Washington State Department of Social and Health Services

Transforming Lives

REPORT TO THE LEGISLATURE

Quarterly Child Fatality Report

RCW 74.13.640

January – March 2017

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Washington State Department of Social & Health Services
Transforming lives

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Executive Summary

This is the Quarterly Child Fatality Report for January through March 2017 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 ombuds. 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 ombuds.

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 January 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 Ombuds (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 five (5) child fatalities that occurred in the first quarter of 2017. All child fatality review reports can be found on the DSHS website: https://www.dshs.wa.gov/ca/publications/childrens-administration-child-fatality-reports

The reviews in this quarterly report include child fatalities and near fatalities from three regions.

Region	Number of Reports
1	2
2	3
3	0
Total Fatalities and Near-Fatalities Reviewed During 1st Quarter 2017	5

This report includes Child Fatality Reviews conducted following a child's death that was 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 or injury. A critical incident review consists 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 and representatives from the Office of the Family and Children's Ombuds.

The charts below provide the number of fatalities and near-fatalities reported to CA and the number of reviews completed and those that are pending for calendar year 2017. The number of pending reviews is subject to change if CA discovers new information through reviewing the case. For example, CA may discover that the fatality or near-fatality 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 2017			
Year	Total Fatalities Reported to Date Requiring a Review	Completed Fatality Reviews	Pending Fatality Reviews
2017	6	0	6

Child Near-Fatality Reviews for Calendar Year 2017			
Year	Total Near-Fatalities Reported to Date Requiring a Review	Completed Near-Fatality Reviews	Pending Near-Fatality Reviews
2017	1	0	1

The child fatality reviews referenced in this Quarterly Child Fatality Report is subject to public disclosure and is posted on the DSHS website. https://www.dshs.wa.gov/ca/publications/childrens-administration-child-fatality-reports

Near-fatality reports are not subject to public disclosure and are not posted on the public website.

Notable First Quarter Findings

Based on the data collected and analyzed from the five (5) fatalities during the 1st quarter, the following were notable findings:

- Three (3) of the five (5) cases referenced in this report were open at the time of the child's death.
- Two (2) of the five (5) fatality cases resulted from the child drowning.
- Two (2) of the five (5) fatality cases resulted from the infant dying in unsafe sleep environments.
- One (1) child died from blunt force trauma inflicted by the mother's boyfriend.
- Two (2) children died while in the care of a person other than a parent.
- In all five (5) cases referenced in this report the children were two years of age or younger when the fatality occurred.
- Three (3) of the five (5) cases referenced in this report were the result of abuse or neglect by the children's parents or caregivers.
- Two (2) children in this report were Caucasian, two (2) were Native American and one (1) was African-American.
- Children's Administration received intake reports of abuse or neglect in each of the cases in the report prior to the death of the child. In one (1) case, there were two (2) intakes reported to CA prior to the fatality; in three (3) cases there were between 8 to 19 intakes prior to the child's death. In one (1) fatality case, there were 27 intakes on the family prior to the fatal incident.
- Due to the small sample of cases reviewed, no statistical analysis was conducted to determine relationships between variables.

Washington State Department of Social & Health Services

CA Children's Administration

Child Fatality Review

P.S.

RCW 74.13.500 2016
Date of Child's Birth

June 10, 2016
Date of Fatality

October 6, 2016
Child Fatality Review Date

Committee Members
Cristina Limpens, MSW, Senior Ombuds, Office of the Family and Children's Ombuds
Jerry Sells, M.D., Retired Pediatric Physician
Pam Hubbard, LMHC, CDP, Co-Occurring Disorder Therapist, Evergreen Recovery Centers
Michelle Clark-Rogers, Child Protective Services, Children's Administration

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

Executive Summary

On October 6, 2016, 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 RCW 74.13.515 P.S. and RCW 74.13.515 family.[2] The child will be referenced by RCW 74.13.515 initials, P.S., in this report.

P.S. was born in RCW 74.13.515 2016. At the time of RCW 74.13.515 birth, CA received an intake with concerns of RCW 13.50.100 . A Child Protective Services (CPS) worker was assigned to investigate. P.S. had been born RCW 74.13.520 and it was the understanding of the CPS worker that RCW 74.13.515 would remain in the hospital for a couple of weeks. The CPS worker requested notification before RCW 74.13.515 was to be discharged.

On RCW 74.13.515, 2016, the CPS worker was notified by the mother that P.S. had been discharged from the hospital. The worker made contact that day with the father of P.S. and both half-sisters but the mother and P.S. were not present. On June 10, 2016, law enforcement notified CA that P.S. had passed away while in the bathtub with RCW 74.13.515 mother. The medical examiner's office determined the cause and manner of death were both undetermined. However, within the undetermined cause of death, the report suggests the cause of death to be asphyxia mechanism, either positional or related to drowning. The autopsy also identified an unsafe environment within the diagnosis; in addition to the mother's RCW 74.13.520, the infant was held against the morbidly obese, sleeping, naked mother in a bathtub containing water.

At the time of RCW 74.13.515death, P.S. lived with RCW 74.13.515mother, father and two half-siblings. Additionally, the mother has two other children who live with their father out of state.

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 retired pediatric physician who also participates on the

[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 near death of a child. The CFR Committee's review is generally limited to documents in the possession of or obtained by DSHS or its contracted service providers. The Committee has no subpoena power or authority to compel attendance and generally only hears from DSHS employees and service providers. It does not hear the points of view of the child's parents and relatives, or of other individuals associated with the child. A Child Fatality Review is not intended to be a fact-finding or forensic inquiry or to replace or supersede investigations by courts, law enforcement agencies or other entities with legal responsibility to investigate or review some or all of the circumstances of a child's fatal injury. Nor is it the function or purpose of a Child Fatality Review to recommend personnel action against DSHS employees or other individuals.

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

local child protection team for CA, a co-occurring treatment provider and a Child Protective Services supervisor with CA. Neither CA staff nor any other Committee members had previous involvement with this family.

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

The Committee interviewed the previously assigned family voluntary services (FVS) worker, the CPS investigator and CPS supervisor for the intake related to the birth of P.S. The area administrator was available by phone; however, the Committee did not identify any questions to ask her.

Family Case Summary

There were a total of 16 intakes prior to the birth of P.S. between June 2, 2010 and March 31, 2014, related to P.S.'s mother and RCW 13.50.100. The intakes included allegations relating to RCW 13.50.100, RCW 13.50.100, RCW 13.50.100, RCW 13.50.100. The majority of intakes related to the mother's RCW 13.50.100and RCW 13.50.100. In September 2013, there was a founded finding for RCW 13.50.100 related to the mother RCW 13.50.100. The other five assessments were unfounded.

CA opened a Family Voluntary Services case with the Bellingham office. That case remained open from March 31, 2014 until January 12, 2015. The family engaged in, and completed a majority of services referred by CA staff; however, the mother RCW 13.50.100.

On RCW 74.13.515., 2016, an intake was received alleging P.S. had been born RCW 74.13.520 that the mother obtained RCW 13.50.100and she admitted to RCW 13.50.100 throughout her pregnancy. The mother stated sometimes she RCW 13.50.100. The mother also stated she RCW 74.13.520 The referrer of the intake stated the mother was bonding well with the child and she is breastfeeding. The baby was expected to stay in the RCW 74.13.515care unit for one to three weeks.

