Children's Administration
Executive Child Fatality Review

J.W.

January 2004
Date of Child's Birth

August 22, 2011
Date of Child's Death

January 12, 2012
Executive Review Date

Committee Member
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Table of Contents

Executive Summary	3-4
Case Overview	4
Review Committee Discussion and Findings	5-6
Recommendations	6

Executive Summary RCW 74.13.500

On January 12, 2012, the Department of Social and Health Services (DSHS), Children's Administration (CA) convened an Executive Child Fatality Review (ECFR)[1] of the case involving the death of 7-year old J.W. (DOB: 01-2004). J.W. was in the care and custody of his mother and stepfather at the time of his death in Myrtle Point, Oregon. The family's CA case was closed at the time of J.W.'s death, however services had been offered by CA to the family within the 12 months preceding his death. CA conducts fatality reviews to identify practice strengths and challenges as well as systemic issues in an effort to improve performance and better serve children and families. A committee that included community professionals and CA staff reviewed case documents, policy and procedures, and best practices to examine the child welfare practices, system collaboration, and service delivery to J.W. and his family.

On August 23, 2011, in an attempt to locate J.W.'s father, Oregon Child Protective Services (CPS) contacted Washington State CPS reporting that J.W. (age 7) and his mother were killed in an automobile accident in Myrtle Point, Oregon. J.W.'s stepfather, who was driving the vehicle, was said to be intoxicated, driving at a high speed while attempting to elude police and crashed into a trailer killing J.W.[2] and his mother. Other family members (J.W.'s two siblings) were in the car at the time and sustained injuries requiring medical treatment and were released following a short hospital stay. The surviving siblings were placed into protective custody by Oregon law enforcement and subsequently in out of home care. J.W.'s stepfather was arrested and incarcerated on two counts of vehicular manslaughter. CA case information indicates the family had relocated to the Roseburg/Myrtle Point, Oregon area after having been contacted by Washington CPS in July 2011 regarding a new intake.

The family's CA history includes four intakes between November 2008 and July 2011 referencing allegations of negligent treatment and maltreatment. Intakes alleged issues related to domestic violence, unsafe living conditions in the home, animal cruelty and chronic substance abuse. Of the four intakes, two were screened in and assigned for investigation (November 2010 and July 2011) and two were screened out[3] (November 2008 and May 2011). The November 2010 investigation resulted in an unfounded finding while the July 2011 intake was not completed as CA staff noted they were unable to locate the family to complete an investigation.

The fatality committee members included CA staff and community members representing disciplines associated with the case. Committee members had no involvement in J.W.'s case. In addition to the case file, committee members received a chronology of the services provided to the family by CA, the 2011 accident report from Myrtle Point, Oregon, the Washington Administrative Code (388-15-009[4]) referencing the definition of child abuse and neglect and CA policies regarding child protective services (CPS) investigations.

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[1] Given its limited purpose, an Executive Child Fatality Review by Children's Administration should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. A review is generally limited to documents in the possession of or obtained by DSHS or its contracted service providers and the panel may be precluded from receiving some documents that may be relevant to the issues in a case because of federal or state confidentiality laws and regulations. A review panel has no subpoena power or authority to compel attendance and generally will only hear from DSHS employees and service providers. The panel may 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 take personnel action or recommend such action against DSHS employees or other individuals.

[2] Cause of death was massive head and internal injuries. J.W. died en route to the hospital following the accident.

[3] The two intakes were screened out because neither contained an allegation of child abuse or neglect that meets the Washington Administrative Code definition of child abuse and neglect. The intakes were documented in Children's Administration's management information system, however CA is not authorized to act on screened out intakes.

[4] WAC 388 -15 -009 What is Child Abuse and Neglect?

During the course of the review, committee members discussed issues related to CPS investigative practice and procedures, supervision, workload issues, and data base resources available to CA intake and CPS investigating staff. Following review of the documents, the family's case history and consultation with the office's management staff the review committee made findings and recommendations which are detailed at the end of this report.

