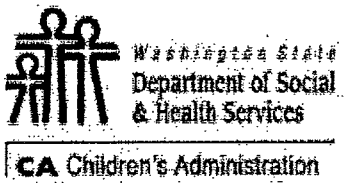
RCW 74.13.640



Child Fatality Review

V.E.

November 2014
Date of Child's Birth

December 27, 2014
Date of Child's Death

Committee Members
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Executive Summary

On April 1, 2015, the Department of Social and Health Services (DSHS) Children's Administration (CA) convened a Child Fatality Review (CFR) to assess the department's practice and service delivery to a 5 week old female child and her biological family.[1] The child is referenced by her initials, V.E.,[2] in this report. At the time of her death, V.E. was placed in the home of her paternal grandmother, V.B., in the Spokane area. The department had placed her in this home pursuant to a Shelter Care Order entered through Spokane County Superior Court. V.E. was placed in out of home care due to allegations that her parents, referred to as C.E. and D.E., were not safely able to care for her. The incident initiating this review occurred on December 27, 2014, when V.E. was found unconscious and unresponsive in the home of her parents. She had been left in their care the night before by her paternal grandmother. A cause of death has not yet been determined.

The CFR Committee included CA staff and community members selected from diverse disciplines with relevant expertise, including child welfare, mental health, medicine, and the Office of the Family and Children's Ombuds. None of the committee members had previous direct involvement with this family.

Prior to the review each committee member received a case chronology; a family genogram; a summary of CA involvement with the family; and un-redacted case documents including referrals, case notes, assessments and medical records. The hard copy of the file was available at the time of the review. Supplemental sources of information and resource materials were also available to the Committee including copies of state laws and CA policies relevant to the review and workload and case assignment data for this unit during the time that the case was open.

The committee interviewed the CPS investigator who initiated the placement, her supervisor and the CFWS social worker and her supervisor. Following a review of

[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 near-death of the 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] The parents and relatives are not identified by name in this report because no criminal charges were filed relating to the incident.

the case file documents, completion of staff interviews, and discussion regarding department activities and decisions, the Committee made findings and recommendations that are presented at the end of this report.

Case Overview

On December 27, 2014, five-week-old V.E. was found unconscious and unresponsive in her parent's home in the Spokane area. She had been removed from their care at birth and placed with her paternal grandmother, V.B., due to allegations that the parents' untreated substance abuse and instability posed a significant risk to her safety. The grandmother agreed as a condition of placement to follow the court-ordered visitation plan that specified that the parents were not to have contact with the baby without prior approval from the department. The cause of death is as yet undetermined.

Case Summary **RCW 74.13.500**

C.E. was court-ordered to participate in mental health counseling and substance abuse treatment. Services in those programs were terminated due to lack of participation. The mother's compliance with random urine analysis testing was sporadic and she admitted to ongoing use of marijuana.

On November 19, 2014, Deaconess Medical Center called to report C.E. had given birth to V.E., her third child, at 38 weeks gestation. Hospital staff had placed V.E. on an administrative hold based on concerns about both parents' history of untreated mental illness and substance abuse. Shortly after her birth, V.E. was slow to eat on her own and was placed on a feeding tube in order to ensure weight gain. A Family Team Decision-Making Meeting (FTDM)[3] was held on November 21 to determine a plan for the baby. The parents expressed their preference that their daughter be placed with the paternal grandmother and the department tentatively agreed with this plan pending the result of background

