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

Child Fatality Review

P.C.

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

October 20, 2017
Date of Child's Death

February 01, 2017
Date of the Fatality Review

Committee Members
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Executive Summary

On February 01, 2018, the Department of Social and Health Services (DSHS), Children's Administration (CA), convened a Child Fatality Review (CFR)[1] to assess CA's practice and service delivery to [redacted]-month-old P.C. and [redacted] family.[2] The child will be referenced by the initials P.C. in this report. The incident initiating this review occurred on October 20, 2017, when P.C.'s mother reportedly found P.C. in bed with [redacted] twin sibling and not breathing around 12:35 p.m. P.C.'s mother called 911 and P.C. was subsequently transported to a local hospital by paramedics where [redacted] was pronounced dead at 1:39 p.m. At the time of [redacted] death, P.C. was residing with [redacted] mother and twin sibling.

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, a Developmental Disabilities Administration(DDA) administrator, a pediatric and child abuse medical expert, a CA quality assurance CPS program manager and a CPS supervisor with CA. Neither CA staff nor any other Committee members had previous direct involvement with this family.

Prior to the review, each Committee member received a family genogram, a case chronology, a summary of CA involvement with the family and the 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 medical reports, relevant state laws and CA policies.

During the course of this review, the Committee interviewed the Child Protective Services investigators. Following the review of the case file documents, completion of interviews and discussion regarding department activities and decisions, the Committee discussed possible areas for practice improvement. The Committee did not conclude with any findings related to CA's response or CA systems, but it developed one recommendation for CA to consider.

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

Family Case Summary

Prior to P.C.'s death, CA received three intake[3] reports as to P.C.'s mother. One intake screened out[4] in 2016 prior to P.C.'s birth; CA received two subsequent reports resulting in investigations[5] twice between April 2017 and July 2017. The first report that was investigated came in to CA on April 15, 2017. CA was notified that P.C. and RCW 74.1 twin sibling were born on RCW 74.13.515 2017. P.C. was born with RCW 74.13.520 and was medically fragile.[6] The report included concerns for RCW 13.50.100. Further, the report indicated that the mother was RCW 13.50.100 . The investigator completed a Plan of Safe Care[7] with the mother and was able to verify from medical providers that they did not believe any of their concerns rose to a level that would make the children unsafe in their mother's care. Moreover, the investigator was able to assess the mother's behaviors and was not able to identify specific behaviors or obvious indicators related to RCW 13.50.100 . CA closed this case after the CA investigator completed collateral contacts, assessments and provided the mother with safe sleep[8] information including a warning of the suffocation/smothering risks of the

[3] An "intake" is a report received by CA in which a person or persons have reasonable cause to believe or suspect that a child has been abused or neglected. A decision to screen out an intake is based on the absence of allegations of child abuse or neglect as defined by Washington Administrative Code (WAC) 388-15-009.

[4] CA will generally screen out the following intakes: 1) Abuse of dependent adults; 2) Allegations where the alleged perpetrator is not acting in loco parentis; 3) Child abuse and neglect that is reported after the victim has reached age 18, except that alleged to have occurred in a licensed facility; 4) Child custody determinations in conflictual family proceedings or marital dissolution, where there are no allegations of child abuse or neglect; 5) Cases in which no abuse or neglect is alleged to have occurred; and 6) Alleged violations of the school system's statutory code or administrative code

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

[5] CA will accept for investigation a 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. In assessing imminent risk of serious harm, the overriding concern is a child's immediate safety. Imminent is defined as having the potential to occur at any moment, or that there is a substantial likelihood that harm will be experienced. Risk of serious harm is defined as: a high likelihood of a child being abuse or experiencing negligent treatment or maltreatment that could result in one of more of the following outcomes: death; life endangering illness; injury requiring medical attention; substantial risk of injury to the physical; emotional and/or cognitive development of a child. [Source: CA Practices and Procedures Guide 2220. Intake Process and Response]

