Children's Administration
Executive Child Fatality Review

M.S.

September [redacted] 2009
Date of Child's Birth
July 2, 2011
Date of Child's Death
October 27, 2011
Executive Review Date

Committee Member
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Executive Summary

On October 27, 2011, 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 21-month old, M.S. (DOB: 09-[redacted]-2009; DOD: 7-2-11). M.S. was a dependent of the state at the time of her death. She had recently returned home on trial return home on June 7, 2011. A committee that included community professionals and CA staff reviewed case documents and interviewed CA staff to examine child welfare practices, system collaboration, and service delivery to M.S. and her family.

On July 3, 2011 the Guardian ad Litem (GAL) supervisor assigned to M.S.'s dependency case reported to CA's Central Intake office that she had been notified by the child's family that M.S. drowned in the family's above ground pool on the evening of July 2, 2011. The referrer reported she was told the child's mother was on a cell phone when she saw M.S. go outside the family home. M.S.'s mother, E.S., assumed she was being supervised by her father who was outside with their other child at the time. However, according to the referrer, M.S.'s father (R.A.) was in another part of the yard playing with M.S.'s brother not near the above ground pool and unaware M.S. was outside unsupervised. The referrer reported the family's above ground pool has an attached ladder that the parents report is usually put up when the pool is not in use; however had been left attached the evening of July 2, 2011 and was accessible to M.S. The referrer reported the family called 911 and law enforcement and emergency medical technicians responded, performed CPR at length, but were unable to revive M.S.

An autopsy was performed at the request of Yakima County Coroner's Office noting *Cause of Death – Probable Fresh Water Drowning – Asphyxia, Manner: Accidental.*

The family's CA history includes 13 intakes of child abuse and neglect. The incident which led to M.S. and her sibling being placed in out-of-home care occurred in May 2010. On May 12, 2010 M.S. was transported to Sacred Heart Hospital in Spokane after being left unsupervised in the bathtub and the victim of a near-drowning. As a result of this incident law enforcement officials placed M.S. and her older sibling into protective custody and upon release from the hospital M.S. was placed in the same foster home as her sibling. A dependency was established in July 2010. Following a year in out-of-home care and services provided by CA, M.S. and her brother were returned home on trial return home in June 2011.

A case summary relating to M.S. and her family was prepared and provided to the ECFR committee. A copy of the family's case file was also available to the committee. During the course of the review the committee discussed issues related to service delivery, the significance of patterns identified in the case regarding allegations reported to the department, domestic violence, and substance abuse.

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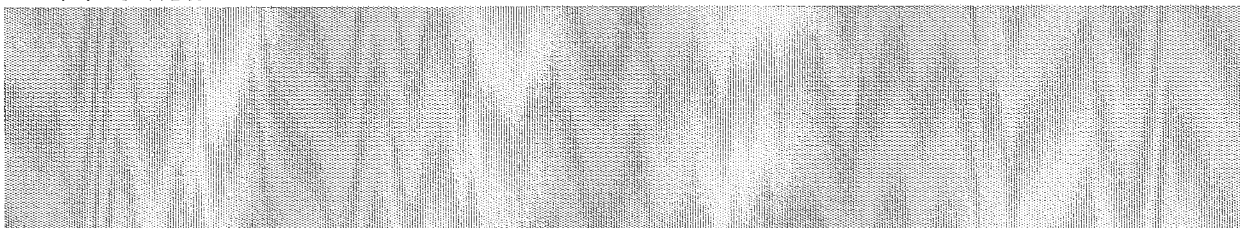
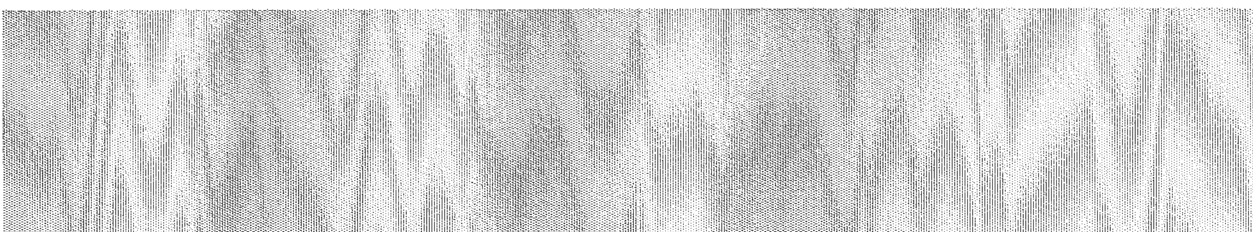
[1] Given its limited purpose, a Child Fatality Review by Children's Administration should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. A review is generally limited to documents in the possession of or obtained by DSHS or its contracted 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.

