

Report to the Legislature

Quarterly Child Fatality Report

RCW 74.13.640

April – June 2014

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Executive Summary

This is the Quarterly Child Fatality Report for April through June 2014 provided by the Department of Social and Health Services (DSHS) to the Washington state Legislature. RCW 74.13.640 requires DSHS to report on each child fatality review conducted by the department and provide a copy to the appropriate committees of the legislature:

Child Fatality Review — Report

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

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

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

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

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

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

This report summarizes information from completed reviews of four (4) child fatalities and four (4) near-fatalities that occurred in the second quarter of 2014. All of these cases were conducted as executive child fatality reviews. All prior child fatality review reports can be found on the DSHS website: <http://www.dshs.wa.gov/ca/pubs/fatalityreports.asp>.

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

| Region | Number of Reports |
|--|-------------------|
| 1 | 6 |
| 2 | 2 |
| 3 | 0 |
| Total Fatalities and Near Fatalities Reviewed During 2 nd Quarter, 2014 | 8 |

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

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

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

The charts below 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 2014. The number of pending reviews is subject to change if CA discovers new information through reviewing the case. For example, CA may discover that the fatality or near-fatality was anticipated rather than unexpected, or there is additional CA history regarding the family under a different name or spelling.

| Child Fatality Reviews for Calendar Year 2014 | | | |
|---|--|----------------------------|--------------------------|
| Year | Total Fatalities Reported to Date Requiring a Review | Completed Fatality Reviews | Pending Fatality Reviews |
| 2014 | 11 | 0 | 11 |

| Child Near-Fatality Reviews for Calendar Year 2014 | | | |
|--|---|---------------------------------|-------------------------------|
| Year | Total Near Fatalities Reported to Date Requiring a Review | Completed Near-Fatality Reviews | Pending Near-Fatality Reviews |
| 2014 | 5 | 0 | 5 |

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

Notable Second Quarter Findings

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

- In one fatality case, the child was dependent and placed in her mother’s care on an in-home dependency when she was struck by a car while crossing a street with her mother. The Child Protective Services investigation determined the mother was at fault for crossing a busy four lane road and not using a crosswalk. The investigation was closed with a founded finding for negligent treatment.

- Five (5) of the eight (8) cases referenced in this report were open at the time of the critical incident.
- Two (2) children died in car accidents; the drivers of the cars (a mother and mother's paramour) were intoxicated at the time of the accidents.
- Four (4) children were Caucasian, three (3) were Native American, and one (1) was African American.
- In the four near-fatality cases, all of the child victims were three years old or younger. Three (3) of the four (4) suffered serious head injuries.
- Children's Administration received intake reports of abuse or neglect in all of the child fatality and near-fatality cases prior to the death or near-fatal injury of the child. One case had only one (1) prior intake before the critical incident; all of the cases had more than four (4) intakes prior to the critical incident. The most received prior to the critical incident was fifteen (15).
- Due to the small sample of cases reviewed, no statistical analysis was conducted to determine relationships between variables.



Child Fatality Review

E.B-G.

February 2008

Date of Child's Birth

October 18, 2013

Date of Child's Death

January 9, 2014

Child Fatality Review Date

Committee Members

Kat Armstrong, MED, LMHC, CDP, MHP, Clinical Supervisor, YFA Connections

Heidi Bulkley, MS, Guardian Ad Litem, Spokane County, Juvenile Court and Probation

Sarah Foley, Associate Director of Counseling and Outreach, YWCA Alternatives to Domestic Violence

Dorene Perez, MSW, Area Administrator, Yakima, DSHS, Children's Administration

Observer

Cassie Anderson, ICW Child Protective Services Supervisor, Spokane, DSHS, Children's Administration

Facilitator

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

Executive Summary

On January 9, 2014, the Department of Social and Health Services (DSHS), Children's Administration (CA) convened a Child Fatality Review (CFR)² to review the department's practice and service delivery to a five-year-old female child and her family. The child will be referenced by her initials, E.B-G., in this report. At the time of her death, E.B-G. shared a home with her mother, her mother's boyfriend (J.R.), and her siblings. The incident initiating this review occurred on October 18, 2013 when E.B-G. died from injuries related to a pedestrian/vehicle accident.

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 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 the complete case file and relevant state laws and CA policies.

During the course of the review, the Committee interviewed the previously assigned Child Protection Services (CPS) social worker, Child and Family Welfare Services (CFWS) supervisor, and area administrator. In addition to CA staff, the Committee interviewed the mother's individual counselor. The Committee requested the report reflect their appreciation to the mother's counselor for her participation in the review process. The CFWS social worker assigned to the case at the time of the fatality was not available for an interview. The Committee noted the challenges of conducting a thorough review without the presence of all staff involved with the case. Following a review of the case file documents, completion of interviews, and discussion regarding department activities and decisions, the Committee made findings and recommendations presented at the end of this report.

² 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.

[REDACTED]

Subsequently, CA received ten other intakes between January 2007 and October 2013. Those intakes included an intake on June 3, 2009, where E.B-G. and her siblings were placed in out-of-home care due to substance abuse and domestic violence. On July 14, 2010, the dependency was dismissed and the case was closed following the completion of services. On May 25, 2011, the biological father of E.B-G. received a founded finding following a domestic violence (DV) incident. [REDACTED]

On November 20, 2012, CA screened in an intake related to a DV incident between the mother and the mother’s boyfriend (J.R.). Law enforcement records reflect J.R. had physically assaulted the mother and kicked a stack of CDs that flew through the air and cut E.B-G.’s knee requiring minor medical attention. The mother and J.R. agreed to cooperate with voluntary services.

On March 28, 2013, CA received another intake related to DV in the family home. The intake alleged J.R. threw a baby bag at the mother while she was holding E.B-G.’s sibling, their nine-month-old child. The intake was screened out.³ [REDACTED]

[REDACTED]

On April 3, 2013, a dependency petition was filed and the children were placed into relative care. In the petition the worker wrote, “[The mother’s] history indicates a pattern of having the court dismiss restraining orders shortly after they are filed.” The case was transferred to a CFWS social worker following the shelter care hearing.

On June 21, 2013, an agreed court order was filed returning the children to their mother’s care. J.G. and J.R. were both granted court ordered visitation but they

³ CA will generally screen out intakes alleging the following: 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; 6) And alleged violations of the school system's Statutory Code, Administrative Code, statements regarding discipline policies.

RCW 74.13.515

RCW 70.02.020

were not allowed to reside at the family residence. [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

On October 19, 2013, CA received a report from Sacred Heart Medical Center indicating that at approximately 6:30 p.m. on October 18, 2013, the mother, E.B-G., and a sibling were crossing Monroe Street in Spokane when a vehicle traveling approximately 35 mph struck them. The driver was not under the influence of drugs and alcohol and appeared to be following all traffic laws at the time of the accident. The driver passed all sobriety testing. The mother was admitted to the hospital with significant injuries. The sibling was treated for a broken clavicle and released from the hospital. E.B-G. died the following morning from her injuries. The mother tested positive for methamphetamine upon her arrival at the hospital. On December 17, 2013, CA learned that law enforcement had also obtained blood and urine samples from the mother shortly after the accident. The exact time and date of law enforcement's blood and urine samples were unknown at the time of the CFR. The blood sample and urine tests requested by law enforcement were negative for the presence of methamphetamine. CA staff requested, but were unable to obtain copies of the mother's drug tests that were

⁴ Drug test results: Positive--A test result which indicates that a drug or metabolite is present. Negative--A test result which indicates that no drug or metabolite is present or no drug or metabolite is present in an amount greater than the cutoff concentration. No show--Indicates when the client fails to provide a urine sample as requested.

