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

Child Fatality Review

A.O.

December 2010
Date of Child's Birth

August 18, 2015
Date of Fatality

December 3, 2015
Child Fatality Review Date

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Executive Summary

On December 3, 2015, The Department of Social and Health Services Children's Administration (CA) convened a Child Fatality Review[1] (CFR) to examine the department's practice and services delivery to four-year-old A.O.[2] and her family. The incident initiating this review occurred on August 18, 2015 when the motor home in which A.O. and her mother were living caught fire. This motor home is located on the property of the deceased child's grandmother in RCW 13.50.100, Washington. At the time of the fatality, CA had an open Child Protective Services (CPS) investigation on this family. A.O. has two siblings who were not involved in the fire and a half-sibling, RCW 13.50., who lives with her father and who was not part of this investigation.

The CFR committee included members selected from disciplines within the community with relevant expertise including representatives from law enforcement, community mental health and chemical dependency treatment, public health, child welfare, the Office of the Family and Children's Ombuds and Children's Administration. Neither CA staff nor any committee members had previous direct involvement with the case management.

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 and assessments, police reports and evaluations. Supplemental sources of information and resource material regarding caseload data and CA policies were available to the committee at the time of the review.

The Committee interviewed the CPS supervisor and investigator who were assigned to the case at the time of the fatality as well as the CPS supervisors who supervised the case in 2014 and after the fire in August 2015. Following a review of the case file documents, interviews with CA staff and discussion regarding

[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 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 I the function or purpose of a Child Fatality Review to recommend personnel action against DSHS employees or other individuals.

[2] A.O.'s parents are not identified by name in this report because they have not been charged in an accusatory instrument with committing a crime related to a report maintained by the department in its case management and information system. The names of A.O.'s siblings are subject to privacy law. [Source: RCW 74.13.500(1)(a)]

department activities and decisions, the Committee made findings and recommendations which are detailed at the end of this report.

Case Summary

This family's history with CA began in 2002 after CA received a report that alleged neglect of RCW 13.50.100 oldest child. CA received three additional intakes between 2005 and 2009; in 2007 a dependency was initiated on RCW 13.50.100 oldest daughter, RCW 13.50., after RCW 13.50. was RCW 10.97.050 The dependency was dismissed when RCW 13.50.100 father obtained custody. In 2009, RCW 13.50.10 engaged in voluntary services with the department to address substance abuse and parenting skills issues. From 2012 until 2014, CA received six intakes regarding RCW 13.5., A.O. and RCW 13.5. alleging substance abuse, lack of supervision and unsanitary living conditions. CA investigators made several attempts to engage RCW 13.50.10 in services throughout this period but she declined to participate. The case was staffed with an Assistant Attorney General (AAG) during this period but no legal action was initiated.

In June 2014, CA received an intake from a citizen who found A.O. and RCW 13.50. walking alone along US Highway 2 near Elk, Washington attempting to flag down cars. The CPS investigator visited the home to discuss the lack of supervision and was told by RCW 13.50. that this was an isolated event. The investigator offered RCW 13.50.10 assistance to obtain housing but the mother declined help and soon moved to the grandmother's home in RCW 13.50.100 where she reported sleeping in a motor home in the yard. A decision was made to close the case but prior to closure CA received another intake from law enforcement alleging lack of supervision of RCW 13.50. and A.O. Specifically, law enforcement received a complaint on September 29, 2014 that RCW 13.50. and her older children were seen at local car racetrack. RCW 13.50.10 appeared to be passed out and her children were unsupervised and had nearly been struck by cars in the pit area of the track. Police responded to the complaint, RCW 10.97.050 and released A.O. and RCW 13.5. to a family friend. When the CPS investigator made contact with RCW 13.50., she denied being under the influence or that her children were in danger. She agreed to do a urinalysis but failed to appear for the appointment. The case was staffed with an AAG but no legal action was initiated.

The case remained closed until June 9, 2015 when a family friend reported RCW 13.50. had left her children with their aunt and grandmother for the past six months and further reported that the grandmother was a hoarder whose residence was not safe for young children. The referrer reported that the grandmother had left the youngest child, 18-month-old RCW 13.50, in the referrer's care after the child had received two black eyes due to unsafe conditions in the grandmother's home.

The referrer said that she did not have the financial means to take care of the child or the authority to seek medical care. This intake was initially assigned as a Family Assessment Response (FAR)[3] CPS case but in an initial case staffing the assigned worker and supervisor concurred that the mother's history of resistance to CA intervention did not make this an appropriate case for the FAR program. Consequently, the case was assigned as an investigative case.

