Report to the Legislature

Quarterly Child Fatality Report

RCW 74.13.640

April – June 2015

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Executive Summary

This is the Quarterly Child Fatality Report for April through June 2015 provided by the Department of Social and Health Services (DSHS) to the Washington State Legislature. RCW 74.13.640 requires DSHS to report on each child fatality review conducted by the department and provide a copy to the appropriate committees of the legislature:

Child Fatality Review — Report

(1)(a) The department shall conduct a child fatality review in the event of a fatality suspected to be caused by child abuse or neglect of any minor who is in the care of the department or a supervising agency or receiving services described in this chapter or who has been in the care of the department or a supervising agency or received services described in this chapter within one year preceding the minor's death.

(b) The department shall consult with the office of the family and children's ombudsman to determine if a child fatality review should be conducted in any case in which it cannot be determined whether the child's death is the result of suspected child abuse or neglect.

(c) The department shall ensure that the fatality review team is made up of individuals who had no previous involvement in the case, including individuals whose professional expertise is pertinent to the dynamics of the case.

(d) Upon conclusion of a child fatality review required pursuant to this section, the department shall within one hundred eighty days following the fatality issue a report on the results of the review, unless an extension has been granted by the governor. A child fatality review report completed pursuant to this section is subject to public disclosure and must be posted on the public web site, except that confidential information may be redacted by the department consistent with the requirements of RCW 13.50.100, 68.50.105, 74.13.500 through 74.13.525, chapter 42.56 RCW, and other applicable state and federal laws.

(2) In the event of a near fatality of a child who is in the care of or receiving services described in this chapter from the department or a supervising agency or who has been in the care of or received services described in this chapter from the department or a supervising agency within one year preceding the near fatality, the department shall promptly notify the office of the family and children's ombudsman. The department

may conduct a review of the near fatality at its discretion or at the request of the office of the family and children's ombudsman.

In April 2011, SHB 1105 was passed by the legislature and signed into law by Governor Gregoire. The revised child fatality statute (RCW 74.13) became effective July 22, 2011 and requires the department to conduct fatality reviews in cases where a child death is suspected to be caused by abuse or neglect. This eliminated conducting formal reviews of accidental or natural deaths unrelated to abuse or neglect. The revised statute requires the department to consult with the Office of Family and Children's Ombuds (OFCO) if it is not clear that the fatality was caused by abuse or neglect. The department can conduct reviews of near-fatalities or serious injury cases at the discretion of the department or by recommendation of OFCO. The statutory revision allows the department access to autopsy and post mortem reports for the purpose of conducting child fatality reviews.

This report summarizes information from completed reviews of two (2) child fatalities that occurred in the second quarter of 2015. All prior child fatality review reports can be found on the DSHS website: https://www.dshs.wa.gov/ca/publications/childrens-administration-child-fatality-reports

The reviews in this quarterly report include child fatalities from one region.

Region	Number of Reports
1	2
2	0
3	0
Total Fatalities and Near-Fatalities Reviewed During 2nd Quarter, 2015	2

This report includes Child Fatality Reviews conducted following a child's death that was suspicious for abuse and neglect and the child had an open case or received services from the Children's Administration (CA) within 12 months of his/her death or injury. A critical incident review consists of a review of the case file, identification of practice, policy or system issues, recommendations and development of a work plan, if applicable, to address any identified issues. A

review team consists of a larger multi-disciplinary committee including community members whose professional expertise is relevant to the family history. The review committee members may include legislators and representatives from the Office of the Family and Children's Ombuds.

The charts below provide the number of fatalities and near-fatalities reported to CA and the number of reviews completed and those that are pending for calendar year 2015. The number of pending reviews is subject to change if CA discovers new information through reviewing the case. For example, CA may discover that the fatality or near-fatality was anticipated rather than unexpected, or there is additional CA history regarding the family under a different name or spelling.

Child Fatality Reviews for Calendar Year 2015			
Year	Total Fatalities Reported to Date Requiring a Review	Completed Fatality Reviews	Pending Fatality Reviews
2015	8	4	4

Child Near-Fatality Reviews for Calendar Year 2015			
Year	Total Near Fatalities Reported to Date Requiring a Review	Completed Near-Fatality Reviews	Pending Near-Fatality Reviews
2015	8	3	5

The two (2) child fatality reviews referenced in this Quarterly Child Fatality Report are subject to public disclosure and are posted on the DSHS website. https://www.dshs.wa.gov/ca/publications/childrens-administration-child-fatality-reports

Near-fatality reports are not subject to public disclosure and are not posted on the public website.

