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

Child Fatality Review

E.B-G.

February 2008
Date of Child's Birth

October 18, 2013
Date of Child's Death

January 9, 2014
Child Fatality Review Date

Committee Members
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Executive Summary

On January 9, 2014, the Department of Social and Health Services (DSHS), Children's Administration (CA) convened a Child Fatality Review (CFR)[1] to review the department's practice and service delivery to a five-year-old female child and her family. The child will be referenced by her initials, E.B-G., in this report. At the time of her death, E.B-G. shared a home with her mother, her mother's boyfriend (J.R.), and her siblings. The incident initiating this review occurred on October 18, 2013 when E.B-G. died from injuries related to a pedestrian/vehicle accident.

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 involvement with the case.

Prior to the review, each committee member received a case chronology, a summary of CA involvement with the family and unredacted CA case documents (e.g., intakes, safety assessments, investigative assessments, provider records, law enforcement records, and 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 the complete case file and relevant state laws and CA policies.

During the course of the review, the Committee interviewed the previously assigned Child Protection Services (CPS) social worker, Child and Family Welfare Services (CFWS) supervisor, and area administrator. In addition to CA staff, the Committee interviewed the mother's individual counselor. The Committee requested the report reflect their appreciation to the mother's counselor for her participation in the review process. The CFWS social worker assigned to the case at the time of the fatality was not available for an interview. The Committee noted the challenges of conducting a thorough review without the presence of all staff involved with the case. Following a review of the case file documents, completion of interviews, and discussion regarding department activities and decisions, the Committee made findings and recommendations presented at the end of this report.

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[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.

Case Overview

[redacted] Subsequently, CA received ten other intakes between January 2007 and October 2013. Those intakes included an intake on June 3, 2009, where E.B-G. and her siblings were placed in out-of-home care due to substance abuse and domestic violence. On July 14, 2010, the dependency was dismissed and the case was closed following the completion of services. On May 25, 2011, the biological father of E.B-G. received a founded finding following a domestic violence (DV) incident. [redacted]

On November 20, 2012, CA screened in an intake related to a DV incident between the mother and the mother's boyfriend (J.R.). Law enforcement records reflect J.R. had physically assaulted the mother and kicked a stack of CDs that flew through the air and cut E.B-G.'s knee requiring minor medical attention. The mother and J.R. agreed to cooperate with voluntary services.

On March 28, 2013, CA received another intake related to DV in the family home. The intake alleged J.R. threw a baby bag at the mother while she was holding E.B-G.'s sibling, their nine-month-old child. The intake was screened out.[2] [redacted] On April 3, 2013, a dependency petition was filed and the children were placed into relative care. In the petition, the worker wrote, "[The mother's] history indicates a pattern of having the court dismiss restraining orders shortly after they are filed." The case was transferred to a CFWS social worker following the shelter care hearing.

[2] CA will generally screen-out intakes alleging the following: 1) Abuse of dependent adults or persons 18 years of age or older. Such services are provided by the Adult Protective Services (APS) section; 2) Third-party abuse committed by persons other than those responsible for the child's welfare; 3) Child abuse and neglect (CA/N) that is reported after the victim has reached age 18, except that alleged to have occurred in a licensed facility; 4) Child custody determinations in conflictual family proceedings or marital dissolution, where there are no allegations of CA/N; 5) Cases in which no abuse or neglect is alleged to have occurred; 6) And alleged violations of the school system's Statutory Code, Administrative Code, statements regarding discipline policies.

On June 21, 2013, an agreed court order was filed returning the children to their mother's care. J.G. and J.R. were both granted court ordered visitation, but they were not allowed to reside at the family residence.

[redacted]