Because the assigned investigator was on annual leave, a co-worker made the initial contact with RCW 13.5[redacted]. at the referrer's home on June 11, 2015. Though the child no longer had visible injuries, credible witnesses reported that a month earlier RCW 13.5[redacted] had two black eyes. The following evening an afterhours social worker made an initial visit to the grandmother's home, saw the other children and documented concerns about safety both inside and outside of the house. The grandmother and aunt presented themselves to the social worker as the children's primary caregivers and said they had regular contact with RCW 13.50.10[redacted]

The assigned investigator held a Family Team Decision-Making Meeting[4] (FTDM) on June 17, 2015 to develop a case plan and help assess the family's situation. The grandmother and aunt participated by phone, as did A.O.'s father. The mother did not attend. During the meeting a plan was developed that stated the social worker would assess the conditions in the grandmother's home and the relatives were to complete background checks, take the children to their doctor and supervise them when out of doors.

The day after the FTDM the CPS investigator attempted to assess the grandmother's residence but was met at the driveway by the grandmother and aunt. The grandmother stated that she didn't want to work with CA to make the home safe so she, the aunt and children had moved to a neighbor's home. The investigator observed the neighbor's home and found no safety hazards. The investigator left the residence with the understanding that the relatives and all three children would remain at the neighbor's house and they would complete criminal background checks with the department. Over the next month, the investigator made several unsuccessful attempts to locate the mother through letters and phone calls.

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[3] Family Assessment Response (FAR), is a Child Protective Services response to a screened-in allegation of abuse or neglect that focuses on the integrity and preservation of the family when less severe allegations of child maltreatment have been reported. Parental engagement and collaboration with CA are essential to the FAR pathway. [Source: CA Practices and Procedures Guide 2332]

[4] 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 Practices and Procedures Guide 1720]

On August 21, 2015, local media reported that A.O. and her mother had died in a fire at the motor home on the grandmother's property. Both mother and child had been sleeping in the motor home when it caught fire, killing them both. RCW 13.50.100 other children were reportedly inside the grandmother's house at the time and were not injured. The department filed a motion to take the surviving children into protective custody and on September 4, 2015 the aunt turned them over to law enforcement. Law enforcement placed the children into care. RCW 13.50 is now in RCW 13.1 father's custody and RCW 13.50 is in foster care.

Committee Discussion

The majority of Committee discussion centered on CA case activities and decision making that occurred during the investigations in 2014 and 2015. Some discussion occurred as to earlier CA involvement in order to understand the case history and earlier efforts by the department to engage the mother in services. At the completion of the review of the case file documents, staff interviews and discussions regarding CA activities and decisions, the Committee found no critical errors by the department. However, the Committee did identify opportunities where additional reasonable actions by the social worker might have served to enhance the assessment of child safety.

The Committee noted several areas of strength. Committee members felt that the decision to assign the case to CPS investigation rather than CPS-FAR demonstrated good practice and a sound recognition that the more collaborative approach with a CPS-FAR case was not appropriate for this situation. The Committee commended the worker for insisting on assessing the conditions of the grandmother's home herself as well as her recognition of the need to assess the physical conditions in the neighbor's home and request background checks. The Committee also noted that the case notes were well written and easy to follow.

Some initial discussion occurred about CA protocol regarding collaboration with law enforcement on investigations of alleged child abuse and neglect. Though the expectation of notice to law enforcement is clear in cases of alleged physical abuse and sexual abuse, CA staff seemed unaware of the possibility of collaboration with law enforcement in cases of chronic neglect. The Committee noted that it may be helpful to involve law enforcement in investigations when there is a pattern of chronic neglect and this is included as a practice recommendation at the end of this report.

The Committee spent some time discussing the Child Safety Framework,[5] which requires the social worker to gather comprehensive information about family functioning in order to assess safety and risk. As a systems issue, the Committee believed there is additional need for training and clarification about the worker's responsibility when they are faced with complex family arrangements and multiple caregivers in a household. For example, the June 2015 intake identified the mother as the caregiver and subject of the investigation. However, the relatives' statement that they had been the primary caregivers for the children for several months may have given rise to a need to evaluate the relatives' parental capacities in addition to the mother's for the purpose of more comprehensively assessing child safety. The Committee believed that the June 2015 intake raised questions about the relative's judgment after they left RCW 13.[redacted]., who was injured at the time, in the care of someone who did not have the means or legal authority to fully provide for or seek medical treatment for this child.

