Washington State Department of Social & Health Services

CA Children's Administration

Child Fatality Review

B.T.

RCW 74.13.515 **2017**
Date of Child's Birth

February 24, 2017
Date of Death

July 27, 2017
Child Fatality Review Date

Committee Members
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Executive Summary

On July 27, 2017, the Department of Social and Health Services (DSHS) Children's Administration (CA) convened a Child Fatality Review (CFR)[1] to examine the department's practice and service delivery to RCW 74.13.515-old B.T. and RCW 74.1 family.[2] The incident initiating this review occurred on February 24, 2017 when B.T. was discovered unresponsive by RCW 74.1 mother who had fallen asleep with the infant in her arms after a feeding. Emergency responders were unable to revive the infant who was declared deceased at a local hospital. A Child Protective Services (CPS) investigation had been active since RCW 74.13.515, 2017 in response to a Risk Only[3] intake regarding the birth of B.T. in Yakima. At the time, a Child and Family Welfare Services (CFWS) case was open in the Lakewood office relating to a RCW 13.50.10 .

The CFR Committee included CA and community professionals with relevant experiences and expertise in child and family advocacy, child abuse and infant safe sleep. Efforts to secure a chemical dependency professional to sit on the Committee were unsuccessful. Neither the Children's Administration CFWS Program Manager nor the Permanency Planning Program Manager was able to attend the review. 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 history of CPS involvement. Also provided were un-redacted CA documents specific to the initial Risk Only investigation and the investigation of the fatality, as well as death scene law enforcement reports. Supplemental sources of information (e.g., medical records) and resource

[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 parents are not used in this report as neither have been identified in an accusatory instrument with committing a crime related to this incident. B.T.'s siblings are not identified in this report due to privacy laws. *See* RCW 74.13.500

[3] CA may investigate intakes that do not allege an actual incident of Child Abuse or Neglect (CA/N), but have risk factors that place a child at imminent risk of serious harm. [Source: CA Practices and Procedures Guide 2200 Intake Process and Response]

materials (e.g., relevant CA policies) were available to the Committee at the time of the CFR.

During the course of the review, the Committee interviewed the Lakewood CFWS worker and her relatively new supervisor regarding their involvement with the family. The Committee was also provided with information from the Yakima CPS worker who had been interviewed by one of the CFR facilitators prior to the review. Following review of the case file documents, completion of the interviews, and discussion regarding department activities and decisions, the Committee made several findings and one recommendation presented at the end of this report.

Case Overview

The family had CPS involvement prior to B.T.'s birth in 2017. In 2011, CPS legally intervened on behalf of the mother's first child RCW 13.50.100 . In RCW 13.50.1 2015, a second child was born and CPS again became involved due to RCW 13.50.100 and RCW 13.50.100 . In late February 2016, RCW 13.50.100 . The mother continued to have RCW 13.50.100 .

In December 2016, the RCW 13.50.100 . Subsequently, the CPS investigation into allegations of RCW 13.50.100 and RCW 13.50.100 were determined to be unfounded.[5]

In early RCW 74.13.515 2017, RCW 74.13.515 before the mother was due to give birth to B.T., the CFWS worker was notified that the mother was being RCW 13.50.100 due to the mother's RCW 13.50.100 . The mother was otherwise

[4] RCW 13.50.100 . [Source: Medscape]

[5] 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. Founded 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 occur. [Source: RCW 26.44.020]

RCW 13.50.100. The CFWS worker electronically contacted legal representatives for the department and for the mother, to discuss the possibility of placing a hospital hold when the mother delivered and filing a dependency petition. None of those actions occurred.

On RCW 74.13.515 2017, a hospital social worker notified CA that the mother RCW 74.13.520 RCW 74.13.520 RCW 74.13.520. The newborn (B.T.) initially RCW 74.13.520 but no hospital/physician hold was initiated.[7] At the time, the mother was RCW RCW

The information provided by the hospital lacked specific allegations of child abuse or neglect as defined in WAC 388-15-009. However, the intake screened in as a CPS Risk Only case due to concerns over the mother's RCW 13.50.100 history, having had RCW 13.50.100, and recently being RCW 13.50.100.

A Yakima CPS worker made in-person contact with the mother and B.T. at the hospital on RCW 74.13.515. The newborn was discharged to mother's care after five days of medical monitoring RCW 74.13.520. The hospital reported concerns to the CFWS worker, based on observations of the mother, that the mother may not have sufficient parenting abilities.

