Washington State Department of Social & Health Services

CA Children's Administration

Child Fatality Review

R.A.

RCW 74.15.515 **2015**
Date of Child's Birth

August 3, 2017
Date of Child's Death

September 21, 2017
Date of the Fatality Review

Committee Members
Patrick Dowd, Director, Office of the Family & Children's Ombuds
Dr. Roy Simms, M.D., Acting Chief Medical Director, Coordinated Care of Washington; Primary Care Pediatrician, Yakima Pediatrics, Community Health of Central WA
Jim Weed, Detective Sergeant, Ellensburg Police Department
Angie Keith, Supervisor, Children's Administration
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Facilitator
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Table of Contents

Table of Contents

Executive Summary

On September 21, 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 2-year-old R.A and [redacted] family.[2] The child will be referenced by the initials R.A.in this report. The incident initiating this review occurred on June 22, 2017, when [redacted] was taken to a local hospital by paramedics after the mother called 911 stating R.A. was seizing. At the hospital, the child was found to have a subdural hematoma. Law enforcement notified CA of the injuries and R.A.'s hospitalization. The report was made with allegations of child abuse and neglect due to the mother and her newly identified paramour giving inconsistent explanations of the circumstances surrounding the incident. At the time of the incident, R.A. was residing with [redacted] mother and sibling. Prior to the incident, R.A. would travel between [redacted] mother and father for court ordered visitation at [redacted] father's home.

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 law enforcement officer, a pediatric and child abuse medical expert, a CA intake and safety 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 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 investigator and supervisor. Following the review of the case file

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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] 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: 74.13.500(1)(a)]

documents, completion of interviews and discussion regarding department activities and decisions, the Committee discussed possible areas for practice improvement, while recognizing the limited time CA was involved prior to the incident. The Committee did not conclude with any findings or recommendations related to CA's response or CA systems.

Family Case Summary

The CA case history for this family includes six reports since August 2016, three of which screened in for investigation. On June 8, 2017, two reports received by CA screened in[3] for investigation. The first report included allegations of physical abuse and negligent treatment. R.A. was reported to have had multiple injuries to vulnerable areas of RCW 74.1 body. CA later received a confirming report that R.A. had verified breaks in RCW 74.1 right arm (ulna and radius), with no explanation by the parents for the cause of the injury. R.A.'s parents, although separated and residing in different homes, were named as subjects of physical abuse and negligent treatment. It was determined by CA that the child was in the care of RCW 74. mother and that the mother delayed seeking medical care for the child overnight. The following day on June 9, 2017, RCW 13.50.100 called in a report accusing R.A.'s father of neglect and alleging that R.A. was returned to RCW 13.50.100 after visitation with injuries. This report screened out as the allegations had previously been reported twice and was under investigation. The parents were blaming each other for the condition of the child.

On June 11, 2017, another report was called into CA that was screened in for investigation. Law enforcement along with CA made initial contacts with the children, parents and collateral sources; R.A. was found to have bruising on RCW 74. right shoulder. R.A.'s sibling was found to be RCW 13.50.100 [redacted]. The investigator was able to find that the father to R.A.'s sibling resides in another state RCW 13.50.100 [redacted]. On June 15, 2017, an orthopedic surgeon who was reviewing R.A.'s medical records called CA concerning the previously reported injuries. The orthopedic surgeon indicated that a child with such injuries would have been in great pain and crying initially out, making it apparent RCW 74. was in need of immediate medical attention. The orthopedic surgeon questioned the mother's explanation of circumstances surrounding the injury and the delay on the part of the mother in seeking medical care. The orthopedic surgeon further noted curiosity and concern when the child was

[3] Intake social workers determine program response type and response times (emergent or non-emergent) for an investigation. CA intakes fall into three categories: CPS - Involves a child who is allegedly abused, neglected, or abandoned and includes child abuse allegations. CPS Risk Only - Involves a child whose circumstances places him or her at imminent risk of serious harm but does not include child abuse allegations. Non-CPS - Involves a request for services for a family or child.

verbally apologetic to medical staff about [redacted] injuries. This report screened out[4] for investigation as it was duplicate information already under investigation.