[6] A child is considered "medically fragile" when meeting the following criteria: (1) Child has medical conditions that require the availability of 24-hour skilled care from a health care professional or specially trained family or foster family member; (2) These conditions may be present all the time or frequently occurring; (3) If the technology, support, and services provided to a medically fragile child are interrupted or denied, the child may, without immediate health care intervention, experience death. [Source: CA Practices and Procedures Guide 45171. Medically Fragile Children]

[7] CA caseworkers must complete a "Plan of Safe Care" as required by the Child Abuse Prevention and Treatment Act (CAPTA) when a newborn has been identified as substance affected by a medical practitioner. Substances are defined as alcohol, marijuana and all drugs with abuse potential; including prescription medications. [Source: CA Practice and Procedures Guide 1135. Infant Safety Education and Intervention]

[8]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 aged birth to one year, even if

observed bumpers in the crib as well as the risk of overlay suffocation associated with P.C. sharing a sleeping area with [redacted] sibling. The mother indicated to the investigator that she had a separate sleeping bassinette for P.C.'s sibling and that she was not going to remove the bumpers; however, she removed them while the investigation was open. Additionally, the CA investigator provided the mother with a pack and play portable crib and the Period of Purple Crying[9] video and information. The investigation was closed without identified safety threats[10] at the closure.

On July 12, 2017, CA received a report concerning P.C. and [redacted] twin sibling being [redacted]. The referent reported that P.C. had [redacted], was mobile, and was [redacted]. Further, the mother was suspected of using [redacted] and possibly [redacted]. During the course of the investigation, the assigned investigator found that the recommended medical care for P.C. had not been scheduled or received as needed since the closure of the previous investigation. The investigator observed unsafe sleeping practices and warned the mother against using bumpers and against P.C. sharing a crib with [redacted] sibling. The mother refused to remove the bumpers and relayed to the assigned investigator that as a parent she would make the daily sleeping and medical decisions. Another safety risk included

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the child is not identified as an alleged victim. [Source: CA Practice and Procedures Guide 1135. Infant Safety Education and Intervention] * Safe Sleep is a nationwide campaign to promote safe sleeping habits for children. Safe sleep practice can reduce the risk of SIDS. According to the National Institute of Child Health and Human Development the top 10 safe sleep guidelines are: 1) Always place your baby on his or her back to sleep, for naps and at night. 2) Place your baby on a firm sleep surface, such as on a safety-approved crib mattress, covered by a fitted sheet. 3) Keep soft objects, toys, and loose bedding out of your baby's sleep area. 4) Do not allow smoking around your baby. 5) Keep your baby's sleep area close to, but separate from, where you and others sleep. 6) Think about using a clean, dry pacifier when placing the infant down to sleep, 7) Do not let your baby overheat during sleep. 8) Avoid products that claim to reduce the risk of SIDS because most have not been tested for effectiveness or safety. 9) Do not use home monitors to reduce the risk of SIDS. 10) Reduce the chance that flat spots will develop on your baby's head: provide "Tummy Time" when your baby is awake and someone is watching; change the direction that your baby lies in the crib from one week to the next; and avoid too much time in car seats, carriers, and bouncers.

[9] 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. During this phase of a baby's life they can cry for hours and still be healthy and normal. The Period of Purple Crying begins at about 2 weeks of age and continues until about 3-4 months of age.

[10] A threat of danger is a specific family situation or behavior, emotion, motive, perception or capacity of a family member that threatens child safety. The danger threshold is the point at which family functioning and associated caregiver performance becomes perilous enough to be perceived as a threat or produce a threat to child safety. The safety threshold determines impending danger. Safety threats are essentially risk influences that are active at a heightened 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. Therefore, the safety threshold includes only those family conditions that are judged to be out of a caregiver's control. [Source: Safety Threshold]

persons the mother allowed around the children, associates with current and past criminal and violent behavior. They frequented the home and were around the children.

CA filed a dependency petition as to P.C. and [redacted] sibling and both children were removed from their mother's care by court order pending a shelter care hearing. After a contested shelter care hearing, the judge ordered the children returned to the mother's physical care against CA's recommendation. The dependency petition was not dismissed at the shelter care hearing and with court oversight and CA's constant monitoring and support over a two-month period, the mother was able to minimally complete or initiate court ordered services and set up P.C.'s needed medical appointments. After consultation and assessment, the assigned worker and CA supervisor working the dependency case did not find sufficient evidence to proceed to a fact finding hearing. CA then voluntarily dismissed the dependency petitions for both of the children. The cases were dismissed in September 2017 and the mother immediately moved to another city with her children.

