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

Child Fatality Review

G.C.

RCW 74.13.515 **2014**
Date of Child's Birth

September 28, 2016
Date of Child's Death

January 4, 2017
Date of the Fatality Review

Committee Members
Patrick Dowd, Director, Office of the Family & Children's Ombuds
Marie Bastin, Public Health Nurse, Indian Health Services, Toppenish
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Jennifer Cooper, Region 1 CPS Quality Practice Specialist, Children's Administration
Frank Murray, Former Program Manager, Yakima County Court Appointed Special Advocates

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Executive Summary

On January 4, 2017, the Department of Social and Health Services (DSHS), Children's Administration (CA) convened a Child Fatality Review (CFR)[1] to assess the department's practice and service delivery to RCW 74 month-old G.C. and RCW 74 family.[2] The child will be referenced by RCW 74 initials, G.C., in this report. At the time of RCW 74 death, G.C. lived with RCW 74 maternal grandmother and three older siblings. The Review Committee included members selected from the community with relevant expertise from diverse disciplines including, the Office of the Family and Children's Ombuds, a practice consultant with CA, a supervisor with CA, a Public Health Nurse, a former Guardian Ad Litem director with Yakima CASA and a tribal prosecutor. Neither CA staff nor any other Committee members had previous direct involvement with this family.

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 case notes, referrals for services, assessments and medical records. A hard copy of the file was available at the time of the review. Supplemental sources of information and resource materials were also available to the Committee, including state laws and CA policies relevant to the review.

The Committee interviewed CA social workers and a supervisor who had previously been assigned to the case in 2014. The investigative supervisor was not interviewed as she was no longer employed with CA at the time of the review. Following the review of the case file documents, completion of staff interviews and discussion regarding CA activities and decisions, the Committee made findings and recommendations that are presented at the end of this report.

Background

On September 26, 2016, CA received a report from RCW 74.13.515 Hospital regarding the near-fatality of RCW 74.1 month-old G.C. who was in the care of RCW 74 maternal grandmother at the time of the incident. It was alleged that on

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

[2] Family members are not named 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 and management information system. [Source: RCW 74.13.500(1)(a)]

September 25, 2016, G.C. nearly drowned in a canal located on the family's property. The maternal grandmother was reportedly cooking dinner and saw the child wandering in the back yard. She told authorities that she assumed G.C. was returning to the home when she called [redacted] name and saw [redacted] turn around. When G.C. did not return, the family looked for [redacted]. G.C. was found by [redacted] uncle submerged in the canal. Cardiopulmonary resuscitation (CPR) was attempted on G.C. and authorities were called. G.C. was airlifted from [redacted] Hospital to [redacted], where [redacted] remained until [redacted] passed away on September 28, 2016. G.C.'s biological mother is an enrolled member of the [redacted] Tribe. G.C.'s siblings have remained in the care of their [redacted].

Family Case Summary

G.C.'s maternal grandparents have [redacted] history with the department dating back to 1993, including allegations and findings of [redacted], [redacted] and [redacted]. The maternal grandmother was [redacted] for much of her own children's lives due to [redacted]. The maternal grandfather or extended family [redacted] in the maternal grandmother's [redacted]

G.C.'s mother and a legal father to one of G.C.'s siblings had [redacted] referrals between May 2010 and June 2015. [redacted] of the reports screened out[3] and [redacted] screened in as a risk only response[4] which led to an [redacted] and the provision of Family Voluntary Services[5] (FVS) in 2014. The allegations in all [redacted] referrals concerned [redacted] by G.C.'s mother, including [redacted]

[3] CA will generally screen out the following intakes: 1) Abuse of dependent adults; 2) Allegations where the alleged perpetrator is not acting in loco parentis; 3) Child abuse and neglect 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 child abuse or neglect; 5) Cases I which no abuse or neglect is alleged to have occurred; and 6) Alleged violations of the school system's statutory code or administrative code. [Source: CA Practices and Procedures Guide]

[4] CA will accept for investigation a risk-only intake when information collected gives reasonable cause to believe that risk or safety factors exist that place the child at imminent risk of serious harm. In assessing imminent risk of serious harm, the overriding concern is a child's immediate safety. Imminent is defined as having the potential to occur at any moment, or that there is a substantial likelihood that harm will be experienced. Risk of serious harm is defined as: a high likelihood of a child being abuse or experiencing negligent treatment or maltreatment that could result in one of more of the following outcomes: death; life endangering illness; injury requiring medical attention; substantial risk of injury to the physical; emotional and/or cognitive development of a child. [Source: CA Practices and Procedures Guide]

[5] Family Voluntary Services (FVS) support families' early engagement in services, including working with the family to create Voluntary Service Agreements or Voluntary Placement Agreements and providing ongoing case management services and assessment of safety and risk to children. Voluntary case plans are used to engage families willing to participate in services intended to reduce current and future abuse or neglect issues that do not require court intervention. Voluntary services are short-term to help increase parents' protective capacity and manage child safety. [Source: CA Practices and Procedures Guide Chapter 3000]

RCW 13.50.100 and RCW 13.50.100 at the time G.C. was delivered. The FVS case was closed on November 20, 2014.

