Report to the Legislature

Quarterly Child Fatality Report

RCW 74.13.640

January - March 2012

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Washington State Department of Social & Health Services

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Executive Summary

This is the Quarterly Child Fatality Report for January through March 2012 provided by the Department of Social and Health Services (DSHS) to the Washington State Legislature. RCW 74.13.640 requires DSHS to report on each child fatality review conducted by the department and provide a copy to the appropriate committees of the legislature:

> ***Child Fatality Review — Report***
>
> *(1)(a) The department shall conduct a child fatality review in the event of a fatality suspected to be caused by child abuse or neglect of any minor who is in the care of the department or a supervising agency or receiving services described in this chapter or who has been in the care of the department or a supervising agency or received services described in this chapter within one year preceding the minor's death.*
>
> *(b) The department shall consult with the office of the family and children's ombudsman to determine if a child fatality review should be conducted in any case in which it cannot be determined whether the child's death is the result of suspected child abuse or neglect.*
>
> *(c) The department shall ensure that the fatality review team is made up of individuals who had no previous involvement in the case, including individuals whose professional expertise is pertinent to the dynamics of the case.*
>
> *(d) Upon conclusion of a child fatality review required pursuant to this section, the department shall within one hundred eighty days following the fatality issue a report on the results of the review, unless an extension has been granted by the governor. A child fatality review report completed pursuant to this section is subject to public disclosure and must be posted on the public web site, except that confidential information may be redacted by the department consistent with the requirements of RCW 13.50.100, 68.50.105, 74.13.500 through 74.13.525, chapter 42.56 RCW, and other applicable state and federal laws.*
>
> *(2) In the event of a near fatality of a child who is in the care of or receiving services described in this chapter from the department or a supervising agency or who has been in the care of or received services described in this chapter from the department or a supervising agency within one year preceding the near fatality, the department shall promptly notify the office of the family and children's ombudsman. The department may conduct a review of the near fatality at its discretion or at the request of the office of the family and children's ombudsman.*

In April 2011, SHB 1105 was passed by the legislature and signed into law by Governor Gregoire. The revised child fatality statute (RCW 74.13) became effective July 22, 2011 and requires the department to conduct fatality reviews in cases where a child death is

suspected to be caused by abuse or neglect. This eliminated conducting formal reviews of accidental or natural deaths unrelated to abuse or neglect. The revised statute requires the department to consult with the Office of Family and Children's Ombudsman (OFCO) if it is not clear that the fatality was caused by abuse or neglect. The department can conduct reviews of near fatalities or serious injury cases at the discretion of the department or by recommendation of OFCO. The statutory revision allows the department access to autopsy and post mortem reports for the purpose of conducting child fatality reviews.

This report summarizes information from completed reviews of 3 fatalities that occurred in the first quarter of 2012. All of the reviews were conducted as executive child fatality reviews. All prior Child Fatality Review reports are found on the DSHS website: http://www.dshs.wa.gov/ca/pubs/fatalityreports.asp.

The reviews in this quarterly report include fatalities from each of the three regions.[1]

Region	Number of Reports
1	1
2	1
3	1
Total Fatalities and Near Fatalities Reviewed During 1st Quarter, 2012	3

This report includes Child Fatality Reviews conducted following a child's death that is suspicious for abuse and neglect and the child had an open case or received services from the Children's Administration (CA) within 12 months of his/her death. Child Fatality Reviews consist of a review of the case file, identification of practice, policy or system issues, recommendations and development of a work plan, if applicable, to address any identified issues. A review team consists of a larger multi-disciplinary committee including community members whose professional expertise is relevant to the family history. The review committee members may include legislators or representatives from the Office of the Family and Children's Ombudsman.

The chart below provides the number of fatalities and near fatalities reported to CA and the number of reviews completed and those that are pending for calendar year 2012. The number of pending reviews is subject to change if CA learns new information through reviewing the case. For example, CA may learn that the fatality or near-fatality

[1] DSHS implemented a reconfiguration of the regional boundaries in May 2011. The existing six regions were consolidated into three.

was anticipated rather than unexpected, or there is additional CA history regarding the family under a different name or spelling.

Child Fatality Reviews for Calendar Year 2012			
Year	Total Fatalities Reported to Date Requiring a Review	Completed Fatality Reviews	Pending Fatality Reviews
2012	7	0	7

Child Near-fatality Reviews for Calendar Year 2012			
Year	Total Near Fatalities Reported to Date Requiring a Review	Completed Near-Fatality Reviews	Pending Near-Fatality Reviews
2012	1	0	1

The fatality reviews contained in these Quarterly Child Fatality Reports are posted on the DSHS website.

Notable Findings

Based on the data collected and analyzed from the 3 fatalities reviewed between January and March 2012, the following were notable findings:

- Two (2) of the cases were open at the time of the child's death. One of the cases was open in the Child and Family Welfare Service program, the other was open under Child Protective Services (CPS).
- Two of the children were infants under the age of three (3) months old. The other child was seven (7) years old.
- Two (2) were male and (1) was female.
- All three (3) children were Caucasian, and one was also of Hispanic ethnicity.
- In the two fatalities listed as a homicide, both children were Caucasian.
- One (1) fatality occurred in Oregon. The family moved to Oregon and the family was involved in a car accident when the child's stepfather attempted to elude police. The seven-year-old child and his mother were killed in the accident.
- In the other fatality listed as a homicide, the child died from blunt force trauma. The perpetrator was the child's mother. CA had opened a CPS case on the mother days before the child's death.
- Children's Administration had intake reports of abuse or neglect in all three child fatality cases prior to the death of the child. Two of the cases had between one and four prior intakes and one had 13 prior intakes. The case with 13 prior intakes was classified by a medical examiner as a natural/medical death. The two other cases were both classified as homicides.

