Report to the Legislature

Quarterly Child Fatality Report

RCW 74.13.640

July - September 2014

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Executive Summary

This is the Quarterly Child Fatality Report for July through September 2014 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 four (4) child fatalities and two (2) near-fatalities that occurred in the third quarter of 2014. All of these cases were conducted as executive child fatality reviews. All prior child fatality review reports can be found on the DSHS website: http://www.dshs.wa.gov/ca/pubs/fatalityreports.asp.

The reviews in this quarterly report include fatalities and near-fatalities from two regions.[1]

Region	Number of Reports
1	0
2	3
3	3
Total Fatalities and Near Fatalities Reviewed During 3rd Quarter, 2014	6

This report includes Child Fatality Reviews and Near-Fatality reviews conducted following a child's death or near-fatal incident 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

[1] DSHS implemented a reconfiguration of the regional boundaries in May 2011. The existing six regions were consolidated into three.

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 2014. 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 2014			
Year	Total Fatalities Reported to Date Requiring a Review	Completed Fatality Reviews	Pending Fatality Reviews
2014	12	4	8

Child Near-Fatality Reviews for Calendar Year 2014			
Year	Total Near Fatalities Reported to Date Requiring a Review	Completed Near-Fatality Reviews	Pending Near-Fatality Reviews
2014	8	2	6

The four (4) fatality reviews referenced in this Quarterly Child Fatality Report are posted on the DSHS website. Near-fatality reports are not subject to public disclosure and are not posted on the public website or included in this report.

Notable Third Quarter Findings

Based on the data collected and analyzed from the four (4) fatalities and two (2) near-fatalities reviewed between July and September 2014, the following were notable findings:

- Two (2) children died in unsafe sleep environments. The death of one child was deemed to be undetermined by the medical examiner. This 13-month-

old child was found with a comforter and blanket covering his head. Another child was two-months-old and was co-sleeping with his mother at the time of his death. His twin brother died in an unsafe sleep environment one month prior. The department had an open case and a safety plan with the mother after the death of the first child to avoid future unsafe sleep practices.

- All of the children referenced in this report were five years old or younger.
- One (1) child died from blunt force trauma inflicted by her mother. The case was not open at the time of the child's death.
- One near-fatality occurred in California. The near fatal injuries to the child were inflicted by her biological father. He obtained custody of the child through family court.
- Three (3) children were Caucasian, two (2) were African American/Black, and one (1) was Hispanic/Native American.
- Children's Administration received intake reports of abuse or neglect in all of the child fatality and near-fatality cases prior to the death or near-fatal injury of the child. All but one of the cases had less than six (6) intakes prior to the critical incident. One case received thirteen (13) intakes prior to the critical incident.
- Due to the small sample of cases reviewed, no statistical analysis was conducted to determine relationships between variables.

Child Fatality Review

K.H.

September 2011
Date of Child's Birth

February 25, 2014
Date of Fatality

May 29, 2014
Child Fatality Review Date

Committee Members
Cristina Limpens, MSW, Office of the Family and Children's Ombuds
Nicole Muller, Practice Consultant, Children's Administration
Carmen Cody, MSW, Director, Nuestros Ninos
Lindsey Wade, Detective, Tacoma Police Department, Criminal Investigations Division, FBI South Sound Child Exploitation Task Force

Observer
Paul Smith, Critical Incident Practice Consultant, Children's Administration

Facilitator
Libby Stewart, Critical Incident Review Specialist, Children's Administration

Executive Summary

On May 29, 2014, the Department of Social and Health Services (DSHS), Children's Administration (CA) convened a Child Fatality Review (CFR)[2] to assess the department's practice and service delivery to two-year-old K.H. and her family. K.H. will be referenced by her initials throughout this report.

The incident initiating this review occurred on February 25, 2014, when K.H. was found non-responsive in the living room at her home. It was determined that K.H. died from blunt force abdominal trauma and her death was ruled a homicide. K.H. also sustained a skull fracture which was either healing or had healed at the time of her death.

K.H. was in the care of her mother, Monique Hachtel.[3] Ms. Hachtel was arrested and charged with Murder in the Second Degree in connection with K.H.'s death. Ms. Hachtel, her five-year-old daughter and three-year-old son were living with her sister-in-law and family. The children's father, Ms. Hachtel's husband, remained in Mexico. Ms. Hachtel and her children were primarily English speaking but appeared to communicate well in Spanish. The most recent intake prior to February 25, 2014, came in on November 24, 2013, alleging physical abuse. The last case activity conducted on that intake was February 10, 2014.

The Review Committee included members selected from the community with relevant expertise from diverse disciplines including a CA contracted provider who specifically serves minority populations, a homicide detective with a strong background in working child abuse cases, the Ombuds Office and a CPS Practice Consultant with CA. A medical professional was scheduled to sit on the Committee; however, she was unavailable due to a large traffic backup. She was traveling from quite a distance to attend the review. Neither CA staff nor any other Committee members had previous direct involvement with this family.

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[2] Given its limited purpose, a Fatality Review (CFR) should not be construed to be a final or comprehensive review of all of the circumstances surrounding the near death of a 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.

[3] Monique Hachtel is named in this report due to her current criminal charges of Murder II, in relation to K.H.'s death. The names of K.H. and her siblings are subject to privacy laws.[Source: RCW 74.13.500(1)(a)]

Prior to the review, each Committee member received a case chronology, a summary of CA involvement with the family and un-redacted CA case documents (e.g., intakes, investigative assessments, investigative assessment tools, case notes and medical records). Supplemental sources of information and resource materials were available to the Committee at the time of the review. These included the current case files, medical records, coroner report, law enforcement report, relevant state laws and CA policies.

The Committee interviewed the Child Protective Services (CPS) worker and CPS supervisor assigned to the November 24, 2013 intake.

Family Case Summary

This family had three intakes which were reviewed by the Committee. The family first came to the attention of CA on January 20, 2012; an intake was received by CA regarding allegations of medical neglect to K.H. At the time of that intake, K.H. was four months old and had a severe diaper rash and a rash on her scalp. The caller was concerned that the mother, Monique Hachtel was not providing adequate care to treat the rashes. Ms. Hachtel admitted to the CPS worker it took her a long time to obtain medical care for K.H. and she had no explanation as to why. The intake was assigned for a CPS investigation.

During the CPS investigation, the CPS worker learned Ms. Hachtel was married and had three children with her husband. Ms. Hachtel's husband resided in Mexico. Ms. Hachtel lived in Washington with K.H., her almost two-year-old son and her three-year-old daughter. Ms. Hachtel said she left Mexico due to domestic violence perpetrated by her husband. The social workers offered voluntary mental health services but the mother refused. Before the conclusion of the January 2012 CPS investigation, Ms. Hachtel moved out of her home and it was believed she had moved back to Mexico. This investigation was closed as unfounded for Negligent Treatment and/or Maltreatment of K.H.[4]

On November 24, 2013, CA received an intake when K.H. was taken to the hospital for a broken femur. K.H. also had bruising on her chest. Ms. Hachtel reported the bruising was caused by older children playing too rough with K.H. She stated K.H. was in the care of her brother-in-law when K.H. fractured her femur. Ms. Hachtel reported the broken femur was caused by K.H. falling off the bed and catching her leg in the gap between the bedframe and mattress.