Notable Second Quarter Findings

Based on the data collected and analyzed from the two (2) fatalities April and June 2015, the following were notable findings:

- Both cases referenced in this report were open at the time of the child's death.

- At the time of the child's death, both cases were open in the Child and Family Welfare Services (CFWS) program.
- Both of the children referenced in this report were two (2) years of age or younger when the fatality occurred.
- One (1) fatality occurred during a co-sleeping event with a parent.
- One (1) child died from blunt force trauma.
- One (1) child was Caucasian, the other was Hispanic.
- Children's Administration received intake reports of abuse or neglect in both cases prior to the death of the child. Both cases had two intakes reported to Children's Administration before the child died.
- Due to the small sample of cases reviewed, no statistical analysis was conducted to determine relationships between variables.

Child Fatality Review
N.T.

April 2012
Date of Child's Birth

December 26, 2014
Date of Child's Death

April 15, 2015
Child Fatality Review Date

Committee Members
Patrick Dowd, Director, Office of the Family and Children's Ombuds
Monica Jenkins, Child Protective Services Program Consultant, Children's Administration, Region One
Jeff Gwinn, CASA Volunteer Coordinator, Walla Walla County
Athena Clark, Detective, Richland Police Department
Michele Leifheit, New Leif LLP
Christine Garcia, Area Administrator, Children's Administration, Grant and Kittitas Counties
Nelly Mbajah, MSW, Placement and Permanency Supervisor, Children's Administration

Consultant
Jennifer Meyer, Assistant Attorney General

Facilitators
Susan Danielson, Critical Incident Review Specialist, Children's Administration
Rob Larson, Area Administrator, Children's Administration, Spokane

Observer
Andrea Quintero, CPS and Family Assessment Response (FAR) Supervisor, Grant County

Executive Summary

On April 15, 2015, the Department of Social and Health Services (DSHS) Children's Administration (CA) convened a Child Fatality Review (CFR) to assess the department's practice and service delivery to a 2-year-old boy and his biological family.[1] The child is referenced by his initials, N.T.,[2] in this report. At the time of his death, N.T. resided with his parents and younger sibling in Kennewick. The department had previously removed N.T. from his parents' care in July 2012 based on allegations that he was the victim of physical abuse. N.T. was in out-of-home care from that time until April 2014 when he was returned to his mother's care. The dependency was dismissed in October 2014. The incident initiating this review occurred on December 26, 2014 when N.T. died as a result of non-accidental trauma.

The CFR Committee included CA staff and community members selected from diverse disciplines with relevant expertise, including child welfare, mental health, law enforcement, and the Office of the Family and Children's Ombuds. None of the committee members had previous direct involvement with this 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 referrals, case notes, assessments, and medical records. The hard copy of the file was available at the time of the review. Supplemental sources of information and resource materials were also available to the Committee including copies of state laws and CA policies relevant to the review and workload and case assignment data for this unit during the time that the case was open.

The Committee interviewed the CA social worker and supervisor who had previously been assigned to the case and the Area Administrator who supervised the Richland Office for the majority of the time the child was dependent. Following a review of the case file documents, completion of staff interviews, and

[1] 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 the function or purpose of a Child Fatality Review to recommend personnel action against DSHS employees or other individuals.

[2] The parents and relatives are not identified by name in this report because no criminal charges were filed relating to the incident.

discussion regarding department activities and decisions, the Committee made findings and recommendations that are presented at the end of this report.

Case Overview

On December 23, 2014, N.T. was airlifted to Sacred Heart Medical Center (SHMC) in Spokane where it was found that he was suffering from anoxic brain injury[3] as well as human bites, multiple bruises of differing ages, a fractured arm, possible ligature marks, and lip abrasions. He was pronounced dead on December 26, 2014. The cause of death has been identified as child abuse and the manner of death as homicide. At the time of the fatal incident N.T. resided with his mother, N.B., and his younger brother. It is unclear if his father, M.T., resided in the home at the time. N.T. was the subject of a prior dependency in Benton County from July 2012 to October 2014. At the time of N.T.'s death, the case was inactive pending completion of paperwork. At the time of this review, this case was open for Child and Family Welfare Services (CFWS)[4] and his younger sibling was in out-of-home care.

Case Summary

This family first came to the attention of Children's Administration on June 28, 2012 when 2-month-old N.T. was admitted to SHMC in Spokane with multiple subdural hematomas and retinal hemorrhages. The examining physician diagnosed N.T. with abusive head trauma. The parents stated they did not know how their son was injured but provided several possible explanations, none of which were considered by the attending physician to be consistent with the injuries. The department filed a dependency petition on N.T.'s behalf on July 11, 2012 and upon his release from the hospital he was placed in the care of relatives.