The CPS investigator met with the mother and child at the hospital the next day. The mother engaged in a lengthy conversation with the CPS investigator. The CPS investigator asked the mother to call her the following week to set up a time to allow the CPS investigator to see the family home before P.S. was discharged

from the hospital. The CPS investigator followed up with the hospital social worker and reiterated the request to be notified when P.S. was discharged before it actually occurred.

On RCW 74.13.515, 2016, the CPS investigator called the mother to check in. The mother notified her that P.S. had already been discharged home. The investigator set up a time to meet them at the home within two hours from the time of the phone call. When the investigator arrived at the home only the father and two half-sisters were present. The mother then cancelled the next scheduled home visit for the following day.

On June 10, 2016, an intake was received stating RCW 74.13.515old P.S. had passed away while in the bathtub with RCW 74.13.515mother. The mother admitted to law enforcement she had been drinking prior to the father placing the baby with her in the bathtub. Law enforcement also stated the home was in awful condition and not fit for children to live in. The two surviving RCW 13.50.100 were placed with their RCW 13.50.100. RCW 13.50.100 regarding those children.

During the CA and law enforcement investigations, the parents admitted that the mother drank throughout the day, that P.S. had been a fussy and difficult baby and the parents had been struggling to care for her. CA founded the allegation for negligent treatment or maltreatment as to both parents regarding the death of P.S. and the living conditions for all three children.

Committee Discussion

For purposes of this review, the Committee mainly focused on case activity at the birth of P.S. up until the fatality. The FVS case out of Bellingham and CPS investigation regarding the fatality were also briefly discussed.

The Committee discussed the closure of the FVS case by the Bellingham office. There was no indication to the Committee that CA should have taken any different steps regarding the case at that time. The Committee agreed with the FVS worker's assessment that there remained risk due to the mother's RCW 13.50.100 while acknowledging the parents did successfully complete other supportive in-home services. The risk was mitigated by the ages of the children in the home at that time.

It did not seem as though there was a sense of urgency regarding the assessment at the time P.S. was born. The Committee identified the history of the mother's RCW 13.50.100, RCW 13.50.100 and prior RCW 13.50.100of her other children, coupled with the father's RCW 13.50.100as areas that necessitated more in-depth assessment.

The Committee appreciated that the Mt. Vernon area does not have a robust public health nurse program, which presents a barrier to strong collaboration with CA staff and other social service agencies and engagement of a large number of families. The Committee did discuss a desire to have a more collaborative relationship with CA staff in order to support families such as P.S.'s family in providing a decrease to risk of future abuse or maltreatment.

An area of concern discussed by the Committee was the caseload size for the assigned CPS investigator at the time of the fatality. The Committee discussed ways other offices have handled such high workload and caseloads, such as reliance upon other CPS-trained staff in other positions within the office taking on lower level CPS investigations to help alleviate the workload.

Findings

The Committee did not find any critical errors that directly correlated with the fatality. However, the Committee identified areas where practice could improve.

The assessment of the RCW 74.13.51, 2016 intake could have been more comprehensive. The Committee identified that there was a lack of collateral contacts and corroboration of the information provided by the mother. The mother appeared to present well to the CPS investigator and provided a lot of positive information regarding her prior services and sobriety. The Committee believed that contact with the prior Family Voluntary Services worker would have benefitted the CPS investigator and provided a clearer understanding of the risk posed to P.S. A couple of areas that support this finding include the inaccuracy of the Structured Decision Making Risk Assessment®[3] and the Safety Assessment[4] both of which were completed after the fatality.

Another area the Committee identified as needing improvement was the caseload for the assigned CPS investigator. This particular worker was identified by the office as one of their most senior and strongest investigators. She had a caseload total of 37 cases at the time of the fatality. Between the time of the initial intake on RCW 74.13.51, 2016 and the time of the fatality on June 10, 2016, the worker received 14 new intakes to include high risk intakes of life threatening injuries to infants, which often cause an increase in workload due to the

[3] Actuarial risk assessment is a statistical procedure for estimating the probability that a critical event will occur at some future time. SDMRA® uses factors associated with higher rates of abuse and neglect to identify families who are most likely to experience a future event of child abuse or neglect. SDMRA® supports Children's Administration staff in making decisions about the highest risk families who should receive intervention. [Source: CA Practices and Procedures Guide Chapter 2451]

[4] A complete Safety Assessment must be completed on all CPS and DLR/CPS intakes (including new intakes on active cases) no later than 30 calendar days from date of intake. DLR/CPS follows additional requirements per DLR/CPS Use of Safety Assessment and Safety Planning Tools Policy. [Source: CA Practices and Procedures Guide Chapter 1120]

complexity of such cases. Workload and caseload increases, such as the ones identified in this case, often inhibit a worker's ability to complete timely and appropriate assessments.

Another identified area of concern was what appeared to be a lack of a comprehensive understanding of the mother's co-occurring condition as opposed to only RCW 13.50.100issues. It appeared as though CA focused mainly on the mother's RCW 13.50.100and did not request specific co-occurring treatment.

The Committee also identified a positive finding. The finding related to the CPS investigators discussion of safe sleep with P.S.'s mother and father as well as her quick response when she learned of the newborn's discharge home. The Committee commended the worker for her diligence on these two areas.

Recommendations

The area administrator in Bellingham should reach out to the hospital where P.S. was born to discuss communication between the hospital and CA. Specific to this case was the issue of notification to CA prior to the discharge of P.S.

All CA offices should obtain training from Sterling Reference Laboratories regarding understanding, interpreting and utilization of urinalysis reports. The area administrator from Mt. Vernon was already working on obtaining a similar training and will incorporate this recommendation.

Washington State Department of Social & Health Services

CA Children's Administration

Child Fatality Review

M.B.H.

RCW 74.13.515 2016
Date of Child's Birth

June 29, 2016
Date of Fatality

October 20, 2016
Child Fatality Review Date

Committee Members
Mary Moskowitz, J.D., Senior Ombuds, Office of the Family and Children's Ombuds
Ralph C. Jefferson Jr., J.D., Juvenile Court Services Director, Lummi Nation
Stan Atkins, NCC-AP1 Chemical Dependency Professional, Stillaguamish Tribe
Jana Bouzek, Detective, Bellingham Police Department
Heidi Kennedy, M.S.W., Child Protective Services/Family Assessment Response Supervisor, Children's Administration

Observer
Cheryl Hotchkiss, Critical Incident Review Specialist, Children's Administration

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

Executive Summary

On October 20, 2016, the Department of Social and Health Services (DSHS), Children's Administration (CA) convened a Child Fatality Review (CFR)[5] to assess the department's practice and service delivery to RCW 74.13.515-old M.B.H. and RCW 74.13.515 family.[6] The child will be referenced by RCW 74.13.515 initials in this report.

On June 29, 2016, CA received an intake stating M.B.H. died while bed sharing with RCW 74.13.515 mother. The mother, father and M.B.H. stayed in a small travel trailer on the maternal grandmother's property. The mother awoke that morning and found M.B.H. unresponsive. Law enforcement was contacted. According to the police report, RCW 13.50.100 plants were located in the trailer as well. The medical examiner's report stated the death was an accident but a contributing factor may have been an unsafe sleep environment. The CPS investigation into the death was completed as unfounded for abuse or neglect and there were no criminal charges related to the incident.

At the time of the fatality, there was an open child protective services investigation involving M.B.H.'s RCW 13.50.100 who lives with the RCW 13.50.100. There were no allegations of alleged abuse or neglect related to M.B.H. or his next eldest half-brother.