[4] Unfounded means: The determination following an investigation by CPS that, 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 as defined in WAC 388-15-009. RCW 26.44.020

Ms. Hachtel's relatives, with whom she lived, are primarily Spanish speaking. They have five children, four under the age of 18 and one 18-year-old who lived in the home. The two older children spoke both English and Spanish. Ms. Hachtel's brother-in-law was the subject of the November 2013 intake regarding the broken femur. The CPS worker interviewed the brother-in-law and used Ms. Hachtel as the interpreter. No other household members were interviewed.

A medical consultant with expertise in child abuse found the broken femur injury to K.H. could have been caused by accidental trauma as reported by Ms. Hachtel. The CPS supervisor reported that he called the appropriate law enforcement jurisdiction and they were not going to investigate the broken femur based on the finding by the physician.

In November 2013, following K.H.'s discharge from the hospital, the CPS worker conducted two home visits. No concerns were noted at the time, and the case was closed on February 12, 2014, following a final phone contact with the mother.

On February 25, 2014, an intake was received from law enforcement requesting assistance regarding the protective custody of K.H.'s siblings and cousins immediately following K.H.'s death. K.H. was found non-responsive in the family living room. According to the family members, K.H. was exhibiting signs of significant distress and pain for days before her death. Family members urged Ms. Hachtel to obtain medical care for K.H. Ms. Hachtel was questioned by law enforcement and was subsequently arrested and charged with Murder in the Second Degree. K.H. sustained multiple injuries due to blunt force abdominal trauma and her death was ruled a homicide. K.H. had also sustained a skull fracture which was healing or had already healed at the time of her death.

Committee Discussion

While the Committee's primary focus was on the actions and decisions made by CA during the period of November 2013 until February 12, 2014, the entire CA history of involvement with the family was reviewed and discussed.

The Committee agreed with the supervisor's decision to upgrade the response time in the first intake on January 20, 2012 from an alternate intervention 10-day response[5] to a 72-hour CPS investigation.[6] The Committee believed the CPS

[5] In 2012, CA intakes determined to involve low to moderate low risk were assigned as 10-day alternate response. An alternative response intervention connects families to services, concrete supports, and community resources. Where available, such intakes could be forwarded to an Early Family Support Service (EFSS) or other community agencies that were willing to accept the intake for services and/or monitoring. After October 20, 2013, legislated changes required CA to implement a differential response system designed as an alternative pathway for accepted reports of low to moderate risk of child maltreatment. This pathway, known as Family Assessment Response (FAR), provides a comprehensive

investigative practice could have been enhanced by a more thorough assessment of Ms. Hachtel's mental health issues and domestic violence allegations. Specifically, the Committee noted there was no documentation of daily functioning of Ms. Hachtel or her children. The Committee also noted a lack of assessment related to her attachment with her children and the investigation focused on the identified victim and did not appear to include assessment of the two other children in the home.

Regarding the January 2012 intake, the Committee believed the CPS worker should have followed up with K.H.'s pediatrician because the caller alleged medical neglect. Ms. Hachtel declined voluntary services that were offered to her that included a mental health assessment and the Birth to 3 Program. This decision to decline supportive services was a red flag to the Committee. The Committee discussed the unfounded finding associated with the January 20, 2012 intake. The Committee believed a more appropriate finding would have been inconclusive or unable to determine; however, there is no legal basis for such a result and the Committee noted the only options allowed by statute for investigative findings were unfounded or founded at the time of this investigation.[7]

The focus of the discussion moved to the November 2013 intake. The supervisor indicated he called the manufacturer to corroborate the improper fit of the mattress with the bedframe that reportedly caused the fractured femur which the manufacturer confirmed. He also stated he called the appropriate law enforcement agency rather than faxing the report. The Committee was concerned by the lack of case notes by the CPS supervisor documenting contact with law enforcement to fulfill the policy requirement for cross reporting. The second concern was the lack of documentation regarding the phone call made by the supervisor to the furniture manufacturer.

The Committee was made aware of significant turnover and continuous vacancies in this office. This led to higher caseloads for workers and a larger span of supervision responsibilities. The Committee understood that it was difficult to accurately and timely document all contacts as well as complete and close out

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assessment of child safety, risk of subsequent child abuse or neglect, family strengths and need. A family's involvement in the Family Assessment Response program is voluntary. [Source: Family Assessment Response in Washington]

[6] A non-emergent investigation response is required for children who are NOT in present or impending danger. A non-emergent investigation response requires CA workers to have face to face contact with all alleged child abuse or neglect victims within 72 hours from the date and time CA receives the intake. [Source: CA Practices and Procedures Guide Section 2310(B)(5)]

[7] "Inconclusive" means the determination following an investigation by the department, prior to October 1, 2008, that based on available information a decision cannot be made that more likely than not, child abuse or neglect did or did not occur.[Source: previous version RCW 26.33.020]

CPS investigations when the volume of new assignments out paces the employee's ability to complete prior assignments

While taking into consideration vacancies and high caseload counts, the Committee questioned the CPS worker's decision to not interview all persons residing in the home during the femur fracture investigation. The CPS worker and supervisor both stated it is too time consuming to comply with the request for an interpreter and that the requests were rarely filled.

During the discussion, contact was made with the Limited English Proficiency (LEP) program manager. She was able to educate the Committee regarding the process and challenges, for the Tumwater CA office particularly, regarding filling in-person interpreter requests. An analysis of the month of November 2013 revealed one request by CA for an interpreter and that request went unfilled (there is no information provided as to why it was not filled). The Tumwater CA office continues to lack a certified Spanish speaking employee. An alternative option is to utilize the Language Line. Language Line is a resource utilized by CA staff via a phone to interpret conversations.

The CPS worker stated she did not interview the siblings, ages three years and four years, because they were not of an age where the worker believed they could provide reliable information. There were also other children living in the home, ages five years, seven years, twelve years and eighteen years, who were not interviewed. The Committee believed best case practice would be to interview all children, regardless of age, and/or to clearly document the attempt. It is understood that children have varying levels of verbal skills at differing ages. The CA workers should document a child's developmental levels to include verbal skills in a case notes.

The Committee noted it was also alleged by Ms. Hachtel that the older children caused the bruise to K.H.'s chest. The Committee believed investigation around this injury was insufficient. The Committee believed the CPS worker should have requested permission from the mother to have the two siblings evaluated by their pediatrician and the medical records for all children should have been reviewed. The Committee believed that even though K.H. was the identified victim, it is important that all children be included in a CPS assessment.

The Committee asked about the lack of photographs regarding the mattress and bedframe. The CPS worker said she had not been trained regarding photographing the scene of a possible non-accidental trauma site. When discussion moved to the CPS history for the relatives where the family was residing, the CPS worker stated she relied heavily on what was reported in the intake. The Committee believed the alleged subject's name was incorrectly

spelled; therefore, inaccurate information was obtained regarding CPS history. When asked about conducting her own search in CA's client database, the CPS worker said she was not trained on how to conduct detailed person searches within FamLink.[8] The CPS worker said she is now aware that history provided in an intake is not always complete and workers should review this as part of regular case practice. The Committee discussed the challenges with FamLink and the limitations presented by the need for accuracy related to the spelling of a person's name to accurately obtain information. It was suggested that good practice would be verifying all household member's names with appropriate identification.