In October 2012, the parents signed an agreed order of dependency in which they denied knowing the cause of the child's injuries but acknowledged that there was sufficient basis to determine that there was no parent willing and capable of safely caring for their child. The parents were court-ordered to participate in parenting assessments, attend all meetings related to the care of the child, and participate in the visitation plan. The father was ordered to complete a drug and alcohol evaluation, an anger management assessment, and follow all treatment recommendations from those assessments. The parents were allowed up to three supervised visits per week with their child.

[3] Anoxic Brain injury results from a total lack of oxygen to the brain. [Reference: BrainandSpinalCord.org]
[4] Child and Family Welfare social workers assume responsibility of a child welfare care after the children have been removed from their caregivers and a dependency petition filed.

N.T. remained in out-of-home care with a relative from July 2012 through April 2014. His mother completed a parenting assessment, parent education, and a psychological evaluation prior to his return. She was offered visits up to three times per week but often did not attend all of them. The father completed a parenting assessment and through he initially visited his child weekly, his participation in all aspects of the service plan ceased in January 2013. From that point, he had no contact with the department, with providers, or with the court regarding his child. The law enforcement investigation into the alleged assault of N.T. was reviewed by the Yakima County Prosecutor's Office but they declined to pursue charges based on the absence of a specific identified perpetrator. In May, after the entry of a No Contact Order between the parents, the mother's visits were changed from supervised to monitored[5] and began occurring in her home. The No Contact Order was entered through the Dependency Court, though the mother denied domestic violence between her and the baby's father.

In June 2013, the couple's second child was born and a new intake was made in July documenting concern about the safety of this child, based on the fact that N.T. had experienced serious injuries of unknown origin while in the care of his parents. At a Family Team Decision Making Meeting[6] held shortly after the baby's birth, a consensus was reached that the new baby would remain in the mother's care, and the mother agreed to continue to participate in court-ordered services. The mother changed residence several times through this period, often staying with family members. The mother made conflicting statements about the status of her relationship with the father of her children to the department and to providers. Though she reported that she did not have contact with him, the department received collateral information that seemed to indicate that they were in contact.

At the Dependency Review Hearing in April 2014, the department recommended continued out-of-home placement based on the fact that it remained unclear who abused N.T. The child's Guardian ad Litem (GAL) and the parents' attorneys opposed this and on April 22, 2014 an agreed Dependency Review Order was entered that returned N.T. to his mother's care. The order stated that the mother

[5] Supervised visits require the presence of another assigned adult who maintains sight and sound supervision of parent-child contact and intervenes as needed. Monitored visits require another assigned adult to monitor the parent child contact periodically and interview as needed.

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

was to participate in Family Preservation Services (FPS),[7] maintain contact with the GAL and assigned social worker, and reside with her sister in Kennewick. The department also recommended that N.B. participate in individual counseling but this was not ordered by the court. An FTDM was held on May 2 where a transition plan was developed to ease N.T.'s return home. The plan stated that in addition to the services ordered by the court, N.T. would attend licensed day care and continue with his speech therapy. At the time of his return home, N.T. was reported to be in good health and receiving services with Early Head Start.

After N.T.'s return home, the social worker was unable to maintain regular contact with the mother and see the children in their home. The mother reported that her work schedule prevented her from meeting with the worker; because of this the social worker made most of her contacts with N.T. at the home of a relative in Grandview who the mother identified as the child's day care provider. The FPS provider also had difficulty engaging the mother and noted it took two months to complete the intake. However, even when engaged in services, the mother cancelled and re-scheduled appointments with the FPS provider multiple times.

At the September Dependency Review Hearing, the department reported that N.B. had made good progress and asked that the dependency continue. The Review Order continued the dependency but stated that the case could be dismissed ex parte in October after N.T. had been with his mother for six months. On October 24, 2014, the dependency was dismissed by ex parte order with agreement of all parties. The social worker made one more contact with the family shortly after this date.

On December 23, 2014, the department received an intake stating that N.T. was taken to Sacred Heart Medical Center with human bite marks, multiple bruises of different ages, lip abrasions, a fractured arm, possible ligature marks, and anoxic brain injury. The attending physician's assistant who documented the injuries reported N.T. had been severely medically neglected and chronically and severely physically abused. Both N.T. and his brother were placed into protective custody. N.T. was declared deceased on December 26, 2014.