Since his discharge from the hospital after his birth, M.B.H. lived with both of RCW 74.13.515parents. However, RCW 74.13.515was often cared for by other maternal relatives, mainly RCW 74.13.515maternal grandmother. M.B.H. was healthy and up to date with RCW 74.13.515medical care at the time of RCW 74.13.515death.

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; and a Lummi Nation tribal member with employment experience in law enforcement, who previously worked as an attorney and is currently the director of juvenile court with the Lummi Nation. The Committee

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

also included a chemical dependency professional who specializes in opiate replacement therapies, a child abuse detective and a child protective services supervisor. There was also an observer who is a critical incident review specialist with CA. No Committee member or the observer had previous involvement with this family.

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

The Committee interviewed the previously assigned Family Voluntary Service worker (FVS)[7] and the CPS worker on the two most recent investigations and their supervisor.

Family Case Summary

The history involving M.B.H., RCW 74.13.515 siblings and parents includes allegations relating to the mother's history of RCW 13.50.100, including alleged RCW 74.13.520 RCW RCW 74.13.520 and RCW 74.13.520. Also alleged, was drug use by the parents and relatives where the parents have resided on and off with the children. There were a total of 10 intakes received prior to the fatality alleging RCW 13.50.100and RCW 13.50.100by the parents and relatives; RCW 13.50.100by the mother's husband to the eldest child, resulting in a criminal conviction; failure to comply with a RCW 13.50.100between the RCW 13.50.100and RCW 13.50.100; and RCW 13.50.100. There was one founded finding relating to the physical assault of the RCW 13.50.100by the RCW 13.50.100.

Due to the RCW 13.50.100between the RCW 13.50.100and RCW 13.50.100, the RCW 13.50.100became a RCW 13.50.100for the RCW 13.50.100. This arrangement has since become a permanent court order for placement and care.

The mother was involved with RCW 74.13.520 during the entire time she was pregnant and parenting M.B.H. The mother's husband also has a history of RCW 13.50.100 and began to receive RCW 74.13.520. At the time CA opened an

[7] Family Voluntary Services (FVS) support families' early engagement in services, including working with the family to create Voluntary Service Agreements or Voluntary Placement Agreements and providing ongoing case management services and assessment of safety and risk to children. Voluntary case plans are used to engage families willing to participate in services intended to reduce current and future abuse or neglect issues that do not require court intervention. Voluntary services are short-term to help increase parents' protective capacity and manage child safety. [Source: CA Practices and Procedures Guide Chapter 3000]

investigation in March of 2015 for RCW 13.50.100to the RCW 13.50.100, the parents were in compliance with their RCW 74.13.520. However, the mother RCW 74.13.520

A risk only assessment was initiated at the time of M.B.H.'s birth. That assessment resulted in the opening of a FVS case that closed on March 25, 2016. During the FVS case, both parents remained in compliance with their RCW 74.13.520 .

At the time of the fatality, M.B.H. was cared for primarily by RCW 74.13.515 parents and maternal grandmother. The RCW 13.50.100was in the temporary care of the RCW 13.50.100and the RCW 13.50.100was cared for on and off by the mother and RCW 13.50.100r. The fathers for the RCW 13.50.100were not involved in their care. M.B.H. and RCW 74.13.515 parents lived in a travel trailer near the maternal grandmother's home on the RCW 74.13.515.

The mother is an enrolled member of the RCW 74.13.515. M.B.H.'s father does not identify as Native American, nor does he claim any Native American heritage. During each investigation and throughout the life of the FVS case, CA worked closely with RCW 74.13.515 social workers. The collaboration between CA and the RCW 74.13.515 was confirmed during interviews with Tribal child welfare staff.

Committee Discussion

For purposes of this review, the Committee mainly focused on case activity from the time M.B.H. was born until RCW 74.13.515passed away. There was some discussion regarding history prior to RCW 74.13.515birth and regarding the death investigation.

There was significant discussion surrounding the family's RCW 13.50.100issues and struggle with RCW 13.50.100. That coupled with the historical issues surrounding government child welfare involvement and how such involvement may be felt and perceived by tribal families can create a difficult path towards engagement between CA and tribal families.

The Committee discussed the work by the FVS worker to engage with the family and continue to gather collateral information. The worker faced resistance at times but balanced the resistance against the information she gathered, which indicated there was no imminent risk of harm to the children at the time she closed both cases.

CA staff often struggle with the idea of asking a parent to provide a urinalysis shortly after their child has passed away when there are allegations of parental

substance abuse. However, it has been repeatedly recommended as best case practice to help provide proof that a parent may or may not have been under the influence at the time of the incident. A positive urinalysis alone is not enough to conclude that child abuse or neglect has occurred; however, it is taken into consideration along with all of the other information gathered during an assessment. The Committee agreed with the CPS investigator and her supervisor that it would have been ideal to have obtained a urinalysis of both parents at the time of the fatality. The CPS investigator could not locate the parents until three days after the fatality. A urinalysis taken that far after M.B.H.'s death would not have been beneficial in assessing a parent's sobriety three days prior.

Findings

The Committee did not identify any findings related to missed opportunities or failure to adhere to CA policies. The Committee did identify positive practice by CA.

The Committee noted that FVS cases per policy are to remain open for 90 days. However, the Bellingham office identified that this family was in need of support beyond the 90-day closure date. There was an appropriate assessment and collaboration with the RCW 74.13.515 Nation and the case remained opened for an extended 90 days. It appeared to the Committee that all child welfare workers and the supervisor involved balanced the need for case closure and active efforts to ameliorate the need for future involvement with this family.

Child Fatality Review

A.H.

RCW 74.13.515 2014

Date of Child's Birth

September 12, 2016
Date of Child's Death

December 13, 2016
Date of the Fatality Review

Committee Members
Patrick Dowd, Director, Office of the Family & Children's Ombuds
Annabelle Payne, Director, Pend Oreille County Mental Health Services
Jamie Huguenin, Supervisor, Department of Corrections
Kevin Sharp-Smith, Supervisor, Children's Administration
Julie Ellis, Region 1 FAR Program Manager, Children's Administration
Patricia Erdman, Region 1 Regional Administrator, Alliance for Child Welfare Excellence

Facilitators
Cheryl Hotchkiss, Critical Incident Review Specialist, Children's Administration

Observer
Cody Schuler, Social Service Specialist, Children's Administration

Executive Summary

On December 13, 2016, the Department of Social and Health Services (DSHS), Children's Administration (CA) convened a Child Fatality Review (CFR)[8] to assess the department's practice and service delivery to 2-year-old A.H. and **RCW 74.13.515** family.[9] The child will be referenced by the initials A.H. in this report. The family had recently received Family Assessment Response (FAR)[10] services which closed on September 1, 2016. On September 13, 2016, CA was notified by the Spokane County Sheriff's Office of A.H.'s death that occurred a day earlier on September 12. The Spokane County Medical Examiner determined the cause and manner of death to be a homicide due to blunt force trauma to the abdomen. A.H.'s mother reported to authorities that she left A.H. and her other three children in the care of live-in boyfriend Jason Obermiller[11] who had extensive criminal history for assault and domestic violence.

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 mental health treatment provider, a FAR program manager, a CPS supervisor, a Regional Administrator with the Alliance for Child Welfare Excellence and a Department of Corrections supervisor. Neither CA staff nor any other Committee members had previous direct involvement with this family.

