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Children's Administration
Executive Child Fatality Review

L.W.

Novembe 2011
Date of Child's Birth

December 28, 2011
Date of Child's Death

May 11, 2012
Executive Review Date

Committee Member
Honorable Judge Paul Bastine, Spokane County Superior Court, retired
Patrick Donahue, CASA/GAL Program Coordinator, Spokane County Juvenile Court
Jenna Kiser, Child Protective Services Program Consultant, Children's Administration, Region 1 South
Connie Lambert-Eckel, Deputy Regional Administrator, Children's Administration, Region 1
Tim Nelson, Implementation and Quality Assurance Program Consultant, Children's Administration, Region 1
Susan Schultz, Program Manager, Spokane Regional Health District
Dr. Katherine Whipple, MD, Internal Medicine and Pediatrics[1]

Invitee
Representative from the Coeur D'Alene Tribe[2]

Facilitator
Nicole LaBelle, Regional Programs Administrator, Children's Administration, Region 1

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[1] Dr. Whipple is a descendent of the Spokane Tribe and member of the Association of American Indian Physicians.
[2] L.W's father was an enrolled member of the Coeur D'Alene Tribe. L.W. was not eligible for enrollment. A representative of the Tribe declined participation with this Executive Child Fatality Review.

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Executive Summary

On May 11, 2012, the Department of Social and Health Services' (DSHS) Children's Administration (CA) convened an Executive Child Fatality Review (ECFR) Committee to review the death of a 5-week-old boy, L.W. (DOB: 1 2011; DOD: 12-28-11). L.W. was in the care and custody of his mother at the time of his death in Spokane, Washington. Prior to his death a Child Protective Services investigation was initiated from an intake in November 2011. The investigation was being concluded and the family was receiving services from CA at the time of L.W's death. CA conducts fatality reviews to identify practice strengths and challenges as well as systemic issues in an effort to improve performance and better serve children and families. The Committee reviewed case documents and interviewed CA staff to examine child welfare practices, system collaboration, and service delivery to L.W. and his family.[3]

On December 28, 2011, L.W.'s mother contacted the CA assigned social worker and reported that earlier that morning she had found L.W. unresponsive beside her in bed. L.W.'s mother called 911 and emergency responders transported L.W. to the hospital. Resuscitation attempts were unsuccessful and L.W. was pronounced dead at the hospital.

L.W. was the youngest of six children born to the mother

An autopsy was performed by the Spokane County Medical Examiner's Office noting cause of death as diphenhydramine toxicity; manner, accidental. CA learned of the Medical Examiner's conclusion on April 4, 2012.

[3] Given its limited purpose, an Executive Child Fatality Review should not be construed as a final or comprehensive review of all of the circumstances surrounding the death of a child. The ECFR 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 may not hear the view of the child's parents and relatives, or of other individuals associated with a deceased child's life or death. An Executive 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 an ECFR to recommend personnel action against DSHS employees or other individuals.

[4] Source: CA Practice Guide to Intake and Investigative Assessment, Chapter 4, page 25: CPS Risk Only Intakes are defined as intakes that do not allege child abuse and neglect as defined by WAC 388-15-009, but have risk factors that place a child at imminent risk of serious harm.

[5] The two intakes were screened out because neither contained an allegation of child abuse or neglect that under the definition of child abuse and neglect. WAC 388-15-009. The intakes were documented in Children's Administration's management information system, however CA is not authorized to act on screened out intakes.

