Washington State Department of Social & Health Services

CA Children's Administration

**A.W.**

RCW 74.13.5 **2017**
Date of Child's Birth

**September 27, 2017**
Date of Death

**February 15, 2018**
Child Fatality Review Date

**Committee Members**

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***Executive Summary***

On February 15, 2018, the Department of Social and Health Services, Children's Administration convened a Child Fatality Review (CFR)[1] to examine the department's practice and service delivery to [RCW] month old A.W. and [RCW 74.1] family.[2] The incident initiating this review occurred on September 27, 2017 when the mother, her boyfriend, A.W., and the child's toddler sibling took a nap together on a full size bed. When the adults awoke, they found A.W. unresponsive. Emergency responders called to the residence transported A.W. to a local hospital where continued resuscitation efforts were unsuccessful. Child Protective Services (CPS) had an open case at the time of the fatality. At the completion of the autopsy examination and post-mortem ancillary studies, the [RCW 74.13.515] County Medical Examiner ascertained both cause and manner of death to be undetermined.

The CFR Committee included professionals with expertise in child and family advocacy, child abuse, child health and development, infant care and child safety and chemical dependency. None of the Committee members had any direct involvement with the family. In advance of the review, each Committee member received a summarized chronology of the family's CPS involvement. Also provided were un-redacted CA documents and law enforcement reports. Supplemental information and resource materials were available to the Committee at the time of the CFR, including [RCW 74.13.515] County Medical Examiner's Office records.

During the review, the Committee interviewed two CA caseworkers and their supervisor; the current caseworker also gave a brief update on the case. Following review of the case record, staff interviews and discussion regarding department policies, activities and decisions, the Committee made several findings and recommendations presented at the end of this report.

[1] Given its limited purpose, a Child Fatality Review should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. The Child Fatality Review 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 will only hear from DSHS employees and service providers. It does 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 recommend personnel action against DSHS employees or other individuals.

[2] The names of the adult caregivers are not used in this report as neither has been identified in an accusatory instrument with committing a crime related to this incident. A.W.'s sibling is not identified in this report due to privacy laws. [See RCW 74.13.500]

***Family Case Summary***

CA first became aware of A.W. and [redacted] family in [redacted] 2017, when A.W. and [redacted] mother were admitted to a local hospital after the child's spontaneous delivery at a residence. Although the newborn appeared healthy, the hospital determined [redacted] was [redacted], but there were no signs [redacted] was [redacted].[3] The hospital [redacted] reported concerns for [redacted], lack of a stable living situation and indications that the mother was unprepared to meet A.W.'s basic needs at discharge. The information provided to CA resulted in a CPS Risk Only intake.[4]

Prior to hospital discharge, CPS made contact with both mother and A.W. and gathered information from multiple family members and hospital staff. This information was used to assess child safety and risk and identify the family's potential service needs. This included completing a Plan of Safe Care[5] as well as reviewing infant safe sleep recommendations[6] and the Period of Purple Crying[7] with the mother. After verifying the mother's plan to move with her two children to a relative's home and assessing the newborn's sleep environment at the home, CPS provided numerous concrete resources to support the newborn's care. CPS also recommended the mother complete a urinalysis (UA) and participate in a Family Team Decision Making Meeting (FTDM).[8] During the FTDM, the mother agreed to Family Voluntary Services (FVS)[9] and, if the UA

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3 "[redacted]. [Source: CA Practices and Procedures Guide – Appendix A: Definitions]

4 Children's Administration will screen in a CPS Risk Only intake when information collected gives reasonable cause to believe that risk or safety factors exist that place the child at imminent risk of serious harm.

5 Children's Administration caseworkers must complete a "Plan of Safe Care" as required by the Child Abuse Prevention and Treatment Act (CAPTA) when a newborn is identified as substance affected by a medical practitioner. [See: CA Practice and Procedures Guide 1130. Safety Plan]

6 Safe Sleep is a nationwide campaign to promote safe sleeping habits for children. In October 2014, CA instituted a policy that requires social workers to discuss Safe Sleep guidelines with all families caring for children under the age of one year. The guidelines are based on recommendations from the American Academy of Pediatrics Task Force.

