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

Children's Administration
Child Fatality Review

N.I.

July 2010
Date of Child's Birth

December 6, 2012
Date of Fatality Incident

March 28, 2013
Child Fatality Review Date

Committee Members
Lynelle Anderson, Detective, Pierce County Sheriff's Department
Paul Evans, Intake Supervisor, Central Intake, DSHS, Children's Administration
Christi Lyson, Assistant Director, Institute for Family Development
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Marti Miller, Child Protective Services Supervisor, Ellensburg, DSHS, Children's Administration
Kathryn Oneita, Indian Child Welfare Director, Small Tribes of Western Washington (STOWW)
Kevin Rundle, Director of Legal Services, YWCA, Pierce County

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RCW 74.13.640

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Executive Summary

On March 28, 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 two-year-old N.I. and his family. N.I. is a Caucasian male with Native American ancestry. Paternity was established post fatality as to N.I., and his father was determined to be T.A. The father reports having both Cherokee and Choctaw ancestry.

On December 6, 2012, the day of the fatality, N.I.'s mother telephoned 911 at approximately 2:30 a.m., as her son was found unresponsive in the family home. Emergency responders transported N.I. to the hospital, but they were unable to establish a heartbeat and he was pronounced dead. The Pierce County Medical Examiner's Office completed an autopsy and toxicology screen. The toxicology report showed N.I. had a fatal amount of methamphetamine in his system at the time of his death.

The CFR Committee included community members selected from diverse disciplines with relevant expertise, including representatives from domestic violence, mental health, parent education, law enforcement, Indian child welfare and Children's Administration (CA). Committee members, including CA staff, had no prior involvement with the family.

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, 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 state laws and CA policies relevant to the review and the complete case file.

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

Following a review of the case file documents, interview of 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.

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[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.I.'s family first came to the attention of the department on June 23, 2009. [redacted] The father and the mother were not in a relationship at the time of the initial intake, but resumed their relationship when the case closed in October 2010. The case was open to the original investigator from June 2009 until December 2010; however, it was inactive for the last three months of that period.

[redacted] A July 31, 2010 intake stating the mother had given birth to N.I. and that the baby (N.I.) would be tested for drug exposure was also screened out.

A February 10, 2011 intake alleging adults were smoking methamphetamine in the same room where N.I. received breathing treatments screened in. The home allegedly had garbage bags spilling onto the floor within reach of N.I.'s two-year-old sister. The mother's methamphetamine use allegedly influenced her ability to safely care for her children. The assigned social worker attempted to engage the mother in services through a voluntary case plan.[6] The mother was offered urinalysis (UA) testing,[7] a chemical dependency evaluation, and Early Family Support System (EFSS) services. The mother completed a chemical dependency evaluation but the social worker was unable to pay for the evaluation as she did not go to the agreed upon contracted provider. The

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[2] CA intake staff must screen in intake reports meeting the following criteria: 1) a child (birth to 5 years old), reported by a licensed physician or medical professional on "the physician's behalf", or 2) a non-mobile infant (birth to 12 months) with bruises, regardless of the explanation for how the bruises occurred. 3) CA must accept an intake where a child is alleged to have been abused or neglect by the child's parent, guardian, or custodian, 4) the subject is a licensed foster parent, group care provider, or a volunteer or employee of a child care agency, 5) a person alleged to have committed CA/N in an institutional setting. CA staff must not treat allegations of CA/N in licensed or certified facilities as third party abuse or neglect.

[3] Unfounded– The determination that, following an investigation by CPS, based on available information: it is more likely than not that child abuse or neglect did not occur, or there is insufficient evidence for the Department to determine whether the alleged child abuse did or did not occur. WAC 388-15-005.

[4] There is a high co-occurrence of domestic violence in cases of child abuse and neglect. However, a child's exposure to domestic violence, in and of itself, does not constitute child abuse and neglect. Domestic violence, which physically harms a child or puts a child in clear and present danger, would constitute an allegation of child abuse. Source: Children's Administration Practices and Procedures Guide 2220.

[5] CA will generally screen-out intakes where: 1) Abuse of dependent adults or persons 18 years of age or older. Such services are provided by the Adult Protective Services (APS) section. 2) Third-party abuse committed by persons other than those responsible for the child's welfare. 3) CA/N that is reported after the victim has reached age 18, except those 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. 6) Allege violations of the school system's Statutory Code, Administrative Code, statements regarding discipline policies.