Prior to the review, each Committee member received a case chronology, a summary of CA involvement with the family and un-redacted CA case documents (*e.g.*, intakes, investigative assessments and case notes). Supplemental sources of information and resource materials were available to the Committee at the time

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[8] 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 near death of a child. The CFR Committee's review is generally limited to documents in the possession of or obtained by DSHS or its contracted service providers. The Committee has no subpoena power or authority to compel attendance and generally, only hears from DSHS employees and service providers. It does not hear the points of view of the child's parents and relatives, or of other individuals associated with the child. A Child Fatality Review is not intended to be a fact-finding or forensic inquiry or to replace or supersede investigations by courts, law enforcement agencies or other entities with legal responsibility to investigate or review some or all of the circumstances of a child's fatal injury. Nor is it the function or purpose of a Child Fatality Review to recommend personnel action against DSHS employees or other individuals.

[9] 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)]

[10] Family Assessment Response (FAR) is a Child Protective Services (CPS) alternative response to an investigation of a screened-in allegation of child abuse or neglect. FAR focuses on child safety along with the integrity and preservation of the family when lower risk allegations of child maltreatment have been reported. [Source: CA Practices and Procedures Guide 2332]

[11] The full name of Jason Obermiller is used in this report because he was charged with committing a crime related to this report of abuse investigated by DSHS. [Source: RCW 74.13.500(1)(a)].

of the review. These included medical reports, relevant state laws and CA policies.

During the course of this review the Committee interviewed the Child and Family Welfare Services (CFWS) worker and the FAR supervisors. The FAR workers who had previously been assigned were not available to be interviewed as one had left employment with the department and the other was obligated to participate in another case meeting. Following the review of the case file documents, completion of interviews and discussion regarding department activities and decision, the Committee identified areas for practice improvement and made one related recommendation. The recommendation is at the end of this report.

Family Case Summary

From 2009 through 2013, prior to A.H.'s birth in RCW 74.13.515 2014, CA received six intakes, four of which resulted in CPS investigations. These early intakes included allegations of RCW 13.50.100 (e.g., lack of proper supervision), and concerns regarding RCW 13.50.100 , RCW 13.50.100, RCW 13.50.100, and RCW 13.50.100 of the mother and/or her partners. In December 2013, CA received an intake reporting RCW 13.50.100in the home. A.H.'s father (who is also father to one older sibling) was in the home against previous department recommendations due to his RCW 13.50.100, RCW 13.50.100and history of RCW 13.50.100and RCW 13.50.100. The children were RCW 13.50.100.

Upon A.H.'s birth in RCW 74.13.515 2014, CA decided against removing him because the other children were RCW 13.50.100 A.H.'s mother and father had made progress in services RCW 13.50.100 although CA documentation shows continued concerns with the mother's lack of insight regarding the impact her intimate relationships have on her children and her.

Between May 20, 2015 and July 7, 2016, CA received five intake reports, three of which screened in for the FAR pathway and two that screened out. The

RCW 13.50.100

allegations included RCW 13.50.100, domestic violence, RCW 13.50.100, RCW 13.50.100 RCW 13.50.100, and the mother's continual contact and relationships with criminally involved and/or dangerous persons. The children's fathers had not been providing care for them, nor did they have contact with the children.

CA received a report on July 17, 2015, that A.H.'s father was RCW 13.50.100 as he was attempting to RCW 13.50.100with the mother. A.H.'s mother responded by calling law enforcement. The FAR workers did not find sufficient evidence supporting the allegations to warrant further department intervention or placement of the children. The FAR worker did not observe anyone residing in the home besides the mother and the children during the FAR intervention. The FAR case closed on September 1, 2016, with the children remaining in the care and supervision of their mother. Soon after the FAR case closed, the mother allowed Jason Obermiller and two other adults (one with gang affiliation and criminal records) to move into the family home.

On September 13, 2016, CA received an intake from the Spokane County Sheriff's office alleging that A.H. had died while in the care of Jason Obermiller. Several other adults were reported to be in the home at the time of the child's death. Upon examination, there were bruises to A.H.'s head, abdomen, all of RCW 74.13.515 extremities and throughout the body. The Medical Examiner determined the child's death to be a homicide caused by blunt force trauma to the abdomen. The surviving siblings were RCW 13.50.100 .

A search of the home by law enforcement revealed a RCW 13.50.100 in the mother's bedroom. A.H's mother was founded[14]

RCW 13.50.100

for negligent treatment or maltreatment of A.H. The mother was incarcerated in Spokane County RCW 13.50.100. Jason Obermiller was arrested and incarcerated and charged with 2nd degree murder.

Committee Discussion

The Committee briefly discussed the 2009-2014 public child welfare involvement with the family that occurred prior to A.H.'s birth. For some Committee members, such a historical accounting helped to provide a necessary background for understanding patterns of chronic neglect (e.g., failure to protect). In the process of evaluating these early CA intervention efforts, as well as subsequent ones, some generalized discussion occurred regarding chronic neglect, consistent environmental chaos and dysfunction, and persistent multiple risk factors (e.g., domestic violence, criminal issues, mental health, unsafe caregivers, drug and alcohol issues, and poverty). The Committee found the staff interviews helpful in understanding how CA assesses the impact of chronic neglect on the safety and well-being of children.

The Committee specifically discussed CA's involvement occurring shortly after A.H. was born in RCW 74.13.515 2014. This included exploring the reasons CA did not file a dependency petition on newborn A.H. RCW 13.50.100 CA and Alliance[15] staff provided clarification regarding placement decisions for newborns RCW 13.50.100. This included consideration of the status of the RCW 13.50.100, the current functioning and progress of the parents with services, and assessment of active safety issues in the home that may be managed with a safety plan. In this case, RCW 13.50.100, RCW 13.50.100 .

Some Committee members expressed concern that the CFWS worker may not have fully assessed or articulated safety threats or issues to the court but understood the challenges of communicating the difference between progress and compliance. The Committee noted that one service goal during the CFWS assignment (mother's ability to acknowledge or have insight into the impact her relationships have had on her children) was not achieved RCW 13.50.100. The Committee was unconvinced that, at the time of RCW 13.50.100, the mother truly understood her role in protecting her children from unsafe persons or situations, especially unstable relationships with partners with violence histories.

[15] The Alliance for Child Welfare Excellence is a program through the University of Washington, in partnership with DSHS, to provide regular training to CA staff. The Alliance provides the Regional Core Training (RCT) that all new CA case carrying employees must complete before they can be assigned cases.

Committee discussions centered on the written and verbal accounts regarding the FAR case activities and decisions from May 2015 through early September 2016. The Committee considered information about early implementation of FAR and subsequent changes to this program (e.g., screening policies). Under current policy[16] any screened in report within 12 months of a closed dependency will be screened into the CPS investigative pathway rather than the CPS/FAR pathway. The Committee noted the intake supervisor's decision to override the intake worker's initial screen out decision on March 16, 2016[17] and assign for FAR intervention.

Of particular interest to the Committee was the quality of inquiry, seeking collateral contacts for information, and corroboration of information. The Committee noted instances of good practice such as documenting the children's general appearance, contacting school staff, and obtaining medical records related to the children. However, there were missed opportunities for collateral contacts such as contacting relatives, the mother's medical provider, intake referents, past persons in the home, and law enforcement. These untapped sources of information may have provided a rationale for further safety analysis and intervention. In particular, the Committee felt that the September 2016 FAR response could have evidenced more substantive curiosity about others living in or frequenting the home. The lack of documentation that the workers utilized FamLink[18] to assess all persons identified as having recently resided in the home or been in caretaking roles for the children was concerning. The Committee believed that a FamLink or MODIS[19] and criminal history search on such persons is essential in assessing household functioning and child safety.