Committee Discussion

The Committee discussion focused on CA policy, practice, and systems responses in an effort to evaluate the reasonableness of decisions made and actions taken by department staff. Though the primary focus was on the actions and decisions

[7] Family Preservation Services (FPS) are short-term, family-based services designed to assist families in crisis by improving parenting and family functioning while keeping children safe. [Source: CA Practices and Procedures Guide, Appendix A: Definitions]

made by department staff during the period of the child's dependency (July 2012 – October 2014), some discussion occurred about information gathered during the fatality investigation which provided previously unknown insight into the family relationships during the dependency. The Committee utilized staff interviews to provide additional information related to caseload size, staff turnover, changes in management, and a basic overview of the court system. At the completion of the review of the case file documents, staff interviews, and discussions regarding CA activities and decisions, the Committee identified several areas of practice improvement that could serve to strengthen practice and improve child safety.

The Committee spent a considerable amount of time in discussion and with staff gaining an understanding of the progression of the case from the initial investigation through the dismissal of the dependency in October 2014. The Committee recognized that it is very challenging to develop and maintain a case plan when a child has significant unexplained injuries and no specific perpetrator is identified or charged. While there was solid medical evidence that N.T. had been abused, the lack of resolution of the criminal investigation narrowed the focus of the intervention and impacted the department's ability to articulate a clear risk of harm to the court.

The Committee also felt that the lack of clear identification of the abuser led to an inability to articulate the parental deficiencies in the context of risk and danger to the child shaped the provision of services. There was ongoing discussion that the actual services identified in the court report and therefore ordered by the court lacked a specific focus on the primary issue of severe unexplained physical abuse and trauma to the child. Though the initial case plan included a provision stating additional services for the parents would be evaluated as the criminal investigation progressed, this issue was not revisited when it eventually became apparent there would be no resolution to the criminal investigation. As a result, the services provided were not specific to the identified safety threats. In reviewing the ongoing assessments done on this case, the Committee noted that there were several components of the Child Safety Framework[8] that were not followed. The Committee felt that this was unlikely to have affected the outcome of the case but it could have provided a consistent structure to gather additional information needed to reassess family functioning and target services to address parental deficiencies.

[8] In partnership with the National Resource Center for Child Protective Services, (NRC-CPS), Washington state Children's Administration implemented the Child Safety Framework in November 2011. A key concept of this model is that the scope of child welfare work is not defined by determining the presence or absence of injuries or incidents, but rather in identifying present or impending safety threats, and working with families to mitigate those threats.

The Area Administrator reported that the Richland CA office experienced significant staffing shortages during 2014 that led to increased workloads and caseload in all the CFWS units. The assigned worker's caseload increased from 21 children in April 2014 to 32 children when the court case was dismissed six months later.[9] The Committee recognized that this increase in workload may have impacted the worker's ability to have regular contact with the mother and her children in their home as well as her ability to gather sufficient information from service providers and extended family to fully assess household composition and functioning.

The Committee noted several areas of strength. The records were well-organized and case notes were clear. Monthly contacts with the child were done consistently throughout the dependency. The Committee noted some delay in entry of documentation but understood that timeliness can be a challenge when faced with high caseloads and chose not to make a finding about this issue. Shared decision making was used at key points throughout the case to enhance critical thinking. The Committee appreciated the candor staff brought to the review process as well as their commitment to child welfare.

Findings

1. **Child Safety Framework (CSF):** The Committee found several aspects of the CSF that were not used at key points as required by policy.
    - **Investigations:** The Committee felt that the investigative assessments done in 2012 and 2013 were incident-focused and lacked sufficient information to do a comprehensive assessment of the household.
    - **Family Assessment:** Though the policy requiring the use of a family assessment was suspended for a period of time during N.T.'s dependency, it was reinstated as a requirement in October 2013. The Committee noted that insufficient information was gathered throughout the case to adequately assess parenting functioning and parental capacity. The Committee felt there were missed opportunities to gather and document additional information about parental functioning from collateral sources, such as family members, the child's service providers, or from the parents themselves. The Committee recognized that the department's inability to engage the father made it difficult to assess his functioning but also noted that he has another family and their input may have helped to assess his parental functioning.

[9] Recommended caseload size for CFWS workers, per the Braam settlement, is 18 children.

