RCW 74.13.640(d)

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

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

**G.C.**

**August 2009**
Date of Child's Birth

**February 24, 2012**
Date of Child's Death

**June 18, 2012**
Child Fatality Review Date

**Committee Members:**
Ken Levinson, Director of Family Services, Nooksack Indian Tribe
Betsy Tulee, Children's Administration, Indian Child Welfare Program Manager
Gina Crosswhite, Detective, Bellingham Police Department
Francie Gass, Parenting Instructor/Adjunct Faculty Bellingham Technical College
Janice Stettler, Children's Administration Supervisor, Oak Harbor Division of Children and Family Services

**Observers:**
Sharon Gilbert, M.S.W., Children's Administration Deputy Director of Field Operations
Laurie Alexander, M.S.W, Children's Administration Area Administrator, Bellingham Division Of Children and Family Services
Robert Larson, Children's Administration Critical Incident Case Review Specialist

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

**Table of Contents:**

## Executive Summary

On June 18, 2012, the Department of Social and Health Services (DSHS), Children's Administration (CA) convened a Child Fatality Review[1] (CFR) to review the Department's practice and service delivery to a 2-year-old dependent child and the relatives with whom he was placed nearly three months before his death on February 24, 2012. On the day of his death the relative care providers[2] were alerted by their children that something was wrong with G.C. in the shower. Finding G.C. unresponsive the relative care providers contacted 911 and emergency responders were dispatched to the home where efforts to resuscitate the child were not successful. The Whatcom County Medical Examiner later determined the manner of death to be consistent with accidental drowning, with inadequate parental oversight as a contributing factor.

The CFR Committee included CA staff and community members selected from diverse disciplines with relevant expertise, including representatives from law enforcement, parenting instruction, social work, and Indian Child Welfare. Representatives from the Office of the Family and Children's Ombudsman and the Upper Skagit Indian Tribe were invited but were unable to attend. Although some Committee members were aware of the fatality incident through various media reports, none had any previous direct involvement with the family with the exception of the representative from G.C.'s Tribe (Nooksack). Prior to the review each Committee member received a summarized chronology of known CA involvement with the relative placement family as well as copies of case file materials (e.g., intakes, case notes, safety assessments, Child Protective Services investigative reports).

Available to Committee members on site at the review were (1) additional case related documents (e.g., medical and developmental screening records, autopsy report, various case staffing/case planning reports, legal documents relating to G.C.'s dependency), (2) CA practice guides relating to CPS investigations and assessment of risk and safety, (3) relevant state laws and CA policies regarding investigation of child abuse and neglect, and (4) copies of relevant Indian Child Welfare (ICW) laws and policies. During the course of the review two CA social workers involved with the case were made available for interview by the Committee.

Following review of the case file documents, the interview with the Child Protective Services social worker and the Child and Family Welfare Services supervisor, and discussion regarding social work activities and decisions, the review committee made findings and recommendations which are detailed at the end of this report.

---

[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.

[2] The names of the relative caregivers are not identified by name in this report as neither adult has been charged with a crime related to the fatality incident. The names of their biological children are also subject to privacy laws.

## Case Overview

G.C. first came to the attention of Children's Administration on June 28, 2011 when in collaboration with the Nooksack Tribe and extended family he was placed into relative foster care following allegations of neglect. A dependency petition was filed on August 19, 2011 and dependency was established on September 19, 2011. In response to alleged breach of safety and supervision expectations by the relative caregiver, G.C. was then moved to a different relative placement following a Family Team Decision Making[3] (FTDM) meeting in early December 2011. The relatives who assumed placement and care of G.C. in December 2011 had previously been a placement resource for other relative children. During those prior placements there were allegations of neglect in the home which were determined to be unfounded after an investigation.

In mid-December 2011 CPS received a report alleging neglect based on reported deterioration of G.C.'s hygiene and behaviors since being moved to his new relative placement. The CPS investigation resulted in an unfounded finding[4] and the relative caregivers declined further services. G.C. remained in the care of the relatives and in early February 2012 the Department and the Nooksack Tribe supported the plan to return G.C. to the care of his biological mother under an in-home dependency. Before the planned reunification could take place G.C. died on February 24, 2012 from an apparent accidental drowning while showering with his cousins. A CPS investigation determined that the relative caregivers had failed to adequately supervise G.C. and the investigation resulted in a founded finding of neglect.

## Committee Discussion:

The major focus of the Committee's review was with regard to the Department's history of involvement with the relative family with whom G.C. was placed in December 2011. The discussions focused on CA policy, practice, and system response to the family in an effort to evaluate the reasonableness of decisions made and actions taken by CA. Actions taken by non-CA agencies were briefly discussed, but considered outside the scope of this review in terms of generating any findings or recommendations.