Furthermore, the Committee discussed whether the workers had a clear understanding of the mother's physical and mental health, and their impact on her ability to make safe decisions for her children. While the worker obtained information from a RCW 13.50.100provider, the Committee believed a deeper inquiry could have been beneficial in developing an intensive aftercare planning (e.g., wrap around services) with available community resources. The Committee however, did not reach consensus as to specific findings or recommendations

[16] Screen in for CPS Investigation when a dependency action involving the child victim or household was closed within the previous 12 months [Source: CA Practices and Procedures Guide Chapter 2200]
[17] An "intake" is a report received by Children's Administration 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 WAC 388-15-009.
[18] FamLink is the case management information system that Children's Administration implemented on February 1, 2009, replacing CAMIS, which was the case management system CA had used since the early 1990s.
[19] MODIS is CA's digital case archiving system. Closed files are stored in this system so that workers are able to view the case history on their computers.

around this issue. The Committee recognized that the July 2016 FAR worker obtained the mother's medical and health records, and discussed whether utilizing the CA Medical Consultant network[20] would have been helpful in assessing family and child safety. The Committee noted limitations for a formal CA medical consult relating to adult records, which would require a signed consent form.

Given indications that the FAR worker may have believed CPS referrals were made in retaliation against the mother, the Committee discussed the possibility of confirmatory bias[21] by the worker. Such bias may have resulted in the failure to recognize the mother's regression to previous patterns of behavior, lack of insight and inability to protect her children from harm, as well as an incomplete assessment of the household, parental functioning and child safety.

The Committee considered the possibility that the historical pattern of failing to protect on the part of the mother could have been more fully assessed and applied to the safety assessment[22] for both the CFWS and FAR interventions. While the Committee discussed concepts of immediate harm versus ongoing risk[23] to the children it did not reach a full consensus as to whether or not there was an identifiable safety threat[24] during either the CFWS or FAR cases.

Findings

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. However, the Committee identified missed opportunities

[20] 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.
[21] The tendency to search for, interpret, focus on and remember information in a way that confirms one's preconceptions.
[22] 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. A Safety Assessment is completed at key decision points in a case to identify impending danger and to inform and implement safety plans with families to control or manage those threats. [Source: CA Practices and Procedures Guide Chapter 1100]
[23] Allegations of child abuse or neglect assert specific events, incidents, patterns and conditions defined by law and policy as child abuse and neglect. Allegations always describe past events, incidents and conditions. Risk factors include all other information that lacks assertions of abuse or neglect but which are relevant to assessing the likelihood of future child abuse and neglect.
[24] 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 heighten 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 Handout]

for global assessment of the parental functioning and household function that might have provided CA information for a more thorough safety assessment. The Committee believed that the FAR responses met the minimum requirements but did not fully address the mother's current RCW 13.50.100functioning in conjunction with the historical patterns of her lack of insight and allowing dangerous persons or situations around her children. The Committee identified the following areas of practice that could have been improved during CA's intervention on this case:

- Verification that progress with Family Preservation Services[25] (FPS) goals during the CFWS case plan were documented and assessed, specifically related to the goals around the mother's ability to protect her children. The case was dismissed with an uncorrected parental deficiency related to the mother's inability to protect and lack of acknowledgement of the impact her relationships have had on her children. There was no documented progress with the FPS provider on that specific goal during the dependency.
- The Committee felt that the 2015 and 2016 FAR responses were incident-focused and that there was a lack of curiosity and assessment about who frequented the home and the pattern of multiple/varying roommates or persons living in the home (chronic issues for this family). The FAR responses were limited in relation to seeking information about the mother's current mental health, current physical health, loss of employment, use of available child care resources, and not fully incorporating historical CA involvement into the current assessments.

Recommendations

In response to concerns that the 2015-2016 contacts were overly incident-focused at times, CA should develop or enhance currently available training for social workers and supervisors statewide on global assessment of families involved with CA. This training should emphasize and focus on the following:

- Assessing other adults in the home, interviewing clients and verifying statements, obtaining consultation or interpretation of records (specifically medical, mental health and chemical dependency) and how to incorporate and analyze historical CA records into current assessments.

[25] Family Preservation Services is an intensive home-based intervention for children at imminent risk of placement or who are in placement where services can manage threats in the family home. The expected outcome is centered around the increased ability of the parent's to safely care for their children as well as connecting the families to community resources.

- Use of clinical supervision at the 30-day case review[26] to identify and address gaps in information gathering and assessment, assess for bias, and include development of case plan and the social workers next steps.

[26] CA policy requires that social work supervisors conduct monthly supervisory case reviews with each assigned social worker and document each case review in the client's electronic case file. [Source: CA Practices and Procedures Guide Chapter 46100]

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

Child Fatality Review

G.C.

RCW 74.13.515 2014
Date of Child's Birth

September 28, 2016
Date of Child's Death

January 4, 2017
Date of the Fatality Review

Committee Members
Patrick Dowd, Director, Office of the Family & Children's Ombuds
Marie Bastin, Public Health Nurse, Indian Health Services, Toppenish
Ronna Washines, Tribal Prosecutor, Yakama Nation
Melissa Hall, Supervisor, Children's Administration
Jennifer Cooper, Region 1 CPS Quality Practice Specialist, Children's Administration
Frank Murray, Former Program Manager, Yakima County Court Appointed Special Advocates

Facilitators
Cheryl Hotchkiss, Critical Incident Review Specialist, Children's Administration

Consultant
Brett Helling, Region 1 Intake Administrator, Children's Administration

Executive Summary

On January 4, 2017, the Department of Social and Health Services (DSHS), Children's Administration (CA) convened a Child Fatality Review (CFR)[27] to assess the department's practice and service delivery to RCW 74.13.515.-month-old G.C. and his family.[28] The child will be referenced by RCW 74.13.515initials, G.C., in this report. At the time of RCW 74.13.515death, G.C. lived with RCW 74.13.515maternal grandmother and three older siblings.

The Review Committee included members selected from the community with relevant expertise from diverse disciplines including, the Office of the Family and Children's Ombuds, a practice consultant with CA, a supervisor with CA, a Public Health Nurse, a former Guardian Ad Litem director with Yakima CASA and a tribal prosecutor. Neither CA staff nor any other Committee members had previous direct involvement with this family.

Prior to the review, each Committee member received a case chronology, a family genogram, a summary of CA involvement with the family and un-redacted case documents including case notes, referrals for services, assessments and medical records. A hard copy of the file was available at the time of the review. Supplemental sources of information and resource materials were also available to the Committee, including state laws and CA policies relevant to the review.

The Committee interviewed CA social workers and a supervisor who had previously been assigned to the case in 2014. The investigative supervisor was not interviewed as she was no longer employed with CA at the time of the review. Following the review of the case file documents, completion of staff interviews and discussion regarding CA activities and decisions, the Committee made findings and recommendations that are presented at the end of this report.

Background

[27] Given its limited purpose, a Child Fatality Review (CFR) should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. The CFR Committee's review is generally limited to documents in the possession of or obtained by DSHS or its contracted service providers. The Committee has no subpoena power or authority to compel attendance and generally, only hears from DSHS employees and service providers. It does not hear the points of view of the child's parents and relatives, or of other individuals associated with the child. A Child Fatality Review is not intended to be a fact-finding or forensic inquiry or to replace or supersede investigations by courts, law enforcement agencies or other entities with legal responsibility to investigate or review some or all of the circumstances of a child's fatal injury. Nor is it the function or purpose of a Child Fatality Review to recommend personnel action against DSHS employees or other individuals.