- **Safety Assessments:**[10] Ongoing safety assessments were not used at key decision points to assess child safety and inform decision making. The safety assessments done in July and August of 2012 identified safety threats, yet a subsequent safety assessment completed when the new baby was born in 2013 was not consistent with the assessments; this discrepancy is not reconciled in the documentation. The Committee could not find that safety assessments had been conducted prior to consideration of N.T.'s return home or prior to case dismissal. The Committee felt that consistent use of the safety assessment could have provided an ongoing structure to the case plan and focus on the issues of child safety.
- **Safety planning:**[11] The Safety Plan was not revised through key points in the case, such as changes in household composition, the birth of the new child, and prior to N.T.'s return home. Though there appeared to be efforts to address safety planning at the FTDM held prior to N.T.'s return home, the Committee felt the plan could have been stronger if it had included input and participation from key participants in the child's life, such as his paternal relatives, his therapeutic provider, and his primary care physician.

2. **Health and Safety Contacts**: The Committee found that health and safety contacts were not conducted according to policy that the majority of health and safety contacts be conducted in the family home. While the worker saw the child two times per month after his return home, the worker's inability to see the child in his home impaired the ongoing gathering of information needed to assess child safety. This put the worker in a position to accept the mother's statements about her relationship with the child's father at face value.

Recommendations

1. The Committee recommended that the department collaborate with the Alliance for Child Welfare to provide training on the Child Safety Framework that is specific to CFWS cases. It is recommended that the training focus the following:
    - Global assessment and gathering of information throughout the case in order to identify parental deficiencies and correctly identify tasks and

[10] Safety Assessment is used throughout the life of the case to identify impending danger and determine whether a child is safe or unsafe. It is based on comprehensive information gathered about the family at the time the safety assessment is completed. [Source: CA Practices and Procedures Guide, Chapter 1100]

[11] A safety plan is required for all children where there is a safety threat(s) indicated on the safety assessment. The safety plan is written arrangement between a family and CA that identifies how safety threats to a child will be immediately controlled and managed.

services that can address those deficiencies and measure progress in addition to compliance.
    - Safety assessment at key decision points.
    - Safety planning, including understanding key elements of strong safety plans, and implementing safety plans when children are returned home.
2. The Committee recommended that challenging cases like this where there are unexplained injuries to a child, that supervisors and line staff consider seeking assistance from the CPS Regional Practice Consultant or CPS Program Manager to help articulate their case to the court and to clearly frame services so that they are targeted to address parental deficiencies.
3. The Committee suggested that best practice would be to require the establishment of a parenting plan prior to dismissal of the case.
4. The Committee noted that there seem to be variations in practice regarding the department's response when new children are born to families who have dependent children. The Committee recommended that the department use Regional Program Consultants to promote consensus and clarity about who is responsible to call intake and how these intakes are assigned. In addition, the Committee recommended that the Richland office consider having shared planning meetings with families prior to the birth of new children on open CFWS cases.

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

Child Fatality Review

V.E.

November 2014
Date of Child's Birth

December 27, 2014
Date of Child's Death

Committee Members
Hiedi Bulkley, CASA, Spokane County Juvenile Court Dependency Unit
Caroline Law, Public Health Nurse, Spokane County Health District
Nancy Sundin, Supervisor, Children's Administration
Jenna Kiser, Safety Program Manager, Children's Administration
Patrick Dowd, Director, Office of the Family and Children's Ombuds

Facilitator
Susan Danielson, Critical Incident Review Specialist, Children's Administration

Observer
David Kopp, Social Service Specialist, Children's Administration

Executive Summary

On April 1, 2015, the Department of Social and Health Services (DSHS) Children's Administration (CA) convened a Child Fatality Review (CFR) to assess the department's practice and service delivery to a 5 week old female child and her biological family.[12] The child is referenced by her initials, V.E.,[13] in this report. At the time of her death, V.E. was placed in the home of her paternal grandmother, V.B., in the Spokane area. The department had placed her in this home pursuant to a Shelter Care Order entered through Spokane County Superior Court. V.E. was placed in out of home care due to allegations that her parents, referred to as C.E. and D.E., were not safely able to care for her. The incident initiating this review occurred on December 27, 2014, when V.E. was found unconscious and unresponsive in the home of her parents. She had been left in their care the night before by her paternal grandmother. A cause of death has not yet been determined.

The CFR Committee included CA staff and community members selected from diverse disciplines with relevant expertise, including child welfare, mental health, medicine, and the Office of the Family and Children's Ombuds. None of the committee members had previous direct involvement with this 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 referrals, case notes, assessments and medical records. The hard copy of the file was available at the time of the review. Supplemental sources of information and resource materials were also available to the Committee including copies of state laws and CA policies relevant to the review and workload and case assignment data for this unit during the time that the case was open.