The Committee discussed concerns that a CPS worker with less than one year experience was routinely assigned high risk critical cases. [9] This specific CPS worker was utilized in this manner due to her extensive background in the mental health field. While this concern was shared by all of the Committee members, it was also discussed that offices have limited staff resources to draw from. At the time of the fatality and November 2013 intake, this office was utilizing social workers from other offices to temporarily fill vacancies.

The Committee identified several opportunities where additional reasonable actions by the CPS worker might have served to enhance the assessment of K.H. and her siblings' well-being and safety. These suggestions are outlined in the findings below.

Findings

- The Committee identified areas of improvement related to the November 24, 2013 investigation to include obtaining correct spelling of household members' names to obtain accurate CPS history, which could have enhanced the safety assessment of the children in the home. This information should have been utilized in order to accurately complete the Structured Decision Making Risk Assessment® Tool (SDMRA).[10] Timely completion of the Safety Assessment and utilization of criminal background checks would also have strengthened the investigation.

[8] FamLink is the name of CA's Statewide Automated Child Welfare Information System (SACWIS) that replaced CAMIS.

[9] DSHS Strategic Plan Metrics – Children's Administration (April 2014): "It takes an average of two years for an investigator to become proficient. It takes an average of 3 months to hire a new CPS investigator. The high turnover rate also impacts staff that remains. They are burdened with higher caseloads and mentoring new staff."

[10] The Structured Decision Making Risk Assessment® (SDMRA) is a household-based assessment focused on the characteristics of the caregivers and children living in that household. By completing the SDMRA following the Safety Assessment, the worker obtains an objective appraisal of the risk to a child. The SDMRA informs when services may or must be offered. [Source: CA Practices and Procedures Guide Section 2541]

- The CPS social worker should have interviewed all household members to include K.H.'s siblings. Utilization of interpreter services as outlined in the Limited English Proficiency (LEP) Policy 4320 Operations Manual should have occurred as appropriate.
- The November 2013 investigation would have been improved by taking photographs of the bedframe and mattress. The Committee agreed photographs would have aided the child abuse medical consultant's assessment of the reported mechanism of injury to K.H. Some Committee members who have had CPS investigative experience discussed providing all known criminal history and CPS history of alleged subjects to medical consultants. The Committee agreed this would have been best case practice as it related to Ms. Hachtel's brother-in-law as the identified subject.
- The Committee found that the department did not fully assess K.H.'s wellbeing by not contacting medical professionals to confirm that Ms. Hachtel obtained the proper follow up care for K.H. related to her femur fracture. The Committee believed that a home visit should have occurred before closing the case February, 12, 2014.
- The Global Assessment of Individual Needs (GAIN) form should have been completed by the CPS worker.[11] Per policy, this form is to be completed within 45 days on all adults as a subject on the referral, parents and or persons acting in loco parentis and living in the child's home. Both mental health and chemical dependency issues were identified previously regarding Ms. Hachtel.
- The intake on November 24, 2013, should have been faxed to the appropriate law enforcement agency and this action should have been documented.
- The contact with the furniture maker should also have been documented. The cross reporting of an alleged non-accidental injury is a policy driven action.[12] However, the contact with the furniture maker is a vital collateral

[11] The GAIN-SS is a validated screening tool used with adults (parent(s), guardian(s) or legal custodian(s)) and youth, age 13 and over. It identifies a need for a chemical dependency, mental health or co-occurring assessment to be completed by a community professional. The GAIN-SS does not identify service needs. The goal of the screen is to increase the number of people identified for a mental health, substance abuse or co-occurring disorder assessment. [CA Policy, GAIN SS]

[12] The social worker or supervisor shall report, as required by RCW 26.44.030(4) and 74.13.031(3), to law enforcement within 24 hours of receipt of a report by the department in cases where the response time is labeled "emergent" and the child's welfare is believed to be in immediate danger. With the exception of a child fatality, which the social worker or supervisor shall report immediately, the social worker or supervisor shall notify law enforcement within 72 hours of receipt of any reported incident of: Sexual abuse. Non-accidental physical injury of a child. Incidents where the investigation reveals reasonable cause to believe that a crime against a child may have been committed. Unless otherwise agreed in a local written working agreement with law enforcement, developed in consultation with the Attorney General's Office, DCFS staff making an oral report to law enforcement shall, within five days of receipt of the intake, also

contact that the Committee agreed would carry substantial weight in assessing the viability of the explanation provided by Ms. Hachtel and her brother-in-law in conjunction with what the CPS worker personally observed.

- The Committee noted the CPS social worker provided Ms. Hachtel with a crib. This was an added support to the family and provided a safe sleeping environment for K.H.
- The CPS supervisor informed the Committee that before he took his new position, he obtained access to barcode and ACES for all of the CPS workers. These are computer programs through Temporary Assistance for Needy Families (TANF) that aid workers in locating and contacting clients. The Committee was pleased with the diligence needed to obtain these beneficial resources for staff.

Recommendations

- The Tumwater CA office should standardize the process for requesting interpreters to lessen the burden on social workers and supervisors. Once standardized, there should be training for all staff regarding the process of requesting an interpreter.
- Regional Core Training through the Alliance for Child Welfare Excellence should include specific training on searching for history on individuals named in intakes.

report in writing. The person making the report shall file a copy in the department case record or in an administrative file when no case record exists. A FamLink Law Enforcement Report or a legibly completed Report of Child Abuse and Neglect (Intake/Referral), DSHS 14-260, may be used to comply with the requirement for a written referral. [Source: CA Practices and Procedures Guide Section 2571]

Child Fatality Review

J.H.

May 2008
Date of Child's Birth

January 8, 2014
Date of Fatality

June 10, 2014
Child Fatality Review Date

Committee Members
Cynthia Norris, Domestic Violence Empowerment Coordinator, Olympia Family Support Center of South Sound
Brenda Sullens, B.A., Family Preservation Counselor/Trainer, Family Preservation Services of Washington
Cristina Limpens, MSW, Office of Family and Children's Ombuds
Dawn Flammang, Social Services Specialist 3, Division of Children and Family Services, Children's Administration

Medical Consultant to the Committee
Michael J. Larson, M.D.

Observers
Bryan Davis, Office of Family and Children's Ombuds
Amy Boswell, Social Services Specialist 4, Division of Children and Family Services

Facilitator
Bob Palmer, Critical Incident Case Review Specialist, Children's Administration

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RCW 74.13.640

Executive Summary

On June 10, 2014, the Department of Social and Health Services, Children's Administration convened a Child Fatality Review[13] to examine the department's practice and service delivery to a five-year-old and his family. In this report the initials J.H. reference the child.