On June 28, 2015, G.C.'s mother called CA Central Intake to request RCW 13.50.100 . The mother reported that she RCW 13.50.100 . The intake was screened out due to there being no allegations of child abuse or neglect.

In September and October of 2015, CA received reports alleging neglect by both G.C.'s mother and maternal grandmother. In September 2015, G.C.'s mother was alleged to be RCW 13.50.100 and failing to supervise G.C. RCW 13.50.100. The report screened in for a CPS investigation. During this investigation, an uncle to G.C. was planning to seek third party custody of the children. CA staffed the children's placement with the Local Indian Child Welfare Advisory Committee[6] (LICWAC), which recommended that the children be placed with their uncle. When the uncle was unable to obtain housing, however, the maternal grandmother initiated third party custody of all three children through tribal court. On October 27, 2015, CA received a referral alleging that the maternal grandmother RCW 13.50.100 . The allegations screened-in for investigation but were determined to be unfounded.[7] The investigation was closed on January 4, 2016.

Discussion

The Committee discussed the fact that the mother of the children called CA Central Intake on June 28, 2015, requesting RCW 13.50.100 . The Committee noted that the mother RCW 13.50.100 . However, multiple members of the Committee inquired as to why the report screened out and what, if any, assistance CA could have provided. Discussion developed around the possibility of a voluntary placement agreement[8] or a Child and Family Welfare

[6] A LICWAC is a body of volunteers, approved and appointed by CA who staff and consult with the Department on cases of Indian children who: are members of a tribe, band or first Nations has not responded, or has chosen not to be involved, or is otherwise unavailable; or for whom the child's tribe, band, or First Nations has officially designated the LICWAC to staff the case; or are defined as a recognized Indian child.

[7] 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 mean 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. [Source: RCW 26.44.020]

[8] A Voluntary Placement Agreement (VPA) safety supports a time-limited plan for a short-term removal and placement in out-of-home care for a child who cannot safely remain in the parent or legal guardian's home. [Source: CA Practice and Procedures Guide Chapter 4307. Voluntary Placement Agreement]

Services case in situations like this. The Regional Area Intake Administrator provided consultation to the Committee and informed the Committee that unless there is an allegation of child abuse or neglect or an allegation of a risk of imminent harm to a child, an intake will likely screen out for CA intervention.[9] The Committee discussed the Washington Administrative Code[10] definitions for child abuse or neglect and understood that a CPS pathway might not have been appropriate at the time the mother called in. However, while it acknowledged that the intake worker provided the mother with some suggestions on how to proceed in the event that she was RCW 13.50.100 the Committee nonetheless opined that it would have liked to have seen the worker provide additional information to the mother, such as information on voluntary placement agreements.

The Committee felt that the assigned workers could have more fully reviewed historical data pertaining to the mother and maternal grandmother during its intervention in September 2015. Specifically, the Committee opined that the analysis of the maternal grandmother's records and the mother's records as a child should have been more thorough, thus potentially resulting in more thorough child safety assessments, and the Committee voiced concerns that there was no assessment of the maternal grandmother's ability to care for and supervise her grandchildren. When interviewed, both CA workers who were assigned to the mother's case during the 2014-16 interventions, reported that they spoke to previously assigned case workers about the grandparents' history and the mother's history as a child. However, the Committee identified that CA was aware of the children moving into the grandmother's care in September 2015, and it opined that CA should have included in its assessment of the maternal grandmother as a potential placement, her RCW 13.50.100 due to RCW 13.50.100 .

The Committee members also spent considerable time discussing the canal and waterways on and near the grandmother's property. The Committee members questioned the maternal grandmother's awareness of the supervision needs of the small children around the waterways. The Committee recognized the worker's attempt to visit the home and check on the children, but the Committee would have liked the CA worker to have had discussions of supervision of children near waterways.

