assessment led to a failure to fully assess the safety of L.H. while in the care of his mother. The Committee noted there was a lack of verification by the assigned caseworkers regarding the mother's statements, maternal grandmother's observations during her daily contact per the safety plan and collateral contacts to fully assess the allegations.