

**Report to the Legislature**

**Quarterly Child Fatality Report**

RCW 74.13.640

October – December 2013

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## Executive Summary

This is the Quarterly Child Fatality Report for October through December 2013 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 seven (7) child fatalities and one (1) near-fatality that occurred in the fourth quarter of 2013. All of the reviews 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 a near-fatality from all three regions.<sup>1</sup>

Region	Number of Reports
1	3
2	1
3	4
Total Fatalities and Near-Fatalities Reviewed During 4th Quarter, 2013	8

This report includes one Near-Fatality review conducted following a 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 incident review consists of a review of the case

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<sup>1</sup> DSHS implemented a reconfiguration of the regional boundaries in May 2011. The existing six regions were consolidated into three.

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 chart below provides the number of fatalities and near-fatalities reported to CA and the number of reviews completed and those that are pending for calendar year 2013. 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 2013			
Year	Total Fatalities Reported to Date Requiring a Review	Completed Fatality Reviews	Pending Fatality Reviews
2013	15	9	6

Child Near-Fatality Reviews for Calendar Year 2013			
Year	Total Near Fatalities Reported to Date Requiring a Review	Completed Near-Fatality Reviews	Pending Near-Fatality Reviews
2013	16	7	4

The fatality reviews contained in these Quarterly Child Fatality Reports are posted on the DSHS website. Near-fatality reports are not subject to public disclosure and are not included in this report.

<http://www.dshs.wa.gov/ca/pubs/fatalityreports.asp>

## **Notable Findings**

Based on the data collected and analyzed from the seven (7) fatalities and one (1) near-fatality reviewed between October and December 2013, the following were notable findings:

- In three (3) of the seven (7) fatalities cases during this review period, the cause of death was drowning.
- In one drowning death, the child was dependent and was placed in a licensed foster home. He drowned while swimming in a river. The Child Protective Services investigation determined the foster parents were negligent in their supervision of this 10-year-old boy.
- Three children died from blunt force trauma. In two (2) cases the injuries were caused by the mother's boyfriend.
- Five (5) fatalities occurred while the family had an open case with CA. In all five cases, the children died from abuse or neglect.
- Two (2) children were Native American, five (5) were Caucasian and one (1) was Hispanic.
- Seven (7) of the eight (8) critical incidents resulted in a founded finding for abuse or neglect by Child Protective Services.
- All of the critical incident cases had prior reports to CA intake prior to the child's death or near-fatal injury. Two (2) cases had more than fifteen (15) prior reports to CA intake, one had eight (8) prior reports and all others had less than four (4) prior intake reports.
- Due to the small sample of cases reviewed, no statistical analysis was conducted to determine relationships between variables.



## **Child Fatality Review**

**A.F.**

**December 2012**

Date of Child's Birth

**April 11, 2013**

Date of Child's Death

**July 24, 2013**

Child Fatality Review Date

### **Committee Members**

Amanda Dryer, Therapist, Empowering, Inc. Services  
Forest Jacobson, Family Voluntary Services Supervisor, Pierce South, DSHS,  
Children's Administration  
Mary Meinig, Director, Office of Family and Children's Ombuds  
Alisson Staley, Family Support Specialist, Vanessa Behan Crisis Nursery

### **Observers**

Bryan Davis, Special Projects Coordinator, Office of Family and Children's Ombuds  
Shannon Sullivan, Child Protective Services Supervisor, Richland, DSHS, Children's  
Administration

### **Facilitator**

Robert Larson, Critical Incident Case Review Specialist, DSHS, Children's  
Administration

### ***Executive Summary***

On July 24, 2013, the Department of Social and Health Services (DSHS), Children's Administration (CA) convened a Child Fatality Review (CFR)<sup>2</sup> to review the department's practice and service delivery to three-month-old A.F. and his family. A.F. was found deceased on the morning of April 11, 2013 after co-sleeping with his mother on a beanbag chair at the family home.

The CFR Committee included community members selected from diverse disciplines with relevant expertise, including representatives from a child advocacy center, mental health, parent education, Office of Family and Children's Ombuds, and Children's Administration (CA). All Committee members, including CA staff, had no prior involvement with the family.

Prior to the review, each committee member received a case chronology, a summary of CA involvement with the family and non-redacted CA case documents (e.g., intakes, safety assessments, investigative assessments, provider records, and Child Protective Services investigative reports).

Supplemental sources of information and resource materials were available to the Committee at the time of the review. These included copies of state laws and CA policies relevant to the review and the complete case file.

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

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

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<sup>2</sup> Given its limited purpose, a Child Fatality Review should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. The Child Fatality Review Committee's review is generally limited to documents in the possession of or obtained by DSHS or its contracted service providers. The Committee has no subpoena power or authority to compel attendance and generally will only hear from DSHS employees and service providers. It does not hear the points of view of a child's parents and relatives, or those of other individuals associated with a deceased child's life or fatality. A Child Fatality Review is not intended to be a fact-finding or forensic inquiry or to replace or supersede investigations by courts, law enforcement agencies, medical examiners or other entities with legal responsibility to investigate or review some or all of the circumstances of a child's death. Nor is it the function or purpose of a Child Fatality Review to recommend personnel action against DSHS employees or other individuals.



**Case Overview**

**RCW 74.13.515**

A.F. was born in December 2012.

[REDACTED]

[REDACTED]

[REDACTED]


[REDACTED]

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<sup>3</sup> FPS - Family Preservation Services are intensive in-home services for families designed to prevent out-of-home placement of children or to facilitate family reunification.

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

<sup>5</sup> FVS social worker - Family Voluntary Services social workers offer parents services designed to reduce the safety threats while the children remain in the care and custody of their parents.




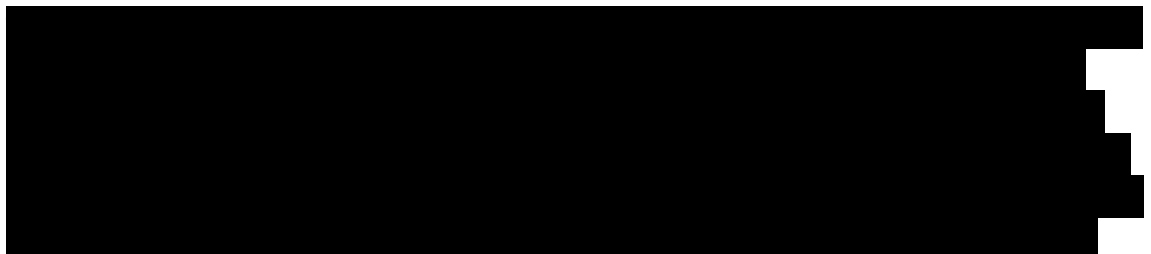
The social worker ceased active work on the case in December 2012 upon the closure of FPS services. FPS services were originally initiated in August 2012. However, the social worker did not initiate the official process of closing the case until March 21, 2013. The social worker informed the Committee that she considered the case inactive and essentially closed as the primary concern regarding the home condition was addressed when the family moved to the grandmother's residence.

A.F. was born approximately one week following the closure of FPS services in December 2012. CA investigators obtained the following information following the fatality. On March 30, 2013, A.F. was diagnosed with an upper respiratory infection. The mother failed to show for the follow-up medical appointment on April 8, 2013. The child's doctor noted that A.F. did not have any history of well child exams outside of the March 30, 2013 appointment. The doctor scheduled a second follow-up appointment for April 11, 2013. On the night of April 10, 2013, the mother fell asleep on a beanbag type chair. The mother woke up the following morning to discover A.F. was cold to the touch. The mother called 911 for assistance but emergency responders were unable to revive A.F. A.F.'s doctor called CA the morning of the fatality to report the mother's failure to follow through with A.F.'s medical appointments. The doctor was unaware of A.F.'s death at the time she contacted CA.

**RCW 74.13.515**

***Committee Discussion***

The Committee primarily focused on case activity after July 26, 2013. However, the Committee did spend some time reviewing case activity prior to July 26, 2013 in an effort to identify areas for improved practice. The Committee's primary discussions focused on collateral contacts, safe sleep, case closure, drug testing, caregiver assessment, mental health services, and a CPS investigation into an allegation of .



[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

The Committee also expressed concern that the supervisor would rely on drug tests by the housing assistance program as a mitigating factor. The Committee noted most local housing assistance programs provide little to no drug testing and the nature/reliability of those drug tests vary dramatically. Additionally, federal and state confidentiality rules generally prohibit providers from sharing the results of UAs with social workers.

The Committee spent considerable time discussing the value of collateral contacts to the investigative process. The Committee believed social workers failed to make collateral contacts due to their focus on the conditions of the home. Social workers described the home as disorganized, chaotic, infested with bugs and unsanitary (black mold). Whereas, the Committee understood the assigned social worker's concern and focus on the home condition, the Committee also believed additional collateral contacts were needed for a more global assessment of the situation. Possible collateral contacts recommended by the Committee included:

- 1) Contacting the mother's probation officer to determine the reason she is currently on probation.

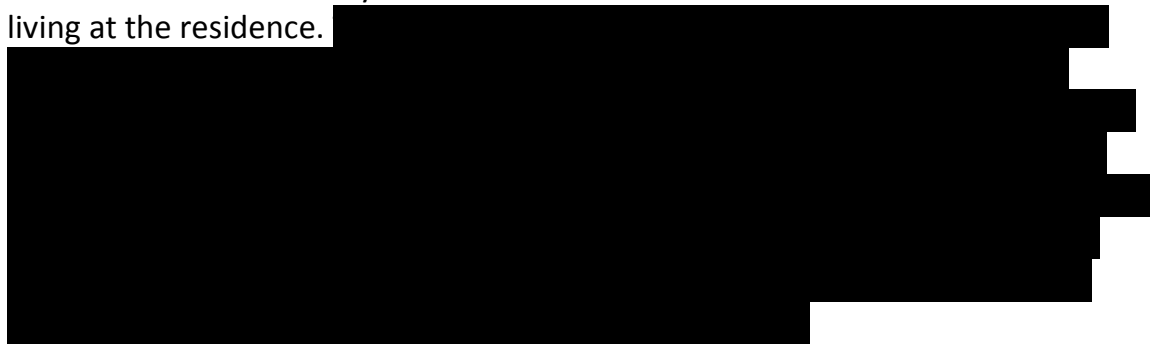
- 2) Contacting the children's doctor. The committee noted further investigation was needed as one of the children was described as being small with a clearly visible rib cage.
- 3) Contacting the mother's obstetrician to determine her participation, if any, in prenatal care.
- 4) Contacting the children's school to determine the children's school attendance along with any other notable strengths or concerns.
- 5) Contacting the mother's mental health provider.

