Washington State Department of Social & Health Services

CA Children's Administration

Child Fatality Review

K.B.

RCW 74.13.515 **2016**
Date of Child's Birth

October 4, 2016
Date of Child's Death

February 23, 2017
Date of the Fatality Review

Committee Members
Patrick Dowd, Director, Office of the Family & Children's Ombuds
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Executive Summary

On February 23, 2017, the Department of Social and Health Services Children's Administration (CA) convened a Child Fatality Review (CFR)[1] to assess the department's practice and service delivery to a RCW 74.13.515-old infant and RCW 74.1 family.[2] The child is referenced by RCW 74.1 initials, K.B., in this report. The incident initiating this review occurred on October 4, 2016, when K.B., who was residing with RCW 74.1 mother and maternal grandfather, died while co-sleeping with RCW 74.1 mother. Three weeks prior to the incident Child Protective Services (CPS) had initiated an investigation regarding the family.

The CFR Committee included CA and community professionals with relevant expertise in child advocacy, child abuse and child safety, law enforcement and pediatric medicine. None of the Committee members had any previous direct involvement with this family.

Prior to the review, the Committee was provided 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. The 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. Following the review of the case file documents, completion of staff interviews and discussion regarding CA activities and decisions, the Committee made recommendations that are presented at the end of this report.

Case Summary

Three reports, including two that were screened out, came to CA in 2014 concerning the mother and the father of RCW 13.50.100. The allegations concerned RCW 13.50.100, RCW 13.50.100 and the mother attempting to RCW 13.50.100

[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 the 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] The parents are not identified by name in this report as no criminal charges were filed relating to the incident. [Source: RCW 74.13.500(1)(a)]

RCW 13.50.100. Due to significant safety concerns identified by CPS, K.B.'s maternal grandmother pursued and was awarded third party custody[3] of RCW 13.50.100 in December of 2014.

CA received a report in April 2016 alleging RCW 13.50.100 by K. B.'s mother while she was RCW 13.50.100. The report screened out[4] as K.B. had not yet been born.[5] In RCW 74.13.515 2016, two reports screened in[6] for CPS investigation. At the hospital when K.B. was born, RCW 13.50.100 between K.B.'s mother and father was reported in conjunction with RCW 13.50.100 and RCW 13.50.100. On October 4, 2016, K.B.'s maternal grandfather called CA to inform that K.B. had died while sleeping with K.B.'s mother. Law enforcement later informed CA that a search warrant was implemented on the home and they took the mother to the police station for an interview and for bloodwork to assess for substances. CA was not able to access the bloodwork results taken by law enforcement and the cause of death was considered as undetermined according to the medical records. The result of CA's investigation of K.B.'s death was unfounded[7] for abuse and neglect.

Committee Discussion

Although believing that some aspects of the 2014 CPS involvement with the family was germane to the 2016 case involving K.B., the Committee discussed the

[3] Third party custody, or nonparental custody, is a legal mechanism whereby an individual who is not a child's parent may obtain physical and legal custody of a child through a court order. An individual seeking a custody order must submit, along with his or her motion for custody, an affidavit declaring that the child is not in the physical custody of one of its parents or that neither parent is a suitable custodian and setting forth facts supporting the requested order. The party seeking custody shall give notice, along with a copy of the affidavit, to other parties to the proceedings, who may file opposing affidavits. [Source: RCW 26.10.032 (1)]

[4] 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 CA/N; 5) Cases in which no abuse or neglect is alleged to have occurred; and 6) Alleged violations of the school system's statutory code or administrative code.

[5] Washington state law does not authorize Children's Administration (CA) to screen in intakes for a CPS response or initiate court action on an unborn child. [Source: CA Practices and Procedures Build Chapter 2200]

[6] Intake social workers determine program response type and response times (emergent or non-emergent) for an investigation. CA intakes fall into three categories: CPS – Involves a child who is allegedly abused, neglected, or abandoned and includes child abuse allegations. CPS Risk Only – Involves a child whose circumstances places him or her at imminent risk of serious harm but does not include child abuse allegations. Non-CPS – Involves a request for services for a family or 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 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. [Source: RCW 26.44.020]

screening decisions made for the December 2014 intake. This report came to CA after regular business hours and the state centralized call unit took the report. The intake was screened out and assigned for review to King County jurisdiction as the mother was residing in King County. The Committee surmised that the Richland office may have assessed the screening decision differently than the King County office based on historical information known locally that may not have been documented in FamLink, CA's case management system.