[3] Family Team Decision Making (FTDM) meetings bring people together who are involved with the family to make critical decisions regarding the removal of a child from their home, changes in out-of-home placement, and reunification or placement into a permanent home. [Source: CA Practice and Procedures Guide 1720]

checks[4] on the grandmother and her household members. The investigator reviewed the grandmother's case history in the FamLink[5] system and stated she did not find any negative actions.[6] A complete review of the grandmother's criminal history indicated she had a conviction for a drug-related crime 2001 and multiple convictions for theft dating from 2006 to 2013. The investigator reviewed this with her supervisor as well as the Child Welfare Family Services (CWFS) social worker and supervisor who were resuming ongoing responsibility for the case.[7] The investigator was asked to seek additional clarifying information from the grandmother who reported she had been through counseling to address her problems and that she had voluntarily given up her nursing license. She also related that she had been involved with CA to address conflict with her teen-aged children and had been a placement provider to another family within the past year. Prior to placement, the paternal grandmother signed an agreement that specified that the parents were not to have unsupervised contact with the baby and were not to be in her home without prior approval. It also stated that the baby was not to be left with anyone other than the paternal grandmother without department approval. The baby was discharged from the hospital on December 2 and released to the care of her grandmother.

After V.E. was placed with her grandmother, department staff conducted a health and safety visit in the grandmother's home[8] on December 11, 2014. At that time, the worker observed the baby and her sleep environment and reviewed the baby's needs with the grandmother. The assigned Child Health and Education Tracking (CHET)[9] worker visited the placement home on December 17

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[4] Background checks are required for all persons that will have unsupervised access to children in the care and custody of CA and safety plan participants with unsupervised access to the children names in the safety plan. This includes, at minimum, a review of criminal history as well as a review of CA Records to ascertain if the applicant has a criminal conviction or negative action that would disqualify them as potential placement resources.

[5] FamLink is the case management information system that CA implemented on February 1, 2009; it replaced CAMIS, which was the case management system used by the agency since the 1990s.

[6] "Negative Actions" may include a finding of abuse or neglect of a child or vulnerable adult; termination, revocation, suspension or denial of a license, relinquishment of a license in lieu of an agency negative action, DOH disciplinary authority findings, revocation, suspension, denial or restriction placed on a professional license.

[7] Child Welfare Family Services social workers assume responsibility of a child welfare care after the children have been removed from their caregivers and a dependency petition filed.

[8] CA social workers are required to visit with all children in person on a monthly basis if the case is open for services. The goal of these visits is to ensure the child is safe and the child's basic needs are met. Per policy, the majority of these contacts must take place in the home. [Source: CA Practices and Procedures Guide 4420]

[9] Child Well-Being Health and Education Tracking (CHET). Children under the legal authority of CA, who are expected to remain in care for 30 days or more, are to receive a well-being screen that assesses child's health, educational, emotional/behavioral, cultural and developmental needs. [Source: CA Practices and Procedures Guide 43092]

and reviewed the child's needs with the grandmother. The parents were provided with supervised visits four days per week at the facility of a local visitation provider. Because one of the baby's scheduled visits was to take place on Christmas day and the agency provider was unavailable, the CFWS social worker allowed the parents a single visit in the grandmother's home on Christmas Day. The worker specified that the grandmother was to supervise the parent's interactions with the baby at all times.

At approximately 6:00 am on December 27, 2014, law enforcement and emergency medical technicians were called to the parents' home to attend to an infant who was unconscious and unresponsive. Baby V.E. was transported to a nearby hospital and pronounced dead at 7:00 am. A Children's Administration intake was generated regarding this incident that alleged neglect by the grandmother for leaving the baby with the parents. In subsequent interviews, the CPS investigator learned that the grandmother had left the baby in the parents' care twice on December 26 and again in the early morning hours on December 27. The mother reported she had left the baby alone in an adult bed after feeding her at about 3:30 am. She woke at about 6:00 am and found the baby unresponsive with blood on her nose. The parents called emergency responders who were unable to revive the baby. An autopsy was done; no sign of injury, abuse, or neglect was found. Toxicology reports were still pending at the time of this review.