On June 22, 2017, R.A. was again taken to the hospital. The mother had called 911. Paramedics reported that upon arrival, R.A. was in an active seizure and paramedics intubated [redacted] The mother reported to paramedics that R.A. had fallen the night before in the back of the house on the wooden stairs, falling backwards and hitting [redacted] head on a concrete patio floor. R.A. was transported to the local hospital ER and was given a computerized tomography (CT)[5] scan, which came back positive for bleeding in the brain. R.A. was taken to emergency surgery to drill holes in [redacted] skull to release cranial pressure and then later was transported [redacted] Medical Center. R.A.'s profound injuries were inconsistent with the history [redacted] mother provided. The medical record identified that R.A. would have been symptomatic immediately after the event. The delay in presentation and inadequate story to explain [redacted] injury, plus the prior arm fracture of unknown cause were of concern for inflicted injury and child abuse. The mother and her paramour (who was present during the incident) changed their account on the sequence of events leading up to the injuries. CA was not aware of the mother's paramour's identity or involvement in her life prior to the incident. R.A. died due to complications from [redacted] injuries on August 3, 2017 while on comfort care.[6]

Committee Discussion

The Committee discussed the response to the intake that screened out on June 15, 2017. The Committee agreed with the intake worker's screening decision, as the allegations were duplicative and already being investigated. The medical expert on the Committee did not disagree with the orthopedic surgeon's concerns; however, provided an alternative assessment that the injury may have occurred from a fall, but not in all circumstances would a child respond with agonizing pain or complaints. After some discussion and recognizing that it is not required in policy, the Committee thought it would have been more helpful and better practice had the assigned worker or supervisor contacted the surgeon

[4]Generate a new screened out intake when a CA caseworker receives a second report of child abuse or neglect already documented in an intake (excluding facility related intakes) [Source: CA Practices and Procedures Guide 2200. Intake Process and Response]

[5] A computerized tomography (CT) scan combines a series of X-ray images taken from different angles and uses computer processing to create cross-sectional images, or slices, of the bones, blood vessels and soft tissues inside your body. CT scan images provide more detailed information than plain X-rays do. [Source: Mayo Clinic]

[6] Comfort Care Measures refers to medical treatment of a dying person where the natural dying process is permitted to occur while assuring maximum comfort. It is in contrast to other levels of intervention such as removal of all support modalities and long-term full care (intensive care support, mechanical life-support, multiple surgeries).

immediately as a collateral contact to gain further insight to the concerns and for a more comprehensive assessment of child safety.

The Committee found the staff interviews helpful in understanding how the local CA office functions and works to achieve policy measures and gather information for child safety. The Committee briefly noted systemic issues that seemed to go beyond CA's capacity to respond more fully to the demands of policy and work requirements in effort to assess for child safety. The Committee recognized the challenges CA staff have in triaging cases when there are vacancies in a unit, absenteeism, high caseloads, and/or emergent placement of a child on case(s) in the unit. Some Committee members believed CA should make provisions or additional resources for CA staff for the investigation of cases when the number of cases being assigned exceeds the capacity for CA to adequately investigate or gather information in a timely manner. Further, a portion of the Committee opined the importance of having a standardized or universal system for case assignments as well as basic competencies for all supervisors. Limited discussion occurred surrounding the CA's current Supervisor Core Training[7] (SCT) related to basic supervision competencies. Regardless of the noted systemic issues, the Committee believed to be a statewide issue for CA, there was an appreciation for the local supervisor's management of her unit and overall management skills.

Furthermore, the Committee was impressed with the partnership between the local CA investigative unit and local law enforcement agencies. It seemed to the Committee that partnership between CA and the medical communities lacked efficiency and effectiveness in comparison to partnerships with local law enforcement and medical communities statewide. The Committee did not conclude with related recommendations or findings for CA.

Understanding CA's inability to remedy or oversee outside agencies' protocols, some Committee members believed that the medical community failed to respond immediately to the child's evaluation needs at the initial June 8, 2017 visit. Recognizing the opinion regarding procedure of outside agencies is not within purview of this review, some Committee members voiced the importance

[7] SCT: This updated competency-based training program provides the foundation for effective supervisory practice in the child welfare system. This instructor led program will prepare new supervisors to become comfortable in assuming their new role, learning what it means to be a supervisor in the child welfare system, and to understanding the new responsibilities of this position. This program is offered for a 3-month period and covers topics such as: Becoming a Supervisor; Workload and Caseload Management; Navigating FamLink for Effective Supervision; Supervising with Data; Elements of Administrative Supervision; Talent Management; Elements of Clinical Supervision; Self Care, Secondary Trauma, Burnout Prevention and Conflict Management; Building and Facilitating Effective Teams; Role of the Supervisor in Critical Incidents and AIRS; Professional Ethics; ICW Government to Government. [Source: Alliance for Child Welfare Excellence]

of noting that due to the medical evidence and questions surrounding the circumstances, a skeletal survey should have been ordered immediately by medical staff at that initial hospital visit.

