Report to the Legislature

Quarterly Child Fatality Report

RCW 74.13.640

July - September 2012

Children's Administration
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Executive Summary

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

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

may conduct a review of the near fatality at its discretion or at the request of the office of the family and children's ombudsman.

In April 2011, SHB 1105 was passed by the legislature and signed into law by Governor Gregoire. The revised child fatality statute (RCW 74.13) became effective July 22, 2011 and requires the department to conduct fatality reviews in cases where a child death is suspected to be caused by abuse or neglect. This eliminated conducting formal reviews of accidental or natural deaths unrelated to abuse or neglect. The revised statute requires the department to consult with the Office of Family and Children's 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 7 fatalities and 1 near-fatality that occurred in the third quarter of 2012. All of the reviews are conducted 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	1
2	4
3	3
Total Fatalities and Near Fatalities Reviewed During 3rd Quarter, 2012	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

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

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 Ombudsman.

The chart below provides the number of fatalities and near fatalities reported to CA and the number of reviews completed and those that are pending for calendar year 2012. The number of pending reviews is subject to change if CA 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 2012			
Year	Total Fatalities Reported to Date Requiring a Review	Completed Fatality Reviews	Pending Fatality Reviews
2012	18	7	9

Child Near-Fatality Reviews for Calendar Year 2012			
Year	Total Near Fatalities Reported to Date Requiring a Review	Completed Near-Fatality Reviews	Pending Near-Fatality Reviews
2012	5	1	4

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

Notable Findings

Based on the data collected and analyzed from the 7 fatalities and 1 near-fatality reviewed between July and September 2012, the following were notable findings:

- The review of the Braden and Charlie Powell fatalities was completed during the 3rd quarter of 2012. Their deaths received considerable local and national media attention. They were dependent children at the time of their deaths.
- In addition to the Powell children, a review of the death of another dependent child occurred during the 3rd quarter. This 14-year-old died after being struck by a car. His death was determined to be an accident.

- Five (5) of the seven (7) fatalities occurred while the family had an open case with CA.
- Three (3) of these five (5) fatalities were deemed homicides by a medical examiner or coroner.
- Three (38%) of the fatalities occurred when the child was under the age of 3 years old. In 2012, 67% of the fatalities and near-fatalities reviewed were of children who died when they were under three years of age.
- Seven (7) were male and (1) was female.
- Six (6) children were Caucasian, one (1) was Black/African American, and one was Native American.
- Not all of the fatalities were suspicious for abuse or neglect. Two (2) fatalities did not result in a founded finding for abuse or neglect by CPS. One (1) of these fatalities was a Third Party homicide and the other was an accidental death after the child was struck by a car.
- Children's Administration received intake reports of abuse or neglect in all of the child fatality cases prior to the death of the child. There were 23 prior intakes prior to the near fatal incident regarding the one (1) near fatality reviewed during the quarter.
- Due to the small sample of cases reviewed, no statistical analysis was conducted to determine relationships between variables.

Table 1.1

3rd Quarter 2012, Child Fatalities and Near Fatalities by Age and Gender						
Age	**Number of Males**	**% of Males**	**Number of Females**	**% of Females**	**Age Totals**	**% of Total**
<1	0	-	0	-	0	-
1-3 Years	3	38%	0	-	3	38%
4-6 Years	1	12%	0	-	1	12%
7-12 Years	2	25%	0	-	2	25%
13-16 Years	1	12%	0	-	1	12%
17-18 Years	0	-	1	12%	1	12%
Totals	7	100%	1	100%	8	100%

N=8 Total number of child fatalities and near fatalities for the quarter.

Table 1.2

3rd Quarter 2012, Child Fatalities and Near Fatalities by Race	
Black or African American	1
Native American	1
Asian/Pacific Islander	0
Hispanic	0
Caucasian	7
Totals*	**9**

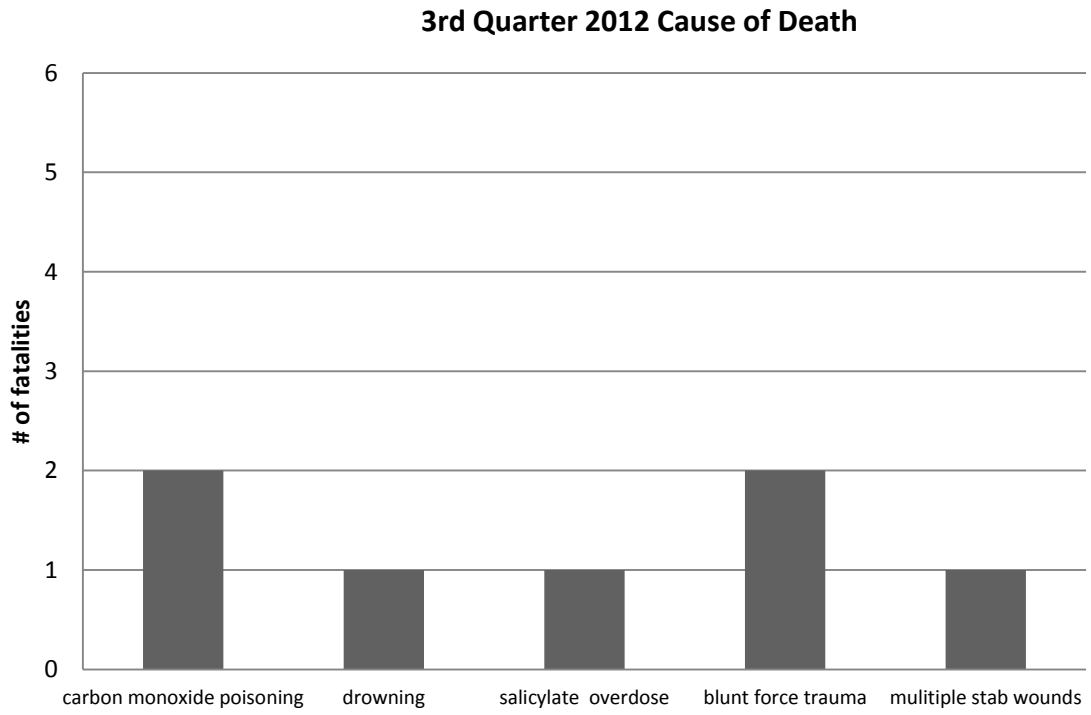
*Children may be from more than one race.

Table 1.3

3rd Quarter 2012, Child Fatalities by Manner of Death	
Accident	2
Homicide (3rd party)	1
Homicide by Abuse	3
Natural/Medical	0
Suicide	0
Unknown/Undetermined	1
Totals	7

N=7 Total number of child fatalities for the quarter.

Table 1.4



N=7 Total number of child fatalities for the quarter.

Table 1.5

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

N=7 Total number of child fatalities for the quarter.

Summary of the Findings and Recommendations

Review committees can make a finding or recommendation regarding the social work practice, policies, laws or system issues following their review of the case history leading up to the child fatality or near-fatal incident.[2] At the conclusion of every case receiving a full Committee review, the Committee decides whether they will make recommendations as a result of issues identified during the review of the case. Recommendations were made in seven of the eight child fatalities and near fatalities cases reviewed between July and September 2012.

Findings were made in all eight cases reviewed during the quarter. In six of the child fatalities reviewed, the Committees found that overall the quality of social worker practice was very good or the actions by social workers were reasonable given the circumstances in the case.

In a case involving an infant death, the Committee found that the social worker made reasonable decisions during the prior CPS investigation into a skull fracture to an 8-month-old infant. However, the Committee found that the social worker could have considered other possible scenarios as to how the child sustained the injury. The Committee noted that both law enforcement and physicians believed the father's story that his daughter threw her head back striking the edge of the kitchen table. The Committee recommended that the department engage with

[2] A finding is an opinion or a conclusion reached by the Review Committee. A recommendation is made by the Committee to address an issue with the case or to address deficits they identified in practice or policy. Committees can reach a finding in a case without making a formal recommendation.

the CPS medical consultants to consider not only if the injury to a child is probable, but is it likely given the parent(s)' account.

In the same case, the Committee concluded that the CPS worker did not conduct a thorough investigation, specifically in completing a criminal background check on the parents and completing the Structured Decision Making® (SDM) assessment. The SDM risk assessment is a tool used by CPS social workers and supervisors to consider when to provide ongoing services to families.

The Committee recommended that the department continue to provide a Lessons Learned from child fatalities training to all CA staff.

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

There were three (3) separate findings by Committees suggesting that domestic violence in the home was not properly assessed by the assigned social workers. The Committees recommended that social workers receive ongoing training in domestic violence.

Committees found in several cases that critical information was not shared between CA staff and Court Appointed Special Advocates (CASA), law enforcement and mental health providers.

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

3rd Quarter 2012, Issues & Recommendations	
Contract issues	2
Policy issues	1
Practice issues	9
Quality social work	0
System issues	7
Total	**19**

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

Child Fatality Review

A.S.

September 2004
Date of Child's Birth

January 30, 2012
Date of Child's Death

June 27, 2012
Child Fatality Review Date

Committee Members
Linda Cummings, M.A., Department of Social and Health Services (DSHS), Division of Developmental Disabilities (Region 2-Everett)
Mary Anne Boyce, R.N., Public Health Nurse Early Intervention Program, Snohomish Health District
Renea Wardlaw, Detective, Everett Police Department
Dacia Morgan, M.A., M.F.T., Clinical Supervisor, Institute for Family Development
Anibal Ruiz, Children's Administration Supervisor, King East Division of Children and Family Services

Observer
Kelle Kennedy, M.S.W., Children's Administration Supervisor, Sky Valley Division of Children and Family Services

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

Executive Summary

On June 27, 2012, Children's Administration (CA) convened a Child Fatality Review[3] (CFR) to review the department's practice and service delivery to a 7-year-old boy, A.S., and his family prior to the death of the child on January 30, 2012. On the day of his death, the child's father brought the deceased A.S. to a hospital. The cause of death was not known at that time, and believed to be related to the child's medical conditions. The Snohomish County Medical Examiner later determined that the child died as the result of salicylate[4] overdose, with the manner of death then ruled "accidental, homicide, or undetermined." The family did not have an open case with Children's Administration at the time of the child's death, but ten months earlier, in February 2011, dependency actions on both A.S. and his older sibling were dismissed by the Snohomish County Juvenile Court.