The Committee interviewed the CPS investigator who initiated the placement, her supervisor and the CFWS social worker and her supervisor. Following a review of the case file documents, completion of staff interviews, and discussion

[12] 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 near-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 near fatal injury. Nor is it the function or purpose of a Child Fatality Review to recommend personnel action against DSHS employees or other individuals.

[13] The parents and relatives are not identified by name in this report because no criminal charges were filed relating to the incident.

regarding department activities and decisions, the Committee made findings and recommendations that are presented at the end of this report.

Case Overview

On December 27, 2014, five-week-old V.E. was found unconscious and unresponsive in her parent's home in the Spokane area. She had been removed from their care at birth and placed with her paternal grandmother, V.B., due to allegations that the parents' untreated substance abuse and instability posed a significant risk to her safety. The grandmother agreed as a condition of placement to follow the court-ordered visitation plan that specified that the parents were not to have contact with the baby without prior approval from the department. The cause of death is as yet undetermined.

RCW 74.13.500

Case Summary

[redacted] C.E. was court-ordered to participate in mental health counseling and substance abuse treatment. Services in those programs were terminated due to lack of participation. The mother's compliance with random urine analysis testing was sporadic and she admitted to ongoing use of marijuana. [redacted]

On November 19, 2014, Deaconess Medical Center called to report C.E. had given birth to V.E., her third child, at 38 weeks gestation. Hospital staff had placed V.E. on an administrative hold based on concerns about both parents' history of untreated mental illness and substance abuse. Shortly after her birth, V.E. was slow to eat on her own and was placed on a feeding tube in order to ensure weight gain. A Family Team Decision-Making Meeting (FTDM)[14] was held on November 21 to determine a plan for the baby. The parents expressed their preference that their daughter be placed with the paternal grandmother and the department tentatively agreed with this plan pending the result of background

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

checks[15] on the grandmother and her household members. The investigator reviewed the grandmother's case history in the FamLink[16] system and stated she did not find any negative actions.[17] A complete review of the grandmother's criminal history indicated she had a conviction for a drug-related crime 2001 and multiple convictions for theft dating from 2006 to 2013. The investigator reviewed this with her supervisor as well as the Child Welfare Family Services (CWFS) social worker and supervisor who were resuming ongoing responsibility for the case.[18] The investigator was asked to seek additional clarifying information from the grandmother who reported she had been through counseling to address her problems and that she had voluntarily given up her nursing license. She also related that she had been involved with CA to address conflict with her teenaged children and had been a placement provider to another family within the past year. Prior to placement, the paternal grandmother signed an agreement that specified that the parents were not to have unsupervised contact with the baby and were not to be in her home without prior approval. It also stated that the baby was not to be left with anyone other than the paternal grandmother without department approval. The baby was discharged from the hospital on December 2 and released to the care of her grandmother.

After V.E. was placed with her grandmother, department staff conducted a health and safety visit in the grandmother's home[19] on December 11, 2014. At that time, the worker observed the baby and her sleep environment and reviewed the baby's needs with the grandmother. The assigned Child Health and Education Tracking (CHET)[20] worker visited the placement home on December 17

[15] Background checks are required for all persons that will have unsupervised access to children in the care and custody of CA and safety plan participants with unsupervised access to the children names in the safety plan. This includes, at minimum, a review of criminal history as well as a review of CA Records to ascertain if the applicant has a criminal conviction or negative action that would disqualify them as potential placement resources.

[16] FamLink is the case management information system that CA implemented on February 1, 2009; it replaced CAMIS, which was the case management system used by the agency since the 1990s.

[17] "Negative Actions" may include a finding of abuse or neglect of a child or vulnerable adult; termination, revocation, suspension or denial of a license, relinquishment of a license in lieu of an agency negative action, DOH disciplinary authority findings, revocation, suspension, denial or restriction placed on a professional license.

[18] Child Welfare Family Services social workers assume responsibility of a child welfare care after the children have been removed from their caregivers and a dependency petition filed.

[19] CA social workers are required to visit with all children in person on a monthly basis if the case is open for services. The goal of these visits is to ensure the child is safe and the child's basic needs are met. Per policy, the majority of these contacts must take place in the home. [Source: CA Practices and Procedures Guide 4420]

[20] Child Well-Being Health and Education Tracking (CHET). Children under the legal authority of CA, who are expected to remain in care for 30 days or more, are to receive a well-being screen that assesses child's health, educational, emotional/behavioral, cultural and developmental needs. [Source: CA Practices and Procedures Guide 43092]

and reviewed the child's needs with the grandmother. The parents were provided with supervised visits four days per week at the facility of a local visitation provider. Because one of the baby's scheduled visits was to take place on Christmas day and the agency provider was unavailable, the CFWS social worker allowed the parents a single visit in the grandmother's home on Christmas Day. The worker specified that the grandmother was to supervise the parent's interactions with the baby at all times.