The incident initiating this review occurred on January 8, 2014, when emergency medical responders were unable to resuscitate J.H. following a 911 call regarding an unresponsive child at the family home. First responders described the conditions of the residence as "deplorable" with an overwhelming smell of animal feces. CPS investigated similar home conditions a year earlier. According to the Thurston County Coroner, the child died from acute streptococcal pneumonia of the lungs,[14] with Prader-Willi Syndrome[15] (PWS) as a contributory cause. The manner of death was determined to be natural.

The CFR Committee included CA staff and community members selected from disciplines with relevant expertise including child and family counseling, domestic violence, child and family advocacy, public child welfare and child abuse investigation. None of the participating Committee members had any prior involvement with the family. Although unable to be present during the review, a physician provided written consultation to the Committee regarding the noted medical issues the child had at the time of the death.

Prior to the review, each Committee member received a summary of the mother's CA history as a child, the father's prior CPS involvement regarding his other children from previous relationships, a chronology of CA involvement (2008-2014) with J.H. and his family,[16] and relevant un-redacted CA case

[13] 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 a 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 CFR 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 death. Nor is it the function or purpose of a CFR to recommend personnel action against DSHS employees or other individuals.

[14] Streptococcus pneumonia is a bacterium commonly found in the nose and throat. The bacteria can sometimes cause severe illness in children, the elderly and other people with weakened immune systems. It spreads person to person by inhaling or direct exposure to the bacteria droplets through coughing or sneezing from an infected person. Symptoms can include an abrupt onset of fever or chills, headache, cough, chest pain, disorientation, shortness of breath, and weakness. [Source: The Center for Acute Disease Epidemiology]

[15] Prader-Willi Syndrome (PWS) is a rare genetic (chromosomal) disorder present at birth. A key feature is the constant feeling of hunger that usually begins after the first year of life. There is no cure for PWS. Growth hormone, exercise, and dietary supervision can help build muscle mass and control weight. Other treatments may include sex hormones and behavior therapy. Most people with PWS will need specialized care and supervision throughout their lives.

[16] The names of J.H.'s parents are not included in this report as no criminal charges emerged from the investigation of the death of their son. The names of J.H.'s siblings are subject to privacy laws. [Source: RCW 74.13.500(1)(a)]

documents (e.g., intakes, case notes, safety assessments, investigative assessments).

Supplemental sources of information and resource materials were available to the Committee at the time of the review, including information provided by the Committee medical consultant, medical articles on PWS and strep pneumonia, the contracted Family Preservation Service provider's summary of services (2013), and the deceased child's medical records.

During the course of the review, the Committee interviewed the Tumwater Child Protective Services supervisor and the Family Voluntary Services worker involved in the case prior to the fatality. Following review of the case file documents, completion of the staff interviews, and discussion regarding department activities and decisions, the Committee made findings presented at the end of this report. The Committee made no recommendations.

Case Overview

CA first became aware of the family in November 2008, six months after the birth of J.H. and his twin sister when the father alleged his partner had been neglecting their two children prior to her leaving the home following a domestic violence incident. Lacking specific allegations that met legal definitions of abuse or neglect, the intake screened out. Similarly, a report of lack of prenatal care by the mother in May 2009 also screened out.

In October 2009, CA received information from an anonymous source regarding significant health hazards in the home, parental failure to meet the children's basic needs (feeding, changing, supervising), and failing to meet the needs of a special needs child. The intake screened in for CPS investigation of allegations of negligent treatment. Investigative activities did not confirm the allegations made by the anonymous referrer and the case closed late December 2009.

In October 2010, CA intake received information regarding lack of adequate supervision in the home and frequent use of alcohol and marijuana by the parents. Assessed at intake to be low-level neglect allegations, case assignment went to alternate response.[17]

In late 2011, CA received allegations that the father had been drinking alcohol while driving two of his other children back to their custodial parent following visitation. The assigned CPS investigator was unable to gather sufficient evidence

[17] In 2010, Alternate Intervention Policy required CPS to respond within 10 calendar days to an alternate intervention intake. The CA social worker could send a letter, make a phone call to the caretakers(s), or make a brief home visit. CA could also send such an intake to an Early Family Support Service or other community agencies willing to accept the intake for services and/or monitoring.

to verify the allegation and the case closed January 2012 with an unfounded finding.

A year later in March 2013, CA intake received information regarding significant health hazards in the home, such as animal feces and garbage throughout the home. Having verified the reported conditions of the home, the CPS investigator founded the allegations of negligent treatment by the parents to J.H. and his three siblings.[18] The mother agreed to participate in Family Voluntary Services (FVS)[19] and Family Preservation Services (FPS)[20] were initiated to help improve the home conditions, to provide concrete services (e.g., funds for utilities, clothing, and cleaning supplies), and to support the mother and children in connecting with services in the community. The father moved out of the home under a No Contact Order stemming from a domestic violence incident and did not make himself available to services. The case closed July 30, 2013.

On January 9, 2014, local law enforcement notified CA that J.H. had died a day earlier, when, following a 911, emergency medical responders were unable to resuscitate J.H. First responders described the conditions of the residence to be "deplorable" with an overwhelming smell of animal feces, similar to the home conditions a year earlier that CPS had investigated. At the time of the fatality it was unknown if the health hazards observed in the home had contributed to the child's death. The department filed dependency petitions on the surviving siblings who were court ordered into out-of-home care. When completed, the CPS investigation supported a founded finding as to the allegation of negligent treatment based on the clear and present neglectful conditions found at the home.

As later determined by the Thurston County Coroner, J.H.'s cause of death was acute streptococcal pneumonia of the lungs, with Prader-Willi Syndrome as a contributory cause. The manner of death was determined to be natural. There are no criminal charges pending regarding the circumstances surrounding the child's death.

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[18] CPS findings in Washington state follow a preponderance of evidence standard rather than "clear and convincing evidence" or "reasonable doubt" standards of proof. In this way "Founded means 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(9)]

[19] Families involved in CPS investigative cases that need in-home services, transfer to Family Voluntary Services (FVS). A Voluntary Case Plan seeks 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 parent's protective capacity and manage child safety. Continued assessment of child safety occurs throughout the case.

[20] Family Preservation Services means in-home or community-based services that draw on the strengths of the family and its individual members, while addressing family needs to strengthen and keep the family together where possible. FPS services may focus on services designed to improve parenting skills, to promote a safe, stable, and supportive family environment, and to foster the well-being of the children and their adult caregivers. [Source: RCW 74.14C.010]

CFR Committee Discussion

While some discussion occurred as to earlier public child welfare involvement with the family (2008-2012), the major focus centered on the written and worker verbal accounts regarding CA case activities and decisions during the CPS and FVS involvement in 2013. No in-depth discussions occurred as to the CPS investigation of the fatality with the exception of reviewing initial concerns that the child's illness (streptococcal pneumonia) may have been impacted by neglectful care and the subsequent opinion of the Committee medical consultant that the concerns were not supported by medical science.

In the process of evaluating CA intervention efforts with the family, some generalized discussion occurred regarding intergenerational child abuse and neglect, patterns of chronic neglect, and the impact of consistent environmental chaos and dysfunction in the face of persistent multiple risk factors (e.g., domestic violence, drug and alcohol issues, poverty). The Committee noted numerous barriers to family engagement, including rural isolation that made access to services difficult.