**RCW 74.13.515**

The Committee believed the case should have remained open and active for services following the birth of A.F. and the transition of the family into the maternal grandmother's home. The FPS provider closed her services at the recommendation of the social worker approximately one week prior to A.F.'s birth. All case activity ceased with the closure of FPS. The Committee maintains that it is best practice for the social worker to monitor the transition of the mother to her new residence to ensure a successful transition and the monitoring the family following the birth of a new baby.

The Committee noted that the social worker regularly carried a large caseload of Family Reconciliation Services (FRS) cases. The Committee further noted the requirements associated with an FRS case are very different from those of an FVS case. Thus, the Committee was not surprised that the social worker treated this case very similarly to her FRS cases. However, CA policy dictates children in their own homes who are receiving FVS services should receive monthly health and safety visits.<sup>6</sup> The last documented health and safety visit was dated November 28, 2012. The Committee believes health and safety visits should have continued through March 2013.

The Committee believed the investigative process may have benefitted from additional criminal history checks in relation to the mother and other individuals living at the residence.



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<sup>6</sup> CA [Practices and Procedures Guide 4420](#).

The Committee spent a significant amount of time discussing CA's response to the concerns surrounding the mother's mental health. [REDACTED]

[REDACTED] However, there was limited documentation identifying how the mother's mental health influenced her ability to parent and the impacts of the mother's mental health issues on her children.

Under CA's practice model, social workers work with family members to address concerns or behaviors that are compromising the safety of the children in the home.<sup>7</sup> The Committee recommends that individuals with unsafe parenting behaviors are encouraged to work with providers to develop individual, specific plans of action that detail how they will manage their own behavior and increase their parenting capacities. These plans should be co-constructed with the provider, usually following an assessment of their need for increased skill development. The plan details specific changes in the behavior that the parent/individual will be demonstrating and how that behavior change will be measured. The plan should have incorporated the social worker's concerns about the mother's mental health. The Committee recommends the unit assigned at the time of the fatality receive additional training related to the creation and monitoring of such plans.

### ***Findings***

- 1) The Committee believed CA's drug testing of the mother was insufficient.
- 2) The Committee believed additional collateral contacts should have been completed to ensure a more global assessment of the family situation.
- 3) The Committee understood the social worker's focus on the condition of the home given the allegation in the intake. However, the Committee believed the case should have remained open to assess the situation following the birth of A.F. and the transition of the family to the maternal grandmother's residence.
- 4) The social workers assigned to this case did not adequately assess all caregivers including the mother.
- 5) The Committee believed monthly health and safety visits should have continued through March 2013 as specified by CA policy.

### ***Recommendations***

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<sup>7</sup> CA's current practice model is Solution Based Casework (SBC).

- 1) The Committee noted pictures of the home environment would have provided an accurate and unbiased reflection of the home environment. The written description of the home environment varied significantly and it was difficult to assess the home without photographic evidence. The Committee recommends all CA social workers receive a reminder about the benefits of photographing the home environment.
- 2) The Committee recommends social workers talk to parents about Safe Sleep<sup>8</sup> as a routine part of the investigation when working with expectant mothers.
- 3) The Committee recommends the unit assigned at the time of the fatality receive additional training related to the creation and monitoring of Solution Based Casework (SBC) case plans.

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<sup>8</sup> Safe Sleep is a nationwide campaign to promote safe sleeping habits for children. Safe sleep practice can reduce the risk of SIDS. According to the National Institute of Child Health and Human Development the top 10 safe sleep guidelines are: 1) Always place your baby on his or her back to sleep, for naps and at night. 2) Place your baby on a firm sleep surface, such as on a safety-approved crib mattress, covered by a fitted sheet. 3) Keep soft objects, toys, and loose bedding out of your baby's sleep area. 4) Do not allow smoking around your baby. 5) Keep your baby's sleep area close to, but separate from, where you and others sleep. 6) Think about using a clean, dry pacifier when placing the infant down to sleep, 7) Do not let your baby overheat during sleep. 8) Avoid products that claim to reduce the risk of SIDS because most have not been tested for effectiveness or safety. 9) Do not use home monitors to reduce the risk of SIDS. 10) Reduce the chance that flat spots will develop on your baby's head: provide "Tummy Time" when your baby is awake and someone is watching; change the direction that your baby lies in the crib from one week to the next; and avoid too much time in car seats, carriers, and bouncers.



## **Child Fatality Review**

**T.D.**

**November 2009**

Date of Child's Birth

**April 26, 2013**

Date of Fatality Incident

**October 3, 2013**

Child Fatality Review Date

### **Committee Members**

Arthur Laur, Detective Sergeant, Aberdeen Police Department

Sue Bucy, Deputy Director, Child Advocacy Center of Grays Harbor County

Gloria Callaghan, Director, Domestic Violence Center Grays Harbor County

Bobette Webber, CDP, Social Treatment Opportunity Program

Mary Meinig, MSW, Director Office of Family and Children's Ombuds

Rachel Colthorp, Social Services Specialist, Port Angeles Division of

Children and Family Services

### **Observer**

Julie Sanchez, Social Service Supervisor, Aberdeen Division of Children and Family Services

### **Facilitator**

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

### ***Executive Summary***

On October 3, 2013, the Department of Social and Health Services (DSHS) Children’s Administration (CA) convened a Child Fatality Review<sup>9</sup> (CFR) to examine the department’s practice and service delivery to three-year-old T.D. and his family. The incident initiating this review occurred on April 26, 2013 when paramedics and law enforcement responded to a medical emergency call regarding an unresponsive child at the family residence. At the time of the incident T.D. was in the care of his father.<sup>10</sup> The child was determined to be deceased on scene. Autopsy results later determined that T.D. suffered blunt force trauma causing a subdural hematoma (but no skull fracture), and the manner of death was ruled “Undetermined.” Child Protective Services had initiated an investigation of alleged neglect two weeks prior to the fatality.

The CFR Committee included CA staff and community members selected from disciplines with relevant expertise representing law enforcement, chemical dependency, domestic violence, parenting education, child advocacy, and public child welfare. None of the Committee members, including CA staff, had any prior direct involvement with the family.

Prior to the review, each committee member received a detailed case chronology of CA involvement. Committee members also received non-redacted CA case documents (e.g., intakes, case notes, safety assessments, investigative assessments) for two prior CPS investigations (2012-2013). Supplemental sources of information and resource materials were available to the Committee at the time of the review. These included copies of state laws, CA policies relevant to the review, law enforcement reports and autopsy findings, and miscellaneous case documents such as medical records.

During the course of the review, the Committee interviewed Aberdeen DCFS staff including the Area Administrator, a Child Protective Services supervisor and three social services specialists involved in the case. A state Child Protection Medical

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<sup>9</sup> Given its limited purpose, a Child Fatality Review (CFR) should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of 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.

<sup>10</sup> The name of the father is not included in the report as the manner of death is “Undetermined” and there are no current charges regarding the fatality. The mother’s name is not included in this report, as she was not involved in the investigation. Neither the name of the deceased child nor his sibling is included in this report.



Consultant<sup>11</sup> was available by phone had the Committee determined the need for any additional medical clarification. Following review of the case file documents, completion of the staff interviews, and discussion regarding department activities and decisions, the Committee made findings and recommendations presented at the end of this report.

**RCW 74.13.515**

### ***Case Overview***

At the time of T.D.'s birth in November 2009, CA had been providing Family Voluntary Services (FVS) for several months.<sup>12</sup>

The parents engaged in services completing Homebuilders<sup>13</sup> and partially completing a parenting program. The case closed in early February 2010.

CPS again became involved with the family following two intakes (September-October 2010) alleging neglect; primarily parental failure to meet the children's basic needs including hygiene, supervision, and nurturance. Referrers also expressed concerns (non-allegations) regarding possible drug use by the parents, persistent chaotic living environments and lack of stable housing, and parental ambivalence.<sup>14</sup> The parents separated each taking one of the children. At the mother's request, relatives assumed care of T.D. temporarily. The case closed in January 2011 with the children's father assuming sole caretaking of T.D. and his sibling. The mother's parental involvement appeared significantly diminished from that point forward. The CPS investigation resulted in the allegations being unfounded due to lack of evidence.<sup>15</sup>

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<sup>11</sup> The tasks of the statewide Child Protection Medical Consultants (CPMC) network include providing telephonic consultations, case staffing/case review, training, court testimony, and written consults to CA staff, law enforcement officials, prosecuting attorneys, and physicians regarding child maltreatment cases.

<sup>12</sup> Family Voluntary Services support families' early engagement in services, including working with the family to create Voluntary Service Agreements or Voluntary Placement Agreements and providing ongoing case management services and assessment of safety and risk to children. Voluntary Case Plans are used to engage families willing to participate in services intended to reduce current and future abuse or neglect issues that do not require court intervention. Voluntary services are short term to help increase parents' protective capacity and manage child safety. Continued assessment of child safety occurs throughout the case. [Source: Children's Administration Practice and Procedure Guide]

<sup>13</sup> HOMEBUILDERS® provides intensive, in-home crisis intervention, counseling, and life skills education for families as a means to prevent future crises including out-of-home placement.

<sup>14</sup> Parental ambivalence relates to the nurturing and affectionate aspects of a parent-child relationship. It is often identifiable by behavioral or verbal indicators that suggest contradictory attitudes toward the relationship, incompatible expectations, mixed emotions, and self-doubt regarding being able to handle a parent/caretaker role.

