Washington State Department of Social & Health Services

CA Children's Administration

Child Fatality Review

A.G.

January 2009
Date of Child's Birth

June 16, 2013
Date of Fatality

October 2, 2013
Child Fatality Review Date

Committee Members

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RCW 74.13.640

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Executive Summary

On October 2, 2013, Children's Administration (CA) convened a Child Fatality Review[1] (CFR) Committee to examine the practice and service delivery in the case involving a four-year-old multi-racial (Native American, African American, Caucasian) Hispanic male child and his family.[2] The child will be referenced by his initials, A.G., in this report. At the time of his death, A.G. shared a home with his adoptive mother, his twelve-year-old adoptive sibling and the man with whom A.G.'s mother maintained a personal relationship. The identity of A.G.'s biological father is unknown.

The incident initiating this review occurred on June 15, 2013, when A.G. was found alone and unresponsive in a swimming pool located in the apartment complex where A.G. lived with his family. After being called to the scene, emergency medical personnel transported A.G. to a local hospital where his heartbeat was restored. Still in grave condition, A.G. was then air-lifted to a regional hospital where he was pronounced dead the following day.

When a child dies from alleged child abuse or neglect and the child's family had received services from Children's Administration within a year of the child's death, Washington state law requires CA to conduct a CFR. The review is conducted by a team of CA staff and community members with relevant expertise from diverse disciplines. Neither CA staff nor any other committee members had previous direct involvement with the case.

In addition to the participants present at the review, the Choctaw Nation of Oklahoma, the tribe in which A.G. was eligible for membership, was invited by Children's Administration to select a representative to participate in this review. A response to the invitation was not received.

Prior to the review, each committee member received a chronology of known case information, and un-redacted CA case-related documents. Additional documents were made available to the Committee at the time of the review.

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[1] Given its limited purpose, a Child Fatality Review (CFR) should not be construed to be a final or comprehensive review of all of the circumstances surrounding the 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 or 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.

[2] A.G.'s caregivers are not named in this report because they were not charged in an accusatory instrument with committing a crime related to a report maintained by the department in its case management information system.[Source-Revised Code of Washington 74.13.500(1)(a)]

These included medical and law enforcement reports and copies of relevant CA policies and practice guides.

During the course of the review, the CFR Committee members interviewed the CA social worker most recently involved with the case prior to A.G.'s death. Following review of the case file documents, interviews and discussion regarding social work activities and decisions, the Review Committee made findings and recommendations, which are detailed at the end of this report.

Case Overview

Children's Administration's involvement with this family began on May 26, 2012 when a police officer contacted Child Protective Services (CPS) to report A.G. had been found walking alone on a city street early on a weekend morning. The police found it difficult to communicate with A.G. because he had limited language skills. After attempting to locate A.G.'s family for about 45 minutes, the police officer contacted CPS. Arrangements were made for a CPS social worker providing emergency weekend coverage to meet A.G. and the police officer at the local police station. A short time later, A.G.'s mother contacted the police to report her son was missing. The mother reported she had slept-in following a late night of studying. After waking up and discovering A.G. was missing, she called 911 and began searching for her son. After talking with the mother and assessing the family's home to be safe, the police officer released A.G. to the care of his mother. Both the police officer and CPS social worker spoke with A.G.'s mother about the seriousness of the situation and recommended installing child safety locks to prevent another incident of A.G. wandering away from home. After the emergency social worker and police officer addressed the immediate concerns about A.G.'s safety, an ongoing investigative CPS social worker was assigned to the case to continue the investigation of alleged neglect.

On May 31, 2012, an investigative CPS social worker documented conducting a home visit with A.G. and his mother. The social worker confirmed that the family had installed safety devices on the doors in their home. No safety concerns were identified by the social worker during the visit. The social worker noted A.G.'s limited language skills and learned from this mother that A.G. had delayed language development for which he had previously received speech therapy. The social worker also learned A.G. had been adopted in another state by his maternal aunt following the death of his biological mother. The family had only

recently moved to Washington. The CPS investigation was closed on July 25, 2012 as unfounded[3] for negligent[4] treatment of a child.

