

**Report to the Legislature**

**Quarterly Child Fatality Report**

RCW 74.13.640

October – December 2015

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## Executive Summary

This is the Quarterly Child Fatality Report for October through December 2015 provided by the Department of Social and Health Services (DSHS) to the Washington state Legislature. RCW 74.13.640 requires DSHS to report on each child fatality review conducted by the department and provide a copy to the appropriate committees of the legislature:

### ***Child Fatality Review — Report***

*(1)(a) The department shall conduct a child fatality review in the event of a fatality suspected to be caused by child abuse or neglect of any minor who is in the care of the department or a supervising agency or receiving services described in this chapter or who has been in the care of the department or a supervising agency or received services described in this chapter within one year preceding the minor's death.*

*(b) The department shall consult with the office of the family and children's ombudsman to determine if a child fatality review should be conducted in any case in which it cannot be determined whether the child's death is the result of suspected child abuse or neglect.*

*(c) The department shall ensure that the fatality review team is made up of individuals who had no previous involvement in the case, including individuals whose professional expertise is pertinent to the dynamics of the case.*

*(d) Upon conclusion of a child fatality review required pursuant to this section, the department shall within one hundred eighty days following the fatality issue a report on the results of the review, unless an extension has been granted by the governor. A child fatality review report completed pursuant to this section is subject to public disclosure and must be posted on the public web site, except that confidential information may be redacted by the department consistent with the requirements of RCW 13.50.100, 68.50.105, 74.13.500 through 74.13.525, chapter 42.56 RCW, and other applicable state and federal laws.*

*(2) In the event of a near fatality of a child who is in the care of or receiving services described in this chapter from the department or a supervising agency or who has been in the care of or received services described in this chapter from the department or a supervising agency within one year preceding the near fatality, the department shall promptly notify the office of the family and children's ombuds. The department may conduct a review of the near fatality at its discretion or at the request of the office of the family and children's ombuds.*

In April 2011, SHB 1105 was passed by the legislature and signed into law by Governor Gregoire. The revised child fatality statute (RCW 74.13) became effective October 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 three (3) child fatalities and two (2) near-fatalities that occurred in the fourth quarter of 2015. All prior child fatality review reports can be found on the DSHS website: <https://www.dshs.wa.gov/ca/publications/childrens-administration-child-fatality-reports>

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

Region	Number of Reports
1	2
2	0
3	3
Total Fatalities and Near-Fatalities Reviewed During 4th Quarter 2015	5

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

The charts below provide the number of fatalities and near-fatalities reported to CA and the number of reviews completed and those that are pending for calendar year 2015. 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 2015			
Year	Total Fatalities Reported to Date Requiring a Review	Completed Fatality Reviews	Pending Fatality Reviews
2015	14	8	6

Child Near-Fatality Reviews for Calendar Year 2015			
Year	Total Near-Fatalities Reported to Date Requiring a Review	Completed Near-Fatality Reviews	Pending Near-Fatality Reviews
2015	9	5	4

The three (3) child fatality reviews referenced in this Quarterly Child Fatality Report are subject to public disclosure and are posted on the DSHS website.

<https://www.dshs.wa.gov/ca/publications/childrens-administration-child-fatality-reports>

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

***Notable Fourth Quarter Findings***

Based on the data collected and analyzed from the three (3) fatalities and two (2) near-fatalities during the 4th quarter, the following were notable findings:

- Four (4) of the five (5) cases referenced in this report were open at the time of the child’s death or near-fatal injury.
- Two (2) of the child fatalities referenced in this report occurred when the children were under 12 months of age.
- The three (3) fatalities occurred on open cases.
- Two (2) fatalities were the result of abuse or neglect.

- Two (2) children who died were dependent and in out-of-home placements. One child was in a relative placement and died from blunt force trauma. His aunt was charged with murder in connection with his death. A two-month-old infant died in foster care from Sudden Unexpected Infant Death (SUID) after he was placed in an unsafe sleep environment by his foster father.
- One (1) child fatality was coded as homicide by a medical examiner.
- Three (3) children were Caucasian and two (2) were Native American.
- In the two (2) cases involving Native American children, the tribe's social service agencies were actively involved in the case planning including placement decisions.
- Four (4) of the five (5) cases referenced in this report received considerable media attention after the death or near fatal injury of the child.
- Children's Administration received intake reports of abuse or neglect in four (4) of the five (5) cases prior to the death or near-fatal injury of the child. A child died while placed in licensed foster care. The foster parents had no prior reports of abuse or neglect. Of the other four (4) cases, one case had three (3) intakes reported to CA prior to the critical incident, one had five (5) prior intakes, and another had two (2) prior intakes. A near fatality case had 23 intakes reported to CA prior to the critical incident.
- One near fatality case did not meet the statutory requirement for a review as the child was not deemed to suffer near fatal injury. This child (and her twin sister) was severely malnourished by her mother. However, given the severity of the children's medical condition and concerns with the actions taken on the case, the decision was made to conduct an internal review with only Children's Administration staff and a representative with OFCO. OFCO was consulted on the decision to review this case and agreed with this decision. The CA staff on the review committee had no prior involvement with the case and were selected from offices outside the county where the case originated.
- Due to the small sample of cases reviewed, no statistical analysis was conducted to determine relationships between variables.



## **Child Fatality Review**

**G.B.**

**October 2009**

Date of Child's Birth

**April 18, 2015**

Date of Child's Death

**September 16, 2015**

Child Fatality Review Date

### **Committee Members**

Buffy Via, Pierce County Juvenile Court Guardian ad Litem/CASA Coordinator

Juliette Knight, MSW, Children's Administration, Indian Child Welfare Program Manager

Elizabeth Bokan, J.D., Office of Family and Children's Ombuds (OFCO)

Catherine N. Edwards, Executive Director, Hoh Tribe

Lorraine Cress, ICW Case Manager, Hoh Tribe

Mary Pagni-Leavitt, Children's Administration, CFWS Program Manager

### **Facilitators**

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

Susan Danielson, Critical Incident Case Review Specialist, Children's Administration

**RCW 74.13.640**

## **Executive Summary**

On September 16, 2015, the Department of Social and Health Services Children’s Administration (CA) convened a Child Fatality Review<sup>1</sup> (CFR) to examine the department’s practice and service delivery to **RCW 13.50.100** G.B., whose parents are **RCW 13.50.100**. The child and two siblings were dependent Indian children<sup>2</sup> out of Port Angeles (Clallam County) and in tribally approved relative placement in Spokane County. On April 18, 2015, the child died from blunt force injuries suspicious for abuse while in placement with his paternal aunt Cynthia Khaleel.<sup>3</sup> The aunt subsequently pled not guilty to a charge of second degree murder and the criminal prosecution is currently pending.