Committee members interviewed the GAL supervisor and the social worker assigned to the case at the time of M.S.'s death. The committee's discussion addressed issues related to the coordination of communication between service providers, critical thinking, shared decision making, and case elements.[2] Following a review of the family's history, case records and discussion, the committee made findings and recommendations that are detailed at the end of this report.

Case Overview





R.A. is associated with 4 intakes (beginning in May 2010) referencing M.S. and her sibling (an older brother)[8]; 2 in which he is identified as a subject of abuse and neglect that resulted in founded findings for neglect and negligent treatment.

In May 2010 CA initiated an investigation in collaboration with law enforcement into allegations of neglect (lack of supervision) after it was reported M.S. had nearly drowned in the family bathtub. It was reported her father had placed M.S. in the bathtub while her mother was outside with their other child. M.S.'s father then left to take the garbage out while seven-month-old M.S. remained in the bath tub. It was reported M.S.'s parents proceeded to argue in the front yard when they realized M.S. was left unattended in the bath tub. Collaterals provided a consistent explanation to the incident and M.S.'s father took responsibility for the incident. As a result of this incident a founded finding was made and a petition to remove M.S. and her brother from the family home was filed in court due to continuing concerns for their safety. Upon release from the hospital, medical staff expressed concern about developmental delays noted during M.S.'s hospitalization that were not related to the drowning

[2] Activities conducted according to CA Practice and Procedure Manual and Case Services Manual e.g.) Monthly Social Worker Visits, Documentation, Investigation Criteria, Intake Decisions, etc.

[5] Source: WAC 388-15-009 What is Child Abuse and Neglect?

[6] FamLink is Children's Administration's management information system.

[8] M.S. has three brothers; one who lives with his father who is not a dependent, and two others; one older who was part of the May 2010 dependency matter and a younger brother born during the dependency who was not placed in out of home care.

incident but more likely to ongoing neglect of M.S. by her caregivers. The shelter care hearing was held on May 17, 2010, and the court ordered the children to remain in out-of-home care until services could be provided to address safety threats and parental protective capacities. Dependency for both children was established in July 2010.

CA provided services during the dependency process which included drug and alcohol assessments, individual counseling, domestic violence, anger management and visitation. Service providers reported although the parents were slow to engage in services, they did begin to comply in their attendance and noted some progress in addressing issues related to parenting, substance use,[9] and relationship issues. Disclosure of domestic violence was made by M.S.'s mother in December 2010, however recanted shortly thereafter. Follow up regarding possible domestic violence in the home was included in services addressing anger management and relationship issues; however a referral or consultation with a domestic violence program was not noted in the case record.

During the course of the dependency and prior to return home of the children, CA received three intakes following visits in the parental home. The referrer (foster parent) reported concerns regarding bruises to the children and hygiene issues following visits. Following investigation of the three intakes, unfounded findings were made. In May 2011, as required by policy prior to returning children home, the case was staffed with the local Child Protection Team[10] (CPT). The CPT, after consultation with the assigned social worker and GAL, agreed that return home was an appropriate plan with the condition the case remain open for a minimum of six months and the family continue to participate in any identified services (domestic violence referral was recommended). The children were returned home following court approval on June 7, 2011. The assigned social worker conducted a monthly health and safety visit on June 10, 2011 according to CA Policy[11] noted no concerns, and the children were doing well in the family home. CA policy requires two health and safety visits each month for children returned home on a trial return home for the first 120 days.