7 The Period of Purple Crying is a method of helping parents understand the time in their baby's life where there may be significant periods of crying. [Source: What is the Period of Purple Crying?]

8 Family Team Decision Making Meetings (FTDM) 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 Practices and Procedures Guide 1720. Family Team Decision Making Meetings]

9 Family Voluntary Services is a child welfare services program for families not involved in dependency matters. FVS social workers offer the parent(s) services designed to reduce the safety threats while the children remain in the care and custody of their parent(s). [See: CA Practices and Procedures Guide 3000. Family Voluntary Services]

result was positive, a chemical dependency assessment . Results of her RCW 13.50.100 UA completed on May 25, 2017 were RCW 13.50.100 for drugs.

The case transferred to FVS and a referral was made for contracted Family Preservation Services (FPS).[10] During several contacts with the family in June and July of 2017, neither the FVS worker nor the FPS provider observed any safety concerns for the children. Both infant safe sleep and the Plan of Safe Care were re-reviewed with the mother. The mother RCW 13.50.100 for all subsequent UAs and when confronted by the FVS worker, declined any further services or CA contact with her children. Following inter-departmental discussions regarding case planning options, including legal intervention, the case was closed.

On September 14, 2017, CPS again became involved after receiving information about suspected RCW 13.50.100 to A.W. and RCW 74.1 toddler sibling. A CPS worker and two RCW 74.13.515 Police Department (RC PD) officers went to the residence where the family was staying. The mother appeared upset by the allegations, but allowed the children to be examined for RCW 13.50.100. Law enforcement RCW 13.50.100 . RC PD detectives followed up several days later and RC PD again did not observe RCW 13.50.100. The Multi-Disciplinary Team with the local Child Advocacy Center (CAC)[11] recommended medical examinations of the children at RCW 74.13.515 Children's Hospital. The examinations, which occurred a week prior to A.W.'s passing, showed RCW 13.50.100. Based on those results, the allegations of RCW 13.50.100 were later determined to be unfounded.[12]

On September 27, 2017, CA received notification that A.W. had passed away following unsuccessful resuscitation efforts by first responders and hospital

[10] Family Preservation Services are short-term, family-based services designed to assist families in crisis by improving parenting and family functioning while keeping children safe. FPS is aimed at preventing out of home placements for children and is generally authorized for a limited period. [See: CA Practices and Procedures Guide 4502. Intensive Family Preservation Services, Family Preservation Services]

[11] The CAC of RCW 74.13.5 County is a member of the Washington State Chapter of the National Children's Alliance (NCA), which is the accrediting organization. The NCA has established standards for CACs that include (1) child-focused, child-friendly facilities for children and their non-offending family members, (2) multidisciplinary team case staffing participation by law enforcement, prosecution, medical experts, social work, and advocacy, (3) medical evaluation onsite or through referral, (4) therapy onsite or through referral, (5) onsite forensic interviews, (6) and case tracking. [Source: Children's Advocacy Centers of Washington]

[12] CA findings are based on a preponderance of the evidence. RCW 13.50.100 . Findings are determined when the investigation is complete. Founded means the determination following an investigation by the department that, based on available information, it is more likely than not that RCW 13.50.100 did occur. Unfounded means the determination following an investigation by the department that available information indicates that, more likely than not, RCW 13.50 did not occur, or that there is insufficient evidence for the department to determine whether the alleged RCW 13.50.100 did or did not occur.

emergency department staff. Reportedly, the mother, her boyfriend, A.W. and RCW 74.1 toddler sibling were napping together on a full size bed. When the adults awoke, they reported A.W. appeared to be "wrapped in a blanket" and unresponsive. Noted during the death scene investigation were concerns regarding unsanitary conditions of the home environment, bed sharing (co-sleeping, surface sharing), and possible aspiration of formula due to bottle propping. The department RCW 13.50.100 on the sibling, who was RCW 13.50.100.

