Washington State Department of Social & Health Services

CA Children's Administration

Department of Social and Health Services
Children's Administration
Child Fatality Review

C.C.

July 2009
Date of Child's Birth

November 29, 2012
Date of Fatality Incident

March 15, 2013
Child Fatality Review Date

Committee Members:

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RCW 74.13.640

Table of Contents

Executive Summary

On March 15, 2013, the Department of Social and Health Services (DSHS), Children's Administration (CA) convened a Child Fatality Review (CFR)[1] to examine the practice and service delivery in the case involving a three-year-old male named C.C. and his family. The incident initiating this review occurred on November 29, 2012, when the Spokane Police Department received a 911 call from C.C.'s mother reporting her son was not breathing. The responding emergency personnel were unsuccessful in their attempts to revive C.C. The Spokane County Medical Examiner later certified C.C.'s cause of death as undetermined. The Medical Examiner reported that there was no identifiable cause of death following the death scene investigation, review of medical records, autopsy examination, toxicology, and laboratory studies.

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

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

During the course of the review, the CFR Committee members interviewed the Child Protection Services Social Worker and Supervisor assigned to investigate the fatality. The CFR Committee also interviewed an Intake Supervisor associated with the case.

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

Case Overview

C.C. was the youngest son of his mother's two children. C.C.'s father was not residing in the family home at the time of the fatality. The incident initiating this review occurred on November 29, 2012, when C.C. was discovered not breathing in his bed. C.C. resided

[1] 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.

with his mother, 15-year-old brother, mother's boyfriend, D.D., and D.D.'s 16-year-old son.

D.D. first came to the attention of Children's Administration (CA) in January 1994. D.D.'s CPS history includes five founded findings[2] for physical abuse[3] between 1994 and 2002. In early 2012, D.D. began a relationship with C.C's mother. CA has received twenty-seven intakes regarding children residing in the same home as D.D.

C.C.'s mother first came to the attention of CA on July 27, 2012. A TANF worker[4] reported the following concerns to intake after meeting with the mother at the local Community Services Office: The mother was "animated" and "hysterical" and had a strong odor of marijuana. The family was homeless, but reported to be staying with a male friend. The mother said she was unable to adequately feed or care for C.C. The mother stated her children "may be better off in foster care." This intake screened in for alternate intervention.[5]

On November 28, 2012, CA received a phone call from a neighbor. The referrer expressed concern that C.C's mother left him in the care of the teenage boys living in the home. The referrer reported the boys had previously held C.C. over the side of the balcony by his hands and left C.C. alone. The referrer also reported C.C. had bruises all of the time and the parents reportedly were dealing drugs and smoking marijuana. D.D. and his 16-year-old son reportedly got into arguments resulting in physical fights. The 16-year-old reportedly punches holes in the wall of the residence. The case screened in[6] for investigation.

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

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[2] **CA findings** are based on a preponderance of the evidence. Child Abuse or Neglect is defined in RCW 26.44, WAC 388-15-009, and WAC 388-15-011. Findings are determined when the investigation is complete. **Founded** means the determination that, following an investigation by CPS, based on available information: it is more likely than not that child abuse or neglect did occur. **Unfounded** means the determination that, following an investigation by CPS, based on available information: it is more likely than not that child abuse or neglect did not occur, or there is insufficient evidence for the Department to determine whether the alleged child abuse did or did not occur.

[3] **Abuse--**Washington state law defines abuse or neglect as "sexual abuse, sexual exploitation, or injury of a child by any person under circumstances which cause harm to the child's health, welfare, or safety, or the negligent treatment or maltreatment of a child by a person responsible for or providing care to the child. Source: RCW 26.44.02

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

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

[6] **Screen In**—CA screens in for investigation all allegations that meet the definition of child abuse or neglect as defined by RCW 26.44.020

Discussion

The Committee spent considerable time discussing the investigation and events after the fatality due to the limited recent CA activity prior to the fatality. The Committee discussed the household members' CPS history and the impacts of system changes on data retention. The Committee noted D.D. has five founded findings going back to 1994; however, social worker documentation in the case file frequently erroneously identified D.D. as only having one prior founded finding. The Committee explored the reasons why social workers failed to locate all five founded findings. The Committee noted CA's change from a paper system, to CAMIS,[7] and eventually to FamLink[8] resulted in various methods of locating client history including founded findings. D.D.'s founded findings are from 1994, 1995, 1996, 1998 and 2002. D.D.'s first two founded findings can be located in a review of MODIS[9] records. Neither of the first two founded findings can be located in FamLink. D.D.'s second two founded findings can be located in FamLink. However, the second two founded findings were difficult to locate due to their location under the historical summary assessments hyperlink and not under the investigative assessments hyperlink, as is current practice. The final founded finding is easily located through the investigation hyperlink in FamLink.

It should be noted that there was no due process associated with founded findings of abuse or neglect prior to the enactment of the Child Abuse Prevention and Treatment Act (CAPTA) in 1998.[10] Founded findings prior to 1998 are not considered conclusive in a CPS investigation and are not considered reliable because of the lack of due process. Additionally, the social worker had no opportunity to review D.D.'s findings, as the case was open for only a few hours prior to the fatality.

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

The Committee believed Washington state children would benefit from continued efforts by CA to educate the community about child abuse. The Committee noted that neighbors had witnessed bruising on C.C. and witnessed the teenagers holding C.C. over the edge of a balcony, but there was a delay in the reporting of those concerns. The Committee believed CA's ability to protect children is limited to the information

[7] **CAMIS** is an automated system which stores data regarding intakes, placement, case activity, contracts, licensing, and other case-specific information related to CA. CAMIS was the case management system for CA from the early 1990s to February 1, 2009.
[8] **FamLink** is the name of CA's Statewide Automated Child Welfare Information System (SACWIS) that replaced CAMIS.
[9] **MODIS** is a web based system used by DSHS for storing and viewing imaged documents.
[10] The Child Abuse Prevention and Treatment Act (Public Law 93-247) provides federal funding to States in support of prevention, assessment, investigation, prosecution, and treatment activities and also provides grants to public agencies and nonprofit organizations for demonstration programs and projects. Additionally, CAPTA identifies the Federal role in supporting research, evaluation, technical assistance, and data collection activities; establishes the Office on Child Abuse and Neglect; and mandates the National Clearinghouse on Child Abuse and Neglect Information. CAPTA also sets forth a minimum definition of child abuse and neglect.

provided by the community in which a child resides. For this reason, the Committee recommends CA continue community outreach about child abuse. The Committee recommends community education include tools such as You Tube, social media, and regular contact with community organizations.

The Committee discussed the July 27, 2012 intake that screened in for alternate intervention. The Committee noted CA sent a letter to the family as a response to the intake. The Committee noted practice regarding alternate intervention varies from office to office. Where available, CA Intake can refer the family to a contracted alternate intervention, called Early Family Support Services (EFSS). If there is no provider available, CA sends a letter informing the family of local resources that may assist with services. The Committee discussed the varying level of service for alternate intervention across Washington state and believed all parts of the state should receive the same service. The Committee also noted CA's practice of mailing a letter was within policy.

Findings

None

Recommendations:

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