Washington State Department of Social & Health Services

CA Children's Administration

Child Fatality Review

M.F.

[redacted] **2017**
Date of Child's Birth

February 5, 2017
Date of Fatality

May 11, 2017
Child Fatality Review Date

Committee Members
Mary Moskowitz, J.D., Ombuds, Office of the Family and Children's Ombuds
Zee Triplett, Safety Administrator, Children's Administration
Mary Mills, Chemical Dependency Professional, Therapeutic Health Services
Diane Toy, LMHC, Therapist, Institute for Family Development

Observer
Heather Lofgren, MSW, Quality Practice Specialist, Children's Administration

Facilitator
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Executive Summary

On February 16, 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 M.F. and [redacted] family.[2] The child will be referenced by [redacted] initials in this report.

On February 5, 2017, the medical examiner's office contacted CA to notify the department that M.F. had passed away. At the time of [redacted] death, M.F. was living with [redacted] mother, maternal grandfather and maternal aunt. M.F.'s father did not reside with [redacted] There was an open child protective services (CPS) investigation and the case was transferring to family voluntary services (FVS) due to the mother's [redacted], the father's alleged [redacted]. The mother had completed [redacted] and was referred for [redacted].

The medical examiner's report states the cause of death was unexpected infant death associated with co-sleeping with one adult and the manner of death was undetermined. The CPS investigation regarding the death was closed as founded for negligent treatment by M.F.'s mother. The case is currently closed.

The CFR Committee included members selected from diverse disciplines within the community with relevant expertise including the Office of the Family and Children's Ombuds, chemical dependency, child abuse and child safety. Another Committee member was an in-home service provider with expertise in infant mental health and parenting assistance. No Committee member, nor the observer, had previous involvement with this 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 the most recent volumes of the case, the medical

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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 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] M.F.'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)]

examiner's report, the law enforcement report, relevant state laws and CA policies.

The Committee interviewed the CPS supervisor who also supervised the FVS worker who was slated to receive the case and the Family Team Decision Making[3] (FTDM) meeting facilitator. The original CPS worker no longer works for CA and was not available for this review.

Family Case Summary

On November 29, 2016, CA received a report from law enforcement stating that they contacted a woman who was RCW 13.50.100 (M.F.'s mother) and she admitted to RCW 13.50.100. Law enforcement arrested M.F.'s mother on a felony warrant. This intake was screened out.[4]

On RCW 74.15.515 2017, CA received a report stating that M.F. had been born the previous day. RCW 74.1 was RCW 74.13.520 and would remain at RCW 74.15 515 Hospital. The mother's chart indicated she had a history of RCW 13.50.100 and that she had had only RCW 13.50.100. The hospital also reported the father has a history of RCW 13.50.100, the family is homeless and moving their motor home from one place to another. This intake was assigned for a CPS investigation. The mother was engaged in the RCW 13.50.100 program for mothers at RCW 74.15.515 Hospital.

The CPS worker made contact with the hospital staff and mother and also observed M.F. The CPS worker then made contact with the maternal grandfather and scheduled a Family Team Decision Making meeting to discuss M.F.'s safety and plans for discharge.

The FTDM occurred on January 11, 2017. The father was invited but did not attend the meeting. The mother attended by phone along with a RCW 13.50.100 professional from RCW 74.15.515 Hospital. The grandfather attended in person as did CA staff. A decision was made to allow M.F. to discharge to RCW 74.1 mother, but then for mother and M.F. to live with the maternal grandfather and maternal aunt. The safety plan called for the relatives to keep M.F. within line-of-sight supervision at all times. The mother was not to be unsupervised with M.F. The mother agreed to ongoing voluntary services through CA to support her

[3] Family Team Decision Making (FTDM) meetings bring people together who are involved with the family to make critical decisions regarding the removal of child(ren) from their home, changes in out-of-home placement, and reunification or placement into a permanent home.

[4] Washington state law does not authorize Children's Administration to screen in intakes for a CPS response or initiate court action on an unborn child. [Source: Children's Administration Practice Guide to Intake and Investigative Assessment]

bonding and parenting as well as to monitor her RCW 13.50.100 . The grandfather also agreed to be a placement resource, if necessary, for M.F.