The postmortem examination report regarding A.W., finalized in late January 2018, indicated no evidence of injury, no anatomic findings to account for the death and toxicology test results that were negative for alcohol or drugs. However, due to the possibility of asphyxiation during bed sharing, the cause and manner were both classified as undetermined.

***Committee Discussion***

For purposes of this review, the Committee mainly focused on actions taken and decisions made during the CPS and FVS interventions (RCW 74.13.51 July 2017). Only limited discussion took place as to the CPS investigation of unsubstantiated RCW 13.50.100 allegations reported in mid-September. The Committee also reviewed the law enforcement and Medical Examiner information relating to the September 27, 2017 fatality incident, but did not dedicate much discussion time to the department actions post-fatality.

Committee members discussed the CA documentation and the additional recollections presented by the CA staff who were interviewed during the CFR. The Committee considered relevant CA practice and procedural standards for intervention and service response, including policy and required timelines for documentation and completion of work. Overall, the caseworkers appeared to meet policy and expected practice standards. Although several situations were noted where CA policies were not followed, they appeared to have no direct connection to the circumstances of the fatality. For example, the FVS worker said the contracted FPS provider conducted consecutive health and safety monitoring visits. Those visits may not have followed CA child and caregiver visit requirements.[13]

Given that the circumstances of the fatality involved the infant sleep environment, the Committee took a close look at the caseworkers' activities

[13] For FVS cases, with children age five or younger and residing in the home, two in-home health and safety visits must occur every calendar month. One of the two visits may be conducted by a qualified CA staff or contracted provider. [See: CA Practices and Procedures Guide 4420. Health and Safety Visits with Children and Monthly Visits with Caregivers and Parents]

regarding infant safety education and intervention. The documented efforts by the caseworkers to reinforce infant safe sleep recommendations, including cautions regarding bed sharing, appeared to follow policy. It was noted that CPS initially provided the family with a co-sleeper/baby box for the newborn, as permitted by the policy at that time ([redacted] 2017). The Committee discussed the fact that such devices do not meet federal safety standards.[14] Subsequent to the review, it was confirmed that CA revised policy in November 2017.[15] Noted during the review was that fact that the infant was not in a co-sleeper/baby box at the time of [redacted] death but was instead sharing a full size bed with [redacted] mother, the mother's boyfriend and the child's toddler sibling.

As a balance to simply reviewing policy-directed practice, the Committee spent considerable time discussing the qualitative nature of the information gathering, assessment, analysis and service planning. This included reviewing and discussing the quality of the critical thinking, curiosity, collateral contacts, corroboration of information, collaboration with outside agencies, communication (internal and external) and comprehensiveness of the understanding of the family.[16] Thus, the Committee discussed whether the caseworkers, in the process of conducting safety and family assessments, sufficiently gathered, probed and understood the family member's individual and collective needs prior to service planning.

A key area of Committee discussion involved issues of safety and risk.[17] Significant discourse occurred around the collection of risk factors associated with the family, such as unstable housing, [redacted] and behaviors common to substance abusers. The Committee was not convinced that the caseworkers were sufficiently aware of the mother's history of [redacted] or the potential implications of such

[14] According to the United States Consumer Product Safety Commission, cardboard boxes for babies are currently not subject to any mandatory safety standards. These products do not meet the federal definition of a crib, bassinet, play yard, or handheld carrier. [Source: CPSC Statement on Cardboard Baby Boxes]

[15] CA staff must engage the parent or caregiver to create a safe sleep environment if one does not exist. This includes DCFS staff providing parents and unlicensed caregivers with a pack and play or bedside co-sleeper that meets the Consumer Product Safety Commission Standard as soon as possible if the child does not have a safe and separate sleeping area. [See: CA Practices and Procedures Guide 1135. Infant Safety Education and Intervention]

[16] In 2015, these domains, known as The Seven Cs, were incorporated into the statewide Children's Administration Lessons Learned Training to guide discussions about key areas for qualitative evaluation of practice.