On July 3, 2011 CA received the intake noting M.S.'s death. CA and Grandview Police Department initiated an investigation into the death and determined M.S., then 17 months old, was outside the family home unsupervised and accidently drowned in the above ground pool located on the family property.[12] The Yakima County Coroner determined cause and manner of death: probable fresh water drowning – asphyxia, accidental. CA's fatality investigation resulted in a founded finding of neglect/negligent treatment against M.S.'s mother. Following CA's intervention and with the assistance of law enforcement based on concerns for child safety and the parents' ability to supervise their children, the surviving siblings[13] were placed in out of home care[14] on July 4, 2011.

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[9] Case documentation notes both parents participated in random urinalyses during the course of the dependency. Attendance and follow through in recommended treatment was sporadic.

[10] Source: CA Practice and Procedures Manual Chapter 2500 Section 2562 (2) (b) (iii) Child Protection Teams CPT consultation is required: *"In all cases prior to return home or dismissal of dependency, when the child is age six or younger and any risk assessment has resulted in a risk level of moderately high or high risk."*

[11] Source: CA Practice and Procedures Manual Chapter 4420 Social Worker Monthly Health and Safety Visits

[12] The family property included several mobile homes and one fixed dwelling. During the investigation it was noted the above ground pool located on the back of the family property could not be seen from M.S.'s family home.

[13] M.S.'s older brother, already a Washington dependent and a third child born during the course of the dependency (November 2010) were placed in protective custody.

Review Committee Discussion and Findings

To develop a thorough understanding of the family and case, the review committee identified dynamics that appeared to influence decision-making by the department, e.g.) intake screening decisions and investigations, identification and assessment of family dynamics and how they affected parenting, service delivery and progress, and placement decisions. The committee requested and met with the Child Family Welfare Services (CFWS) social worker assigned to the case at the time of M.S.'s death and the GAL's supervisor.

Casework: The committee discussed at length the CPS investigations and CFWS case management decisions made in this case over the course of the family's involvement with CA. They found the following:

- **Intake screening decisions:** Intakes received on January 28, 2009, March 18, 2009 and August 9, 2009 were screened out recommending no need for intervention by CA. Allegations referenced illicit substance use by M.S.'s mother while pregnant and concern for safety of other children while she was using. The intakes did not note allegations of child abuse or neglect as defined by WAC 388-15-009. However the committee found based on the mother's documented substance abuse history and previous founded findings the intakes merited intervention and recommended they should have screened in as CPS Risk Only.[15]

- **Investigation and case management elements:** The committee found some case elements required by CA policy did not occur. Investigative and case management standards should include:
    - Collaborating with law enforcement when parallel investigations are occurring (especially in cases of a child fatality) as defined by the respective county's established protocol.[16]
    - A review of the family history to gain an understanding of previous interventions and as a means to identify patterns of parental behaviors that affect child safety.
    - Obtain sufficient collateral information which may include a child's medical records, and interviews with sources familiar with the family.
    - Seek and document information obtained from service providers that address behavioral progress in services not just compliance. Committee members found case documentation was minimal which affected decision making.
    - Social worker monthly health and safety visits occurred both in the family home and while the children were in out-of-home placement throughout this case according to policy. Current policy[17] includes observations of the home environment shall be completed at the time of the visit. However, the committee found current policy does not recommend observations of the areas outside the home to check for safety hazards.

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[14] Children were placed in licensed foster care as there were no relatives deemed available at the time for placement.