- Due to the small sample of cases reviewed, no statistical analysis was conducted to determine relationships between variables.

Table 1.1

1st Quarter 2012, Child Fatalities and Near Fatalities by Age and Gender						
Age	**Number of Males**	**% of Males**	**Number of Females**	**% of Females**	**Age Totals**	**% of Total**
<1	1	33%	1	33%	2	67%
1-3 Years	0	-	0	-	0	-
4-6 Years	0	-	0	-	0	-
7-12 Years	1	33%	0	-	1	33%
13-16 Years	0	-	0	-	0	-
17-18 Years	0	-	0	-	0	-
Totals	2	67%	1	33%	3	100%

N=3 Total number of child fatalities and near fatalities for the quarter.

Table 1.2

1st Quarter 2012, Child Fatalities and Near Fatalities by Race	
Black or African American	0
Native American	0
Asian/Pacific Islander	0
Hispanic	1
Caucasian	3
Totals*	**4**

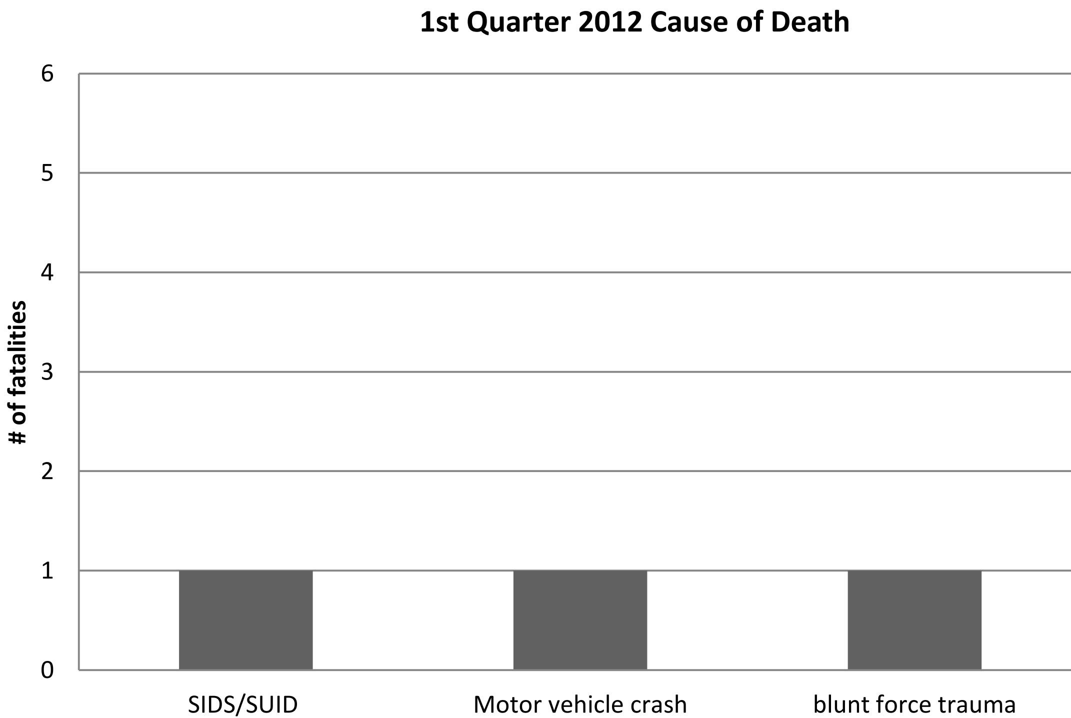
*Children may be from more than one race.

Table 1.3

1st Quarter 2012, Child Fatalities by Manner of Death	
Accident	0
Homicide (3rd party)	0
Homicide by Abuse	2
Natural/Medical	1
Suicide	0
Unknown/Undetermined	0
Totals	3

N=3 Total number of child fatalities for the quarter.

Table 1.4



N=3 Total number of child fatalities for the quarter.

Table 1.5

1st Quarter 2012 Number of Reviewed Fatalities by Prior Intakes						
Manner of Death	**0 Prior Intakes**	**1-4 Prior Intakes**	**5-9 Prior Intakes**	**10-14 Prior Intakes**	**15-24 Prior Intakes**	**25+ Prior Intakes**
Accident	-	-	-	-	-	-
Homicide (3rd party)	-	-	-	-	-	-
Homicide	-	2	-	-	-	-
Natural/Medical	-	-	-	1	-	-
Suicide	-	-	-	-	-	-
Unknown/ Undetermined	-	-	-	-	-	-

N=3 Total number of child fatalities for the quarter.

Summary of the Findings and Recommendations

Review committees can make a finding or recommendation regarding the social work practice, policies, laws or system issues following their review of the case history leading up to the child fatality or near-fatal incident. At the conclusion of every case receiving a full team review, the team decides whether any recommendations should result from issues identified during the review of the case by the fatality review team. Recommendations were made in only one of the three child fatalities reviewed between January and March 2012.

A finding is an opinion or a conclusion reached by the committee. A recommendation is made by the committee to address an issue with the case or to address deficits in practice or policy. Committees can reach a finding in a case without making a formal recommendation.

Findings were made in all three cases reviewed during the quarter. Committees found that case documentation by both the assigned social worker and supervisor were insufficient and did not follow department standards.

