Report to the Legislature

Quarterly Child Fatality Report

RCW 74.13.640

April – June 2013

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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 April through June 2013 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 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 four (4) fatalities and four (4) near-fatalities of children that occurred in the second quarter of 2013. All of the near-fatality reviews are conducted the same as executive child fatality reviews. All prior child fatality review reports can be found on the DSHS website: http://www.dshs.wa.gov/ca/pubs/fatalityreports.asp.

The reviews in this quarterly report include fatalities and near-fatalities from all three regions.[1]

Region	Number of Reports
1	3
2	3
3	2
Total Fatalities and Near Fatalities Reviewed During 2nd Quarter, 2013	8

This report includes Child Fatality Reviews and Near-Fatality reviews conducted following a child's death or near-fatal incident 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

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

history. The review committee members may include legislators and representatives from the Office of the Family and Children's Ombuds.

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 2013. 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 2013			
Year	Total Fatalities Reported to Date Requiring a Review	Completed Fatality Reviews	Pending Fatality Reviews
2013	7	1	6

Child Near-Fatality Reviews for Calendar Year 2013			
Year	Total Near Fatalities Reported to Date Requiring a Review	Completed Near-Fatality Reviews	Pending Near-Fatality Reviews
2013	8	0	8

The fatality reviews contained in these Quarterly Child Fatality Reports are posted on the DSHS website. Near-fatality reports are not subject to public disclosure and are not included in this report.

Notable Findings

Based on the data collected and analyzed from the four (4) fatalities and four (4) near-fatalities reviewed between April and June 2013, the following were notable findings:

- One fatality occurred in California; the newborn infant was released to her father shortly after her birth. The department was not involved in this decision. The child died from inflicted injuries to her head and torso. Her father was convicted of voluntary manslaughter.
- Three (3) of the four (4) fatalities reviewed were of children who died when they were under the age of three.
- Three (3) of the four (4) fatalities were determined to be the result of abuse or neglect. None of the abuse/neglect related fatalities occurred when CA had an open case on the family.

- Two (2) fatalities were deemed homicides by a medical examiner or coroner.
- One fatality and one near-fatality received considerable media attention. These child victims were siblings and the fatality and near-fatality occurred at the same incident.
- Four (4) children were Caucasian, one (1) was Black/African American, two were Native American, and one (1) was Hispanic.
- Children's Administration received intake reports of abuse or neglect in all of the child fatality and near-fatality cases prior to the death or near-fatal injury of the child. The case of a near-fatality and fatality occurring during the same incident had fourteen (14) intake reports to CA prior to the critical incident. Two fatality cases each had nine (9) prior reports to CA intake. None of the other cases had more than five (5) intakes prior to the critical incident.
- Due to the small sample of cases reviewed, no statistical analysis was conducted to determine relationships between variables.

RCW 74.13.640

Child Fatality Review

C.C.

March 2011
Date of Child's Birth

October 8, 2012
Date of Fatality

February 15, 2013
Date of Fatality Review

Committee Members
Peggy Devoy, Indian Child Welfare Program Manager, Region 3 Children's Administration
Tom Stokes, Area Administrator, Region 3 Children's Administration
Dr. Frances Chalmers, Medical Consultant, Aging & Disability Services Administration
Cammy Hart-Anderson, Division Manager, Snohomish County Human Services Department
Detective Cori Shackleton, Police Detective, Marysville Police Department
Lori Vanderburg, Manager, Compass Health and Dawson Place Child Advocacy Center

Legal Consultants
Shelia Huber, Senior Counsel, Office of the Attorney General
Jennifer Meyer, Assistant Attorney General, Office of the Attorney General

Observer
Sharon Gilbert, Deputy Director of Field Operations, Children's Administration
Thomas Shapley, Senior Director, Department of Social and Health Services Public Affairs
Chris Case, Assistant Director, Department of Social and Health Services Public Affairs
Diana Hefley, Reporter, The Herald Newspaper

Co-Facilitators
Judge Tom Tremaine, Presiding Judge, Kalispel Tribal Court
Ronda Haun, Critical Incident Case Review Specialist, Children's Administration

Executive Summary

On February 15, 2013, Children's Administration (CA) convened a Child Fatality Review[2] (CFR) Committee to examine the practice and service delivery in the case involving a female Native American 18-month-old toddler named C.C. and her family. The incident initiating this review occurred on October 8, 2012, when C.C. was discovered not breathing and unresponsive in a vehicle parked on tribal land. Resuscitation attempts were unsuccessful, and she was pronounced dead at a local hospital. The Snohomish County Medical Examiner later determined C.C. died from parental neglect by her mother, Christina Carlson.[3]

The Child Fatality Review Committee included CA staff and community members selected from diverse disciplines with expertise relevant to the dynamics of this case, including child welfare, law enforcement, substance abuse, mental health, pediatric medicine, and the Indian Child Welfare Act. The Tulalip Tribes of Washington, of which J.C. was eligible for membership, was notified of the review and invited to identify a tribal representative to participate in the review. In response to the invitation, Tulalip Tribes prepared a written statement for the committee explaining Tulalip tribal laws have no provisions for sharing any child welfare information and thereby prohibited tribal participation in the review. The invited representative from the Office of the Family and Children's Ombudsman was unable to attend. Legal consultants from the Office of the Attorney General participated in the review by providing a summary of Washington state laws pertaining to child abuse and neglect and the state[4] and federal[5] Indian Child Welfare Acts. They also answered the committee's legal questions generated

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[2] 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 deceased child's life or death. 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 recommend personnel action against DSHS employees or other individuals.

[3] Christina D. Carlson is named in this report because she was charged with committing a crime related to this report of neglect investigated by Children's Administration.[Source: Unites States Attorney's Office and RCW 74.13.500(1)(a)]

[4] The legislature finds that the state is committed to protecting the essential tribal relations and best interests of Indian children by promoting practices designed to prevent out-of-home placement of Indian children that is inconsistent with the rights of the parents, the health, safety, or welfare of the children, or the interests of their tribe. [Source: RCW 13.38.030]

[5] The federal Indian Child Welfare Act (ICWA) of 1978 (25 U.S.C. 1901 et seq.) was the first federal legislation enacted to protect Indian children and families. This landmark law defines the rights of tribes to assume jurisdiction over children who are members or eligible to be members in a tribe.[Source: CA Indian Child Welfare Manual]

during the review. Neither CA staff nor committee members had previous direct involvement with the case.

Prior to the review, each committee member received a case chronology of known information regarding the parents and child, and un-redacted CA case-related documents. Additional documents were made available to the committee at the time of the review. These included a medical summary, the memorandum of understanding between the Tulalip Tribes and Children's Administration, copies of media coverage of the incident, and relevant CA policies and practice guides.

During the course of the review, the CFR Committee members interviewed the Child Protective Services supervisors and the social worker involved with the case. Following review of the case file documents, interviews, and discussion regarding social work activities and decisions, the Review Committee made findings and recommendations which are detailed at the end of this report.