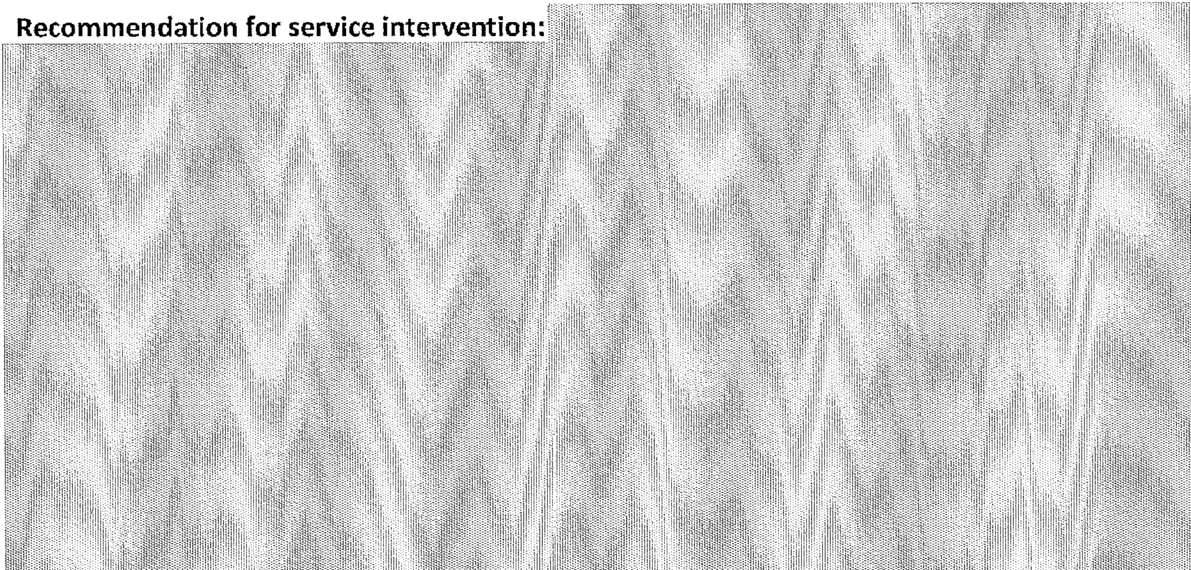
[15] Source: CA Practice Guide to Intake and Investigative Assessment, Chapter 4, page 25: CPS Risk Only Intakes are defined as intakes that do not allege child abuse and neglect as defined by WAC 388-15-009, but have risk factors that place a child at imminent risk of serious harm.

[16] Source: RCW 26.44.185 County protocols referencing child fatalities, child physical abuse and chronic neglect cases.

[17] Source: CA Practice and Procedures Manual Chapter 4420 (B) (1) Social worker visits with child

- CA policy requires a Family Team Decision Making (FTDM)[18] meeting will be held when considering reunification. Committee members noted a Child Protection Team (CPT) staffing occurred as required by policy; however a FTDM was not scheduled prior to return home in June 2011.

- **Recommendation for service intervention:**



Patterns: The committee observed that a pattern of child abuse and neglect reports to the department had occurred from 2008-2011 (13 intakes in 3 years). The presence of multiple risk factors and safety threats existed throughout the record consistently, creating the need to thoroughly assess the family in order to gain an understanding of the parents' ability to safely parent their children. When assessing for present and impending danger for a child, CA policy directs that staff be aware of the heightened risk to children when the parent shows a pattern of failing to meet the child's physical, medical, educational and emotional needs (e.g. repeated disclosures of domestic violence, supervision issues and illicit substance abuse[20]).

Intakes and inconsistent compliance in services noted in this case demonstrated a pattern in parental behavior directly impacting the health and safety of their children. The committee found recognizing and understanding the pattern of behaviors and events, verified through collateral sources, can support intervention (taking action) and subsequent decision making to increase child safety while assessing a parent's ongoing progress in improving their protective capacities. Diligent efforts in locating, accessing and utilizing information from other sources assists in keeping children safe and identifying family patterns can affect decision making,[21] service needs and case plans.

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[18] Source: CA Practice and Procedures Manual Chapter 4302 Family Team Decision Making Meetings
[19] Family Voluntary Services are voluntary and the family has no court involvement. CA and the family develop a time-limited agreement based on the family's needs that outlines the services offered to improve their child's health and safety.
[20] Substance abuse and domestic violence was identified as major issues in this case. The committee observed the parents' follow through with these issues was inconsistent throughout involvement with CA staff.
[21] Decisions such as those made on new intakes or the need for out of home placement or services.