On October 20, 2017, the local Deputy Medical Examiner notified CA of the child's death and surrounding circumstances. The cause and manner of death is unexplained. According to the autopsy, the circumstances surrounding P.C.'s death remained unclear, partly because the mother gave conflicting stories. There was no evidence of injury to P.C.'s brain or significant internal evidence of injury; however, the mother could or would not provide authorities with explanations for the contusion and abrasions of the frontal scalp and forehead associated with subgaleal hemorrhage.[11] Microscopic examination of the forehead showed that injuries were acute. Additionally, the examiner documented in the autopsy that P.C. (who was an infant with RCW 74.13.520) was bed-sharing with [redacted] twin sibling; therefore, unintentional overlaying cannot be excluded.

Committee Discussion

The Committee agreed with the investigator and CA's assessed safety concerns in July 2017 and the decision to petition for dependency and request removal of the children from the mother's care. Danger to P.C. was especially great based on [redacted]

[11] Subgaleal hemorrhage is a rare but potentially lethal condition found in newborns.[1] It is caused by rupture of the emissary veins, which are connections between the dural sinuses and the scalp veins. Blood accumulates between the epicranial aponeurosis of the scalp and the periosteum. This potential space extends forward to the orbital margins, backward to the nuchal ridge and laterally to the temporal fascia. In term babies, this sub aponeurotic space may hold as much as 260 mL of blood.[2] Subgaleal hemorrhage can therefore lead to severe hypovolemia, and up to one-quarter of babies who require neonatal intensive care for this condition die. [Source: Neonatal subgaleal hemorrhage: diagnosis and management Deborah J. Davis CMAJ. 2001 May 15; 164(10): 1452–1453]

special needs and the mother's medical neglect of the child. The Committee noted that the language in the petition was highly focused on the mother's personal behaviors versus P.C.'s medical needs and the medical neglect that was a result. The CPS investigator was able to inform the Committee that the pertinent information related to P.C.'s medical needs, the medical neglect and threat to P.C.'s safety was relayed to the court in the shelter care testimony. Regardless of the information the CPS investigator reported to the court, the children were returned to their mother's against CA's recommendation. The Committee noted that the CPS investigator assigned in July 2017 was very well versed in the case and with the needs of the child. The investigator was able to clearly articulate the issues of child safety and medical neglect to the Committee. Based on the investigator's presentation to the Committee, they wondered what more the court might have needed to know in order keep the children in the state's custody. Some Committee members wondered if CA might have been able to articulate a stronger argument to the court for keeping P.C. in out-of-home care while allowing RCW 74.1 sibling, who did not have the same medical needs as P.C., to remain with the mother. Some Committee members thought the court might have been more amenable to keep P.C. in the state's care based on RCW 74.1 medical needs not being met in comparison to lesser-documented concerns for RCW 74.1 sibling.

One area of debate among the Committee members was if a new intake report should have been generated based on P.C.'s physician's assessed risk to P.C. on August 1, 2017. The doctor stated that it was his professional opinion that P.C. was at high risk of neglect due to RCW 74.1 developmental needs, medical needs and due to the mother's noted anger and outbursts. This information was not part of testimony or information presented to the court at the shelter care hearing. The Committee discussed further that the mother had sought the required medical care for her child per the court order and the Committee understood the challenges CA investigators face trying to persuade judicial officers to keep children in out-of-home care when the parent is compliant with the order. The Committee recognized the challenges the investigator faced in articulating child safety concerns when the parent is cooperative with court ordered services in the required timeframes and shows minimal progress. The Committee recognized that CA and its attorney cannot substitute their judgment for that of the court and that the agency cannot assume responsibility for the court's decision if DCFS communicated information available to it to the court.