Case Overview

Children's Administration (CA) has been intermittently involved with Ms. Carlson since 1995. Children's Administration, in collaboration with Tulalip Tribes, investigated a number of reports alleging Ms. Carlson was neglectful of C.C.'s older siblings. Shortly before C.C.'s birth in March, 2011, Children's Administration received a report indicating Ms. Carlson was abusing pain medication while pregnant. The resulting Child Protective Services intake[6] was screened out for further investigation because the alleged victim was an unborn child.

On December 2, 2011, when C.C. was nine months old, Child Protective Services received a report alleging C.C. was being neglected by her mother. The allegations included lack of supervision, inadequate nutrition, and untreated medical needs. The report generated a non-emergent[7] intake and was assigned for investigation by Child Protective Services. Prior to initiating the investigation, in accordance with the "Memorandum of Understanding Between the Tulalip Tribes of Washington and DSHS Children's Administration for Sharing Responsibility in Delivering Child Welfare Services to Children of the Tulalip

[6] An "intake" is a report received by Children's Administration in which a person or persons has reasonable cause to believe a child (person under the age of 18 years of age) has been abused or neglected.[Source: RCW 26.44.030]

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

Tribes,"[8] the Child Protective Services social worker assigned to investigate the reported concerns contacted a social worker from beda?chelh, the Tulalip Tribes family services agency.

Between December 2, 2011 and December 6, 2011, the CA social worker documented several unsuccessful attempts to locate C.C. on tribal land. Under state and federal law, CA social workers have no authority to independently investigate allegations of abuse and neglect on tribal land and do so only under the auspices of an agreement which provides permission from the tribe. At each attempt, the CA social worker was accompanied by the tribal social worker. On December 8, 2011, the CA social worker contacted the tribal social worker and requested permission to independently search for the family on tribal land. The request was not granted but the tribal social worker agreed to meet with the CA social worker within a few days to try again to locate the family.

Meanwhile, the CA social worker contacted one of Ms. Carlson's relatives and learned Ms. Carlson might be intentionally avoiding contact with both the tribal and CA social workers. Contact was eventually made on December 14, 2011 when both social workers met with C.C. and her parents in their home. During the home visit the CA social worker did not observe any safety or neglect concerns regarding C.C. Specifically, she was clean, dressed appropriately, appeared well-nourished and had no signs of injury or bruising. There were no observable safety hazards in the home. The social workers confirmed there was an ample supply of food in the home. Regardless of no observable signs of child abuse or neglect, the parents indicated an interest the case services available from their tribe and agreed to engage in the services offered by the tribal social worker.

For the next several months, the CA social worker and tribal social worker communicated by email and during case staffings about the family's progress toward engaging in tribal services. Together the social workers attempted to conduct home visits in May, June, and July of 2012 but were repeatedly unsuccessful in locating the family.

In August, the CA social worker documented her attempts to reestablish contact with the family by leaving phone messages with relatives, checking various state databases, and an online jail registry. On September 19, 2012, the CA social worker and supervisor decided to close the investigation because the family still

[8] The Indian Child Welfare Act (ICWA) 25 U.S.C. 1901, et. seq., authorizes the state of Washington to enter into agreements concerning the care and custody of Indian children and jurisdiction over child custody proceedings involving Indian children.[Source: Children's Administration Indian Child Welfare Manual]. A copy of the agreement between Tulalip Tribes and Children's Administration is available at http://www.dshs.wa.gov/pdf/ca/tulalipAgreement.pdf

could not be located and the investigation had extended far beyond the standard investigative timeframe.

On October 8, 2012, the Child Protective Services supervisor finalized the closure of the investigation. A few hours later, Children's Administration was notified by the Snohomish County Medical Examiner that C.C. was deceased after being found in a parked car on tribal land. C.C. had been unattended in the car for long periods of time. This report generated a new Child Protective Services investigation.

A subsequent medical examination revealed C.C., at the time of her death, was severely malnourished, and her body was covered with feces, urine, lice, bedbugs, and a bleeding rash. On November 6, 2012, the Snohomish County Medical Examiner determined C.C.'s death was a result of neglect and her manner of death was homicide.

The Child Protective Services investigation regarding CC.'s death was completed on December 6, 2012 resulted in a founded allegation of child maltreatment.[9]

On January 13, 2013, Ms. Carlson was charged in United States District Court with second degree murder and two counts of criminal maltreatment.[10]

Committee Discussion

The discussion began by reading a statement from a legal representative of the Tulalip Tribes explaining why Tulalip Tribes was unable to participate in the review. The letter also provided cultural suggestions for consideration by the Committee. In honor of the traditions of the Tulalip Tribes and those involved in this incident, a moment of silence was observed by the committee. While the Committee believed it would have been beneficial to have tribal participation during the review, the Committee respects the decision of the Tulalip Tribes and its tribal laws and policies and appreciated Tulalip Tribes for providing the written statement.

The Committee then engaged in a discussion of case activities and case planning provided to this family. The discussion focused on the Indian Child Welfare Act, coordination with tribal social workers to provide Child Protective Services to Native American children living on tribal land, timeframes for Child Protective

[9] Findings are based on a preponderance of the evidence. Child Abuse or Neglect is defined in RCW 26.44.020, WAC 388-15-009, and WAC 388-15-011. Findings are determined when the investigation is complete. Founded means the determination that, following an investigation by CPS, based on available information: it is more likely than not that child abuse or neglect did occur.

[10] Source: http://www.justice.gov/usao/waw/press/2013/Jan/carlson.html

Services investigations,[11] protocols for locating families, recent changes in the executive order pertaining to Child Protection Teams[12] and the impact of staff changes.

The committee learned about state and federal laws and state policies relevant to child welfare services for Native American children. The committee explored how CA social workers notify tribes of new investigations involving Native American children, how CA social workers must request tribal permission to access children and parents living on tribal land, information sharing between CA and tribal social workers and how tribes and CA have distinct child welfare laws, policies and timeframes. The Committee discussed the current "Memorandum of Understanding between the Tulalip Tribes of Washington and DSHS Children's Administration for Sharing Responsibility in Delivering Child Welfare Services to Children of the Tulalip Tribes" and questioned if the memorandum provides adequate guidance to social workers and supervisors from CA and Tulalip Tribes. The Committee noted the importance for CA to build and maintain positive working relationships with tribes and how frequent staff changes make it more difficult to maintain those relationships.

The Committee noted this case remained open beyond the timeframes required by policy to complete a Child Protective Services investigation in order to attempt to engage the parents in voluntary services. From information obtained from the involved social worker and supervisors, it is the understanding of the Committee that the decision to keep the case open beyond the standard timeframe for an investigation was based on concerns about the family history of child neglect.