On February 16, the Lakewood CFWS worker and the GAL for the RCW 13.50.100 met at a Yakima shelter where the mother and baby were residing. During

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6 RCW 13.50.100. [Source: CA Practices and Procedures Guide – Appendix A: Definitions]

7 RCW 26.44.056; *See also* RCW 26.44.030(8)

8 RCW 13.50.100.

9 RCW 13.50.100. [Source: PubMed Health]

that visit, the mother was reminded about infant safe sleep during a safe sleep assessment, including caution against bed sharing.[10]

On February 24, 2017, CA intake was notified of the death of B.T. Reportedly the mother had fallen asleep with her infant during feeding and awoke to find the child unresponsive. The hospital Emergency Department attending physician who declared the death noted no evidence of injury or trauma to the infant. Post-mortem findings concurred - no evidence of trauma or wedging. Cause of death, as determined by the Yakima County Coroner's Office, was "probable positional asphyxia." The manner of death was classified as accidental. Law enforcement declined to pursue any criminal investigation. The CPS investigation regarding the circumstances of the fatality resulted in the allegations being unfounded.

Committee Discussion

While the primary focus of the child fatality review was centered on actions and decisions made by the department during the RCW 74.13.515 of B.T.'s life, the Committee briefly looked at the mother's CA history involving her older children. This history provided an important context for understanding the mother's pattern of parenting deficiencies and struggles with RCW 13.50.100 and RCW 13.50.100

Largely through the interview process with the CFWS worker assigned to the RCW 13.50.100 case involving B.T.'s sibling, the Committee considered information regarding the mother's RCW 13.50.100 and her RCW 13.50.100 . This included exploring what information the worker had gathered about RCW 13.50.100 and RCW 13.50.100 compliance and progress, and what discussions the CFWS worker had had with the mother regarding the pregnancy and postnatal planning for the baby.

Some discussion occurred about the December 2016 CPS investigation of the RCW 13.50.100 . The RCW 13.50.100 .[11] The only witnesses to indications that the child had been RCW 13.50.100 . The Committee noted that while the RCW 13.50.1 was interviewed by three CA workers about the

[10] Current CA policy requires CA staff to conduct a safe sleep assessment when placing a child in a new placement setting or when completing a CPS intervention involving a child age birth to one year, even if the child is not identified as an alleged victim.

[11] Supervised visits require someone designated to be within direct line of sight and sound of the child and all parties to the visit at all times. Monitored visits require periodic check-ins with the visiting parties. Unsupervised visits do not require any oversight other than at drop off and pick up of the child.

incident, the [redacted] was never interviewed. The Committee was not able to determine how significant the lack of contact with the [redacted] was in terms of the results of that investigation. The Committee did inquire with the CFWS worker as to any impact that incident had on her assessment of the mother's ability to safely parent her [redacted] child as well as B.T., who would be born less than [redacted] later. The worker indicated that after the [redacted] incident she became less enthusiastic about the request by the mother's attorney for the department to begin looking at [redacted].

The Committee devoted significant time looking at the [redacted] abrupt and unexpected notification to the CFWS worker of the [redacted] of the mother [redacted] before she was to give birth. Prior to the notification the worker understood the mother was continuing to make [redacted]. At [redacted], the mother maintained her participation in the [redacted] and continued to do so even after delivery of B.T. The [redacted] Summary Report, not completed and released by the [redacted] until a week after B.T. was born, assessed the mother's [redacted]. The report also indicated that the mother had completed her [redacted] plan in January. The CFWS worker, when interviewed, did not appear to have knowledge of the specifics of that plan.

The Committee examined the actions taken and decisions made by the department in reaction to the mother's abrupt [redacted]. Clearly the CFWS worker was challenged with an immediate need to help find alternative living situations for the mother, to find available [redacted] resources and to prepare for B.T.'s birth. The CFWS worker recalled having electronically contacted the Assistant Attorney General assigned to the mother's case, the mother's attorney and the [redacted] child's GAL,[12] to discuss the situation. A copy of an email corroborates this.

The Committee was interested in the basis for the decision to not file a dependency petition for B.T. upon [redacted] birth. The Committee considered the mother's prior history, status of the [redacted] on the older sibling, the mother's [redacted] and the sudden [redacted]. The Committee deliberated as to

[12] A Guardian ad Litem (GAL) is an individual appointed by the court to represent the best interests of a child or incapacitated person involved in a case in superior court. [Source: Washington Courts]

how conducting an FTDM[13] before or even after the birth of B.T. might have been beneficial to case decisions and case planning. Such a meeting might have afforded the opportunity for improved assessment of the mother's ability to meet the needs of her newborn.