The Committee heard from the assigned investigator and supervisor regarding their heightened level of concern for the children based on the numerous received reports, unexplained circumstances surrounding the incidents leading to those reports and the behaviors of R.A.'s mother. The investigator and supervisor reported to the Committee how they responded and started their assessment by working with law enforcement to interview both children, relatives and R.A.'s parents. The CA staff that were interviewed further conveyed that they had constant communication and discussion of investigative evidence or lack thereof between the investigator and supervisor in the office. The investigator and supervisor identified challenges interviewing and gaining information from R.A.'s mother in comparison to R.A.'s father. Both parents equally shared negative opinions of each other; however, the investigator's and supervisor's initial contacts with R.A.'s father were more helpful in gaining information on [redacted] daily life and care of the child when he had visitation. R.A.'s mother presented to CA and law enforcement with behavior indicative of someone under the influence of substances or possible mental health issues. The investigator and supervisor relayed that R.A.'s mother continually returned the conversations to her opinions on her ex-husband rather than her daily life and functioning. Recognizing the apparent deceptiveness or external influences prohibiting the mother from communicating effectively for safety assessment[8] of the children, the Committee wondered if further curiosity and time spent during the initial contacts may have improved the quality of information gained for a more thorough understanding of the daily life and safety of the children. The Committee discussed the concept of a supervisor or more experienced worker helping in such situations to model interviewing techniques in attempt to gain needed information.

According to the Committee, there seemed to be some ambiguity on next steps for the investigator to take even after multiple case staffings with the supervisor. The Committee discussed the possibility of collaboration and communication with a CA program consultant, a request for urinalysis of R.A.'s mother and holding a Family Team Decision Making Meeting[9] (FTDM) immediately after the

[8] Safety Assessment is used throughout the life of the case to identify impending danger and determine whether a child is safe or unsafe. It is based on comprehensive information gathered about the family at the time the safety assessment is completed. [Source: CA Practices and Procedures Guide Chapter 1120]

[9] 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,

second interview of R.A.'s mother on June 15, 2017. These approaches may have improved information gathering or have assisted with any ambiguity for investigative tasks.

The CA investigator and supervisor informed the Committee they had planned to request a CA medical consultant review, but were waiting to receive a medical report. The Committee recognized that, although the case was newly assigned and staff were within designated policy timeframes[10] for their investigation, the Committee would have preferred to see CA staff make an immediate telephone call to a CA medical consultant[11] based on the reported heightened concern for the children.

Based on a review of the case documents and interviews with staff, the Committee did not find any critical errors made by department staff directly linked to child's death. The Committee did not have any findings or recommendations.

changes in out-of-home placement, and reunification or placement into a permanent home. There may be instances when a 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 a FTDM could provide placement options. Permanency planning starts the moment children are placed out of their homes and are discussed during a Family Team Decision-Making meeting. Am FTDM will take place in all placement decisions to achieve the least restrictive, safest placement in the best interests of the child. By utilizing this inclusive process, a network of support for the child(ren) and adults who care for them are assured. [Source: CA Practices and Procedures Guide Chapter 1720]

[10] Time frames-Safety, Risk and Investigative Assessments: 4.d.i. Complete a safety assessment within 30 calendar days from the date of the intake, and at key decision points in a case. 4.d.ii If a safety threat is identified and cannot be managed with a safety plan, review the case with a supervisor to determine if the child should be placed in out-of-home care. 4.d.iii. Complete the Structured Decision Making Risk Assessment (SDRMA) within 60 calendar days from the date and time CA receives the intake. Services must be offered to family with a high SDMRA score, and may be offered to families with a moderately high score. Ongoing risk assessment continues throughout the life of a case from the initial CPS intake until the case is closed. 4.d.iv. Complete the Investigative Assessment (IA) on all investigations within 60 calendar days of date and time CA receives the intake. 4.d.v. Document and submit for supervisor approval, a FamLink timeframe extension for investigations remaining open beyond 90 calendar days from the date and time CA receives the intake due to law enforcement or prosecutor collaboration. [Source: CA Practices and Procedures Guide Chapter 2331]

[11] The tasks of the statewide Child Protection Medical Consultants (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.