[6] A voluntary case plan is 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 a parent's protective capacity and manage child safety. Continued assessment of child safety occurs throughout the case.[Source: CA Practices and Procedures-Policy 2441]

[7] Urinalysis (UA) drug testing is a testing of a urine sample (specimen) for drugs.

mother refused to reschedule her chemical dependency evaluation with a contracted provider. The social worker attempted, but was unable to obtain the completed chemical dependency evaluation. The mother provided two UAs during this investigation. She failed to show for one UA and tested positive for marijuana on the second UA. The mother refused EFSS services, and the case closed after the mother refused ongoing voluntary services. The allegations of negligent treatment or maltreatment were unfounded.

On August 30, 2011, CA received an intake alleging a lack of food in the home, unsanitary living conditions, drug use by the mother, and physical abuse of both children by their mother. The intake screened in for investigation. The allegations of neglect were founded[8] and on October 5, 2011, a Family Team Decision Meeting (FTDM) was held; the following safety plan was implemented: N.I. would stay with his maternal uncle and N.I.'s sister would live with her father. The social worker encouraged the father to continue with his chemical dependency outpatient treatment, and DV classes. The mother was offered Family Preservation Services (FPS),[9] Public Health Nurse (PHN) services, and chemical dependency services. On October 12, 2011, the father tested positive for methamphetamine. The CPS case was transferred to the Family Voluntary Services (FVS) unit in October 2011.

On November 16, 2011, an intake was received alleging the children are "hacking and coughing" all night long. The referrer stated he took a crack pipe away from the mother. A subsequent intake was received on November 24, 2011 alleging continued breathing concerns with N.I. and domestic violence between N.I.'s mother and her boyfriend. Both intakes screened in for investigation by CPS. CA lost contact with the mother from November 2011 until June 2012. In June 2012 the mother was offered UA services, PHN services, parenting classes, and a chemical dependency evaluation. On July 2, 2012, the mother tested positive for marijuana and methamphetamines. The FVS case closed due to the mother's failure to cooperate with services and a decision that there was insufficient evidence to file a dependency petition. The decision not to file a dependency petition was made after consultation with the court unit supervisor. The allegations of neglect were unfounded.

On November 18, 2011, CA received an intake alleging the father's residence "reeked" of marijuana, and the father was failing to provide sufficient supervision of N.I.'s sister. The allegations were investigated by CPS and determined to be unfounded.

On August 6, 2012, N.I.'s doctor contacted CA to report the mother's failure to follow through with N.I.'s medical treatment. The intake screened in. The assigned social

[8] Founded--The determination that, following an investigation by CPS, based on available information: it is more likely than not that child abuse or neglect did occur. WAC 388-15-005

[9] FPS—Family Preservation Services--are intensive in-home services for families designed to prevent out-of-home placement of children or to facilitate family reunification.

worker attempted unsuccessfully to locate the family throughout August 2012. The case closed due to the inability to locate the family.
On December 6, 2012, N.I. died from ingesting methamphetamine.

Discussion
The Committee discussion focused on several key areas including social worker documentation, case inactivity, services offered to the family, and decisions surrounding potential out-of-home placement.

Documentation: The Committee discussed the documentation surrounding the June 2009 and October 2009 intakes. The social worker's documentation stated that the mother had no substance abuse issues. The social worker also documented that she believed the father provided false information in his report to intake. The social worker's investigation resulted in no evidence of drug use outside of the allegations in the intake. However, the Committee believed the social worker should have requested UAs or completed additional collateral contacts regarding the mother's drug use prior to making the concrete assertion that the mother had no substance abuse issues. On July 16, 2009, the CPS supervisor documented, "Social worker will be following-up with the father regarding his allegations. She will be talking to him about making false allegations and warning him about erroneous referrals made to this department." The Committee believed the social worker and supervisor had insufficient information to determine the father had provided false information.

Case Inactivity: The Committee noted that there were two periods of inactivity related to this case. The periods were from October 2009 until December 2010, and again from December 2011 until June 2012. During both periods, the case was open with minimal case activity. The Committee expressed concern that the case was considered high risk during the second inactive period and the Committee believed there should have been a greater effort to locate and engage the family. CA has established a "Guideline for Reasonable Efforts to Locate Children and/or Parents." The social worker did not document sufficient efforts to locate the family as referenced in the "Guideline for Reasonable Efforts to Locate Children and/or Parents."