The Committee then discussed the department's response to the Risk Only intake reporting B.T.'s birth. This discussion involved looking at the activities of the office assigned to the already open case (Lakewood) and the office (Yakima) conducting the courtesy face-to-face contact with the mother and newborn at the hospital. The Yakima worker's case note was brief with limited description. The Committee was made aware that the worker had, in a pre-review interview, admitted she had not documented more in depth discussions with the mother and her father (maternal grandfather of the newborn) regarding the postnatal plans for caring for the infant.

The Committee considered both the documentation and additional recollections provided to the Committee by the CFWS worker who, in the company of the sibling's GAL, met with the mother and newborn at a shelter in Yakima two days after hospital discharge. Discussions with the mother as to infant safe sleep and dangers of bed sharing, as well as about service planning, were documented. The worker covered Plan of Safe Care areas at that meeting, although a formal plan was not found in the case file.[14] Some debate occurred among Committee members as to whether a Plan of Safe care was required in this case, as the medical records indicated RCW 74.13.520 but did not confirm B.T. had been [redacted]

The Committee also discussed whether the Lakewood and Yakima staff understood their respective roles and responsibilities per CA policy regarding Risk Only intakes on open CFWS cases.[15] In review of the inter-office communications

[13] Family Team Decision-Making meeting (FTDM) is a facilitated team process, which can include birth/adoptive parents, guardians, extended family members, youth (as appropriate), community members, service providers, child welfare staff and/or caregivers. These meeting are held to make critical decisions regarding the placement of children following and emergent removal of child(ren) from their home, changes in out-of-home placement and reunification or placement into a permanent home. There may be instances when an FTDM can be held prior to placement if there is not an immediate safety threat such as a child who is on a hospital hold and an FTDM could provide placement options. [Source: Family Team Decision-Making Meeting Practice Guide]

[14] 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. The plan must address the health and substance use disorder treatment needs of the infant and family, and include monitoring of the plan to determine whether and how local entities are making referrals and delivering appropriate services to the infant and affected family or caregiver. [Source: CA Practice and Procedures Guide 1135 Infant Safety Education and Intervention]

[15] Assign CPS Risk Only intakes on an open case to the assigned CPS Family Assessment Response (FAR), CPS investigation, FVS or Child and Family Welfare Services (CFWS) caseworker to complete the

and coordination between Lakewood and Yakima offices, there appeared to be some confusion as to the roles and responsibilities for completion of work. Most pronounced was the apparent delayed awareness by the Lakewood office that it was their responsibility to do the safety, risk, and investigative assessments associated with the Risk Only investigation. This may have been further muddled when a new CPS investigation was assigned to the Yakima office following the child fatality incident.

Finally, the Committee briefly discussed the fact that information contained in a psychological and parenting evaluation, initiated in October 2016, was not completed until after B.T.'s birth and not made available until March (post fatality). Based on a battery of personality and parenting inventories, the clinician had assessed similar concerns about the mother's RCW 13.50.100 as reported by the mother's RCW 13.50.100 and the hospital staff when B.T. was born. Having such information earlier in the case would likely have provided an opportunity for additional considerations for case planning such as RCW 13.50.100 . It should be noted that the report from the clinical psychologist indicated that, RCW 13.50.100 .

Findings

The Committee found no critical errors in terms of decisions and actions taken by CA. However, the Committee did find instances where additional or alternative social work activity may have been beneficial to the assessment of the family situation. While these noted practice areas did not have clear significance to the apparent accidental death, the Committee deemed them worthy of consideration for improved practice.

- Conducting an FTDM before, or even after, the birth of B.T. might have been beneficial to case decisions and case planning. Such a shared planning venue might have afforded the opportunity for improved analysis of the mother's abilities to safely meet the needs of her newborn and other risks.
- Based on information provided by the CFWS worker during the Committee interview, there appeared to be instances where some contacts were either not documented or could have been more detailed. This included consultations regarding case planning.
- That the case was active in Lakewood, but the mother had been residing in Yakima for seven months, presented a number of challenges for the

CPS investigation; including the initial face-to-face contact with the child, safety, risk and investigative assessments. [Source: CA Practices and Procedures Guide 2331 CPS Investigation]

worker. The challenges were increased when new intakes were generated out of Yakima, necessitating intra-office cooperation, collaboration and communication. The Committee found some deficiencies in these areas that served as barriers to completed work.

Recommendation

CA should review the current policies regarding active CFWS cases involving RCW 13.50.100 and RCW 13.50.100 children as occurred in this case. Consideration should be given to improving guidance to workers and supervisors on how to proceed with completing a comprehensive, ongoing assessment of children who are not a part of an open case yet are under the care of a parent who has other RCW 13.50.100children. This could include guidance on cases that involve multiple offices.