RCW 74.13.500

Children's Administration

Executive Child Fatality Review

R. E. Case

Date of Birth: 01/ /2007
Date of Death: 07/03/2009
Date of Review: 11/20/2009

Committee Members:
Debbie Fenske, Area Administrator, Division of Children & Family Services (DCFS), Region 1
Debbie O'Neil, Assistant Service Area Manager, Department of Early Learning, Eastern Washington
Rory Schilling, Social Work Supervisor, DCFS, Region 2 (Walla Walla Office)
Roy Simms, MD, Regional Medical Consultant, Region 2

Observers:
Sheri Hart, Social Worker 3, Division of Licensed Resources (DLR), Children's Administration
Rachel Pigott, Special Projects and Data Base Coordinator Office of the Family and Children's Ombudsman
Robert Rodriquez, Child Protective Services Program Manager, DCFS, Region 2
Rocio Romo-Burkhardt, Licensing Supervisor, Department of Early Learning, Yakima
Jennifer Triggs, Social Work Supervisor, DLR, Children's Administration

Facilitator:
Marilee Roberts, Practice Consultant, Office of Risk Management, Children's Administration

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Executive Summary

On July 3, 2009, Children's Administration (CA) Central Intake (CI) accepted an intake from Grandview Police Department reporting the death of 2 ½-year old R.E. The referent stated that they responded to R.E.'s family home along with Emergency Medical Technicians (EMT) after receiving a 911 call. They found R.E. non-responsive, not breathing and cold to the touch. EMTs transported the child to Sunnyside Community Hospital where he was pronounced dead shortly after arrival in the emergency room. Law enforcement and medical staff reported R.E. presented with suspicious bruising to the right side of his head. Based on a preliminary assessment as reported by law enforcement, R.E. died in what appeared as suspicious circumstances and an investigation followed. CA did not have an open case on this family at the time of R.E.'s death,

The Thurston County Medical Examiner conducted an autopsy at the request of the Yakima County Coroner. Information from the Division of Licensed Resources/Child Protective Services investigation indicated R.E. had a history of a fall from a bicycle at an unlicensed child care home and suffered a brief illness prior to his death. Autopsy results noted recent hemorrhage of the duodenum. However, the cause of the hemorrhage was undetectable at autopsy and could have resulted from blunt impact injury such as falling off a bicycle. The Medical Examiner found no evidence of lethal head trauma despite the contusion on R.E.'s forehead. The autopsy determined *cause of death as acute peritonitis; manner as undetermined.*

Information provided by the referent said R.E. had been attending child care in an unlicensed home on a regular basis prior to his death. The referent reported R.E. had fallen off a bicycle and became ill while at child care two days before his death. Therefore, in conjunction with Division of Children and Family Services (DCFS) Child Protective Services (CPS) and law enforcement, investigations by the Department of Early Learning[1] (DEL) and the Division of Licensed Resources Child Protective Services[2] (DLR/CPS) were also conducted.

A review of the family's history with CA notes six previous intakes prior to the R.E's death. Family composition at the time of the intakes included R.E.'s mother, father and two siblings ages 15 and 8. Three intakes alleging physical abuse and neglect (supervision) screened as low risk resulting in either a low risk letter being sent to the family or a referral to an Early Family Support Services (EFSS[3]) program. Three other intakes include two identified as Third Party reports referred to law enforcement and one intake screened as information only.

The record reflects no intakes were screened at a level requiring a high standard child protective services (CPS) investigation or face to face interview with the children or the

[1] Department of Early Learning has authority over child care facilities.
[2] Division of Licensed Resources child protective services investigates allegations of child abuse and neglect in licensed and unlicensed child care facilities.
[3] EFSS is a voluntary service offered to families when an intake meets the criteria for alternate intervention.

family. In addition, no intakes received referencing this family's history identified the deceased child as an alleged victim of child abuse or neglect.

In May 2009 CA did refer the family to services (Early Family Support Services) following receipt of an intake referencing sibling conflict and parental supervision. Though the case was closed to CA at the time of R.E.'s death services were being offered in the home by a contracted provider. The contracting agency notifies CA of any service intervention, their outcomes and recommendations for future service need. A written exit summary was provided to CA and is included in the family's case file.

In November 2009, Children's Administration (CA) convened an Executive Child Fatality Review[4] (ECFR) committee to review the practice and service delivery in the case involving R.E and his family.

Committee members included a diverse group of CA staff representing several regions and programs. Review committee members[5] had no involvement in the R.E. case. Team members were provided case documents consisting of family history/chronology including all intake information, police report, a summary of the autopsy results prepared by Dr. Roy Simms, CA Region 2 Medical Consultant, and the medical examiner and coroner's information and findings. In addition, the social work supervisor overseeing the fatality investigation was available for questions by review team members.