RCW 74.13.515

taken post-fatality. CA's knowledge of test results were obtained through verbal reports by medical professionals and law enforcement.

The mother was on her way to complete a UA at the time of the accident. The UA was requested by the social worker due to the mother's failure to show for UA testing on October 17, 2013. Witnesses to the accident consistently stated that the mother and children were not in a crosswalk when the vehicle struck them. Witnesses also reported they appeared to pause in the middle of the street to avoid a southbound vehicle immediately prior to impact. According to police records, two of the witnesses stated that they asked each other, "What is that lady doing walking in the roadway with cars coming?" Some witnesses reported the mother was walking with a child on each side of her with the family dog on a leash immediately prior to being struck by the vehicle.

[REDACTED]

[REDACTED]

Committee Discussion

The Committee noted CA social workers could not have predicted the events that took place on the night of the fatality. The discussion, findings, and recommendations identified in the sections below identify where CA staff might have considered additional or alternative social work practice that may have enhanced CA's service delivery, case plan, and analysis of the family.

On March 28, 2013, CA received an intake alleging J.R. had thrown a diaper bag at the mother's face while she was holding her baby. The intake was screened out. The Committee believed CA policy supported this intake being screened in as risk-only due to the recent pattern of DV in the home, the proximity of the child to the DV, and the recent injuries to children in the home that were associated with another DV incident on November 11, 2012.

The Committee reviewed the services offered to the family and noted the CA social worker appropriately referred the mother to DV victim's advocacy services, offered J.R. a DV perpetrator assessment pending a neuropsychological evaluation, and provided the mother with individual counseling to address the pattern of DV.

The Committee reviewed the mutually agreed upon services from the shelter care order filed in Spokane County Juvenile Court on April 9, 2013. The court order stated the mother shall complete "YWCA DV prevention services and follow recommendations." The Committee noted the value of offering DV advocacy to the mother but questioned the inclusion of DV advocacy and recommendations in a mutually agreed upon court order. First, a domestic violence advocate may not, without the consent of the victim, be examined as to any communication between the victim and the DV advocate." ([RCW 5.60.060\(8\)](#)). Second, DV advocates provide their services on a voluntary basis and will not provide assessments or recommendations for CA social workers to be utilized in court orders. The YWCA DV advocacy program will generally only confirm a client's attendance but will not provide information regarding the client's compliance or progress. For this reason, the Committee believes a contracted service provider should be utilized when CA social workers need recommendations and an assessment of progress. In this case, the department appropriately utilized the mother's individual counselor for an assessment of the mother's progress as it relates to DV and the mother's ability to maintain a safe home environment.

Following a review of the case file and interviews, the Committee believed this case may have benefitted from increased chemical dependency services. The Committee noted the mother's lengthy history of substance abuse and treatment prior to the dependency. For this reason, the Committee believed the mother should have received a chemical dependency assessment following her positive UA for methamphetamine on August 9, 2013. The Committee believed the mother's pattern of no-shows warranted a chemical dependency assessment. The Committee noted the mother and J.R. both alleged the other was using drugs in early April 2013. The Committee believed these allegations along with the mother's history of addiction warranted the initiation of random UAs in April 2013.

A Family Team Decision-Making Meeting (FTDM) was held on May 28, 2013 and an agreement was reached that the children would return to the care of their mother on June 7, 2013. The Committee discussed the mother's progress in services at the time of the decision to reunify the children with their mother. The case record indicates the mother had participated in individual counseling, DV services, parent education, and couples counseling. The Committee noted the mother had only completed one individual counseling session prior to the FTDM. The Committee believed one individual counseling session was insufficient for the provider to assess the mother's progress. The Committee also noted the parenting classes and visitation were not appropriate for the assessment of progress as they are unrelated to the primary concerns of substance abuse and domestic violence. The Committee also believed couples counseling was not an appropriate service as the DV issues in the family had not been resolved. Thus, the Committee believes couples counseling should not have been provided to the family or part of the decision making process. Based on the information available to the Committee at the time of the review, they believed the mother had not demonstrated a period of significant measurable behavior change at the time of reunification. In addition, the Committee noted a return home court order was entered on June 21, 2013. E.B-G. resided with her mother for two weeks prior to the court order supporting the return home. The Committee believed the social worker never intended to return E.B-G. to relative care and thus believed the official return home date was June 7, 2013. The Committee believed E.B-G. should not have been returned home prior to a court order supporting the return home.

On July 5, 2013, the CFWS social worker completed a safety assessment and safety plan. The safety assessment determined the children would be unsafe in the care of their mother without the presence of a safety plan to mitigate the identified safety threats. The safety plan states, "The mother has placement of her children. She will participate in all services. Her children are in daycare full time. Visits with both fathers are supervised. The stepfather is also participating in services." The service providers associated with the case agreed to help ensure the safety of the children by monitoring the home environment. The Committee found the safety plan lacked elements needed to address the identified safety threats. The Committee believed the plan should have specified how service providers and family members could help monitor and mitigate the risks associated with DV and chemical dependency. Following a review of the reunification decision, services, and safety plan, and interview of the supervisor, the Committee believed that clinical supervision associated with this case could have been improved.

The Committee reviewed the court orders associated with this case and noted the guardian ad litem's (GAL) signature was not present on the July 26, 2013 review hearing order. The Committee noted the GAL's signature should be present on all court orders when a GAL has been assigned.

CA staff informed the Committee that they attempted, but were unable to obtain copies of the mother's UA results following the fatality due to the ongoing investigation by law enforcement. The Committee believes CA should have had access to the mother's UAs, and the presence of these reports would have enhanced their understanding of the events surrounding the time of the fatality.

Findings

- 1) Based upon the information available to the Committee at the time of the fatality, the Committee believes the mother participated in insufficient services to adequately assess her progress at the time of reunification.
- 2) The Committee believes couples counseling should have been provided to the mother only after the DV issues had been resolved.
- 3) The Committee found the safety plan lacked elements needed to address the safety threats identified by the social worker in the safety assessment.
- 4) The Committee found the March 28, 2013 intake should have screened in as risk only.
- 5) The Committee found CA should have required the mother and J.R. to complete random UAs starting in April 2013. The Committee also believes the mother should have been required to complete a chemical dependency assessment following the UA that was positive for methamphetamine on August 9, 2013. The Committee found these services should have been offered to the mother through the dependency court process.
- 6) The Committee believed E.B-G. should not have been returned home without a court order supporting her return to the mother's care.