In a case involving an infant death, the committee found that an unsafe sleep environment was a factor in the child's death. The committee also found that the social worker made reasonable efforts to ensure that the mother was educated on a safe sleep environment.

Another team found that law enforcement and CA staff should meet to improve communication when both agencies are investigating the same incident.

In two of the reports, the committee commended the social worker for quality social work practice.

In the one case, the committee recognized that CA has guidelines for supervisory reviews for all program areas and are available to CA staff, but that use of the guidelines is not required. The guidelines are designed to identify whether case elements are completed and documented in the case file. During the review, the local office management discussed changes in the management structure of the office and the plan to increase supervisory oversight and guidance on cases.

A review committee recommended that the local office management review the accessibility and availability of DSHS database systems that track and document persons' and families' usage of social services. The committee recommended that CA social workers be trained to use such programs to locate hard to find families.

Issues and recommendations that were cited during the child fatality reviews completed during the quarter fell into the following categories:

1st Quarter 2012, Issues & Recommendations	
Contract issues	0
Policy issues	0
Practice issues	1
Quality social work	0
System issues	1
Total	**2**

Children's Administration
Executive Child Fatality Review

J.W.

January ██, 2004
Date of Child's Birth
August 22, 2011
Date of Child's Death
January 12, 2012
Executive Review Date

Committee Member
Launi Burdge, Area Administrator, Children's Administration, Region 1 North
Eddie Freyer, Undersheriff, Walla Walla County Sheriff's Office
Pat Flores, Chemical Dependency Professional, Serenity Point Counseling
Mary Meinig, Director, Office of the Family and Children's Ombudsman
Ann Passmore, YWCA Domestic Violence Program, Walla Walla/Columbia County
Shannon Sullivan, Social Worker 4 Supervisor, Region 1 South

Observer
Theresa Malley, Area Administrator, Region 1 South

Facilitator
Marilee Roberts, Practice Consultant, Field Operations, Children's Administration

Executive Summary

On January 12, 1012, the Department of Social and Health Services (DSHS), Children's Administration (CA) convened an Executive Child Fatality Review (ECFR)[2] of the case involving the death of 7-year old J.W. (D[redacted]). J.W. was in the care and custody of his mother and stepfather at the time of his death in Myrtle Point, Oregon. The family's CA case was closed at the time of J.W.'s death, however services had been offered by CA to the family within the 12 months preceding his death. CA conducts fatality reviews to identify practice strengths and challenges as well as systemic issues in an effort to improve performance and better serve children and families. A committee that included community professionals and CA staff reviewed case documents, policy and procedures, and best practices to examine the child welfare practices, system collaboration, and service delivery to J.W. and his family.

On August 23, 2011, in an attempt to locate J.W.'s father, Oregon Child Protective Services (CPS) contacted Washington State CPS reporting that J.W. (age 7) and his mother were killed in an automobile accident in Myrtle Point, Oregon. J.W.'s stepfather, who was driving the vehicle, was said to be intoxicated, driving at a high speed while attempting to elude police and crashed into a trailer killing J.W.[3] and his mother. Other family members (J.W.'s two siblings) were in the car at the time and sustained injuries requiring medical treatment and were released following a short hospital stay. The surviving siblings were placed into protective custody by Oregon law enforcement and subsequently in out of home care. J.W.'s stepfather was arrested and incarcerated on two counts of vehicular manslaughter. CA case information indicates the family had relocated to the Roseburg/Myrtle Point, Oregon area after having been contacted by Washington CPS in July 2011 regarding a new intake.

The family's CA history includes four intakes between November 2008 and July 2011 referencing allegations of negligent treatment and maltreatment. Intakes alleged issues related to domestic violence, unsafe living conditions in the home, animal cruelty and chronic substance abuse. Of the four intakes, two were screened in and assigned for investigation (November 2010 and July 2011) and two were screened out[4] (November 2008 and May 2011). The November 2010 investigation resulted in an unfounded finding while the July 2011 intake was not completed as CA staff noted they were unable to locate the family to complete an investigation.

The fatality committee members included CA staff and community members representing disciplines associated with the case. Committee members had no involvement in J.W.'s case. In addition to the case file, committee members received a chronology of the services provided to the family by CA, the 2011 accident report from Myrtle Point, Oregon, the Washington Administrative Code (388-15-009[5])

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[2] Given its limited purpose, an Executive Child Fatality Review by Children's Administration should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. A review is generally limited to documents in the possession of or obtained by DSHS or its contracted service providers and the panel may be precluded from receiving some documents that may be relevant to the issues in a case because of federal or state confidentiality laws and regulations. A review panel has no subpoena power or authority to compel attendance and generally will only hear from DSHS employees and service providers. The panel may 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 take personnel action or recommend such action against DSHS employees or other individuals.

[3] Cause of death was massive head and internal injuries. J.W. died en route to the hospital following the accident.

[4] The two intakes were screened out because neither contained an allegation of child abuse or neglect that meets the Washington Administrative Code definition of child abuse and neglect. The intakes were documented in Children's Administration's management information system, however CA is not authorized to act on screened out intakes.

[5] WAC 388 -15 -009 What is Child Abuse and Neglect?

referencing the definition of child abuse and neglect and CA policies regarding child protective services (CPS) investigations.

During the course of the review, committee members discussed issues related to CPS investigative practice and procedures, supervision, workload issues, and data base resources available to CA intake and CPS investigating staff. Following review of the documents, the family's case history and consultation with the office's management staff the review committee made findings and recommendations which are detailed at the end of this report.