The CFR Committee included CA staff and community members selected from diverse disciplines with relevant expertise, including representatives from the law enforcement, parenting instruction, social work, developmental disabilities, and public health. Committee members had no previous direct involvement with the case, although most were aware of the fatality incident through various media reports. Prior to the review each Committee member received a summarized chronology of CA's involvement with the family, relevant case file materials (intakes, case notes, safety and risk assessments, CPS investigative reports) and service exit summaries.

Additional sources of information and resource materials were available to the Committee at the time of the review. These included (1) additional case-related documents such as medical and developmental screening records, legal documents relating to the prior dependency action, case staffing/shared planning meeting documents, and various reports regarding the parents, (2) CA practice guides relating to Child Protective Services (CPS) investigations and assessment of risk and safety, (3) copies of state laws and CA policies relevant to the review. CA

[3] 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 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.

[4] Salicylates can be found in numerous prescription medications, hundreds of over-the-counter medications including aspirin, and many topical products containing methyl salicylate (oil of wintergreen) which are highly toxic when ingested by young children.

staff involved with the case were made available for interviews by the Committee, but were not called.

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

RCW 74.13.505

Case Overview

In early 2008, CPS was contacted with allegations of neglect; the parents were failing to provide supervision sufficient to meet the needs of the two developmentally disabled children in the home. The allegations were not substantiated by the CPS investigation. Although the risk assessment completed on the family indicated moderate high risk, the family declined services, and the case was closed in June of 2008.

No further reports were received until March 2010 when law enforcement contacted CPS requesting placement for A.S. and his sibling due to gross neglect. The condition of the family home was found to be uninhabitable, posing a significant health risk to the two special needs children. The department initiated dependency actions on both children based on the neglect. The parents remediated the condition of the home and in June the children were court ordered to return home but remained in the legal custody of the department. The parents completed numerous services, made additional progress in improving safety, and successfully completed Family Preservation Services (FPS). The dependency was dismissed in February 2011 and the case was closed.

Ten months later on January 30, 2012, 7-year-old A.S. died. A CPS investigation was initiated in collaboration with local law enforcement. The cause and manner

[5] The names of the parents are not being used in this report as neither has been charged in connection to the fatality incident.

of death initially was thought to be related to medical issues and the county Medical Examiner (ME) concluded that the circumstances of the death did not warrant a full autopsy. Shortly after cremation, toxicology results revealed that A.S. died as a result of a salicylate overdose. The manner of death was then ruled "accidental, homicide, or undetermined" by the county ME. It is unknown as to how the child came to have a lethal dose of salicylate in his system and no criminal charges have been filed. The CPS investigation resulted in a finding of "founded for neglect" as to both parents in the death of their son. The department filed a dependency action on the older sibling and the child was placed in CA custody; the sibling is placed in relative foster care.

Committee Discussion

Committee members reviewed and discussed the documented CA activities and decisions from the early involvement (2006-2008) to the more recent pre-fatality involvement (2010-2011) with the family. Review of the post-fatality social work activities was limited primarily to the CPS fatality investigation. Committee discussions focused on CA policy, practice, and system response to the family in an effort to evaluate the reasonableness of decisions made and actions taken by CA. Actions taken by non-CA agencies were briefly discussed, but considered outside the scope of this review in terms of generating any findings or recommendations.

No significant CA policy issues were identified during the Committee discussions. In terms of demonstrated practice, the social work generally appeared to be of good quality and was well documented during the 2010-2011 involvement with the family. The Committee found no critical errors, and all substantive decisions made and actions taken during CA involvement appeared to be reasonable and supportable. However, the Committee found instances where additional actions could have been considered. These noted opportunities for improved practice are detailed below.

Findings

<u>Earlier involvement with CA (2006-2008)</u>

- The Committee found a possibility that the earlier CPS investigation results, assessments, family engagement activities, and case closure decisions may have been influenced by worker bias. The parents were described as cooperative, educated, employed, and as presenting well. The Committee found that workers may have viewed the parents as more capable of meeting the needs of their two severely developmentally disabled children than was actually the case. This might explain how the risk assessments completed in 2006-2007 appeared to underestimate risk

and overestimate family strengths. A more accurate assessment (moderate high risk) was completed in 2008 using the newly implemented Structured Decision Making[6] (SDM).

- The engagement with the family in 2006 to 2008 appears to have been somewhat limited. This may be because the social workers believed the parents were capable of meeting the children's needs, as noted above. The Committee found several windows of opportunity where workers might have been more proactive, if not more assertive, with the parents in connecting the family with services. These might have included referrals to Infant Toddler Early Intervention Program (Birth to Three), Children with Special Health Care Needs, Public Health for Nursing Child Assessment Satellite Training (NCAST), and/or Project SafeCare. Whether these services would have been accepted by the parents or how they might have impacted the family is unknown. The Committee believed that the family likely would have benefited from more active engagement strategies from CA.

<u>CA services 2010-2011</u>

- Less than three months after being removed from his parents' care due to the uninhabitable conditions of the home, A.S. was court ordered to return home. While the condition of the family residence may have been remediated, the Committee questioned whether there had been sufficient time to assess the capacity of the parents to sustain intensive supervision and safety. A more gradual transition process may have been helpful in providing time for in-home observations to evaluate parenting prior to a full return home. A court transcript was not available for review by the Committee, so the basis of the return home decision is not clear. However, CA case documents show that the case worker neither expected nor supported the court's decision to return home of the children in June 2010. Many services (e.g., psychological evaluations/parenting assessments, reunification assessment, multi-discipline team staffing) normally completed before transitioning a child home occurred well after the children were returned.
- The Committee found the department's support to dismiss the dependency in February 2011 to be reasonable given the demonstrated progress made by the family. However, given reported concerns by the

[6] The Structured Decision Making® (SDM) risk assessment is an evidence-based actuarial tool from the Children's Research Center (CRC) that was implemented by Washington State Children's Administration in October 2007. It is one source of information for CPS workers and supervisors consider when making the decision to provide ongoing services to families.

child's guardian ad litem[7] shortly before the final court hearing, an alternative reasonable option would have been to ask the court for a short delay in the dismissal of the dependency.

Recommendations

Upon review and discussion, the Child Fatality Review Committee forwards no recommendations.

[7] A GAL is an individual appointed by the court to represent the best interests of a child. See RCW 13.34.

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

Child Fatality Review

April 26-27, 2012 and June 8, 2012

Charles Powell
DOB: 01-2005

Braden Powell
DOB: 01-2007

Committee Members

Richard Anderson, Deputy Prosecutor, King County
Brett Ballew, Managing Attorney, Office of Public Defense
Randi Becker, Senator (R), 2nd Legislative District
Jim Doerty, Judge, King County Superior Court
Jake Fawcett, Fatality Review Coordinator, Washington State Coalition Against Domestic Violence
Brad Graham, Detective, Tacoma Police Department, Criminal Investigations Division
Natalie Green, Region 2 Deputy Regional Administrator, Children's Administration
Barbara James, Executive Director, Washington State Court Appointed Special Advocate
Jim Kastama, Senator (D), 25th Legislative District
Kevin Krueger, Chief Risk Officer, Department of Social and Health Services
Mary Meinig, Director, Office of Family and Children's Ombudsman
Dr. Richard Packard, Licensed Psychologist and Certified Sex Offender Treatment Provider

Consultants

Denise Revels Robinson, Assistant Secretary, Children's Administration
Sheila Huber, Assistant Attorney General, Office of the Attorney General
Thomas Shapley, Senior Director of Public Affairs, Department of Social and Health Services
Sharon Gilbert, Deputy Director Field Operations, Children's Administration

Nancy Sutton, Region 3 Regional Administrator, Children's Administration

Facilitators
Erwin McEwen, Senior Strategic Consultant, Casey Family Programs
Marilee Roberts, Practice Consultant, Children's Administration

Observers
Jennifer Sullivan, Reporter, Seattle Times

Executive Summary

On April 26-27, 2012 and June 8, 2012, the Department of Social and Health Services (DSHS), Children's Administration convened a Child Fatality Review[8] referencing a case involving the deaths of 7-year-old, Charles "Charlie" Powell (DOB: 01-2005) and his 5-year-old brother, Braden Powell (DOB: 01-2007) on February 5, 2012. Charlie and Braden were dependents of the state of Washington and in a relative foster care placement with their maternal grandparents at the time of their deaths. Charlie and Braden were on a supervised visit with their father, Joshua Powell,[9] in the father's home when he killed them and then himself in a planned house fire. The Child Fatality Review Committee reviewed case documents and interviewed Children's Administration staff and law enforcement officials involved in the case to examine the child welfare practices, system collaboration, and service delivery to the children and their family.

On February 5, 2012 at 12:20 p.m. Children's Administration Central Intake received a call from an unidentified person[10] reporting she believed Joshua Powell had killed his children. The caller stated, *"This is an emergency. You need to get a hold of [*social worker's first name*]. I think Josh Powell killed his kids."* The intake worker contacted Pierce County 911 and provided the information received from the referrer. At approximately 1:00 p.m. on this same date multiple media sources reported that Joshua Powell had killed his children and himself in a house fire.

On February 5, 2012 Charlie and Braden were transported to their father's home by a Children's Administration's contracted visitation supervisor for a planned 3-hour court ordered supervised visit with their father. Upon arrival at the home the visitation supervisor stated the boys ran to their father who quickly shut the front door, preventing her from entering the home. Attempts were made by the visitation supervisor to gain Mr. Powell's attention by knocking on the door to get entry into the home, however he did not respond. Preliminary reports[11] from law

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[9] The full names of Joshua Powell and the children are being used in this report as their names are linked to a number of public documents regarding the disappearance of Susan Powell in December 2009 and to the investigation into the deaths of the children.

[10] The identity of the person was learned at a later date and the intake was amended to reflect the name of the referrer.

[11] Law enforcement has not yet concluded their investigation and the case remains open at the time of this report.

enforcement indicate while the visitation supervisor attempted to gain access to the home Mr. Powell hit his children with a hatchet before setting the home on fire with gasoline, killing the children and himself. The Pierce County Medical Examiner determined Charlie's and Braden's cause of death was *carbon monoxide poisoning;* manner*: homicide*.

The family's Children's Administration history began in March 2010 and includes four screened out intakes[12] between March 2010 and June 2011. In September 2011, Children's Administration received an intake alleging negligent treatment of Charlie and Braden. The call from the Pierce County Sheriff's office reported the children were being placed in protective custody based on information that had been obtained during a search of the family home in August 2011 and resulted in the arrest of the children's paternal grandfather on child pornography and voyeurism charges. The children were placed in licensed foster care for six days; Children's Administration later placed the children with their maternal grandparents. At the time of their deaths the children were in the care and custody of Children's Administration and had court ordered supervised visitation with their father twice weekly. One of the two visits occurred in the father's home, the other occurred in the home of family friends. Discretion regarding location, duration and supervision of the visits was given to Children's Administration by the juvenile court judge overseeing the case.