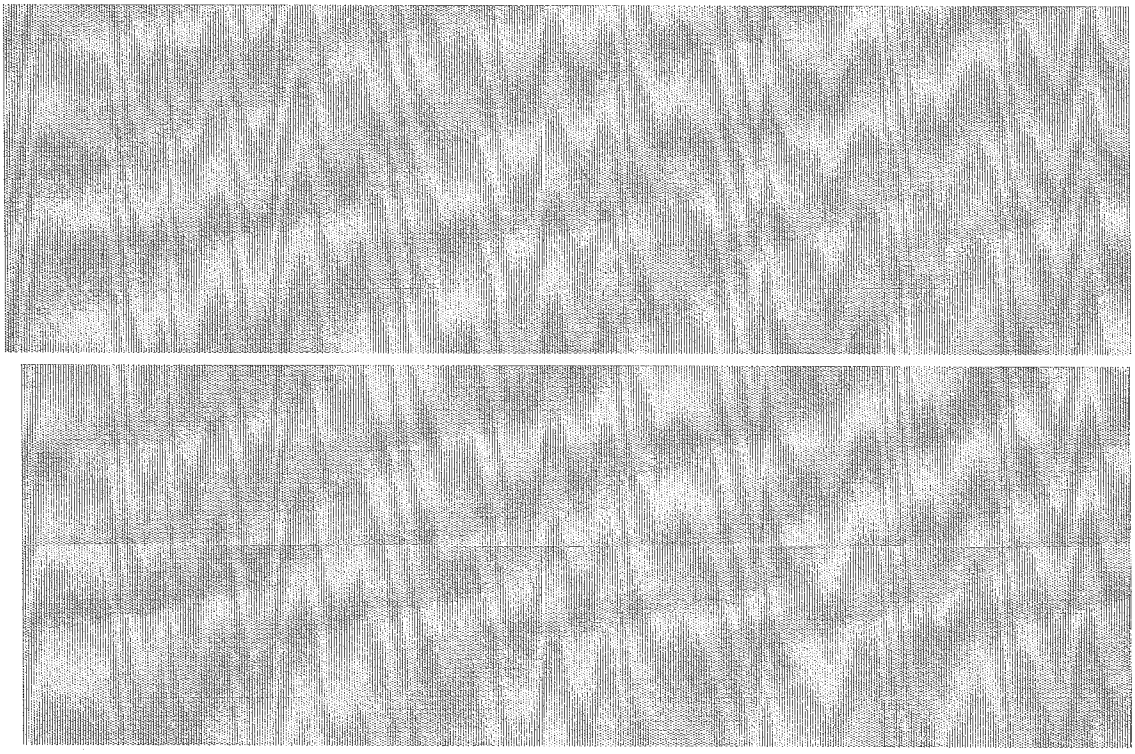
[redacted]

On October 19, 2013, CA received a report from Sacred Heart Medical Center indicating that at approximately 6:30 p.m. on October 18, 2013, the mother, E.B-G., and a sibling were crossing Monroe Street in Spokane when a vehicle traveling approximately 35 mph struck them. The driver was not under the influence of drugs and alcohol and appeared to be following all traffic laws at the time of the accident. The driver passed all sobriety testing. The mother was admitted to the hospital with significant injuries. The sibling was treated for a broken clavicle and released from the hospital. E.B-G. died the following morning from her injuries. The mother tested positive for methamphetamine upon her arrival at the hospital. On December 17, 2013, CA learned that law enforcement had also obtained blood and urine samples from the mother shortly after the accident. The exact time and date of law enforcement's blood and urine samples were unknown at the time of the CFR. The blood sample and urine tests requested by law enforcement were negative for the presence of methamphetamine. CA staff

[3] Drug test results: Positive--A test result which indicates that a drug or metabolite is present. Negative--A test result which indicates that no drug or metabolite is present or no drug or metabolite is present in an amount greaterthan the cutoff concentration. No show—Indicates when the client fails to provide a urine sample as requested.

requested, but were unable to obtain copies of the mother's drug tests that were taken post-fatality. CA's knowledge of test results were obtained through verbal reports by medical professionals and law enforcement.

The mother was on her way to complete a UA at the time of the accident. The UA was requested by the social worker due to the mother's failure to show for UA testing on October 17, 2013. Witnesses to the accident consistently stated that the mother and children were not in a crosswalk when the vehicle struck them. Witnesses also reported they appeared to pause in the middle of the street to avoid a southbound vehicle immediately prior to impact. According to police records, two of the witnesses stated that they asked each other, "What is that lady doing walking in the roadway with cars coming?" Some witnesses reported the mother was walking with a child on each side of her with the family dog on a leash immediately prior to being struck by the vehicle.



Committee Discussion

The Committee noted CA social workers could not have predicted the events that took place on the night of the fatality. The discussion, findings, and recommendations identified in the sections below identify where CA staff might have considered additional or alternative social work practice that may have enhanced CA's service delivery, case plan, and analysis of the family.

On March 28, 2013, CA received an intake alleging J.R. had thrown a diaper bag at the mother's face while she was holding her baby. The intake was screened out. The Committee believed CA policy supported this intake being screened in as risk-only due to the recent pattern of DV in the home, the proximity of the child to the DV, and the recent injuries to children in the home that were associated with another DV incident on November 11, 2012.

The Committee reviewed the services offered to the family and noted the CA social worker appropriately referred the mother to DV victim's advocacy services, offered J.R. a DV perpetrator assessment pending a neuropsychological evaluation, and provided the mother with individual counseling to address the pattern of DV.

The Committee reviewed the mutually agreed upon services from the shelter care order filed in Spokane County Juvenile Court on April 9, 2013. The court order stated the mother shall complete "YWCA DV prevention services and follow recommendations." The Committee noted the value of offering DV advocacy to the mother, but questioned the inclusion of DV advocacy and recommendations in a mutually agreed upon court order. First, a domestic violence advocate may not, without the consent of the victim, be examined as to any communication between the victim and the DV advocate." (RCW 5.60.060(8)). Second, DV advocates provide their services on a voluntary basis and will not provide assessments or recommendations for CA social workers to be utilized in court orders. The YWCA DV advocacy program will generally only confirm a client's attendance, but will not provide information regarding the client's compliance or progress. For this reason, the Committee believes a contracted service provider should be utilized when CA social workers need recommendations and an assessment of progress. In this case, the department appropriately utilized the mother's individual counselor for an assessment of the mother's progress as it relates to DV and the mother's ability to maintain a safe home environment.