Case Overview

As noted above, J.W.'s family's history with CA staff includes four intakes, two of which were assigned for investigation (November 2010 and July 2011).

In November 2010 CA staff initiated a child protective services (CPS) investigation into allegations related to domestic violence, unsafe conditions in the home and animal cruelty. Primary concerns referenced J.W.'s stepfather and several incidents of domestic violence which involved the death of family pets. Also, J.W.'s mother's made a disclosure stating she was uncertain she could ensure her children's safety at the time. During CA staff's initial intervention with the family it was noted J.W.'s stepfather was increasingly agitated and non-cooperative. Law enforcement subsequently placed J.W. and his siblings[6] in protective custody and in out of home care until such time it was determined J.W. and his siblings could return home safely. Following actions by J.W.'s mother to file a petition for protection, the family's agreement they would abide by a safety plan restricting[7] contact with his stepfather and the family's willingness to participate in Family Voluntary Services (FVS), the children returned home prior to a shelter care hearing[8].

The case remained open for three and half months with the understanding the family would participate in services and abide by the safety plan. However, the review committee was unable to find any documentation to indicate CA staff had contact with the family during this time to ensure they were following the safety plan or had been referred to services. The case remained open until March 2011 when it was closed. No case documentation or supervisory reviews as to CA staff's involvement or activity with the family were found.

In July 2011 CA staff received another intake referencing J.W. and his family and concerns regarding continued violations of protection orders, living conditions, and possible substance abuse. CA staff made contact with the family timely and completed the initial face to face with the children and assessed their immediate health and safety. CA staff was not able to meet with the children's mother during the initial contact, however made arrangements with the children's stepfather to meet with her on another day. The assigned social worker attempted to contact the family on the scheduled day, however they were not home. On this same day contact with law enforcement and a relative indicated the family had left the area[9] to avoid CPS. CA staff closed the case noting they were unable to locate the family. The case record does not reflect CA staff initiated any contact with the respective CPS agency in Oregon where it was known the family had relocated.

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[6] J.W. had an older sibling, age 10 and a half sibling, age 3.
[7] The mother and stepfather agreed to participate in supervised visitation with a neutral party.
[8] In the event a child is placed in protective custody he or she may not be held longer than 72 hours without a shelter care hearing. CA Case Services Manual Chapter 5720 (A)
[9] Information regarding the community where the family moved was provided to CA.

On August 23, 2011 Oregon CPS contacted Washington CPS requesting contact information for J.W.'s father for purposes of notifying him of J.W.'s death and as a possible placement option for J.W.'s surviving siblings. Oregon CPS indicated that J.W. was killed, along with his mother, in an automobile accident after his stepfather had committed a burglary and attempted to elude local law enforcement. J.W.'s mother died at the scene and J.W. died of massive head injuries en route to the local hospital. J.W.'s stepfather was arrested and charged with two counts of vehicular manslaughter and remains incarcerated. Following a short hospital stay for their injuries, J.W.'s siblings were placed in protective custody by law enforcement.

Discussion and Findings

To develop a thorough understanding of the family and the case, the review committee identified dynamics that appeared to influence decision-making. The committee reviewed decisions and actions taken by CA staff regarding intake screening decisions and investigations, assessment of child safety and family dynamics and family engagement.

Casework: The committee discussed at length the CPS investigations and Family Voluntary Services program decisions made in this case over the course of the family's involvement with CA staff. The committee found investigating social workers made active efforts to engage the family on several occasions to discuss the allegations and work with the family to ensure child safety. However, the absence of documentation in the case record made it difficult for the review committee to understand CA staff's actions and whether CA policies and procedures were followed while the case remained opened. For example, several investigative and case management expectations were not documented and should have included at a minimum the following:

- Written documentation of face to face meetings and investigative interviews[10] with all children in the family home.
- The development of collateral contacts and use of available data base systems[11] to assist in understanding family dynamics and supports verification of information shared by family members.
- Case plan development and monthly contact with family members to assess family progress.
- At a minimum monthly supervisory oversight on open investigations and cases.
- Shared decision making meetings (i.e. Child Protective Team, Family Team Decision Making meetings [FTDM]) to assist in case plan development and recommend service needs. CA policy requires that a FTDM meeting be held when children have been placed in protective custody and prior to their return home[12].

Resource Use and Communication: The review committee found that there was a significant amount of information known about and referencing this family in data base systems available to CA staff. However the committee was unable to determine if these resources, such as NCIC[13], Barcode and ACES[14] were accessed by staff during the 2010 or 2011 investigations or when developing the case plan. In particular, Barcode is a database with information that can support assessing a family and identifying service needs. Utilizing this system can provide an efficient and effective means to gather information

[10] CA Practices and Procedures Guide 2310 (B) (9)

[11] CA can access several data systems (NCIC, Barcode, Economic Services Administration, etc.) for information to assist in assessing a family's needs for intervention and services.

[12] CA Practices and Procedures Guide Chapter 4302 Family Team Decision Making Meetings

[13] National Crime Information Center

[14] Department of Social and Health Services database systems that contain information regarding a family known to DSHS that can support appropriate intervention and response to a family needs.

and communicate it as needed when working with a family. When meeting with local management the committee found that not all CA CPS investigating staff in the office have access to this particular database.

Additionally, when unable to locate a family in which CA has received an intake, best practice guidelines suggest CA staff make reasonable efforts to locate the children and parents in order to complete an investigation. Best practice guidelines and CA policy[15] provide staff with several methods to assist them in locating families prior to closing a case with the reason code - Unable to Locate. In this particular case, CA staff were notified by law enforcement and relatives of the family that the family had moved in order to avoid contact with CA staff. The review committee found that prior to closing the July 2011 intake (which requires supervisor review) CA staff should have contacted the CPS office in the community where the family was said to have relocated as a means to follow up on the concerns identified when the family left.