Following a review of the family's history, case records and discussion, the Committee made findings and recommendations that are detailed at the end of this report.

Case Overview

In January 2010, Joshua Powell and his two young boys moved from West Valley City, Utah to Mr. Powell's father's home in Puyallup, Washington. The family move followed the suspicious disappearance of Susan Powell, Joshua Powell's wife and the children's mother. Mr. Powell was considered "a person of interest" in the disappearance (and possible murder) of Susan Powell by West Valley City law enforcement.

The family history with Children's Administration began in March 2010 and includes four intake reports made prior to September 2011. The intakes received between March 2010 and June 2011[13] reported concerns about statements made by Charlie at school in light of news reports in the media regarding the

[12] 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 Washington Administrative Code 388-15-009.

[13] Intakes received: March 1, 2010, August 20, 2010, February 18, 2011 and June 10, 2011.

disappearance of the children's mother in December 2009. The referrers called child protective services to report Charlie's statements given their knowledge about his mother's disappearance. The information provided by the referrers did not screen in for a child protective services investigation or further action by Children's Administration because the information provided did not raise allegations that met the definition of child abuse or neglect as defined in Washington Administrative Code 388-15-009. All intakes received by Children's Administration regarding the Powell family were forwarded to law enforcement for their review.

In September 2011, Pierce County Sheriff's Office contacted Children's Administration stating they were placing Charlie and Braden into protective custody and requesting assistance at the home where the children were living with their father and other relatives, including the children's paternal grandfather. Law enforcement stated they were at the home serving an arrest warrant on the children's paternal grandfather on charges related to child pornography and voyeurism. Law enforcement officials further reported that although it did not appear the children had been exposed to any child pornography at the time, they had yet to examine all the information on the computers seized during the August 2011 search of the home to determine if Joshua Powell was involved in the child pornography. At the request of West Valley City, Utah, police Pierce County law enforcement did not provide information to Department of Social and Health Services, Children's Administration staff regarding the Utah investigation into the disappearance of Susan Powell. The case was assigned for a child protective services investigation based on the allegations of child neglect by their father.

Charlie and Braden were initially placed in foster care, however following an initial shelter care hearing on September 27, 2011, the children were placed in the home of their maternal grandparents. A contested shelter care hearing was held the following day on September 28, 2011, and an order was entered requiring Charlie and Braden to remain in foster care (with the maternal grandparents), requiring supervised visits between the children and their father every Sunday for three hours, and requiring Mr. Powell to obtain a psychological evaluation.

Initial visits between Mr. Powell and his sons began within three days of the children's placement and were supervised by Children's Administration. Following the shelter care hearings, supervision of the visits was provided by Foster Care Resource Network, an agency contracted with Children's Administration to provide supervised visitation. Visits occurred weekly for three

hours initially at the offices of Children's Administration, however moved to the offices of Foster Care Resource Network at Children's Administration's direction in early October 2011. Other services provided included counseling for Charlie and Braden and in-home services to the maternal grandparents to support the children's placement.

Although the child protective services investigation resulted in an *unfounded* finding for child neglect,[14] Mr. Powell agreed to the entry of an order establishing a dependency over both his children in October 2011. During the course of the dependency Mr. Powell established a new residence separate from his father's home and requested visits with his children be moved from the community based facility (Foster Care Resource Network) to his new home. When considering Mr. Powell's request, Children's Administration noted the impact visitation was having on other families at Foster Care Resource Network due to the high profile nature of the Powell case.[15] Children's Administration considered maintaining visits in the more restrictive community setting (Foster Care Resource Network) or moving them to a more private, less restrictive setting such as Mr. Powell's home. The Child Fatality Review Committee received information from the visitation supervisor and others indicating that Mr. Powell's visits with his children were well structured (included snacks and activities), interactions were positive and included appropriate limit setting, affection, and attention to both children. After consulting with the children's Guardian ad Litem and the psychologist conducting Mr. Powell's court ordered psychological evaluation, Children's Administration approved moving visits from Foster Care Resource Network's community based resource center to Mr. Powell's new home in November 2011. Children's Administration confirmed with all parties that visits would continue to be supervised but occur on Sundays in Mr. Powell's new home.

The Revised Code of Washington (13.34.136) and Children's Administration Practice and Procedures[16] support family visitation in the least restrictive environment and the department views this as providing visitation in the family home, absent any safety concerns.

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[14] Unfounded finding is defined as follows: The determination following an investigation by child protective services that based on the 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 or neglect did or did not occur. In this case there was insufficient evidence to support a finding that, more likely than not, Mr. Powell exposed his children to child pornography.

[15] Other families visiting at the community center recognized Mr. Powell and his children while visiting. Concerns regarding possible distractions due to the notoriety of the family during family visitation for both Mr. Powell and the other families was considered.

[16] Revised Code of Washington 13.34.136 (2) (b) (ii) Permanency Plan of Care and Children's Administration Practice and Procedures Section 4252 (C) (1)

During the course of the case Mr. Powell requested an additional weekly visit with his children and identified a family friend who was willing to provide the supervision in the friend's home. Again, Children's Administration staffed this request with the children's Guardian ad Litem, the Foster Care Resource Network visitation supervisor, and the psychologist completing Mr. Powell's psychological evaluation. After receiving approved background clearances on the identified family friends, and based on observations of Mr. Powell's parenting and interactions with his children during the Sunday visits, an additional weekly visit was approved by the court and began in early December 2011.

In January 2012, Mr. Powell's attorney filed a motion in the dependency action asking the court to require Children's Administration to place the children in Mr. Powell's home or, alternatively, to move the children out of the maternal grandparents' home. A hearing on the motion was scheduled for early February 2012. Prior to the hearing the West Valley City Police Department in West Valley City, Utah provided Children's Administration with confidential information (digital computer images) they had obtained during the search of Mr. Powell's home in August 2011. A Utah court order restricted access to the images.[17] One of the individuals who were permitted to view the images was the psychologist completing Mr. Powell's psychological evaluation. Based on the psychologist's amended evaluation after reviewing the computer images, the juvenile court judge denied Mr. Powell's motion during a court hearing on February 1, 2012. The judge ordered the children to remain in relative foster care with the maternal grandparents and ordered Mr. Powell to participate in a psycho-sexual evaluation. Four days later, on February 5, 2012, during a supervised visit in his home, Mr. Powell set his home on fire killing himself and his sons.

Committee Discussion

A case chronology along with the complete case file relating to the family was prepared and provided to the Child Fatality Review Committee. Additional information provided to the Committee is noted in Appendix A of this report. Committee members also interviewed Children's Administration social workers assigned to the case, Children's Administration Intake supervisor, the contracted visitation supervisor, the Assistant Attorney General assigned to the case, and Pierce County Sheriff's Office detectives. The Committee discussed issues related to the assessment of child safety and Children's Administration practice and

[17] An order from the Third Judicial District Court in Salt Lake County, Utah dated January 12, 2012; specifically identified the persons (8) permitted to view the information. The 8 persons permitted to view the images under the supervision of the Pierce County Sheriff's office were: the assigned Pierce County Sheriff detective, Assistant Attorney General representing Children's Administration in the dependency action, the attorney for the maternal grandparents, Mr. Powell's attorney, the children's Guardian ad Litem, the juvenile court judge overseeing the dependency process, Children's Administration's assigned social worker, and the psychologist conducting Mr. Powell's psychological evaluation.

procedures, including decisions related to parent-child visitation, out-of-home placement, domestic violence, and collaboration and information sharing among investigative agencies.

The Committee commented on the thoroughness of the work in this case, which included diligence in ensuring consultation and collaboration with partner agencies (law enforcement), Guardian ad Litem and providers, documentation of case activity and progress, and consistent contact with Mr. Powell, the children and their relative care providers. The Committee stated all parties acknowledged child safety takes precedence and that efforts were made to share information to the extent possible to ensure child safety, while not compromising respective criminal investigations.

The Committee learned that in January 2010, Mr. Powell moved to Washington from Utah shortly after the reported disappearance of his wife in December 2009. At the time of Mr. Powell's relocation, Utah law enforcement officials considered Mr. Powell a person of interest in his wife's disappearance and a criminal investigation in Utah remained open. In August 2011, Utah law enforcement authorities, in collaboration with Pierce County law enforcement authorities, executed a search warrant on the home where Mr. Powell was living with his two sons. The search warrant was related to the criminal investigation by Utah authorities into Susan Powell's disappearance. Information obtained in this search resulted in the arrest of Mr. Powell's father and the subsequent out-of-home placement of Charlie and Braden (September 2011).

The Committee acknowledged the complexity of this case and the involvement of two law enforcement agencies[18] from two different jurisdictions made communication and information sharing with Children's Administration challenging, given the different investigation interests of the involved agencies. Law enforcement officers investigating Susan Powell's disappearance did have ongoing communication with social workers in this case, and officers told social workers that they believed Mr. Powell had killed his wife. However, the communication generally consisted of law enforcement expressing an opinion as to Mr. Powell's involvement in Susan Powell's disappearance. The Committee learned the law enforcement evidence gathered related to Susan Powell's disappearance would have raised specific safety concerns for the children, but that information was not made available to Children's Administration prior to the children's death.

[18] The two police agencies were West Valley City Police Department in West Valley City, Utah and Pierce County Sheriff's Office, Pierce County, Washington.

The Committee noted information raising child safety concerns was part of a search warrant that was issued by a Pierce County Superior Court and sealed at the request of Utah law enforcement officers due to their ongoing criminal investigation in Utah regarding the disappearance and possible murder of Susan Powell. The Committee discussed whether the information in the sealed warrant could have been used by Children's Administration when conducting ongoing assessments of safety for the children, and to provide additional support for services required of the father in the dependency proceedings. Information that law enforcement in Utah had, which was unavailable to Children's Administration, could have been used in assessing the need for services and the structure of any contact between Mr. Powell and his children (e.g. duration of contact, location and supervision needs).

The Committee also acknowledged that discovery[19] in dependency matters can pose additional challenges to information sharing between law enforcement agencies and Children's Administration as it requires all information available and used by Children's Administration to establish dependency be provided to parents and their attorneys. The Committee recognized the disclosure of criminal investigation information for the purposes of dependency proceedings could compromise an ongoing law enforcement investigation.