The CPS worker conducted a walk-through of the maternal grandfather's home. There were two contacts from the hospital social worker expressing concerns that M.F.'s mother was not visiting regularly, and when she did, it was for short periods of time. In addition, the mother was not taking an active effort to participate in RCW 74. care RCW 13.50.100 . Contact was made with the mother's RCW 13.50.100 provider who indicated the mother was RCW 13.50.100 . The CPS worker contacted the mother and referred her for RCW 13.50.100 An appointment was made for two days later to meet with the CPS and FVS workers and the mother. The RCW 13.50.100 was RCW 13.50.100

The CPS and FVS social workers met with the mother together to discuss the hospital social workers' concerns. While the mother did not demonstrate the most appropriate decision making, the CPS and FVS workers still felt that her case could proceed at that time to voluntary services. During this meeting the Period of Purple Crying and safe sleep were also discussed.[5]

M.F. was discharged on RCW 74.15.515 2017. On February 1, 2017, the FVS and CPS workers made a joint home visit. They met with the maternal grandfather, maternal aunt, mother and M.F. Another walk-through of the home occurred. M.F.'s sleep environment was observed. The safety plan and expectations were reviewed again between all of the adults. The workers discussed the in-home services again with the mother. The mother appeared to be fixating on wanting her own housing, even stating she would lie on a new assessment to appear as though she needed RCW 13.50.100 so she could obtain housing through that process.

On February 5, 2017, CA received an intake stating M.F. had passed away. The medical examiner stated the mother had fallen asleep in a chair with M.F. on her chest. When she woke, RCW 74 was unresponsive.

Committee Discussion

For purposes of this review, the Committee mainly focused on case activity from the time M.F. was born until RCW 74 passed away. There was minimal discussion regarding the death investigation. There were six calendar days between the time

[5] CA is committed to improving child safety outcomes for children under one year of age through early intervention and education with parents and out-of-home caregivers. [Source: CA Practices and Procedures Guide Chapter 1135. Infant Safety Education and Intervention]

that M.F. was discharged home to [redacted] mother and the time that [redacted] passed away. During that time, the CPS and FVS workers made a health and safety visit in the home, met with the mother and spoke with the relatives and attempted to meet with the father.

After this fatality and prior to this review, the CA office obtained a training regarding [redacted] from a local [redacted] provider regarding current challenges presented by the [redacted]. The Committee discussed that this was a good start, but a more in-depth training for all offices and case carrying staff regarding the behavioral indicators of use or abuse as well as how to collaborate with [redacted] providers would be a good next step. The Committee noted it would be ideal to take the next step to train caregivers and providers regarding child safety and [redacted]

There was discussion regarding the many facets to [redacted] as it collides with child safety. Two that are of great importance to child welfare would include the collaboration and communication between CA and [redacted] providers. Case carrying staff should know the basic questions to ask providers such as a parent's [redacted], what is the mother's [redacted] after having given birth, safe storage of [redacted] what discussions has the [redacted] provider had with the parent regarding safe sleep while using an [redacted] what are behavioral indicators to be concerned about, etc.

The Committee also discussed that a referral for a Public Health Nurse either from the hospital or from CA would have been beneficial for this mother and they also supported the idea that CA was going to refer the family for Promoting First Relationships.[6] However, the Committee did not identify that either of the supports would have had a direct impact on the ultimate outcome of this case.

There was some confusion about the mother's [redacted], including when she began [redacted] where was she going and her [redacted] plan. However, while that was not clear, the inclusion of a [redacted] during the FTDM and communication between the staff at [redacted] Hospital and CA was sufficient. It would have been ideal to have had the documentation of the mother's assessment for [redacted] discharge summary and current documentation of a [redacted] plan if available.

The Committee supported the staff's identification that a more in-depth discussion of line-of-sight supervision and how that was to play out during the evening hours would have been appropriate. However, it appeared as though the

[6] Promoting First Relationships, an evidence based service for families with a child between the ages of 0 and 3 years of age. [Evidence Based Practices - Description and Directory]

staff did discuss on numerous occasions safe sleep and supervision issues with the mother and relatives.

All CA staff involved were concerned about the mother's RCW 13 50.100 however, they identified that the mother was willing to cooperate, that there were appropriate and supportive family and that reasonable efforts must be made prior to legal intervention. The Committee agreed with this conclusion as well.

Findings

The Committee did not identify any critical errors during the short time this case was opened to CA. The Committee identified positive practice conducted by the staff regarding their assessment and engagement of least restrictive interventions with the family. This also included the identification by the Committee that practices, such as the FVS and CPS worker meeting with the family together, showed a genuine attempt to have a successful and smooth transition from one worker to the next.

Recommendations

CA shall develop or obtain a training for staff regarding the behavioral indicators of persons using and abusing RCW 13.50.100 and RCW 13.50.100 This training should provide staff with tools on how to assess the risk to child safety for parents using or abusing RCW 13.50.100 and/or RCW 13.50.100 as well as provide guidance on what to do with that information after it was been received.