Following a review of the casefile and interviews, the Committee believed this case may have benefitted from increased chemical dependency services. The Committee noted the mother's lengthy history of substance abuse and treatment prior to the dependency. For this reason, the Committee believed the mother should have received a chemical dependency assessment following her positive UA for methamphetamine on August 9, 2013. The Committee believed the mother's pattern of no-shows warranted a chemical dependency assessment. The Committee noted the mother and J.R. both alleged the other was using drugs in early April 2013. The Committee believed these allegations along with the

mother's history of addiction warranted the initiation of random UAs in April 2013.

An FTDM was held on May 28, 2013 and an agreement was reached that the children would return to the care of their mother on June 7, 2013. The Committee discussed the mother's progress in services at the time of the decision to reunify the children with their mother. The case record indicates the mother had participated in individual counseling, DV services, parent education, and couples counseling. The Committee noted the mother had only completed one individual counseling session prior to the FTDM. The Committee believed one individual counseling session was insufficient for the provider to assess the mother's progress. The Committee also noted the parenting classes and visitation were not appropriate for the assessment of progress as they are unrelated to the primary concerns of substance abuse and domestic violence. The Committee also believed couples counseling was not an appropriate service as the DV issues in the family had not been resolved. Thus, the Committee believes couples counseling should not have been provided to the family or part of the decision making process. Based on the information available to the Committee at the time of the review, they believed the mother had not demonstrated a period of significant measurable behavior change at the time of reunification. In addition, the Committee noted a return home court order was entered on June 21, 2013. E.B-G. resided with her mother for two weeks prior to the court order supporting the return home. The Committee believed the social worker never intended to return E.B-G. to relative care and thus believed the official return home date was June 7, 2013. The Committee believed E.B-G. should not have been returned home prior to a court order supporting the return home.

On July 5, 2013, the CFWS social worker completed a safety assessment and safety plan. The safety assessment determined the children would be unsafe in the care of their mother without the presence of a safety plan to mitigate the identified safety threats. The safety plan states, "The mother has placement of her children. She will participate in all services. Her children are in daycare full time. Visits with both fathers are supervised. The stepfather is also participating in services." The service providers associated with the case agreed to help ensure the safety of the children by monitoring the home environment. The Committee found the safety plan lacked elements needed to address the identified safety threats. The Committee believed the plan should have specified how service providers and family members could help monitor and mitigate the risks associated with DV and chemical dependency. Following a review of the reunification decision, services, and safety plan, and interview of the supervisor,

the Committee believed that clinical supervision associated with this case could have been improved.

The Committee reviewed the court orders associated with this case and noted the guardian ad litem's (GAL) signature was not present on the July 26, 2013 review hearing order. The Committee noted the GAL's signature should be present on all court orders when a GAL has been assigned.

CA staff informed the Committee that they attempted, but were unable to obtain copies of the mother's UA results following the fatality due to the ongoing investigation by law enforcement. The Committee believes CA should have had access to the mother's UAs, and the presence of these reports would have enhanced their understanding of the events surrounding the time of the fatality.

Findings

1) Based upon the information available to the Committee at the time of the fatality, the Committee believes the mother participated in insufficient services to adequately assess her progress at the time of reunification.
2) The Committee believes couples counseling should have been provided to the mother only after the DV issues had been resolved.
3) The Committee found the safety plan lacked elements needed to address the safety threats identified by the social worker in the safety assessment.
4) The Committee found the March 28, 2013 intake should have screened in as risk only.
5) The Committee found CA should have required the mother and J.R. to complete random UAs starting in April 2013. The Committee also believes the mother should have been required to complete a chemical dependency assessment following the UA that was positive for methamphetamine on August 9, 2013. The Committee found these services should have been offered to the mother through the dependency court process.
6) The Committee believed E.B-G. should not have been returned home without a court order supporting her return to the mother's care.

Recommendations

1) The Committee recommends all social workers receive and demonstrate a strong understanding of the safety assessment and safety planning

process prior to the carrying of cases and the completion of Regional Core Training (RCT).[4]

2) The Committee recommends all CA social workers receive an annual refresher training regarding the completion of safety assessments and safety plans.

Nondiscrimination Policy

The Department of Social and Health Services does not discriminate and provides equal access to its programs and services for all persons without regard to race, color, gender, religion, creed, marital status, national origin, sexual orientation, age, veteran's status or the presence of any physical, sensory or mental disability.

[4] Regional Core Training (RCT) - The RCT is the initial, intensive, task-oriented training that prepares newly hired Social Service Specialists to assume job responsibilities. RCT starts on the first day of employment and lasts for 60 days, or the first two months of employment. Competencies are used to assess learning needs and to identify a developmental plan for the new workers. Retrieved from: http://allianceforchildwelfare.org/sites/default/files/sites/default/files/career/alliance_training_september_2013_0.pdf