The Committee utilized staff interviews to provide additional sources of information for consideration. This included inquiry and discussions about caseload size of the assigned social workers, the general makeup of the supervisory unit in terms of worker experience levels and availability of trained investigators, staff turnover, and changes in management at the Tumwater DCFS office. Brief discussion occurred regarding the expedited closure of the Family Voluntary Services in July 2013, due to the worker closing out many of her assigned cases prior to temporarily leaving her position with the department.

The Committee acknowledged the challenges faced by CA to maintain a high level of practice during a time of significant workload, staff turnover, and reliance on workers with relatively limited experiences in child protection.[21] The Committee was unable to conclude with certainty the impact of such circumstances on case practice in this case.

At 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 did identify several opportunities where additional reasonable actions by the worker might have served to enhance the assessment of the parents' ability to meet the safety and well-being needs of their children, including J.H. The inclusion of this information below serves as suggested areas where improved practice could have occurred.

[21] DSHS Strategic Plan Metrics – Children's Administration (April 2014): "It takes an average of two years for an investigator to become proficient. It takes an average of 3 months to hire a new CPS investigator. The high turnover rate also impacts staff that remains. They are burdened with higher caseloads and mentoring new staff."

Findings

Intakes

- In review of all intakes associated with J.H. and his family, the Committee found the intake decisions and assigned response times to be generally supportable. However, two intakes were identified (2008, 2010) where different decisions at intake might have also been reasonably supportable, but the Committee was unable to reach full consensus on these.
- The May 2013 intake (screen out) included information that the parents had been allowing registered sex offenders to frequent the home. While no specifics were provided at intake to indicate the identified registered sex offenders had unsupervised access to the children, a decision to screen in the report for risk only[22] would have been supportable.

CPS Investigations

- During the course of the 2009 CPS investigation, the worker interviewed the parents together. Given the documented intimate partner violence history involving the parents, separate interviews of the parents should have occurred, as is currently supported in the CA Social Worker's Practice Guide to Domestic Violence (February 2010).[23]
- In 2012, the worker completed a risk assessment (SDM®)[24] on the custodial parent's household rather than the household of J.H.'s father who was the identified subject of the investigation. This was not consistent with CA procedures that direct workers always assess the subject's household if the subject is a parent.

Family Voluntary Services (2013)

- Although the Committee noted several instances of good social work practice by the FVS worker, the worker admittedly failed to follow CA policy and practice with regard to documenting home visits and contact with the children.
- Although not reaching full consensus, there were noted opportunities where the worker might have conducted more in-depth inquiries in the process of assessing risk and safety. These included following up on an incident where one of the children fell out of a window, and following up

[22] CA will screen in a CPS Risk Only intake when information collected lacks allegations but gives reasonable cause to believe that risk or safety factors exist that place the child at imminent risk of serious harm. [Source: CA Practices and Procedures Guide Section 2220(D)]

[23] DSHS/Children's Administration: Social Worker's Practice Guide to Domestic Violence (published February 2010; revised May 2012)

[24] The Structured Decision Making® (SDM®) risk assessment is an actuarial household-based assessment focused on the characteristics of the caregivers and children living in that household. By completing the SDM® following the Safety Assessment, the worker obtains an objective appraisal of the risk to a child. The SDM® informs when services may or must be offered.

on the nature of the reported registered sex offenders having access to the children in the home.

Family Preservation Services (contracted provider)

The Committee noted two concerns regarding the contracted FPS provider.

- Pairing an inexperienced FPS therapist with a family with a substantive pattern of chronic neglect was not optimal in this case.
- The FPS Exit Summary presented by the therapist at closure of services appeared minimal and lacked details regarding interventions and accomplishment of family goals.

Recommendations

The Committee made no recommendations.

Child Fatality Review

J.B-D.

December 2012
Date of Child's Birth

January 19, 2014
Date of Fatality

May 8, 2014
Child Fatality Review Date

Committee Members
Mary Meinig, MSW, Director of the Office of the Family and Children's Ombuds
Keli Drake, MSW, Children and Family Welfare Services Program Manager, Children's Administration
Thom Young, Supervisor, Children's Administration
Yolanda Duralde, MD, Medical Director of the Child Abuse Intervention Department, Mary Bridge Children's Hospital and the Pierce County Child Advocacy Center

Observer
Sydney Doherty, Children's Administration, Social Worker 4

Facilitator
Libby Stewart, Critical Incident Review Specialist, Children's Administration

RCW 74.13.640

Executive Summary

On May 1, 2014, the Department of Social and Health Services (DSHS), Children's Administration (CA) convened a Fatality Review (CFR)[25] to assess the department's practice and service delivery to thirteen-month-old J.B-D.[26] and his family. The incident initiating this review occurred on January 19, 2014, when J.B-D. was found non-response in his portable crib while in the care of his father and the father's girlfriend. At the time of the fatality CA had an open Child Protective Services (CPS) investigation and the CPS worker had been attempting to locate the family.

The Review Committee included members selected from disciplines within the community with relevant expertise from diverse disciplines. Neither CA staff nor any other Committee members had previous direct involvement with this family or licensed providers.

Prior to the review, each Committee member received a case chronology, a summary of CA involvement with the family and un-redacted CA case documents (e.g., intakes, investigative assessments, investigative assessment tools, case notes, and medical records). Supplemental sources of information and resource materials were available to the Committee at the time of the review. These included the current case files, relevant state laws, and CA policies.

The Committee interviewed the current CPS supervisor. The CPS investigator ended her employment with the department before this investigation was completed and she was unavailable to participate in this process.

Family Case Summary

There was an intake made at the birth of J.B-D. and another two days after his birth. Both intakes were screened out for lack of a specific child abuse or neglect allegation.[27] On January 4, 2014, DSHS received an intake regarding alleged

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[25] Given its limited purpose, a Fatality Review (CFR) should not be construed to be a final or comprehensive review of all of the circumstances surrounding the near death of a 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.

[26] J.B-D.'s family members are 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 and management information system.[Source: RCW 74.13.500(1)(a)]

[27] CA will generally screen-out intakes the following intakes: 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

physical abuse to J.B-D. while in the care of his father and the father's girlfriend. There were allegations of domestic violence between the father and his girlfriend and alleged medical neglect of J.B-D. Five days after the January 4, 2014 intake, a subsequent intake was screened in for neglect. A physician called and stated J.B-D. presented at the emergency department with diarrhea and vomiting. J.B-D. was brought to the hospital by a family friend who told the physician that the father's girlfriend could not deal with J.B-D. any longer and left him with sour milk. The physician called CA to find out if CA approved of the hospital releasing J.B-D. to this woman's care. CA did not see a reason to stop J.B-D. from being discharged to the woman who brought him. The intake was assigned for a CPS investigation.

During the CPS investigation, the assigned CPS worker was informed by the father's girlfriend that J.B-D.'s mother had been arrested in the recent past. At that time the mother gave J.B-D. to a relative or friend and eventually J.B-D. ended up in his father's care. At that time the father's girlfriend assumed primary care of J.B-D due to the father's incarceration. The family did not have stable housing and would stay with friends in order to have a place to sleep.