Supervisor Reviews/Oversight: The committee noted required monthly supervisor reviews[16] are essential to CA staff's work. These reviews provide the opportunity for clinical supervision and feedback and supports decision making based on information and facts available in a thorough investigation. In addition to supporting shared decision making, supervisory reviews assist social workers in developing a service plan. Without documentation in the case file it was difficult for the committee to determine if any supervisory oversight occurred in this case. In both instances when this case was open for investigation (November 2010 and July 2011) and for services (November 2010-March 2011) the committee was unable to determine if the case had been reviewed while open and prior to closure. Supervisory reviews particularly at closure identify whether case elements are completed or if any additional follow up or documentation is needed.

Recommendations

Supervisor Reviews and Casework Documentation: The absence of casework documentation and supervisor reviews in this case made it difficult to identify what interventions were made while this case was open from November 2010-March 2011. The review committee acknowledged CA staff have current practice and procedure expectations for both casework documentation and supervisor reviews. Guidelines for supervisor reviews for all program areas are available to CA staff. Utilizing the guidelines is not a requirement; however they are available to supervisors when reviewing cases on a monthly basis, for closure or program transfer. The guidelines are designed to identify whether case elements are completed and documented in the case file.
Local office management shared with the review committee that recent changes in the management structure of the office had occurred and a plan to increase supervisory oversight and guidance on cases as directed by policy has been implemented.

Data Base System Availability: During the course of the review the committee discussed the DSHS database systems, such as Barcode, available to CA staff for use when investigating allegations of abuse or neglect or providing services to families. The review committee noted database systems can provide additional information during the fact finding stages of a case and to support findings. It is unclear from the case record if this information was accessed. The information available within the Barcode system and other systems can assist in verifying information provided by the family during the course of a case as well as assist in case plan development and service implementation. The review committee

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[15] CA Practice and Procedures Guide Chapter 5200 (B) Unable to Locate Parent and/or Relative Caretaker
[16] CA Practices and Procedures Guide Chapter 46100 Supervisory Monthly Reviews and CA Operations Manual Chapter 6223 Supervisory Monitoring

recommends local office management review the accessibility and availability of data base systems, such as Barcode, for front line social work staff and include training on data base usage.

Children's Administration

Executive Child Fatality Review

A.R. Case

Date of Birth: 06/26/2011
Date of Death: 09/10/2011
Date of Review: 01/27/2012

Committee Members:
Pat Shaw, Program Manager, Clark County Public Health
Mary Blanchette, Executive Director, Clark County Children's Justice Center
Peggy Lewis, BRS Program Consultant, Region 2, Children's Administration
Bill Paresa, Area Administrator, Division of Children and Family Services (DCFS), Region 3 South
Jennifer Holbrook, Child Protective Services Supervisor, DCFS, Vancouver
Shelley Arneson, Child and Family Welfare Services Social Worker, DCFS, Vancouver
Kathy Shirlla, Clark County Court Appointed Special Advocate (CASA)

Observers:
Lynda Richart, Skamania County Court Appointed Special Advocate (CASA)
Mary Meinig, Director, Office of the Family and Children's Ombudsman
Paul Smith, Critical Incident Program Manager, Children's Administration Headquarters

Facilitator:
Edith Hitchings, Deputy Regional Administrator, Region 2 South, Children's Administration

RCW 74.13.515

Executive Summary

On September 10, 2011, the Skamania County Sheriff's Department received a report that two-month-old A.R. was found not breathing. Law enforcement arrived at the home of the child's grandparents. A.R.'s mother (A.S.) also lived in the grandparents' home. A.S. told first responders that she woke up at about 5:30 a.m. and fed her daughter about four ounces of formula. A.R. fell back asleep on her back next to her mother in the same bed. There was no bedding on top of them as the temperature was warm outside. The child was wearing only a diaper. The child fell back asleep and about an hour later A.S. woke to go to the bathroom. When she returned from the bathroom, she checked on her daughter who was non-responsive. A.S. called for her father who came to the room and started CPR. A 911 call was made at or around the same time.

Police officers responded and performed CPR until paramedics arrived. Paramedics continued CPR for an additional 30 minutes. Paramedics transported A.R. to Skyline Hospital in White Salmon and continued CPR. Resuscitative efforts were continued at the hospital; however, she was nonresponsive the entire time and was finally pronounced dead at 8:53 in the morning.

The emergency room doctor reported no obvious indicators that A.R.'s death was the result of abuse or neglect. The child's grandfather reported A.R. had a stuffy nose and a slight temperature of about 100 degrees.

It was reported to the team that the weather had been warm on and around the day of A.R.'s death. The air quality in the area was poor due to heavy smoke in the area from a forest fire that lasted several days.

A.R. was removed from her mother's care on June 28, 2011. She was initially placed in foster care but was later moved to her grandparents' care on July 5, 2011. She was still in the care of her grandparents when she died. Her mother also lived in the home. An initial safety plan was put in place that required the grandparents to provide all of the supervision of A.R. On August 10, 2011, the safety plan was nullified by a court order. The court lifted the requirement that A.S. could not have unsupervised contact with her daughter. The court order stipulated that the grandparents monitor A.S.'s contact with her daughter. A.R. was allowed to sleep in the same room with her mother in a bassinet.