Another area of discussion by the Committee was Children's Administration's screening for domestic violence and whether further assessment for domestic violence should have occurred in this case. In February 2010, a Social Worker's Practice Guide to Domestic Violence was distributed to all Children's Administration social workers. The Practice Guide recommends screening for domestic violence at intake and throughout the life of each case, and completing a specialized domestic violence assessment when domestic violence is identified. Children's Administration policy requires the intake worker to answer a universal screening question: "Has anyone used or threatened to use physical force against an adult in the home?" If the answer to this question is "yes," there are three additional questions that must be answered related to domestic violence. Further assessment is recommended to gather information from available sources to identify any safety threats to the children related to domestic violence and support decisions regarding child safety. Other assessment tools used by social workers throughout the life of a case also incorporate questions related to domestic violence. In the intakes received regarding the Powell family, the intake workers answered "no" to the universal domestic violence screening questions.

[19] Discovery in dependency cases affords all parties with the opportunity review all information used to establish dependency.

After much discussion, the Committee agreed that there was sufficient information provided by investigators regarding the disappearance of Susan Powell that social workers could have answered "yes" to the universal domestic violence screening question, which would have prompted further inquiry into issues related to domestic violence in the Powell family, in spite of the lack of any prior police reports alleging domestic violence in Utah or Washington. The Committee acknowledged information in the sealed warrant received after the children's death provided greater detail about the disappearance of Susan Powell but that information was unavailable to Children's Administration at the time decisions were being made.[20]

The Committee also discussed Children's Administration's actions and service delivery regarding the dependency case. At the September 2011 shelter care hearing the juvenile court judge ordered the following: Charlie and Braden to be placed in Children's Administration custody and in relative foster care placement with their maternal relatives; Mr. Powell to participate in a psychological evaluation; counseling for both children; and weekly supervised visitation between the children and their father. The Committee discussed that despite Mr. Powell's objection to the relative placement he was actively involved in the case plan and participated in all court-ordered services. Mr. Powell participated in the psychological evaluation and was well-prepared for visits with his children. Case documentation indicated he was actively involved with his children during visits and demonstrated appropriate parenting. Children's Administration approved moving supervised visits to Mr. Powell's home in November 2011 and increasing the frequency of visits in December 2011 based on observations of Mr. Powell with his children and of Mr. Powell's home. Law enforcement officers involved in the criminal investigation of Mr. Powell told the Committee that they were not aware that supervised visits were moved to his home. The detectives stated they would have had concerns about visits in his home; however they consider decisions regarding visitation up to Children's Administration and the court.

Law enforcement officials from Utah and Washington maintained contact with Children's Administration throughout the dependency matter as a means to support child safety. In November 2011, when Utah detectives contacted Children's Administration and were told Mr. Powell intended to request his children be returned to his care, the Utah detective stated they had information that could help support continued out-of-home placement. Utah officials stated they would request court permission to release the information to Children's

[20] Information contained in the sealed search warrant became available in April 2012, after the children's death, when the court ordered the warrant unsealed in the separate criminal case involving the children's paternal grandfather.

Administration.[21] In early January 2012, Mr. Powell's attorney filed a motion requesting the children be returned to his care or in the event the children were not returned home that they be placed in an alternative out-of-home placement.[22] Consequently, Utah law enforcement officials requested a court order to allow the release of some information (computer images) obtained during the August 2011 search of the Powell home. A court order dated January 12, 2012, from the Third District Court, Salt Lake County, Salt Lake City, Utah was provided to a Pierce County Sheriff's detective by Utah law enforcement officials. The order specifically identified eight (8) individuals who could view the images, required that the viewing occur under the supervision of Washington state law enforcement officials (Pierce County Sheriff's Department), and prohibited sharing the images with any person not specifically listed in the order.

The images found on Joshua Powell's computer included animated images depicting inappropriate behavior between adults, children and well known cartoon characters. The juvenile court judge and the psychologist conducting Mr. Powell's psychological evaluation were permitted by the court order to view the images prior to the court hearing on Mr. Powell's motion asking that the children be placed in his care.

The Committee learned that on February 1, 2012, after having reviewed the computer images provided by Utah law enforcement and the addendum to Mr. Powell's psychological evaluation,[23] the judge denied Mr. Powell's motion and ordered that the children remain in their relative placement and further ordered that Mr. Powell undergo a psycho-sexual evaluation that would include a polygraph examination. The Committee discussed the impact the judge's ruling and the intrusiveness the type of evaluation ordered may have on a parent. The Committee discussed the possibility of reassessing a parent's emotional stability when a judge rules against a motion for return of their children and orders additional services, particularly a service as intrusive as a psycho-sexual evaluation. This assessment could include whether any changes in parent/child contact are necessary for child safety.

Committee Findings and Recommendations

The Committee made the following findings and recommendations based on the interviews with Children's Administration social workers, visitation provider, Assistant Attorney General, and law enforcement officials, review of the case

[21] Utah officials stated they would need a court order allowing the release of the information before sharing it with Children's Administration.

[22] Mr. Powell had identified an alternative placement for the children who had completed background checks required by Children's Administration.

[23] The evaluation recommended continued out-of home placement for the children and for Mr. Powell to undergo a psycho-sexual evaluation.

record, Children's Administration Practice and Procedures, the Revised Code of Washington, and the Washington Administrative Code.

While the Committee made recommendations to improve practice based on review of this case, the Committee did not draw conclusions about whether any actions by Children's Administration, law enforcement, or the court could have prevented Mr. Powell's actions.

Committee Findings

1. The Committee noted that at the onset of this case, Children's Administration accounted for the high profile nature of the case (due to the national attention and publicity) and its complexity (due to involvement of multiple investigative agencies and jurisdictions). Given the Committee's collective experience being involved in or in reviewing thousands of child welfare cases, the Committee found the work in this case was consistent with and sometimes exceeded accepted standards for child welfare practice and procedures regarding case decisions and actions with the exception noted in Finding 2. The conduct and interaction of professionals involved in this case demonstrated the highest concern for the children's health, safety and welfare.
2. Children's Administration policy requires universal screening for domestic violence at intake and throughout the life of each case. The Committee found that information available to social workers regarding the disappearance of Susan Powell was sufficient to prompt additional questions to gather more information about the existence of domestic violence, if any, in this family and any related safety threats to the children. The Social Workers' Practice Guide to Domestic Violence provides information including legal considerations and best practices for gathering information about domestic violence and applying that information to case decisions. Distribution of the practice guide was not augmented with in-person or on-line training curricula to support use of the guide. Although the professionals involved in this case demonstrated the highest concern for the children's health, safety, and welfare, the lack of training on best practices regarding domestic violence in addition to the complexity of the jurisdictional issues between Utah and Washington mentioned in this report may have contributed to the lack of further exploration of domestic violence in this case.
3. In regard to decisions referencing visitation in this case, the Committee found that, although not required, Children's Administration did not consult with law enforcement officials on the decision to move supervised visits to Mr. Powell's home. The Committee noted that when there is an

open criminal investigation regarding a parent involved in a dependency action, consultation between law enforcement and Children's Administration about parent/child contact or visits may be beneficial. Consultation with law enforcement could result in obtaining information that might affect decisions about changes in visitation such as duration, location and need for supervision.

4. The Committee found that after completing an overview of the case that included a review of all court transcripts the Committee was unable to locate information articulating the judge's reasons as to why Mr. Powell's objection to relative placement was overruled by the judge.[24]

Committee Recommendations

1. In dependency proceedings when there is an active criminal investigation Children's Administration should make concerted efforts to include and consult with the assigned detective prior to making changes in parent/child contact, e.g. visitation in accordance with the respective county protocols required by RCW 26.44.185.[25]
2. Given the intrusive nature of a psycho-sexual evaluation, Children's Administration should reassess parent/child contact (e.g. visitation duration, supervision, location) prior to the next parent-child visit when a judge orders a parent undergo such psycho-sexual evaluation in the course of a dependency proceeding.
3. Because the identification of domestic violence is critical when making case decisions intended to increase safety for children, ongoing training and regular consultation on domestic violence for Children's Administration staff is recommended. Training should address how to use the Children's Administration's Social Worker's Practice Guide to Domestic Violence and assessing safety threats to children.
4. In cases where the judge orders a child's placement with a specific caregiver over the objection of a parent, the Committee recommended the reasons be articulated in the court record.

[24] Revised Code of Washington 13.34.160-Foster Home Placement - Parental Preferences
[25] Revised Code of Washington 26.44.185 Revision and Expansion of Protocols

Appendix A

Resources Made Available During Review

1. Case File Information
    a. Complete hard copy of case file
    b. Redacted electronic case file – made available on line
2. Pierce County Superior Court Transcripts
    a. September 27, 2011 Shelter Care Hearing
    b. September 28, 2011 Shelter Care Hearing
    c. October 26, 2011 Fact Finding Hearing
    d. February 1, 2012 Placement Hearing
3. Washington State Statutes (Revised Code of Washington and Washington Administrative Code)
    a. RCW 13.34. Juvenile Court Act
        i. 13.34.060 Shelter Care – Placement – Custody – Duties of parties
        ii. 13.34.130 (1) (b) (ii) (B) – Order for Disposition for a Dependent Child
        iii. 13.34.136 Permanency Plan of Care
        iv. 13.34.260 Foster Home Placement – Parental Preferences
    b. RCW 13.50 Keeping and Release of Records by Juvenile Justice or Care Agencies
        i. 13.50.010 Definitions – Condition When Filing Petition or Information – Duties to Maintain Accurate Records and Access
        ii. 13.50.100 Records Not Relating to Commission of Juvenile Offenses – Maintenance and Access
    c. RCW 24.44 Abuse of Children
        i. 26.44.030 Reports – Duty and Authority
        ii. 26.44.185 Revision and Expansion of Protocols
    d. RCW 74.13 Duties of the department – Child welfare and day care advisory Committee
        i. 74.13.031 Duties of the Department – Child Welfare
    e. RCW 74.14 Children and Family Services
        i. 74.14A.020 Services for Children
    f. WAC 388-15-009 What is Child Abuse or Neglect?
    g. Washington Courts Rule GR 15 – Destruction, Sealing and Redaction of Court Records

4. Children's Administration Practice and Procedures Guide
    a. Chapter 2000 Child Protective Services
        i. Section 2200 Intake
        ii. Section 2220 Guidelines
    b. Chapter 2500 Service Delivery
        i. Section 2541 Structured Decision Making®
    c. Chapter 4200 Child Welfare Services Assessment
        i. Section 4254 Parent Child Sibling Visitation Policy
        ii. Section 4261 Placement Priorities
5. Children's Administration Case Services Manual
    a. Chapter 4400 Out of Home Case Planning
        i. Section 4422 Most Family – Like Setting
        ii. Section 4423 Relative Placement, Parental Preference, Relative Search, Relative Notification and Documentation
6. Children's Administration Structured Decision Making® (Risk Assessment) Procedures Manual
7. Children's Administration Visitation Contract Information
8. Children's Administration Social Worker's Practice Guide to Domestic Violence, February 2010
9. Washington State Institute for Public Policy Report – Outcomes of Referrals to Child Protective Services: Comparing Reporters, June 2009
10. Office of the Family and Children's Ombudsman – Patterns in Mandated Reporter Referrals 2006-2008, July 2009
11. County Child Sexual Abuse, Physical Abuse and Fatality Investigation Protocols – Pierce County, June 2010
12. Training PowerPoint provided by Washington's Assistant Attorney General's Office (Children's Administration)- Child Protective Services Investigative Training – Legal Framework

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

Child Fatality Review

B.H.

