



RCW 13.50.100



## **Child Fatality Review**

**June 1999**

Date of Child's Birth

**January 4, 2016**

Date of Fatality

**June 13, 2016**

Child Fatality Review Date

### **Committee Members**

Randy Maynard, Sergeant, Criminal Investigations Divisions, Kennewick Police Department

Kimberlee Abe-Gunter, Quality Assurance Program Manager, Developmental Disabilities Administration

Rebecca Wilson, Child and Family Services Supervisor, Children's Administration, Yakima

Patrick Dowd, Director, Office of the Family and Children's Ombuds

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### **Facilitator**

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## **Executive Summary**

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On June 13, 2016, the Department of Social and Health Services (DSHS) Children's Administration (CA) convened a Child Fatality Review (CFR)<sup>1</sup> to assess the Department's practice and service delivery to sixteen-year-old [REDACTED] and [REDACTED] family.<sup>2</sup> The child is referenced by his initials, [REDACTED] in this report. At the time of [REDACTED] death, [REDACTED] resided with [REDACTED] adoptive parents, [REDACTED] four adoptive siblings and [REDACTED] two biological siblings. The incident precipitating this review occurred on January 4, 2016 when [REDACTED] died of acute intoxication due to sodium nitrite ingestion. [REDACTED] mother reported to police that she had given [REDACTED] this substance, which is commonly referred to as [REDACTED], because she believed it would curb [REDACTED] sexualized behavior. The family had a Child Protective Services (CPS) case open during the preceding 12 months. **RCW 13.50.100**

The CFR committee consisted of community members and CA staff with relevant expertise in child development, mental health, law enforcement and child welfare as well as a representative from the Office of the Family and Children's Ombuds. No committee members had previous involvement with family.

Prior to the review, each committee member received a case chronology, a family genogram, a summary of CA involvement with the family and un-redacted case documents including a family home study, mental health evaluations, law enforcement reports and the medical examiner's report. Supplemental sources of information and resource material regarding caseload data and CA policies were available to the committee at the time of the review.

The Committee interviewed the CPS investigator who had most recently been assigned to the case, the CA social worker who conducted the adoptive home study in 2008 and the current CPS Supervisor who provided an overview of case load and workload issues that impacted this office during the time the case was open. The Committee spoke briefly with a caseworker from the Developmental Disabilities Administration (DDA) who provided an overview of the services DDA

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<sup>1</sup> 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.

<sup>2</sup> [REDACTED] family is not named in this report because they have not been charged in an accusatory instrument with committing a crime related to a report maintained by the department in its case management information system. [Source: [RCW 74.13.500\(1\)\(a\)](#) **RCW 13.50.100**]

provided to the family. Following a review of the case file documents, interviews with CA staff and discussion regarding department activities and decisions, the Committee made several recommendations for purposes of practice improvement that are detailed at the end of this report.

### **Case Summary**

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Children’s Administration first became involved with this family in 2007 when they contacted CA stating they were interested in adoption. In February 2008, Utah State Department of Human Services requested that CA conduct a home study of the family because they were interested in adopting [REDACTED] and [REDACTED] two siblings. At that time, Z.S. and his siblings were residing in foster care in Utah and were eligible for adoption. The CA home study was approved and the Utah Department of Human Services placed the children with the family in July 2008 through guidelines established in the Interstate Compact on the Placement of Children (ICPC).<sup>3</sup> After their placement in Washington state, the CA case remained open until the children’s adoption was finalized in February 2009.

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In January 2010, CA received an intake that alleged [REDACTED]  
[REDACTED] Because [REDACTED]  
[REDACTED] was a licensed child care provider, the intake was assigned to a CPS investigator with the Division of Licensed Resources (DLR).<sup>4</sup> The parents denied the allegations of [REDACTED], but acknowledged that they were struggling to deal with behaviors exhibited by their adopted children and often used physical exercise as a method of discipline. The investigation was unfounded for [REDACTED]  
[REDACTED]<sup>5</sup> and the case was closed after the family reported they were participating in family therapy and support services. Concurrent with the DLR investigation, the Department of Early Learning (DEL)<sup>6</sup> reviewed the family child care license to evaluate the care of the children in licensed child care. The DEL complaint was

<sup>3</sup> Interstate Compact on the Placement of Children (ICPC) is a uniform reciprocal law enacted in every state that governs the interstate placement of foster children. The Compact prohibits states from sending a dependent child to live with an out-of-state caregiver without first obtaining approval from the receiving state’s child welfare agency following a home study and other assessments of the caregiver. [[RCW 26.34.010](#)]

<sup>4</sup> The Division of Licensed Resources/Child Protective Services Investigation takes place when a child is believed to have been abused or neglected in a facility licensed to care for children.

<sup>5</sup> 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 mean 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](#)]

<sup>6</sup> The [Department of Early Learning](#) is a state agency that oversees licensing and monitoring of day care homes and centers.

closed with no restrictions on her license. In November 2011, the family applied for a foster care license through Children's Administration but withdrew their application prior to completion of the application process. [RCW 13.50.100](#)

On January 2, 2014, CA received an intake that alleged [REDACTED] of the oldest adopted child, [REDACTED]. A CPS investigator made initial contact with the child at the family home and [REDACTED]. When the child was interviewed two weeks later by a different CPS investigator, [REDACTED] denied the allegations of [REDACTED]. The case remained open with no documented activity until October 5, 2014 when CA received another intake alleging [REDACTED] was [REDACTED] to the children. A new social worker was assigned who was also given the task of completing the prior investigation. The social worker interviewed all the children, who all denied that they were [REDACTED]. The parents denied using [REDACTED] but acknowledged that they use physical exercise as a form of discipline. The investigator did not observe any [REDACTED] on the children and closed the investigation as unfounded. The case was closed on January 22, 2015. On January 30, 2015, CA received an intake alleging neglect of the youngest adopted child. This was screened out and not assigned for investigation<sup>7</sup>.