The Committee acknowledged the short time span between the assignment of the intake dated RCW 74.13.515 19, 2016 and K.B.'s death on October 4, 2016. A Family Team Decision Making meeting[8] (FTDM) was held on September 23, 2016 identifying that a safety plan[9] was needed. The Committee discussed the decision to postpone creating the formal safety plan. Although CA had a verbal agreement with the parents of K. B. and other family supports, the Committee discussed the importance of having a very specific and written safety plan upon determining there is a safety threat to a child. The Committee opined that a safety plan could have been constructed immediately at the FTDM. The Committee discussed the potential benefit of having all safety plan participants present and included in the creation of the safety plan, that they understand their expected roles therein and that they complete background checks if required.

The Committee pondered the local law enforcement agency withholding certain records from CA and the impact that action had on CA's inability to proceed with a substantiated finding of child abuse and neglect. The Committee discussed how

[8] Family Team Decision Making meeting (FTDM) is a facilitated team process, which can include birth/adoptive parents, guardians, extended family members, youth (as appropriate), community members, service providers, child welfare staff and/or caregivers. These meeting are held to make critical decisions regarding the placement of children following and emergent removal of child(ren) from their home, changes in out-of-home placement, and reunification or placement into a permanent home. There may be instances when a FTDM can be held prior to placement if there is not an immediate safety threat such as a child who is on a hospital hold and a FTDM could provide placement options. Permanency planning starts the moment children are placed out of their homes and are discussed during a Family Team Decision-Making meeting. An FTDM will take place in all placement decisions to achieve the least restrictive, safest placement in the best interests of the child. By utilizing this inclusive process, a network of support for the child(ren) and adults who care for them are assured. [Source: CA Practices and Procedures Guide Chapter 1720]

[9] The Safety Plan is a written agreement between a family and CA that identifies how safety threats to a child will be immediately controlled and managed. The Safely Plan is implemented and active as long as threats to child safety exist and caregiver protective capacities are insufficient to protect the child. A safety plan is required for all children where there is a safety threat(s) indicated on the safety assessment. Note: when creating an in-home safety plan, the following criteria must be met: 1) there is at least one parent/caregiver or adult in the home; 2) the home is calm enough to allow safety providers to function in the home; 3) the adults in the home agree to cooperate with and allow an in-home safety plan; 4) sufficient, appropriate and reliable resources are available and willing to provide safety services/tasks. [Source: CA Practices and Procedures Guide Chapter 1130]

local law enforcement protocols can impact CA's ability to gather sufficient information for safety assessments and findings of abuse or neglect.

The Committee discussed how CA's assessment of historical and possible current parental substance abuse may have impacted this case. The Committee recognized the challenges faced by CA social workers to fully assess clients for current chemical dependency issues, such as cases where clients may intentionally minimize their drug use or need for treatment and justify their use based on prescription authorization or legality of a substance. The Committee discussed possible disparities in response by CA workers across the state when considering a legal or prescribed drug versus an illegal drug. The Committee discussed the importance for CA staff to assess the impact that substance use or abuse has on a parent's ability to safely care for his/her children regardless of the legality of a substance, by considering observations, historical CA records and collateral information.

The Committee spent a considerable amount of time discussing the importance of CA staff receiving sufficient and ongoing training to inform social work practice. Emphasized in conversation were two areas of training - substance use and domestic violence. The Committee was concerned to learn that training on substance use and its impact on child safety and child welfare has not been available for to CA staff for a prolonged period of time. The Committee believed that assessing the parent's substance use and/or abuse in this case could have been more thorough, but recognized that without sufficient training on how to assess substances as it relates to child safety, any assessments may be limited.

The Committee heard from the supervisor and CA caseworker that domestic violence training has been offered and available in their local office; however, due to conflicts with schedules, neither the supervisor nor the CA caseworker were able to attend. The Committee discussed that during the 2016 investigations, had the assigned social worker and supervisor attended the domestic violence training, they would likely have received helpful information to assist them in sorting out who the victim and perpetrator were and been able to more fully assess the child's safety. Attending available training on substance use and domestic violence that include information on their impacts on child safety should be considered a priority for staff.

Findings

Given that the manner of the child's death remains undetermined, the Committee did not find critical errors or make correlating conclusions with regard to actions taken or decisions made by the CA.

Recommendations

- The Committee recommends that CA consider requiring a safety plan to be developed immediately at the time of an FTDM if a safety threat has been identified and the FTDM plan calls for a safety plan to be developed.
- The Committee recommends that the local DCFS office social worker and supervisory staff attend the two-day domestic violence training available in their region.
- The Committee recommends that CA provide yearly training to all CA staff on the assessment of legal and illegal substances and their impact on a person's ability to safely care for a child.