Recommendations

- 1) The Committee recommends all social workers receive and demonstrate a strong understanding of the safety assessment and safety planning process prior to the carrying of cases and the completion of Regional Core Training (RCT).⁵
- 2) The Committee recommends all CA social workers receive an annual refresher training regarding the completion of safety assessments and safety plans.

⁵ [Regional Core Training \(RCT\)](#) is the initial, intensive, task-oriented training that prepares newly hired Social Service Specialists to assume job responsibilities. RCT starts on the first day of employment and lasts for 60 days, or the first two months of employment. Competencies are used to assess learning needs and to identify a developmental plan for the new workers.



Child Fatality Review

T.H.

November 2004

Date of Child's Birth

November 21, 2013

Date of Child's Death

March 26, 2014

Child Fatality Review Date

Committee Members

Colleen Hinton, MSW, Ombuds, Office of the Family and Children Ombuds
Geneva Prigan, Indian Child Welfare (ICW), Child and Family Welfare Services
(CFWS), Spokane, DSHS, Children's Administration
Becky Twohy, CDP-DMHP, Central Washington Comprehensive Mental Health
Ronna Washines, Esq., Chief Prosecutor, Yakama Nation
Dale Wotring, LICSW, Director, Evergreen Counseling Services

Observer

Ernie Gowen, Permanency Administrator, Region 1 Yakima, DSHS, Children's
Administration

Facilitator

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

Executive Summary

On March 26, 2014, the Department of Social and Health Services (DSHS), Children's Administration (CA) convened a Child Fatality Review (CFR)⁶ to review the department's practice and service delivery to a nine-year-old female child and her family. The child will be referenced by her initials, T.H., in this report. At the time of her death attawai⁷ T.H. shared a home with her mother, her mother's boyfriend (M.S.), and her four siblings. T.H. is the second oldest of the five siblings. The incident initiating this review occurred on November 21, 2013 when T.H. and her family were involved in a single vehicle rollover accident. T.H. and a seven-year-old brother were ejected from the car and T.H. died at the scene. The brother was hospitalized for one day for minor injuries and was discharged. The mother is alleged to have been drinking and driving at the time of the accident.

At the time of the fatality, T.H.'s family resided near Dallesport on Yakama Nation tribal trust land in close proximity to the Yakama Nation reservation. T.H.'s mother is enrolled in the Warm Springs Tribe. T.H. and her father are both enrolled members of the Yakama Nation.

The review was conducted by a team of CA staff and community members with relevant expertise from diverse disciplines. With the exception of the representative from the Yakama Nation, none of the participating committee members had any 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 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.

⁶ 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.

⁷ Attawai is a word in the Yakama language that means the deceased one and is considered a sign of respect for the deceased person.

The Committee interviewed two CA social workers and a supervisor who were assigned to the case prior to the fatality. Following a review of the case file documents, completion of staff interviews, and discussion regarding department activities and decisions, the Committee made findings and recommendations presented at the end of this report.

Case Summary

CA received seven intakes from 2011 to 2013 regarding T.H.'s family prior to the fatality. Two of the intakes were investigated by Child Protective Services (CPS) and determined to be unfounded, two of the intakes were founded and three intakes did not have a finding as they were screened out⁸ or assigned to alternative response.^{9, 10} T.H.'s family first came to Children's Administration's (CA) attention on October 12, 2011 when an intake was received alleging unsafe living conditions, neglect, and chronic head lice. The family was offered and initially accepted Family Preservation Service (FPS) services. FPS services were ended after multiple unsuccessful attempts by the FPS provider to engage the mother. The CPS case was closed as unfounded on April 5, 2012.¹¹

⁸ CA will generally screen-out the following intakes: 1) Abuse of dependent adults or persons 18 years of age or older. Such services are provided by the Adult Protective Services (APS) section; 2) Third-party abuse committed by persons other than those responsible for the child's welfare; 3) 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; 6) And alleged violations of the school system's Statutory Code, Administrative Code, statements regarding discipline policies.

⁹ In 2012, CA intakes determined to involve low to moderate low risk were assigned as 10-day alternate response. An alternative response intervention connected families to services, concrete supports, and community resources. Where available, such intakes could be forwarded to an Early Family Support Service (EFSS) or other community agencies that were willing to accept the intake for services and/or monitoring. After October 20, 2013, legislative changes required CA to implement a differential response system designed as an alternative pathway for accepted reports of low to moderate risk of child maltreatment. This pathway, known as Family Assessment Response (FAR), provides a comprehensive assessment of child safety, risk of subsequent child abuse or neglect, family strengths and need. A family's involvement in the Family Assessment Response program is voluntary. [Source: [Family Assessment Response in Washington](#)]

¹⁰ In August 1982, the Yakama Nation and DSHS completed a memo of understanding (MOU) regarding the care and custody of Indian children, jurisdiction of child custody proceedings and ordering transfer of jurisdiction on a case-by-case basis. The MOU requires the department to conduct CPS investigations and services on Yakama Tribal Land. The MOU also states the Toppenish Community Service Office (CSO) of DSHS, by mutual acceptance, has the responsibility of investigating Child Protective complaints received on the Yakama Indian Reservation. Child Protective complaints involving Indian families will be handled in the following manner: "When complaints are received during regular working hours, they will be discussed as soon as possible with the contact person at Nak-Nu-We-Sha prior to the investigation of the complaints. The circumstances surrounding the complaint will be discussed, exchanging sufficient information so that Nak-Nu-We-Sha may determine the nature and depth of their involvement. In emergency situations occurring outside of working hours the CSO standby worker will contact the tribal standby number and will take whatever action the situation requires after consultation." (The CSO no longer conducts child abuse and neglect investigations. Children's Administration currently conducts all investigations into child abuse for DSHS.)

¹¹ Unfounded--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. [WAC 388-15-005](#).

On April 18, 2012, CA received an intake alleging T.H. had a bloody nose as a result of her mother slapping her in the face. The CPS investigation was completed with a founded¹² finding and a safety plan created.¹³ The case was closed on June 19, 2012 after the mother refused further services. On November 6, 2012, CA received an intake alleging the children were continuing to come to school dirty, without appropriate clothing, and with chronic head lice. The allegations were investigated and the case closed as unfounded on December 20, 2012. On April 11, 2013, CA received a telephone call alleging the children's odor was so significant that it overwhelmed the classroom. The allegations were determined to be founded. On April 25, 2013, the case was closed due to the mother's refusal of services. No further case activity took place prior to the fatality on November 21, 2013.

The incident initiating this review occurred on the evening of November 21, 2013 when T.H. and her family were involved in a single vehicle rollover accident. The mother was driving at the time of the accident. The mother has been charged with driving under the influence and manslaughter. The children observed the mother and M.S. (mother's boyfriend) drinking in the car prior to the accident. T.H. and a sibling were ejected from the car at the time of the accident and T.H. died at the scene.