<sup>15</sup> CA findings are based on a preponderance of the evidence. Child Abuse and Neglect are defined in [RCW 26.44](#), [WAC 388-15-009](#), and [WAC 388-15-011](#). Findings are determined when the investigation is complete. Founded means the determination that, following an investigation by CPS, based on available information: it is more likely than not that child abuse or neglect did occur. Unfounded means the determination that, following an investigation by CPS, based on available information: it is more likely

One year later, T.D.'s father contacted CA to request services. The father reported having difficulty with parenting and struggling with substance abuse relapse impulses and anger behaviors. The father agreed to a Voluntary Service Agreement that included participation in a parenting skill class, chemical dependency assessment, child developmental screening, and counseling. The FVS worker experienced resistance from both the father and his partner during monthly home visits. Multiple efforts to engage the father in individual and family services were unsuccessful and the father and his partner continued to deny access to the home and to any significant contact with the children. In June 2012, the father indicated he no longer wanted any CA services. The voluntary services case closed with no substantive progress, the family declining further services, and insufficient basis for legal intervention by the department.

On April 12, 2013, an Advance Registered Nurse Practitioner (ARNP) examined T.D. for flu-like symptoms and rectal bleeding possibly caused by hard stool. The examination showed two small bruises in the genital and rectal areas. The child stated his sibling had caused the injuries but did not provide a clear explanation. The ARNP contacted CA which accepted the intake for investigation of allegations of neglect as there was no clear indication at the time of any physical or sexual abuse caused by the child's parent. CA immediately forwarded the report to local law enforcement who then requested CPS not to discuss the subject of possible sexual abuse with the family until a detective could contact the family.

Law enforcement did conduct a welfare check several days later and found no apparent indications that T.D. was unsafe. A followup exam by the primary care physician (PCP) showed the bruise in the genital area had disappeared and the rectal area bruise had faded. The primary care physician encouraged the family to accept the referral made by the earlier medical provider for further examination at the local Child Advocacy Center<sup>16</sup> although documentation indicates that the PCP felt such an exam likely was unnecessary. Safety interviews conducted by CPS with both children did not reveal any present or imminent danger. T.D. unexpectedly died before a forensic interview could occur. A forensic interview of the sibling did occur. Based on the information available to CPS the allegations from April 12, 2013 were unfounded.

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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.

<sup>16</sup> The Child Advocacy Center of Grays Harbor is a member of the Washington State Chapter of the National Children's Alliance (NCA), which is the accrediting organization. The NCA has established standards for CACs that include (1) child-focused, child-friendly facilities for children and their non-offending family members, (2) multidisciplinary team case staffing participation by law enforcement, prosecution, medical experts, social work, and advocacy, (3) medical evaluation onsite or through referral, (4) therapy onsite or through referral, (5) onsite forensic interviews, (6) and case tracking. [Sources: [Children's Advocacy Centers of Washington](#)]

On April 27, 2013, CA received notification from Grays Harbor Sheriff's Office of T.D.'s death. On-scene responders (medical and law enforcement) saw no obvious indicators of trauma but the circumstances of death were described by the referrer as being "somewhat suspicious." Autopsy results later determined that T.D. suffered blunt force trauma causing a subdural hematoma (but no skull fracture) and the manner of death was ruled "Undetermined." There was no evidence of any other trauma or injuries. Toxicological results showed Carboxy-THC in T.D.'s system, likely representing passive inhalation of marijuana, but having no direct connection to cause of death. The CPS investigation found evidence of neglect by the father but no evidence of abuse or neglect directly related to T.D.'s death. The criminal investigation remains active without arrest or criminal charges at this time.

### ***Discussion***

Committee discussions focused on CA policy, practice, and system responses in an effort to evaluate the reasonableness of decisions made and actions taken by the department. Committee members reviewed and briefly discussed early CA involvement in Lewis County when T.D. was in the care of both parents (2009-2010), but mainly focused on recent CA involvement when T.D. was under the primary care of his father in Grays Harbor County (2012-2013). Discussions occurring as to the family involvement with non-CA agencies were considered outside the purpose and scope of the Child Fatality Review but served to generate discussion on inter-agency collaboration.

The Committee looked at both risk factors<sup>17</sup> and family strengths assessed by CA throughout the span of contact with the family. Persistent "red flag" risk factors included episodes of severe anger and intimate partner violence by the father, substance abuse and resistance to chemical dependency services, frequent unstable housing, struggles with effective parenting, and parental ambivalence<sup>18</sup> particularly by the father toward T.D. Strengths frequently documented included the family's occasional willingness to seek help and take advantage of services offered, utilizing relative resources for support, and intervals between reports of alleged child abuse or neglect.

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<sup>17</sup> Allegations of child abuse or neglect assert specific events, incidents, patterns and conditions defined by law and policy as child abuse and neglect. Allegations always describe past events, incidents, conditions, etc. Risk factors include all other information that lacks assertions of abuse or neglect but which are relevant to assessing the likelihood of future child abuse and neglect.

<sup>18</sup> Parental ambivalence relates to the nurturing and affectionate aspects of a parent-child relationship. It is often identifiable by behavioral or verbal indicators that suggest contradictory attitudes toward the relationship, incompatible expectations and mixed emotions, and self-doubt regarding being able to handle a parent/caretaker role.

The Committee reviewed the quality and level of interventions by CA in consideration of the limits of legal authority accorded the department to intervene (e.g., [RCW 26.44](#) and [RCW 13.34](#)). The Committee noted possible opportunities for more assertive intercession by CPS in 2009-2010. During the FVS involvement (2012), the worker documented multiple efforts to engage the father who, despite having requested such services, was not responsive. The Committee was unable to determine with any certainty how more aggressive intervention during earlier involvement with the family would have affected the circumstances of the child fatality in 2013.

The Committee discussed at length the April 12, 2013 intake accepted for investigation two weeks before the fatality. The Committee was unable to reach full consensus as to whether the intake should have been designated for 24-hour (emergent) response rather than the 72-hour (non-emergent) response or even if a more immediate response would have had any perceptible impact on the fatality two weeks later.

### ***Findings***

Given that the manner of the child's death remains undetermined, the Committee found it difficult to come to any conclusions with regard to actions taken and decisions made by the department. The Committee found no obvious critical oversights and the social work appeared to generally meet CA policies, procedures, and practice expectations. The documentation by the CPS worker investigating the pre-fatality allegations made on April 12, 2013 appeared to be exceptional.

While having no direct impact as to the fatality incident, the Committee notes two systems issues that appear to be persistent barriers to inter-agency communication and collaboration in Grays Harbor County. (1) Aberdeen CA staff reported having great difficulty getting direct access to medical providers for a particular local medical facility, often given medical information from facility staff rather than from physicians as requested by workers. (2) The process of forwarding CA intakes to one specific law enforcement agency in the county appears to be unreliable, resulting in occasional "lost" faxes and delays in the assignment to detectives from that agency.

### ***Recommendations***

- The Committee recommends that the Aberdeen DCFS Area Administrator initiate contact with the local medical facility identified during the review where staff experience difficulty getting direct contact with medical providers. The goal should be to engage in dialog to explore ways to

- improve information sharing as permitted by RCW 26.44 and to explore opportunities for agency cross training.
- The Committee recommends that Aberdeen DCFS attempt to work toward improving the referral process with the specific law enforcement agency identified during the review. The goal would be to develop a more reliable system for forwarding and tracking the intakes sent to the law enforcement agency thereby improving timely assignments to detectives.



## **Child Fatality Review**

**T.D.**

**April 2010**

Date of Child's Birth

**May 7, 2013**

Date of Fatality

**September 10, 2013**

Date of Fatality Review

### **Committee Members:**

Deanna Bedell, Intake and Substance Abuse Program Manager, DSHS, Children's Administration

Mary Meinig, MSW, Director, Office of the Family and Children's Ombuds

Jennifer Rees, Promoting First Relationships' Program and Training Manager, Barnard Center for Infant Mental Health and Development University of Washington

MerrieLynn Rice RN, BSN, IBCLC, Nurse-Family Partnership Supervisor, Tacoma Pierce County Health Department

### **Observers:**

Jennifer Gaddis, Child and Family Welfare Services, Family Voluntary Services, and Drug Court Supervisor, Pierce West Office, Children's Administration

Yen Lawlor, Statewide Practice Consultant, DSHS, Children's Administration

### **Facilitator:**

Ronda Haun, Critical Incident Case Review Specialist, DSHS, Children's Administration

**RCW 74.13.640**

### ***Executive Summary***

On September 10, 2013, Children’s Administration (CA) convened a Child Fatality Review<sup>19</sup> (CFR) Committee to examine the practice and service delivery in the case involving a three-year-old Caucasian male child and his family. The child will be referenced by his initials, T.D. in this report. At the time of his death, T.D. shared a home with his mother, his younger sibling (19 months old) and Derrick Myers,<sup>20</sup> with whom T.D.’s mother maintained a personal relationship. The identity of T.D.’s father is unknown.

The incident initiating this review occurred on May 7, 2013 when T.D. died shortly after being brought to a hospital by his mother. Following his death, T.D. was diagnosed by a team of medical professionals to have multiple non-accidental blunt force injuries.

When a child dies from alleged child abuse or neglect and the child’s family received services from Children’s Administration within a year of the child’s death, Washington state law requires CA to conduct a CFR. While T.D. and his family did not receive direct services from CA, they were referred by CA in December of 2012 for voluntary Early Family Support Services (EFSS) from a contracted community agency.

The review was conducted by a team of CA staff and community members with relevant expertise from diverse disciplines. Neither CA staff nor any other committee members had previous direct involvement with the case.

Prior to the review, each committee member received a chronology of known case information and un-redacted CA case-related documents. Additional documents were made available to the Committee at the time of the review. These included copies of medical and law enforcement reports, media coverage of the incident, the Early Family Support Services contract, and copies of relevant CA policies and practice guides.

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<sup>19</sup> Given its limited purpose, a Child Fatality Review (CFR) should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of 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 deceased child’s life or death. A Child Fatality Review is not intended to be a fact-finding or forensic inquiry or to replace or supersede investigations by courts, law enforcement agencies, medical examiners or other entities with legal responsibility to investigate or review some or all of the circumstances of a child’s death or 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.