The CFR Committee was comprised of CA staff, community members and Hoh tribal staff with pertinent expertise from a variety of fields and systems, including child abuse investigation, public child welfare services, Indian Child Welfare (ICW), and child advocacy. None of the Committee members had any previous direct involvement with the family with the exception of the representatives from the Hoh Tribe.

Prior to the review each Committee member received a narrative summary of CA involvement with G.B. and his biological family, and a separate chronology of CA involvement with Cynthia Khaleel including pre and post placement of G.B. and his siblings. Committee members also received reports to the court by both the CA worker and the Guardian ad Litem (GAL).<sup>4</sup> Relevant un-redacted case file documents from the Port Angeles and Spokane offices were provided to the Committee members, including worker and supervisor case notes, shared planning meeting notes, and the home study report that was finalized post-fatality.

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<sup>1</sup> 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.

<sup>2</sup> **Washington state Indian Child** means an Indian child meeting the definition of “Federally Recognized Indian Child” and whose tribe is a federally recognized tribe located within the state of Washington. [Source: [Indian Child Welfare Manual 14.0](#)]

<sup>3</sup> The full name of Cynthia Khaleel is used in this report because she was charged with committing a crime related to this report of abuse investigated by DSHS. The names of the deceased child and his siblings are subject to privacy laws. [[RCW 74.13.500\(1\)\(a\)](#)].

<sup>4</sup> A **Guardian ad Litem** (GAL) is an individual appointed by the court to represent the best interests of a child or incapacitated person involved in a case in superior court. [Source: [Washington Courts](#)]



Available to Committee members at the time of the CFR were educational and medical records for G.B. and the Spokane County Medical Examiner's Office records regarding the child fatality (autopsy and ancillary studies).

During the course of the review, three Port Angeles field staff involved with the case and the Area Administrator were interviewed. The Child and Family Welfare Services (CFWS) worker, who had been assigned the case from July 2013 through December 2014, was not available for interview as she is no longer employed by Children's Administration. Additionally, two Spokane Children's Administration supervisors were interviewed.

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

### ***Case Overview***

G.B. first came to the attention of Children's Administration in May 2011 following a report of a RCW 13.50.100 sibling with non-accidental injuries. Both children were placed into protective custody and the CPS investigation resulted in physical abuse allegations being founded RCW 13.50.100.<sup>5</sup> G.B. was subsequently found dependent by Clallam County Juvenile Court as to the RCW 13.50.100 only and the two siblings remained in the care of their mother. The dependency was dismissed when the father was RCW 13.50.100 in June 2012; the case closed in September 2012.

In May 2013, CPS initiated two investigations of allegations of negligent treatment by the RCW 13.50.100. A Family Team Decision Making (FTDM)<sup>6</sup> meeting was held in late May with tribal representation. The decision was made for G.B. and his sibling to remain in the care of their RCW 13.50.100. In June, while the case was still open, the family unexpectedly left the state for California. California CPS placed G.B. and his sibling and filed for dependency based on evidence of neglect. California dismissed the dependency matter and dependency was refiled in Washington (Clallam County) where the children were placed into temporary relative care, which was supported by the Hoh Tribe. A RCW 13.50.100 -sibling born in late RCW 13.50.100 2013 was also placed into out-of-home care following the filing for dependency on her behalf.

In March 2014, following contact with paternal Aunt Cynthia Khaleel, a FTDM was held to explore permanent placement of the children. At the time, the aunt resided in RCW 13.50.100 and her husband was RCW 13.50.100. In April, the aunt came to the Port Angeles

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<sup>5</sup> Founded means the determination that following an investigation by the department, based on available information, it is more likely than not that child abuse or neglect did occur [RCW 26.44.020(9)].

<sup>6</sup> 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: [CA Practice and Procedures Guide 1720](#)]

area for an intensive one week visitation with G.B. and his siblings. Following numerous visits with the children throughout that week, Cynthia Khaleel indicated a desire to have all of the children placed in her home. She moved to RCW 13.50.100, Washington with her three biological children. Her husband remained RCW 13.50.100. The Port Angeles social worker reported conducting a walk-through of the Khaleel home in July.

G.B.'s mother died RCW 13.50.100. Soon after, G.B. and his RCW 13.50.100 went on court approved extended visitation with their aunt. The Hoh Tribe recommended the boys remain permanently with Cynthia Khaleel. G.B. and his RCW 13.50.100 were legally placed with their paternal aunt in early September following review by LICWAC.<sup>7</sup> The assigned worker from Port Angeles documented that she had conducted in-person monthly health and safety visits with G.B. and his caregiver in September, October, and November of 2014. This documentation was questioned by the department in December due to activities that were recorded but could not be reconciled.

On December 12, 2014, Spokane intake received a report that G.B. had been observed at school with bruises and marks on his face and head that may or may not have been accidental or self-inflicted. Additional concerns were noted for supervision of the children in the home. Intake identified G.B. as having an active child welfare case out of Port Angeles and notified that office. The Spokane office had been unaware of the placement of G.B. and his sibling in the home of Cynthia Khaleel. At intake it was also discovered that Cynthia Khaleel had two prior CPS investigations. One occurred in 2008 regarding a RCW 13.50.100 (unfounded). The second occurred in November 2013 when Cynthia Khaleel allegedly failed to properly supervise a non-related child RCW 13.50.100 (unfounded). Cynthia Khaleel was visiting from RCW 13.50.100 at the time. The two investigations were not linked and the identified last name in the 2013 intake was not Khaleel.

Spokane CPS responded within 24 hours to the allegations reported on December 12, 2014. During the initial contact at the Khaleel, home a worker did observe and photograph a fading bruise on G.B.'s forehead, a small bruise on his eye and on the bridge of the nose, and a small scratch on his cheek. Cynthia Khaleel stated that G.B. hit his head on a bathroom vanity and also got injured during roughhousing around the sofa. She denied the allegations of poor supervision. The intake and photos taken by the Spokane CPS worker were sent to law enforcement which declined to investigate. Notification of the intake was made to the Hoh Tribe. Spokane staff contacted the Port Angeles worker to review the case and to raise concerns that neither a request for

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<sup>7</sup> Local Indian Child Welfare Advisory Committee (LICWAC) is a body of department approved and appointed volunteers who staff and consult with the department on cases of Indian children who are members of a federally recognized tribe or are members of a tribe but for whom the tribe has decided not to intervene or has not responded. The child's tribe may officially designate the LICWAC to speak for the tribe. [Source: [Indian Child Welfare Manual 10.0](#)]

courtesy supervision nor a home study had been requested by Port Angeles prior to placement of G.B. and his sibling.