There were no other children placed in the home at the time of A.R's death. The only persons in the home at the time of A.R.'s death were A.R., her mother, and maternal grandparents.

A.S. had an open case in the Stevenson Division of Children and Family Services (DCFS) office when A.R. was born. [redacted] the department was providing court-ordered services to A.S. M[redacted]

A Child Protective Service (CPS) intake was screened in for investigation on circumstances of A.R.'s death. Her death was also investigated by the Skamania County Sheriff's Department.

The autopsy was completed by the Klickitat County Coroner. The coroner reported the autopsy showed no signs of trauma. The toxicology report indicated no drugs or alcohol in A.R's system. The official cause of death is listed as Sudden Infant Death Syndrome. The CPS investigation was closed with an unfounded finding for negligent treatment or maltreatment. Skamania County Sheriff's closed their case without filing charges.[17]

On January 27, 2012, Children's Administration (CA) convened a multi-disciplinary committee to review adherence to policy and the social work practice in this family's case.[18] The fatality review team was represented by disciplines associated with the case and had no involvement or limited involvement with this family. The fatality review team members included court appointed special advocates, a member from the Clark County Children Justice Center and the Clark County Public Health Department. The team also included CA staff who had no direct connection to the case. The director of the Office of the Children and Family Ombudsman was present at the review.

Relevant case documents were made available to the fatality review team. These documents included: law enforcement reports, family history including intake information, Individual Social Service Plan, a chronology of the case upon assignment of the case and a summary of the incident the morning of A.R.'s death.

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[17] Revisions to RCW 74.13.640 went into effect in July 2011. RCW 74.13.640 reads: (a) The department shall conduct a child fatality review in the event of a fatality suspected to be caused by child abuse or neglect of any minor who is in the care of the department or a supervising agency or receiving services described in this chapter or who has been in the care of the department or a supervising agency or received services described in this chapter within one year preceding the minor's death. (b) The department shall consult with the office of the family and children's ombudsman to determine if a child fatality review should be conducted in any case in which it cannot be determined whether the child's death is the result of suspected child abuse or neglect. Although it was eventually determined by Child Protective Services, law enforcement, and the county coroner that A.R. did not die from suspected abuse or neglect, the department consulted with the office of the family and children's ombudsman and the decision was made to conduct a child fatality review of this case.

[18] Given its limited purpose, a Child Fatality Review by Children's Administration should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. A review is generally limited to documents in the possession of or obtained by DSHS or its contracted service providers and the panel may be precluded from receiving some documents that may be relevant to the issues in a case because of federal or state confidentiality laws and regulations. A review panel has no subpoena power or authority to compel attendance and generally will only hear from DSHS employees and service providers. The panel may 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 take personnel action or recommend such action against DSHS employees or other individuals.

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Following review of the case history, case records and law enforcement records, the review team discussed the case history, system collaboration, and service delivery regarding this child and her mother. The team discussed the department's efforts to address the issues that interfered with A.S.'s ability to parent her children —including mental health and her substance abuse issues. The team addressed safe sleep issues and efforts to educate communities and clients on safe sleep issues. The findings, issues and recommendations were discussed by the review team and this discussion is detailed at the end of this report.

RCW 74.13.515

RCW 74.13.520

Case Overview

A.S. is the mother of four children M.G., 6 years old; J.M., 3 years old; M.M., 22 months old; and A.R, who was six months old at the time of her death.

In June 2011, A.S. gave birth to A.R. at an Oregon hospital (she was a resident of Washington state at the time). The department received a report from hospital staff

that A.S. had delivered a substance exposed baby girl. A

A meconium test for A.R. was positive for opiates. The department filed a dependency petition on A.R. two days later. She was briefly placed in foster care following her discharge from the

RCW 74.13.515

hospital. A Family Team Decision Meeting (FTDM) was conducted and the maternal grandparents to A.R. were identified as a relative placement. The family's plan arranged during the FTDM allowed for to A.S. live with her parents, but all contact with her daughter was to be supervised. The grandparents agreed that A.R. would sleep in a crib in their room at night. An aunt would provide supervision during the day when the grandparents were at work.

Services were offered to A.S. immediately after the dependency petition filing in June 2011. A.S. participated in a psychological evaluation with a parenting assessment, and drug/alcohol evaluation. A.S. completed a drug/alcohol education course.

She was referred to the Skamania County Early Support for Infants and Toddlers program, and a mental health assessment, but had not participated in these services prior to her daughter's death.

On August 10, 2011, a Shelter Care review hearing was held in Skamania County Superior Court. The court ordered that A.S. could have liberal unsupervised contact, monitored only by the grandparents. The easing of the supervision requirement was due to A.S.'s cooperation and participation in services. A.S. was allowed to have her daughter's crib moved to her bedroom and was allowed liberal unsupervised contact. The court order was still in effect when A.R. died one month later.

Paternity on A.R. was not established at the time of her death.

Issues Identified by the Review Team

The review team discussed actions taken by law enforcement and Children's Administration's after hours staff regarding the November 20, 2010 intake. The team acknowledged the excellent social work practice evidenced in the case file after the case was assigned to a local CPS social worker. Case staffings were frequently conducted to discuss A.S's progress, additional service needs and any other recommendations. The fatality review team's findings include the following:

- The team discussed the remote area of the state where the family lived and the limited access to resources and services, including the availability of a public health nurse and mental health services. DCFS staff from the Stevenson office and the GAL commented on the lack of available services to the families in Skamania County. This is a hardship on most families who often have to drive to Clark County to accessing appropriate services.