During the investigation, the social worker was alerted that the father had been released from jail and planned on returning to live with his girlfriend and J.B-D. which would violate the criminal no contact order that had been put in place by the court after the domestic violence charges had been filed. The CPS social worker requested law enforcement conduct a welfare check on J.B-D. When law enforcement arrived, the officer was told by the resident that the father, his girlfriend, and J.B-D. were not there and were not allowed to return. The social worker attempted to locate J.B-D. but was unable to do so before his death.

The circumstances surrounding J.B-D.'s death remain unknown. He did not have signs of trauma and the cause and manner of death are unknown. The law enforcement investigation remains open at this time. Based on the short length of time between the intake on January 4, 2014 and J.B-D.'s death on January 19, 2014, the investigation of the two screened in intakes was not concluded. Therefore the CPS investigative findings were made post-fatality.

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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. 6) Alleged violations of the school system's Statutory Code, Administrative Code, statements regarding discipline policies.

Committee Discussion

The Committee struggled with how J.B-D. could have passed away and that the cause or manner of death remains unknown. J.B-D. had been observed as an active child who could pull himself up and easily maneuver his body. There were acknowledged risks to his care but the risks did not rise to a level of imminent or present danger as is necessary for CA to request removal from a parent's care and custody. All collateral information received was positive as it pertained to J.B-D.'s care during the investigations. The allegations were not proven to be accurate at the time of the investigations. J.B-D. was sleeping in a broken portable crib with a significant amount of bedding and items in this crib. The Committee was concerned regarding J.B-D.'s sleeping arrangement and whether this contributed to his death.

There was considerable discussion surrounding why a nonrelative was caring for J.B-D. and his mother's ability to have cared for him. J.B-D.'s mother attended one of his medical appointments with the father's girlfriend, yet the mother did not attempt to take J.B-D. back with her after this appointment. The girlfriend was able to obtain medical care and welfare benefits and these supportive services were verified by the social worker.

The Committee discussed how the CPS social worker diligently requested collateral information from the daycare and medical facilities where J.B-D. had contact. Appropriate collateral contacts were made to assess the care provider's, the father's girlfriend, ability to safely provide care for J.B-D. Per policy, the worker referred the intake to the appropriate law enforcement agency, requested criminal history checks on both the mother, father and the father's girlfriend and was timely with contacts with the child and care provider.

There were no findings or recommendations made during this review process. The Committee concurred the case was appropriately investigated by the CPS social worker.

Child Fatality Review

E.G.

January 2014
Date of Child's Birth

March 21, 2014
Date of Fatality

June 19, 2014
Child Fatality Review Date

Committee Members
Mary Meinig, MSW, Director, Office of the Family and Children's Ombuds
Jenna Kiser, MSW, CPS Program Manager, Children's Administration
Tory Clarke Henderson, Healthy Communities and Adverse Childhood Experiences Consultant/Child Death Review Coordinator, Department of Health
Brittney Cyr, MSW, Supervisor, Family Voluntary Services, Children's Administration
Ronda Haun, Statewide Quality Assurance/Continuous Quality Improvement Manager, Children's Administration

Consultant
Jennifer Meyer, Assistant Attorney General, Attorney General's Office

Observer
Dianna Lucas, Social Service Specialist, Child Protective Services, Children's Administration

Facilitator
Libby Stewart, Critical Incident Review Specialist, Children's Administration

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RCW 74.13.640

Executive Summary

On June 19, 2014, the Department of Social and Health Services (DSHS), Children's Administration (CA) convened a Child Fatality Review (CFR)[28] to assess the department's practice and service delivery to seventy-two-day-old E.G. and his family. In this report, E.G. is referred to by his initials. The incident initiating this review occurred on March 21, 2014 when E.G. was found non-responsive in bed with his mother and maternal great-grandmother. E.G. was in the care of his mother at the time of his death. E.G. and his mother lived with the maternal great-grandparents at the time of his death. The medical examiner determined E.G's death to be unexplained infant death with parental co-sleeping and the manner of death was classified as undetermined. CA had an open Family Voluntary Services (FVS) case with the family at the time of E.G.'s death; CA opened a case the previous month after E.G.'s twin brother passed away while sleeping in bed with their mother.

The Review Committee included members selected from diverse disciplines within the community with relevant expertise including a Department of Health Child Death Review Coordinator, Children's Administration Statewide QA/CQI Manager, Child Protective Services (CPS) Program Manager, FVS Supervisor and the Ombuds Office. An Assistant Attorney General was also present to consult regarding any legal questions. Another community professional with expertise in fatality investigations was unable to attend due to an emergency. Neither CA staff nor any other Committee members had previous direct involvement with this family.

Prior to the review, each Committee member received a case chronology, a summary of CA involvement with the family and unredacted CA case file documents (e.g., intakes, investigative assessments, investigative assessment tools, case notes and medical records). Supplemental sources of information and resource materials were available to the Committee at the time of the review. These included the medical examiner's report, a law enforcement report, the mother's CPS history as a child, relevant state laws and CA policies.

[28] 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 a 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.

During the time this case was open to CA, E.G. and his mother moved to three different familial locations. Staff from each of the three offices that had jurisdiction of the case were interviewed by the Committee. The case started in Everett then moved to Bellingham and ended in the Smokey Point office in Arlington.

Family Case Summary

This family came to the attention of CA on February 2, 2014 when an intake was received regarding the death of E.G's twin brother. The caller reported concerns for possible neglect related to co-sleeping[29]/bed sharing[30] on a deflating air mattress. E.G., his brother and their mother were sleeping on the mattress. The mother's significant other was sleeping in the same room but not on the mattress when E.G.'s twin brother was found unresponsive. E.G.'s brother was taken to a hospital. On February 7, 2014, E.G.'s sibling was taken off life support and he passed away that same day. At the time of the first intake, E.G. and his brother were one-month-old.

At the time of E.G.'s brother's death, E.G., their mother and mother's significant other were living with E.G.'s maternal aunt and her family. The aunt's family is comprised of a toddler and two parents. The two families were sharing a two bedroom apartment.

The intake received on February 2, 2014 was assigned for a risk only CPS investigation.[31] Based on the family's address, the investigation was assigned to the Everett office. The CPS worker contacted the family at the hospital and learned of the mother's plan to move in with her own mother, E.G.'s maternal grandmother, in Bellingham. The CPS worker continued to assess the safety of E.G. and the circumstances surrounding E.G.'s sibling's medical situation.