<sup>20</sup> T.D.’s mother is not named in this report because she has 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. Derrick Myers, her boyfriend, is named because he was charged with two counts of murder. [Source: [RCW 74.13.500\(1\)\(a\)](#)]

During the course of the review, the CFR Committee members interviewed the CA staff and contracted service providers involved with the case prior to T. D.'s death.

Following review of the case file documents, interviews, and discussion regarding social work activities and decisions, the review Committee made findings and recommendations, which are detailed at the end of this report.

### ***Case Overview***

CA's involvement with T.D. and his family began on December 13, 2012 when a hospital social worker, on behalf of a licensed physician, contacted CA to report T.D. and his younger sibling were not immunized and did not have a primary care physician. The physician noted these concerns after meeting the family for the first time after T.D. had been brought to a hospital emergency department by his mother for treatment of an upper respiratory infection. CA's policy mandates accepting for investigation all intakes<sup>21</sup> involving young children made by (or on the behalf) of a licensed physician. The policy also allows for the intakes to be screened-out for investigation upon review by a CA administrator or regional CPS program manager.<sup>22</sup> An intake, indicating the family consisted of T.D., his mother, and his younger sibling, was completed by an intake social worker and assigned a response time of non-emergent investigation by Child Protective Services.

On December 14, 2012, an intake supervisor, a CPS supervisor, and an intake program administrator reviewed the intake and determined the allegations did not meet Washington state's legal definition<sup>23</sup> of child maltreatment. The intake screening decision was changed from a non-emergent investigation response to a 10-day response by a contracted provider to offer the family Early Family Support Services (EFSS) services.

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<sup>21</sup> CA intake social workers receive, gather, and assess information about a child's need for protection or request for service. Intake social workers determine program response type and response times (emergent or non-emergent) for an investigation. Once an intake screens in, the intake worker determines how soon contact should be made with the family and child.

<sup>22</sup> CA Intake staff must screen in intake reports involving a child (birth to 5 years old), reported by a licensed physician or medical professional on "the physician's behalf." An Intake Supervisor must consult with local Area Administrator or regional CPS Program Manager when they are recommending the intake be screened out. All screening decision made as a result of a consultation must be documented in FamLink. [Source: [CA Practices and Procedures Guide 2210](#)]

<sup>23</sup> "Negligent treatment or maltreatment" means an act or a failure to act, or the cumulative effects of a pattern of conduct, behavior, or inaction, that evidences a serious disregard of consequences of such magnitude as to constitute a clear and present danger to a child's health, welfare, or safety, including but not limited to conduct prohibited under [RCW 9A.42.100](#). When considering whether a clear and present danger exists, evidence of a parent's substance abuse as a contributing factor to negligent treatment or maltreatment shall be given great weight. The fact that siblings share a bedroom is not, in and of itself, negligent treatment or maltreatment. Poverty, homelessness, or exposure to domestic violence as defined in [RCW 26.50.010](#) that is perpetrated against someone other than the child does not constitute negligent treatment or maltreatment in and of itself.



Families reported to CPS for allegations considered low-risk for maltreatment<sup>24</sup> are eligible for contracted EFSS. Community agencies are contracted and paid by CA to work directly with families to create a voluntary service plan focusing on the following goals:

- Reduce risk of abuse or neglect of children in the home.
- Enhance parenting skills, family and personal self-sufficiency, and family functioning.
- Reduce stress on the family.
- Reduce the likelihood of additional referrals to CPS; and
- Enhance the health status of families and linkages to health services.

CA did not provide direct case management services to T.D. or his family. An open case was maintained by CA for administrative purposes only while the family voluntarily participated in contracted EFSS services.

Between January 22, 2013 and April 8, 2013, the EFSS contracted provider documented completing nine in-person individual meetings with T.D.'s mother or family meetings with the mother and her children. The meetings focused on providing T.D.'s mother with parent training, connecting to community resources and finding furnishings for the family's apartment. Eight of the nine meetings occurred at the contractor's office or in a community setting. T.D.'s mother successfully completed a ten-part parenting skill training offered by the contracted provider. In a summary report dated May 2, 2013, the contractor documented "the children appeared healthy, happy, and clean and bonding with the mother."

On May 7, 2013, T.D. and his younger sibling were left in the care of their mother's boyfriend, Derrick Myers, while their mother was at work. After caring for the children for several hours, Mr. Myers contacted T.D.'s mother at her workplace and requested she return home immediately because T.D. was ill. When she arrived home, she found T.D. complaining of stomach pain. She initially attributed his pain to constipation but as his symptoms worsened to include vomiting and the inability to stand, she drove T.D. to a hospital. When they arrived at the hospital, T.D. was unresponsive and his mother had to carry him from her car into the emergency department where medical staff began immediately performing emergency lifesaving procedures. Despite their efforts, T.D. could not be resuscitated and was pronounced dead a short time later. An examination of his body revealed numerous injuries including a distended

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<sup>24</sup> Families are also eligible for EFSS services following a CPS investigation and the risk on the closing Structured Decision Making<sup>®</sup> (SDM<sup>®</sup>) risk assessment is low to moderate, and is appropriate for EFSS services. SDM<sup>®</sup> is an assessment tool used by CPS to help identify families who are most likely to experience child abuse or neglect.

abdomen, and bruising to his chin, knees, buttocks, lower spine, arms, hands, chest, and abdomen. The postmortem examination completed on May 8, 2013 indicated homicide as the manner of death caused by acute blunt force injuries of the head and abdomen. In addition, the medical examiner's report details acute anal lacerations, blunt force injuries to all body regions, and previous head injuries.

CPS and local police initiated investigations after receiving notification from the hospital that T.D. had died from suspected child abuse. During interviews with a police detective, T.D.'s mother reported she and Mr. Myers had argued about his verbal and physical aggression toward her children. When further investigation revealed T.D.'s sibling also had non-accidental injuries and was significantly underweight, both law enforcement and CPS took action to ensure her safety. On May 8, 2013, Derrick Myers was arrested and charged with two counts of murder related to the death of T.D. Mr. Myers remains incarcerated while awaiting trial.

The CPS investigation, completed on June 4, 2013, substantiated the allegations of child physical abuse by Mr. Myers and child neglect by T.D.'s mother.<sup>25</sup>

### ***Committee Discussion***

After reviewing the case documents and interviewing the involved staff from both CA and the contracted community agency, the Committee discussed the allegations reported on December 13, 2012. The Committee agreed the reported allegations did not meet the legal definition of child abuse and the allegations were not sufficient for an investigation by CPS. The Committee found no evidence of critical errors or oversight by the involved CA staff. The Committee supported the decision to refer the family for voluntary services available from a contracted community provider instead of screening out the intake as permitted by CA policy. The Committee recognized the initial allegations and available case information did not foreshadow the death of T.D. by an unrelated caregiver unknown to both CA and the contracted provider.

The Committee noted the contracted provider addressed the concerns initiating CA's involvement with this family by assisting the mother in obtaining immunizations for her children and to identify a primary health care provider. The engagement of T.D.'s mother in a voluntary service, providing an evidence-based parent training program, and contacting the hospital social worker who reported the allegations in December 2012 were identified by the Committee as examples of strong practice by the contracted provider. Believing services are best delivered to families in their own home, the Committee questioned why the

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<sup>25</sup> Following an investigation, a CPS social worker, based on available information, determines if it is more likely than not that child abuse or neglect did occur.

contracted provider only provided services once in the family home. The contracted provider explained he was responding to T.D.'s mother's expressed preference to meet in his office or community locations. The Committee agreed the need to maintain a relationship with the mother and keep her engaged in services was more important than the location of the service delivery.

***Findings and Recommendations***

The Committee made no findings or recommendations.



**CA** Children's Administration

**Children's Administration  
Child Fatality Review**

**J.G.**

**June 2012**

Date of Child's Birth

**May 21, 2013**

Date of Child's Death

**September 18, 2013**

Child Fatality Review Date

**Committee Members**

Kim Foley, Program Manager, Central Washington Comprehensive Mental Health

Brenda George, Sergeant, Yakima Police Department

Rick Kenney, MSW, LICSW, DCSW, Guardian Ad Litem, Yakima County

Colleen Shea-Brown, JD, Senior Ombuds, Office of the Family & Children's  
Ombuds

Meg Shugarts, MSW, Child Protective Services Supervisor, Lynnwood, DSHS,  
Children's Administration

**Observers**

Marilee Roberts, Program Consultant, DSHS, Children's Administration

**Facilitator**

Robert Larson, Critical Incident Case Review Specialist, DSHS, Children's  
Administration

### ***Executive Summary***

On September 18, 2013, the Department of Social and Health Services (DSHS), Children's Administration (CA) convened a Child Fatality Review (CFR)<sup>26</sup> to review the department's practice and service delivery to an eleven-month-old female child and her family. The child will be referenced by her initials, J.G., in this report. At the time of her death, J.G. shared a home with her father, mother, and her father's wife. Three siblings also resided in the household including one full-sibling, one half-sibling, and one stepsister. The incident initiating this review occurred on May 21, 2013 when J.G. died from drowning in a bucket of water.

The review is conducted by a team of CA staff and community members with relevant expertise from diverse disciplines. Neither CA staff nor any other committee members had previous direct involvement with the case.

Prior to the review, each committee member received a case chronology, a summary of CA involvement with the family and non-redacted CA case documents (e.g., intakes, safety assessments, investigative assessments, provider records, law enforcement records, and Child Protective Services investigative reports).

Supplemental sources of information and resource materials were available to the Committee at the time of the review. These included copies of state laws and CA policies relevant to the review and the complete case file.

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

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

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<sup>26</sup> Given its limited purpose, a Child Fatality Review should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. The Child Fatality Review Committee's review is generally limited to documents in the possession of or obtained by DSHS or its contracted service providers. The Committee has no subpoena power or authority to compel attendance and generally will only hear from DSHS employees and service providers. It does not hear the points of view of a child's parents and relatives, or those of other individuals associated with a deceased child's life or fatality. A Child Fatality Review is not intended to be a fact-finding or forensic inquiry or to replace or supersede investigations by courts, law enforcement agencies, medical examiners or other entities with legal responsibility to investigate or review some or all of the circumstances of a child's death. Nor is it the function or purpose of a Child Fatality Review to recommend personnel action against DSHS employees or other individuals.