The Committee discussed the appropriateness of the investigation timeframes and suggested some flexibility to extend the timeframes is necessary when there are extenuating case circumstances. In addition to the requests from law enforcement or prosecuting attorneys for timeframe extensions allowed by the Revised Code of Washington and CA policy, the Committee supports extending the timeframes when a family cannot be located. The Committee noted

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[11] The social worker shall complete an investigative risk assessment on all investigations of child abuse and neglect upon completion of the investigation within 45 calendar days of Children's Administration receiving the intake [Source: CA Practices and Procedure Guide 2520] For reports of alleged abuse or neglect that are accepted for investigation by the department, the investigation shall be conducted within timeframes established by the department in rule. In no case shall the investigation extend longer than ninety days from the date the report is received, unless the investigation is being conducted under a written protocol pursuant to RCW 26.44.180 and a law enforcement agency or prosecuting attorney has determined that a longer investigation period is necessary. At the completion of the investigation, the department shall make a finding that the report of child abuse or neglect is founded or unfounded.[Source: RCW 26.44.030]

[12] Child Protection Teams provide confidential, multi-disciplinary consultation and recommendations to the department on cases where there will not be a Family Team Decision meeting and there is a risk of serious or imminent harm to a young child and when there is dispute if an out-of home placement is appropriate. Source: CA Practice and Procedures Guide 1740]

extending the timeframes for completing CPS investigations might result in larger caseloads and present a workload challenge to CA.

The Committee reviewed the current and proposed revision of the CA guidelines for reasonable efforts to locate children and parents. The Committee endorsed the revisions. The Committee acknowledged the Children's Administration social worker tried a variety of methods to locate this family but questioned why several months passed in which there were no documented efforts to locate the family.

Effective July 25, 2012, the Executive Order for Child Protection Teams[13] was amended by then Governor Gregoire. The Committee discussed if the amendments were relevant to this case, why this case was not staffed by a local Child Protection Team (CPT), and the role tribes have in determining when a CPT staffing occurs for a child for whom the tribe has an interest.

The Committee explored workload for Child Protective Services social workers, the specialized skills and knowledge required for CA staff assigned to cases involving Native American children and their families, and the importance of retaining an experienced child welfare workforce by both tribes and CA.

Findings

1. After reviewing the current "Memorandum of Understanding Between the Tulalip Tribes of Washington and DSHS Children's Administration for Sharing Responsibility in Delivering Child Welfare Services to Children of the Tulalip Tribes" the Committee believes the agreement does not clearly establish the roles and responsibilities of tribal social workers and CA social workers working together to provide child welfare services to the children and families of Tulalip Tribes.
2. The Committee supports the decision of the CA social worker to maintain an open Child Protective Services case beyond the time frames established by the department and recognized that the decision was prompted by the social worker and supervisor's desires to engage the parents in voluntary services. However, the Committee expressed concern about the lack of documented attempts to locate the family between December 14, 2011 and mid-May, 2012.
3. Although CA policy requires active cases to be reviewed monthly by a supervisor,[14] the Committee found no documentation that a supervisory

[13] A copy of Executive Order 12-04 can be found at http://www.governor.wa.gov/office/execorders/eoarchive/eo_12-04.pdf

[14] Social work supervisors must conduct monthly supervisor case reviews with each assigned social worker and document each case reviewed in the client electronic case file.[Source: CA Practice and Procedures Guide 4610]

review occurred between May 7, 2012 and October 8, 2012. The Committee questions if the lack of supervisory reviews was a consequence of a change in supervisors that occurred in June of 2012.
4. The Committee recognizes the impact of this case on all involved CA and tribal staff and expressed appreciation for their work.

Recommendations

1. The current "Memorandum of Understanding Between the Tulalip Tribes of Washington and DSHS Children's Administration for Sharing Responsibility in Delivering Child Welfare Services to Children of the Tulalip Tribes" should be revised to increase the specificity of the roles and responsibilities of tribal and Children's Administration social workers.
2. The hiring and retention of Child Protective Services social workers and supervisors should be a top priority of Children's Administration.
3. When a change in supervisory coverage for a work unit of Indian Child Welfare social workers occurs, the cases assigned to that unit should be jointly staffed by the previous and new supervisors. The Committee believes this approach would highlight for the new supervisor which cases are particularly complex or involve children at greater risk of maltreatment.

Child Fatality Review

C.C.

July 2009
Date of Child's Birth

November 29, 2012
Date of Fatality Incident

March 15, 2013
Child Fatality Review Date

Committee Members
Blake Beecher, Ph.D., Assistant Professor, Eastern Washington University
Steve Bryant, MA, Newport Child Protective Services Supervisor, DSHS, Children's Administration
April Cathcart, MSW, LSWAA, Director, Empowering, Inc. Services
Jeff Landon, MSW, Acting Director, Sex Offender Treatment Program, Washington State Department of Corrections
Mary Meinig, MSW, Director, Office of Family and Children's Ombudsman

Facilitator
Robert Larson, Critical Incident Case Review Specialist, DSHS, Children's Administration

RCW 74.13.640

Executive Summary

On March 15, 2013, the Department of Social and Health Services (DSHS), Children's Administration (CA) convened a Child Fatality Review (CFR)[15] to examine the practice and service delivery in the case involving a three-year-old male named C.C. and his family. The incident initiating this review occurred on November 29, 2012, when the Spokane Police Department received a 911 call from C.C.'s mother reporting her son was not breathing. The responding emergency personnel were unsuccessful in their attempts to revive C.C. The Spokane County Medical Examiner later certified C.C.'s cause of death as undetermined. The Medical Examiner reported that there was no identifiable cause of death following the death scene investigation, review of medical records, autopsy examination, toxicology, and laboratory studies.

The CFR Committee included community members selected from diverse disciplines with relevant expertise, including representatives from the Department of Corrections, mental health, social work, the Office of the Family and Children's Ombudsman, and Children's Administration (CA). Committee members, including CA staff, had no prior involvement with the family. Prior to the review, each committee member received a case chronology, a summary of CA involvement with the family and non-redacted CA case documents (e.g., intakes, safety assessments, investigative assessments, provider records, Child Protective Services investigative reports).

Supplemental sources of information and resource materials were available to the Committee at the time of the review. These included copies of state laws and CA policies relevant to the review and the complete case file.

During the course of the review, the CFR Committee members interviewed the Child Protection Services social worker and supervisor assigned to investigate the fatality. The CFR Committee also interviewed an intake supervisor associated with the case.

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[15] Given its limited purpose, a Child Fatality Review should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. The Child Fatality Review 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 will only hear from DSHS employees and service providers. It does 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 recommend personnel action against DSHS employees or other individuals.

Following a review of the case file documents, interviews, and discussion regarding social work activities and decisions, the Committee made findings and recommendations, which are detailed at the end of this report.

Case Overview

C.C. was the youngest son of his mother's two children. C.C.'s father was not residing in the family home at the time of the fatality. The incident initiating this review occurred on November 29, 2012 when C.C. was discovered not breathing in his bed. C.C. resided with his mother, 15-year-old brother, mother's boyfriend, D.D., and D.D.'s 16-year-old son.

D.D. first came to the attention of Children's Administration (CA) in January 1994. D.D.'s CPS history includes five founded findings[16] for physical abuse[17] between 1994 and 2002. In early 2012, D.D. began a relationship with C.C's mother. CA has received twenty-seven intakes regarding children residing in the same home as D.D.