Discussion

Committee members reviewed and discussed documented CA activities and decisions spanning the history of CA involvement with the family (2011-2013). The Committee utilized staff interviews to provide additional sources of information for consideration. Committee discussion focused on CA policy as it relates to case documentation, investigative standards, safety planning and shared planning meetings. Committee discussion also focused on CA activity as it relates to Yakama Nation tribal members and investigations on tribal land.

The Committee devoted a significant amount of time discussing the nature of the interactions between the social workers and the child's mother. The Committee learned through a review of case documentation and social worker interviews that the mother was not receptive to CA attempts at engagement. The Committee further learned through social worker interviews that it is not uncommon for individuals living in the same small community as the mother to not allow social workers access to their homes.

¹² Founded--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](#)

¹³ A Safety Plan is required for all children where there is a safety threat(s) indicated on the Safety Assessment. The Safety Plan is a written arrangement between a family and Children's Administration that identifies how safety threats to a child will be immediately controlled and managed. Note: When creating an In-Home Safety Plan the following criteria in the Safety Plan Analysis must be present: 1) There is at least one parent/caregiver or adult in the home. 2) The home is calm enough to allow safety providers to function in the home. 3) The adults in the home agree to cooperate with and allow an In-Home Safety Plan. 4) Sufficient, appropriate, reliable resources are available and willing to provide safety services/tasks.

The Committee believed the mother's resistance created a significant barrier to the process of gathering, assessing, and analyzing information.

Despite the challenges faced by the social workers, the Committee believed they missed opportunities to gather additional information. Specifically, the Committee noted T.H. had an older sibling who was not interviewed by the social workers. The Committee noted the social workers could have contacted this child at school. The Committee believed this sibling might have provided valuable information into the daily functioning of the home environment and this resource should have been utilized.

The Committee found documentation associated with the subject and victim interviews to be insufficient throughout the life of the case. The case record included very limited detail regarding the social workers' conversations with the mother and alleged child victims. The Committee learned through interviewing the social workers that the lack of documentation was partially due to the mother's open hostility towards the workers and the mother's refusal to cooperate during the investigative process. The Committee believed case documentation did not adequately reflect the mother's actions and social worker's attempts at subject interviews. The Committee also believed there was a general lack of detail regarding the victim interviews. Additionally, the Committee noted there was little documentation regarding the health and wellbeing of T.H.'s siblings. The Committee believed the investigations failed to globally assess the entire family and primarily focused on two of the five children living in the home.

The Committee noted the nature of the intakes was consistent in identifying neglect as a concern throughout 2011, 2012, and 2013, with the exception of the one intake that alleged physical abuse. The intakes primarily identified T.H. and one of her siblings as the alleged victims. The Committee noted two of the children were not school-aged and may have been less likely to be included in an intake due to their lack of visibility within the community.

The Committee noted T.H. died in an automobile accident that involved alcohol abuse. A review of the case file showed alcohol abuse was only listed as a concern in one previous intake and was not addressed during any of the CPS investigations. The Committee contemplated whether different investigative techniques/methods could have been used by the social workers to gain additional information about alcohol use in the home. The Committee believed the social workers needed to view the inside of the family home to help them assess for chemical dependency issues and the ongoing neglect concerns. The social workers reported they did not attempt to enter the family home due to the mother's resistance. The social workers assumed the mother would not allow them access to her home or answer specific questions about her household. The Committee believed the social workers should have made stronger attempts to gather the information they needed in order to assess the specific concerns reported in

each intake, for example by asking the family specific questions and requesting access to the home during each and every investigation regardless of the mother's resistance.

The Committee believed this case might have benefitted from the shared planning meeting process.¹⁴ The Committee believed Executive Order 12-04 supported the use of a Child Protection Team (CPT)¹⁵ staffing to assist the agency in case and safety planning due to the age of the youngest child chronicity and severity of the neglect and the resistance of the mother. The Committee also believes any shared planning meeting should have involved Yakama Tribal members as they might have provided additional insight or resources for engaging the family.

The Committee discussed the April 25, 2012 and May 3, 2012 safety plans. They noted the social worker completed the safety plans as a response to T.H.'s disclosure about her mother hitting her in the face and causing her nose to bleed. The Committee noted a safety plan may be completed if the social worker answers 'yes' to the Safety Plan Analysis guide questions. In this case, the Committee believed the social worker should not have answered 'yes' to the following three safety analysis questions:

- 1) The home is calm enough to allow safety providers to function in the home.
The Committee believed the social worker had not gathered sufficient information to determine if the home was calm.
- 2) The adults in the home agree to cooperate with and allow an in-home safety plan.
The Committee noted the mother denied the allegations and was openly hostile during prior CA intervention attempts. For this reason, the Committee believed the mother would not have been cooperative.
- 3) Sufficient, appropriate, reliable resources are available and willing to provide safe services and tasks.

¹⁴ Shared Planning Meeting--All staffings engage parents in the shared planning process to develop family specific case plans focused on identified safety threats and child specific permanency goals. Working in partnership with families, natural supports, and providers helps identify parents' strengths, threats to child safety, focus on everyday life events, and help parents build the skills necessary to support the safety and wellbeing of their children. The shared planning process integrates all CA staffings. [Source: [CA Practices and Procedures Guide 1710](#)]

¹⁵ The Department of Social and Health Services shall consult with a Multidisciplinary Community Protection Team, established pursuant to [RCW 74.14B.030](#) as follows: 1) In all child abuse or neglect investigation cases in which the assessment requires the Department of Social and Health Services to offer services, and a Family Team Decision-Making (FTDM) meeting will not or cannot be held, and the child's age is six years or younger; 2) In all child abuse and neglect cases where serious professional disagreement exists regarding a risk of serious harm to the child and where there is a dispute over whether out-of-home placement is appropriate; and additionally, the Department of Social and Health Services may consult with a Multidisciplinary Community Protection Team in any case where the Department of Social and Health Services believes such consultation may assist it in improving outcomes for a particular child. [Source: [Executive Order 12-04](#)]

The Committee noted the safety plan did not include outside resources, and the social worker had not identified any resources within the home to help monitor the safety plan.

The Safety Plan Analysis guide states, "If any [answers] are NO, remove child." The Committee discussed the requirement for the social worker to pursue out-of-home placement of a child. The Committee did not believe the facts available to the social worker would have met legal sufficiency in Yakama Tribal Court to remove the child from the parents. The Committee included a Yakama Nation prosecutor who would have presented this case in court if a dependency petition had been filed; however, it should also be noted that this case was not staffed by the social workers with the Yakama Tribal Prosecutor at any point prior to the fatality.

The Committee reviewed the safety plan. The Committee noted only the mother and social worker were listed as safety plan participants. The Committee believed the plan should have been more specific and included additional participants who would take action to help keep T.H. safe and help to prevent the identified safety threat from re-occurring. The safety threat identified by the social worker was, "Caregiver cannot or will not explain child's injuries and the explanation is not consistent with the facts."