Service Needs and Follow Through: The committee observed that CA staff accurately identified substance abuse and domestic violence issues in this case which directly impacted parenting capacities. Information provided by the social worker and the GAL supervisor indicated that although no significant defining event had occurred in this family following the children's out of home placement in May 2010, it appeared the family minimized the impact domestic violence and substance use had in meeting their children's safety needs. Recommendations and referrals for services were appropriately generated to support the family in developing an understanding as to how these issues operated in their home and what safety tasks and services were needed to increase their children's health and safety.

CA staffs consult with subject matter experts[22] to assist in providing services and effecting behavioral change in families. Consistent communication should not rely exclusively on written reports, but can include telephone contact and providers inclusion in any identified staffing, which contacts must subsequently be documented according to CA policy.[23] Information shared should focus on a parent's treatment progress rather than just attendance.

Recommendations

Casework: The committee noted CA practice and procedures provide guidance to assist social workers in fulfilling case requirements. The committee confirmed the need to gather and verify information provided by a parent through the use of collateral sources, direct observation and communication, shared planning meetings, supervisor consultation and collaborating with subject matter experts. This collaboration and communication assists in completing a thorough assessment of a family

In referencing social worker monthly health and safety visits the committee recommends enhancement to the existing policy to include an outside perimeter assessment of a home. It was recommended CA could utilize information contained in the C-POD Guidelines[24] (Collaboration, Preservation, Observation and Documentation) used by first responders when responding to child fatalities and serious physical injury cases. The *observation* component includes information on how to assess both the outdoor and indoor environment of a home/facility.

Patterns: During the review, the committee learned about CA's implementation of a new Child Safety Framework in November 2011 that supports and assists social workers in assessment, identification, and management of safety threats throughout the life of a case. The patterns in this case of child abuse and neglect reports, domestic violence, and substance abuse would be thoroughly identified in the new assessment, moving the practice away from incident-focused work to a comprehensive assessment of how this family functioned. The Child Safety Framework also stressed the importance of verifying information gathered (from parents) by contacting collaterals and other child welfare partners working on a case.

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[22] In this case domestic violence and substance abuse providers.

[23] Shared Planning Meetings, Family Team Decision Making meetings, MDTs, etc.

[24] Source: Washington Criminal Justice Training Commission's C-POD Guidelines for First Responders.

The framework also suggests critical thinking and shared decision making through clinical supervision and multidisciplinary team staffings assists in understanding family patterns and helps to mitigate bias in casework.

Service Needs and Follow Through: The committee found that given the complexity regarding domestic violence and substance abuse it is recommended on-going training and regular consultation regarding these issues occur for staff. Assessment of parental issues and deficiencies is critical in developing case plans and improving child safety within families. A domestic violence training curriculum that addresses the broad spectrum of domestic violence to include topics such as perpetrator assessment and accountability, treatment recommendations, understanding patterns and cycles, and safety planning is recommended. A substance abuse training curriculum that assists social workers in understanding the progress of addiction as well as recovery would be beneficial. Training could be conducted in person or through on-line resources.

Supervisor Consultation: CA policy[25] supports supervisors conducting monthly case reviews with their staff and documenting in FamLink. The committee found that while thorough guidance is provided in the policy, additional direction and training would be beneficial to front line supervisors for the purposes of case consultation and supervision. The committee identified the 3 week Academy for supervisors provides an introduction to supervision, however recommended follow up training for supervisors that would address topics such as coaching, mentoring, counseling, interaction, and clinical supervision. It was recommended that CA program managers consider researching the Criminal Justice Training Commission's supervisory course curriculum as a follow up training to Supervisors Academy.

[25] Source: CA Practice and Procedures Manual Chapter 46100(B)(1-3): Monthly Supervisor Case Reviews