C.C.'s mother first came to the attention of CA on July 27, 2012. A TANF worker[18] reported the following concerns to intake after meeting with the mother at the local Community Services Office: The mother was "animated" and "hysterical" and had a strong odor of marijuana. The family was homeless, but reported to be staying with a male friend. The mother said she was unable to adequately feed or care for C.C. The mother stated her children "may be better off in foster care." This intake screened in for alternate intervention.[19]

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[16] CA findings are based on a preponderance of the evidence. Child Abuse or Neglect is defined in RCW 26.44.020, WAC 388-15-009, and WAC 388-15-011. Findings are determined when the investigation is complete. Founded means the determination that, following an investigation by CPS, based on available information: it is more likely than not that child abuse or neglect did occur. Unfounded means the determination that, following an investigation by CPS, based on available information: it is more likely than not that child abuse or neglect did not occur, or there is insufficient evidence for the department to determine whether the alleged child abuse did or did not occur.

[17] Abuse - Washington state law defines abuse or neglect as "sexual abuse, sexual exploitation, or injury of a child by any person under circumstances which cause harm to the child's health, welfare, or safety, or the negligent treatment or maltreatment of a child by a person responsible for or providing care to the child. [Source: RCW 26.44.020]

[18] Temporary Assistance for Needy Families (TANF) is a federal assistance program. It began on July 1, 1997, and succeeded the Aid to Families with Dependent Children (AFDC) program, providing cash assistance to indigent families with dependent children through the Department of Health and Human Services. This cash benefit is often referred to simply as "welfare."

[19] Alternate Intervention - CA must respond within 10 calendar days to an alternate intervention intake. The CA social worker may send a letter, make a phone call to the caretakers(s), or make a brief home visit. CA may send the intake to an Early Family Support Service or other community agencies which are willing to accept the intake for services and/or monitoring.

On November 28, 2012, CA received a phone call from a neighbor. The referrer expressed concern that C.C.'s mother left him in the care of the teenage boys living in the home. The referrer reported the boys had previously held C.C. over the side of the balcony by his hands and left C.C. alone. The referrer also reported C.C. had bruises all of the time and the parents reportedly were dealing drugs and smoking marijuana. D.D. and his 16-year-old son reportedly got into arguments resulting in physical fights. The 16-year-old reportedly punches holes in the wall of the residence. The case screened in[20] for investigation.

The case was assigned to the social worker at 8:55 a.m. on November 29, 2012. The social worker received two voicemail messages from the referrer the day of case assignment. The first voicemail message stated she had new information to share with the social worker. The second message from the referrer stated C.C. was dead. The social worker immediately reported the fatality to intake and CA management.

Discussion

The Committee spent considerable time discussing the investigation and events after the fatality due to the limited recent CA activity prior to the fatality. The Committee discussed the household members' CPS history and the impacts of system changes on data retention. The Committee noted D.D. had five founded findings going back to 1994; however, social worker documentation in the case file frequently erroneously identified D.D. as only having one prior founded finding. The Committee explored the reasons why social workers failed to locate all five founded findings. The Committee noted CA's change from a paper system to CAMIS,[21] and eventually to FamLink[22] resulted in various methods of locating client history including founded findings. D.D.'s founded findings are from 1994, 1995, 1996, 1998 and 2002. D.D.'s first two founded findings can be located in a review of MODIS[23] records. Neither of the first two founded findings can be located in FamLink. D.D.'s second two founded findings can be located in FamLink. However, the second two founded findings were difficult to locate due to their location under the historical summary assessments hyperlink and not

[20] Screen In - CA screens in for investigation all allegations that meet the definition of child abuse or neglect as defined by RCW 26.44.020.
[21] CAMIS is an automated system which stores data regarding intakes, placement, case activity, contracts, licensing, and other case-specific information related to CA. CAMIS was the case management system for CA from the early 1990s to February 1, 2009.
[22] FamLink is the name of CA's Statewide Automated Child Welfare Information System (SACWIS) that replaced CAMIS.
[23] MODIS is a web-based system used by DSHS for storing and viewing imaged documents.

under the investigative assessments hyperlink as is current practice. The final founded finding is easily located through the investigation hyperlink in FamLink.

It should be noted that there was no due process associated with founded findings of abuse or neglect prior to the enactment of the Child Abuse Prevention and Treatment Act (CAPTA) in 1998.[24] Founded findings prior to 1998 are not considered conclusive in a CPS investigation and are not considered reliable because of the lack of due process. Additionally, the social worker had no opportunity to review D.D.'s findings, as the case was open for only a few hours prior to the fatality.

The Committee believes findings need to be easily located by investigative social workers. The Committee noted it is challenging for social workers to locate findings in MODIS. For this reason, the Committee believes any founded finding discovered in MODIS through the course of an investigation should be manually added to FamLink so it can be considered during future investigations.

The Committee believed Washington state children would benefit from continued efforts by CA to educate the community about child abuse. The Committee noted that neighbors had witnessed bruising on C.C. and witnessed the teenagers holding C.C. over the edge of a balcony, but there was a delay in the reporting of those concerns. The Committee believed CA's ability to protect children is limited to the information provided by the community in which a child resides. For this reason, the Committee recommends CA continue community outreach about child abuse. The Committee recommends community education include tools such as You Tube, social media, and regular contact with community organizations.

The Committee discussed the July 27, 2012 intake that screened in for alternate intervention. The Committee noted CA sent a letter to the family as a response to the intake. The Committee noted practice regarding alternate intervention varies from office to office. Where available, CA Intake can refer the family to a contracted alternate intervention, called Early Family Support Services (EFSS). If there is no provider available, CA sends a letter informing the family of local

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[24] The Child Abuse Prevention and Treatment Act (Public Law 93-247) provides federal funding to states in support of prevention, assessment, investigation, prosecution, and treatment activities and also provides grants to public agencies and nonprofit organizations for demonstration programs and projects. Additionally, CAPTA identifies the federal role in supporting research, evaluation, technical assistance, and data collection activities; establishes the Office on Child Abuse and Neglect; and mandates the National Clearinghouse on Child Abuse and Neglect Information. CAPTA also sets forth a minimum definition of child abuse and neglect.

resources that may assist with services. The Committee discussed the varying level of service for alternate intervention across Washington state and believed all parts of the state should receive the same service. The Committee also noted CA's practice of mailing a letter was within policy.

Findings
None

Recommendations

1) The Committee recommends CA continue community outreach about child abuse. The Committee recommends community education include tools such as You Tube, social media, and regular contact with community organizations.
2) The Committee believes findings need to be easily located by investigative social workers. The Committee noted it is challenging for social workers to locate findings in MODIS. For this reason, the Committee believes any founded finding discovered in MODIS through the course of an investigation should be manually added to FamLink so it can be considered during future investigations.

Child Fatality Review

N.I.