The department became involved with A.G. and his family a second time on September 14, 2012 when the police again contacted CPS to report A.G. was found wandering alone near a motel. The manager of the motel did not recognize A.G. as being a guest of the motel and called the police. The police attempted to locate A.G.'s family for approximately two hours before transporting A.G. to the police station. The search continued for an additional forty minutes until A.G.'s mother and her boyfriend arrived at the police station. They explained they had recently moved to the motel where A.G. had been found wandering. After conducting an inspection of the family's room at the motel, the police left A.G. in their care. The police also contacted CPS to report a new allegation of child neglect.

The CPS investigation was initiated with a home visit on September 17, 2012. The social worker and A.G.'s mother discussed the allegations of neglect and identified ways to prevent further incidents of A.G. wandering away from home. The social worker developed an in-home safety plan[5] with A.G.'s caregivers. They agreed to install child safety devices, attend a parenting class and maintain "line of sight" supervision of A.G.

The social worker documented an attempted home visit about a week later but found no one at home. On the same day, the social worker contacted A.G.'s daycare provider and the manager of the motel where the family was living. Both reported no concerns about the ability of A.G.'s mother or her boyfriend to safely care for A.G. On September 28, 2012, the social worker documented speaking with A.G.'s mother to confirm child safety devices had been installed in the home. On October 8, 2012, the social worker completed a referral and authorized payment for A.G.'s mother to participate in a parenting skills program provided by a community agency. On October 29, 2012, the CPS investigation was

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

[4] Negligent treatment or maltreatment means an act or a failure to act, or the cumulative effects of a pattern of conduct, behavior, or inaction, that evidences a serious disregard of consequences of such magnitude as to constitute a clear and present danger to a child's health, welfare, or safety, including but not limited to conduct prohibited under RCW 9A.42.100.

[5] The Safety Plan is a written agreement between a family and CA that identifies how safety threats to a child will be immediately controlled and managed. The Safety Plan is implemented and active as long as threats to child safety exist and caregiver protective capacities are insufficient to protect the child.

completed. The social worker determined the allegation of negligent treatment by A.G.'s mother and her boyfriend was founded.[6]

On June 15, 2013, the department was notified by a hospital social worker of A.G.'s hospitalization following a near-drowning incident. A.G. was found alone and unresponsive in a pool by his mother's boyfriend. The boyfriend lifted A.G. from the pool and carried him back to the apartment while calling for help and performing resuscitation efforts. Emergency response personnel transported A.G. to a local hospital where his heartbeat was restored with shock treatment. The prognosis for survival was poor when A.G. was airlifted to a regional hospital for continued medical care. On June 16, 2013, medical testing determined A.G. had no brain activity.

Life support was discontinued and A.G. was pronounced dead. The medical examiner determined accidental drowning as the cause of death.

During the subsequent CPS and law enforcement investigations, the family reported they had recently moved to an apartment located in a complex with two swimming pools. On the day of incident, A.G. was in the care of his mother's boyfriend while his mother and sister were away from the home. After A.G. left the family's apartment without adult supervision, he opened an unlocked door serving as a gate to one of the pools. He then removed his clothing and shoes and entered the water. No criminal charges were filed. The CPS case was closed on August 15, 2013 with a determination of unfounded for alleged negligent treatment by A.G.'s mother and her boyfriend.

Committee Discussion

The Committee's discussion included a number of the department's responses to the needs of this family to help identify areas for system improvement. One focus of discussion was how in-depth information gathering from a variety of sources is imperative to fully and accurately assessing a family's needs. The Committee discussed how social workers use the information gathered during an investigation to complete Structured Decision Making Tool (SDM®)[7]during a CPS investigation and how the results of the tool impact case planning.

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

[7] SDM® is a structured assessment that includes 18 specific questions with detailed definitions that result in a scored risk classification. The SDM® risk assessment helps identify families who are most likely to experience child abuse or neglect. DCFS investigators use the SDM® in combination with the safety assessment to assess immediate danger to children and help determine whether CA should provide and monitor ongoing services to a family following a CA/N investigation

The Committee discussed how information about family functioning and child safety might be obtained from interviews with other children (not identified as alleged victims) living in the same home as an identified victim. The Committee questioned why there was no documented attempt to interview A.G.'s older sibling during the two CPS investigations. The Committee suggested it would have been best practice to contact the sibling during the investigations even after the sibling moved to the home of a parent in another state.