During the course of the review team members discussed screening decisions on previous intakes received, service delivery parameters and effectiveness affiliated with the EFSS program, and departmental (Children's Administration and the Department of Early Learning) expectations regarding knowledge of and intervention in unlicensed child care facilities.

Following review of the documents, case history and consultation with the social work supervisor the review committee made findings and recommendations which are detailed at the end of this report.

Case Overview

[4] Given its limited purpose, a Child Fatality Review by Children's Administration should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. A review is generally limited to documents in the possession of or obtained by DSHS or its contracted service providers and the panel may be precluded from receiving some documents that may be relevant to the issues in a case because of federal or state confidentiality laws and regulations. A review panel has no subpoena power or authority to compel attendance and generally will only hear from DSHS employees and service providers. The panel may 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 take personnel action or recommend such action against DSHS employees or other individuals.

[5] A member of law enforcement was included in the review team, but was unable to attend the review due to an emergency.

The review committee reviewed all six CPS intakes referencing this family and the screening decisions made. The following is a brief description of each intake and action taken by CA.

Intake 1

Intake 2

Intake 3

Intake 4

[6] Alternative Response Services (ARS) at the time of this intake. Program is now entitled Early Family Support Service (EFSS).

Intake 5

[redacted]

Intake 6

On May 12, 2009 an *intake was screened in for Early Family Support Services* following allegations by R.E.'s brother (now age 8 years) his sister (now age 15 years) continue to pinch and hit him causing injury. Information was reported in the past and the referent is concerned that the older siblings are dishonest to their parents about their interactions. The referent further reported R.E.'s brother spends a great deal of time at his grandmother's home who has expressed concern about his behaviors. It has been reported he is defiant and having disciplinary problems at school. Upon referral to EFSS CA policy requires closure of the case while a contracted EFSS provider engages the family in services to address issues related to the allegations.

The EFSS provider documented initial contact (June 2009) and screening with the family to discuss services; however, were unable to maintain contact with the family citing scheduling issues with R.E.'s mother. An EFSS exit summary received on July 10, 2009 indicates given the circumstances at the time, R.E.'s death on July 3, 2009, the family refused services. The EFSS case was closed.

Intake 7

The next CPS contact with the family was on July 3, 2009 reporting R.E.'s death. Law enforcement and EMTs responded to the family home and found R.E. in the home with his father, an older sibling, her son and two friends of the older sibling. R.E. was unconscious, not breathing and cold to the touch. EMTs transported R.E. to Sunnyside Community Hospital. Upon admission the referent stated emergency room personnel noted several bruises on R.E. including a contusion to the right side of his forehead. Despite attempts to resuscitate R.E. he was pronounced dead shortly after arriving at the hospital. An autopsy was scheduled for the following Monday (July 6, 2009) to determine cause and manner of death. The initial child abuse and neglect allegations referencing the parents were listed as: *Neglect and Negligent Treatment regarding R.E.'s mother and Physical Abuse regarding his father.*

During the course of the investigation investigators learned R.E. was attending child care in an unlicensed facility.[7] Investigators were told R.E. had suffered a fall off a tricycle

[7] Division of Licensed Resources CPS intake was generated and assigned for investigation. DLR/CPS investigated findings regarding negligent treatment on the part of the unlicensed child care provider was

while in child care on July 1, 2009. It was believed the fall was the cause of the bruising to his forehead. The child care provider said she notified the parents of the incident and recommended they seek medical care. On the following day, July 2, 2009, while at child care R.E. became ill, began vomiting and running a fever. Again, the child care provider recommended to the parents that R.E. should see the family's primary care physician. The child care provider told investigators R.E.'s father deferred such decisions to the child's mother.

On July 3, 2009, R.E. was dropped off at child care by R.E.'s mother who told the provider he did not sleep well the previous evening and continued to present with discomfort, vomiting, and fever. As the day progressed the unlicensed child care provider stated she attempted to reach R.E.'s mother on several occasions to inform her of R.E.'s condition, gain permission to medicate R.E., and again recommend he see a physician. The provider told investigators R.E.'s mother expressed concern regarding the time it would take to bring R.E. to the doctor and the cost of medical care.[8] R.E. was picked up at child care at approximately 4:40pm on July 3, 2009 and arrived home at 5:00pm.

While at home the family was unsuccessful in getting R.E. to eat or drink without vomiting. Shortly after arriving home he lost consciousness. Emergency personnel arrived at approximately 5:35pm and resuscitation efforts began, however were unsuccessful. Final autopsy (including toxicology) report received on October 5, 2009 indicates *cause of death: acute peritonitis; manner: undetermined.*

Law enforcement did not place the other children in the home into protective custody at the time of initial contact on July 3, 2009. However, it was recommended by both law enforcement and CPS the children stay with their maternal grandmother (background clearances were completed and clear) until the investigation was completed.