At approximately 6:00 am on December 27, 2014, law enforcement and emergency medical technicians were called to the parents' home to attend to an infant who was unconscious and unresponsive. Baby V.E. was transported to a nearby hospital and pronounced dead at 7:00 am. A Children's Administration intake was generated regarding this incident that alleged neglect by the grandmother for leaving the baby with the parents. In subsequent interviews, the CPS investigator learned that the grandmother had left the baby in the parents' care twice on December 26 and again in the early morning hours on December 27. The mother reported she had left the baby alone in an adult bed after feeding her at about 3:30 am. She woke at about 6:00 am and found the baby unresponsive with blood on her nose. The parents called emergency responders who were unable to revive the baby. An autopsy was done; no sign of injury, abuse, or neglect was found. Toxicology reports were still pending at the time of this review.

After the baby died, a review of the grandmother's record indicates she had been identified as the subject in 20 Child Protective Services intakes. An investigation done in 1994 resulted in founded findings[21] related to abuse and neglect. Three other investigations (completed in 1993, 1999 and 2000) were closed with inconclusive findings. In addition to the assigned CPS investigations, she and her husband have been identified in ten intakes for Family Reconciliation services.

Committee Discussion

The major focus of the Committee discussion centered on documentation regarding observations, actions, and decisions made during the CA involvement with the family in the two months prior to V.E.'s death. The Committee also considered the information gathered during staff interviews as well as policies and procedures related to non-licensed placements and background checks. The Committee also found staff interviews helpful in gaining an understanding of the internal case assignment and case transfer processes in the Spokane office.

[21] "Founded" means the determination that, following an investigation by the department, based on available information: it is more likely than not that child abuse or neglect did occur. [Source: RCW 26.44.020]

The Committee noted very good practice regarding documentation. The case notes entered by both the CFWS and CPS workers were timely and thorough. The CPS and CFWS staff demonstrated good practice collaborating early in the case and in working together to engage the family in services. Given that the child's manner of death remains undetermined, the Committee did not reach a consensus about critical oversights or errors. However, the Committee found several categories of concern and several issues identified as missed opportunities for improved practice and increased child safety.

Placement Decision

The Committee spent a great deal of time discussing the decision to place the baby with the paternal grandmother. They noted that this baby's exposure to prenatal substance abuse and history of poor feeding indicated a need for careful monitoring. While state policy allows the department to place with unlicensed relatives prior to the completion of a home study, proper assessment is required to determine their suitability as a placement resource. In addition, prior approval must be obtained from the Area Administrator. The Committee could not find documentation that the Area Administrator(s) had approved this placement.[22]

One of the key components to assessing relatives for placement is a thorough review of the department's records, electronic and otherwise. Though some of the historic information was not available to the worker at the time of placement because it had not yet been uploaded into the department's digital archive system (MODIS), the Committee noted that the content of the prior intakes, as well as any assessments associated with them, were available for review in the current CA database, FamLink, which is accessible to all workers. Included in this available information was a Summary Risk Assessment[23] completed in 1994, which indicated a founded allegation of child abuse or neglect against the paternal grandmother. According to policy, a finding of abuse or neglect is considered a negative action and placement would have required authorization from the Regional Administrator.[24] The investigator stated computer problems prevented her from a complete review of the grandmother's history. The Committee believed that even if the finding was not available, the content of the prior allegations should have raised sufficient concern in the worker's mind to necessitate further inquiry and review. The Committee questioned whether the worker's bias toward relative placement colored how she reviewed the information in CA's own system. The grandmother's statement to staff that she

[22] See CA Practice and Procedures Guide 45274
[23] The Summary Risk Assessment was replaced by the Investigative Assessment in 1998.
[24] See CA Operations Manual 5522

had not been involved with CPS and had only sought help for her adolescent children seemed to be taken at face value.

The second major component of a background check is a review of the potential caregiver's criminal history. The Committee noted that background checks were requested in a timely manner and concurred with the worker's report that there were no disqualifying crimes that would rule the grandmother out as a placement option. While this is true, the Committee believed that both the drug charge and the multiple thefts were indicators of a need for additional assessment of the grandmother's character and reliability and a review of the placement at a higher level. The investigator seemed to place great weight on the grandmother's statement that she had been an approved placement provider in the past, though this statement could not be verified.