The department had no further involvement with this family until January 11, 2016 when CA received information that [REDACTED] had died on January 4, 2016 under suspicious circumstances. The intake reported that [REDACTED] had apparently died from something [REDACTED] had ingested and that there were no overt signs of abuse or neglect. The autopsy revealed that [REDACTED] had died of acute intoxication due to sodium nitrite ingestion. [REDACTED] mother admitted to giving [REDACTED] to curb [REDACTED] behavior and did not know that this was not appropriate for consumption. This intake was accepted for investigation and the mother was given a founded finding of neglect. [RCW 13.50.100](#)

### ***Committee Discussion***

Committee members reviewed and discussed CA documentation spanning the history of CA involvement with the family from 2007 through 2014. They considered additional verbal accounts presented by staff to gain an understanding of CA policy and practice regarding investigative standards, the home study process and ICPC practice guidelines. In addition, the ICPC program manager was consulted telephonically and helped to provide the Committee with

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<sup>7</sup> 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.

an understanding of the extent of CA's responsibility in the placement of children who are the legal dependents of another state.

In reviewing CA's more recent activity with this family during the 2014-2015 CPS investigations, the Committee was concerned about the gap in CA activity that occurred from January 2014 to October 2014. The Committee reviewed caseload data from that period which indicated that this office had a backlog of over 450 CPS investigations that were overdue for closure. The social worker assigned to the January 2014 investigation had over 50 open investigations, which was the average for this CPS unit. The Committee recognized that this high caseload significantly impacted the worker's ability to provide services and complete investigations in a timely manner.<sup>8</sup> Noting also that the CPS supervisor at that time had not documented any supervisory reviews on this case, the Committee acknowledged that high caseload would have necessarily impacted a supervisor's ability to conduct regular clinical supervision as is required by policy.<sup>9</sup>

The Committee expressed concern about the impact that high caseloads have on CA's ability to assess safety and risk, particularly in cases like this one where there was little case activity for an extended period of time. The Committee spoke with the current CPS supervisor about these concerns and he described how the local office worked with regional CA staff on several strategies to effectively address this backlog. The strategies included the use of data and practice consultants to prioritize cases and the deployment of workers from other CA offices and other programs who had the necessary training to complete investigations.

The Committee appreciated the participation of the staff who were interviewed, including staff who are no longer employed by CA but were willing to participate in order to assist the Committee in gaining an understanding of the case history. The Committee also wished to acknowledge the thorough and timely documentation done by the social worker assigned to the October 2014 investigation, acknowledging that this investigation was done while she was assigned to a different program and carried a full caseload.

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<sup>8</sup> Per CA policy, the Investigative Assessment is to be completed following conclusion of a CPS investigation within 60 calendar days of CA having received an intake. [Source: [CA Practices and Procedures Guide-2540 Investigative Assessment](#)]

<sup>9</sup> CA policy requires that social work supervisors conduct monthly supervisory case reviews with each assigned social worker and document each case review in the client electronic case file. [Source: [CA Practices and Procedures Guide 46100 Monthly Supervisor Case Reviews](#)]

## ***Findings***

At the completion of the review of the case file documents, staff interviews and discussions regarding CA activities and decisions, the Committee found no critical errors by the department. However, the Committee found two areas identified as opportunities for improved practice.

- The January 2014 CPS investigation was incident-focused and could have included more information regarding child safety and parental functioning. The assessments were not completed in a timely manner and there were no ongoing efforts to monitor child safety as is required when the case had been open for more than 90 days.
- There were no supervisory reviews documented from January 2014 through November 2014.

**Action taken:** When interviewed by the Committee, the CPS Supervisor outlined the progress made to eliminate the backlog as well as ongoing efforts to provide regular supervisory oversight and monitoring. The elimination of the backlog has addressed both of the issues above.

## ***Recommendations***

The Committee noted that throughout CA's involvement with this family, there was little documentation of collaboration with staff from the Developmental Disabilities Administration, though the family was receiving services from that administration, including assessments and in-home care. Though the Committee did not make a finding about this, they did believe there were missed opportunities for collaboration and corroboration and chose to make recommendations for the purpose of improving practice.

- The Committee recommended that CA train staff, either through memo or a "Practice Tip," about how to use the FamLink system to recognize when their clients are receiving services from the Developmental Disabilities Administration (DDA).
- The Committee recommended that CA provide guidance to staff about best practice guidelines for collaboration with DDA, including accessing client assessments and services and the importance of including DDA workers in Family Team Decision Making Meetings (FTDM)<sup>10</sup> and permanency planning hearings.

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<sup>10</sup> Family Team Decision Making Meetings bring people together who are involved with the family to make critical decisions regarding the removal of child(ren) from their home, changes in out-of-home placement and reunification or placement into a permanent home. [Source: [CA Practices and Procedures Guide 1720](#)]