The Committee recognized that this was a complex case with multiple caregivers, multiple parents, and several prior interventions by the department. Because of the complexity of the case, the Committee believed that the social worker may have benefitted from gathering additional information from collateral sources as well as the historic CA file in order to gain insight into family functioning and possibly to gain insight that could help assess the relatives' capacity to protect the children. The Committee recognized that the relatives professed a willingness to reside at a neighbor's home to ensure the children were safe but felt that this temporary arrangement did not effectively alter the family dynamics or provide any protection for the children from their mother if and when she resumed her parental role. The Committee believed that best practice would be to fully assess the relatives' protective capacity and formalize the arrangement to clearly state the department's expectation that they were to remain in the neighbor's home and supervise contact with the mother until more information was gathered to assess the situation.

The Committee expressed concern about several systems issues that arose during the discussion. Specifically, they learned that this unit is generally assigned to CPS-FAR cases and that they were handling this case to assist the CPS investigations unit, which was experiencing a staff shortage. As a result, this complex case was assigned a worker with relatively little experience conducting CPS investigations. The Committee appreciated the teamwork in sharing

[5] In partnership with the National Resource Center for Child Protective Services (NRCCPS), Washington State Children's Administration implemented the Child Safety Framework in November 2011. A key concept of this model is that the scope of child welfare work is not defined by determining the presence or absence of injuries or incidents, but rather in identifying present or impending safety threats, and working with families to mitigate those threats.

workload among units to meet the department's mission. However, it also acknowledged that not every worker is an expert in every program and when a worker is assigned to a case that is out of his or her primary area, there is an increased need for strong clinical supervision to provide the social worker with expertise to help ensure the thoroughness of investigations.

Findings

1. Child Safety Framework: The Committee believes that insufficient information was gathered to do a comprehensive assessment of child safety. The investigation appeared to be incident-focused and did not include a comprehensive assessment of all children and adults in the household.
    a. The Committee could not find documentation that comprehensive interviews occurred with the children and the adult caregivers regarding the specific allegations, the family dynamics or the cause of the youngest child's injuries.
    b. The Committee believed that given the potential seriousness of the youngest child's injuries, a medical assessment was warranted. Though the relatives were asked to take all the children for well-child exams, CA did not follow through to ensure this had occurred or seek information from medical providers to specifically assess this child for injury.
    c. The Committee believed there were missed opportunities to gather and document additional information from collateral sources such as local police reports, TANF records and historic reports in the family file.
    d. The Committee felt that the plan developed at the FTDM could have enhanced child safety by including provisions for ongoing monitoring and re-evaluation of the family's compliance with the plan.
2. Health and Safety Visits: The children in the household did not receive private, individual, face-to-face health and safety visits every calendar month as is required when the case has been open beyond 45 days.
3. Supervision: Though monthly supervisory reviews were documented as having occurred regularly and timely, the content lacked clinical direction to provide guidance, critical thinking and feedback to ensure a thorough and timely investigation of the allegations.

Recommendations

1. The Committee recommended that the department continue to provide training on the Child Safety Framework specifically aimed at assessing

child safety. The Committee identified the need for training on the mechanics of childhood injuries, the importance of gathering information throughout the life of a case and guidance about how to assess caregivers when there are multiple adults in a caregiving role in the household.

2. Noting that one of the challenges in this case was that the relatives did not cooperate with efforts to conduct background checks, the Committee recommended that the department expand worker access to databases like LexisNexis so that more workers can use this to assess caregivers in cases where program restrictions do not allow access to NCIC.[6]
3. In cases where there is extensive history indicating neglect, the Committee recommended that CA consider collaborating with local law enforcement for consideration of criminal charges of child neglect.
4. The Committee recommended that this unit receive training on how to access historic CA case information in MODIS.[7] Note: Action has already been taken on this identified training need for this unit.

[6] The National Crime Information Center (NCIC) database is a name and date-of-birth based national database of criminal history information operated by the Federal Bureau of Investigation (FBI). Children's Administration is authorized to access this database only for limited purposes: to ensure worker and child safety in CPS investigations, and for emergency placement in out-of-home care.

[7] Management Operation Document Imaging System (MODIS) is CA's electronic archival storage system. All closed cases are uploaded to MODIS and available to workers.