Findings

- 1) The oldest sibling should have been interviewed by the assigned social workers as part of the investigation and the younger siblings' wellbeing assessed during each investigation.
- 2) The Committee found case documentation associated with the subject and victim interviews was insufficient to capture the sequence of events, case activity, or interaction between the interviewee and interviewer.
- 3) The Committee believed the April 25, 2012 and May 3, 2012 safety plans could not be successfully implemented due to the mother's documented history of failing to cooperate with the investigating social workers. CA policy allows for the creation of safety plans only when the adult caregivers are willing to allow safety providers to function in the family home. In this case, the Committee believed the mother had demonstrated a sufficient pattern of failing to cooperate with safety providers.
- 4) The Committee believed this case warranted a shared planning meeting in the form of a CPT/LICWAC meeting prior to case closure.
- 5) The Committee found the social workers did not request permission to meet with the mother inside the family home during each investigation. The social workers did not ask the parents clarifying questions during interviews. The Committee also found the social workers did not attempt to engage extended family members who might have provided support to this family. The Committee

believed the social workers did not gather sufficient information about the family to fully assess and plan for child safety.

Recommendations

- 1) The Committee recommends CA establish a lower Klickitat County CPT/LICWAC that meets a minimum of one time per month. The purpose of this CPT/LICWAC would be to provide a local staffing resource with knowledge of the local community and people.
- 2) The Committee recommends the Goldendale CA office work with the Yakama Nation to clarify agreements and protocols regarding investigations on Yakama Nation land.¹⁶

¹⁶ The 1982 MOU between DSHS and the Yakama Nation guides the practice of social workers on Yakama Tribal Land. The committee believed all social workers conducting investigations on Yakama Tribal Land should be familiar with the 1982 MOU and how it impacts practice.



Child Fatality Review

G.R-H.

November 2013

Date of Child's Birth

December 15, 2013

Date of Child's Death

January 30, 2014

Child Fatality Review Date

Committee Members

Colleen Hinton, MSW, Office of the Family and Children's Ombuds

Yolanda Duralde, MD, Medical Director of the Child Abuse Intervention Department at
Mary Bridge Children's Hospital and the Pierce County Child Advocacy Center

Amy Scanlon, MA, Social Worker Coordinator, Pierce County Child Advocacy Center

Hae-Man Song, Social Service Program Specialist 3, Pierce County Community
Connections

James Manley, PhD, Director, Pacific Psychology Services

Bonnie Basile, Detective, Bellevue Police Department

Karen Erickson, Supervisor, Family Voluntary Services, Department of Social and Health
Services, Children's Administration

Mireya Beltre, Family Voluntary Services Program Manager, Department of Social and
Health Services, Children's Administration

Observer

Paul Smith, Practice Consultant, Department of Social and Health Services, Children's
Administration

Facilitator

Libby Stewart, Critical Incident Review Specialist, Department of Social and Health
Services, Children's Administration

Executive Summary

On March 13, 2014, the Department of Social and Health Services (DSHS) Children's Administration (CA) convened a Child Fatality Review (CFR)¹⁷ to assess the department's practice and service delivery to a 29-day-old female and her biological family.¹⁸ The child will be referenced by her initials, G.R-H., in this report. At the time of her death, G.R-H. lived with her mother and two-year-old sibling. The incident initiating this review occurred on December 15, 2013 when G.R-H.'s mother woke to find her non-responsive. The mother and child had fallen asleep together on the couch.

The review committee included members selected from disciplines within the community with relevant expertise from diverse disciplines. Neither CA staff nor any other committee members had previous direct involvement with this family.

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

The Committee interviewed the previous Family Voluntary Services (FVS) worker, the FVS supervisor, two of the previous Child Protective Services workers (CPS) and those workers' supervisor. The current child welfare social worker for G.R-H.'s biological family was available for consultation and provided a brief update which was shared with the committee.

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

¹⁷ 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.

¹⁸ G.R-H.'s family members are not named in this report because they have not been charged in an accusatory instrument with committing a crime related to a report maintained by the department in its case and management information system.[Source: [RCW 74.13.500\(1\)\(a\)](#)]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

¹⁹: Intakes on Substance Abuse during Pregnancy - Intake Screening Decision: The intake worker will document a pregnant woman's alleged abuse of substance(s) (not medically prescribed by the woman's medical practitioner) in an intake as "Information Only." [Source: [CA Practice and Procedures Guide 2552](#)]

²⁰ Washington state law does not authorize Children's Administration (CA) to screen in intakes for a CPS response or initiate court action on an unborn child.[Source: [CA Practice Guide to Intake and Investigative Assessment](#)]

²¹ Unfounded--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. [WAC 388-15-005](#).

²² 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.[Source: [RCW 26.44.020\(14\)](#)]

[REDACTED]

[REDACTED]

[REDACTED]

²³ Homebuilders is an evidence-based, short term, intensive home-based service utilized to aid in placement prevention.

²⁴ 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.

²⁵ 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.

²⁶ Family Team Decision-Making meeting (FTDM) is a meeting that occurs whenever a placement decision needs to be made. Typical participants include the parents, the child (as appropriate), relatives, family friends, neighbors, caregivers, community stakeholders, service providers, and Children’s Administration social workers. The purpose of the meeting is to develop an appropriate course of action to keep the child safe by creating a detailed case plan.

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

²⁷ The Structured Decision Making[®] (SDM[®]) risk assessment is a household-based assessment. It estimates the likelihood that a child will experience abuse or neglect in a given household based on the characteristics of the caregivers and children living in that household. To accurately complete the SDM[®] risk assessment, it is critical to accurately identify the household being assessed.

²⁸ The social worker shall complete an investigative risk assessment on all investigations of child abuse and neglect upon completion of the investigation within 45 calendar days of Children's Administration

[REDACTED]

[REDACTED]

On November 18, 2013, an intake was received stating the mother gave birth to G.R-H. The child was placed in the Neonatal Intensive Care Unit due to neonatal abstinence syndrome (NAS).³¹ The intake reports the mother was engaged in [REDACTED] treatment for pain management, has an active CPS worker, and had a

receiving the intake. [[CA Practices and Procedure Guide 2520](#)] For reports of alleged abuse or neglect that are accepted for investigation by the department, the investigation shall be conducted within time frames established by the department in rule. In no case shall the investigation extend longer than ninety days from the date the report is received, unless the investigation is being conducted under a written protocol pursuant to [RCW 26.44.180](#) and a law enforcement agency or prosecuting attorney has determined that a longer investigation period is necessary. At the completion of the investigation, the department shall make a finding that the report of child abuse or neglect is founded or unfounded. [Source: [RCW 26.44.030](#)]

²⁹ Founded--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](#)

³⁰ CA will screen in a CPS Risk Only intake when information collected gives reasonable cause to believe that risk or safety factors exist that place the child at imminent risk of serious harm. [Source: [CA Practices and Procedures Guide 2220\(D\)](#)]

³¹ Neonatal abstinence syndrome (NAS) is a group of problems that occur in a newborn who was exposed to addictive illegal or prescription drugs while in the mother's womb. [Source: [PubMed Health](#)]

founded for abuse of an older child. The intake was assigned for a CPS investigation. The FVS worker saw the mother and newborn (G.R-H.) at the hospital on November 18, 2013.