All the children in the Khaleel home were allowed by Cynthia Khaleel to be interviewed by CPS, but only in her presence (sitting behind the children when interviewed). G.B. was examined and assessed at the Child Advocacy Center in Spokane. The medical child abuse specialist concluded that the injuries could have occurred as explained by Cynthia Khaleel. The allegations were determined to be unfounded by the CPS investigator and the CPS case closed.

A previously scheduled LICWAC staffing occurred in mid-December with participation by the Hoh Tribe and staff from both the Port Angeles and Spokane Children's Administration offices. At that staffing it was recommended that the department initiate a home study and courtesy supervision out of the Spokane office. During a subsequent staffing between the Spokane and Port Angeles offices, several social service needs were recommended by Spokane staff. In addition to the need for immediate initiation of courtesy supervision and home study, it was recommended that the Port Angeles worker help the aunt obtain financial help, provide respite care for Cynthia Khaleel as needed, and to provide educational advocacy to improve services for G.B. and his sibling.

Courtesy supervision by Spokane began mid-January and the Spokane home study worker made in-home contact with Cynthia Khaleel in late January 2015. The home study worker documented numerous challenges facing the aunt in attempting to parent five small children on her own. In early February, the home study worker emailed the Port Angeles CFWS worker expressing reservations about the anticipated placement of RCW 13.50.100 in the Khaleel home. Concerns had surfaced from conflicting statements by Cynthia Khaleel as to the status of her RCW 13.50.100, the parentage of her children, her history with the department, and her reliance on her extended family for support. In addition, the home study worker expressed concern that he could not find documentation that the maternal grandparents, who reportedly had unsupervised access to G.B. and his RCW 13.50.100, had completed background checks.

In early February 2015, the RCW 13.50.100 was court ordered into placement with her siblings' paternal aunt Cynthia Khaleel. The placement was supported by the Hoh Tribe. On February 17, 2015, a CFWS worker from Spokane conducted a routine health and safety visit at the Khaleel home. It was at this contact that the Spokane office became aware that RCW 13.50.100 had been placed in the home by court order. Following the courtesy supervision visit to the home, the case was again staffed by the Port Angeles and Spokane offices. The courtesy worker expressed concerns that the home was "chaotic" and while the aunt appeared well intentioned, she was struggling to meet the needs of six children both financially and otherwise.

In early March, the home study worker and his supervisor met with the aunt to discuss concerns and discrepancies that had arisen during the home study process. On March 24, 2015, the home study worker contacted the Port Angeles worker to review the progress of the home study which had been delayed due to a failure of required forms to be returned. At a home visit in early April, the home study worker met with Cynthia Khaleel and her husband, who was RCW 13.50.100. Again, a list of paperwork that needed to be completed prior to completion of the home study was provided by the home study worker.

On April 17, 2015, CA intake was notified that G.B. had been admitted to a RCW 13.50.100 hospital and was not expected to survive. The child was observed to have multiple injuries and skull fractures and had suffered a massive stroke. Cynthia Khaleel stated that early in the morning of April 17, she had heard a loud “bang” and screaming coming from the bedroom shared by G.B. and his brother. She found G.B. on the floor between his bed and a dresser, with a crib partially tipped over and resting on the dresser. At that time she believed G.B. had fallen while getting into his RCW 13.50.100 crib. She observed no injuries although the child was crying and saying his ear hurt. She put G.B. back to bed, gave him some ice and Motrin, and propped him on a pillow. At about 6:00 a.m., while in the process of getting the children ready for the day, she attempted to wake G.B. He did not move and his pupils were of different sizes. Cynthia Khaleel called 911 and upon arrival the first responders called for a Medivac helicopter for emergency transport.

G.B. was removed from life support on April 18, 2015 and passed away. Upon autopsy, G.B. was found to have multiple external and internal injuries, including bilateral skull fractures, abdominal trauma, and multiple skin contusions involving the head, torso and extremities. The CPS investigator contacted a state Child Protection Medical Consultant (CPMC)<sup>8</sup> who, based upon the medical and law enforcement reports, believed that G.B. had sustained multiple traumas including an abdominal injury that was the result of a deep penetrating force. The complexity and severity of the head injuries suggested a very severe blow that would have caused immediate concussion and would have made it unlikely for the child to have any period of lucidity as described by Cynthia Khaleel.

Cynthia Khaleel was arrested and charged with the death of G.B., subsequently pleading not guilty to the charges.

### ***CFR Committee Discussion***

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<sup>8</sup> The CPMCs are a team of physicians who provide statewide consultation and training regarding medical findings in cases of alleged child abuse and neglect. The tasks of the statewide CPMC network include providing telephonic consultations, case staffing/case review, training, court testimony, and written consults to CA staff, law enforcement officials, prosecuting attorneys, and physicians regarding child maltreatment cases.

The Child Fatality Review Committee largely focused on case activities and decisions from when the department considered G.B.'s paternal aunt as a possible placement (March 2014) until his death while in her care (April 2015). The Committee spent considerable time evaluating the department's level of compliance with a number of CA policies relating to placement of dependent children, including those regarding out-of-area placement, courtesy supervision, home study requests, and health and safety visit requirements. The Committee also briefly considered requirements under the federal Indian Child Welfare ACT (ICWA) and the Washington state Indian Child Welfare Act (ICWA).

The Committee deliberated on a number of practice issues that surfaced from review of case documents and interview responses by CA staff from both the Port Angeles and Spokane offices. Full consensus was not reached as to the significance of each identified practice issue, but some issues were deemed substantive in terms of consequences on the fatality and are so noted in the findings section of this report. Additionally, the Committee discussed the compilation of multiple practice deficits that converged to collectively impact the outcome of the case more than any single factor.

In terms of individual practice issues, the Committee discussed the quality and reliability of information gathered by the CFWS worker as to the aunt for both pre-placement vetting (mid 2014) and post-placement follow up (September-December 2014). This included concerns by the Committee as to a lack of collateral contacts (e.g., school staff) and whether the CFWS worker provided complete and corroborated information to the Hoh Tribe and to her supervisors. The information documented was viewed in contrast to information uncovered by the Spokane home study worker between January and April 2015 that raised concerns as to the aunt's history and current family situation. The Committee also reflected on the post-placement activities, including apparent lack of ongoing assessment and timely follow-up for recommended services and the general inadequate service delivery to G.B. and his siblings and support services to the relative caregiver. Also discussed was the apparent failure of Port Angeles staff to give sufficient consideration to concerns expressed by the Spokane home study and courtesy worker in Spokane in February and March 2015 as to the chaotic placement environment and what appeared to be an overburdened caregiver. The Committee noted the information gathering and assessment of the placement by the home study worker was thorough and of good quality.

