Washington State Department of Social & Health Services
CA Children's Administration

Child Fatality Review

D.S.

RCW 74.13.515 **2016**
Date of Child's Birth

March 8, 2017
Date of Fatality

July 15, 2017
Child Fatality Review Date

Committee Members
Cristina Limpens, Senior Ombuds, Office of the Family and Children's Ombuds
Candy Hamilton, Director of Indian Child Welfare, Stillaguamish Tribe of Indians
Kym Castenada, Shelter Manager, Domestic Violence Services of Snohomish County
Stephanie Frazier, Child Protective Services Program Manager, Children's Administration
Alex Fitzstrawn, Child Protective Services and Family Voluntary Services Supervisor, Children's Administration
Pam Hubbard, LMHC CDP, Outpatient Counselor Supervisor, Evergreen Recovery Center
Shannon Finn, Social Worker, Stillaguamish Tribe of Indians

Facilitator
Libby Stewart, Critical Incident Review Specialist, Children's Administration

Table of Contents

Executive Summary

On June 15, 2017, the Department of Social and Health Services (DSHS), Children's Administration (CA) convened a Child Fatality Review (CFR)[1] to assess the department's practice and service delivery to D.S. and [redacted] family.[2] The child will be referenced by [redacted] initials in this report.

On March 8, 2017, CA received an intake from law enforcement stating [redacted] month old D.S. passed away. D.S. lived with [redacted] mother and father. [redacted] had two older, maternal, half-sisters who visited. D.S. was in the care of [redacted] father at the time of [redacted] death.

During the law enforcement interviews, the mother stated she put D.S. in [redacted] crib when she left the motel. The mother did not return right away after dropping off her daughters and instead went to a casino to avoid arguing with D.S.'s father. Shortly after midnight, D.S.'s father fed [redacted] a bottle of formula then brought [redacted] into the same bed with him. When he woke, D.S. was nonresponsive and cold to the touch. He then called the mother who was on her way back to the motel room. The mother called 911 who responded to the scene. The mother admitted to [redacted] within the last 24 hours and the father admitted to [redacted] within the last 24 hours. Both parents state when they would [redacted], they would use them in another room, then wash their hands before handling D.S. The mother admitted to smoking cigarettes in the same room as D.S.

The medical examiner's report states the pathological diagnoses included sudden unexpected infant death with the contributory factor of unsafe sleep environment consisting of co-sleeping with an adult and [redacted]. However, the report states the [redacted] detected in D.S.'s body did not contribute to [redacted] death. The manner of death was stated as undetermined.

[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 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 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 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] D.S.'s family members are not named in this report because they have not been charged in an accusatory instrument with committing a crime related to a report maintained by the department in its case and management information system. [Source: RCW 74.13.500(1)(a)]

The Review Committee included members selected from diverse disciplines within the community with relevant expertise including the Office of the Family and Children's Ombuds, domestic violence victims advocate, and experts in infant safe sleep, child abuse and child safety. There was one CA staff member who observed the review. The two Committee members representing the RCW 74.13.515 Tribe had prior contact with the family. However, no other Committee members had prior involvement or contact with the family.

Prior to the review, each Committee member received a case chronology, a summary of CA involvement with the family and un-redacted CA case documents (e.g., intakes, investigative assessments and case notes). Supplemental sources of information and resource materials were available to the Committee at the time of the review. These included a law enforcement report, medical examiner's report, relevant state laws and CA policies.

The Committee interviewed the CPS investigator who conducted the investigation at the time of D.S.'s birth, as well as that worker's supervisor.

Family Case Summary

Between May 9, 2004 and June 17, 2016, CA received nine intakes regarding allegations of neglect, RCW 13.50.100 by parents, RCW 13.50.100 and RCW 13.50.100. Of those nine intakes, six were assigned for investigations or assessment. At one point, D.S.'s older sisters were RCW 13.50.100 and a RCW 13.50.100 was initiated. However, RCW 13.50.100 . Neither parent was cooperative during the CPS investigations.

On RCW 74.13.515, 2016, CA received an intake stating the mother had given birth to D.S. The information contained in the intake stated the father was affiliated with the RCW 74.13.515 Tribe and that the mother planned to live with her two older daughters and their father, who is not the father of D.S. The caller reported there was past RCW 13.50.100 between D.S.'s mother and the father of the older girls and that both adults have past RCW 13.50.100 issues. This intake was assigned for a CPS risk only investigation.[3]

During this CPS investigation the mother provided a urinalysis which was RCW 13.50.100 . The mother indicated the RCW 13.50.100 . Neither the mother nor the father of the two older girls were cooperative with the investigation. The adults would not allow the CPS workers to enter the home and observe the living environment or sleep environment.

[3] CA Practices and Procedures Guide Chapter 2200 Intake Process and Response

D.S.'s biological father would not cooperate with the CPS worker's attempt to speak with him regarding the intake.