On December 15, 2013, an intake was received from the King County Medical Examiner reporting the death of 29-day-old G.R-H. and suspected SUIDS³² as the cause of death. The report also alleged neglect of the older sibling. The mother reported she put her older child in a high chair around 11:00 p.m. At about 11:30 p.m. the mother reported she placed G.R-H. on her chest, facing up and they fell asleep. The mother woke around 4:00 a.m. and found G.R-H. non responsive. The two and a half-year-old child was still in the highchair. The mother called 911 for assistance. Law enforcement responded and conducted an investigation.

Committee Discussion

During the course of the review, committee members discussed critical decision points throughout the case, initial and ongoing assessment of safety and risk, utilization of assessment tools, service referrals for assessment purposes (UAs, mental health assessments) and shared decision making. The Committee discussed how CA's Safety Framework stresses the importance of gathering information regarding child safety and risk throughout the life of a case and the importance of verifying information received through collateral contacts to ensure a thorough assessment of child health and safety.

The Committee was impressed with the FVS worker and her ability to positively interact with the mother and build a trusting, child focused relationship. After interviewing the FVS worker the Committee also commended her for working hard to maintain regular health and safety visits even when the mother regularly moved. The locations included extremely remote and lengthy distance as well as a secured domestic violence residence which required prior authorization to enter. The worker also discussed that while her caseload count may not have been high, the destinations she needed to travel to were not local and travel time was extensive. The travel time negatively impacted her ability to conduct other case work duties.

During the course of the review process the Committee discussed the entire CPS history for the mother and children. The Committee believed the first

³² Sudden unexpected infant deaths are defined as deaths in infants less than 1 year of age that occur suddenly and unexpectedly, and whose cause of death are not immediately obvious prior to investigation. [Source: [Sudden Unexpected Infant Death and Sudden Infant Death Syndrome](#)]

investigation starting in August 2012 was not investigated thoroughly and the SDM^{®33} was not completed accurately. As the case progressed with additional

RCW 74.13.515

intakes, the Committee discussed the lack of services to assess and address concerns regarding the allegations of substance abuse and mental health issues of the mother. The Committee felt social workers repeatedly failed to acknowledge concern for possible substance abuse except for one documented case note by a worker who was not assigned to the case. The Committee was concerned about the lack of verification with the [REDACTED] pain clinic regarding the mother's reported use of [REDACTED] for treatment of chronic pain. The Committee expressed concern that historical information was not being reviewed and considered in the subsequent active CPS investigations.

There were discussions regarding the SDM[®] and Investigative Assessment tools. Specifically, there was concern regarding the lack of understanding of the definitions for the 17 safety threats embedded within the tool. A discussion occurred regarding the continuous need to refresh the workers' understanding and utilization of the assessment/investigative tools. The Committee questioned whether the tool is useful if there continues to be an ongoing need to refresh seasoned workers understanding of the tool.

The Committee was concerned at the low number of FVS workers for this specific office. It was identified by the FVS worker that before the child fatality the office had two FVS workers. The Committee was also concerned about supervision to the assigned FVS worker on this case. While committee members acknowledge turnover of staff is an ongoing issue, they were concerned by the two month period for which the FVS worker had to utilize supervision from another CPS supervisor within the office while a new supervisor was hired. The new FVS supervisor was hired a couple weeks before the fatality occurred. The Committee agreed that the current FVS supervisor was providing positive and strong support to the FVS worker. The case load count was provided to the committee. The FVS worker had 14 cases at the time of the fatality. The case count was not determined to be unreasonable by the Committee.

The Committee discussed how regular Multi-Disciplinary Team (MDT) staffings through the Child Advocacy Centers (CAC) are beneficial to investigations for CPS

³³ The Structured Decision Making Risk Assessment[®] (SDMRA) is a household-based assessment focused on the characteristics of the caregivers and children living in that household. By completing the SDMRA following the Safety Assessment, the worker obtains an objective appraisal of the risk to a child. The SDMRA informs when services may or must be offered. [Source: [CA Practices and Procedures Guide 2541](#)]

and law enforcement. This is not a process currently occurring in King County according to the social workers and supervisors interviewed. The size and population of King County was discussed and the challenge it would present for all the agencies to attend a regularly scheduled MDT staffing. However, as an accredited member of the National Children's Alliance, which King County's Children's Justice Center is, it is expected that case reviews should occur no less than once a month.³⁴

When discussing systems issues and investigations with law enforcement involving SUID/SIDS investigations numerous committee members recommended a urinalysis when the situation involves a parent co-sleeping/bed sharing with a current allegation of substance abuse. A majority of committee members expressed a desire for the King County MDT to discuss this recommendation as best case practice.

There was concern for what appeared to be a lack of engagement by the investigative social workers with the father of G.R-H.'s older sibling. There was not a strong effort to communicate with the father or his family prior to the case opening for voluntary services. The paternal grandmother called in two intakes and the father of the surviving child called in one intake. The lack of integrating identified risks from the Homebuilders report into a safety plan or case plan was also discussed.

Findings

1. During the first investigation the witnesses were not interviewed. The Investigative Assessment and Structured Decision Making Tools® were not accurately completed. The errors were not corrected at a supervisory review.
2. There were missed opportunities to offer voluntary services during the first investigation. A staffing with the Attorney General's Office regarding the filing of a dependency petition would have been appropriate upon the receipt of the Medical Consultant's report in August of 2013. The investigative process could be strengthened through the use of substance abuse and mental health evaluations.
3. The intake on December 18, 2012 should have screened in for CPS investigation.
4. The safety plan developed in May 2013 did not include plan participants in the process as required by policy.
5. The Committee was concerned about the lack of timely communication by the contracted Triple P provider to the assigned FVS worker.

³⁴ [National Children's Alliance Standards for Accredited Members Revised 2011](#)

6. The Committee believed best practice would have been to conduct a home visit immediately after G.R-H. was discharged home and to have made collateral contact with her pediatrician to monitor her care and safety.
7. The Committee wanted to commend the FVS worker for establishing a very positive and appropriate relationship with the mother which was acknowledged by the Committee to be a difficult task. The FVS worker impressed the Committee by her clear position of safety first as opposed to placing more value on a positive relationship with the mother.
8. There were good joint investigations with law enforcement starting in May 2013. The Committee was impressed by the use of a hair follicle test when the mother was tested for substance use/abuse and the fact that the FVS worker communicated concerns to providers supervisors associated with this case regarding timely documentation.

Recommendation

1. The Committee recommended re-instating the placement of chemical dependency professionals within the DSHS offices.



Child Fatality Review

S-I.H.