The Committee was made aware that some documentation by the primary child welfare worker from the Port Angeles office has now been questioned by the department as having occurred as recorded. The discrepancies were not discovered until December 2014 resulting in the removal of the worker from the case. This resulted in discussion by the Committee as to the reliability and credibility of what had been reported by the

worker, who was not available for interview by the Committee as she is no longer employed by the department. The Committee was further hampered by the unavailability, due to various circumstances, of several Hoh Tribal staff that had been involved in the case and who may have been able to provide clarification and relevant information.

Members of the Committee considered statements made by Port Angeles supervisors that they were aware that the worker appeared to be enmeshed with the aunt, exhibited confirmatory bias,<sup>9</sup> and significantly relied on the aunt as the primary source of information as to G.B.'s "positive" transition to his Spokane placement. These conditions, along with the apparent distraction with legal conflicts in Family Court between the foster parent of G.B.'s RCW 13.50.100 and the Hoh tribe regarding placement, may have contributed to the worker assertively pursuing relative placement when other information did not support such urgency to move G.B. and his RCW 13.50.100. Additionally, the Committee was made aware that the primary worker had a noted pattern of not meeting timelines for documentation and completion of work and was known to be difficult to supervise, but had never had a critical incident previously on her caseload. While discussing personnel issues are not normally within the scope of conducting Child Fatality Reviews, the Committee found such to be critically relevant to evaluating the impact of the worker's practice in this case as well as the quality of the supervisory oversight.

Some exploratory discussions occurred as to conditions specific to the Port Angeles office. This included consideration of the office culture, such as a high field staff turnover rate resulting in more supervisory focus on inexperienced workers and less on experienced field staff. The Committee considered the reported usual practice in the Port Angeles office for requesting a home study prior to placement of a child into relative care, the process of requesting courtesy supervision by another state office, the level of initial and ongoing inter-office communication, and intra-office case transfer procedures. This was for the purpose of trying to determine if the identified issues and policy violations in this case were anomalous or systemic in that office. Additionally, the Committee discussed the relative search responsibilities in the Port Angeles office, as well as the lack of identified ICW specialists in an area that serves six federally recognized tribes.

In the context of looking at possible recommendations emerging from the review, the Committee discussed post-fatality actions reported to have taken place in the Port

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<sup>9</sup> Confirmation biases are effects in selective collection of evidence and information processing that explains how people search through available information, interpret that information, and hence reach conclusions. Studies of social judgment provide evidence that people tend to overweight positive confirmatory evidence or underweight negative disconfirmatory evidence.

Angeles office after the death of G.B. This included information provided by the Area Administrator of increased guidance and training for workers and supervisors in the areas of courtesy supervision and home study request procedures and policies. The Committee also briefly discussed the fact that significant information came to CA's attention after the fatality regarding Spokane school staff having failed to report several incidents of concerning injuries to G.B. in 2014. The Committee was satisfied that Spokane staff followed procedures to report the failure of the mandated reporters to report the suspicious injuries. No further discussion occurred as to that issue, as reviewing non-CA systems are outside the scope of the Child Fatality Review Committee.

### ***Findings***

1. The Committee found several examples where the placement of G.B. and his siblings in the unlicensed home of the paternal aunt was not conducted in accordance with CA policy. Although not reaching full consensus, a majority of Committee members concluded that critical errors were made in the relative placement process. The most notable issues were:
  - a. Home Study. The request to evaluate Cynthia Khaleel's home was not made in a timely manner. Policy requires that a home study be completed prior to placement unless it is an emergent or urgent placement. The Committee noted that Cynthia Khaleel moved to Washington state in July and the fact that the children were not legally placed in the home until two months later indicates it was not an emergent situation. The Committee felt there was ample opportunity to more thoroughly assess the caregiver prior to placement and that a timely home study may have raised questions earlier about her character and suitability as a placement for the children.<sup>10</sup>
  - b. Courtesy Supervision. When it is necessary for children to be placed outside of the jurisdiction of a local office, that office is to notify the CA office that services the area of the proposed placement in advance and request courtesy supervision. Courtesy supervision was not requested on this case until the children had been in the Spokane area for over four months.<sup>11</sup>
2. Documentation of the health and safety monitoring visits by the assigned Port Angeles social worker did not appear to be in accordance with CA policy. Specifically, CA policy requires an initial health and safety visit within seven days of the child's placement and this does not appear to have occurred. Further

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<sup>10</sup> [CA Practices and Procedures Guide 5110](#) was recently issued to address this and clarifies that if a home study has not been completed prior to placement, a request must be made within thirty days of placement.

<sup>11</sup> Courtesy supervision safely supports a child, in the care and custody of the department, when placed outside of the originating office catchment area. Provides consistent support for children and families when cases are shared between offices and regions. [Source: [CA Practices and Procedures Guide 4430](#)]

health and safety visits are to be conducted monthly with the majority of the contacts occurring in the child's home, and this did not appear to have occurred.<sup>12</sup>

3. Although supervisory reviews regarding the primary CFWS case were regularly conducted and documented, there were conspicuous missed opportunities for key supervisory actions. This included making sure the worker completed the courtesy supervision request and home study request per policy; that the worker followed through on recommendations (e.g., from Shared Planning meetings, LICWAC, prior monthly supervisory reviews, and from Spokane CPS, courtesy supervision, and home study staff); that the worker was actively providing support services for G.B. and his caregiver; that the worker was providing sufficient ongoing management of risk and safety.<sup>13</sup>

### ***Recommendations***

1. The Committee recommends that CA continue its current efforts to streamline the courtesy supervision process, to reduce delays in courtesy supervision case assignment, and to make clear the division of duties and required communications between the sending and receiving offices.
2. CA should continue to pursue integrating the courtesy supervision referral and home study request processes in FamLink so that there is connection to the case management system that is easily reviewed and tracked electronically.<sup>14</sup>
3. CA Policy and Program staff develop and initiate "Quick Tip" practice suggestions to serve as reminders for staff regarding the timeframes for courtesy supervision and home study requests.<sup>15</sup>

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<sup>12</sup> All health and safety visits and monthly visits must be conducted by the assigned CA worker or another qualified CA staff. The number of visits conducted by another qualified CA staff is not to exceed four (4) times per year with no two (2) visits occurring in consecutive months. [Source: [CA Practice and Procedures Guide 4420](#)]

<sup>13</sup> Social work supervisors must conduct monthly supervisor care reviews with each assigned social worker and document each case reviewed in the client electronic file. [Source: [CA Practice and Procedures Guide 46100](#)]

<sup>14</sup> FamLink is the case management information system that Children's Administration implemented on February 1, 2009; it replaced CAMIS, which was the case management system CA had used since the early 1990s.