The Committee heard that CA believed both children to be at risk for harm based on the mother's lack of care, age of the children and the mother's observed and documented inability to take responsibility for her inactions as well as her hostile

and/or deceptive interactions with CA and other community providers. The Committee did not find fault with CA's response to the needs of P.C. Alternately, members discussed possible gaps in the medical community communicating and assessing the child's needs as well as the role of the court.

The Committee heard from the assigned CA staff that multiple case staffings occurred during both investigations. CA staff also stated they communicated with CA program managers, the Area Administrator, law enforcement and medical providers throughout the assigned 2017 investigations. The Committee considered the importance of case consultation and shared decision-making when dealing with complex cases like this one and that CA and the community benefit from such consultations. The Committee believed that information gathering, assessment and analysis is amplified when CA seeks a medical consultation,[12] connects with Developmental Disabilities Administration (DDA) and other DSHS programs, as well as CA staff at all levels in the chain of command.

The Committee discussed a lack of communication with DDA. The Committee wondered if periodic training was available for staff to learn when it is appropriate to refer clients to DDA, how to connect clients with DDA as well as assessing children with disabilities or developmental delays. The Committee discussed that CA investigators' knowledge on such topics varies by caseworker depending on previous education, training, and practice. The Committee identified that there have been liaisons working between CA and DDA and that it might be helpful to reconnect CA staff with their resources in hopes of increasing resource connections, the quality of assessments, and child safety.

Also, the Committee believed that a CA medical consultation and a medical assessment could have occurred in response to either intake in 2017. However,

[12] The purpose of the Consultation Network is to provide statewide consultation and training regarding medical findings in cases of alleged child abuse and neglect. It provides quick, cost free access to a physician with expertise in the diagnosis of complex cases of child abuse and neglect to professionals such as CA social workers and supervisor, physicians and other medical providers, prosecutors and Attorney's General, law enforcement, other professionals in child abuse and neglect and tribal social workers. Child Abuse Consultants are a team of physicians who provide statewide consultation and training regarding medical findings in cases of alleged child abuse and neglect. The Child Protection Medical Consultants (CPMCs) are a team of physicians who provide statewide consultation and training regarding medical findings in cases of alleged child abuse and neglect. The tasks of the statewide 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. Secure medical evaluation and/or treatment. The social worker considers utilizing a medical evaluation in cases when the reported, observable condition or the nature and severity of injury cannot be reasonably attributed to the claimed cause and a diagnostic finding would clarify assessment of risk. Social workers may also utilize a medical evaluation to determine the need for medical treatment. [Source: CA Practices and Procedures Guide 2331. Child Protective Services (CPS) Investigations]

the Committee did not find this as an error on the part of CA as CA acted quickly to remove the child and sought medical care once it was identified that the child had not received necessary medical care for an extended period of time.

Further, the Committee members questioned access and use of electronic information systems available to CA from within DSHS. The Committee discussed limited training on available outside computer information systems and how it would be beneficial for all CA staff to have access to a brief overview of navigating information systems that the Community Services Office has available. The Committee believed that this may have been helpful to understand the mother's needs, as she was receiving RCW 13.50.100 and she indicated to the investigator that she had a RCW 13.50.100 diagnosis. However, the mother declined offered services or to have a comprehensive discussion about her daily life and how the diagnosis may or may not impact her functioning and parental abilities. The Committee believed that the mother's communication was affected by deceptiveness or possible mental health influences, which could have prohibited the mother from communicating effectively for safety assessment of the children. The Committee also wondered if further time spent during the initial contacts, with collateral sources and in attempting to contact extended family may have improved the quality of information gained for a more thorough understanding of the daily life and safety of the children. The Committee wondered if and how effectively these important considerations were articulated to the court.

The Committee did not find any critical errors on the part of CA, noting that the decision to place the children back with the mother was made by the court over CA's objection. Additionally, the Committee did not make any findings, and only generated a recommendation below in hopes to enhance practice.

Recommendations

CA make training available to staff regarding the importance of connections with DDA, available information systems within DSHS including navigation, as well as provide CA staff with periodic reminders of such trainings and local resources or liaisons. The Committee believed that CA should continue to be allowed access to all DSHS computer systems and information for thorough safety assessments.