The Committee noted A.G. was often supervised by his mother's boyfriend and questioned if the department fully assessed his ability to safely care for A.G. A discussion of the department policies regarding accessing criminal history during a CPS investigation was prompted by the Committee reviewing case documentation indicating A.G.'s mother reported her boyfriend had been convicted of several serious crimes.

The Committee noted A.G.'s family demonstrated a number of strengths while interacting with law enforcement officers, child care staff and the involved social workers. The Committee discussed if the presentation of A.G.'s mother as cooperative and hard-working and the evident family strengths influenced the ability of the social workers to objectively assess the family's ability to safely care for A.G.

Case documentation indicated involved staff were aware that A.G. was not receiving developmental services to address his speech and communication delays and may have been in need of routine medical and dental care. The Committee discussed two social work approaches to obtaining services for the child: direct access of services by the social worker or engaging the parent to access the service on behalf of his/her child. If the latter approach is used, the Committee believes the social worker should independently verify the service was actually obtained.

The Committee noted the safety plan indicated A.G.'s mother was to attend a parenting-skills program paid for by the department. Upon learning the mother completed only two sessions of the twelve-session program, the Committee questioned the decision to close the CPS investigation prior to verifying the mother 's participation in an activity related to a safety plan.

The Committee reviewed the three investigative findings associated with this case. The Committee discussed why the findings differed despite very similar allegations involving the same family members. While outside of the primary

purpose of this review, the Committee strongly disagreed with the investigative finding of unfounded following the investigation of A.G.'s death.

Findings

1. The Committee supports the findings resulting from the CPS investigations in May and September of 2012.
2. The Committee believes sufficient information gathering did not occur for a comprehensive assessment of all children and adults living in A.G's household and the safety of a young and vulnerable child may have been overlooked during the course of the CPS investigations.
3. The Committee finds the involved staff did not take sufficient action to ensure A.G. received services to address his well-being needs. Related to this finding was the Committee's concern that A.G.'s medical records were not obtained during the course of the CPS investigation. The Committee suggests information in the medical records may have been helpful for case planning.
4. The Committee noted some case documentation occurred outside of the timelines established by departmental policy. Additionally, the Committee was concerned an involved social worker reported a home visit conducted specifically to confirm the family's compliance with the safety plan was not documented.[8]
5. Prior to closing the CPS investigation in October 2012, the Committee believes the department should have confirmed A.G.'s mother's participation in the voluntary parenting service.

Recommendations

1. The Committee recommends the CPS supervisors working in the Children's Administration office where this case was assigned receive additional training on how to guide CPS social workers in gathering information about the subjects of CPS investigations and how to fully utilize the Structured Decision Making® tool in case planning.
2. When a CPS investigation is conducted in cases involving a child fatality resulting from suspected child abuse or neglect, the Committee recommends the investigation be conducted by CPS staff from an office with no prior involvement with the child or the child's family.

[8] FamLink Documentation Timeframes represent the maximum time from when the work is completed until the documentation of that work must be completed in FamLink. All visits must be documented in a case notes within 3 calendar days

3. Currently, CA policy[9] provides CPS social workers with discretion in deciding when to access the National Crime Information Center (NCIC) database for subjects of CPS investigations and other adults related to an investigation. The Committee recommends, if permissible by law, a change in policy to require social workers to access the National Crime Information Center (NCIC) database during the course of a CPS investigation.

[9] CA is authorized to access the NCIC database for subjects of CPS investigations and other adults related to the investigations. The Purpose Code C check allows the social worker to assess the safety of children in the home and the safety of CA staff conducting the investigation. Requests for NCIC checks for CPS investigations are made in accordance with state and federal laws. (RCW 26.44.030 and PL 109-248). Purpose Code C checks are based on name and date-of-birth information and are a point in time check. Purpose Code C checks are not required and are completed at the discretion of the investigating social worker. [Source-Children's Administration 's Operations Manual 5518]