July 2010
Date of Child's Birth

December 6, 2012
Date of Fatality Incident

March 28, 2013
Child Fatality Review Date

Committee Members
Lynelle Anderson, Detective, Pierce County Sheriff's Department
Paul Evans, Intake Supervisor, Central Intake, DSHS, Children's Administration
Christi Lyson, Assistant Director, Institute for Family Development
Mary Meinig, Director, Office of Family and Children's Ombudsman
Marti Miller, Child Protective Services Supervisor, Ellensburg, DSHS, Children's Administration
Kathryn Oneita, Indian Child Welfare Director, Small Tribes of Western Washington (STOWW)
Kevin Rundle, Director of Legal Services, YWCA, Pierce County

Observer
Sharon Gilbert, Director, Quality and Practice Improvement Division, DSHS, Children's Administration

Facilitator
Robert Larson, Critical Incident Case Review Specialist, DSHS, Children's Administration

RCW 74.13.640

Executive Summary

On March 28, 2013, the Department of Social and Health Services (DSHS), Children's Administration (CA) convened a Child Fatality Review (CFR)[25] to review the department's practice and service delivery to two-year-old N.I. and his family. N.I. is a Caucasian male with Native American ancestry. Paternity was established post-fatality as to N.I.; his father was determined to be T.A. The father reports having both Cherokee and Choctaw ancestry.

On December 6, 2012, the day of the fatality, N.I.'s mother telephoned 911 at approximately 2:30 a.m., as her son was found unresponsive in the family home. Emergency responders transported N.I. to the hospital but they were unable to establish a heartbeat and he was pronounced dead. The Pierce County Medical Examiner's Office completed an autopsy and toxicology screen. The toxicology report showed N.I. had a fatal amount of methamphetamine in his system at the time of his death.

The CFR Committee included community members selected from diverse disciplines with relevant expertise, including representatives from domestic violence, mental health, parent education, law enforcement, Indian child welfare and Children's Administration (CA). Committee members, including CA staff, had no prior involvement with the family.

Prior to the review, each committee member received a case chronology, a summary of CA involvement with the family and non-redacted CA case documents (e.g., intakes, safety assessments, investigative assessments, provider records, Child Protective Services investigative reports).

Supplemental sources of information and resource materials were available to the Committee at the time of the review. These included copies of state laws and CA policies relevant to the review and the complete case file.

The Committee interviewed two CA social workers and a CA supervisor previously assigned to the case.

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[25] Given its limited purpose, a Child Fatality Review should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. The Child Fatality Review 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 will only hear from DSHS employees and service providers. It does 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 recommend personnel action against DSHS employees or other individuals.

Following a review of the case file documents, interview of the CA social workers and supervisor, and discussion regarding department activities and decisions, the Committee made findings and recommendations, which are detailed at the end of this report. **RCW 74.13.515**

Case Summary

N.I.'s family first came to the attention of the department on June 23, 2009. [redacted] The father and the mother were not in a relationship at the time of the initial intake but resumed their relationship when the case closed in October 2010. The case was open to the original investigator from June 2009 until December 2010; however, it was inactive for the last three months of that period.

[redacted] A July 31, 2010 intake stating the mother had given birth to N.I. and that the baby (N.I.) would be tested for drug exposure was also screened out.

A February 10, 2011 intake alleging adults were smoking methamphetamine in the same room where N.I. received breathing treatments screened in. The home

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[26] CA intake staff must screen in intake reports meeting the following criteria: 1) a child (birth to 5 years old), reported by a licensed physician or medical professional on "the physician's behalf" or 2) a non-mobile infant (birth to 12 months) with bruises, regardless of the explanation for how the bruises occurred. 3) CA must accept an intake where a child is alleged to have been abused or neglect by the child's parent, guardian, or custodian, 4) the subject is a licensed foster parent, group care provider, or a volunteer or employee of a child care agency, 5) a person alleged to have committed CA/N in an institutional setting. CA staff must not treat allegations of CA/N in licensed or certified facilities as third party abuse or neglect.

[27] Unfounded - The determination that, following an investigation by CPS, based on available information: it is more likely than not that child abuse or neglect did not occur, or there is insufficient evidence for the department to determine whether the alleged child abuse did or did not occur. WAC 388-15-005

[28] There is a high co-occurrence of domestic violence in cases of child abuse and neglect. However, a child's exposure to domestic violence, in and of itself, does not constitute child abuse and neglect. Domestic violence, which physically harms a child or puts a child in clear and present danger, would constitute an allegation of child abuse. [Source: CA Practices and Procedures Guide 2220.]

[29] CA will generally screen-out intakes where: 1) Abuse of dependent adults or persons 18 years of age or older. Such services are provided by the Adult Protective Services (APS) section. 2) Third-party abuse committed by persons other than those responsible for the child's welfare. 3) CA/N that is reported after the victim has reached age 18, except those 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 CA/N. 5) Cases in which no abuse or neglect is alleged to have occurred. 6) Allege violations of the school system's Statutory Code, Administrative Code, statements regarding discipline policies.

allegedly had garbage bags spilling onto the floor within reach of N.I.'s two-year-old sister. The mother's methamphetamine use allegedly influenced her ability to safely care for her children. The assigned social worker attempted to engage the mother in services through a voluntary case plan.[30] The mother was offered urinalysis (UA) testing,[31] a chemical dependency evaluation, and Early Family Support System (EFSS) services. The mother completed a chemical dependency evaluation but the social worker was unable to pay for the evaluation as she did not go to the agreed upon contracted provider. The mother refused to reschedule her chemical dependency evaluation with a contracted provider. The social worker attempted, but was unable to obtain the completed chemical dependency evaluation. The mother provided two UAs during this investigation. She failed to show for one UA and tested positive for marijuana on the second UA. The mother refused EFSS services and the case closed after the mother refused ongoing voluntary services. The allegations of negligent treatment or maltreatment were unfounded.

On August 30, 2011, CA received an intake alleging a lack of food in the home, unsanitary living conditions, drug use by the mother, and physical abuse of both children by their mother. The intake screened in for investigation. The allegations of neglect were founded[32] and on October 5, 2011, a Family Team Decision Meeting (FTDM) was held; the following safety plan was implemented: N.I. would stay with his maternal uncle and N.I.'s sister would live with her father. The social worker encouraged the father to continue with his chemical dependency outpatient treatment and DV classes. The mother was offered Family Preservation Services (FPS),[33] Public Health Nurse (PHN) services, and chemical dependency services. On October 12, 2011, the father tested positive for methamphetamine. The CPS case was transferred to the Family Voluntary Services (FVS) unit in October 2011.

On November 16, 2011, an intake was received alleging the children are "hacking and coughing" all night long. The referrer stated he took a crack pipe away from the mother. A subsequent intake was received on November 24, 2011 alleging continued breathing concerns with N.I. and domestic violence between N.I.'s mother and her boyfriend. Both intakes screened in for investigation by CPS. CA

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[30] A voluntary case plan is 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 a parent's protective capacity and manage child safety. Continued assessment of child safety occurs throughout the case.[Source: CA Practices and Procedures Policy 2441]

[31] Urinalysis (UA) drug testing is a testing of a urine sample (specimen) for drugs.

[32] Founded - The determination that, following an investigation by CPS, based on available information: it is more likely than not that child abuse or neglect did occur. WAC 388-15-005

[33] FPS - Family Preservation Services--are intensive in-home services for families designed to prevent out-of-home placement of children or to facilitate family reunification.

lost contact with the mother from November 2011 until June 2012. In June 2012, the mother was offered UA services, PHN services, parenting classes, and a chemical dependency evaluation. On July 2, 2012, the mother tested positive for marijuana and methamphetamines. The FVS case closed due to the mother's failure to cooperate with services and a decision that there was insufficient evidence to file a dependency petition. The decision not to file a dependency petition was made after consultation with the court unit supervisor. The allegations of neglect were unfounded.