The Committee discussions centered on three areas: (1) quality social work, (2) policy issues relating to the decision to change G.C.'s placement in December 2011, and (3) the decision to place with relatives with a history of previously reported concerns for supervision of relative children in their care.

---

[3] 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: *DSHS CA Practice and Procedures Guide*]

[4] RCW 26.44.020: *"**Unfounded** means the determination following an investigation by the department that available information indicates that, more likely than not, child abuse or neglect did not occur, or that there is insufficient evidence for the department to determine whether the alleged child abuse did or did not occur... **Founded** means the determination following an investigation by the Department that, based on available information, it is more likely than not that child abuse or neglect did occur."*

## Findings:

Quality Social Work:
In terms of overall practice, the social work performed by CA staff generally appeared to be of good quality and was well documented during the 2011-2012 involvement with G.C. and his relative placement family. Collaborations between local CA, law enforcement, and tribal services were notably positive and appear to reflect strong partnerships. Efforts by CA to be inclusive in shared decision making were evident (e.g., frequent contact with tribal staff; numerous Child Protection Team and Family Team Decision Making meetings). The Committee found CA to be appreciably sensitive and respectful of the Tribe and family members following the tragic death of G.C. The determination of the founded finding regarding the child fatality incident was supportable as defined in WAC 388-15-009. The Committee found no critical practice errors, and all substantive decisions made and actions taken during CA involvement appeared to be reasonable and supportable. The Committee found no clearly discernible alternative actions that reasonably should have been taken by CA that would have likely changed the outcome of the case.

Policy:
The Nooksack Tribe questioned CA's decision in December 2011 to move G.C. from his initial relative placement after the caregiver had allowed the child to be in the unsupervised care of an unapproved relative. The disagreement between CA and the Tribe did not reach impasse[5] and an alternate relative placement was agreed upon. CA's decision to move G.C. was found to be supportable based on (1) the results from a Safety Assessment[6] that indicated G.C. was unsafe in his out-of-home placement and (2) CA policy that required immediate removal of children in such situations. However, the Committee questioned the inflexibility of this CA policy, especially in relative placements and Indian Child Welfare (ICW) cases where the available relative resource pool may already be very limited.

Practice:
While the Committee found nothing in the relative's history of involvement with CA to exclude them from being the placement resource for G.C. in December 2011, there were several concerns reported intermittently (1997-2007) regarding children in their care, both biological and relative children. These included historical concerns for inadequate supervision, discipline, and protection of younger children from the older children in the home. The Committee acknowledges the emergent need to locate a new placement for G.C. in December 2011, and thus CA did not likely have sufficient time to evaluate (1) the anticipated adjustments for 2-year-old G.C. in moving to an unaccustomed home environment with multiple, active, physical older

[5] "**Impasse**" means a deadlock between CA and the Local Indian Child Welfare Advisory Committee (LICWAC).or the child's Tribe following thorough discussion by the CA social worker of the case plan and case decisions with the worker's supervisor and managers, and the LICWAC or tribal designee does not concur with the department's plan and decisions.[Source: Indian Child Welfare Manual; http://www.dshs.wa.gov/ca/pubs/mnl_icw/chapter1.asp]

[6] A Safety Assessment is completed at key decision points in a case to identify impending danger and to inform and implement safety plans with families to control or manage those threats. However, when children in CA's care and custody are determined to be unsafe in licensed or unlicensed care, children are removed from that placement. CA does not maintain a child in placement with a safety plan. [Source: *DSHS CA Practice and Procedures Guide* - Chapter 1000]

children, and (2) the adjustments and preparations needed for the caregivers and their children in having a very young, dependent toddler come into the home where supervision and protection issues had historically been a concern.

## Recommendations:

- Children's Administration is encouraged to re-assess and consider modifying the Child Safety Framework safety plan policy that does not currently allow a child to remain in relative care with a safety plan if a safety threat meets the criteria of an "unsafe child." There may be situations in which a Safety Plan could be initiated within the relative home so that placement disruption (whether temporary or longer term) does not need to immediately occur.
- Children's Administration should continue to reinforce with social workers and FTDM facilitators the importance of evaluating the possible impacts to a child being placed, as well as the impact the placement might have on children already in the home (e.g., the biological children of relative caregivers). It is suggested that promotion of this concept should continue to occur annually in state wide CA training available to social work and program staff, such as the "Lessons Learned" presentations held around the state.