[17] Risk factors are family behaviors and conditions that suggest caregivers are likely to maltreat their child in the future. A safety threat refers to a specific family situation or behavior, emotion, motive, perception or capacity of a family member that is out-of-control, imminent, and likely to have severe effects on a vulnerable child. Safety threats are essentially risk influences that are active at a heighten degree and greater level of intensity. Safety threats are risk influences that have crossed a threshold in terms of controllability that has implications for dangerousness.

Adverse Childhood Experiences[18] on human social, emotional and cognitive development. The Committee recognized that the mother had no prior CPS history as a parent prior to A.W.'s birth and had not demonstrated any behaviors that clearly indicated her children were in present or imminent danger.

The Committee dedicated significant discussion to the decision to wait to refer the mother for a Chemical Dependency assessment. The Committee listened to the caseworkers' and supervisor's reasons to wait for the follow-up UA (which was RCW 13.50.100 for drugs) before making a referral for a comprehensive CD assessment. The Committee also considered the significance of the mother's explanation that she did not have RCW 13.50.100, yet by her own admission, knew it was RCW 13.50.100. When the case transferred to FVS, all subsequent UAs were RCW 13.5.

According to the FVS worker, she was not initially aware of the RCW 13.50.100 UAs as the notifications initially went to the CPS worker.[19] The Committee found little documentation of conversations with the mother about scheduled UAs, or any consequences regarding RCW 13.50.100, thus raising questions about communication between the FVS worker and the mother. No significant conversations occurred between the FVS worker and the relatives with whom the mother was residing, as they were surprised to hear the mother was in RCW 13.50.100with UAs when the FVS case closed.

In evaluating whether the services offered by CA were the most appropriate to meet the needs of the family, some brief discussion occurred about services that were available but not referred. For example, the contracted Early Intervention Program (EIP)[20] is available to CA caseworkers in RCW 74.13.515 County through the RCW 74.13.515 County Health Department. However, the Committee focused more on the services provided by the contracted FPS provider and had concern about the lack of any documented substantive client engagement. The majority of the FPS contact appeared to have been conducted in public areas and was very brief. While there were phone updates provided by the FPS provider to the FVS

[18] The CDC's Adverse Childhood Experiences Study revealed a direct link between childhood trauma and onset of chronic disease, depression, suicide, violence, and other social and emotional problems.
[19] CA moved to an all-electronic reporting system in 2016-17. Caseworkers are e-mailed client UA results (including no-shows) in PDF form as reported in the drug testing portal. CA is currently working on improving the no-show notification options and other recommendations to the UA collection reporting out process.
[20] Early Intervention Program contractors provide direct services to families and link families to community resources. Goals include reducing risk of abuse or neglect of children in the home and the likelihood of referral to CPS, reduction of family stress, and enhancing parenting skills, family functioning, and the health status of family members.

caseworker, there was no evidence that the contract requirements for completing written reports were satisfied. The CA staff interviewed during the CFR reported ongoing concerns for the failure of the particular FPS provider to provide expected services; staff had reported this to the Regional Contracts Unit. The CPS/FVS supervisor was aware of the CA Contracts Unit Complaint Form which is available online via survey monkey format but also indicated that in the past there had been occasional glitches in the survey monkey process.[21]

The Committee devoted significant time looking at the decision to close the FVS case at the end of July. The Committee examined the actions taken and decisions made by the department in reaction to the mother's declining of further voluntary services. The Committee reviewed the inter-department discussions regarding case planning options, including disagreements regarding sufficiency to proceed with legal intervention. While there was clear indication that the caseworkers involved felt strongly about pursuing dependency based on identified risks (rather than safety threats), there appeared reluctance to pursue the matter up the chain of command. There was some indication during the interviews with staff that such reluctance is not uncommon in CA offices in RCW 74.13.515 County.