**Case Overview**

**RCW 74.13.515**

J.G. and her mother first came to CA's attention following her birth. On June [REDACTED], 2012, CA received an intake from a local hospital alleging the mother lacked a support system [REDACTED]

[REDACTED] Upon discharge, the hospital offered and the mother accepted public health nursing services. The June 24, 2012 intake was screened out by CA due to the lack of an allegation of abuse or neglect.<sup>27</sup> The mother had no other CA history prior to the fatal incident.

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

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<sup>27</sup> CA intake staff must screen in intake reports meeting the following criteria: 1) a child (birth to 5 years old), reported by a licensed physician or medical professional on "the physician's behalf," or 2) a non-mobile infant (birth to 12 months) with bruises, regardless of the explanation for how the bruises occurred. CA must accept an intake where a child is alleged to have been abused or neglected by the child's parent, guardian, or custodian, the subject is a licensed foster parent, group care provider, or a volunteer or employee of a child care agency, or a person alleged to have committed child abuse or neglect (CA/N) in an institutional setting. CA staff must not treat allegations of CA/N in licensed or certified facilities as third party abuse or neglect. CA will generally screen out 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) Child abuse and neglect (CA/N) that is reported after the victim has reached age 18, except that alleged to have occurred in a licensed facility; 4) Child custody determinations in conflictual family proceedings or marital dissolution, where there are no allegations of CA/N; 5) Cases in which no abuse or neglect is alleged to have occurred; and 6) alleged violations of the school system's Statutory Code, Administrative Code, statements regarding discipline policies.

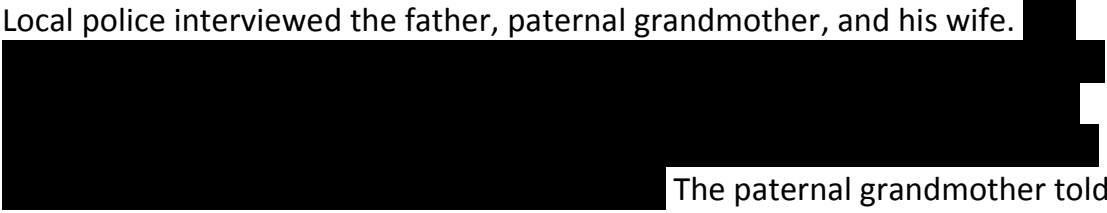
<sup>28</sup> CA will generally screen out intakes where the CA/N is committed by a person other than those responsible for the child's welfare.



**RCW 74.13.515**

On May 21, 2013, J.G. slept in the backseat of the family van while her father washed cars as a source of income. J.G.'s paternal grandmother and her father's wife were also present at the time of the fatality. J.G.'s mother was not present as she was at a doctor appointment for her infant daughter. A bucket of water with rags in it was located on the floorboard next to where J.G. slept. The father reported believing his wife was in the van with J.G.; however, his wife reported leaving J.G. unattended to go to the store. The father's mother was assisting him at the time of the fatality. The father's wife reported finding J.G. in the bucket of water and rags upon returning from the store. She called for help and the father and paternal grandmother attempted to revive J.G. by administering CPR. Emergency Medical Technicians (EMTs) arrived at the scene and J.G. was taken to Memorial Hospital where she was pronounced dead.

Local police interviewed the father, paternal grandmother, and his wife.



The paternal grandmother told law enforcement that she believed the fatal incident was her fault as she should have been with J.G. as the father's wife is unable to provide care. An autopsy was completed on May 21, 2013 and J.G.'s death was ruled as a fresh water drowning with no other signs of trauma. The family is considered to be a Limited English Proficient (LEP) family.<sup>29</sup>

***Discussion***

The primary areas of Committee discussion centered on the April 2010 and March 2013 investigations. The Committee focused specifically on the investigative methods used by the social workers, caseload size, communication between law enforcement and CA, the challenges of meeting the needs of an LEP

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<sup>29</sup> Limited English Proficiency - This means persons whose primary language is not English and they have not developed fluency in the English language. A person with LEP may have difficulty speaking or reading English. CA staff utilizes an interpreter service when working with LEP clientele. An LEP person will also receive documents from CA in his or her primary language so that person can understand important documents related to health and human services.

family and office morale. The Committee discussed the low office morale and believe the causes may be attributed to ineffective communication and leadership within the Yakima Children's Administration office. The findings and recommendations at the end of this report summarize the Committee discussion regarding the aforementioned areas.

The Committee discussed the challenges faced by the social workers when attempting to contact the family. The Committee noted both investigative social workers utilized similar but ineffective techniques in their attempts to contact the family. Both social workers made multiple attempts to visit the family home. Both social workers attempted to contact the family via mail correspondence in their native language. The Committee acknowledged the efforts of the social workers to contact the family but believed the social workers may have been more effective if they had utilized the *Reasonable Efforts to Locate Children and Parents Guideline*. The Committee suggested social workers facing similar circumstances attempt to time the unannounced home visits to coincide with the school-aged child getting on or off the school bus. The Committee noted extended family and prior referrers may also have had suggestions regarding how to contact the family. The Committee also suggested social workers contact school personnel as they usually have an effective method of communicating with parents.

The Committee discussed the benefits of quality clinical supervision. The Committee noted both investigations afforded multiple missed opportunities for increased supervision and critical thinking surrounding the investigative processes. The April 2010 investigations were closed as 'unable to complete.' The Committee believed quality clinical supervision may have provided the social worker with additional techniques for engaging the family. The March 2013 investigation required a face-to-face contact with the children within 72 hours. The social worker was granted two extensions by a supervisor that delayed the investigation for approximately two weeks. The extensions were granted based upon the Yakima County Child Abuse Protocol.<sup>30</sup> However, the Committee

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<sup>30</sup> Yakima County Child Abuse Protocol - Law enforcement agencies should assume primary responsibility for conducting the investigation in the following cases: 1. Sexual assault or sexual abuse of children by persons other than household members. (third party reports) 2. Minor to moderate physical abuse allegedly perpetrated by persons other than a household member. Minor to moderate physical abuse includes cases where injuries do not require immediate medical attention. 3. Abuse or neglect by persons other than a household member (third party reports), except for those types of cases subject to joint investigation (schools, institutions, licensed group care facilities, child care settings, foster care providers). 4. Lack of proper supervision of children, or children being left alone, whether in a residence, vehicle or other unattended. CPS should assume the primary responsibility for handling cases where criminal law violations are less obvious or not present. The purpose of a joint investigation involving both CPS and law



believed the extensions were not warranted as the child had no physical injury and it was unlikely law enforcement would take part in the investigation due to the nature of the allegation. The Committee reviewed the collaborative efforts between CA and local law enforcement and believed increased communication regarding the assignment of cases following an intake would be beneficial.

### **Findings**

- 1) The Committee believed the CPS investigations lacked elements needed to ensure a thorough assessment of child safety. The elements identified by the Committee as lacking include:
  - a) Failure to follow the *Reasonable Efforts to Locate Children and Parents Guideline*
  - b) Insufficient collateral contacts
  - c) Timeliness of investigations

The Committee identified the following factors that may have contributed to the investigative issues identified above: high caseloads, staff turnover, low office morale, and limited training and information around LEP resources.

- 2) The Committee noted the April 2010 investigating social worker received 19 new investigative assignments during April 2010. The Committee believes the investigating social worker received too many case assignments during April 2010.
- 3) The CPS investigators informed the Committee that they received inadequate training and information regarding the use of telephone interpreters.<sup>31</sup>

**Action Taken:** The Yakima office has since provided social workers with the necessary information to utilize telephone interpreters.

- 4) The Committee believes the Yakima office would benefit from the streamlining and coordinating of activities between CA and law enforcement.

### **Recommendations**

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enforcement is to avoid multiple interviews while providing the best protections for the child(ren) and the most thorough investigation. Conducting a joint investigation requires a high level of coordination and flexibility. When law enforcement or CPS receives a case requiring joint investigation, the receiving agency should contact the other agency. Both CPS and the law enforcement agency should assign personnel to conduct the investigation.

<sup>31</sup> CTS Language Link provides multilingual interpretation and translation communication including interpreter services that can be accessed through the phone. The Yakima County Profile reports 65,673 individuals residing in Yakima County who speak Spanish at home. The county population is approximately 231,800. For more information:

<http://www.yakimacounty.us/oem/hmp/yakimacountyprofile.pdf>

- 1) The Committee recommends CA facilitate a joint meeting between the Yakima CA office and law enforcement to review how investigative efforts are coordinated as specified in the Yakima County Child Abuse Protocol.
- 2) The Committee recommends LEP cases be weighed in a manner that sufficiently reflects the additional workload involved. The Committee also recommends CA focus on recruiting and retaining qualified Spanish speaking staff in offices with a high Spanish speaking population.



## **Child Fatality Review**

**S.R.**

**September 2012**

Date of Child's Birth

**June 7, 2013**

Date of Child's Death

**October 16, 2013**

Child Fatality Review Date

### **Committee Members**

Sheila Davidson, GAL/CASA Coordinator, Benton Franklin Juvenile Center  
Erinn Gailey, Program Director, Domestic Violence Services of Benton and  
Franklin Counties

Randy Maynard, Detective Sergeant, Kennewick Police Department  
Jennifer Martinez, Family Preservation Services (FPS) Counselor, Pathways  
Counseling

Mary Meinig, Director Ombuds, Office of the Family & Children's Ombuds  
Bill Paresa, Area Administrator, Vancouver, DSHS, Children's Administration

### **Consultant**

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

### **Facilitator**

Robert Larson, Critical Incident Case Review Specialist, DSHS, Children's  
Administration

### ***Executive Summary***

On October 16, 2013, the Department of Social and Health Services (DSHS), Children's Administration (CA) convened a Child Fatality Review (CFR)<sup>32</sup> to review the department's practice and service delivery to a nine-month-old female child and her family. The child will be referenced by her initials, S.R., in this report. At the time of her death, S.R. shared a home with her mother and her mother's boyfriend. No other children resided in the home at the time of the fatality. The incident initiating this review occurred on June 7, 2013 when S.R. died from non-accidental trauma to the head.