May 1997
Date of Child's Birth

February 17, 2012
Date of Child's Death

July 16, 2012
Executive Review Date

Committee Member
Tim Abbey, Area Administrator (Spokane), Children's Administration, Region 1 (North)
Sue Baker, CASA Program Director, Chelan/Douglas Juvenile Court
Scott Crimin, Division of Developmental Disabilities (DDD) Supervisor
Robert Larson, Critical Incident Case Review Specialist, Children's Administration
Jeanne McShane, Deputy Administrator, Division of Licensed Resources, Children's Administration
Jenifer Schultz, Clinical Psychologist, Behavioral Health Services
Dr. Roy Simms, Child Abuse and Neglect Medical Consultant
Mary Meinig, Director of the Office Children and Families Ombudsman

Presenter
Jane Grandy, B.H.'s assigned CASA

Facilitator
Jenna Kiser, Regional CPS Program Consultant, Children's Administration, Region 1 (South)

RCW 74.13.640(d)
RCW 74.13.515

Executive Summary

On July 16, 2012, the Department of Social and Health Services (DSHS), Children's Administration (CA) convened a Child Fatality Review (CFR)[26] of the case involving the death of 14-year-old, B.H. (DOB: 05-[redacted]-97; DOD: 02-17-12). B.H. was a developmentally delayed legally free youth residing in state licensed foster care in Yakima, Washington at the time of his death. On February 17, 2012 B.H. was in the yard with the foster parents and other foster youth, and then left this area on foot. He traveled approximately one and a half miles along a two lane road that had a speed limit of 50 miles per hour. It was dark, wet and raining. B.H. walked onto the road and was struck by a midsize SUV. B.H. was transported to the local hospital where resuscitation efforts were unsuccessful. Yakima County Medical Examiner's Office determined B.H.'s cause of death was massive head and body trauma, due to motor vehicle/pedestrian accident; manner: accidental.

CA conducts fatality reviews to identify practice strengths and areas needing improvement as well as systemic issues in an effort to improve performance and better serve children and families. The CFR committee members included CA staff and community members representing disciplines associated with the case. Committee members had no involvement in B.H.'s case. A chronology of B.H.'s family as well as licensing case records were prepared and provided to the CFR committee. A copy of the family's case file, the licensing files and CA briefing paper were also available to the committee. Committee members interviewed the social worker, supervisor, Division of Licensed Resources (DLR) investigator, DLR supervisor and the case manager from the Child Placing Agency (CPA) overseeing the licensed foster home assigned to the case at the time of B.H.'s death. During the course of the review the committee discussed the documented social work activities completed by CA staff from intake[27] to case closure. Specific areas of review included the DLR investigations, placement moves, and supervision plans. Following a review of B.H's family's history, his foster care placement history, case records, CA employees' interviews and discussion, the

[26] 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.

[27] An "intake" is a report received by Children's Administration made by a person or persons who have reasonable cause to believe or suspect that a child was abused or neglected.

Committee made findings and recommendations that are detailed at the end of this report.

RCW 13.50.100

Case Overview

B.H. was the middle sibling of three children. [redacted]

[28] The Youth Supervision and Safety Plan (supervision plan) can be used for youth who have high risk behaviors such as running away. The plan requires realistic and achievable action by the care provider. The plans also address activities from which the youth is restricted and the youth's monitoring needs. The current supervision plan form specifically states that it should not include supervision requirements such as, "line of sight, 24/7, or at all times".

The LDP home was provided a completed Child Information and Placement Referral form that outlined B.H.'s behaviors and the completed form also described an incident in which B.H. walked from Moxee to Terrace Heights without permission.

On February 17, 2012 CA was notified that B.H. had wandered away from the foster home onto Ahtanum Road, a two lane road in Yakima, and was hit by a car. Emergency Services were called and B.H. was taken to Memorial Hospital in Yakima where he was pronounced dead. It was reported to CA that B.H. had been outside the foster home working on a sprinkler. The foster parents discovered that B.H. did not go inside with the other children in the home and they went to check on him. The foster parents first checked where B.H. was working on the sprinkler and then began checking the rest of their 40 acre property. The foster parents were unable to locate B.H. so they drove down the road and observed the accident that had occurred in which B.H. was hit by a vehicle. During an interview with the DLR/CPS investigator, the foster parents indicated they were aware they needed to supervise B.H. and check on him every 10 to 15 minutes and were aware he had wandered off on a couple of occasions in other foster homes. DLR/CPS determined that the allegations of Negligent Treatment or Maltreatment by the foster parents was unfounded. [29]

In March 2012, the cause and manner of death was determined by the Yakima County Coroner's office. The cause of death was: massive head and body trauma, due to a motor vehicle/pedestrian accident and the manner of death was: accidental.

Committee Discussion

Committee members reviewed and discussed the documented social work activities completed by Children's Administration from intake to case closure. As a means to provide structure and context to reviewing social work practice, the Committee was provided a case summary and had access to B.H's case file. In addition, the Committee was provided information on policy and procedure as it relates to placement in both state licensed and private agency certified homes, [30] policy on supervision plans for youth in out-of-home placement, policy regarding notification of parties when a new investigation is initiated by DLR, and the youth identified as a victim is a state dependent. In this way, Committee members were better able to evaluate the actions taken and decisions made by the Children's Administration. In addition to social work practice, discussions occurred around policy issues. The discussions largely focused on three areas: the use of out-of-home child safety plans, the licensing and training of foster homes, and the

[29] Unfounded is defined as follows: "[T]he determination following an investigation by child protective services that based on the 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 or neglect did or did not occur." RCW 26.44.020(24)

[30] The department has the sole legal authority to license or approve homes for the care of children in out-of-home placement; however, licensed child-placing agencies (often referred to as "private agencies") may "certify" or attest to the department that a foster home meets the licensing requirements. *See* RCW 74.15.040; WAC 388-148-0010; WAC 388-148-0070.

movement of foster children from one placement to the next. The Committee interviewed the DLR/CPS investigator, CFWS social worker, CFWS supervisor, private agency worker, and CASA.[31]

Findings

Based on the information available to the Committee at the time of the review, it appears that B.H. was left unsupervised for a short period of time. During that time, he left the property and proceeded down a road where he was eventually struck by a car. The Committee focused the majority of its discussion on the supervision plan, placement decisions, licensing of the LDP foster home and the special developmental needs of B.H.

RCW 13.50.100

- The Committee recognizes the difficulty involved in the care and supervision of developmentally delayed youth who require high levels of supervision. The Committee found that the Children's Administration social worker was unable to clearly identify the details of and reasons for B.H.'s supervision plan to the Committee. [redacted] B.H.'s primary safety concerns appeared to directly relate to B.H. wandering off as evidenced by two prior run events.
- The Committee recognizes that it is difficult to locate appropriate foster home placements for foster children with special needs. The Committee found that the placement decisions related to B.H.'s move from the FDP home to the next placement were reasonable. In addition, the Committee found that the social worker had few viable placement options when the foster parents in the TDP home asked CA to move B.H. The social worker essentially had the options of returning B.H. to the FDP home or utilizing a new placement. The FDP home had requested a foster care reimbursement rate greater than that allowable for B.H.'s then current

[31] Six Court Appointed Special Advocates (CASA) volunteers are appointed by judges to watch over and advocate for dependent abused and neglected children. Volunteer CASAs stay with each case until it is closed and the child is placed in a safe, permanent home.

needs;[32] however, the Committee found that the FDP home was provided incorrect information by the assigned social worker about B.H's level of need at the time of his last move. Regardless of the foster care reimbursement rate, it was unclear to the Committee if the FDP home would have been a viable placement as the CASA and social worker reported that the FDP home had conflicting family needs that may have prevented the acceptance of B.H back into their home. The Committee found that B.H.'s LDP was appropriate.

- The Committee found that the social worker appropriately utilized the Family Team Decision Making (FTDM) [33] process prior to the placement of B.H. into the LDP home. The CASA expressed concern that she did not speak up at the FTDM about her concerns regarding B.H.'s needs, but she did report during the meeting that B.H. needed line of sight supervision. The CASA also reported that B.H and the foster father had developed a very good bond and B.H. appeared to really enjoy caring for the horses. In this case, the FTDM was designed to develop a plan around B.H.'s placement needs in the LDP foster home. There were no other viable placement alternatives presented at the FTDM.
- While the FTDM process was used appropriately, it did not fully address B.H.'s supervision needs in the placement as they related to his special needs. An FTDM should focus on both placement and any supervision needs of a foster child. The members of the FTDM discussed B.H.'s supervision needs, but did not develop a concrete supervision plan that was centered on his special developmental needs.