Services: Throughout this case, various services were offered to the family including chemical dependency evaluations and treatment, public health nurse, and family preservation services. The Committee believed the family's level of need and resistance to services may have warranted a more intensive service such as Homebuilders,[10] which provides almost daily contact with families.

The Committee noted that the case file included significant documentation about domestic violence (DV) between the mother and father and believed the mother should have been offered DV victims services.

[10] Homebuilders is a program designed to prevent placement of children, get children back home more quickly, and keep problems from happening again by providing intensive in-home services several times a week for about a month.

The Committee noted the investigative process related to the June 2009 and October 2009 intakes may have been strengthened by requesting the mother comply with UA drug testing.

Placement decisions: The Committee discussed points in the case when CA may have considered filing a dependency petition for out-of-home placement. The first identified point was prior to the FTDM on October 5, 2011.

On October 4, 2011, the assigned social worker requested law enforcement place the children into protective custody due to concerns about the mother's care of the children and the presence of a methamphetamine pipe in the home. Law enforcement declined to place the child into protective custody as the mother was clean and sober at the time of contact. The social worker then contacted the patrol officer's sergeant as she continued to believe the children needed to be placed into protective custody. The sergeant also declined to authorize protective custody.

The Committee thought the social worker demonstrated quality practice by attempting to utilize the patrol officer's sergeant when she remained concerned about the children's safety following her contact with the patrol officer. The Committee was unable to determine how much of the case history was shared with law enforcement and what information was made available to the patrol officer's sergeant when he reviewed the decision to not place the children into protective custody. The Committee noted that the Pierce County Sheriff's Office Investigations Unit can be utilized by CA staff under similar circumstances as the Investigations Unit is better prepared to deal with complex cases, difficult clients, or clients that CA is unable to locate. The Committee believed the safety concerns at this point in the case warranted a discussion with the Assistant Attorney General's Office about the filing of a dependency petition.

The Committee believed CA had a second opportunity to staff the filing of a dependency petition with the Assistant Attorney General's Office following the FTDM on October 5, 2011. The FVS social worker was responsible for implementing and monitoring of the plan agreed to at the FTDM. The Committee noted the FVS social worker did not participate in the FTDM and the Committee believed she may have been better prepared to monitor and implement the case plan if FVS had been invited to attend the FTDM. The CPS supervisor informed the Committee that practice in the Tacoma CA office has changed and FVS social workers now attend FTDMs under similar circumstances. The Committee believed the social worker's lack of contact with the family was particularly concerning due to the mother's lack of cooperation, recent founded finding, and both parents' positive UAs for methamphetamine. In addition, this

case met the criteria for a Child Protection Team (CPT)[11] staffing at multiple points throughout this case and none occurred.

The case transferred to a new social worker in June 2012. The assigned social worker staffed the filing of a dependency petition with her supervisor and the court unit supervisor. The court unit supervisor determined there was insufficient information to support the filing of a dependency petition at that time due to the lack of current allegations regarding the mother and father. The social worker and supervisor informed the Committee the case closed due to the parent refusal of services and the lack of current information supporting a dependency action. The Committee also noted that it had been approximately eight months since CA had significant ongoing contact with the family and the social worker had very limited new information to present at the time of the staffing due to the mother's lack of cooperation. The most recent contact with the family was on June 20, 2012 when law enforcement completed welfare check at the request of the social worker. The mother and children appeared healthy and no concerns were noted by the responding officers. The assigned social worker visited the mother and children on the same day and noted the children appeared clean and well dressed.

Additional discussion points: The Committee noted extended family members provide an additional safety net for children. The Committee believed relatives frequently want to protect children, but lack the knowledge of how to intervene on their behalf. For this reason, the Committee noted that it may be best practice for social workers to be familiar with the third party custody process so they are better able to inform protective family members. Social workers may not provide legal advice about the third party custody process but they could direct them to resources that could assist them with that process.