<sup>15</sup> Quick Tip is a weekly electronic message which appears when CA staff log into their computers. Quick Tips provide practice tips, policy reminders and general CA information. Quick Tips were implemented in August 2014 as a result of a workgroup recommendation to improve regular communication with all staff.





**CA** Children's Administration

**Child Fatality Review**

**C.B.**

**November 2014**

Date of Child's Birth

**April 5, 2015**

Date of Child's Death

**June 30, 2015**

Child Fatality Review Date

**Committee Members**

Brett Myers, Sheriff, Whitman County

Meg Gallagher, RN, Whitman County Health Department

Patrick Dowd, Director, Office of the Family and Children's Ombuds

Emilie McLarnan, Associate Director, Alternatives to Violence in the Palouse

Lyn Andrews, MSW, Supervisor, Children's Administration, Spokane

Lacretia Warnstaff, RN, Early Head Start Director, Okanogan County Child Development Association

Deborah Ray, LMSW, The Alliance for Child Welfare Excellence

**Observer**

Maggie Stewart, MSW, Supervisor, Children's Administration, Spokane

**Facilitator**

Susan Danielson, Critical Incident Review Specialist, Children's Administration

## ***Executive Summary***

On June 30, 2015, the Department of Social and Health Services (DSHS), Children's Administration (CA) convened a Child Fatality Review (CFR)<sup>16</sup> to review the department's practice and service delivery to a four-month-old male child and his family. The child will be referenced by his initials C.B. in this report. At the time of his death, C.B. resided with his parents and older siblings in RCW 74.13.500, Washington. The incident initiating this review occurred on April 5, 2015 when C.B. was found unconscious and unresponsive on the floor of an upstairs bedroom. The medical examiner later determined that he had asphyxiated on a plastic bag. This case had been open for investigation in the months prior to the child's death and was pending case closure when C.B. died. At the time of the child's death, the household consisted of C.B., his older siblings RCW 74.13.500, age three and RCW 74.13.500 age 15 months; their mother, RCW 74.13.500, and RCW 74.13.500 the father of C.B. and RCW 74.13.500's biological father was not part of the household.

The CFR Committee included CA staff and community members from disciplines with relevant expertise including child welfare, law enforcement, domestic violence advocacy, public health, early childhood education and the Office of the Family and Children's Ombuds. None of the committee members had any prior involvement with this family.

Prior to the review each committee member received a case chronology, a family genogram, a summary of CA involvement with the family and un-redacted case documents including intakes, case notes, assessments, provider reports and law enforcement reports. A hard copy of the file was available to the Committee at the time of the review. Supplemental sources of information and resource materials were also available to the Committee for reference including copies of state laws and CA policies relevant to the review and workload and case assignment date for this office during the time that the case was open.

The Committee interviewed the assigned investigator, the supervisor and the Area Administrator who were able to provide additional information about the case as well as information about the context of the Colfax office, including workload, caseload and staff turnover.

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<sup>16</sup>Given its limited purpose, a Child Fatality Review (CFR) should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of the child. The CFR Committee's review is generally limited to documents in the possession of or obtained by DSHS or its contracted service providers. The Committee has no subpoena power or authority to compel attendance and generally only hears from DSHS employees and service providers. It does not hear the points of view of the child's parents and relatives, or of other individuals associated with the child. A Child Fatality Review is not intended to be a fact-finding or forensic inquiry or to replace or supersede investigations by courts, law enforcement agencies or other entities with legal responsibility to investigate or review some or all of the circumstances of a child's fatal injury. Nor is the function or purpose of a Child Fatality Review to recommend personnel action against DSHS employees or other individuals.

RCW 74.13.500

The Colfax CA office became involved with this family in November 2014 when RCW 74.13.500 gave birth to C.B. RCW 74.13.500

The parents reported that RCW 74.13.500 was a full time student at WSU studying child development and the father was the primary caregiver for the children. The father admitted to being frustrated with his daughter when his wife was in the hospital but denied using physical discipline with her. The investigator observed that the family home was cluttered and that the parents seemed overwhelmed by multiple stressors including lack of transportation, conflict between the children, social isolation and lack of social and financial supports.

RCW 74.13.500

Prior to leaving the home, the investigator provided the parents with written information about Infant Safe Sleep<sup>19</sup> and the Period of Purple Crying.<sup>20</sup> RCW 74.13.500

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<sup>17</sup> [RCW 9A.44.079](#)

<sup>18</sup> CA does not accept for investigation allegations where the alleged perpetrator is a third party who is not legally responsible for the alleged victim. In this instance, the alleged perpetrator was identified as the mother's then-boyfriend, and the matter was referred to law enforcement for investigation of third degree rape of a child.

<sup>19</sup> Safe Sleep is a nationwide campaign to promote safe sleeping habits for children. Safe sleep practice can reduce the risk of SIDS. In October 2014, CA instituted a policy that requires social workers to discuss Safe Sleep guidelines with all families caring for children under the age of one year. [Source: [CA Practices and Procedures Guide 1135](#)]

<sup>20</sup> The Period of Purple Crying is a method of helping parents understand the time in their baby's life where there may be significant periods of crying. During this phase of a baby's life they can cry for hours and still be healthy and normal. The Period of Purple Crying begins at about 2 weeks of age and continues until about 3-4 months of age. [Source: [The Period of Purple Crying](#)]

RCW 74.13.500

RCW 74.13.500

The investigator visited the family home on March 9, 2015 and attempted to see the children and re-engage the parents in services. The father explained that he and his wife did not want to participate in the program because his wife's schedule prevented her from attending sessions in their home and they would prefer to attend classes together. The worker offered to schedule the classes in the evenings or on the weekends but he declined those options as well. During the visit the father stated that the younger children were napping and [RCW 74.13.500] was at preschool. The mother was not home during this visit. The worker did not enter the house during this home visit and did not see the children. [RCW 74.13.500]

On April 5, 2015, four weeks after the last family contact documented by the CPS investigator, CA was notified by staff at [RCW 74.13.500] that four-month-old C.B. had died after being brought to the Emergency Room that morning by ambulance. When interviewed about the sequence of events, the parents stated that they had put the baby to sleep on a queen sized bed the night before at about 12:30 a.m. They reported that the baby slept in a bedroom on the second floor of the apartment adjacent to

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<sup>21</sup> Safe Care is an evidenced-based home visitation program aimed at reducing child maltreatment among families with a history of maltreatment or risk-factors for maltreatment.