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[29] Co-Sleeping: A sleep arrangement in which the parent (or another person) and infant sleep in close proximity (on the same surface or different surfaces) so as to be able to see, hear, and/or touch each other. Co-sleeping arrangements can include room sharing or bed sharing. The terms "bed sharing" and "co-sleeping" are often used interchangeably, but they have different meanings. [Source: National Institute of Health]

[30] Bed Sharing: A sleep arrangement in which an infant sleeps on the same surface, such as a bed, couch, or chair, with another person. Sleeping with a baby in an adult bed increases the risk of suffocation and other sleep-related causes of infant death. [Source: National Institute of Health]

[31] Risk Only Intakes: CA will screen in a CPS Risk Only intake when information collected gives reasonable cause to believe that risk or safety factors exist that place the child at imminent risk of serious harm. In assessing imminent risk of serious harm, the overriding concern is a child's immediate safety. Imminent is defined as having the potential to occur at any moment, or that there is a substantial likelihood that harm will be experienced. Risk of Serious Harm is defined as: A high likelihood of a child being abused or experiencing negligent treatment or maltreatment that could result in one or more of the following outcomes: death; life endangering illness; injury requiring medical attention; substantial risk of injury to the physical, emotional, and/or cognitive development of a child. [Source: CA Practices and Procedures Guide Section 2220(D)]

The mother and her family members agreed to a safety plan. The safety plan directed the mother to no longer co-sleep with E.G. and the mother was not to be left alone with E.G. The CPS worker educated the mother on the risks of co-sleeping in conjunction with the other identified concerns present with this family. The mother told the CPS worker she has a prescription for muscle relaxants and pain medications. After the safety plan was completed, family members expressed concern for the mother's inability to wake to care for the children while she was taking the medications.

The CPS worker contacted collateral sources which included law enforcement and medical personnel related to this investigation. On February 10, 2014, the CPS worker and the CPS supervisor called the Bellingham DSHS/CA office and spoke with a CPS supervisor. The Everett office requested the Bellingham office to do a preliminary assessment of the maternal grandmother's home to assess whether it was a safe environment for E.G.

On February 14, 2014, a new intake was received from a mental health professional. The caller reported the mother was brought in by law enforcement the previous night. She was intoxicated and had been in "shoving match" with her mother and others at the home. According to the caller, the mother wanted to take E.G. to bed and lay down with him, thus violating the safety plan put in place by the Everett CPS worker. This intake initially screened out. A CPS supervisor in Bellingham changed that screening decision but then after staffing the case with the Everett Area Administrator, a decision was made to screen out the intake. Since the intake was screened out, a formal investigative assessment was not completed.[32]

On February 14, 2014, a CPS supervisor from the Bellingham office conducted an unannounced visit at the maternal grandmother's home. The mother admitted to consuming too much alcohol the previous night. Although the mother denied having a drinking problem, she admitted that she cannot stop drinking once she starts. The supervisor discussed with the mother what a safe sleep environment would be for E.G. The Bellingham office determined it would be appropriate to

[32] The Investigative Assessment (IA) must be completed in FamLink within 60 calendar days of Children's Administration receiving the intake. A complete Investigative Assessment will contain the following information: A narrative description of: History of CA/N (prior to the current allegations, includes victimization of any child in the family and the injuries, dangerous acts, neglectful conditions, sexual abuse and extent of developmental/emotional harm). Description of the most recent CA/N (including severity, frequency and effects on child). Protective factors and family strengths. Structured Decision Making Risk Assessment® (SDMRA®) tool. Documentation that a determination has been made as to whether it is probable that the use of alcohol or controlled substances is a contributing factor to the alleged abuse or neglect. Disposition; e.g., a description of DCFS case status. Documentation of Findings regarding alleged abuse or neglect.[Source: CA Practices and Procedures Guide 2540]

open an FVS case with the family. The mother agreed to voluntary services through CA.

Earlier that day, the maternal grandmother told the CPS worker in Everett she failed to maintain the safety plan and had allowed the mother to be alone with E.G. The grandmother was reminded of the importance of the safety plan and the possible outcome of legal intervention by the department if the safety plan is not followed. This information was documented in a case note.

On February 21, 2014, an intake was received stating the mother arrived at a medical appointment for E.G. smelling of cigarettes and marijuana. The medical professional informed the mother about the dangers of exposing a child to second hand smoke. The caller also expressed concern because E.G. appeared agitated and irritated. This intake was assigned to a Bellingham CPS worker. That same day, a referral for Project Safe Care services was made by the FVS worker in Bellingham.[33] On February 22, 2014, an afterhours CPS worker conducted a home visit to assess the intake received the prior night. The CPS worker did not detect any smoke smell and observed E.G.'s sleeping arrangements. During the CPS investigation regarding the February 21, 2014 intake, the Bellingham CPS worker discussed the safety plan, appropriate care for a newborn, and the mother was provided a list of community resources regarding grief and parenting. The CPS investigation resulted in an unfounded finding.[34]

On February 28, 2014, the FVS worker, along with the Project Safe Care® worker, visited the mother and E.G. The grandmother confirmed E.G. is never left alone with the mother and the mother denied co-sleeping with E.G. The mother reported she stopped taking her prescribed pain medications. On March 4, 2014, Project Safe Care conducted a double session with the mother.

On March 11, 2014, the Project Safe Care® provider notified the Bellingham FVS worker that the mother and E.G. were kicked out of the maternal grandmother's home on March 6, 2014 and moved to the maternal great-grandparents' home in Arlington (Smokey Point CA office jurisdiction). The mother reportedly had a fight with the maternal grandmother, which resulted in the move. The FVS worker called the grandmother who said E.G.'s mother appeared to struggle with

[33] Project Safe Care® is a weekly home based service lasting 18-20 sessions for families with a child from age birth to 5 years. The expected outcome is to increase parents' understanding and management of child illness and injuries; increase home safety; and improve and enhance safe parenting skills. The provider reviews the safety plan each week. There is no afterhours support for the family. [Source: CA Evidence Based Practices-Description and Directory]

[34] Unfounded means: The determination following an investigation by CPS that, 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 as defined in WAC 388-15-009. RCW 26.44.020 [Source: CA Practices and Procedures Guide Section 2540(5)(b)]

maintaining a calm demeanor and would often yell and scream. The grandmother was concerned by the mother's choice to not engage in mental health counseling.

On March 12, 2014, the Bellingham CA office notified the Smokey Point CA office of the change in circumstances and residence for E.G. and his mother. The Smokey Point office immediately sent out a CPS worker to the maternal great-grandparents' home. During that home visit, the great grandmother answered a phone call from the mother who was at a medical appointment for E.G. The phone was on speaker and the mother was overheard telling her grandmother to not inform the CPS worker she had been co-sleeping with E.G. The great grandmother told her the CPS worker already had learned that information before the phone call. The family was notified that a Family Team Decision-Making Meeting (FTDM) was scheduled for the following day at the Smokey Point office.[35] The mother was requested to provide a urinalysis (UA) the following morning before the FTDM.

There was an internal discussion between the two CPS supervisors and the FVS supervisor in the Smokey Point Office the day before the FTDM was held. A dependency petition was drafted the day before the meeting based on the discussion and majority opinion that there was a need to request removal of E.G. from his mother's care based on the mother's failure to maintain the safety plans and unaddressed or unassessed mental health and substance abuse issues. The CPS supervisor who was drafting the petition also attended the FTDM. The Area Administrator was not part of this meeting.

