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

N.A.

May 2012
Date of Child's Birth

August 16, 2013
Date of Child's Death

November 13, 2013
Child Fatality Review Date

Committee Members
Renea Bloom, CADC, Chemical Dependency Professional, Merit Resource Services
Mary Meinig, Director Ombudsman, Office of the Family & Children's Ombudsman
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Observers
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Facilitator
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Executive Summary

On November 13, 2013, the Department of Social and Health Services (DSHS), Children's Administration (CA) convened a Child Fatality Review (CFR)[1] to review the department's practice and service delivery to a 15-month-old female child and her family. The child will be referenced by her initials, N.A., in this report. At the time of her death, N.A. shared a home with her father and mother. The incident initiating this review occurred on August 16, 2013 when N.A. died from injuries related to a car accident. N.A.'s father was intoxicated and driving at the time of the accident; N.A. was the only passenger in the car. The mother was at the family residence at the time of the accident.

The review is conducted by a team of CA staff and community members with relevant expertise from diverse disciplines. Neither CA staff nor any other committee members had previous involvement with the case.

Prior to the review each committee member received a case chronology, a summary of CA involvement with the family and non-redacted CA case documents (e.g., intakes, safety assessments, investigative assessments, provider records, law enforcement records, and Child Protective Services investigative reports).

Supplemental sources of information and resource materials were available to the committee at the time of the review. These included copies of the complete casefile and relevant state laws and CA policies.

The Committee interviewed two CA social workers and a CA supervisor previously assigned to the case.

Following a review of the case file documents, interviews with the CA social workers and supervisor, and discussion regarding department activities and decisions, the 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.

Case Summary

N.A. and her family first came to the attention of Children's Administration (CA) on June 14, 2013. Law enforcement responded to the family home on June 14, 2013 following a car chase where the father was reported to have driven drunk and eluded police. Law enforcement officers used the vehicle's license plate number to track the vehicle to the family home where they found the mother and father engaged in a loud verbal altercation. Law enforcement attempted to gain entry into the family home by knocking on the door. Law enforcement was forced to kick in the door after the parents failed to respond to their requests to enter the residence. Upon entering, the responding officers drew their weapons after observing blood splattered around the living room. The father responded by picking up N.A. and placing her between himself and law enforcement. Law enforcement records indicate the father was using N.A. as a shield. The father eventually surrendered himself to police custody. N.A. was then placed into foster care and a dependency petition was filed.

On June 18, 2013, the court ordered the return of N.A. to her mother's care following a Local Indian Child Welfare Advisory Committee (LICWAC) staffing where reunification was recommended.[2] The social worker supported the reunification of N.A. with her mother. Case records reflect the mother was engaged in her court ordered services and demonstrating the ability to meet her daughter's basic physical needs. The father was incarcerated when N.A. was reunified with her mother. It should also be noted that the father had a no contact order in place from a May 2013 domestic violence incident which prohibited the father from having contact with the mother until May 10, 2021.

The father's no contact order was dismissed on July 19, 2013 for reasons unknown to CA social workers. On July 26, 2013, the father was released from jail. On August 1, 2013, the social worker arranged for a visit between the father and N.A. in the family home. The mother was also present and in agreement with the visit.

After the father was released from jail, the social worker reminded the parents that the father may not be in the family home outside of the agreed upon visitation plan. The parents agreed to abide by this condition. On August 16, 2013, the mother canceled the father's visit as she was sick. At approximately

[2] A LICWAC is a body of volunteers, approved and appointed by Children's Administration (CA), who staff and consult with the department on cases of Indian children. The LICWAC team acts as a multi-disciplinary team for CA in the development of culturally relevant case plans. A LICWAC may review the social worker's assessment of potential risk factors and makes appropriate recommendations to ensure the safety of each Indian child. Retrieved from: http://www.dshs.wa.gov/ca/pubs/mnl_icw/chapter10.asp#10.01

4:00 p.m., the father arrived at the family home without the knowledge or approval of the social worker and took N.A. out to dinner with her mother's permission. The father was involved in a car accident and N.A. was killed from injuries related to the accident. The father was under the influence of alcohol and methamphetamine at the time of the accident.

Discussion

The Committee discussed the process of gathering and assessing information during a child abuse and neglect investigation. The Committee believed the social workers might have benefitted from the gathering of additional information related to the family's past domestic violence (DV) history. This included law enforcement records, criminal background checks, and information regarding the no contact order that prevented the father from knowingly coming within 500 feet of the mother. The no contact order was initially set to expire on May 10, 2021, and was entered by the Yakima Municipal Court on May 10, 2013. The Committee noted the social workers did not gather police reports regarding the no contact order and the May 10, 2013 DV incident. The Committee believed the social workers could better assess the mother's protective capacity if they had this additional information.

The Committee noted the no contact order was dismissed on July 24, 2013. The Committee believed it was important for the social worker to gather information regarding the court's reasoning for the dismissal of the no contact order. The Committee noted the assigned social worker did a good job of verifying the dismissal of the no contact order but did not know the basis for the dismissal.