Conclusions of Death Investigation

CPS investigative findings regarding the July 3, 2009 intake are as follows:

R.E.'s Mother – Neglect/Negligent Treatment - Founded
R.E.'s Father – Physical Abuse - Unfounded
Neglect/Negligent Treatment[9] - Founded

Review team members agreed with the founded findings in the July 2009 death of R.E. Review of medical information and autopsy/coroner's reports indicated R.E.'s death was potentially preventable if the infection had been recognized and treated by a physician. The parents' delay in seeking medical care and the progression of R.E.'s illness necessitated contacting a physician and constituted neglect.

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deemed *unfounded*. Department of Early Learning initiated their own investigation into the operation of an unlicensed child care provider.

[8] Records indicate the family's Medicaid was current for the month of July 2009.

[9] Allegation of neglect/negligent treatment was added post intake during the investigation phase based on evidence gathered during course of the investigation.

The review team members discussed screening decisions on intakes prior to the July 3, 2009 death report. Although no intake identified R.E. as a victim of abuse and neglect, review team members did indicate screening decisions on intakes received on September 21, 2007, December 9, 2007 and May 12, 2009 should have screened in for investigation based on information at time of intake and history.

Issues related to unlicensed child care providers and what intervention is required were discussed by committee members. In this particular case both the DLR/CPS and Department of Early Learning (DEL) initiated investigations into the death of R.E.

The DLR/CPS investigation focused on issues related to child abuse and neglect by an unlicensed child care provider. Specifically allegations of neglect[10] and failure to report abuse/neglect on behalf of the unlicensed provider were made. Investigation findings were *unfounded* based on the following:

- The Washington State child abuse and neglect mandated reporting law (RCW 26.44.030) does not reference or require unlicensed child care providers as mandated reporters.
- Evidence obtained via witness statements supported information that the child care provider attempted on several occasions to encourage both parents to seek medical care for R.E.
- The child care provider requested her daughter, who worked with R.E.'s mother, to speak with her face to face and emphasize the need to obtain medical care for R.E.
- The child care provider sought and received parental permission prior to administering any medication to R.E.

Oversight of unlicensed child care facilities is conducted by DEL. When an unlicensed facility is identified, as in this case, DEL contacts the provider regarding licensing expectations and follows up with a cease and desist letter[11] until such time the provider is licensed. Only if the child care provider continues to provide unlicensed care after receiving a cease and desist letter and DEL has knowledge of continued care does DEL take further action; up to and including referral for prosecution or civil penalty.

Findings and Recommendations

The committee made the following findings and recommendations based on information provided by the social work supervisor overseeing the investigation, review of the case records, department policy and procedures, Revised Code of Washington (RCW), and Washington Administrative Code (WAC).

Findings

[10] Neglect/Negligent Treatment for failing to report child's illness and concerns regarding parents lack of follow through in seeking medical care.

[11] A cease and desist letter was forwarded to the provider in accordance with RCW 43.215.340, WAC 170-296-0430 and WAC 170-296-0110.

- Intakes 2, 4 and 6, received on September 21, 2007, December 9, 2008, and May 12, 2009 should have screened in for either an investigation or a referral to an EFSS program service.

- CA practice and procedures[12] requires creating a case file and opening a case when referred to EFSS. However, policy does not require CA to provide oversight of services or evaluation of their effectiveness. Unless the EFSS provider has assessed an increase in risk and contacted CA recommending further intervention. An exit summary of services is the only notification CA will receive regarding status of the family.

Recommendations

- Every referral, regardless of the screening decision, should include a review of the referral history of the family including both screened in and screened out referrals. The consideration of family history supports more accurate screening decisions. This report and recommendations should be reviewed with the Intake Units that screened the intakes on this family.

- The review committee identified recent legislation (HB 2106) which will establish a 'performance based contracting' system for all CA contracted service providers by January 1, 2011. In the event the EFSS[13] program is restored, EFSS program performance and evaluation will be required. Developing a method to assess the inherent value of EFSS services through evidence based practice[14] data can assist in noting a reduction in risk and/or show a decrease in recidivism rates is essential in evaluating the program's long term value and effectiveness in supporting child health and safety.

[12] CA Practice and Procedures Chapter 2332
[13] EFSS program services were discontinued in October 2009 due to budget constraints.
[14] Contract revisions for EFSS in July 2009 included the use of Evidence Based Practices for evaluation purposes.