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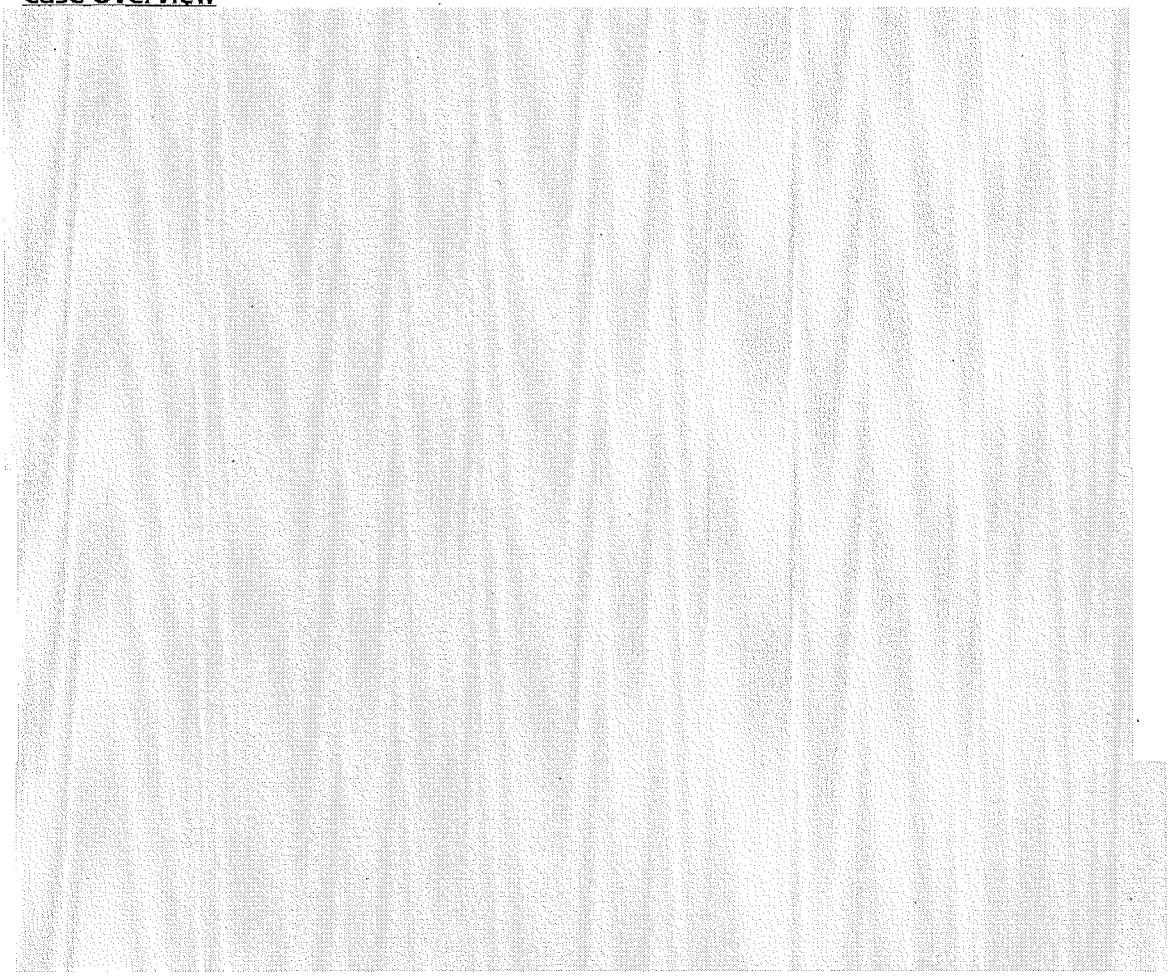
The ECFR Committee members included CA staff and community members representing disciplines associated with the case. Committee members had no involvement in L.W.'s case. A chronology of the intakes, investigations and conclusions, legal history, and services offered and provided to the family was prepared and provided to the ECFR Committee. A copy of the family's case file and L.W.'s autopsy report were also available to the Committee. Committee members interviewed the social worker, supervisor and Area Administrator assigned to the case at the time of L.W.'s death. During the course of the review the committee discussed the legal proceedings the family had been involved in, issues related to services provided to the family and service provider progress reports and summaries to CA. There was also discussion related to safe sleep practices with infants, shared decision making, and case elements.[6] Following a review of the family's history, case records and discussion, the Committee made findings and recommendations that are detailed at the end of this report.

Case Overview



[6] Activities conducted according to CA Practice and Procedure Manual and Case Services Manual e.g.) Monthly Social Worker Visits, Documentation, Investigation Criteria, Intake Decisions, etc.

[7] FamLink is Children's Administration's management information system.