The Committee members requested the child fatality review report reflect how critical the safety planning process is to child safety. The Committee believes each CA social worker should be an expert in the development of strong safety plans. The Committee discussion noted several areas for system improvements around safety planning that are reflected in the findings section of this report. The Committee also recommended improved ongoing training regarding safety planning that is also reflected in the recommendation section of this report.

The Committee discussed the challenges of developing a strong case plan when working with a family struggling with the impacts of domestic violence. As mentioned previously, the Committee noted the importance of gathering reasonably available records (such as police records, court records) related to past domestic violence. The Committee learned through interviewing the previously assigned social workers that the mother may have had a history as

both a perpetrator and victim of domestic violence. The Committee expressed concern that the social worker was unable to provide further details about the mother's alleged history as a perpetrator.

The Committee believes the social worker should not have offered the father visits in the family home. The Committee believes the father had not demonstrated progress in the areas of concern that caused his incarceration and the placement of N.A. into foster care. The areas of concern included substance abuse and domestic violence. The Committee noted the father was released from jail and then reintroduced back into the family home via visits without demonstrating the ability to maintain a drug and alcohol free lifestyle. The Committee noted that the mother self-reported a correlation between the father's substance abuse and the escalating domestic violence episodes. The Committee believes the mother lacked the ability to set limits on the father once he was reintroduced back into the family home.

The Committee noted the mother and father demonstrated a willingness to disregard the existing no contact order by allowing the father into the family home on June 18, 2013. The social worker's referral for Family Preservation Services (FPS) dated July 1, 2013 highlights the social worker's concerns about domestic violence at the time of reunification. The referral reads, "*There is evidence of escalating domestic violence between the parents. There is a no contact order in place through 2021, but both parents have continually and apparently voluntarily broken this order on an ongoing basis.*" The Committee believes the parents' history of violating the previous no contact order might have warranted a delay in reunification.

The Committee expressed concern that the social worker placed the mother in a position of power over the visitation plan given the history of domestic violence. The mother stated on July 10, 2013, "*That she thinks this separation is for the best, they both need to get better individually before they can try to be together.*" The social worker engaged the father in a conversation about visitation upon his release from jail. The social worker documented, "*We [father and social worker] agreed that this social worker will call [the mother] to see if an arrangement [for visits] can be made for tomorrow from 3-5 with this social worker present*." The social worker then spoke with the mother and documented, "*Social worker spoke with [the mother], she was in agreement with the visit, she stated that she felt "kind of nervous." This social worker restated that if she didn't want to do it [in-home visits] she had the right to say so and other arrangements could be made.*" The Committee believed the social worker and her supervisor should have taken

on the responsibility of setting the parameters around the visits and that the visits should have continued out of the home until the father and mother had both demonstrated a period of progress with services.

The Committee acknowledged areas of strength that included quality documentation and the strong engagement skills of the social workers assigned to this case.

Findings

1) The Committee believes Children's Administration staff did not gather sufficient information regarding the pattern of domestic violence in the family home prior to making critical decisions about reunification and visitation.
2) The Committee noted several concerns regarding the safety plan initiated on June 18, 2013. The first concern was related to the reliance on a grandmother with her own concerning Child Protective Services (CPS) history. The Committee believes the grandmother's history should have precluded her from being considered a safety plan participant. In addition, the Committee noted the CPS social worker and Child and Family Welfare Services (CFWS) supervisor were aware of the grandmother's CPS history; however, they failed to notify the assigned CFWS social worker who was unaware of the grandmother's CPS history. The Committee believes strong communication about the safety plan is critical when a case is transferred between social workers. The grandmother's history was a critical piece of the Committee discussion because she was a key participant who agreed to help monitor for safety concerns. Second, the Committee noted the safety assessment was created at a time when the safety plan participants believed the father would not be returning to the home due to his incarceration. The Committee believes the safety plan needed to be reevaluated and updated following the father's release from jail.
3) The Committee noted the mother and father failed to comply with the May 10, 2013 no contact order. For this reason, the Committee believed reunification should have been delayed until the mother had demonstrated the ability to maintain appropriate boundaries.
4) The Committee believes the social worker should not have introduced in-home visits prior to the father demonstrating a period of compliance and progress with services.

Recommendations

1) The Committee recommends all social workers read and discuss the *Social Worker's Practice Guide to Domestic Violence* prior to the completion of the Regional Core Training (RCT).[3]
2) The Committee recommends social workers receive and demonstrate a strong understanding of the safety planning process prior to the carrying of cases and the completion of RCT.
3) The Committee recommends all CA social workers receive an annual refresher training regarding safety planning.

Nondiscrimination Policy

The Department of Social and Health Services does not discriminate and provides equal access to its programs and services for all persons without regard to race, color, gender, religion, creed, marital status, national origin, sexual orientation, age, veteran's status or the presence of any physical, sensory or mental disability.

[3] Regional Core Training - The RCT is the initial, intensive, task-oriented training that prepares newly hired Social Service Specialists to assume job responsibilities. RCT starts on the first day of employment and lasts for 60 days, or the first two months of employment. Competencies are used to assess learning needs and to identify a developmental plan for the new workers. Retrieved from: http://allianceforchildwelfare.org/sites/default/files/sites/default/files/career/alliance_training_september_2013_0.pdf