<sup>22</sup> Failure to thrive is a term used to describe a child who seems to be gaining weight or height more slowly than other children of his or her age and sex. A baby who is failure to thrive may seem slow to develop physical skills. Slow growth can also lead to delays in mental and social skills.

another bedroom where the older children slept. The parents stated that they slept on couches in the living room on the first floor of the apartment. The father reported he and the younger children woke up at about 8 a.m. and RCW 74.13.500. woke up at about 10 a.m. At about 11 a.m. the mother went to check on the baby and found him on the floor next to the bed. The parents attempted CPR and called emergency responders. The baby was taken to RCW 74.13.500 by ambulance where he was pronounced dead at 11:39 a.m. The medical examiner later determined that the baby had asphyxiated on a plastic bag sometime during the night. The investigating officer from WSU Police described the home as filthy and cluttered with health and safety hazards including dirty diapers, soiled clothing, old food and numerous small choking hazards within reach of the children. C.B. had been laid to sleep on two queen sized adult mattresses stacked on the floor of the bedroom. The mattresses were bare without sheets or other linen. They were dirty and smelled strongly of urine. The officer noted several deflated latex balloons on the bed adjacent to where C.B. had been placed to sleep. The department initiated dependency actions on the older children to place them in out-of-home care. Following the CPS investigation of the fatality, the department issued founded findings for negligent treatment against both parents.

### ***Committee Discussion***

The primary focus of Committee discussion centered on documentation regarding observations, actions and decisions made during CA involvement in the five months prior to C.B.'s death. The Committee considered the verbal accounts presented by the investigator, including undocumented observations of the home environment. The Committee also reviewed information gathered during the fatality investigation that provided a description of the circumstances surrounding the baby's death and conditions in the home.

The majority of the Committee discussion focused on CA policies and practice expectations for timely and thorough investigations. The Committee noted that though assessments were completed timely, the investigator seemed to focus primarily on the alleged physical abuse of RCW 74.13.500. and when she felt this had been addressed, did not gather sufficient information to assess the parents. Specifically, subject interviews were not comprehensive, the physical condition of the children was not assessed and no attempt was made to observe or fully evaluate the home for safety concerns. They noted multiple missed opportunities to gather additional available information that could have broadened the understanding of the family's situation and lead to a more comprehensive view of the family functioning. Specifically, the Committee noted that the family was involved with several service providers in the community, but the worker did not corroborate the parent's statements about their involvement or seek additional collateral contacts that could have provided important information about their parental capacity and commitment to child rearing. The investigator took at face value that they

were engaged in these services without critically assessing the extent and level of involvement by corroborating the parent's assertions. The Committee felt that the parents' inconsistent attendance at appointments and their lack of cooperation with services should have been indicators of struggles, not protective factors. Similar to this, though the worker made an effort to gather the children's medical records the Committee could not find any indication that the content of the medical records was incorporated into the evaluation of the child and family functioning.

There were several points throughout the case where the Committee noted a lack of curiosity on the part of the investigator that significantly limited the information available to evaluate the allegations. They noted that although the investigator made three separate home visits, she did not go upstairs to see where the children slept. It was unclear to the Committee what factors prevented the worker from observing the home during the third home visit in March and they considered whether a different investigative approach could have been used by the social worker to gain access to the home. Even in the absence of parental permission to enter the home, the Committee noted that the worker could have seen [RCW 74.13.500](#) at her preschool. The Committee also felt that the Safe Care provider who had visited the family home in late January could have provided substantive information about the conditions in the home and her observations of the parent/child interaction.

The lack of evaluation of the home situation led to a discussion about the department's Infant Safety Policy that became effective on October 31, 2014. The policy requires the worker to review the Infant Safe Sleep Guidelines with the caregivers, assess the sleep environment, engage the caregiver in creating a safe sleep environment and consult with the supervisor when there are concerns about the caregiver's ability to maintain child safety. Though the policy does not explicitly state that the worker is to observe the sleep environment, the Committee felt that observation of the sleep environment was implicit and necessary to assess the sleep environment. This understanding of the policy was supported by statements from both the Area Administrator and Supervisor who stated it is their expectation that social workers observe where the child is sleeping and document that they have done so. The Committee discussed the importance of engagement when talking to caregivers about safe sleep particularly because caregivers may be given conflicting messages in the media.

In discussing the documentation requirements for CPS investigations, the Committee noted that the Safety Assessments, Present Danger Assessments and Investigative Assessments are separate documents that do not easily lend themselves to a holistic view of the family or provide a clear understanding of the story of the case. The Committee felt that the fragmented design does not necessarily promote critical thinking and the complexity of the process may lead workers to view the forms as a

series of “check boxes” rather than a guide to developing a comprehensive understanding of the case.

In reviewing the February intake, the Committee disagreed with the screening decision and felt that this should have been accepted for investigation. The Committee felt that regardless of the screening decision, the allegations warranted a home visit to assess the safety of the child and a collateral contact to insure that the child’s condition had been addressed.

The Committee discussed the importance of clinical supervision to provide direction and guidance to social workers, particularly with high risk cases where the family has refused services. The Committee believed that strong clinical supervision may have provided the social worker with additional guidance and direction about collateral contacts, corroboration of the parent’s statements and additional techniques for engaging the family and for accessing the home. The Committee heard information that because of staff shortages in the Colfax office, the supervisor carried a caseload and she felt that this negatively impacted her ability to focus on clinical supervision.

### ***Findings***

1. The Committee disagreed with the decision to screen out the February 5, 2015 intake and felt that it met screening criteria for neglect and should have been assigned for investigation.
2. The Committee believed the CPS investigation did not include key elements needed to ensure a thorough assessment of child safety and family functioning. The elements include:
  - a. Subject interviews/child contact: Documentation of the contacts with the parents did not contain sufficient information to assess the allegations or fully explore their functioning as parents. The parent contacts did not include comprehensive interviews regarding the specific allegations nor was it documented if the investigator observed whether or not the child had injuries.
  - b. Collaterals: The Committee noted that this family was involved with multiple service providers throughout the community yet there was little direct contact documented with providers. The Committee felt that this information could have been used to develop a more comprehensive assessment of child functioning and parental capacity.
  - c. Corroborating information was not sought with providers who had ongoing contact with this family. The Committee felt that the parents’ statements about their participation in community services were taken at face value without a critical assessment of their level of engagement.