After the baby died, a review of the grandmother's record indicates she had been identified as the subject in 20 Child Protective Services intakes. An investigation done in 1994 resulted in founded findings[10] related to abuse and neglect. Three other investigations (completed in 1993, 1999 and 2000) were closed with inconclusive findings. In addition to the assigned CPS investigations, she and her husband have been identified in ten intakes for Family Reconciliation services.

Committee Discussion

The major focus of the Committee discussion centered on documentation regarding observations, actions, and decisions made during the CA involvement with the family in the two months prior to V.E.'s death. The Committee also considered the information gathered during staff interviews as well as policies and procedures related to non-licensed placements and background checks. The

[10] "Founded" means the determination that, following an investigation by the department, based on available information: it is more likely than not that child abuse or neglect did occur. [Source: RCW 26.44.020]

Committee also found staff interviews helpful in gaining an understanding of the internal case assignment and case transfer processes in the Spokane office.

The Committee noted very good practice regarding documentation. The case notes entered by both the CFWS and CPS workers were timely and thorough. The CPS and CFWS staff demonstrated good practice collaborating early in the case and in working together to engage the family in services. Given that the child's manner of death remains undetermined, the Committee did not reach a consensus about critical oversights or errors. However, the Committee found several categories of concern and several issues identified as missed opportunities for improved practice and increased child safety.

Placement Decision

The Committee spent a great deal of time discussing the decision to place the baby with the paternal grandmother. They noted that this baby's exposure to prenatal substance abuse and history of poor feeding indicated a need for careful monitoring. While state policy allows the department to place with unlicensed relatives prior to the completion of a home study, proper assessment is required to determine their suitability as a placement resource. In addition, prior approval must be obtained from the Area Administrator. The Committee could not find documentation that the Area Administrator(s) had approved this placement.[11]

One of the key components to assessing relatives for placement is a thorough review of the department's records, electronic and otherwise. Though some of the historic information was not available to the worker at the time of placement because it had not yet been uploaded into the department's digital archive system (MODIS), the Committee noted that the content of the prior intakes, as well as any assessments associated with them, were available for review in the current CA database, FamLink, which is accessible to all workers. Included in this available information was a Summary Risk Assessment[12] completed in 1994, which indicated a founded allegation of child abuse or neglect against the paternal grandmother. According to policy, a finding of abuse or neglect is considered a negative action and placement would have required authorization from the Regional Administrator.[13] The investigator stated computer problems prevented her from a complete review of the grandmother's history. The Committee believed that even if the finding was not available, the content of the prior allegations should have raised sufficient concern in the worker's mind to

[11] See CA Practice and Procedures Guide 45274

[12] The Summary Risk Assessment was replaced by the Investigative Assessment in 1998.

[13] See CA Operations Manual 5522

necessitate further inquiry and review. The Committee questioned whether the worker's bias toward relative placement colored how she reviewed the information in CA's own system. The grandmother's statement to staff that she had not been involved with CPS and had only sought help for her adolescent children seemed to be taken at face value.

The second major component of a background check is a review of the potential caregiver's criminal history. The Committee noted that background checks were requested in a timely manner and concurred with the worker's report that there were no disqualifying crimes that would rule the grandmother out as a placement option. While this is true, the Committee believed that both the drug charge and the multiple thefts were indicators of a need for additional assessment of the grandmother's character and reliability and a review of the placement at a higher level. The investigator seemed to place great weight on the grandmother's statement that she had been an approved placement provider in the past, though this statement could not be verified.

The Committee viewed the grandmother's admission of the relinquishment of her nursing license was another indication of a need for further corroboration. Policy states that the relinquishment of a professional license in lieu of an agency revocation is a negative action that would necessitate review by the Regional Administrator prior to placement. The worker's lack of curiosity about this issue impacted the state's ability to fully assess the appropriateness of this placement.

The Committee also felt that the efforts to assess the grandfather for character and suitability were not documented. Though background checks were completed on him that indicated no disqualifying information, the fact that he was identified as a subject in prior intakes warranted further inquiry about his role in the family and his willingness to work with the department and follow a court order.