June 2008

Date of Child's Birth

December 30, 2013

Date of Child's Death

April 9, 2014

Child Fatality Review Date

Committee Members

Colleen Hinton, MSW, Office of the Family and Children's Ombuds

Cheryl Rich, Family Engagement Program Manager, Department of Social and Health Services Children's Administration

Maureen Sorenson, MSW, Guardian Ad Litem, Family Drug Court, Pierce County

Rick Kendig, M.Ed., Contracted Therapeutic Services Provider

Robert Welch, MSW, Metropolitan Development Council, Co-Occurring Services Therapist

Facilitator

Libby Stewart, Critical Incident Review Specialist, Department of Social and Health Services, Children's Administration

Executive Summary

On April 9, 2014, the Department of Social and Health Services (DSHS) Children's Administration (CA) convened a Child Fatality Review (CFR)³⁵ to assess the department's practice and service delivery to 5-year-old S-I.H. and his family.³⁶ At the time of his death, S-I.H. lived with his mother, siblings, and mother's boyfriend Tony Goodnow, Sr.³⁷ The incident initiating this review occurred on December 29, 2013, when S-I.H. sustained fatal injuries during a motor vehicle crash. S-I.H. was an unrestrained passenger in a vehicle driven by Tony Goodnow, Sr. who was allegedly under the influence of alcohol at the time. A month prior to the fatal incident CA had closed a child welfare services case following dismissal of dependencies on S-I.H. and his siblings in King County Juvenile Court.

The review Committee included members selected from disciplines within the community with relevant expertise from diverse disciplines, including mental health and chemical dependency, child advocacy, and public child welfare. No Committee member had previous direct involvement with the family or service providers.

Prior to the review, each Committee member received a case chronology, a summary of CA involvement with the family and un-redacted CA case documents (e.g., intakes, investigative assessments, investigative assessment tools and case notes). Supplemental sources of information and resource materials were available to the Committee at the time of the review. These included the current case files, relevant state laws, police reports, court documents, King County Family Treatment Court (KCFTC)³⁸ website material, and CA policies.

The Committee interviewed one of the previous CA Family Treatment Court (FTC) case workers and the current supervisor of CA FTC. The current child welfare social worker

³⁵ 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.

³⁶ S-I.H.'s family members are not named in this report because they have not been charged in an accusatory instrument with committing a crime related to a report maintained by the department in its case and management information system. [Source: [RCW 74.13.500\(1\)\(a\)](#)]

³⁷ Mr. Goodnow, Sr. is named due to his current criminal charges of Vehicular Homicide and Reckless Endangerment Domestic Violence.

³⁸ Family Treatment Court is an alternative to regular dependency court and is designed to improve the safety and well-being of children in the dependency system by providing parents access to drug and alcohol treatment, judicial monitoring of their sobriety and individualized services to support the entire family. [Source: [King County Family Treatment Court Program](#)]

for S-I.H.'s biological family was available for consultation had the Committee desired to speak with him.

Following a review of the case file documents, interviews with the CA staff and discussion regarding department activities and decisions, the Committee made findings and a recommendation which are detailed at the end of this report.

Family Case Summary

The family came to the attention of CA in March 2005 resulting in an alternate response with the Early Intervention Program through public health. Over the course of seven years, CA received nine additional intakes regarding allegations of neglect and physical abuse, with repeated reported concerns regarding illicit drug use by the mother and that the children were exposed to domestic violence in the home. Of the five CPS investigations occurring during that period, none resulted in a founded finding. Both CA services and community services (e.g., Early Family Support Services) were offered to the family but the mother failed to engage. Independent of the department, Family Court became involved in July 2009 and a CASA (Court Appointed Special Advocate) became involved. According to documentation obtained by CA, the CASA made numerous recommendations to the court, including that the mother engage in mental health treatment to address domestic violence issues, submit to random urinalyses (UA),³⁹ and complete a chemical dependency assessment.

In October 2011, CA initiated a CPS investigation following reports of young children being left alone. The assigned social worker concluded contact with the family on October 26, 2011. According to the investigative assessment completed on January 22, 2012, there was no evidence to support the allegations of negligent treatment. Five days later King County Sheriff Deputies went to the family residence based on information about a convicted felon having access to weapons. At the home, deputies observed the mother and an adult male in the home to be in possession of illicit drugs and the children were living in a neglectful environment. All adults in the home were arrested and S.-I.H. and his siblings were placed in protective custody. CA initiated dependency actions on the children who were placed in out-of-home care, eventually in relative care. The allegations of neglect by the mother were determined to be founded⁴⁰ and the case was transferred to Child and Family Welfare Services (CFWS).

³⁹ Urinalysis - The testing of urine for illegal drugs, alcohol or other controlled substances.

⁴⁰ CA findings are based on a preponderance of the evidence regarding allegations of child abuse or neglect as defined in [RCW 26.44.020](#), [WAC 388-15-009](#), and [WAC 388-15-011](#). 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 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. Inconclusive means that based on available information following an investigation, a decision cannot be made that more likely than not child abuse or

In May 2012, the mother subsequently was accepted into the King County Family Treatment Court (KCFTC), also known as drug court. While residing in the same sober living environment as Tony Goodnow, Sr., the mother became pregnant. In April 2013, S-I.H.'s biological father petitioned Juvenile Court for placement. A Family Team Decision-Making meeting (FTDM) was held and it was agreed by all parties (including S-I.H.'s father) that it would be in the best interests of all the children to be returned to the care of their mother.⁴¹ S-I.H. and his siblings were returned to their mother's care on May 17, 2013 with in-home services provided by Homebuilders.⁴²

At reunification the mother was living with Tony Goodnow, Sr. Mr. Goodnow was asked to complete a waiver⁴³ process due to his criminal history which included burglary, assault, drug paraphernalia, and indecent exposure. A safety plan was put in place which directed all contact between Tony Goodnow, Sr. and the children to be supervised by the children's mother. Mr. Goodnow was asked to do random UA testing but failed to comply. The mother gave birth to her fourth child, Tony Goodnow, Sr.'s child, in August 2013. The dependency matters involving S-I.H. and his siblings were dismissed and the case was closed on November 20, 2013.

On December 29, 2013, Tony Goodnow, Sr. was alleged to be driving under the influence of intoxicants. S-I.H. was in the vehicle as was one of his siblings. The sibling was restrained but S-I.H. was not. Tony Goodnow, Sr. lost control of the vehicle and the vehicle hit a tree. S-I.H. was ejected from the car and incurred fatal injuries.

Committee Discussion

While the Committee's primary focus was on the actions and decisions made by the department during the period of the child's dependency (January 2012-November 2013), the entire CA history of involvement with the family was reviewed and discussed.

The Committee spent considerable time reviewing Solution Based Casework (SBC),⁴⁴ the current practice mode of CA, as well as the CA Child Safety Framework,⁴⁵ and Sirta's

neglect did or did not occur. Inconclusive as a finding option was discontinued for any CPS investigation occurring on or subsequent to October 1, 2008.

⁴¹ Family Team Decision-Making meeting (FTDM) is a meeting that occurs whenever a placement decision needs to be made. Typical participants include the parents, the child (as appropriate), relatives, family friends, neighbors, caregivers, community stakeholders, service providers, and Children's Administration social workers. The purpose of the meeting is to develop an appropriate course of action to keep the child safe by creating a detailed case plan.

⁴² Homebuilders is a contracted intensive family preservation program through DSHS.