RCW 13.50.100

- The Committee found that the assigned social worker did not inform the CASA of the allegation of [redacted] towards B.H. in the TDP as required by law. [34]
- The Committee found insufficient documentation supporting the change of a CAPTA[35] finding of abuse or neglect by a caregiver in the LDP foster home. The Committee was concerned that a CAPTA finding from August 1991 was changed from founded to inconclusive in 2006 after the foster parents were previously denied a license in June 2000 based on the founded finding and the fact that they did not fully disclose their history

[32] Foster care reimbursement rates are established by using the foster care rate assessment tool based on the child's current needs and the circumstances of the foster parents. *See* WAC Chapter 388-25
[33] Family Team Decision Making (FTDM) meetings bring people together who are involved with the family to make critical decisions regarding the removal of child(ren) from their home, changes in out-of-home placement, and reunification or placement into a permanent home (CA Practices and Procedures Manual 4302).
[34] RCW 26.44.030(18)
[35] Child Abuse Prevention and Treatment Act (CAPTA) (42 U.S.C.A. §5106g). In 1998 the federal CAPTA law was enacted requiring that subjects be notified of and allowed to appeal founded findings.

with CA on their Background Authorization form. The Committee did not find the change inappropriate, but noted that the documentation in the record did not explain the reason for the changed finding.

- The Committee found that a developmentally delayed child who was not physically or sexually aggressive was being placed in Behavioral Rehabilitation Services (BRS)[36] homes with physically and sexually aggressive youth.[37]

RCW 13.50.100

- The Committee found inadequate documentation of medical and therapeutic treatment of B.H. following the alleged [redacted] in the TDP.

Recommendations

- The Committee found that the assigned Children's Administration social worker did not notify the CASA that B.H. was the alleged victim of abuse or neglect in his TDP. The assigned social worker reported that she was unaware of the law regarding this issue. The Committee expressed concern about the volume and frequency of changes of policies, laws, and procedures that Children's Administration staff are required to know. The Committee recommends that Children's Administration ensure it has an effective way to communicate these changes to staff on an ongoing basis. Children's Administration should have a method to aid social workers in quickly and easily accessing laws, policies, and procedures.
- Foster parents who care for developmentally delayed children should be provided training related to these children's needs and supervision requirements. This recommendation should not prevent a developmentally delayed child from being placed in a foster home. This training should instead supplement training that is already provided to foster parents who care for developmentally delayed children.
- Efforts should be made to focus on recruiting and retaining homes that will be available to children with high needs (e.g. developmentally delayed children).
- Children's Administration and private agency workers need to be able to exchange information with each other about foster care applicants' previous licenses, denials, findings, and background checks. The

[36] Behavior Rehabilitation Services (BRS) are temporary intensive wraparound support and treatment programs for youth wit, high service needs and are used to safely stabilize youth and assist in achieving a permanent plan or a less intensive service (CA Practices and Procedures 4533).

[37] All youth identified as SAY/PAAY must have a signed Youth Supervision Plan (DSHS-15-352) prior to placement, but no later than 72 hours and the plan must be documented in FamLink within 7 calendar days. Youth identified as SAY/PAAY must only be placed with licensed caregivers who have completed the CA SAY/PAAY training. CA Practices and Procedures Manual 4536

Committee recommends changing statutes that limit this exchange of information to allow it to occur. [38]

- The decision to reverse a founded finding made before 1998 (when the federal CAPTA law was enacted requiring that subjects be notified of and allowed to appeal founded findings) should be approved at a higher management level than the Area Administrator when the subject of the finding is appealing so they may provide care for children or vulnerable adults. If the pre-CAPTA founded finding is reversed the electronic record should include the reason for reversal.
- The Committee recommends increased local (Yakima area) communication between the Division of Developmental Disabilities and Children's Administration so that CA can obtain information related to eligibility, services, and resources for developmentally delayed children in foster care.

[38] An unfounded, screened-out, or inconclusive report may not be disclosed to a child-placing agency, private adoption agency, or any other provider licensed under chapter 74.15 RCW. RCW 26.44.031(4). No unfounded allegation of child abuse or neglect as defined in RCW 26.44.020(1) may be disclosed to a child-placing agency, private adoption agency, or any other licensed provider. RCW 13.50.100(11)

RCW 74.13.500

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

Child Fatality Review

G.C.

August 2009
Date of Child's Birth

February 24, 2012
Date of Child's Death

June 18, 2012
Child Fatality Review Date

Committee Members
Ken Levinson, Director of Family Services, Nooksack Indian Tribe
Betsy Tulee, Children's Administration, Indian Child Welfare Program Manager
Gina Crosswhite, Detective, Bellingham Police Department
Francie Gass, Parenting Instructor/Adjunct Faculty Bellingham Technical College
Janice Stettler, Children's Administration Supervisor, Oak Harbor Division of Children and Family Services

Observers
Sharon Gilbert, M.S.W., Children's Administration, Deputy Director of Field Operations
Laurie Alexander, M.S.W, Children's Administration Area Administrator, Bellingham Division of Children and Family Services
Robert Larson, Children's Administration Critical Incident Case Review Specialist

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

Executive Summary

On June 18, 2012, the Department of Social and Health Services (DSHS), Children's Administration (CA) convened a Child Fatality Review[39] (CFR) to review the department's practice and service delivery to a 2-year-old dependent child and the relatives with whom he was placed nearly three months before his death on February 24, 2012. On the day of his death the relative care providers[40] were alerted by their children that something was wrong with G.C. in the shower. Finding G.C. unresponsive the relative care providers contacted 911 and emergency responders were dispatched to the home where efforts to resuscitate the child were not successful. The Whatcom County Medical Examiner later determined the manner of death to be consistent with accidental drowning, with inadequate parental oversight as a contributing factor.

The CFR Committee included CA staff and community members selected from diverse disciplines with relevant expertise, including representatives from law enforcement, parenting instruction, social work, and Indian Child Welfare. Representatives from the Office of the Family and Children's Ombudsman and the Upper Skagit Indian Tribe were invited but were unable to attend. Although some Committee members were aware of the fatality incident through various media reports, none had any previous direct involvement with the family with the exception of the representative from G.C.'s tribe (Nooksack). Prior to the review each Committee member received a summarized chronology of known CA involvement with the relative placement family as well as copies of case file materials (e.g., intakes, case notes, safety assessments, Child Protective Services investigative reports).

Available to Committee members on site at the review were (1) additional case related documents (e.g., medical and developmental screening records, autopsy report, various case staffing/case planning reports, legal documents relating to G.C.'s dependency), (2) CA practice guides relating to CPS investigations and assessment of risk and safety, (3) relevant state laws and CA policies regarding investigation of child abuse and neglect, and (4) copies of relevant Indian Child Welfare (ICW) laws and policies. During the course of the review two CA social

[39] 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.

[40] The names of the relative caregivers are not identified by name in this report as neither adult has been charged with a crime related to the fatality incident. The names of their biological children are also subject to privacy laws.

workers involved with the case were made available for interview by the Committee.

Following review of the case file documents, the interview with the Child Protective Services social worker and the Child and Family Welfare Services supervisor, 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

G.C. first came to the attention of Children's Administration on June 28, 2011, when in collaboration with the Nooksack Tribe and extended family; he was placed into relative foster care following allegations of neglect. A dependency petition was filed on August 19, 2011, and dependency was established on September 19, 2011. In response to alleged breach of safety and supervision expectations by the relative caregiver, G.C. was then moved to a different relative placement following a Family Team Decision Making[41] (FTDM) meeting in early December 2011. The relatives who assumed placement and care of G.C. in December 2011 had previously been a placement resource for other relative children. During those prior placements there were allegations of neglect in the home which were determined to be unfounded after an investigation.

In mid-December 2011, CPS received a report alleging neglect based on reported deterioration of G.C.'s hygiene and behaviors since being moved to his new relative placement. The CPS investigation resulted in an unfounded finding[42] and the relative caregivers declined further services. G.C. remained in the care of the relatives and in early February 2012, the department and the Nooksack Tribe supported the plan to return G.C. to the care of his biological mother under an in-home dependency. Before the planned reunification could take place G.C. died on February 24, 2012, from an apparent accidental drowning while showering with his cousins. A CPS investigation determined that the relative caregivers had failed to adequately supervise G.C. and the investigation resulted in a founded finding of neglect.

[41] Family Team Decision Making (FTDM) meetings bring people together who are involved with the family to make critical decisions regarding the removal of a child from their home, changes in out-of-home placement, and reunification or placement into a permanent home [Source: DSHS CA Practice and Procedures Manual 1720]

[42] RCW 26.44.020(24) "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. RCW 26.44.020(9) "Founded" means the determination following an investigation by the department, prior to October 1, 2008, that based on available information, it is more likely than not that child abuse or neglect did occur.

Committee Discussion

The major focus of the Committee's review was with regard to the department's history of involvement with the relative family with whom G.C. was placed in December 2011. The discussions focused on CA policy, practice, and system response to the family in an effort to evaluate the reasonableness of decisions made and actions taken by CA. Actions taken by non-CA agencies were briefly discussed, but considered outside the scope of this review in terms of generating any findings or recommendations.

The Committee discussions centered on three areas: (1) quality social work, (2) policy issues relating to the decision to change G.C.'s placement in December 2011, and (3) the decision to place with relatives with a history of previously reported concerns for supervision of relative children in their care.

Findings

Quality Social Work

In terms of overall practice, the social work performed by CA staff generally appeared to be of good quality and was well documented during the 2011-2012 involvement with G.C. and his relative placement family. Collaborations between local CA, law enforcement, and tribal services were notably positive and appear to reflect strong partnerships. Efforts by CA to be inclusive in shared decision making were evident (e.g., frequent contact with tribal staff; numerous Child Protection Team and Family Team Decision Making meetings). The Committee found CA to be appreciably sensitive and respectful of the tribe and family members following the tragic death of G.C. The determination of the founded finding regarding the child fatality incident was supportable as defined in WAC 388-15-009. The Committee found no critical practice errors, and all substantive decisions made and actions taken during CA involvement appeared to be reasonable and supportable. The Committee found no clearly discernible alternative actions that reasonably should have been taken by CA that would have likely changed the outcome of the case.

Policy

The Nooksack Tribe questioned CA's decision in December 2011 to move G.C. from his initial relative placement after the caregiver had allowed the child to be in the unsupervised care of an unapproved relative. The disagreement between CA and the tribe did not reach impasse[43] and an alternate relative placement was

[43] "Impasse" means a deadlock between CA and the Local Indian Child Welfare Advisory Committee (LICWAC).or the child's tribe following thorough discussion by the CA social worker of the case plan and case decisions with the worker's supervisor and managers, and the LICWAC or tribal designee does not concur with the department's plan and decisions.[Source: Indian Child Welfare Manual; http://www.dshs.wa.gov/ca/pubs/mnl_icw/chapter1.asp]

agreed upon. CA's decision to move G.C. was found to be supportable based on: (1) the results from a Safety Assessment[44] that indicated G.C. was unsafe in his out-of-home placement and (2) CA policy that required immediate removal of children in such situations. However, the Committee questioned the inflexibility of this CA policy, especially in relative placements and Indian Child Welfare (ICW) cases where the available relative resource pool may already be very limited.