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

On September 26, 2016, CA received a report from RCW 74.13.515Hospital regarding the near-fatality of RCW 74.13.515-month-old G.C. who was in the care of RCW 74.13.515maternal grandmother at the time of the incident. It was alleged that on September 25, 2016, G.C. nearly drowned in a canal located on the family's property. The maternal grandmother was reportedly cooking dinner and saw the child wandering in the back yard. She told authorities that she assumed G.C. was returning to the home when she called RCW 74.13.515name and saw RCW 74.13.515turn around. When G.C. did not return, the family looked for him. G.C. was found by RCW 74.13.515uncle submerged in the canal. Cardiopulmonary resuscitation (CPR) was attempted on G.C. and authorities were called. G.C. was airlifted from RCW 74.13.515 to RCW 74.13.515, where RCW 74.13.515remained until RCW 74.13.515passed away on September 28, 2016. G.C.'s biological mother is an enrolled member of the RCW 74.13.515Tribe. G.C.'s siblings have remained in the care of their RCW 13.50.100

Family Case Summary

G.C.'s maternal grandparents have RCW 13.50.100 history with the department dating back to 1993, including allegations and findings of RCW 13.50.100, RCW 13.50.100, RCW 13.50.100. The maternal grandmother was absent for much of her own children's lives due to substance abuse. The maternal grandfather or extended family RCW 13.50.100 in the maternal grandmother's RCW 13.50.100.

G.C.'s mother and a legal father to one of G.C.'s siblings had RCW 13.50.100 referrals between May 2010 and June 2015. RCW 13.50.100 of the reports screened out[29] and RCW 13.50.100 screened in as a risk only response[30] which led to an RCW 13.50.100 and the provision of Family Voluntary Services[31] (FVS) in 2014. The allegations in all

[29] 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 I which no abuse or neglect is alleged to have occurred; and 6) Alleged violations of the school system's statutory code or administrative code. [Source: CA Practices and Procedures Guide]

[30] 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]

[31] Family Voluntary Services (FVS) support families' early engagement in services, including working with the family to create Voluntary Service Agreements or Voluntary Placement Agreements and providing ongoing case management services and assessment of safety and risk to children. Voluntary case plans are used to engage families willing to participate in services intended to reduce current and future abuse or neglect issues that do not require court intervention. Voluntary services are short-term to help increase

RCW 13.50.100 referrals concerned RCW 13.50.100 by G.C.'s mother, including RCW 13.50.100 and RCW 13.50.100 at the time G.C. was delivered. The FVS case was closed on November 20, 2014.

On June 28, 2015, G.C.'s mother called CA Central Intake to request RCW 13.50.100 The mother reported that she RCW 13.50.100 . The intake was screened out due to there being no allegations of child abuse or neglect.

In September and October of 2015, CA received reports alleging neglect by both G.C.'s mother and maternal grandmother. In September 2015, G.C.'s mother was alleged to be RCW 13.50.100 and failing to supervise G.C. RCW 13.50.100. The report screened in for a CPS investigation. During this investigation, an uncle to G.C. was planning to seek third party custody of the children. CA staffed the children's placement with the Local Indian Child Welfare Advisory Committee[32] (LICWAC), which recommended that the children be placed with their uncle. When the uncle was unable to obtain housing, however, the maternal grandmother initiated third party custody of all three children through tribal court. On October 27, 2015, CA received a referral alleging that the maternal grandmother RCW 13.50.100 . The allegations screened-in for investigation but were determined to be unfounded.[33] The investigation was closed on January 4, 2016.

Discussion

The Committee discussed the fact that the mother of the children called CA Central Intake on June 28, 2015, requesting RCW 13.50.100 . The Committee noted that the mother did not know a specific date of when or even if an arrest would occur. However, multiple members of the Committee inquired as to why the report screened out and what, if any, assistance CA could have provided. Discussion developed

parents' protective capacity and manage child safety. [Source: CA Practices and Procedures Guide Chapter 3000]

[32] A LICWAC is a body of volunteers, approved and appointed by CA who staff and consult with the Department on cases of Indian children who: are members of a tribe, band or first Nations has not responded, or has chosen not to be involved, or is otherwise unavailable; or for whom the child's tribe, band, or First Nations has officially designated the LICWAC to staff the case; or are defined as a recognized Indian child.

[33] Unfounded means the determination following an investigation by the department that available information indicates that, more likely than not, child abuse or neglect did not occur, or that there is insufficient evidence for the department to determine whether the alleged child abuse did or did not occur…Founded mean the determination following an investigation by the department that, based on available information, it is more likely than not that child abuse or neglect did occur. [Source: RCW 26.44.020]

around the possibility of a voluntary placement agreement[34] or a Child and Family Welfare Services case in situations like this. The Regional Area Intake Administrator provided consultation to the Committee and informed the Committee that unless there is an allegation of child abuse or neglect or an allegation of a risk of imminent harm to a child, an intake will likely screen out for CA intervention.[35] The Committee discussed the Washington Administrative Code[36] definitions for child abuse or neglect and understood that a CPS pathway might not have been appropriate at the time the mother called in. However, while it acknowledged that the intake worker provided the mother with some suggestions on how to proceed in the event that she was RCW 13.50.100, the Committee nonetheless opined that it would have liked to have seen the worker provide additional information to the mother, such as information on voluntary placement agreements.

The Committee felt that the assigned workers could have more fully reviewed historical data pertaining to the mother and maternal grandmother during its intervention in September 2015. Specifically, the Committee opined that the analysis of the maternal grandmother's records and the mother's records as a child should have been more thorough, thus potentially resulting in more thorough child safety assessments, and the Committee voiced concerns that there was no assessment of the maternal grandmother's ability to care for and supervise her grandchildren. When interviewed, both CA workers who were assigned to the mother's case during the 2014-16 interventions, reported that they spoke to previously assigned case workers about the grandparents' history and the mother's history as a child. However, the Committee identified that CA was aware of the children moving into the grandmother's care in September 2015, and it opined that CA should have included in its assessment of the maternal grandmother as a potential placement, her RCW 13.50.100 due to RCW 13.50.100.

The Committee members also spent considerable time discussing the canal and waterways on and near the grandmother's property. The Committee members questioned the maternal grandmother's awareness of the supervision needs of

[34] A Voluntary Placement Agreement (VPA) safety supports a time-limited plan for a short-term removal and placement in out-of-home care for a child who cannot safely remain in the parent or legal guardian's home. [Source: CA Practice and Procedures Guide Chapter 4307]

[35] The department is only authorized to intervene via an investigation or family assessment response when it receives complaints of recent acts or failures to act on the part of a parent or caretaker that results in death, serious physical or emotional harm, or sexual abuse or exploitation, or that presents an imminent risk of serious harm, and on the basis thereof offer child welfare services in relation to the problem to such parents, legal custodians, or persons serving in loco parentis, and/or bring the situation to the attention of an appropriate court or another community agency. [See RCW 74.13.031 and RCW 26.44.030]

[36] WAC 388-15-009 What is child abuse or neglect?

the small children around the waterways. The Committee recognized the worker's attempt to visit the home and check on the children, but the Committee would have liked the CA worker to have had discussions of supervision of children near waterways.