The review is conducted by a team of CA staff and community members with relevant expertise from diverse disciplines. Neither CA staff nor any other Committee members had recent direct involvement with the case.

Prior to the review, each committee member received a case chronology, a summary of CA involvement with the family, and un-redacted CA case documents (e.g., intakes, safety assessments, investigative assessments, provider records, law enforcement records, and Child Protective Services investigative reports).

Supplemental sources of information and resource materials were available to the Committee at the time of the review. These included copies of state laws and CA policies relevant to the review and the complete case file.

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

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

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<sup>32</sup> Given its limited purpose, a Child Fatality Review should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. The Child Fatality Review Committee's review is generally limited to documents in the possession of or obtained by DSHS or its contracted service providers. The Committee has no subpoena power or authority to compel attendance and generally will only hear from DSHS employees and service providers. It does not hear the points of view of a child's parents and relatives, or those of other individuals associated with a deceased child's life or fatality. A Child Fatality Review is not intended to be a fact-finding or forensic inquiry or to replace or supersede investigations by courts, law enforcement agencies, medical examiners or other entities with legal responsibility to investigate or review some or all of the circumstances of a child's death. Nor is it the function or purpose of a Child Fatality Review to recommend personnel action against DSHS employees or other individuals.

**Case Summary**

S.R. is the youngest of four siblings. S

[REDACTED]

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

[REDACTED]

A Family Team Decision Making Meeting (FTDM) was held on September 4, 2012 to determine a case plan related to S.R.<sup>33</sup> The mother reported to the FTDM team that she knew the father was not supposed to be around her older children, but she needed his support and believed he should be at the birth of his daughter. The mother informed the FTDM participants that she would continue to maintain a residence separate from the father. The social worker verified the mother had maintained a separate residence for three months prior to the birth of S.R. The FTDM team recommended S.R. remain in the mother's care and that the father's access would be supervised due to his previous allegations of domestic violence, physical abuse, sexual abuse, and neglect. Following the FTDM, the mother was

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<sup>33</sup> Family Team Decision Making Meeting (FTDM) is a facilitated team process which can include birth/adoptive parents, guardians, extended family members, youth (as appropriate), community members, service providers, child welfare staff and/or caregivers. These meetings are held to make critical decisions regarding the placement of children following an emergent removal of child(ren) from their home, changes in out-of-home placement, and reunification or placement into a permanent home. There may be instances when an FTDM can be held prior to placement if there is not an immediate safety threat such as a child who is on a hospital hold and an FTDM could provide placement options. Permanency planning starts the moment children are placed out of their homes and are discussed during a Family Team Decision Making meeting. A Family Team Decision Making meeting will take place in all placement decisions to achieve the least restrictive, safest placement, in the best interest of the child. By utilizing this inclusive process, a network of support for the child(ren) and adults who care for them is assured. [Source: [Washington State Family Team Decision-Making Meeting Practice Guide](#)]

provided multiple in-home services including a Public Health Nurse, domestic violence advocacy, housing assistance, and Family Preservation Services (FPS).

On December 10, 2012, the father was arrested after a domestic violence incident at the mother's address. The father was not supposed to be at the mother's residence according to the safety plan initiated by the social worker. The mother and father had differing stories regarding the December 10, 2012 incident. The mother reported the father arrived at the house immediately prior to the incident and had not previously been allowed in the home; however, the father stated the mother had allowed him to stay at her residence. The social worker was unable to verify which parent was telling the truth. Following the incident the mother and S.R. moved into a domestic violence shelter to ensure the safety of herself and her child. The mother obtained a restraining order and continued with her plan to divorce the father.

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

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

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

### ***Discussion***

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

## RCW 74.13.515

mandatory reporting law for child abuse and neglect, and out-of-home placement decisions.

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

The Committee noted the family's history [REDACTED]

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

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

The Committee discussed the impacts of domestic violence on the family and the use of the Domestic Violence Protocol by the CA social worker. The Committee noted the mother's case history indicated a pattern of domestic violence.

Committee members noted CA provided the mother with services designed to increase her independence and her ability to protect herself and her children from unsafe relationships. The Committee discussed the importance of building supports around a parent so the parent feels capable of meeting their own needs and no longer needs to rely on the support of the domestic violence perpetrator.

The Committee noted the social worker followed policy by utilizing the FTDM process when considering the removal of S.R. from her mother's care. The Committee noted the FTDM process does not involve neutral parties and only includes individuals familiar with the family. The Committee believed this case might have benefited from additional shared planning activity in the form of a child protection team; however, the Committee did not believe this would have changed the outcome of the case.

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

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

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

***Findings***

None

***Recommendations***

None





## **Child Fatality Review**

**A.G.**

**January 2009**

Date of Child's Birth

**June 16, 2013**

Date of Fatality

**October 2, 2013**

Child Fatality Review Date

### **Committee Members**

Carmelita Adkins, Region 2 Indian Child Welfare Program Consultant, Children's Administration

Detective Chris Ivanovich, Police Detective, Thurston County Sheriff's Office

Sheila Lewallen, MA, Licensed Mental Health Counselor and Community Victim Liaison, Department of Corrections

Mary Meinig, MSW, Director, Office of Family and Children's Ombuds

Heather Reid, MSW, Licensed Medical Social Worker, Providence St. Peter's Hospital Sexual Assault Clinic

### **Facilitator**

Ronda Haun, Critical Incident Case Review Specialist, Children's Administration

**RCW 74.13.640**

### ***Executive Summary***

On October 2, 2013, Children’s Administration (CA) convened a Child Fatality Review<sup>34</sup> (CFR) Committee to examine the practice and service delivery in the case involving a four-year-old multi-racial (Native American, African American, Caucasian) Hispanic male child and his family.<sup>35</sup> The child will be referenced by his initials, A.G., in this report. At the time of his death, A.G. shared a home with his adoptive mother, his twelve-year-old adoptive sibling and the man with whom A.G.’s mother maintained a personal relationship. The identity of A.G.’s biological father is unknown.

The incident initiating this review occurred on June 15, 2013 when A.G. was found alone and unresponsive in a swimming pool located in the apartment complex where A.G. lived with his family. After being called to the scene, emergency medical personnel transported A.G. to a local hospital where his heartbeat was restored. Still in grave condition, A.G. was then air-lifted to a regional hospital where he was pronounced dead the following day.

When a child dies from alleged child abuse or neglect and the child’s family had received services from Children’s Administration within a year of the child’s death, Washington state law requires CA to conduct a Child Fatality Review. The review is conducted by a team of CA staff and community members with relevant expertise from diverse disciplines. Neither CA staff nor any other committee members had previous direct involvement with the case.

In addition to the participants present at the review, the Choctaw Nation of Oklahoma, the tribe in which A.G. was eligible for membership, was invited by Children’s Administration to select a representative to participate in this review. A response to the invitation was not received.

Prior to the review, each committee member received a chronology of known case information, and un-redacted CA case-related documents. Additional

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<sup>34</sup> Given its limited purpose, a Child Fatality Review (CFR) should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of 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 deceased child’s life or death. A Child Fatality Review is not intended to be a fact-finding or forensic inquiry or to replace or supersede investigations by courts, law enforcement agencies, medical examiners or other entities with legal responsibility to investigate or review some or all of the circumstances of a child’s death or 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.

<sup>35</sup> A.G.’s caregivers are not named in this report because they were not charged in an accusatory instrument with committing a crime related to a report maintained by the department in its case management information system.[Source: [RCW 74.13.500\(1\)\(a\)](#)]

documents were made available to the Committee at the time of the review. These included medical and law enforcement reports and copies of relevant CA policies and practice guides.

During the course of the review the CFR Committee members interviewed the CA social worker most recently involved with the case prior to A.G.'s death. Following review of the case file documents, interviews and discussion regarding social work activities and decisions, the Review Committee made findings and recommendations, which are detailed at the end of this report.

### ***Case Overview***

Children's Administration's involvement with this family began on May 26, 2012 when a police officer contacted Child Protective Services (CPS) to report A.G. had been found walking alone on a city street early on a weekend morning. The police found it difficult to communicate with A.G. because he had limited language skills. After attempting to locate A.G.'s family for about 45 minutes, the police officer contacted CPS. Arrangements were made for a CPS social worker providing emergency weekend coverage to meet A.G. and the police officer at the local police station. A short time later, A.G.'s mother contacted the police to report her son was missing. The mother reported she had slept-in following a late night of studying. After waking up and discovering A.G. was missing, she called 911 and began searching for her son. After talking with the mother and assessing the family's home to be safe, the police officer released A.G. to the care of his mother. Both the police officer and CPS social worker spoke with A.G.'s mother about the seriousness of the situation and recommended installing child safety locks to prevent another incident of A.G. wandering away from home. After the emergency social worker and police officer addressed the immediate concerns about A.G.'s safety, an ongoing investigative CPS social worker was assigned to the case to continue the investigation of alleged neglect.

On May 31, 2012, an investigative CPS social worker documented conducting a home visit with A.G. and his mother. The social worker confirmed that the family had installed safety devices on the doors in their home. No safety concerns were identified by the social worker during the visit. The social worker noted A.G.'s limited language skills and learned from this mother that A.G. had delayed language development for which he had previously received speech therapy. The social worker also learned A.G. had been adopted in another state by his maternal aunt following the death of his biological mother. The family had only

recently moved to Washington. The CPS investigation was closed on July 25, 2012 as unfounded<sup>36</sup> for negligent<sup>37</sup> treatment of a child.

The department became involved with A.G. and his family a second time on September 14, 2012 when the police again contacted CPS to report A.G. was found wandering alone near a motel. The manager of the motel did not recognize A.G. as being a guest of the motel and called the police. The police attempted to locate A.G.'s family for approximately two hours before transporting A.G. to the police station. The search continued for an additional forty minutes until A.G.'s mother and her boyfriend arrived at the police station. They explained they had recently moved to the motel where A.G. had been found wandering. After conducting an inspection of the family's room at the motel, the police left A.G. in their care. The police also contacted CPS to report a new allegation of child neglect.