- d. Though information in the casefile included prior concerns about domestic violence between the parents, this was not assessed or addressed.
3. The Committee felt that the family's refusal to engage in services warranted a reassessment of risk and child safety and consideration should have been given to holding a Family Team Decision-Making Meeting or Shared Planning Meeting.
4. The CA policy on Infant Safety Education and Intervention was not followed.
5. Though supervisory reviews were done consistently and timely, the content lacked critical thinking and clinical supervision.

### ***Recommendations***

1. The Committee recommended that the Area Administrator work with Regional CPS Program staff to identify a mentor for the supervisor to partner with to improve and reinforce clinical supervision skills and to develop a plan for continued staff development and training among staff. The Committee recognized the challenges faced by supervisors in smaller offices who are required to have expertise in all programs and recommended that the mentor be a staff member who is experienced with supervision and understands the challenges of supervising multiple programs.
2. The local office will collaborate with the Alliance for Child Welfare Excellence to ensure that all staff are trained in the appropriate approach to discuss safe sleep with clients and with the local public health department on outreach and education.
3. The Committee recommended that the local office staff and Area Administrator consider cross training of staff to help with case coverage during times of staff shortages. The Committee recognized that the Colfax Office currently has some relatively new staff and this may be a long range goal but the Committee saw a benefit to this for staff.
4. The Committee recommended that CA reevaluate the tools used in the Safety Framework as they are currently designed in order to make the assessment process more cohesive.





## **Child Fatality Review**

**C.T.**

**February 2015**

Date of Child's Birth

**May 25, 2015**

Date of Fatality

**September 24, 2015**

Child Fatality Review Date

### **Committee Members**

Patrick Dowd, Director, Office of the Family and Children's Ombuds

Mary Pagni-Leavitt, Child and Family Welfare Services Program Manager, Children's Administration

Shea Hopfauf, Social and Health Program Consultant Region 2, Children's Administration

Ericka Thompson, Foster Parent, Foster Parent Liaison and Recruiter

Rebecca Taylor, Supervisor, Division of Licensed Resources, Children's Administration

Yolanda Marzest, MSW, Manager of Program Operations, The Alliance for Child Welfare

### **Observer**

Jessica Wright, MSW, Family Assessment and Response Worker, Children's Administration

### **Facilitator**

Libby Stewart, Critical Incident Review Specialist, Department of Social and Health Services, Children's Administration

## ***Executive Summary***

On September 24, 2015, the Department of Social and Health Services (DSHS), Children's Administration (CA) convened a Child Fatality Review (CFR)<sup>23</sup> to assess the department's practice and service delivery to 3-month-old C.T., his family and his foster family.<sup>24</sup> The child will be referenced by his initials, C.T., in this report.

At the time of his death, C.T. and his **RCW 13.50.100** lived with a licensed foster family. The incident initiating this review occurred on May 25, 2015, when C.T. was found unresponsive after being placed on a couch in the foster family's living room. C.T. **RCW 13.50.100** and one other foster child were being cared for by the foster father while the foster mother and their **RCW 13.50.100** were out of the house. The cause of death was classified as Sudden Unknown Infant Death with an undetermined manner of death, per the Thurston County Sheriff's Office investigator's report.

The Review Committee included members selected from diverse disciplines within the community with relevant expertise including a licensed foster parent who is also a liaison between DSHS and other foster parents and a manager with The Alliance for Child Welfare who supervises trainers providing training to new and established foster parents. Other Committee participants included the Office of the Family and Children's Ombuds, a Child and Family Welfare Services program manager with CA, a Division of Licensed Resources supervisor and Social and Health Program Consultant with CA. Also present was an observer who is a Family Assessment and Response worker with CA. Neither CA staff nor any other Committee members had previous involvement with this family.

Prior to the review, each Committee member received a case chronology, a summary of CA involvement with the family and un-redacted CA case documents (e.g., intakes, investigative assessments, home study and case notes). Supplemental sources of information and resource materials were available to the Committee at the time of the review. These included medical reports, law enforcement reports, DLR Minimum Licensing Requirements handbook, timeline of foster care placements, relevant state laws and CA policies.

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<sup>23</sup> Given its limited purpose, a Fatality Review (CFR) should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. The CFR Committee's review is generally limited to documents in the possession of or obtained by DSHS or its contracted service providers. The Committee has no subpoena power or authority to compel attendance and generally only hears from DSHS employees and service providers. It does not hear the points of view of the child's parents and relatives, or of other individuals associated with the child. A Child Fatality Review is not intended to be a fact-finding or forensic inquiry or to replace or supersede investigations by courts, law enforcement agencies or other entities with legal responsibility to investigate or review some or all of the circumstances of a child's near fatal injury. Nor is it the function or purpose of a Child Fatality Review to recommend personnel action against DSHS employees or other individuals.

<sup>24</sup> No criminal charges have been filed relating to the incident and therefore no names are identified. The name of C.T. and his sibling is subject to privacy laws. [Source: [RCW 74.13.500\(1\)\(a\)](#)].

During the course of this review, the Committee interviewed the assigned licenser for the foster family, her supervisor, the placement desk coordinator with CA, the DLR/CPS investigator and his supervisor regarding the fatality, the previously assigned courtesy social worker, the worker who completed the home study for the foster family and the CFWS supervisor assigned to C.T.'s case.

### ***Family Case Summary***

The biological family came to the attention of CA on April 29, 2014, when an intake was received indicating that 2-month old [RCW 13.50.100] was alleged to have [RCW 70.02.020] while in the care of the parents [RCW 13.50.100]. [RCW 13.50.100] was placed in out-of-home care and a dependency petition was filed. [RCW 13.50.100] required [RCW 70.02.020] based on her injuries. [RCW 13.50.100]'s case was assigned in Mason County.

On February 11, 2015, an intake was received from a Lewis County hospital stating C.T. had been born. C.T.'s mother told hospital staff she had no prenatal care [RCW 13.50.100]. This intake was assigned to the Centralia office for a Risk Only investigation.<sup>25</sup> A decision was made during a staffing between two Area Administrators and a Program Consultant to override the assignment made by intake. The Centralia office did not conduct a new investigation but did file a dependency petition. The petition was based on the parent's failure to correct the deficiencies that led to the harm [RCW 13.50.100].

C.T. was discharged to a foster family in Thurston County. That same foster family took placement of [RCW 13.50.100] 5 days later. A relative home study was in process. The children were placed in Thurston County but the case assignments were in Lewis and Mason Counties. A courtesy supervision worker out of Thurston County was assigned to conduct the monthly health and safety visits. On April 21, 2015, the courtesy supervision worker questioned the number of children in the home. The foster family was licensed for two children under the age of 2 years. However, there were four children under the age of 2 years in the home. Of the four children, three were [RCW 13.50.100] and one was the [RCW 13.50.100] of the foster parents. The courtesy supervision worker who observed this overcapacity discussed it with the placement desk coordinator and noted it in her monthly health and safety visit case note. All of the health and safety visits were conducted with the foster mother only.

