Washington State Department of Social & Health Services

CA Children's Administration

Child Fatality Review

RCW 74.13.500

December 2013
Date of Child's Birth

July 11, 2014
Date of Fatality

December 11, 2014
Child Fatality Review Date

Committee Members

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Executive Summary

On December 11, 2014, Children's Administration (CA) convened a Child Fatality Review[1] (CFR) to examine the department's practice and service delivery to six-month-ol and her family. The incident initiating this review occurred on July 11, 2014, when first responders were called to the family home following a 911 call about an unresponsive infant. Emergency Medical Technicians arrived to find the infant without any vital signs. The child's father[2] reported to Mason County Sheriff's detectives that he placed the infant on a couch and then fell asleep in a chair nearby. When he awoke he found his infant daughter wedged in the couch cushion and unresponsive. The family had an open Child Protective Services case at the time of the fatality.

The CFR Committee included professionals from Children's Administration and the community with knowledge of child abuse investigation, child safety and infant safe sleep, and public child welfare. None of the Committee members had any direct involvement with the family. A representative from the Office of Family and Children's Ombuds was unable to attend the review due to sudden onset of illness. Efforts to include law enforcement representation and a developmental disability expert on the Committee were not successful.

Prior to the review, each Committee member received a chronology of department activities regarding both the pre-fatality and the fatality investigations, and relevant unredacted CA case documents (e.g., intakes, case notes, safety assessments, investigative assessments). Several case related documents made available to the Committee at the time of the review included law enforcement reports, the Mason County Coroner's findings, and a Child Protection Medical Consultant report.[3] A variety of reference materials were also

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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 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 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 CNFR to recommend personnel action against DSHS employees or other individuals.

[2] The parents are not identified by name in this report as no criminal charges were filed relating to the incident. The names of A.P.'s siblings are subject to privacy laws. [Source: RCW 74.13.500(1)(a)].

[3] The tasks of the statewide Child Protection Medical Consultants (CPMC) network include providing telephonic consultations, case staffing/case review, training, court testimony, and written consults to CA staff, law enforcement officials, prosecuting attorneys, and physicians regarding child maltreatment cases.

made available to Committee members including RCW 26.44.020 (definition of negligent treatment), RCW 74.13.640 (conducting child fatality reviews), and current CA policy and practice guidelines for infant safety.

During the course of the review, the Committee interviewed two Shelton Division of Children and Family Services (DCFS) staff involved in the case. Following review of the case file documents, completion of the staff interviews, and discussion regarding department activities and decisions, the Committee noted several missed opportunities for improved practice that are included in the Findings section of this report. There were no recommendations emerging from the review.

Case Overview

The family first came to the attention of the Children's Administration on May 2, 2014, when CPS initiated an investigation based on reported injuries to an older child in the home Results from an examination by a specialist indicated the circumstances to be non-abuse/neglect related, subsequently resulting in the allegation being unfounded.[4]

On July 11, 2014, two months after the last documented activity by the CPS worker, CA was notified by Mason County law enforcement of the death o at the family residence. Medical first responders dispatched to the home following a 911 call about an unresponsive infant found without any vital signs. The child's father reported to Mason County Sheriff's detectives that he placed the infant on a couch and then fell asleep in a chair nearby. When he awoke he found his infant daughter wedged in the couch cushion and unresponsive.

While there were no obvious indications of inflicted trauma to the infant, the home was deemed such a health hazard by law enforcement that the other children were placed into protective custody. The department initiated dependency actions on all the siblings and the case transferred to Child and Family Welfare Services.

The Mason County Coroner attributed the cause of death as mechanical asphyxia due to wedging and classified the manner of death as accidental. Law enforcement declined to pursue any charges regarding the incident. A state Child

[4] Child Abuse or Neglect is defined in RCW 26.44, WAC 388-15-009, and WAC 388-15-011. Findings are determined when the investigation is complete and are based on a preponderance of the evidence standard. Unfounded means the determination that, following an investigation by CPS, based on available information: it is more likely than not that child abuse or neglect did not occur, or there is insufficient evidence for the Department to determine whether the alleged child abuse did or did not occur.

Protection Medical Consultant reviewed law enforcement records and the autopsy report (including toxicology findings) and concluded that the death was accidental. Following the CPS investigation of the fatality, negligent treatment allegations were founded against the father.

CFR Committee Discussion

The major focus of Committee discussion centered on documentation regarding observations, actions, and decisions made during the CPS involvement with the family two months prior t s death, some of which were documented after the death o he Committee also considered the verbal accounts presented by the assigned worker when interviewed during the review, including undocumented observations of the home environment. In addition, the Committee deliberated on the CPS investigative and assessment activities connected to the fatality investigation, such as the information gathered as to the circumstances surrounding the infant's death and new information about the family that had not been known in the prior investigation.