The CPS investigation was initiated with a home visit on September 17, 2012. The social worker and A.G.'s mother discussed the allegations of neglect and identified ways to prevent further incidents of A.G. wandering away from home. The social worker developed an in-home safety plan<sup>38</sup> with A.G.'s caregivers. They agreed to install child safety devices, attend a parenting class, and maintain "line of sight" supervision of A.G.

The social worker documented an attempted home visit about a week later but found no one at home. On the same day the social worker contacted A.G.'s daycare provider and the manager of the motel where the family was living. Both reported no concerns about the ability of A.G.'s mother or her boyfriend to safely care for A.G. On September 28, 2012, the social worker documented speaking with A.G.'s mother to confirm child safety devices had been installed in the home. On October 8, 2012, the social worker completed a referral and authorized payment for A.G.'s mother to participate in a parenting skills program provided by a community agency. On October 29, 2012, the CPS investigation was

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<sup>36</sup> Unfounded is the determination that, following an investigation by CPS, based on available information: it is more likely than not that child abuse or neglect did not occur, or there is insufficient evidence for the department to determine whether the alleged child abuse did or did not occur. [Source: [WAC 388-15-005](#)]

<sup>37</sup> Negligent treatment or maltreatment means an act or a failure to act, or the cumulative effects of a pattern of conduct, behavior, or inaction, that evidences a serious disregard of consequences of such magnitude as to constitute a clear and present danger to a child's health, welfare, or safety, including but not limited to conduct prohibited under [RCW 9A.42.100](#).

<sup>38</sup> The Safety Plan is a written agreement between a family and CA that identifies how safety threats to a child will be immediately controlled and managed. The Safety Plan is implemented and active as long as threats to child safety exist and caregiver protective capacities are insufficient to protect the child.

completed. The social worker determined the allegation of negligent treatment by A.G.'s mother and her boyfriend was founded.<sup>39</sup>

On June 15, 2013, the department was notified by a hospital social worker of A.G.'s hospitalization following a near-drowning incident. A.G. was found alone and unresponsive in a pool by his mother's boyfriend. The boyfriend lifted A.G. from the pool and carried him back to the apartment while calling for help and performing resuscitation efforts. Emergency response personnel transported A.G. to a local hospital where his heartbeat was restored with shock treatment. The prognosis for survival was poor when A.G. was airlifted to a regional hospital for continued medical care. On June 16, 2013, medical testing determined A.G. had no brain activity.

Life support was discontinued and A.G. was pronounced dead. The medical examiner determined accidental drowning as the cause of death.

During the subsequent CPS and law enforcement investigations, the family reported they had recently moved to an apartment located in a complex with two swimming pools. On the day of incident, A.G. was in the care of his mother's boyfriend while his mother and sister were away from the home. After A.G. left the family's apartment without adult supervision, he opened an unlocked door serving as a gate to one of the pools. He then removed his clothing and shoes and entered the water. No criminal charges were filed. The CPS case was closed on August 15, 2013 with a determination of unfounded for alleged negligent treatment by A.G.'s mother and her boyfriend.

### ***Committee Discussion***

The Committee's discussion included a number of the department's responses to the needs of this family to help identify areas for system improvement. One focus of discussion was how in-depth information gathering from a variety of sources is imperative to fully and accurately assessing a family's needs. The Committee discussed how social workers use the information gathered during an investigation to complete Structured Decision Making Tool® (SDM®)<sup>40</sup> during a CPS investigation and how the results of the tool impact case planning.

The Committee discussed how information about family functioning and child safety might be obtained from interviews with other children (not identified as

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<sup>39</sup> Founded is the determination that, following an investigation by CPS, based on available information it is more likely than not that child abuse or neglect did occur. WAC 388-15-005.

<sup>40</sup> SDM® is a structured assessment that includes 18 specific questions with detailed definitions that result in a scored risk classification. The SDM® risk assessment helps identify families who are most likely to experience child abuse or neglect. DCFS investigators use the SDM® in combination with the safety assessment to assess immediate danger to children and help determine whether CA should provide and monitor ongoing services to a family following a CA/N investigation.

alleged victims) living in the same home as an identified victim. The Committee questioned why there was no documented attempt to interview A.G.'s older sibling during the two CPS investigations. The Committee suggested it would have been best practice to contact the sibling during the investigations even after the sibling moved to the home of a parent in another state.

The Committee noted A.G. was often supervised by his mother's boyfriend and questioned if the department fully assessed his ability to safely care for A.G. A discussion of the department policies regarding accessing criminal history during a CPS investigation was prompted by the Committee reviewing case documentation indicating A.G.'s mother reported her boyfriend had been convicted of several serious crimes.

The Committee noted A.G.'s family demonstrated a number of strengths while interacting with law enforcement officers, child care staff, and the involved social workers. The Committee discussed if the presentation of A.G.'s mother as cooperative and hardworking and the evident family strengths influenced the ability of the social workers to objectively assess the family's ability to safely care for A.G.

Case documentation indicated involved staff were aware that A.G. was not receiving developmental services to address his speech and communication delays and may have been in need of routine medical and dental care. The Committee discussed two social work approaches to obtaining services for the child: direct access of services by the social worker or engaging the parent to access the service on behalf of his/her child. If the latter approach is used, the Committee believes the social worker should independently verify the service was actually obtained.

The Committee noted the safety plan indicated A.G.'s mother was to attend a parenting-skills program paid for by the department. Upon learning the mother completed only two sessions of the twelve-session program, the Committee questioned the decision to close the CPS investigation prior to verifying the mother's participation in an activity related to a safety plan.

The Committee reviewed the three investigative findings associated with this case. The Committee discussed why the findings differed despite very similar allegations involving the same family members. While outside of the primary purpose of this review, the Committee strongly disagreed with the investigative finding of unfounded following the investigation of A.G.'s death.

## **Findings**

1. The Committee supports the findings resulting from the CPS investigations in May and September of 2012.
2. The Committee believes sufficient information gathering did not occur for a comprehensive assessment of all children and adults living in A.G.'s household and the safety of a young and vulnerable child may have been overlooked during the course of the CPS investigations.
3. The Committee finds the involved staff did not take sufficient action to ensure A.G. received services to address his wellbeing needs. Related to this finding was the Committee's concern that A.G.'s medical records were not obtained during the course of the CPS investigation. The Committee suggests information in the medical records may have been helpful for case planning.
4. The Committee noted some case documentation occurred outside of the timelines established by departmental policy. Additionally, the Committee was concerned an involved social worker reported a home visit conducted specifically to confirm the family's compliance with the safety plan was not documented.<sup>41</sup>
5. Prior to closing the CPS investigation in October 2012, the Committee believes the department should have confirmed A.G.'s mother's participation in the voluntary parenting service.

## **Recommendations**

1. The Committee recommends the CPS supervisors working in the Children's Administration office where this case was assigned receive additional training on how to guide CPS social workers in gathering information about the subjects of CPS investigations and how to fully utilize the Structured Decision Making® tool in case planning.
2. When a CPS investigation is conducted in cases involving a child fatality resulting from suspected child abuse or neglect, the Committee recommends the investigation be conducted by CPS staff from an office with no prior involvement with the child or the child's family.
3. Currently, CA policy<sup>42</sup> provides CPS social workers with discretion in deciding when to access the National Crime Information Center (NCIC)

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<sup>41</sup> FamLink Documentation Timeframes represent the maximum time from when the work is completed until the documentation of that work must be completed in FamLink. All visits must be documented in a case notes within 3 calendar days

<sup>42</sup> CA is authorized to access the NCIC database for subjects of CPS investigations and other adults related to the investigations. The Purpose Code C check allows the social worker to assess the safety of children in the home and the safety of CA staff conducting the investigation. Requests for NCIC checks for CPS investigations are made in accordance with state and federal laws. ([RCW 26.44.030](#) and [PL 109-248](#)). Purpose Code C checks are based on name and date-of-birth information and are a point in time check.

database for subjects of CPS investigations and other adults related to an investigation. The Committee recommends, if permissible by law, a change in policy to require social workers to access the National Crime Information Center (NCIC) database during the course of a CPS investigation.





## **Child Fatality Review**

**E.S.**

**November 2002**

Date of Child's Birth

**June 30, 2013**

Date of Fatality

**November 5, 2013**

Child Fatality Review Date

### **Committee Members**

Mary Meinig, MSW, Director, Office of the Governor, Office of the Family and Children's Ombuds

Deena Parra, Foster Parent Liaison, Olive Crest

Alisabeth Beecher, Foster Home Licensor, Compass Health

Linda Tosti-Lane, Licensing Supervisor, Children's Administration

Elizabeth Bennett, Director, Community Benefit and Guest Services and Drowning Prevention Expert, Seattle Children's

Mary Donnelly, School Counselor, Everett School District

### **Consultant**

Felix Idahosa, Contracts Program Consultant, Children's Administration

### **Facilitator**

Ronda Haun, Critical Incident Case Review Specialist, Children's Administration

**RCW 74.13.64**

### **Executive Summary**

On November 5, 2013, Children’s Administration (CA) convened a Child Fatality Review<sup>43</sup> (CFR) Committee in response to the death of a ten-year-old male child. The deceased child will be referred to by his initials, E.S., in this report. At the time of his death, E.S. was in the custody of the Department of Social and Health Services pursuant to a juvenile court dependency proceeding and living in a licensed foster home while receiving Behavioral Rehabilitation Services (BRS).<sup>44</sup> E.S.’s foster home was certified for licensing by a private agency contracted by CA to provide both child placing<sup>45</sup> services and BRS.

The incident initiating this review occurred on June 30, 2013 when E.S. died while swimming in a river during an outing to a public park with his foster family. Emergency personnel were called to the park after E.S. was swept away by the river current. After an approximate forty minute search, emergency personnel found E.S. in the river. He was unresponsive and had no pulse. He was transported to a local hospital where resuscitation efforts were unsuccessful and he was pronounced dead.