The Committee viewed the grandmother's admission of the relinquishment of her nursing license was another indication of a need for further corroboration. Policy states that the relinquishment of a professional license in lieu of an agency revocation is a negative action that would necessitate review by the Regional Administrator prior to placement. The worker's lack of curiosity about this issue impacted the state's ability to fully assess the appropriateness of this placement.

The Committee also felt that the efforts to assess the grandfather for character and suitability were not documented. Though background checks were completed on him that indicated no disqualifying information, the fact that he was identified as a subject in prior intakes warranted further inquiry about his role in the family and his willingness to work with the department and follow a court order.

Some discussion centered on whether or not the use of a specific placement order or an updated placement agreement form might have helped to clarify the department's expectations about parent contact. While either of these things may have provided more structure to the placement, the Committee felt that both the CFWS and CPS social workers had been very clear about the department's expectations regarding parent contact and that the grandmother's own statements verify this.

Case Assignment

Interviews with staff helped the Committee to understand case assignment processes in the Spokane office which provided a context for additional discussion. This office customarily assigns cases involving adolescents to specific units when a child reaches the age of twelve. In this case, the mother's case was re-assigned to a new CFWS social worker when her older child turned 12 in June

2014 even though they were aware at the time that the mother was pregnant. When the new intake was received at the time of the baby's birth, the intake was assigned to a CPS investigator and was then co-assigned to the original CFWS social worker, resulting in three different assigned workers. The Committee felt some consideration should be given in the future to allowing the case to remain with the same CFWS social worker who would be able to provide continuity in case planning and greater opportunities for planning prior to the child's birth.

Intake/Investigation

Though the Committee focused primarily on the actions prior to the child's death, they questioned the decision not to identify the parents as subjects in the investigation of the death. The Committee felt the fact that the child was in the parent's care when she died in violation of a court order and their admitted history of substance abuse was adequate reason to include them as subjects. This would have provided the department with the opportunity to more fully explore the circumstances of the baby's death which could be very important in assessing risk and safety in this household. In addition, the Committee was concerned that because the information about the baby's death was electronically linked to a different case, future workers assigned to this family may miss important information about parental protective capacity.

Findings

1. The Committee could not find documentation that the non-emergent placement with the grandmother was approved in advance by the Area Administrator as required by CA Policy and Procedures 45274.
2. CA policy requires background checks to assess the suitability of all persons who have unsupervised access to children in the care and custody of the department. Placement with persons whose background checks include crimes or negative actions on the DSHS Secretary's List of Crimes and Negative Actions list must be authorized in advance using the CA Administrative Approval Process. The Committee found several areas where those guidelines were not followed.
    a. The placement with the grandparents was not adequately assessed for suitability and reliability. The 1994 finding of abuse or neglect by the grandmother is considered a negative action and placement in this home should have had approval from the Regional Administrator or Deputy Regional Administrator. In addition, the Committee could not find documentation that the character and suitability of the grandfather was assessed. There were no discussions documented with the paternal grandfather regarding

his history in the CA system, his attitude about the placement, his willingness to work with the department, and follow court orders.

b. While it is true that the results of the grandmother's criminal background check did not contain any disqualifying information, the drug-related conviction, though over ten years in the past, required administrative approval, and the recent nature and extent of the theft convictions should have raised concern about the character and suitability this relative for placement.
c. The grandmother's admission that she had relinquished her nursing license should have been explored further. If she had relinquished her license in lieu of an agency negative action, approval of this placement would have needed to be completed with the Regional Administrator or Deputy Regional Administrator.

Recommendations

1. In order to ensure that relevant information about parental capacity gathered during the investigation of the child's death is included in the parent's case history, the Committee recommends that the current worker review the investigation and incorporate this in the current Comprehensive Family Evaluation.
2. The Committee recommended that the Spokane office staff work with the Alliance for Child Welfare Excellence to complete training on the application and use of the background check policy, to include the use of shared decision-making and critical thinking to evaluate history, recognize patterns of behavior, and assess a potential caregiver for suitability and reliability.
3. The Committee recommended that the Spokane office consider maintaining the case assignment with an existing assigned worker when a new child is expected, rather than re-assigning to an adolescent unit. This would reduce the number of workers assigned and may encourage the use of shared planning and early engagement to plan for the new child prior to delivery.
4. The Committee recommends that Spokane office staff seek consultation with the home study unit in assessing the suitability of non-licensed placements prior to making placement decisions.