The Committee noted that law enforcement has instant access into an alleged subject's[12] past contacts with law enforcement. The Committee discussed the potential benefits to social workers of investigative tools used by law enforcement such as Lynx Northwest, LexisNexis and Spillman.[13] As a result, the Committee recommends CA consider adding resources such as Lynx Northwest, LexisNexis or Spillman.

N.I.'s family was identified as having Native American ancestry. Per policy, all cases involving families with Native American ancestry should be staffed with the identified tribe or the Local Indian Child Welfare Advisory Committee (LICWAC).[14] This case was

[11] Child Protection Teams provide confidential, multi-disciplinary consultation and recommendations to the Department on cases where there is a risk of serious or imminent harm to a young child and when there is dispute if an out-of home placement is appropriate.
[12] Subject--means any parent of, guardian of, custodian of or any other persons 18 years of age or older responsible for a child who allegedly causes the abuse or maltreatment of a child, or who allegedly allows the abuse or maltreatment to be inflicted on a child.
[13] LexisNexis and Spillman—are tools used by government agencies to quickly access a full suite of advanced investigative tools to quickly locate people, detect fraud, uncover assets and discover connections between suspects, witnesses or associates. The Committee believes local law enforcement agencies utilize these systems.
[14] 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 who: Are members of a Tribe, Band, or First Nations but for whom the Tribe, Band, or First

not staffed with LICWAC as required.[15] In addition, the Committee noted that the father's name and/or information was frequently missing from the Native American Questionnaires located in the case file. The Committee believes the social workers should have listed the reason why the father was not listed on this form.

The Committee noted that there were significant areas of quality work performed by CA staff between 2009 and the fatality in 2012. The Committee noted that the two CPS investigators related to the February 10, 2011 intake and the August 30, 2011 intake both did an excellent job of considering case history when developing their case plan. In addition, both social workers attempted to work with the family to address the children's medical needs. The Committee believed the investigations by both of these social workers was comprehensive and demonstrated quality work.

Findings

1) The FVS social worker assigned to the case from November 2011 until June 2012 should have made a more concerted effort to locate and engage the family due to the significant risks associated with this case. CA has established a "Guideline for Reasonable Efforts to Locate Children and/or Parents" (DSHS Form 02-607). The social worker did not document sufficient efforts to locate the family as referenced in the "Guideline for Reasonable Efforts to Locate Children and/or Parents."
2) The Committee believed CA had an opportunity to staff the filing of a dependency petition with the Assistant Attorney General's Office in October 2011.
3) This case should have been staffed with a Child Protection Team in October 2011 and again in July 2012. The CPT policy at the time (CA policy 97-02) of these investigations required a CPT staffing when a case in which the risk assessment, following initial investigation, results in a moderately high or high risk classification and the child victim is age six or younger.
4) The mother should have been offered DV victims services.
5) This case should have been staffed with LICWAC.
6) An Assistant Attorney General should have been included in the case staffing in July 2012. Additionally, it was noted by the Committee that the social worker assigned to the case in July 2012 did an excellent job of locating the family and attempting to engage the mother in services, but the Committee found the case may have benefitted from the social worker completing additional collateral contacts. Specifically, the Committee believed a phone call to the child's doctor may have provided valuable information about the children's safety and well-being.

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 Recognized Indian Child.

[15] The social worker must staff the case in the following preferential order: With representatives designated by the child's Tribe to staff the case with the social worker; With a tribal LICWAC designated by the child's Tribe to staff the cases of all tribal children with the social worker; With the CA LICWAC designated to staff cases involving Indian children in the custody of the CA and meeting the criteria of this section, when the child's Tribe is unavailable.

Recommendations

1) During the course of the review, the Committee noted that several of the reports provided to the Committee reflected the review facilitator as the author of those reports. The Committee learned that CA's computer system, FamLink, automatically places the name of the person printing the document as the author of the document. The Committee recommended that a change request be submitted to Children's Administration Technology Services to ensure all documents printed from Famlink accurately reflects the actual author.
2) CA to consider adding resources such as Lynx Northwest, LexisNexis or Spillman. CA should evaluate these databases and determine if these systems are able to provide social workers with information needed to increase child safety.
3) The Committee noted that the father's name and/or information was frequently missing from the Native American Questionnaire. The Committee recommends social workers explain why a father is not listed on the Native American Questionnaire. Additional training should be provided to social workers to ensure this recommendation is completed.