The Committee explored the possible impact of caseworker caseload/workload[22] and caseworker inexperience. At the time of initial involvement with the family ([redacted] 2017), the CPS investigator's caseload was low due to being new to CA. At the time of the second investigation in September 2017, the CPS worker's assignments were consistent with the state average.[23] The FVS worker to whom the case transferred, was new to FVS but experienced in other CA programs. At the time of assignment, she was assigned more than the recommended number of cases. The Committee found it difficult to come to any substantive conclusions about caseload.

However, the inexperience of the CPS worker appeared to contribute to errors initially made in the Structured Decision Making Risk Assessment® (SDMRA)

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[21] The Contracts Complaint tool was implemented by CA in 2015 to get feedback from the field and other key participants in the public child welfare process. Subsequent to this review, concern for glitches in the complaint process was passed onto the Regional Contracts Manager Unit and the CA Headquarters Contracts Manager.

[22] 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: Child Welfare Information Gateway]

[23] According to Children's Administration current data, the average caseload size for CPS investigators is 18. For investigative workers in child protective services, the Council on Accreditation (COA) recommends that caseloads do not exceed 15 investigations or 15-30 open cases. The Child Welfare League of America (CWLA) recommends a caseload size of 12 intake reports per month per worker and workers providing on-going services have no more than 17 active families.

tool.[24] This conclusion was supported by the CPS worker's admission that she had only a marginal understanding of the tool at the time of completing the SDMRA. The initial underestimation of some risk factors did not affect the overall assessed risk level and or the decision to offer services to the family in [redacted] 2017.

***Findings***

The Committee did not identify any critical errors made by CA that were directly associated with the fatality event. The Committee was limited in its ability to draw conclusions regarding any practice or system failures that directly contributed to the death of A.W., especially given the indeterminate cause and manner of A.W.'s death. However, the Committee did identify instances where additional or alternative social work activity may have been beneficial to the assessment of the family situation and service delivery. Again, while the Committee did not identify any critical errors, the Committee deemed these issues worthy of consideration for improved practice.

- The Committee questioned the early decision to wait to refer the mother for a Chemical Dependency assessment. Given that the first CA intake was designated Risk Only and largely based on concern for RCW 13.50.100 by the mother, the Committee speculated that more immediate and more in-depth assessment would have been reasonable and beneficial. The mother appeared to become less receptive and more resistant as the case went on and opportunities to assess chemical dependency/co-occurring issues essentially evaporated.
- While recognizing instances of collateral contacts being made by the workers, in general they seemed relatively tangential inquiries. The Committee believed there were missed opportunities for more probative conversations with relatives and other family supports to corroborate the mother's statements of individual and family progress with services.
- In consideration of both written documentation and worker interview responses, the Committee seriously questioned whether or not the contracted FPS provider satisfied the expected service delivery per the FPS contract.
- Overall, the level of activity toward client engagement under Family Voluntary Services appeared reserved and too easily conceding, and might have more actively involved family supports.

[24] The Structured Decision Making Risk Assessment® (SDMRA) is an evidence-based actuarial tool from the Children's Research Center (CRC) implemented by Washington State Children's Administration in October 2007. It is one source of information used by CPS when making decisions to provide ongoing services to families. [See: CA Practices and Procedures Guide 2541: Structured Decision Making Risk Assessment® (SDMRA)]

***Recommendations***

- CA re-initiate the Chemical Dependency Professional (CDP) liaison program. This program previously allowed for CDPs to be located in CA field offices. CDPs were available for substance abuse related consultation and providing information about substance use, client engagement and community resources. The Committee is aware that current state budget constraints may pose a barrier to this recommendation.
- To improve accountability of contracted providers, CA should pursue different ways to inform CA staff about contractor expectations and the process for reporting concerns about contracted provider service delivery.
- Continue to re-evaluate chemical dependency trainings offered to CA staff to include presenting specific substance abuse/use issues surfacing from child fatality and near-fatality reviews.
- Region 3 management should consider meeting with the local Attorney's General Office about the process and protocol for disagreements with legal advice.[25]

[25] Note: Children's Administration Dependency Petition Process policy is currently under revision. Included in the proposed revision is procedural guidance for situations where there is disagreement about the legal sufficiency to file a dependency.