Case Overview

As noted above, J.W.'s family's history with CA staff includes four intakes, two of which were assigned for investigation (November 2010 and July 2011).

In November 2010 CA staff initiated a child protective services (CPS) investigation into allegations related to domestic violence, unsafe conditions in the home and animal cruelty. Primary concerns referenced J.W.'s stepfather and several incidents of domestic violence which involved the death of family pets. Also, J.W.'s mother made a disclosure stating she was uncertain she could ensure her children's safety at the time. During CA staff's initial intervention with the family it was noted J.W.'s stepfather was increasingly agitated and non-cooperative. Law enforcement subsequently placed J.W. and his siblings[5] in protective custody and in out of home care until such time it was determined J.W. and his siblings could return home safely. Following actions by J.W.'s mother to file a petition for protection, the family agreed they would abide by a safety plan restricting[6] contact with his stepfather and the family's willingness to participate in Family Voluntary Services (FVS), the children returned home prior to a shelter care hearing[7].

The case remained open for three and a half months with the understanding the family would participate in services and abide by the safety plan. However, the review committee was unable to find any documentation to indicate CA staff had contact with the family during this time to ensure they were following the safety plan or had been referred to services. The case remained open until March 2011 when it was closed. No case documentation or supervisory reviews as to CA staff's involvement or activity with the family were found.

In July 2011 CA staff received another intake referencing J.W. and his family and concerns regarding continued violations of protection orders, living conditions, and possible substance abuse. CA staff made contact with the family timely and completed the initial face to face with the children and assessed their immediate health and safety. CA staff was not able to meet with the children's mother during the initial contact, however made arrangements with the children's stepfather to meet with her on another day. The assigned social worker attempted to contact the family on the scheduled day, however they were not home. On this same day contact with law enforcement and a relative indicated the family had left the area[8] to avoid CPS. CA staff closed the case noting they were unable to locate the family. The case record does not reflect CA staff initiated any contact with the respective CPS agency in Oregon where it was known the family had relocated.

On August 23, 2011 Oregon CPS contacted Washington CPS requesting contact information for J.W.'s father for purposes of notifying him of J.W.'s death and as a possible placement option for J.W.'s surviving siblings. Oregon CPS indicated that J.W. was killed, along with his mother, in an automobile accident after his stepfather had committed a burglary and attempted to elude local law enforcement. J.W.'s mother died at the scene and J.W. died of massive head injuries en route to the local hospital. J.W.'s stepfather was arrested and charged with two counts of vehicular manslaughter and remains incarcerated. Following a short hospital stay for their injuries, J.W.'s siblings were placed in protective custody by law enforcement.

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[5] J.W. had an older sibling, age 10 and a half sibling, age 3.

[6] The mother and stepfather agreed to participate in supervised visitation with a neutral party.

[7] In the event a child is placed in protective custody he or she may not be held longer than 72 hours without a shelter care hearing. [CA Case Services Manual Chapter 5720 (A)]

[8] Information regarding the community where the family moved was provided to CA.

Discussion and Findings
To develop a thorough understanding of the family and the case, the review committee identified dynamics that appeared to influence decision-making. The committee reviewed decisions and actions taken by CA staff regarding intake screening decisions and investigations, assessment of child safety and family dynamics and family engagement.

Casework: The committee discussed at length the CPS investigations and Family Voluntary Services program decisions made in this case over the course of the family's involvement with CA staff. The committee found investigating social workers made active efforts to engage the family on several occasions to discuss the allegations and work with the family to ensure child safety. However, the absence of documentation in the case record made it difficult for the review committee to understand CA staff's actions and whether CA policies and procedures were followed while the case remained opened. For example, several investigative and case management expectations were not documented and should have included at a minimum the following:

- Written documentation of face to face meetings and investigative interviews[9] with all children in the family home.
- The development of collateral contacts and use of available data base systems[10] to assist in understanding family dynamics and supports verification of information shared by family members.
- Case plan development and monthly contact with family members to assess family progress.
- At a minimum monthly supervisory oversight on open investigations and cases.
- Shared decision making meetings (i.e. Child Protective Team, Family Team Decision Making meetings [FTDM]) to assist in case plan development and recommend service needs. CA policy requires that a FTDM meeting be held when children have been placed in protective custody and prior to their return home[11].