Practice

While the Committee found nothing in the relative's history of involvement with CA to exclude them from being the placement resource for G.C. in December 2011, there were several concerns reported intermittently (1997-2007) regarding children in their care, both biological and relative children. These included historical concerns for inadequate supervision, discipline, and protection of younger children from the older children in the home. The Committee acknowledges the emergent need to locate a new placement for G.C. in December 2011, and thus CA did not likely have sufficient time to evaluate: (1) the anticipated adjustments for 2-year-old G.C. in moving to an unaccustomed home environment with multiple, active, physical older children, and (2) the adjustments and preparations needed for the caregivers and their children in having a very young, dependent toddler come into the home where supervision and protection issues had historically been a concern.

Recommendations

- Children's Administration is encouraged to reassess and consider modifying the Child Safety Framework safety plan policy that does not currently allow a child to remain in relative care with a safety plan if a safety threat meets the criteria of an "unsafe child." There may be situations in which a Safety Plan could be initiated within the relative home so that placement disruption (whether temporary or longer term) does not need to immediately occur.
- Children's Administration should continue to reinforce with social workers and FTDM facilitators the importance of evaluating the possible impacts to a child being placed, as well as the impact the placement might have on children already in the home (e.g., the biological children of relative caregivers). It is suggested that promotion of this concept should continue to occur annually in state wide CA training available to social work and program staff, such as the "Lessons Learned" presentations held around the state.

[44] 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. However, when children in CA's care and custody are determined to be unsafe in licensed or unlicensed care, children are removed from that placement. CA does not maintain a child in placement with a safety plan. [Source: DSHS CA Practice and Procedures Guide 1120]

RCW 74.13.640(d)

Washington State Department of Social & Health Services

CA Children's Administration

Children's Administration

Executive Child Fatality Review

J.T.

April 1994
Date of Child's Birth

March 17, 2012
Date of Child's Death

August 7, 2012
Child Fatality Review Date

Committee Members

Carol Almero, MA, LMHC, CSOTP, Director of Residential Treatment Services, Friends of Youth
Debra Boiano, MSW, Regional Licensor, Children's Administration
Hoppy Hopkins, Chemical Dependency Professional
James Kairoff, Family Reconciliation Services (FRS) & Child and Family Welfare Services (CFWS) Adolescent Supervisor, Children's Administration
Mary Meinig, MSW, Director, Office of Family and Children's Ombudsman
Kris Sanborn, LICSW, Clinical Supervisor II, YMCA, Family Services and Mental Health

Observers/Facilitator's Aides

Paul Smith, Critical Incident Program Manager, Children's Administration
Rhonda Haun, Critical Incident Case Review Specialist, Children's Administrator

Facilitator

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

Executive Summary

On August 7, 2012, Children's Administration (CA) convened a Child Fatality Review[45] (CFR) committee to examine the practice and service delivery in the case involving 17-year-old J.T. and her family. The incident initiating this review occurred on March 17, 2012 when J.T. was found unconscious and suffering from stab wounds. J.T. was visiting a friend at an apartment in Tukwila when she was attacked by a 17-year-old male acquaintance who was staying at the same apartment. He told police that after J.T. fell asleep he "felt an urge to hurt someone." He was later charged with second degree murder.

J.T. was a dependent youth residing in the Virginia Miller House (VMH) Group Home. She had permission from her assigned social worker and VMH staff to leave VMH and go to her uncle's home for an overnight visit with her father. J.T. and her father had a disagreement about her original intent to visit his home; he felt she was intending to visit friends instead and he told her to return to VMH. J.T. did not return to VMH and met up with friends later that night.

J.T. was transported to Harborview Medical Center where she was pronounced dead a short time later. The Medical Examiner reported the stabbing as a homicide and the injuries were the result of non-accidental trauma.

The CFR Committee included CA staff and community members selected from diverse disciplines with relevant expertise, including representatives from the fields of mental health, chemical dependency, staffed residential facilities, foster care licensing, and social work. Committee members had no previous involvement with the case. Prior to the review each committee member received a chronology of known information regarding the father and child, un-redacted CA case-related documents and some relevant service provider reports.

Available to committee members at the review were: (1) additional case related documents (e.g., records, court records and case file), (2) copies of relevant laws relating to CPS duties, legal definitions involving child maltreatment, and licensing requirements for staff residential facilities. During the course of the

[45] 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.

review the DLR licensor was made available for interview by the CFR Committee members.[46]

Following review of the case file documents, interview of the Department of Licensed Resources (DLR) licensor and discussion regarding social work activities and decisions, the Review Committee made findings and recommendations which are detailed at the end of this report.

RCW 13.50.100

RCW 70.02.020

Case Overview

[redacted]

[46] The Committee requested to interview J.T.'s last assigned social worker. The former worker no longer works for CA but initially agreed to come to the fatality review to be interviewed. However, a scheduling conflict on the day of the review precluded him from attending.

[47] When an allegation is "Unfounded" it means that CPS investigated the allegation and, based on the information available, determined that it was more likely than not that the alleged abuse or neglect did not occur, or that there was insufficient evidence to determine whether the abuse did or did not occur.

[redacted]

[48] When an investigation is "Founded" it means that CPS investigated the allegation and, based on the information available, has determined that it was more likely than not that the abuse and/or neglect occurred.

[49] Virginia Miller House (VMH) is an "Interim Care Program." Virginia Miller House accepts female youth between 12 to 18 years old. The youth usually have behaviors that make it difficult to maintain a less restrictive placement. The program is staffed 24 hours a day, seven days a week. There is one or more staff for every three youth during the day.

On March 17, 2012, J.T. was granted a weekend pass by VMH staff. J.T. had been granted permission to ride the bus alone as part of her independent living skills. The assigned social worker confirmed that J.T. was authorized to visit her dad on the weekend and was approved for overnights at the uncle's home. J.T. was expected to go to her uncle's home where she would spend the weekend. J.T. did not go to her uncle's home as agreed upon. Instead, J.T. met up with two high school friends and went to their house. Another peer from the alternative high school came to the friends' home and he reportedly stabbed J.T. around 2:40 a.m.

Committee Discussion

Committee members reviewed and discussed the documented social work activities completed by Children's Administration from intake to case closure. As a means to provide structure and context to reviewing social work practice, the

[50] BRS Wraparound is a Children's Administration contracted service. The contractor supports families (including relative placements) in the stabilization of children in their current placements. The contractor provides the family with consultation, case aides, 24-hour on-call staff, and assistance with parenting techniques for behaviorally challenged youth.

[51] Shared Planning Meetings bring individuals together to help make decisions for children about safety, permanency and well-being. [Source: DSHS Practices and Procedures Guide 1710]

Committee was provided a case summary and had access to J.T's case file. In addition, the Committee was provided information on policy and procedure as it relates to placement in state licensed staffed residential facilities such as VMH. In this way, committee members were better able to evaluate the reasonableness of actions taken and decisions made by Children's Administration social workers. In addition to social work practice, discussions occurred around policy issues. The discussions largely focused on the following areas: the age of the child and how that impacted case decisions, the licensing and monitoring of the staffed residential facility, the Becca Law,[52] and services offered to J.T. during her out-of-home placements.

The Committee noted that J.T. was 17 years old at the time of her death and 15 years old at the time she came into care. The Committee recognized that older children present unique challenges to social workers and care providers. The Committee acknowledged that J.T. needed to have some personal investment in her case plan if it was going to succeed while noting how challenging it can be to motivate any teen child. J.T.'s case plan was noted to have appropriately included Independent Living Skills (ILS).

RCW 70.02.020

RCW 13.50.100

J.T.'s chemical dependency services and mental health treatment were discussed by the Committee. The Committee was concerned that J.T. should have been offered mental health therapy

[52] The Becca Law (RCW28A.225.010) was enacted by Washington state Legislature to: protect children who are endangering themselves; keep families together through assessment and treatment services; provide tools for schools, parents and Juvenile Court to keep children in school; and to hold children and parents accountable to the order of the Court.

[53] Career Link is a high school completion program for students ages 16-21 who no longer attend traditional high school. Students are offered the opportunity to work on academic skills, personal development, and earn progress towards a high school diploma

[redacted] J.T. was 15-years-old at the time of this concern. There was no evidence in the case file that she had received or was offered mental health treatment prior to her initial placement.

[redacted]. However, very few records were received and the Committee was concerned about the lack of provider reports in the case file. The Committee expressed concern that the social worker may not have been aware of all the documents that he should have been receiving from the providers. The Committee found insufficient documentation regarding J.T.'s [redacted] treatment, chemical dependency treatment, placement and education.

The Committee discussed J.T.'s placement history and found that J.T.'s care in her uncle's home was appropriate. The Committee also determined that the use of BRS Wraparound Services was beneficial to J.T.'s stability in this placement. The BRS Wraparound provider was noted to have done an excellent job of providing reports to the social worker and delivering services to J.T. and her relatives.

J.T. was placed at VMH during the majority of her time in out-of-home placement. A review of the case file provided the Committee with limited information regarding J.T's level of care while at VMH. The Committee noted that the VMH director did not respond to requests to be interviewed by the Committee and this resulted in a limited understanding of the safety measures in place at that facility. The Committee noted that available documentation showed a positive relationship between J.T. and some VMH staff. The Committee discussed the number of CPS licensing reports and compliance agreements regarding VMH. Some of the intakes resulted in compliance agreements. The Committee was informed by the DLR Licensor that the compliance agreements were designed to help VMH meet standards consistently. There was significant discussion around the use of compliance agreements and how many compliance agreements are needed to remedy concerns about a provider. Committee

members believed VMH may have benefitted from Council on Accreditation[54] (COA) accreditation. The Committee members believed Children's Administration would benefit from contracting with COA accredited placement providers whenever reasonably possible.

The Committee noted that J.T. had a cellphone and usually checked in with VMH staff; however, she did not check in the night of her fatality. J.T. had multiple contacts with her father the night of her death. J.T.'s father told investigators that he had directed J.T. to return to VMH due to her unwillingness to come directly to the uncle's house. The father did not inform VMH that J.T. should be returning to VMH.