On September 29, 2016, the mother met with the CPS worker and the director of Indian Child Welfare from the RCW 74.13.515 Tribe at the DCFS office. The mother stated any RCW 13.50.100 with the father of her older children occurred a long time ago and denied any current RCW 13.50.100 issues. The CPS worker discussed the Period of Purple Crying,[4] safe babies/safe moms and safe sleep during this meeting.[5]

The CPS worker requested medical records for all three children and met with the two older children as part of the investigation. The CPS worker also spoke with the school counselors for the older girls; neither reported any concerns. D.S.'s father failed to respond to any of the CPS worker's attempt to speak with or meet with him. The investigation was closed on November 23, 2016.

On March 8, 2017, CA received the intake regarding the death of D.S. This intake was assigned as a risk only investigation. A subsequent intake was received on May 8, 2017, from the medical examiner's office stating that during their investigation test results showed that D.S. had RCW 74.13.520 at the time of RCW 74.1 death. This intake was screened out. The intake area administrator documented that there was already a current investigation regarding the death and this was not a new incident.

The CPS worker investigating the death altered the investigative assessment to include allegations of negligent treatment or maltreatment. Both parents were founded for these allegations as to D.S.

Committee Discussion

For purposes of this review, the Committee mainly focused on case activity from the time D.S. was born until RCW 74.1 passed away. The Committee did discuss the content prior to D.S.'s birth but the focus of the review was to evaluate the contact and service delivery to the family between the birth and passing of D.S.

The Committee noted that the CPS investigators were met with hostility which in turn made successful interventions challenging at best. The CPS worker who conducted the investigation stemming from the RCW 74.13.515, 2016 intake worked diligently to collaborate with the tribe and requested tribal assistance in connecting with D.S.'s father. However, even with this collaboration it was

[4] What is the Period of Purple Crying?

[5] CA Practices and Procedures Guide Chapter 1135 Infant Safety Education and Intervention.

difficult for the CPS worker to have a comprehensive understanding of this family.

One area the Committee felt needed further assessment was the mother's RCW 13.50.100 status and an understanding of the mother's RCW 13.50.100 which are commonly RCW 13.50.100. The suggestion by the Committee was that the CPS worker could have reached out to discuss these issues with the RCW 13.50.100 and the mother's RCW 13.50.100 to gain a better understanding of the mother's current RCW 13.50.100 status. Understanding a parent or care provider's RCW 13.50.100 status can be a vital part of assessing child safety.

The Committee discussed with the CPS investigator the answers contained in the Structured Decision Making Risk Assessment® tool (SDMRA).[6] The Committee questioned whether the SDMRA was completed correctly as it related to RCW 13.50.100, RCW 13.50.100 and RCW 13.50.100. The CPS investigator indicated there was no evidence to prove an indicated response to those areas. This response was countered by the Committee noting that a lack of cooperation by the parents and lack of gathering corroborating evidence does not make the statements untrue, just unanswered. The tool also allows for comments at the end and the ability to raise the risk level which would require further actions such as a child protection team staffing to assess the need for further CA intervention.

RCW 13.50.100 between D.S.'s mother and the father of the older girls was reported on multiple occasions prior to the birth of D.S. One intake stated that the mother's RCW 13.50.100; however, this fact was never discussed with the mother. The Committee noted this was a missed opportunity to further explore RCW 13.50.100.

Findings

While the Committee identified two areas where practice could have been improved, they also indicated there were no critical errors by CA. The identified areas below are stated as a way to suggest improvement in practice, but not indicative of relation to the critical incident.

The Committee noted a more thorough investigation could have included collateral contacts such as the RCW 13.50.100 for the mother's RCW 13.50.100

[6] The Structured Decision Making Risk Assessment® (SDMRA) is a household-based assessment focused on the characteristics of the caregivers and children living in that household. By completing the SDMRA following the Safety Assessment, the worker obtains an objective appraisal of the risk to a child. The SDMRA informs when services may or must be offered. [Source: CA Practices and Procedures Guide Chapter 2541 Structured Decision Making Risk Assessment®]

which the mother indicated was RCW 13.50.100. Another collateral could have included obtaining the mother's prenatal records. This may have allowed for a more global understanding of any RCW 13.50.100 or RCW 13.50.100 issues for the mother.

CA policy states staff should observe the sleeping environment of all children under the age of one year. While the mother and her ex-boyfriend were not cooperative with showing the CPS worker the home or sleep environment on the first contact with the residence, the Committee agreed that further attempts should have been made. The Committee understood that D.S.'s father was nonresponsive to the CA worker. And while the Committee understands that educating care providers and parents does not stop them from bed sharing, the CPS worker could have attempted to provide that education to the father by sending him the appropriate documents or pamphlets with information regarding safe sleep and Period of Purple Crying. The CPS worker could also have gone directly to the motel to attempt contact.

The Committee did not make any recommendations related to this case.