The Committee was concerned that CA didn't follow the LICWAC recommendations to place with the identified uncle or to re-staff the case with LICWAC prior to case closure. Lack of clinical supervision for a new caseworker was discussed as a possible contributing factor to the LICWAC re-staffing having not occurred. The Committee was also concerned that CA staff could have more fully assisted the identified uncle with obtaining housing. The Committee recognized the importance of utilizing the LICWAC recommendations, especially in a case of recommendations for relative caregivers, as LICWAC tends to know its community and the capabilities of recommended caregivers more personally than CA.

In reviewing the quality of the 2015 investigation, the Committee expressed concern that the assigned investigator, who had been in that position for less than a few months, was still in her trial service period and as such, may have benefitted from regular clinical supervision to ensure that her assessments were comprehensive and addressed all allegations. The Committee believed that the supervisor's role was to ensure compliance with LICWAC's recommendations, ensure adequate gathering of information for safety assessments and ensure that policy is followed and to provide guidance to new workers.

The Committee also discussed information sharing by CA with extended family and the court presiding over the maternal grandmother's third party custody case. A few Committee members were curious as to the parameters CA is held to in regard to information sharing. Consultation was provided via the program manager on the Committee and the CPS Supervisor. The Committee was informed of the limitations CA is held to regarding what can be shared in third party or other custodial matters. The Committee heard that often a court order is required in order to share information with the courts outside of a dependency proceeding due to confidentiality rights of the child and his or her parents, guardians or custodians.

Findings

The Committee did not come to a consensus regarding whether a critical error on the part of CA was directly linked to the death of the child. Some Committee members felt that CA having knowledge of the children moving in with the grandmother was a critical error. Some felt that more fully vetting her suitability and ability to provide safe care and supervision was critical and was linked to the

death of the child. Other Committee members did not believe that there was a direct link between the vetting of the grandmother and the child's death. The Committee did, however, agree on the findings listed below:

- CA Policy 1130 requires that Safety Plans control or manage threats to a child's safety, have an immediate effect and contain safety services and actions only. These must be immediately accessible and available. The 2014 CPS safety plan could have more specifically identified safety threats. The safety plan was compiled of services and did not provide safety tasks to ensure child safety.
- CA Policy 1120 and CA Policy 1140 requires that an updated Safety Assessment be completed on all FVS cases. According to CA Policy 1120, a review of the Safety Assessment is required at case transfer, when there is a change of anyone residing in the home or visiting the premises for more than 14 days and when closing the case. There was not an updated safety assessment completed during the 2014 FVS case assignment.
- CA Policy 1140 requires that a Comprehensive Family Evaluation (CFE) be completed within 45 calendar days of an FVS case assignment. The CFE is to be updated every 90 days after the prior completion of a CFE on FVS cases, when developing or changing a case plan or prior to case closure. A CFE was not completed during the 2014 FVS case assignment.
- The FVS case worker could have more fully assessed the biological father's RCW 13.50.100, RCW 13.50.100 and overall parenting needs.
- During the September 2015 and October 2015 responses, CA did not follow through with the LICWAC recommendation for placement with an identified uncle. CA did not re-staff with LICWAC when the children went to live with the maternal grandmother. Additionally, CA did not re-staff with LICWAC prior to closure as LICWAC recommended.
- CA was aware of the children going to the grandmother's care and did a minimal home check. The department did not screen the relative placement options to include the following:
    - FamLink/MODIS analyses and applicable waivers for historical findings.
    - Criminal background checks.
    - Relative placement checklist and conversations about the danger of the outdoor waterway next to the home.

Recommendations

CA in Region 1 should consider creating, offering more frequently, or enhance currently available training on assessing safety that captures the below topics:

- Tactics for gathering and analyzing information on family members, CA history and criminal history.
- Clinical supervision of staff to assist in the information gathering process to include analysis of gathered information.
- Utilizing LICWAC recommendations, when to re-staff with LICWAC and make more informed placement decisions that align with CA practice and procedures policy.

Region 1 CA has scheduled trainings throughout 2017 with the regional CPS program managers at varied local and regional offices to cover gathering of information, collateral contacts, safety assessment training and AAG Lessons Learned training. In addition, a two-day training was offered on January 23-24, 2017, in the local office addressing the Indian Child Welfare Act.

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

Child Fatality Review

S.J.

RCW 74.13.515 2016
Date of Child's Birth

August 9, 2016
Date of Fatality

December 1, 2016
Child Fatality Review Date

Committee Members
Cristina Limpens, Senior Ombuds, Office of the Family and Children's Ombuds
Melanie Robinson, Detective, Kent Police Department
Ruth Wolbert-Neff, Chemical Dependency Professional/Opioid Replacement Therapist, Tacoma Pierce County Health Department
Tracey Czar, J.D. Guardian Ad Litem, Pierce County Juvenile Court
Zee Triplett, Safety Administrator, Children's Administration

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

Executive Summary

On December 1, 2016, the Department of Social and Health Services (DSHS), Children's Administration (CA) convened a Child Fatality Review (CFR)[37] to assess the department's practice and service delivery to RCW 74.13.515-month-old S.J. and RCW 74.13.515family.[38] The child will be referenced by RCW 74.13.515initials in this report.

On August 9, 2016, S.J.'s mother called her assigned child and family welfare services (CFWS) social worker and stated S.J. had passed away. The CFWS worker reported the incident to CA. Local law enforcement as well as CPS conducted an investigation. There were no criminal charges and the child protective services (CPS) investigation was unfounded. The medical examiner's report stated the cause of death was compressional asphyxia and the manner of death was accidental. The report also stated the mother reported overlying on her child's abdomen and legs. She was sharing the bed with S.J. and another one of her children.

At the time of the fatality, there was an open CFWS case RCW 13.50.100 . A RCW 13.50.100 had RCW 13.50.100 . There was not an open case involving S.J. at the time of RCW 74.13.515death. S.J. lived with RCW 74.13.515mother, two older sisters and the children's great grandmother. S.J.'s alleged father is reportedly deceased.

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 guardian ad litem for child dependency matters, a chemical dependency professional who specializes in opiate replacement therapies for pregnant and parenting mothers, a child abuse detective and CA's Region 2 Safety Administrator. The Children's Administration CPS program manager was unable to attend the review. No Committee member had previous involvement with this family.

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[37] 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 near death of a child. The CFR Committee's review is generally limited to documents in the possession of or obtained by DSHS or its contracted service providers. The Committee has no subpoena power or authority to compel attendance and generally only hears from DSHS employees and service providers. It does not hear the points of view of the child's parents and relatives, or of other individuals associated with the child. A Child Fatality Review is not intended to be a fact-finding or forensic inquiry or to replace or supersede investigations by courts, law enforcement agencies or other entities with legal responsibility to investigate or review some or all of the circumstances of a child's fatal injury. Nor is it the function or purpose of a Child Fatality Review to recommend personnel action against DSHS employees or other individuals.

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

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

The Committee interviewed the CFWS supervisor who completed the risk only assessment at the time of S.J.'s birth, the currently assigned CFWS social worker and his supervisor as well as the area administrator.

Family Case Summary

The first intake regarding S.J.'s mother as a parent was in January 2000. There was a total of 26 intakes before S.J.'s birth, regarding RCW 13.50.100. The intakes included allegations of RCW 13.50.100and RCW 13.50.100; the majority of issues surrounded RCW 13.50.100. There were also reports of the children RCW 13.50.100 by adults and the children, RCW 13.50.100and RCW 13.50.100. The RCW 13.50.100were RCW 13.50.100between 2000 and 2005 and were RCW 13.50.100 . Then in June 2013, RCW 13.50.100were RCW 13.50.100and RCW 13.50.100 .