The Committee utilized staff interviews to provide additional sources of information for consideration. These interviews included inquiry as to the CPS field experience of both the worker and supervisor, and the worker's active caseload and workload at the time of case assignment.[5]

A death involved mechanical asphyxia due to wedging on an unsafe sleep surface, Committee members reviewed the recently implemented Children's Administration Infant Safety Policy (effective October 31, 2014) created to help reduce the risk of injury and death for children birth to one year old.

Some discussion occurred as to CA practices and procedures as a means to better understand and evaluate the work done in this case. This included brief discussion as to the May 2014 intake designation of neglect allegations for one of the children. The Committee members also looked at the CA guidelines for making collateral contacts, for conducting National Crime Information Center[6] (NCIC) background checks, and

[5] Caseload and workload are not synonymous. While a worker's caseload generally equates to the number of assigned cases, workload involves the complexity of cases requiring intensive intervention and additional administrative requirements. [Source: U.S. Department of Health & Human Services, Administration for Children & Families, Child Welfare Information Gateway]

[6] The National Crime Information Center (NCIC) system is a name and date-of-birth based national database of criminal history information operated by the Federal Bureau of Investigations (FBI). Children's Administration is authorized to access this database only for limited purposes: to ensure worker and child safety in CPS investigations, and for emergency placements in out-of-home care. [*See* 109 P.L. 248 (Adam Walsh Act); 28 C.F.R. §20.33; *see also* RCW 26.44.240]

designated timelines for completed work. Additionally, Committee members spent considerable time discussing the information-gathering activities by the assigned worker in completing the Safety Assessment,[7] the Structured Decision Making Risk Assessment® (SDMRA®),[8] and the Investigative Assessment.[9]

Findings

At completion of the review of the case file documents, staff interviews, and discussions regarding CA activities and decisions, the Committee found no clear critical errors by the department. However, the Committee identified several missed opportunities in the May 2014 investigation for improved practice that, while having no discernible implications for the critical incident occurring in July 2014, were determined to be worthy of inclusion in this report.

- Inconsistent with the department's current Child Safety Framework, the CPS worker appeared to be incident focused on the alleged injury of an older child in the home rather than safety focused on all the children in the home.[10] The case disposition appeared to be findings driven rather than assessment driven in that significant weight was given to the medical assessment that the child's injuries were not child abuse or neglect. The Committee believes that the CPS worker may not have had clear understanding of the family situation due to a lack of a broader curiosity outside the determination of the allegation.
- While contact with a medical professional and school staff reflected good practice, there were missed opportunities for contact with other collaterals (e.g., relatives, California CPS, and Developmental Disabilities Administration). These sources of information, if sought, may have provided a rationale for offering the family services.

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[7] In partnership with the National Resource Center-CPS (NRC-CPS), Washington state Children's Administration implemented the Child Safety Framework in November 2011. The safety framework is built on key principles of gathering, assessing, analyzing, and planning for a child's safety through (1) collecting information about the family to assess child safety, (2) identifying and understanding present and impending danger threats, (3) evaluating parent/caregiver protective capacities, (4) determining if a child is safe or unsafe, and (5) taking necessary action to protect an unsafe child.

[8] The Structured Decision Making Risk Assessment® (SDMRA) is an evidence-based actuarial tool from the Children's Research Center (CRC) that was implemented by Washington state Children's Administration in October 2007. It is one source of information for CPS workers and supervisors to consider when making the decision to provide ongoing services to families.

[9] A completed Investigative Assessment includes, but is not limited to, documentation of findings and disposition such as case status following investigation.

[10] In partnership with the National Resource Center-CPS (NRC-CPS), Washington State Children's Administration implemented the Child Safety Framework in November 2011. A key concept of this model is that the scope of child welfare work is not defined by determining the presence or absence of injuries or incidents, but rather in identifying present or impending safety threats, and working with families to mitigate those threats.

- The two month absence of any social worker activities (May 6th to July 11th) was somewhat concerning in that the SDMRA® and Investigative Assessment for the May 2014 investigation were not completed until after the fatality and were based on one family contact made 2 months earlier.
- At least two items on the SDMRA® appeared to be marked inaccurately resulting in under-assessment of risk. These items included failure to account for prior CPS history from California and the identification of the mother as primary caregiver rather than the father. The latter appears to have reflected an unintentional gender bias acknowledged by the worker when interviewed. Had the SDMRA® items reflected more accuracy, it is possible that the cumulated risk score would have indicated moderately high which would suggest staffing the case for voluntary services.
- Some timeframes for completion of work for the May 2014 investigation were not met. These included completion of the Safety Assessment, SDMRA®, and Investigative Assessment, all of which were completed after the July fatality.[11]

[11] Per Children's Administration policy, a Safety Assessment is required to be completed no later than 30 calendar days from the date of an intake. The SDMRA® is to be completed no longer than 60 days after the intake was received. Similarly, the Investigative Assessment is to be completed following conclusion of a CPS investigation, within 60 calendar days of CA having received an intake.