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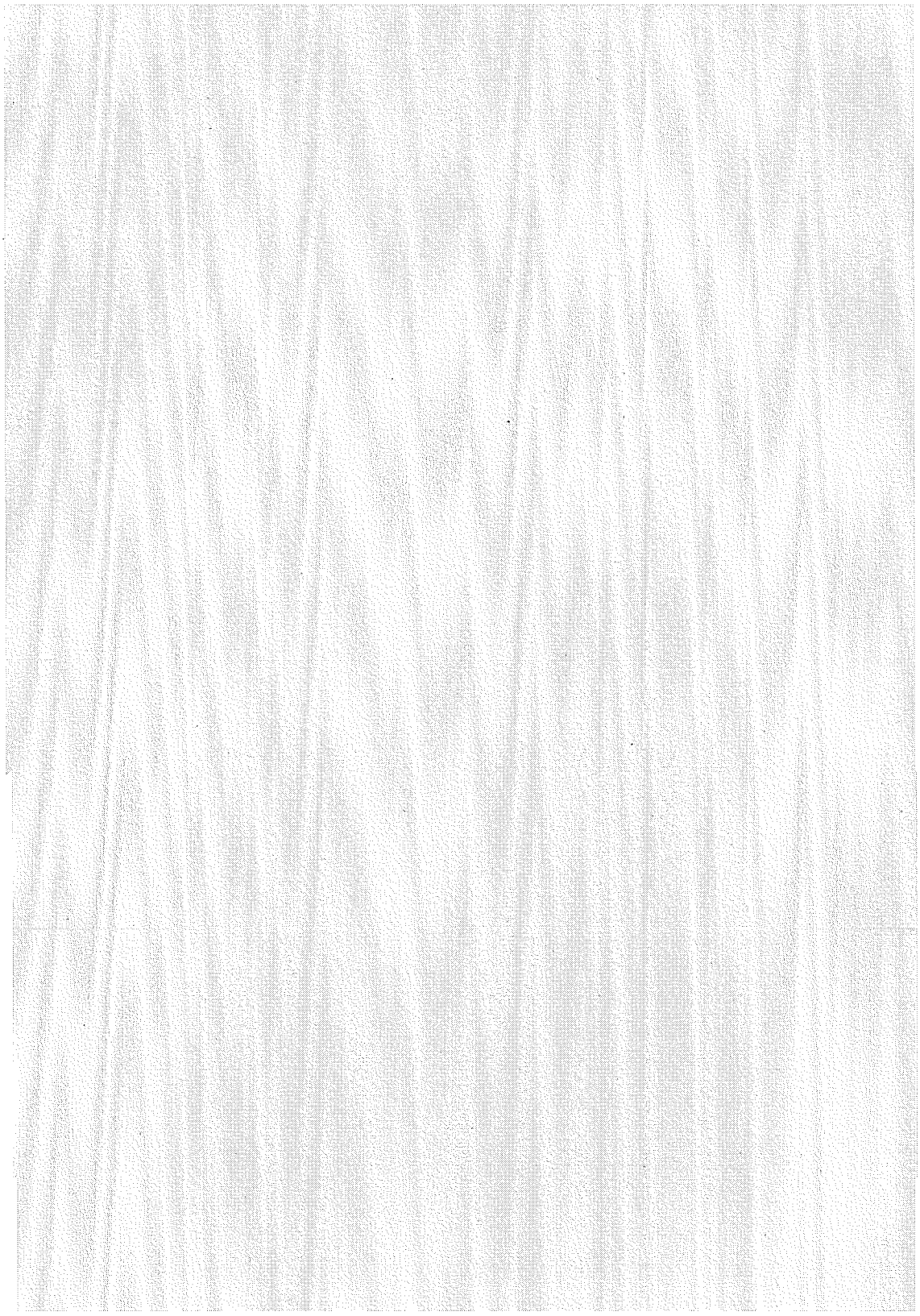

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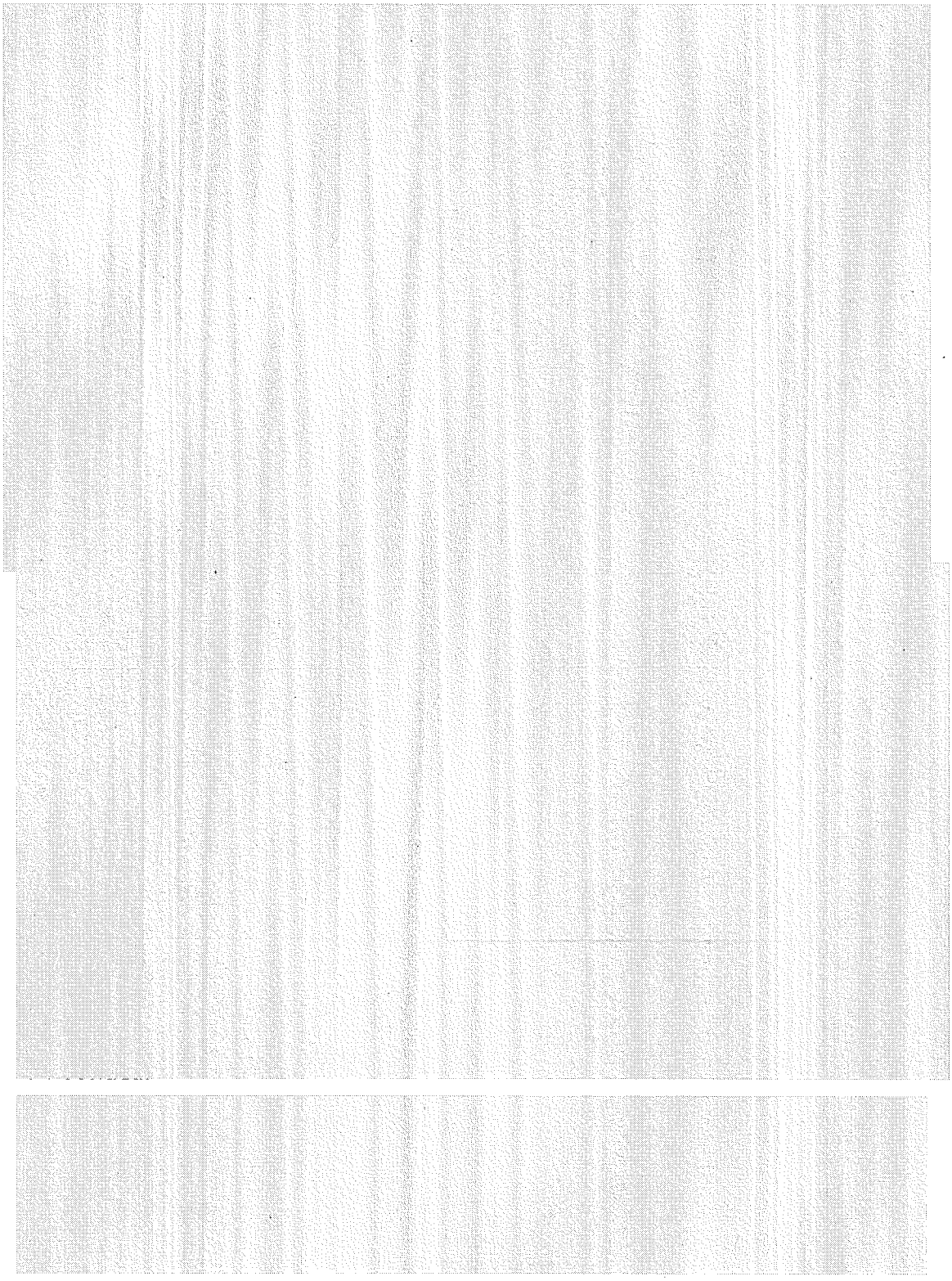