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[9] The department is only authorized to intervene via an investigation or family assessment response when it receives complaints of recent acts or failures to act on the part of a parent or caretaker that results in death, serious physical or emotional harm, or sexual abuse or exploitation, or that presents an imminent risk of serious harm, and on the basis thereof offer child welfare services in relation to the problem to such parents, legal custodians, or persons serving in loco parentis, and/or bring the situation to the attention of an appropriate court or another community agency. [See RCW 74.13.031 and RCW 26.44.030]

[10] WAC 388-15-009 What is child abuse or neglect?

The Committee was concerned that CA didn't follow the LICWAC recommendations to place with the identified uncle or to re-staff the case with LICWAC prior to case closure. Lack of clinical supervision for a new caseworker was discussed as a possible contributing factor to the LICWAC re-staffing having not occurred. The Committee was also concerned that CA staff could have more fully assisted the identified uncle with obtaining housing. The Committee recognized the importance of utilizing the LICWAC recommendations, especially in a case of recommendations for relative caregivers, as LICWAC tends to know its community and the capabilities of recommended caregivers more personally than CA.

In reviewing the quality of the 2015 investigation, the Committee expressed concern that the assigned investigator, who had been in that position for less than a few months, was still in her trial service period and as such, may have benefitted from regular clinical supervision to ensure that her assessments were comprehensive and addressed all allegations. The Committee believed that the supervisor's role was to ensure compliance with LICWAC's recommendations, ensure adequate gathering of information for safety assessments and ensure that policy is followed and to provide guidance to new workers.

The Committee also discussed information sharing by CA with extended family and the court presiding over the maternal grandmother's third party custody case. A few Committee members were curious as to the parameters CA is held to in regard to information sharing. Consultation was provided via the program manager on the Committee and the CPS Supervisor. The Committee was informed of the limitations CA is held to regarding what can be shared in third party or other custodial matters. The Committee heard that often a court order is required in order to share information with the courts outside of a dependency proceeding due to confidentiality rights of the child and his or her parents, guardians or custodians.

Findings

The Committee did not come to a consensus regarding whether a critical error on the part of CA was directly linked to the death of the child. Some Committee members felt that CA having knowledge of the children moving in with the grandmother was a critical error. Some felt that more fully vetting her suitability and ability to provide safe care and supervision was critical and was linked to the death of the child. Other Committee members did not believe that there was a direct link between the vetting of the grandmother and the child's death. The Committee did, however, agree on the findings listed below:

- CA Policy 1130 requires that Safety Plans control or manage threats to a child's safety, have an immediate effect and contain safety services and actions only. These must be immediately accessible and available. The 2014 CPS safety plan could have more specifically identified safety threats. The safety plan was compiled of services and did not provide safety tasks to ensure child safety.
- CA Policy 1120 and CA Policy 1140 requires that an updated Safety Assessment be completed on all FVS cases. According to CA Policy 1120, a review of the Safety Assessment is required at case transfer, when there is a change of anyone residing in the home or visiting the premises for more than 14 days and when closing the case. There was not an updated safety assessment completed during the 2014 FVS case assignment.
- CA Policy 1140 requires that a Comprehensive Family Evaluation (CFE) be completed within 45 calendar days of an FVS case assignment. The CFE is to be updated every 90 days after the prior completion of a CFE on FVS cases, when developing or changing a case plan or prior to case closure. A CFE was not completed during the 2014 FVS case assignment.
- The FVS case worker could have more fully assessed the biological father's RCW 13.50.100, RCW 13.50.100 and overall parenting needs.
- During the September 2015 and October 2015 responses, CA did not follow through with the LICWAC recommendation for placement with an identified uncle. CA did not re-staff with LICWAC when the children went to live with the maternal grandmother. Additionally, CA did not re-staff with LICWAC prior to closure as LICWAC recommended.
- CA was aware of the children going to the grandmother's care and did a minimal home check. The department did not screen the relative placement options to include the following:
    - FamLink/MODIS analyses and applicable waivers for historical findings.
    - Criminal background checks.
    - Relative placement checklist and conversations about the danger of the outdoor waterway next to the home.

Recommendations

CA in Region 1 should consider creating, offering more frequently, or enhance currently available training on assessing safety that captures the below topics:

- Tactics for gathering and analyzing information on family members, CA history and criminal history.
- Clinical supervision of staff to assist in the information gathering process to include analysis of gathered information.

- Utilizing LICWAC recommendations, when to re-staff with LICWAC and make more informed placement decisions that align with CA practice and procedures policy.

Region 1 CA has scheduled trainings throughout 2017 with the regional CPS program managers at varied local and regional offices to cover gathering of information, collateral contacts, safety assessment training and AAG Lessons Learned training. In addition, a two-day training was offered on January 23-24, 2017, in the local office addressing the Indian Child Welfare Act.