Resource Use and Communication: The review committee found that there was a significant amount of information known about and referencing this family in database systems available to CA staff. However the committee was unable to determine if these resources, such as NCIC[12], Barcode and ACES[13] were accessed by staff during the 2010 or 2011 investigations or when developing the case plan. In particular, Barcode is a database with information that can support assessing a family and identifying service needs. Utilizing this system can provide an efficient and effective means to gather information and communicate it as needed when working with a family. When meeting with local management the committee found that not all CA CPS investigating staff in the office have access to this particular database.

Additionally, when unable to locate a family in which CA has received an intake, best practice guidelines suggest CA staff make reasonable efforts to locate the children and parents in order to complete an investigation. Best practice guidelines and CA policy[14] provide staff with several methods to assist them in locating families prior to closing a case with the reason code - Unable to Locate. In this particular case, CA staff were notified by law enforcement and relatives of the family that the family had moved in order to avoid contact with CA staff. The review committee found that prior to closing the July 2011 intake (which requires supervisor review) CA staff

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[9] CA Practices and Procedures Guide 2310 (B) (9)
[10] CA can access several data systems (NCIC, Barcode, Economic Services Administration, etc.) for information to assist in assessing a family's needs for intervention and services.
[11] CA Practices and Procedures Guide Chapter 4302 Family Team Decision Making Meetings
[12] National Crime Information Center
[13] Department of Social and Health Services database systems that contain information regarding a family known to DSHS that can support appropriate intervention and response to a family needs.

[14] CA Practice and Procedures Guide Chapter 5200 (B) Unable to Locate Parent and/or Relative Caretaker

should have contacted the CPS office in the community where the family was said to have relocated as a means to follow up on the concerns identified when the family left.

Supervisor Reviews/Oversight: The committee noted required monthly supervisor reviews[15] are essential to CA staff's work. These reviews provide the opportunity for clinical supervision and feedback and supports decision making based on information and facts available in a thorough investigation. In addition to supporting shared decision making, supervisory reviews assist social workers in developing a service plan. Without documentation in the case file it was difficult for the committee to determine if any supervisory oversight occurred in this case. In both instances when this case was open for investigation (November 2010 and July 2011) and for services (November 2010-March 2011) the committee was unable to determine if the case had been reviewed while open and prior to closure. Supervisory reviews particularly at closure identify whether case elements are completed or if any additional follow up or documentation is needed.

Recommendations

Supervisor Reviews and Casework Documentation: The absence of casework documentation and supervisor reviews in this case made it difficult to identify what interventions were made while this case was open from November 2010-March 2011. The review committee acknowledged CA staff have current practice and procedure expectations for both casework documentation and supervisor reviews. Guidelines for supervisor reviews for all program areas are available to CA staff. Utilizing the guidelines is not a requirement; however they are available to supervisors when reviewing cases on a monthly basis, for closure or program transfer. The guidelines are designed to identify whether case elements are completed and documented in the case file. Local office management shared with the review committee that recent changes in the management structure of the office had occurred and a plan to increase supervisory oversight and guidance on cases as directed by policy has been implemented.

Data Base System Availability: During the course of the review the committee discussed the DSHS database systems, such as Barcode, available to CA staff for use when investigating allegations of abuse or neglect or providing services to families. The review committee noted database systems can provide additional information during the fact finding stages of a case and to support findings. It is unclear from the case record if this information was accessed. The information available within the Barcode system and other systems can assist in verifying information provided by the family during the course of a case as well as assist in case plan development and service implementation. The review committee recommends local office management review the accessibility and availability of data base systems, such as Barcode, for front line social work staff and include training on data base usage.

[15] CA Practices and Procedures Guide Chapter 46100 Supervisory Monthly Reviews and CA Operations Manual Chapter 6223 Supervisory Monitoring