[8] Executive Order 95-04 mandates the use of Child Protection Teams. The purpose of Child Protection Teams (CPTs) are to provide consultation and recommendations on all cases where there is a risk of serious harm to the child and/or where there is dispute over whether out-of home placement is appropriate.

[redacted] she was pregnant with L.W. and gave birth to him on Novembe[redacted] 2011. The hospital contacted CA at the time of birth after the mother reported she had an open case with CPS. The intake was screened as information only.

There were no additional reports regarding L.W. or his family between the time of his birth and his death. The CPS worker was preparing the case for closure when L.W. died.

Review Committee Discussion and Findings

To develop a thorough understanding of the family and case, the review committee identified dynamics that appeared to influence decision-making by CA, e.g., intake screening decisions and investigations, identification and assessment of family

dynamics and how they affected parenting, service delivery and progress, and placement decisions. The review committee also considered the facts and information presented in the court proceedings that led to removals, reunifications and parental relinquishment. The committee requested and met with the CPS social worker, supervisor and Area Administrator assigned to the case at the time of L.W.'s death.

Casework: The committee discussed the CPS investigations, placement interventions, voluntary services delivery and dependency case management decisions made in this case over the course of the family's involvement with CA. The committee identified and acknowledged quality social work practices that encouraged the continued engagement of L.W.'s mother, especially in the wake of CA's interventions

All of the social workers that managed any element of this case also documented active and ongoing efforts in the identification and inclusion of each child's father.

CA policies and procedures appeared to be appropriately implemented and there were multiple shared decision making processes utilized throughout the life of the case to include court processes, CPT, Shared Planning meetings,[9] supervisory reviews and requested case consultations with the Area Administrator and an Assistant Attorney General.

Service Needs: The committee observed that CA staff accurately identified the issues in this case which directly impacted parenting capacities. Recommendations and referrals for services were appropriately generated to support the family in developing an understanding of issues and dynamics operating in the home.

There were two separate psychological evaluations as to L.W.'s mother These evaluations were conducted in the context of determining the mother's employability and any barriers she faced in living independently The committee identified that a referral for and completion of a psychological evaluation for the purposes of identifying challenges or barriers in parental capacity may have been helpful in this case.

The committee also identified that the mother and each sibling received some level of service from Public Health through a home visiting nurse model. Following L.W.'s birth the mother did not receive this service as it is limited through Public Health and she was not eligible when L.W. was born. The committee explored the possibility that the mother may have received more support and education regarding safe sleep practices as well as appropriate medication dispensing to her infant if she was provided services through a home visiting Nurse intervention following L.W.'s birth.

[9] Policy 4301: Shared Planning Meetings bring individuals together to help make decisions for children about safety, permanency and well-being.

Recommendations

A resource recommendation was made by the Committee pertaining to increasing State funding and resources for Public Health Nursing services to serve a broader population than currently available.