Washington State Department of Social & Health Services

CA Children's Administration

Child Fatality Review

S.R.

September 2012
Date of Child's Birth

June 7, 2013
Date of Child's Death

October 16, 2013
Child Fatality Review Date

Committee Members
Sheila Davidson, GAL/CASA Coordinator, Benton Franklin Juvenile Center
Erinn Gailey, Program Director, Domestic Violence Services of Benton and Franklin Counties
Randy Maynard, Detective Sergeant, Kennewick Police Department
Jennifer Martinez, Family Preservation Services (FPS) Counselor, Pathways Counseling
Mary Meinig, Director Ombudsman, Office of the Family & Children's Ombudsman
Bill Paresa, Area Administrator, Vancouver, DSHS, Children's Administration

Consultant
Jenna Kiser, Regional Programs Supervisor, Regions 1 and 2, DSHS, Children's Administration

Facilitator
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RCW 74.13.640

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Executive Summary

On October 16, 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 nine-month-old female child and her family. The child will be referenced by her initials, S.R., in this report. At the time of her death, S.R. shared a home with her mother and her mother's boyfriend. No other children resided in the home at the time of the fatality. The incident initiating this review occurred on June 7, 2013 when S.R. died from non-accidental trauma to the head.

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 recent direct involvement with the case.

Prior to the review each committee member received a case chronology, a summary of CA involvement with the family and unredacted 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 state laws and CA policies relevant to the review and the complete case file.

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

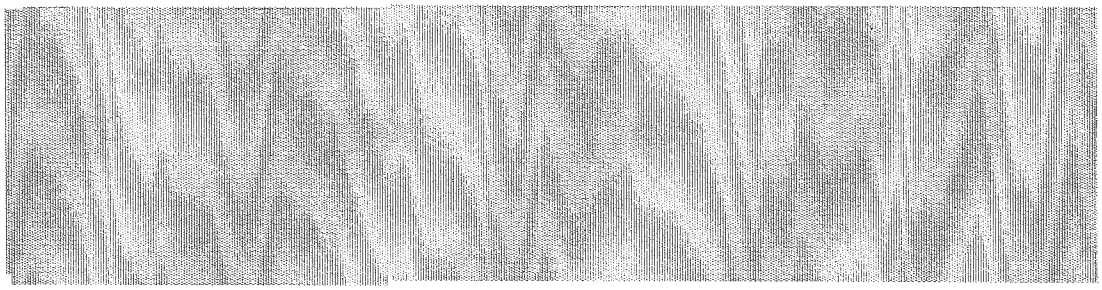
Following a review of the case file documents, interview of the CA social workers and supervisor, and discussion regarding department activities and decisions, the Committee made findings and recommendations, which are detailed at the end of this report.

RCW 74.13.515

Case Summary

S.R. is the youngest of four siblings.

[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.



On September 3, 2012, CA received its first intake regarding S.R. Medical staff reported to CA that the father was present for S.R.'s birth. The referrer became concerned about the father's presence when the mother shared that the father was not allowed unsupervised access to his older children.

A Family Team Decision-Making Meeting (FTDM)[2] was held on September 4, 2012 to determine a case plan related to S.R. The mother reported to the FTDM team that she knew the father was not supposed to be around her older children but she needed his support and believed he should be at the birth of his daughter. The mother informed the FTDM participants that she would continue to maintain a residence separate from the father. The social worker verified the mother had maintained a separate residence for three months prior to the birth of S.R. The FTDM team recommended S.R. remain in the mother's care and that the father's access would be supervised due to his previous allegations of domestic violence, physical abuse, sexual abuse and neglect. Following the FTDM the mother was provided multiple in-home services including a Public Health Nurse, domestic violence advocacy, housing assistance and Family Preservation Services (FPS).

On December 10, 2012, the father was arrested after a domestic violence incident at the mother's address. The father was not supposed to be at the mother's residence according to the safety plan initiated by the social worker. The mother and father had differing stories regarding the December 10, 2012 incident. The mother reported the father arrived at the house immediately prior

[2] 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 meetings are held to make critical decisions regarding the placement of children following an 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. A FTDM will take place in all placement decisions to achieve the least restrictive, safest placement, in the best interest of the child. By utilizing this inclusive process, a network of support for the child(ren) and adults who care for them is assured. (www.dshs.wa.gov/pdf/ca/FTDMPracticeGuide.pdf)

to the incident and had not previously been allowed in the home; however, the father stated the mother had allowed him to stay at her residence. The social worker was unable to verify which parent was telling the truth. Following the incident the mother and S.R. moved into a domestic violence shelter to ensure the safety of herself and her child. The mother obtained a restraining order and continued with her plan to divorce the father.