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<sup>25</sup> Risk Only Intakes :CA will screen in a CPS Risk Only intake when information collected gives reasonable cause to believe that risk or safety factors exist that place the child at imminent risk of serious harm. In assessing imminent risk of serious harm, the overriding concern is a child's immediate safety. Imminent is defined as having the potential to occur at any moment, or that there is a substantial likelihood that harm will be experienced. Risk of Serious harm is defined as: A high likelihood of a child being abused or experiencing negligent treatment or maltreatment that could result in one or more of the following outcomes: death; life endangering illness; injury requiring medical attention; substantial risk of injury to the physical, emotional, and/or cognitive development of a child. [Source: [CA Practices and Procedures Guide 2220](#)]

### ***Foster Family Summary***

The home study regarding the foster family was approved on March 20, 2013. The home study was approved for one child under the age of 2 years. Basic training requirements had been met for that specific age range. On December 27, 2013, the foster care license was increased to two children under the age of 2 years. There were multiple incidents of overcapacity prior to and after the increase to the foster license.

On April 21, 2015, the assigned DLR licensor spoke with the foster mother regarding the overcapacity of four children under the age of 2 years in the home. A staffing occurred between DCFS and DLR that resulted in an agreement for a 30-day approval for an overcapacity while placement was located for C.T. and **RCW 13.50.100**. A supervision plan was agreed to between the foster mother and licensor. The plan stated two adults would be in the home at all times when there are more than two children under the age of 2 years in the home.

On May 25, 2015, C.T. passed away in the foster home while under the care of the foster father. That same day investigations were initiated by DLR/CPS, DCFS/CPS and law enforcement and all children were removed from the foster home. The investigations resulted in unfounded findings for abuse or neglect to all children and no criminal charges were filed.

### ***Committee Discussion***

For purposes of this review, the Committee focused on case activity from the day C.T. was born up until the day of the fatality. The investigation of C.T.'s death was briefly discussed as was the initial case plan regarding the foster family and removal of their **RCW 13.50.100**.

This case highlighted the struggle that foster families face in situations involving critical incidents or when a child moves from their home after a long-term placement. These situations can impact the children of the foster family as well. The Committee discussed the need for a clear, concise and consistent path for obtaining support through the department.

The Committee discussed at length areas where CA could have improved collaboration and critical thinking. These were highlighted by discussions surrounding courtesy supervision workers, their roles and expectations as well as their inclusion in case and/or safety planning. The Committee emphasized the need for collaboration with all assigned staff to include licensors, primary and courtesy supervision workers. The lack of collaboration diminishes the likelihood of comprehensive critical thinking regarding suitable placements and overall safety for children in out-of-home care.

During the staff interviews, the Committee was repeatedly informed of the shortage of available foster homes. Staff discussed the struggles they have to find timely and

appropriate placements based on the specific needs of children. This was balanced with discussion regarding the need for DLR's input prior to an overcapacity placement being made due to the shortage of openings. Prior engagement of DLR was believed to allow more structured critical thinking to combat the pressures inherently present for placement coordinators and assigned social workers. Collaboration between DCFS and DLR staff was thought to strengthen safe and suitable placements. The Committee also discussed the challenges posed for recruitment and retention of appropriate licensed foster homes as well.

### ***Findings***

The Committee discussed areas where a stronger emphasis on critical thinking and collaboration may have assisted in alternative case practice and service delivery to C.T., **RCW 13.50.100** family and the foster family. Those discussions are highlighted in this section.

The Committee believed the intake dated February 2015 regarding the birth of C.T. warranted a new CPS investigation. The mother gave birth to C.T. in a county other than the originating case, the parents were not involved in services with DCFS due to the pending **RCW 13.50.100** and a new assessment of the current circumstances would have been appropriate.

The placement made on March 28, 2013 with C.T.'s foster family was not appropriate based on the foster parent's lack of training necessary to provide effective care to a child with **RCW 13.50.100** specific needs. This placement occurred prior to consultation with the DLR licensor. There were multiple incidents of overcapacity based on the age and number of children placed within this foster home. The record did not reflect consultation or approval from the DLR licensor regarding the majority of these incidents. The supervision plan created in April of 2015 was inadequate and unrealistic. The plan did not provide clear details, all participants were not included in the discussion and ultimately the plan was never delivered to and signed by the licensed providers. While the Committee understood that at the time of each placement the parties involved believed they were making appropriate child centered decisions, the number of children in the home was at an unrealistic level for adequate care.

The Committee also noted several positive actions during this review. When the foster family was first licensed, the licensor utilized critical thinking and appropriately assessed that the foster parents should only handle one child under 2 years of age. The Committee also noted thorough and clearly documented critical thinking regarding the DLR/CPS investigation related to C.T.'s death.

During the health and safety visit on February 20, 2015, the CFWS supervisor for C.T. and the courtesy supervision worker for both C.T. and **RCW 13.50.100** conducted a joint visit

at the foster home. During this visit, the CFWS supervisor not only discussed safe sleep but also took immediate actions to remediate the unsafe sleeping arrangements in the home. On May 6, 2015, the courtesy supervision worker also took immediate actions to remove a blanket the foster mother had placed over C.T.'s face while the child slept in a swing, once again educating the foster mother about safe sleep.

### ***Recommendations***

**CA DLR Specific:** DLR should create a form for the licensed provider to sign stating each person applying for a home study has reviewed and understands the Period of Purple Crying and safe sleep instructions. This form must be signed and dated by each person included in the home study/license. DLR should also reconsider the training hours and how they are required per license. The Committee believes each person on a license should receive training at some point during the time they are licensed.

**CA DCFS:** CA should identify a concise, clear path for who should share information with out-of-home care providers regarding supportive services, such as grief and loss counseling, and have a clear and consistent way for the payments to occur even if there are no children placed in the home.

The Committee identified consistent overcapacity situations occurring with this specific foster family and a failure to engage DLR prior to those decisions occurring. This led to the Committee's recommendation that if an overcapacity is considered during business hours, DLR and all assigned social workers (i.e. primary, courtesy supervision, licensor, etc.) must be consulted prior to the placement occurring. If the placement occurs afterhours, DLR and all assigned social workers must be consulted and provide approval for ongoing placement by the end of the following business day.

When a child in an out-of-home placement is adopted, CA should have a mechanism to update the member tab. This mechanism needs to ensure that the appropriate household composition is reflected on the member page. This will aid in decreasing erroneous overcapacity situations.