Findings

- The review team identified co-sleeping between the mother and her daughter as a potential factor in the child's death. The potential risks of co-sleeping were repeatedly discussed with A.S. and the maternal grandparents by her social worker. The team recognized that the worker made reasonable efforts to ensure that A.R. had a safe sleep environment. The team identified good practice in this case and suggested that best practice on open CPS cases involving infants is for social workers to discuss safe sleep education with the parents.
- The team acknowledged that A.S. lived in a small close knit community. She and her family are well known and closely watched in the community. Children's Administration staff have a long standing relationship with her and her children. A.R.'s death has had a tremendous impact on CA staff, the GAL, and the service providers who worked with this family.
- The team commended the supervisor and social worker on the very thorough casework done by the staff in the Stevenson DCFS office and the level of support provided to A.S.

Recommendation

- The fatality review team made no specific recommendations.

RCW 74.13.500

Children's Administration

Executive Child Fatality Review

I.A.

May ██, 2011
Date of Child's Birth

September 24, 2011
Date of Child's Death

February 1, 2012
Executive Child Fatality Review Date

Committee Members:
Isaac Pope, M.D., Volunteer Pediatrician
Russ Funk, Program Manager, Cascade Mental Health Center, Centralia
Katie Braee, Social Services Advocate, Human Resources Network, Chehalis
Jamey McGinty, Detective, Lewis County Sheriff's Office
Rebecca Scott, Parent Support Services Coordinator, Centralia College
Debbie Lynn, Area Administrator, Children's Administration

Observers:
Mary Meinig, MSW, Director of the Office of Family and Children's Ombudsman
Paul Smith, Critical Incident Program Manager, Children's Administration

Facilitators:
Bob Palmer, Children's Administration Program Consultant, Region 3 North
Thomas "Kui" Hug, Children's Administration Safety and Well-Being Program Manager, Region 3

Executive Summary

On February 1, 2012 Children's Administration (CA) convened an Executive Child Fatality Review[19] (ECFR) committee to examine the practice and service delivery in the case involving 4-month-old I.A. and his mother. The incident initiating this review occurred on September 20, 2011, when Centralia CPS intake was notified of the hospital admission of I.A. for severe injuries believed to be the result of non-accidental trauma while in the care of his mother Rachel Bryan[20].

A review of the family's history with CA showed one previous intake from five days prior (September 15) regarding a lump and tenderness to the infant's back. Of noted concern at that time was the reported inappropriate way the mother spoke to the child. This earlier report was assigned for investigation and thus the case was open with CPS at the time of I.A.'s hospitalization for severe injuries from which he died on September 24, 2011.

The ECFR committee included CA staff and community members selected from diverse disciplines with relevant expertise, including representatives from medical, law enforcement, parenting, mental health, and DV/community advocacy. Committee members had no prior direct involvement with the case, although some had limited general knowledge of the situation. Prior to the review each committee member received a chronology of known information regarding the mother and child, un-redacted CA case-related documents, as well as medical and law enforcement records obtained post-fatality incident. Available to committee members at the review were additional documents (e.g., autopsy report), copies of various laws relevant to CA (e.g., legal definitions of abuse and neglect), and several CA policy and practice guides relating to CPS investigations and assessment of risk and safety. During the course of the review, the CPS investigator, CPS Supervisor, and the Area Administrator were available for interviews, but the committee declined as the documentation provided appeared to be

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[20] The full name of Rachel Bryan is being used in this report as she has been charged in connection to the incident and her name is public record

sufficiently clear in terms of activities and the basis for decisions made. Committee members were provided with pertinent information gathered during a pre-review interview of the CPS investigator by the ECFR facilitator.

Following review of the case file documents and discussion regarding social work activities and decisions during the CPS investigation, the review committee made findings and recommendations which are detailed at the end of this report.

Case Overview

It is known that the mother moved from Washington State to California in early 2010. She gave birth to her son in California in May 2011. In early September of 2011 Rachel and her infant moved back to Washington State following a domestic violence situation involving her partner (I.A.'s biological father) who was subsequently jailed and then returned to prison (parole violation).

CPS first became aware of I.A. and his mother five days prior to the precipitating incident which resulted in the infant death. On September 15, 2011, a nurse practitioner from a pediatric health center called with concerns following a 4-month-old (new patient) who had been brought in by his mother for a reported lump/tenderness to the child's back. Examination and x-rays revealed no apparent medical explanation and no bruising was found. Observations of the mother's interaction with the infant were of noted concern by health center staff. The mother was described as appearing to be on edge, easily agitated, and very abrupt when talking to the infant - saying things like "stop crying," "you'd better stop crying," "you're irritating me."

The report was accepted for investigation and the assigned investigator from Centralia CPS made contact with mother, child, referent, and maternal relative within 24 hours. Additionally, the worker consulted with a state Child Protection Medical Consultant[21] who in turn contacted the medical care provider for additional discussion.

A Family Action Plan[22] was developed by the CPS social worker with the parent to help address housing and transportation, to access counseling and medication, to access a parenting class, and to increase the visibility of the child using natural supports. That weekend Ms. Bryan and I.A. moved in with the maternal grandmother. The CPS worker received a voice message the following Monday (September 19, 2011) from the mother confirming the move to her mother's home in the Centralia area. Ms. Bryan also reported she had several appointments set for that week (health; mental health) and

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[21] 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.