On November 18, 2011, CA received an intake alleging the father's residence "reeked" of marijuana and the father was failing to provide sufficient supervision of N.I.'s sister. The allegations were investigated by CPS and determined to be unfounded.
On August 6, 2012, N.I.'s doctor contacted CA to report the mother's failure to follow through with N.I.'s medical treatment. The intake screened in. The assigned social worker attempted unsuccessfully to locate the family throughout August 2012. The case closed due to the inability to locate the family.

On December 6, 2012, N.I. died from ingesting methamphetamine.

Discussion
The Committee discussion focused on several key areas including social worker documentation, case inactivity, services offered to the family, and decisions surrounding potential out-of-home placement.

Documentation: The Committee discussed the documentation surrounding the June 2009 and October 2009 intakes. The social worker's documentation stated that the mother had no substance abuse issues. The social worker also documented that she believed the father provided false information in his report to intake. The social worker's investigation resulted in no evidence of drug use outside of the allegations in the intake. However, the Committee believed the social worker should have requested UAs or completed additional collateral contacts regarding the mother's drug use prior to making the concrete assertion that the mother had no substance abuse issues. On July 16, 2009, the CPS supervisor documented, "Social worker will be following-up with the father regarding his allegations. She will be talking to him about making false allegations and warning him about erroneous referrals made to this department." The Committee believed the social worker and supervisor had insufficient information to determine the father had provided false information.

Case Inactivity: The Committee noted that there were two periods of inactivity related to this case. The periods were from October 2009 until December 2010,

and again from December 2011 until June 2012. During both periods, the case was open with minimal case activity. The Committee expressed concern that the case was considered high risk during the second inactive period and the Committee believed there should have been a greater effort to locate and engage the family. CA has established a "Guideline for Reasonable Efforts to Locate Children and/or Parents." The social worker did not document sufficient efforts to locate the family as referenced in the "Guideline for Reasonable Efforts to Locate Children and/or Parents."

Services: Throughout this case, various services were offered to the family including chemical dependency evaluations and treatment, public health nurse, and family preservation services. The Committee believed the family's level of need and resistance to services may have warranted a more intensive service such as Homebuilders,[34] which provides almost daily contact with families.

The Committee noted that the case file included significant documentation about domestic violence (DV) between the mother and father and believed the mother should have been offered DV victims services.

The Committee noted the investigative process related to the June 2009 and October 2009 intakes may have been strengthened by requesting the mother comply with UA drug testing.

Placement decisions: The Committee discussed points in the case when CA may have considered filing a dependency petition for out-of-home placement. The first identified point was prior to the FTDM on October 5, 2011.

On October 4, 2011, the assigned social worker requested law enforcement place the children into protective custody due to concerns about the mother's care of the children and the presence of a methamphetamine pipe in the home. Law enforcement declined to place the child into protective custody as the mother was clean and sober at the time of contact. The social worker then contacted the patrol officer's sergeant as she continued to believe the children needed to be placed into protective custody. The sergeant also declined to authorize protective custody.

The Committee thought the social worker demonstrated quality practice by attempting to utilize the patrol officer's sergeant when she remained concerned about the children's safety following her contact with the patrol officer. The Committee was unable to determine how much of the case history was shared

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[34] Homebuilders is a program designed to prevent placement of children, get children back home more quickly, and keep problems from happening again by providing intensive in-home services several times a week for about a month.

with law enforcement and what information was made available to the patrol officer's sergeant when he reviewed the decision to not place the children into protective custody. The Committee noted that the Pierce County Sheriff's Office Investigations Unit can be utilized by CA staff under similar circumstances as the Investigations Unit is better prepared to deal with complex cases, difficult clients, or clients that CA is unable to locate. The Committee believed the safety concerns at this point in the case warranted a discussion with the Attorney General's Office about the filing of a dependency petition.

The Committee believed CA had a second opportunity to staff the filing of a dependency petition with the Attorney General's Office following the FTDM on October 5, 2011. The FVS social worker was responsible for implementing and monitoring of the plan agreed to at the FTDM. The Committee noted the FVS social worker did not participate in the FTDM and the Committee believed she may have been better prepared to monitor and implement the case plan if FVS had been invited to attend the FTDM. The CPS supervisor informed the Committee that practice in the Tacoma CA office has changed and FVS social workers now attend FTDMs under similar circumstances. The Committee believed the social worker's lack of contact with the family was particularly concerning due to the mother's lack of cooperation, recent founded finding, and both parents' positive UAs for methamphetamine. In addition, this case met the criteria for a Child Protection Team (CPT)[35] staffing at multiple points throughout this case and none occurred.

The case transferred to a new social worker in June 2012. The assigned social worker staffed the filing of a dependency petition with her supervisor and the court unit supervisor. The court unit supervisor determined there was insufficient information to support the filing of a dependency petition at that time due to the lack of current allegations regarding the mother and father. The social worker and supervisor informed the Committee the case closed due to the parent refusal of services and the lack of current information supporting a dependency action. The Committee also noted that it had been approximately eight months since CA had significant ongoing contact with the family and the social worker had very limited new information to present at the time of the staffing due to the mother's lack of cooperation. The most recent contact with the family was on June 20, 2012 when law enforcement completed welfare check at the request of the social worker. The mother and children appeared healthy and no concerns were noted by the responding officers. The assigned social worker visited the

[35] Child Protection Teams provide confidential, multi-disciplinary consultation and recommendations to the department on cases where there is a risk of serious or imminent harm to a young child and when there is dispute if an out-of home placement is appropriate.

mother and children on the same day and noted the children appeared clean and well dressed.

Additional discussion points: The Committee noted extended family members provide an additional safety net for children. The Committee believed relatives frequently want to protect children, but lack the knowledge of how to intervene on their behalf. For this reason, the Committee noted that it may be best practice for social workers to be familiar with the third party custody process so they are better able to inform protective family members. Social workers may not provide legal advice about the third party custody process but they could direct them to resources that could assist them with that process.

The Committee noted that law enforcement has instant access into an alleged subject's[36] past contacts with law enforcement. The Committee discussed the potential benefits to social workers of investigative tools used by law enforcement such as Lynx Northwest, LexisNexis and Spillman.[37] As a result, the Committee recommends CA consider adding resources such as Lynx Northwest, LexisNexis or Spillman.

N.I.'s family was identified as having Native American ancestry. Per policy, all cases involving families with Native American ancestry should be staffed with the identified tribe or the Local Indian Child Welfare Advisory Committee (LICWAC).[38] This case was not staffed with LICWAC as required.[39] In addition, the Committee noted that the father's name and/or information was frequently missing from the Native American Questionnaires located in the case file. The Committee believes the social workers should have listed the reason why the father was not listed on this form.

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[36] Subject - means any parent of, guardian of, custodian of or any other persons 18 years of age or older responsible for a child who allegedly causes the abuse or maltreatment of a child, or who allegedly allows the abuse or maltreatment to be inflicted on a child.