When a child dies from alleged child abuse or neglect and the child’s family had received services from CA within a year of the child’s death, Washington state law requires CA to conduct a CFR. The review is conducted by a team of CA staff and community members with relevant expertise from diverse disciplines. Neither CA staff nor any other committee members had previous direct involvement with the case. The primary focus of the review was the service delivery provided to E.S. by the child placing agency, BRS services and the Division of Licensed Resources (DLR).<sup>46</sup>

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<sup>43</sup> Given its limited purpose, a Child Fatality Review (CFR) should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of 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 deceased child’s life or death. A Child Fatality Review is not intended to be a fact-finding or forensic inquiry or to replace or supersede investigations by courts, law enforcement agencies, medical examiners or other entities with legal responsibility to investigate or review some or all of the circumstances of a child’s death or 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.

<sup>44</sup> BRS is a temporary intensive wraparound support and treatment program provided by contracted private agencies in which the primary objective is the stabilization of behavioral concerns which interfere with the child’s ability to maintain stability and continuity in multiple life domains.

<sup>45</sup> The department may license a child placing agency, including a tribal CPA, to operate foster home, staffed residential homes, and/or group care facilities. The child placing agency is only authorized to “certify” or attest to the department that the foster home meets the licensing requirements. [Source: [WAC 388-148-0070](#)]

<sup>46</sup> The Division of Licensed Resources (DLR) was established by Executive Order to improve the health and safety of children in out-of-home care, to strengthen monitoring and licensing of all licensed care

Prior to the review, each committee member received a summary of E.S.'s family case history, a chronology of licensing-related activities and un-redacted licensing-related documents. Additional documents were made available to the Committee at the time of the review. These included medical and law enforcement reports, records provided by the private agency responsible for certifying the foster parents for licensing, training and informational materials related to child safety provided to foster parents and copies of relevant CA policies, manuals and Washington Administrative Codes.<sup>47</sup>

During the course of the review, the CFR Committee members interviewed the DLR licenser and supervisor. Additionally, Committee members consulted with a program consultant from CA about contracts for BRS.

Following review of the case file documents, interviews, and discussion regarding service activities and decisions, the Committee made findings and recommendations which are detailed at the end of this report.

### **Case Overview**

### **RCW 74.13.515**

#### **Family case summary**

[REDACTED]

On January 5, 2011, E.S. was placed in the care and custody of Children's Administration pursuant to a juvenile court proceeding and moved from his home to a residential treatment facility. With the exception of one unsuccessful trial return home, E.S. continued to live in foster care until his death.

On June 21, 2011, E.S. was first placed with the foster parents involved in this incident. He left their home a few months later on September 16, 2011 but returned on November 5, 2011 and remained until his death on June 30, 2013. While in foster care, E.S. received specialized services from BRS to address his behavioral needs.

#### **Foster home summary**

The foster parents were licensed by DLR on May 5, 2011 to provide foster care after first becoming certified as meeting foster home licensing requirements by a child placing agency. The same agency was also contracted to provide BRS services to E.S. The foster parents were initially licensed to care for four children

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resources, and to separate regulatory oversight from placement activities. The division is composed of the Office of Foster Care Licensing (OFCL), and a unit of investigators charged with investigation of allegations of child abuse and/or neglect in licensed child care homes and facilities.[Source: [CA Operations Manual 2240](#)]

<sup>47</sup> Regulations of executive branch agencies are issued by authority of statutes. Like legislation and the Constitution, regulations are a source of primary law in Washington state. The WAC codifies the regulations and arranges them by subject or agency.[Source: [Washington Administrative Code](#)]

between the ages of 6-18 years of age. In February of 2012 the foster parents moved to a smaller home and their licensing capacity was reduced to three children. Prior to E.S.'s death, the foster parents had one prior unfounded allegation of child abuse and neglect and two licensing infractions that were determined to not be valid.

On June 30, 2013, Children's Administration was notified by an employee of a county coroner's office of E.S.'s death by drowning while swimming in a river. At the time of the incident, E.S. was on an outing to a public park with his foster parents and two other foster youth. All three of the foster youth required specialized care to address their behavioral, emotional, and developmental needs. During the outing, two of the three foster youth were allowed to swim without personal flotation devices in a river accessible from within the park boundaries. While wading across the river, E.S. was swept away by the current and was unable to keep his head above the water. Emergency personnel were called to the park and began rescue attempts. Forty minutes later E.S. was found submerged under water in a snag of trees. He had no pulse and was unresponsive. E.S. was pronounced dead after resuscitation efforts at the river and later at a local hospital were unsuccessful. The death was certified by a medical professional as an accidental drowning.

Both DLR and law enforcement conducted investigations of this incident. The police report indicated if E.S. had been wearing a life jacket his death probably could have been prevented. No criminal charges were filed against the foster parents. The DLR investigation resulted in founded findings of child neglect by the foster parents for allowing E.S. and the other foster youth to swim without personal flotation devices. The DLR investigation also confirmed there were a number of signs posted in the park where E.S. died warning of the dangers of swimming in the river.

### ***Committee Discussion***

The Committee discussed in-depth the contractual relationship between CA and the private agency involved in this incident. The Committee examined the CA contracts process for services such as certifying potential foster homes as meeting licensing requirements and providing BRS services. The Committee noted the complex contracting agreements between CA and the private agency involved in providing care to E.S. The Committee explored how CA provided oversight to the contracting private agency to ensure the agency adhered to licensing and contracting requirements while providing safe and high quality care to children. The Committee learned from interviews conducted during the review that the staff responsible for the licensing and contracting oversight of the involved private agency, as well as CA's regional program consultant for BRS

services, are now meeting monthly to improve service coordination and communication.

The Committee reviewed how contracted private agencies determine if a potential foster home is capable of providing licensed foster care and how contracted private agencies monitor and support foster homes following licensing. The Committee discussed both the general training requirements for foster parents and specialized training when foster parents care for children with special needs. After learning CA does not require private agencies to be accredited by an independent organization, the Committee discussed if accreditation would increase the quality of care provided to foster children served by child placing agencies.

The Committee reviewed the documentation indicating E.S. was visited monthly in his foster home by his CA social worker and also had frequent contact by staff from the contracted private agency. The Committee questioned how the responsibility to monitor the safety and wellbeing needs of foster children is shared by social workers and licensing staff from both private agencies and CA. The Committee discussed how E.S.'s foster parents were informed of E.S.'s behavioral needs at the time of placement and how information about E.S. was exchanged between the various professionals involved with his care.

The Committee questioned if CA and private agencies collaborate when determining how many foster children to place in a particular home and if the individual needs of foster children are considered at the time of placement. The Committee discussed how the contracted private agency and CA responded to the report of alleged child abuse and the licensing infractions in E.S.'s foster home. The Committee discussed what additional supports are provided to foster families caring for foster children with special needs.

In response to the cause of E.S.'s death, the Committee discussed how foster parents and CA staff are trained and informed about water safety for children in foster or relative care. The Committee reviewed a variety of training materials, CA's Guidelines for Foster Child Activities, licensing checklists and the specific WAC addressing water safety for foster children.

The Committee acknowledged the thorough investigation of E.S.'s death conducted by the CA social worker and agreed with the investigative findings. While determining the critical incident was not a result of error or oversight by CA or the contracted CPA, the Committee's findings and recommendations listed below highlight opportunities to improve practice.

## **Findings**

1. The Committee believes the home study completed by the private agency during the process of certifying E.S.'s foster parents to become licensed to provide foster care did not contain sufficient information to fully assess the foster parents' skills and abilities to provide specialized foster care.
2. The Committee believes the child placing agency should not have allowed the placement of three children with a wide spectrum of developmental, cognitive, and behavioral needs in the home of newly licensed foster parents with limited prior parenting experience. Additionally, the Committee believes the foster family would have likely benefitted from additional support with the care of three foster children with special needs and from more frequent in-home visits by the agency providing contracted child placing and BRS services.
3. The Committee found no documentation to confirm the foster parents were in compliance with the 30 hours of annual training required of foster parents providing therapeutic BRS foster care.<sup>48</sup>
4. While acknowledging E.S.'s death was not related to fire safety, the Committee did note one of the CA social workers conducting monthly health and safety visits<sup>49</sup> with E.S. routinely asked E.S. if fire drills were conducted in his foster home. The Committee believes the social worker, after learning from E.S. that fire drills had not been practiced for some time in the foster home, should have notified the DLR licenser.

## **Recommendations**

1. By March 2014, CA should convene a workgroup consisting of professionals representing water safety, foster parenting, public health, law enforcement, the Division of Licensed Resources, and CA's contracted training provider to consider the following:
  - Update [WAC 388-148-0170](#) (relating to the water safety of foster children) with specific instruction about when to require foster children to use United States Coast Guard-approved personal flotation devices.
  - Expand [WAC 388-148-0170](#) to require safety and supervision plans when a foster home is in close proximity to an open body of water such as a pond or stream.
  - Develop written guidelines on water safety for use by DLR staff responsible for creating safety and supervision plans for licensed home and facilities.

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<sup>48</sup> [CA's Behavioral Rehabilitative Services Handbook \(pages 43-45\)](#)

<sup>49</sup> 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 well-being needs are being met.

- Revise CA's Guidelines for Foster Child Activities ([DSHS Form 22-533](#)) to include specific guidance about participation in swimming, boating and water recreation by children in foster care.
- 2. Develop and provide social workers with training on the risk and prevention of childhood injuries. The Committee recommends CA consider using existing training materials readily available from organizations promoting injury prevention.
- 3. Revise the Foster Home Inspection Checklist ([DSHS Form 10-183](#)) to include a specific section about water safety in foster homes.
- 4. At the time of initial licensing and licensing renewal, require foster parents to complete training on the risk and prevention of childhood injuries. The Committee recommends the training include information on the proper use of safety equipment such as bicycle helmets, car seats and personal flotation devices.
- 5. Update CA's Placement Agreement Form ([DSHS Form 15-281](#)) to indicate the out-of-home placement provider has read and agreed to comply with the Guidelines for Foster Child Activities.
- 6. The Committee recommends CA conduct annual onsite reviews of CPAs as a strategy to CPA compliance with the myriad of laws, administrative codes and policies relevant to foster care licensing and contracting.

***Nondiscrimination Policy***

*The Department of Social and Health Services does not discriminate and provides equal access to its programs and services for all persons without regard to race, color, gender, religion, creed, marital status, national origin, or sexual orientation.*