[22] A Family Action Plan (FAP) is a family collaboration tool that can be used to document a family's efforts to identify needs/concerns, to problem solve and develop actions steps, and to identify natural supports. It is not a safety plan per se, but may include steps to maintain safety through increased visibility of the child. [Source: DSHS/CA Practice Guide to Intake and Investigative Assessment – Chapter Seven Family Action Planning]

had contacted various community and public agencies (Women, Infant, & Children; DSHS).

On the morning of September 20, 2011, I.A. and Rachel were transported to appointments by her "step-father," returning to his home in Thurston County. That afternoon, while the step-father was working outside, Rachel called 911 to report that her baby was not responding as normal and was in distress. Emergency aid arrived to the residence and the child was transported to Centralia Providence Hospital, presenting with possible seizures, hematoma to both eyes, and an arm fracture. The injuries were determined to be due to non-accidental causes. The child was transported to Mary Bridge Hospital in Tacoma as the child's injuries were very severe and required immediate medical attention. The prognosis at Mary Bridge was that the child was likely to die as a result of the injuries.

When interviewed by a Thurston County Sheriff's Office detective, Rachel Bryan confessed to physically abusing her infant son. The mother reported I.A. was crying for 20 minutes, and she could not handle it any more. She then forcibly pulled the child up into her shoulder, shook him twice, and then forcefully drove him into the mattress twice. The mother was booked for Second Degree Assault of Child. When the child was pronounced dead on September 24, 2011, charges were amended to Murder in the Second Degree with Aggravating Circumstances.

The CPS investigation was completed in October, with "unfounded" findings regarding neglect but "founded" for physical abuse to her son.

Committee Discussion:

Committee members acknowledged the short time span of CPS involvement in this case, with the first intake being received and accepted for investigation on September 15, 2011 (Thursday), contact being made with medical professionals and the family the following day (Friday), and the second intake regarding severe non-accidental injuries occurring on September 20 (Tuesday) that resulted in the removal from life support of I.A. on September 24, 2011. Committee members reviewed information gathered and social work activities completed by the CPS investigator and supervisor from case assignment to case closure. Committee members engaged in extended discussion as to the CPS worker's response to risk factors and "warning signs" identified early in the case.

Findings:

Intake related

The committee was in full agreement that the decision to accept the September 15, 2011 intake for CPS intervention was appropriate, but was unable to reach complete consensus as to the appropriate designated intake type (i.e., accepting the intake on the

basis of allegations or on the basis of Risk Only[23]). There were no associated recommendations specific to intake decisions.

Investigation related
The committee acknowledges good social work practice as evidenced by case file documentation, and recognizes the efforts by the worker to gather information, to assess the family, and to make casework decisions in a short period of time. The committee concludes that the CPS investigative activities and decisions were reasonable and sensible given the information available, and were found to be consistent with current laws and CA policy and practice standards. The worker appears to have been appropriately aware of identified risk factors and "warning signs" suggestive of parental ambivalence[24]. The committee was unable to reach full consensus as to whether the identified concerns sufficiently suggested that I.A. was endangered and therefore should have had a safety plan in place that limited the mother's access to the child as opposed to the Family Action Plan (FAP) that was developed with the parent with family support. The committee does conclude that the FAP did appropriately focus on actions and services that would reasonably be expected to reduce risks and improve parenting and the parent-child relationship. There are no associated recommendations specific to the investigative practice in this case.

Recommendations:

No recommendations emerged that fell within the scope of the Executive Child Fatality Review process.

Miscellaneous Consideration outside the scope of the ECFR:

While not relating to any aspects specific to the circumstances of this particular case, discussion during the review suggested that there may be a need for better communication between CPS and local (Lewis County) law enforcement officers as to

[23] 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. Many intakes without CA/N allegations will have one or more risk factors. This does not necessarily mean that imminent risk of serious harm is present. The more indicators of CA/N, the more likely it is that a child is being abused or neglected. While many concerning reports are received by CA, most will not rise to the level of imminent risk of serious harm. Careful analysis of the balance of risk and protective factors, combined with good clinical judgment and shared decision making, helps in identifying risk-only intakes. [Source: *DSHS CA Practice Guide to Intake and Investigative Assessment* - Chapter Four Risk Only Intakes]

[24] Parental ambivalence relates to the nurturing and affectionate aspects of a parent-child relationship. It is often identifiable by behavioral or verbal indicators that suggest contradictory attitudes toward the relationship, incompatible expectations and mixed emotions, and self-doubt regarding being able to handle a parent/caretaker role.

placing children into protective custody per RCW 26.44.050[25]. It appears that some CA social workers in Lewis County may be reluctant to provide officers with their opinion as to the need for protective custody so as not to appear to tell law enforcement what to do as the decision rests legally with an officer of the law.

The review committee suggested that the Area Administrator (AA) for the Lewis County DCFS office review and assess the procedures and expectations regarding protective custody that may exist in any written working agreement/protocol with local law enforcement, and to initiate discussion with protocol participants if needed changes are identified. It was further suggested that the AA initiate discussion with Centralia social work staff as to how to effectively communicate with responding officers about identified safety threat issues when protective custody is a consideration while acknowledging that the decision rests with the officer. Such discussions should involve participation by representatives from local law enforcement if possible.

Action Taken: The Area Administrator (AA) for the Lewis County DCFS office has been apprised of the above discussion and has agreed to follow up on the suggestions made to improve communication between workers and responding law enforcement regarding assessed child safety threats.

[25] A law enforcement officer may take, or cause to be taken, a child into custody without a court order if there is probable cause to believe that the child is abused or neglected and that the child would be injured or could not be taken into custody if it were necessary to first obtain a court order pursuant to RCW 13.34.050.