[37] LexisNexis and Spillman - are tools used by government agencies to quickly access a full suite of advanced investigative tools to quickly locate people, detect fraud, uncover assets and discover connections between suspects, witnesses or associates. The Committee believes local law enforcement agencies utilize these systems.

[38] A LICWAC is a body of volunteers, approved and appointed by Children's Administration (CA), who staff and consult with the department on cases of Indian children who: Are members of a Tribe, Band, or First Nations but for whom the 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 Recognized Indian Child.

[39] The social worker must staff the case in the following preferential order: With representatives designated by the child's tribe to staff the case with the social worker; with a tribal LICWAC designated by the child's tribe to staff the cases of all tribal children with the social worker; with the CA LICWAC designated to staff cases involving Indian children in the custody of the CA and meeting the criteria of this section, when the child's tribe is unavailable.

The Committee noted that there were significant areas of quality work performed by CA staff between 2009 and the fatality in 2012. The Committee noted that the two CPS investigators related to the February 10, 2011 intake and the August 30, 2011 intake both did an excellent job of considering case history when developing their case plan. In addition, both social workers attempted to work with the family to address the children's medical needs. The Committee believed the investigations by both of these social workers was comprehensive and demonstrated quality work.

Findings

1. The FVS social worker assigned to the case from November 2011 until June 2012 should have made a more concerted effort to locate and engage the family due to the significant risks associated with this case. CA has established a "Guideline for Reasonable Efforts to Locate Children and/or Parents" (DSHS Form 02-607). The social worker did not document sufficient efforts to locate the family as referenced in the "Guideline for Reasonable Efforts to Locate Children and/or Parents."
2. The Committee believed CA had an opportunity to staff the filing of a dependency petition with the Attorney General's Office in October 2011.
3. This case should have been staffed with a Child Protection Team in October 2011 and again in July 2012. The CPT policy at the time (CA policy 97-02) of these investigations required a CPT staffing when a case in which the risk assessment, following initial investigation, results in a moderately high or high risk classification and the child victim is age six or younger.
4. The mother should have been offered DV victims services.
5. This case should have been staffed with LICWAC.
6. An Assistant Attorney General should have been included in the case staffing in July 2012. Additionally, it was noted by the Committee that the social worker assigned to the case in July 2012 did an excellent job of locating the family and attempting to engage the mother in services but the Committee found the case may have benefitted from the social worker completing additional collateral contacts. Specifically, the Committee believed a phone call to the child's doctor may have provided valuable information about the children's safety and wellbeing.

Recommendations

1. During the course of the review, the Committee noted that several of the reports provided to the Committee reflected the review facilitator as the author of those reports. The Committee learned that CA's computer system, FamLink, automatically places the name of the person printing the document as the author of the document. The Committee recommended that a change request be submitted to Children's Administration

Technology Services to ensure all documents printed from FamLink accurately reflects the actual author.

2. CA to consider adding resources such as Lynx Northwest, LexisNexis or Spillman. CA should evaluate these databases and determine if these systems are able to provide social workers with information needed to increase child safety.
3. The Committee noted that the father's name and/or information was frequently missing from the Native American Questionnaire. The Committee recommends social workers explain why a father is not listed on the Native American Questionnaire. Additional training should be provided to social workers to ensure this recommendation is completed.

RCW 74.13.640

Child Fatality Review

K.B.

September 2012
Date of Child's Birth

December 11, 2012
Date of Child's Death

May 9, 2013
Child Fatality Review Date

Committee Members
Linda Thomas, MSW, Catholic Community Services
Deborah McFadden, Lead Attorney, Pierce County Department of Assigned Counsel Dependency Unit
Rhiannon Williams-Sanchez, MSW, LICSW, Pediatric Medical Social Worker, Mary Bridge Children's Health Center and Hospital
Julie Slaughter, Central Intake Supervisor, Children's Administration
Katrina Avent, Program Manager, Department of Corrections/Washington Correctional Center for Women (WCCW)
Mary Meinig, MSW, Director of the Office of Family and Children's Ombudsman (OFCO)
Janice Pitt, CA Social and Health Program Consultant/FTDM Facilitator, Region 3

Legal Consultant to the Child Fatality Review Committee
Carrie Hoon Wayno, Assistant Attorney General, Office of the Attorney General

Observer
Chris Case, Assistant Director Public Affairs, Department of Social and Health Services
Colleen Shea Brown, Office of Family and Children's Ombudsman (OFCO)

Facilitator
Bob Palmer, Critical Incident Case Review Specialist, Children's Administration

Executive Summary **RCW 74.13.515**

On May 9, 2013, the Department of Social and Health Services Children's Administration (CA) convened a Child Fatality Review[40] (CFR) to examine the department's practice and service delivery to 3-month-old K.B. and her family. K.B.'s mother was incarcerated at Washington Correctional Center for Women (WCCW) at the time of K.B.'s birth in September 2012; the infant was discharged by the hospital into the care of the alleged biological father Kevin Boehmer.[41] Mr. Boehmer immediately moved to California with the newborn and on December 11, 2012 K.B. died in Tuolumne County, California as a result of blunt force trauma believed to have been caused by her alleged biological father. Children's Administration had no prior involvement with Kevin Boehmer [redacted].[42]

A CFR was required under RCW 74.13.640(1)(a) because the child's family received services from the department within a year of the child's death from alleged abuse or neglect. The CFR Committee was comprised of CA staff and community members with pertinent expertise from a variety of fields and systems, including hospital social work, the prison division of the Department of Corrections (DOC), CA intake and child welfare services, parent advocacy, child advocacy, and family preservation. An Assistant Attorney General provided legal consultation to the Committee regarding CA's legal authority, jurisdiction, and other legal issues relevant to the review process. None of the Committee members had any previous direct involvement with the family.

Prior to the review each Committee member received: (1) a brief narrative summary of CA involvement with K.B.'s mother and half-siblings; (2) a chronology covering CA activities from the first mention of the incarcerated mother's pregnancy in March 2012 through post-delivery investigation; (3) un-redacted CA

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[40] Given its limited purpose, a Child Fatality Review should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. The Child Fatality Review 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 will only hear from DSHS employees and service providers. It does 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 recommend personnel action against DSHS employees or other individuals.

[41] The alleged father's name is used in this report as he was charged by the Tuolumne County District Attorney with Homicide in connection with the child's death. [Source: RCW 74.13.500]

[42] The name of K.B.'s mother is not used in this report as she was not involved in the fatality that occurred in California. The names of the half-siblings are also not used in this report due to confidentiality. [Source: RCW 74.13.500]

case file documents relating to discussions with WCCW prison staff from before K.B. was born; (4) un-redacted CA investigation case file documentation from after K.B. was born; and (5) California CPS documents obtained from Stanislaus County and Tuolumne County. During the review Committee members were provided with a copy of a working agreement from 2000-2001 between WCCW and Pierce County CPS.

During the course of the review two Aberdeen DCFS supervisors and two Aberdeen DCFS social services specialists involved in the case were interviewed. Following review of the case file documents, completion of the staff interviews, and discussion regarding laws and current DOC and CA policies and practices, the Committee made findings and recommendations, which are presented at the end of this report.