On December 13, 2012, another FTDM was held due to concerns about the mother's ability to maintain boundaries with the father and concerns about the domestic violence incident on December 10, 2012. The FTDM team determined the mother had maintained appropriate boundaries with the father, was taking appropriate protective action and S.R. should remain in the mother's care.

On February 19, 2013, the case was closed as the mother had demonstrated the ability to maintain appropriate boundaries with the father and the ability to provide S.R. with appropriate care. The post-fatality investigation revealed the mother started a new relationship after the case closed. She and her boyfriend shared a residence starting approximately one month prior to the fatality.

On the morning of June 7, 2013, S.R.'s mother discovered S.R. deceased in her crib. The mother called 911 and emergency responders were unable to revive S.R. An autopsy was completed and the child's death was ruled a homicide. The child's injuries included bilateral subdural hematomas, multiple skull fractures, bruising to the eye and blunt force trauma to the vaginal and perineal area. The mother's boyfriend was arrested and charged with the murder of S.R.

Discussion

During the course of the review process, the Committee focused primarily on the case activity following the birth of S.R. and prior to the closure of the case on February 19, 2013. However, it is important to note the Committee did briefly review the entire case history in an effort to provide context for the decisions made after S.R.'s birth. The Committee discussion focused on CA's response to domestic violence, shared decision making, CA's background check policies, the mandatory reporting law for child abuse and neglect and out-of-home placement decisions.

After reviewing instances where additional/different social work activity or decisions may have been considered the Committee found that there were no critical errors in terms of decisions and actions taken during CA involvement with S.R. A major factor influencing the Committee's discussion was the fact that the alleged perpetrator was not living with the mother until after the case was closed. With no new intakes after case closure that alleged abuse or neglect of

S.R., CA staff did not have knowledge of the mother's boyfriend or the ability to assess him.

The Committee noted the family's history [redacted] While the Committee found the family history to be concerning, the Committee noted the social worker needed to be able to show clear evidence of imminent risk of harm prior to the filing of a dependency petition. The Committee noted the mother was compliant with services and making documented progress between S.R.'s birth and case closure. The Committee noted the mother moved into a residence separate from the father three months prior to S.R.'s birth. The Committee also noted the mother appropriately utilized community resources including the DV shelter following the December 10, 2012 incident. The general Committee opinion was that there was insufficient evidence available for the social worker to demonstrate S.R.'s mother was unable and unwilling to take the steps to provide S.R. with a safe environment.

The Committee talked about the complexities of the placement decisions. A main point of focus for the Committee members was the social worker's decision not to file a dependency petition following S.R.'s birth. There were mixed perspectives regarding the legal sufficiency for a dependency petition; however, the Committee agreed that the circumstances of the case would most likely not have resulted an out-of-home placement for S.R. as the mother was cooperative with services, demonstrating progress and the service providers supported the continued placement of S.R. in the mother's home.

The Committee discussed the impacts of domestic violence on the family and the use of the Domestic Violence Protocol by the CA social worker. The Committee noted the mother's case history indicated a pattern of domestic violence. Committee members noted CA provided the mother with services designed to increase her independence and her ability to protect herself and her children from unsafe relationships. The Committee discussed the importance of building supports around a parent so the parent feels capable of meeting his/her own needs and no longer needs to rely on the support of the domestic violence perpetrator.

The Committee noted the social worker followed policy by utilizing the FTDM process when considering the removal of S.R. from her mother's care. The Committee noted the FTDM process does not involve neutral parties and only includes individuals familiar with the family. The Committee believed this case

might have benefited from additional shared planning activity in the form of a child protection team; however, the Committee did not believe this would have changed the outcome of the case.

The Committee noted the mother had a new boyfriend in November 2012 who was not S.R.'s father or the mother's boyfriend at the time of the fatality. The social worker gathered basic identifying information regarding the mother's boyfriend; however, the social worker did not review his criminal history or CPS records. The Committee noted the mother was no longer dating him after December 10, 2012 and thus he was unrelated to the child fatality. The Committee believes any intimate partner of a parent involved in a dependency should warrant a criminal history check and a review of CA records; however, the Committee did not make a practice finding on this issue for this report as this boyfriend was unrelated to the cause of death and the social worker was acting within current policy.

The Committee noted that immediately prior to the fatal incident the child's physician and grandmother were both aware of injuries to S.R. that the Committee found concerning. The Committee noted the case was closed at the time of these injuries and believed the injuries may have warranted a call to CA due to the suspicious nature of the injuries.

The Committee discussed and noted the quality documentation, ongoing engagement of the family and quality of work performed by the social worker involved with this case at the time of the fatality.

Findings
None

Recommendations:
None

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.