During the second RCW 13.50.100in 2013, the mother did not engage in services until September 2015. At that time, she began to address her RCW 13.50.100. The mother was pregnant with S.J. at that time and entered an RCW 13.50.100y. The mother remained engaged in her RCW 13.50.100and gave birth to S.J. in RCW 13.50.1002016.

Prior to the birth, CA consulted with the Assistant Attorney General assigned to the mother's case and decided RCW 13.50.100 regarding S.J. A risk only CPS investigation occurred at S.J.'s birth. While the investigation involving S.J. was closed, the mother's case remained open with RCW 13.50.100.

S.J. remained RCW 74.13.520 for two months after birth. Upon discharge from the hospital, S.J. and RCW 74.13.515 mother moved in with the mother's grandmother. The mother also RCW 13.50.100 at the same time as S.J.'s discharge from the hospital. S.J.'s great grandmother had RCW 13.50.100 . CA was aware of, and in agreement with, the family's plan.

During regular health and safety visits pertaining to the RCW 13.50.100 , the mother reported she was engaged in RCW13.50.100 . The CFWS worker observed S.J. during some of his health and safety visits. He briefly discussed that the baby should sleep by RCW 74.13.515in RCW 74.13.515own bed. During the CFWS worker's first contact with S.J. he observed an unsafe sleep environment. That same day the CFWS worker provided the mother with a pack-n-play to remedy the unsafe sleeping conditions.

On August 9, 2016, the assigned CFWS worker received a call from the mother stating that S.J. had passed away earlier that morning. The mother stated the death was a SIDS related death and she contacted the police and the coroner.[39] In total, S.J. was observed three times by the assigned CFWS worker prior to RCW 74.13.515death.

Committee Discussion

For purposes of this review, the Committee mainly focused on case activity from the time S.J. was born until RCW 74.13.515passed away. There was some discussion regarding the family's history prior to RCW 74.13.515birth and regarding the death investigation.

There was significant discussion surrounding the stability of the office at the time this case transferred to the currently assigned worker in March 2016. The current CFWS worker had an extremely high case load and was assisting in coverage of health and safety visits on other workers' caseloads. The office had undergone substantial turnover and had almost a 50 percent vacancy rate within the CFWS units. The Committee discussed how it would be a challenge for the staff under these conditions to comply with best case practices.

During interviews with the assigned CFWS social worker and his supervisor, it appeared as though there was not a clear understanding of the CFWS worker's responsibility as it pertained to S.J. since there was not an open case involving RCW 74.13.515. The Committee contemplated the issues that may have impacted the work on this case including the CFWS worker not only covering his high caseload but also working to cover others' caseloads, the CFWS worker's status as newly hired therefore not coming with on-the-job experience to assist in

[39] Sudden Infant Death Syndrome (SIDS) is defined as the sudden death of an infant less than one year of age that cannot be explained after a thorough investigation is conducted, including an autopsy, examination of the death scene and a review of the clinical history. SIDS is a type of SUID. [Source: Centers for Disease Control and Prevention]

decision making, and lack of clinical supervision due to the office wide need for all staff to cover unassigned caseloads.

The Committee appreciated the struggle this case highlighted: to have faith that a parent can change; the ability to change and RCW 13.50.100 even after a lengthy history of RCW 13.50.100; and other risk factors and how that impacts the desire to allow for consistent, safe bonding between a newborn and a parent. While not all of the Committee members agreed with the decision RCW 13.50.100 , they appreciated the inclusion of the AAG in the decision making and the thought process that was clearly discussed by the area administrator and CFWS supervisor who conducted the Risk Only assessment intake at S.J.'s birth.

There was a discussion regarding how collaboration between RCW 13.50.100 Therapy providers can help educate CA staff regarding many areas highlighted in this case. Those discussions could have included a description of the mother's demonstrated RCW 13.50.100 and positive change in behaviors, any conversations regarding safe sleep to include the fact that the mother herself stated she does not easily wake while sleeping and what signs, such as nodding off during conversations, necessitate a discussion with the prescriber, if not a RCW 13.50.100. It was also discussed that there have been numerous recent conversations regarding a need for CA staff to receive ongoing education regarding opiate replacement therapies and how those therapies pertain to assessing child safety.

Findings

The Committee did not find that a critical error occurred. The Committee identified overarching themes where CA could have bolstered collaboration and corroboration to improve case practice.

CA did not staff the case with a Child Protection Team (CPT) as required by policy. The Structured Decision Making Assessment® tool that was completed at the time of S.J.'s birth resulted in a high level of risk. Per CA policy this would also have necessitated a discussion and offer of ongoing voluntary services if it was deemed that the case was not sufficient for legal intervention.[40] A Shared Planning Meeting such as a Family Team Decision Making Meeting could have also been utilized. CA could also have included the Court Appointed Special

[40] Cases with a high SDMRA score must be staffed with a Child Protection Team (CPT) for identified child victims aged six years or younger. [Source: CA Practices and Procedures Guide Chapter 2541]

Advocate assigned to S.J.'s siblings during staffings and meetings regarding how CA was to proceed at the time of S.J.'s birth.

The Committee believed that there were missed opportunities by the CFWS social worker to gather information from collateral contacts that would have provided a more comprehensive picture of the mother's ability to safely parent S.J. This would have included contacts with providers that were reportedly working with the mother, such as a public health nurse, domestic violence support groups, parent child assessment program worker, mental health providers and out-patient chemical treatment providers. The worker did not corroborate the information provided by the mother by contacting the appropriate collateral contacts.

Another area that could have provided a more comprehensive view of the mother's capabilities and functioning included a neuropsychological evaluation. Originally the mother was court ordered to complete a psychological evaluation; however, after receiving concerns from the mother's inpatient treatment provider regarding cognitive comprehension, a request was made to the mother's attorney to change the service to a neuropsychological evaluation. This request was never responded to prior to the fatality.[41]

The outpatient treatment program could have provided a description of the mother's demonstrated sobriety. It would also have been appropriate to discuss the CFWS worker's observation of the mother nodding off during one home visit and if that had any bearing on the mother's sobriety or dosing level.

CA did not comply with the Plan of Safe Care, Period of Purple Crying and Safe Sleep policy.[42]

CA did not conduct a new safety assessment of the household when the mother and S.J. moved in with the two dependent children and their relative care provider.[43]

Recommendation

CA should review the current policies regarding situations involving dependent and non-dependent children with the same parent, as occurred in this case, and

[41] Neuropsychological evaluation (NPE) is a testing method through which a neuropsychologist can acquire data about a subject's cognitive, motor, behavioral, linguistic, and executive functioning. In the hands of a trained neuropsychologist, these data can provide information leading to the diagnosis of a cognitive deficit or to the confirmation of a diagnosis, as well as to the localization of organic abnormalities in the central nervous system (CNS). The data can also guide effective treatment methods for the rehabilitation of impaired patients. [Source: Medscape Neuropsychological Evaluation]

[42] Source: CA Practices and Procedures Guide Chapter 1135

[43] Source: CA Practices and Procedures Guide Chapter 1120

consider any revision or clarification. The revision or clarification could possibly allow for the assigned social worker and supervisor to have a clearer indication of how to proceed with the responsibility of CA to complete a comprehensive, ongoing assessment of children who are not a part of an open case yet are under the care of their parent who has other dependent children.