Some discussion centered on whether or not the use of a specific placement order or an updated placement agreement form might have helped to clarify the department's expectations about parent contact. While either of these things may have provided more structure to the placement, the Committee felt that both the CFWS and CPS social workers had been very clear about the department's expectations regarding parent contact and that the grandmother's own statements verify this.

Case Assignment

Interviews with staff helped the Committee to understand case assignment processes in the Spokane office which provided a context for additional discussion. This office customarily assigns cases involving adolescents to specific units when a child reaches the age of twelve. In this case, the mother's case was re-assigned to a new CFWS social worker when her older child turned 12 in June 2014 even though they were aware at the time that the mother was pregnant. When the new intake was received at the time of the baby's birth, the intake was assigned to a CPS investigator and was then co-assigned to the original CFWS social worker, resulting in three different assigned workers. The Committee felt some consideration should be given in the future to allowing the case to remain with the same CFWS social worker who would be able to provide continuity in case planning and greater opportunities for planning prior to the child's birth.

Intake/Investigation

Though the Committee focused primarily on the actions prior to the child's death, they questioned the decision not to identify the parents as subjects in the investigation of the death. The Committee felt the fact that the child was in the parent's care when she died in violation of a court order and their admitted history of substance abuse was adequate reason to include them as subjects. This would have provided the department with the opportunity to more fully explore the circumstances of the baby's death which could be very important in assessing risk and safety in this household. In addition, the Committee was concerned that because the information about the baby's death was electronically linked to a different case, future workers assigned to this family may miss important information about parental protective capacity.

Findings

1. The Committee could not find documentation that the non-emergent placement with the grandmother was approved in advance by the Area Administrator as required by CA Policy and Procedures 45274.
2. CA policy requires background checks to assess the suitability of all persons who have unsupervised access to children in the care and custody of the department. Placement with persons whose background checks include crimes or negative actions on the DSHS Secretary's List of Crimes and Negative Actions list must be authorized in advance using the CA Administrative Approval Process. The Committee found several areas where those guidelines were not followed.
    a. The placement with the grandparents was not adequately assessed for suitability and reliability. The 1994 finding of abuse or neglect by

the grandmother is considered a negative action and placement in this home should have had approval from the Regional Administrator or Deputy Regional Administrator. In addition, The Committee could not find documentation that the character and suitability of the grandfather was assessed. There were no discussions documented with the paternal grandfather regarding his history in the CA system, his attitude about the placement, his willingness to work with the department, and follow court orders.

b. While it is true that the results of the grandmother's criminal background check did not contain any disqualifying information, the drug-related conviction, though over ten years in the past, required administrative approval, and the recent nature and extent of the theft convictions should have raised concern about the character and suitability this relative for placement.
c. The grandmother's admission that she had relinquished her nursing license should have been explored further. If she had relinquished her license in lieu of an agency negative action, approval of this placement would have needed to be completed with the Regional Administrator or Deputy Regional Administrator.

Recommendations

1. In order to ensure that relevant information about parental capacity gathered during the investigation of the child's death is included in the parent's case history, the Committee recommends that the current worker review the investigation and incorporate this in the current Comprehensive Family Evaluation.
2. The Committee recommended that the Spokane office staff work with the Alliance for Child Welfare Excellence to complete training on the application and use of the background check policy, to include the use of shared decision-making and critical thinking to evaluate history, recognize patterns of behavior, and assess a potential caregiver for suitability and reliability.
3. The Committee recommended that the Spokane office consider maintaining the case assignment with an existing assigned worker when a new child is expected, rather than re-assigning to an adolescent unit. This would reduce the number of workers assigned and may encourage the use of shared planning and early engagement to plan for the new child prior to delivery.

4. The Committee recommends that Spokane office staff seek consultation with the home study unit in assessing the suitability of non-licensed placements prior to making placement decisions.