On March 13, 2014, the mother, her family and supports were present for the FTDM. The Smokey Point CPS worker and her supervisor were also present. CA and the family agreed to a safety plan which included the great-grandmother sleeping in the same bed with the mother to prevent her from further bed sharing with E.G. The mother had failed to provide a UA that morning and was once again asked to submit a sample. The Area Administrator, who participated in the second half of the FTDM, directed the FVS supervisor to devise a safety plan with the mother and her family after the FTDM had concluded. The mother agreed to a chemical dependency assessment, attendance at sober support groups, ongoing random UAs, continued participation in Project Safe Care® services, and to live in her current location (with the maternal great grandparents).

[35]Family Team Decision-Making Meetings (FTDM) 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 Section 1720]

On March 18 and 20, 2014, the assigned Smokey Point FVS social worker made two unannounced home visits. On the first visit, the mother appeared impaired. The mother stated if E.G. is going to die she wants him to die in her arms. The mother also told the FVS worker she had to make appointments with her as opposed to showing up unannounced. The FVS worker informed the mother that while she is assessing the safety of E.G. and getting to know the family better her practice is to make unannounced home visits. The FVS worker was thorough in her documentation regarding her discussions of grief, safe care for an infant and safe sleep. On the second unannounced visit, the FVS worker found the mother not impaired but remained concerned about the mother's ability to maintain the safety plan parameters. However, based on both of the unannounced visits, the FVS worker remained concerned for the safety of E.G. The FVS worker spoke with her supervisor about possibly filing a dependency petition if the situation continued.

On March 21, 2014, an intake was received stating E.G. was found unresponsive and brought to the hospital. The mother later admitted to bed sharing with E.G. at the time of his death. That same day the UA results from March 13 was received by the CA office. The UA was positive for a number of differing substances and it is unknown if they were prescribed.

Committee Discussion

The Committee interviewed nine staff members in person and four staff members by phone. The Committee's discussion focused on safety planning, identification of risk factors in conjunction with co-sleeping and/or bed sharing, service delivery to ameliorate risk factors, and staff communication.

There was an overarching theme throughout the review of timely and thorough communication between the three offices and appropriate response times in relation to learning of the residential changes by the family.

The Committee acknowledged this case was open for only thirty-four business days. During that time, E.G. and his mother moved three times, thus involving contact and services with three CA offices. Collateral contacts shared both supportive and concerning details regarding the mother's ability to safely care for E.G. During the death investigation in February, law enforcement and the hospital provided supportive comments regarding the mother and her ability to care for E.G. as did the Bellingham Project Safe Care worker. However, other medical providers who called in intakes, expressed concerns regarding the mother's ability to safely care for E.G.

It was clear based on a majority of the staff interviews that it was difficult for the involved CA workers to distinguish between the mother's grief over the loss of E.G.'s twin and other possible contributing factors for her behaviors.

The Committee discussed case junctures where there were missed opportunities to assess the mother's mental health and chemical dependency. However, the Committee acknowledged there were also times that the mother was provided community resources to address her grief and loss. The Everett CPS worker obtained grief support information in the Bellingham area and provided this to the mother and grandmother. When the Everett CPS worker obtained concerning information from the mother's medical provider, she immediately shared the information with the FVS worker in Bellingham. The Committee noted the mother was in the Bellingham catchment area for eighteen working days. During that time, a CPS supervisor, CPS worker, Afterhours CPS worker, FVS worker, and Project Safe Care staff made contact with the mother. The FVS worker was attempting to build a trusting relationship with the mother and had planned on requesting the mother to complete a chemical dependency assessment but was unable to do so before the mother moved to Arlington (Smokey Point office).

CA staff has the ability to consult with Assistant Attorneys General (AAGs) regarding legal sufficiency to file a dependency petition to either work with an in-home or out of home plan for a child or children. In this particular case, consultation was not sought. The Committee noted this would have been appropriate at the time of the FTDM on March 13, 2014.

The Committee identified areas of quality practice during this review. The areas of quality practice are:

- The Committee agreed that the first intake on February 2, 2014 was comprehensive.
- The Committee agreed that the Everett CPS worker communicated effectively with the family, law enforcement, medical professionals, and the Bellingham CA office. The CPS worker's communication was consistent and her documentation was thorough.
- The Smokey Point FVS worker was knowledgeable about safe sleep and spoke with a clear understanding of child safety.

Findings

- The Committee found the February 14, 2014 intake should have screened in for a CPS investigation.
- The department did not obtain a copy of the police report and mental health records from the February 13, 2014 incident. These documents

could have informed the investigation and assessment of the mother's ability to safely care for E.G.

- Chemical dependency services, including urinalyses and a mental health assessment for the mother, could have informed the investigation following the February 13, 2014 incident and could have strengthened the investigation and assessment.
- The Committee found that the Smokey Point office should have consulted with an Assistant Attorney General (AAG) on March 13, 2014, to see if there was legal sufficiency to file an out of home dependency petition. The factors the Committee considered to be imminent safety risks were: the mother did not follow the safety plan by co-sleeping/bed sharing with E.G.; the mother's alleged substance abuse issues and the mother's inability to control her behaviors to such a degree that she was asked to leave the maternal grandmother's residence.
- Another resource available to CA staff is Practice Consultants. The Committee agreed a Practice Consultant could have been utilized to provide a chronology of this case as part of a discussion related to the safety of E.G. in his mother's care. This case included the fatality of a twin sibling, three moves to three different CA offices, five intakes, and inconsistent communication from safety plan participants all within 34 business days. Those factors made assessing this case very challenging for CA staff.
- The Committee found many of the CA staff struggled with allowing the mother to grieve the loss of E.G.'s twin yet assessing for risk to E.G.'s safety at the same time. The Committee found many staff believed the mother's mannerisms or behaviors were related to grief rather than possible pre-existing or mental health or substance abuse issues. It also appeared that many staff members were incident-focused on the issue of mother co-sleeping/bed sharing instead of identifying other safety risks.

Findings Related to Safety Planning

- The Committee questioned the use of a safety plan that requires a parent to be supervised by a third party at all hours of the day and night. The Committee found that this type of plan is not manageable and if it is necessary to consider such a plan, then a consultation with the AAG's office as to whether there is legal sufficiency to file a dependency petition should occur.
- The Committee also found there was no monitoring of the first safety plan out of the Everett CA office. The identification of a monitoring person or persons in a safety plan, day and night, is essential to the effectiveness of a safety plan.

- The Committee also suggested that the Bellingham CA office should have conducted an FTDM and engaged the family in creating their own safety plan.
- The Committee questioned the decision by the Smokey Point office to have the FVS supervisor engage the family in creating a safety plan given that the supervisor was not present during the FTDM. The Committee believes the FVS supervisor should have either been in the meeting from the beginning or that the CPS supervisor and AA who had been a part of the FTDM should have constructed the safety plan.

Recommendations

- The Committee recommended that all staff receive updated training on a regular basis regarding assessing safety throughout the life of a case and writing effective safety plans. The Committee stated the best method to meet this recommendation would be to utilize infield mentoring by the Alliance for Child Welfare Excellence. The Committee also acknowledged that small group work such as in unit meetings versus large classroom education would be a second, less preferred option.
- The Committee recommended that CA remind staff about practice consultation resources available through CA Quality Improvement or Policy Divisions. The names and contact information for the Practice Consultants and Policy Program Managers should be provided to all staff on a regular basis.