Case Overview

K.B. was born in September 2012. However, her mother's history with Children's Administration predates K.B.'s birth by five years.

In March 2012, , the mother disclosed her third pregnancy and identified California resident Kevin Boehmer as the father. Following the mother's sentencing and transfer to the women's prison, CA responded to several inquiries from WCCW regarding the mother's history with CPS, any known CPS history involving the alleged father, and possible involvement by CPS at delivery of the unborn child since the inmate mother-to-be was not being considered for the parent-child program at the Purdy facility and the child could not stay with the mother in the facility.[43]

In August 2012, WCCW informed CA that the mother had completed a power of attorney that would allow her unborn child to be placed in the custody of Kevin

[43] The Washington's Correction Center for Women (WCCW) has a program that allows minimum security inmates serving less than three years the opportunity to live with their babies in a designated unit. The Residential Parenting Program (RPP) collaborates with Early Head Start to teach the women about parenting and to support healthy attachment, which is critical to an infant's ability to learn.

M. Boehmer. [redacted]

The WCCW counselor was advised to contact Child Protective Services (CPS) Intake when the child was born if there were specific concerns about Mr. Boehmer assuming care of the child. In September, an Aberdeen DCFS worker became aware of the birth of K.B. seven days after delivery. Information gathered by the worker suggested that the alleged father and newborn might be staying at the home of a registered sexual offender which led to an intake that screened in as Risk Only (because there were no allegations of abuse or neglect).[44]

A CPS investigation was initiated and the assigned CPS worker and a DOC officer conducted a site visit to the home of the registered sex offender and found no evidence that the child had ever been in the home. Information gathered by the CPS worker indicated K.B. and the alleged father were living in California. The CPS worker confirmed this information from numerous sources and contacted Mr. Boehmer by phone. Following this verification of the child's whereabouts, the CPS worker contacted California CPS and filed a report. The CPS investigation in Washington was closed and Stanislaus County California CPS opened a case, conducted a home visit with the father and child, and offered him services.

In November 2012, Mr. Boehmer moved to Tuolumne County. On December 9, 2012, three-month-old K.B. was admitted to Sonora Regional Medical Center for non-accidental injuries from which she later died. Kevin Boehmer was eventually charged with homicide.

Committee Discussion

The Committee endeavored to follow the prescribed purpose of Child Fatality Reviews by limiting its findings and recommendations to Children's Administration and not to other public or private agencies involved with the family.

However, the Committee acknowledged the unique set of complex circumstances of this case, which involved multiple systems each having separate legal authorities, policies, and protocols. The Committee considered various Washington laws, Children's Administration policies and practices, DOC

[44] CA will screen in a CPS 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. [Source: CA Practice and Procedure Guide Section 2220]

procedures[45] and interagency communication practices between WCCW and CA. These discussions resulted in the Committee's recognition of: (1) limited authority by CA to initiate hospital alerts or share information on cases that are not open with CA (RCW 74.04.060; WAC 388-15-029); (2) specified limits of legal authority for the state to provide Child Protective Services (ch. 388-15 WAC); (3) limits of legal authority for the state to provide Child Welfare Services (RCW 74.13.031(3)); (4) limits of legal authority for the state to intervene in cases involving unborn children (RCW 26.44.020); (5) the right of an inmate at Purdy women's facility not involved in a child dependency matter to designate a caretaker for her newborn, regardless of verified familial relationship; and (6) limits of disclosure of patient health information by health care providers, including hospitals, as established by HIPPA.[46]

While some discussion occurred regarding prior involvement of Children's Administration with the deceased child's mother and half-siblings, the Committee largely focused on the documented activities and decisions from the time of initial disclosure of the pregnancy in March 2012 through K.B.'s birth in September and the subsequent efforts by CPS to locate the newborn and her alleged father.

Findings

- The actions taken and decisions made by Children's Administration appear to have been reasonable based on established Children's Administration practice and the legal constraints for any Children's Administration intervention that were in place at the time. The Committee found the individual work by the Aberdeen CPS investigator to be exceptional in her efforts to locate the newborn, to gather additional information as to the alleged father, to contact and conduct follow-up with California CPS, and to document decisions and activities.
- The Committee was unable to conclude with any substantive level of certainty that had Children's Administration become involved at the moment of K.B.'s delivery the alleged father could have been prevented from assuming the care of the newborn without evidence that he posed

[45] CFR Committee members were briefed on DOC policy and practices regarding pregnant and delivering mothers incarcerated at WCCW (Purdy) such as the development of an Infant Care Plan, documenting signed power of attorney by an inmate, securing releases of information, and sharing of information with the local Pierce County hospital that provides birthing services for Purdy inmates.

[46] The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) established protections for security and privacy of patient health data. HIPAA's broad privacy provisions are intended to protect the confidentiality of patient health records. Broadly worded exceptions to HIPAA's privacy protections permit reporting and disclosure of public health-related case information on child maltreatment and child fatalities to those conducting activities related to "investigation" and "intervention" [See 45 CFR 160.203(c)]**.** In this case there was no investigation or intervention by CPS until several days after the birth.

substantial threat of harm to the child. Lack of established paternity would not have been a determinative factor as the case did not involve a dependency action regarding the child. There was nothing in the records reviewed to suggest any reason to anticipate a fatality incident and the Committee was unable to identify any obvious and legally supportable consideration that would have determinedly changed the course of events in this case.

- During interviews with the Aberdeen Children's Administration staff involved with the case, it was apparent that the workers were unfamiliar with procedures and practices regarding children delivered by inmates at the Purdy facility. Such cases most frequently are handled by Tacoma Children's Administration office as the prison is located in Pierce County and it appears that workers in other areas of the state are not aware of how such cases are typically handled. The absence of such knowledge was found to have no reasonably discernible connection to the child's later circumstances of death but was notable.

Recommendations

Children's Administration should convene a workgroup tasked with developing an updated working agreement with the Department of Corrections WCCW similar to the one initiated in 2000 between the then Region 5 CA Regional Administrator and the Superintendent of WCCW. It is recommended that:

- The updated working agreement not be limited to a local agreement but be a broader inter-department agreement.
- The work group should include not only CA and DOC/WCCW staff but also include participation by representatives from the Office of Attorney General and attorneys working with clients involved in dependency matters.
- The agreement should cover collaborative protocols for screening of participants eligible for the Residential Parenting Program (RPR) at the Purdy facility as well as procedures for screening pregnant inmates who are not eligible for the program and for which post-delivery caretaking arrangements may or may not need to involve Children's Administration. This might include guidelines regarding use of CA staff to be available to consult with WCCW staff on RPR screening committee meetings and inmate Infant Care Plan development even if not involving a client having an active case with CA to the extent such involvement is authorized by law.
- The workgroup should consider identifying interagency liaisons within CA and DOC that have dedicated responsibilities outlined in the agreement.
- The agreement should provide a clear understanding of roles and responsibilities for both WCCW and CA staff regarding information inquiries,

the specific types of information that can be shared within current legal authority, and case staffing protocols. Once a formalized interagency working agreement is completed, it should be made available to all CA staff as an online reference document.