The Committee discussed the report by a VMH staff that a high needs and medically fragile youth was placed at VMH shortly before the fatality. VMH staff reported this youth required extensive staff time and that their focus was on serving this youth. In doing so, they forgot to check in with J.T. to confirm that she arrived at her uncle's home for her scheduled visit. The Committee noted this was J.T.'s first overnight visit and the first visit where J.T. was not picked up and transported by her uncle. The visit was in compliance with the court order and authorized by the social worker, but no specific plan (regarding times when J.T. would depart and/or arrive) was in place according to the uncle.

RCW 13.50.100

RCW 70.02.020

Committee Findings

1. [redacted] No specific plan to address academic concerns was located in the case file.
2. Voluntary mental health services should have been offered to J.T. immediately following the [redacted] referral [redacted] The Committee stated that

[54] The Council on Accreditation (COA) partners with human service organizations worldwide to improve service delivery outcomes by developing, applying, and promoting accreditation standards.

a Multi-Disciplinary Team staffing may have been beneficial in the assessment of the case at that time.

3. [redacted] The Committee noted evaluations are more beneficial if the evaluator has all reasonably available information prior to the date of the evaluation. Collateral information was critical for J.T. [redacted] The information available to the Committee from the case file failed to show where J.T.'s [redacted] history was provided to the [redacted] evaluators.
4. The assigned social worker encouraged continued contact between J.T. and her uncle following her placement disruption from the uncle's home. The practice of continuing family support despite placement disruption was viewed as good practice by the Committee. The Committee noted that J.T. further benefited from only having one CFWS social worker.
5. There was insufficient communication between the social worker, VMH staff, the father and the uncle on the night of the fatality. The Committee members also acknowledged that there was no possible way of predicting the set of circumstances that eventually led up to J.T.'s death.

Committee Recommendations

1. Providing all collateral information to evaluators is a critical part of any referral process related to mental health and/or chemical dependency evaluations. Mental health and chemical dependency trainings should include a focus on the need for detailed collateral information.
2. Service providers who are contracted with CA to provide services to CA clients should be contractually obligated to participate with reviews and turn over any relevant documents when requested.

RCW 74.13.640(d)

Child Fatality Review

N.S.

March 2010
Date of Child's Birth

March 30, 2012
Date of Child's Death

August 15, 2012
Child Fatality Review Date

Committee Members
Tracey Goncalves, LICSW, Good Samaritan Hospital (Puyallup)
Andrea Ryker, M.S.N., B.S.N., R.N., Public Health Nurse Supervisor/Maternal Child Health, Tacoma-Pierce County Health Department
Nancy Shattuck, Domestic Violence Victim Advocate, Puyallup City Attorney's Office
Lori Linenberger, B.A., National Certified Addictions Counselor II, MOMS/Women's Recovery Center

Medical Consultant to the Committee
Dr. Michelle Terry, M.D. Department of Pediatrics, University of Washington School of Medicine

Observers
Victoria Bennett, LICSW, Children's Administration Supervisor, Pierce South Division of Children and Family Services
Ronda Haun, Critical Incident Case Review Specialist, DSHS, Children's Administration

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

Executive Summary

On August 15, 2012, the Department of Social and Health Services (DSHS), Children's Administration (CA) convened a Child Fatality Review[55] (CFR) to review the department's practice and service delivery to 2-year-old N.S. and his family whose Child Protective Services (CPS) investigation for alleged neglect had been closed nine months prior to the March 30, 2012 death of the child. On the day of his death the child's mother Aleesha Walker[56] called 911 to report she had killed her son. Tacoma Police Department (TPD) officers and emergency medical services (EMS) found the child unresponsive and without a pulse. The child was transported to Mary Bridge Children's Hospital where he was pronounced dead. The Pierce County Medical Examiner later determined the manner of death to be a homicide.

The CFR Committee included community members selected from diverse disciplines with relevant expertise, including representatives from public health, domestic violence advocacy, chemical dependency treatment, and hospital social work. Representatives from the Office of the Family and Children's Ombudsman and local law enforcement were scheduled to participate on the Committee but due to unanticipated circumstances were unable to attend. Although some committee members were aware of the fatality incident through various media reports, none had any previous direct involvement with the family.

Prior to the review each committee member received a summarized chronology of CA involvement with the family and non-redacted CA case documents (e.g., intakes, case notes, safety assessments, Child Protective Services investigative reports). Committee members also received a brief written summary by Dr. Michelle Terry, pediatric consultant to the Committee, regarding the health care N.S. received during his life.

Supplemental sources of information and resource materials were made available to the Committee at the time of the review. These included: (1) additional documents obtained post-fatality (e.g., N.S.'s medical records, domestic violence related legal documents filed in Pierce County, initial police

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[56] The full name of Aleesha Walker is being used in this report as she has been charged in connection to the incident and her name is public record.

reports regarding the fatality incident), (2) CA practice guides relating to Child Protective Services (CPS) investigations, assessment of risk and safety, CA response to domestic violence, and (3) copies of state laws and CA policies relevant to the review.

During the course of the review the CPS investigator was not available for an interview. However, the CPS supervisor involved with the case was made available to the Committee for interview.

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

Case Overview

The family first came to the attention of the Children's Administration in May of 2010 when CA's Child Protective Services (CPS) received an allegation of neglect regarding N.S.'s care. The intake was accepted for Alternate Intervention and referred to the local health department's Early Family Support Services (EFSS) program.[57] A Family Support Worker (FSW) from a local Family Support Center (FSC) conducted a home visit with the mother and child and observed no signs of abuse or neglect. The FSW discussed available community services including parenting resources which the mother declined. The alternate intervention was closed in June 2010.

Eight months later on February 25, 2011, CA received a neglect report alleging unsanitary conditions in the home and concerns for possible intimate partner violence. Following a request by CPS for a child welfare check, local law enforcement went to the home and did not confirm any of the reported concerns. The subsequent CPS investigation resulted in an unfounded finding[58] regarding the allegations of negligent treatment of N.S. While the case was still active CA received an allegation that N.S. may have been exposed to a serious domestic violence (DV) incident.[59] Prior to CPS contact regarding the allegations, Aleesha Walker removed herself and her child from the domestic violence

[57] Washington has an alternate intervention program for low-risk and moderate low-risk families that are referred to Children's Administration. Where available, CA Intake can refer the family to a contracted alternate intervention, called Early Family Support Services (EFSS).

[58] RCW 26.44.020(24) "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. RCW 26.44.020(9) "Founded" means the determination following an investigation by the department, prior to October 1, 2008, that based on available information, it is more likely than not that child abuse or neglect did occur.

[59] 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: DSHS Children's Administration Practices and Procedures Guide 2220]

situation, connected with local DV services, and filed a Temporary Order for Protection against her partner, N.S.'s father. The CPS investigation resulted in an unfounded finding due to lack of evidence that N.S. had been placed in clear and present danger and due to Aleesha Walker prioritizing her child's safety by separating from the alleged DV perpetrator.

Prior to the CPS case closing at the end of June 2011, CPS received allegations of poor health and hygiene of the child, and possible reuniting of Aleesha Walker with the alleged DV perpetrator. None of the allegations were confirmed, and the mother and child were found to be living in a stable and protective environment. Collateral contacts (e.g., the Primary Care Physician, DV advocacy staff) did not support the reported alleged concerns, and the case was closed.

Nine months later on March 30, 2012, two-year-old N.S. was killed and his mother arrested. A CPS investigation was initiated in collaboration with local law enforcement. The manner of death was ruled a homicide. The CPS investigation resulted in a finding of founded for physical abuse against the mother as to the death of her son.

Committee Discussion

Committee members reviewed and discussed the documented CA activities and decisions from the alternate intervention response in 2010 through the multiple CPS investigations conducted between February and June 2011. Committee discussions focused on CA policy, practice, and system response to the family in an effort to evaluate the reasonableness of decisions made and actions taken by CA. In this way the Committee considered case documentation, information provided as to CA policy, and interview responses from the CPS supervisor as to expected practice (e.g., assessing domestic violence, mental health, and substance abuse; considerations made for case closure). Review of post-fatality CPS activities was limited primarily to the information obtained by CA during the brief CPS fatality investigation in March 2012. Actions taken by non-CA agencies were briefly discussed, but considered outside the scope of this review in terms of generating any findings or recommendations.

Given the fact that no information is known as to the situation of N.S. and his family for the nine months between CA case closure and the fatality incident, the Committee found it difficult to derive any tangible conclusions. While there were no apparent critical errors in terms of decisions and actions taken during the CA involvement, the Committee did find instances where additional social work activity could have been considered. However, the absence of these additional activities was found to have no reasonably discernible connection to the circumstances of the child's death. Thus the identified issues below serve as

noted opportunities where improved practice may have been beneficial to the assessment of the family situation, but were not found to be critical oversights.

Findings

- While recognizing the fact that the CPS investigator made numerous collateral contacts during the investigations (e.g., referrer, relatives, the primary care physician, law enforcement, DV staff), several additional sources of information available at the time were not pursued. The worker did not contact some witnesses reported to have been present during domestic violence incidents. The worker did not seek clarification as to why the mother did not have care or custody of an older child, and the worker might have considered contacting the custodial parent of that child. The worker might have considered doing follow-up with the mother's mental health provider or at least seeking a release from the parent to contact the provider.
- In addition to questioning whether the worker had sufficient understanding of the mother's mental health history of issues, the Committee raised doubt as to the worker adequately understanding the domestic violence situation between N.S.'s parents. The worker appeared to be satisfied with the fact that mother eventually sought DV services as evidence of child safety.
- Similarly, the potential impact of the mother's confirmed use of marijuana, in combination with mental health history and domestic violence victimization, may not have been sufficiently understood by the worker. That is, the worker appeared to view substance abuse, mental health, and domestic violence in isolation rather than as a cluster or interactive domains.

Recommendations

- Due to the high co-occurrence of domestic violence and child maltreatment and the importance of accurate assessment for child safety purposes, DV training for Children's Administration (CA) staff is recommended on an on-going basis as an adjunct to the CA Social Worker's Practice Guide to Domestic Violence.
- CA should incorporate the following practice issues into any future "Lessons Learned from Child Fatalities" presentations for CA staff: (1) making purposeful effort to find out why a parent does not have care and/or custody of other biological children, including making contact with the custodial parent or relative caregivers; (2) giving deliberate consideration to referring a marijuana using parent for substance abuse assessment when that parent has any past diagnosis for substance

abuse/chemical dependency issues, especially if co-occurring with mental health and domestic violence issues.

- CA should consider exploring a “continuing education” requirement system whereby social work staff would be required to receive training on mental health, domestic violence, and chemical dependency every few years rather than being optional.