⁴³ As part of determining character, competence and suitability of prospective out-of-home caregivers and other individuals to have unsupervised access to children, Children's Administration (CA) is required to conduct background checks (including criminal history and Child Abuse and Neglect or CA/N history) pursuant to RCW 43.43, [RCW 74.15.030](#), [WAC 388-06](#) and [PL 109-248](#). [Source: [CA Operations Manual Section 5510](#)]

⁴⁴ SBC is the over-arching framework for the theory and practice for social workers within CA. The model seeks to: (1) prioritize partnership to ensure safety by building a consensus with the family and service providers around the primary safety and risk concerns, (2) locate the problem(s) within the everyday life of the family and identify the individual with the high risk behavior that led to maltreatment through an assessment, (3) help families identify

Law.⁴⁶ These discussions served to provide an essential framework for looking at key aspects of CA policy, practice, and service delivery to the family in an effort to evaluate the reasonableness of decisions made and the actions taken by CA at reunification and prior to the fatality.

To a limited degree, the Committee also reviewed non-CA agency aspects of service delivery to the family. This included discussing the differences, depending on the county involved, for Juvenile Court CASAs or Guardians ad Litem (GAL) to request a parent or care provider to provide an unobserved UA on the spot. While such considerations are generally outside the scope and purpose of the CFR, they served to generate discussion on inter-agency collaboration including that between CA and KCFTC partners. The Committee suggested that CA consider initiating discussions with the CASA/GAL programs regarding their willingness and ability to request on demand UAs of parents involved in dependency actions.

The Committee inquired as to workload issues or other systemic barriers to meeting CA policies and practice expectations. When interviewed, the CA FTC supervisor indicated to the Committee that his worker's cases are capped at 12 per social worker, but FTC cases are unique due to significant travel time related to where the families are living, where children are placed, and multiple staffings and court hearings that are required.

cycles of maltreatment and utilize relapse prevention techniques to prevent further maltreatment, (4) develop co-constructed plans with the family that target the primary area of safety and risk by sorting out information into family and individual level objectives, (5) develop tasks to achieve outcomes that are skill-based and not just measured by compliance, and (6) celebrate and document even the smallest success and progress made by the family, and note when improvements have not been made.

⁴⁵ The Child Safety Framework is the foundation for assessing child safety throughout the life of a case. It looks for present and impending safety threats.

⁴⁶ [SHB 1333](#), also known as Sirita's Law, was passed into law in 2007. It requires the department to identify any persons who may act as a caregiver for a child in addition to the parent with whom the child is being placed and determine whether such persons are in need of any services in order to ensure the safety of the child, regardless of whether such persons are a party to the dependency. The department may recommend to the court and the court may order that placement of the child in the parent's home be contingent on or delayed based on the need for such persons to be engaged in or complete services to ensure the safety of the child prior to placement. If services are recommended for the caregiver, and the caregiver fails to engage in or follow through with the recommended services, the department must promptly notify the court.

Findings

Pre-fatality CPS Investigations

- As evidenced in statements made in the investigative assessment by the CPS social worker conducting investigations of two intakes in late 2005, there appears to have been over reliance on another CPS involved family on the caseworker's caseload to report any concerns about S-I.H.'s family.⁴⁷ As a protective factor and safety monitoring source, the Committee found such reliance to be questionable.
- Based on statements found in the April 2011 investigative assessment, which was completed three days into the investigation, the Committee believed the worker blamed the alleged child victim for the injuries she sustained and failed to accurately assess all the injuries sustained by the child. The Committee also found a lack of collateral contacts resulted in insufficient information that compromised an accurate assessment of child safety and findings of the investigation.
- For the CPS investigation initiated in October 2011, the Committee found a lack of sufficient collateral contacts and no indication in the investigative assessment that the worker was familiar with the family's extensive referral history and pattern of similar allegations over time. The Committee found the investigative activities to be insufficient and lacked the information needed for the social worker to assess child safety. Case practice would have been significantly enhanced had these been strengthened, particularly in regards to the decision to close the case. The Committee questioned how the circumstances within the home could have changed so drastically in such a short period of time from the conclusion of the CPS investigation and the placement of the children in protective custody by the King County Sheriff's Department that resulted in dependency of the children.

Reunification Decisions (prior to fatality)

- As noted previously, the Committee believed case decisions would have been significantly enhanced had workers and supervisors conducted a more thorough review of documented CA history and case file information that identified ongoing parental deficiencies. From this perspective, the Committee was concerned that risks and child safety were not fully assessed as to the mother's partner, Tony Goodnow, Sr., prior to reunification. Had the workers known Tony Goodnow, Sr.'s history both as a child and as an adult, the department may have presented a

⁴⁷ The social worker shall complete an investigative risk assessment on all investigations of child abuse and neglect upon completion of the investigation within 60 calendar days of Children's Administration receiving the intake. [Source: [CA Practices and Procedure Guide 2520](#)] For reports of alleged abuse or neglect that are accepted for investigation by the department, the investigation shall be conducted within timeframes established by the department in rule. In no case shall the investigation extend longer than ninety days from the date the report is received, unless the investigation is being conducted under a written protocol pursuant to [RCW 26.44.180](#) and a law enforcement agency or prosecuting attorney has determined that a longer investigation period is necessary. At the completion of the investigation, the department shall make a finding that the report of child abuse or neglect is founded or unfounded. [Source: [RCW 26.44.030](#)]

more assertive argument in court with the support of the full FTC team to require compliance by Mr. Goodnow in services, such as UA testing.

- Although not documented in the report to the court, both the social worker and supervisor indicated to the Committee that the FTC team was, on more than one occasion, made aware of Tony Goodnow, Sr.'s failure to engage in requested random UAs. The Committee voiced concern about the lack of compliance given Mr. Goodnow's criminal history, history of substance abuse issues, lack of documented completion of chemical dependency treatment, cohabitation with a person who also struggled with sobriety, and the fact that he provided care for the children involved in a dependency action.
- With the understanding that most dependency cases are dismissed after six months of court supervision following a return home, the Committee felt this case would have warranted a request for extended court supervision and in-home services based on the lack of compliance with random UAs by Tony Goodnow, Sr., on the mother's continued use of prescribed narcotic pain medications (without required UA testing) following the birth of her fourth child, and concerns identified by in-home providers.
- The Committee identified working with a hospital at the time of a child's birth during an open dependency case as vital. Even if the baby being born is not be part of a legal dependency action as in this case, assessing the baby's health should have included discussions with hospital staff as to the newborn's health and requesting a UA for both mother and child soon after delivery.
- The Committee agreed it would have been appropriate for CA to persistently request a comprehensive psychological evaluation of the mother to assess the mother's capacity for safe parenting. This is based on the mother's documented lengthy history of aggression and mental health issues. The Committee believed that consideration for reunification necessitated the worker having a clear understanding of the mother's mental health issues and sharing such information with the CA FTC team members involved in the case. Case file documents regarding her mental health treatment during the dependency process were extremely limited. The Committee believed the worker should have attempted to obtain more detailed reports from the mother's mental health treatment provider as to the treatment plan, treatment goals, and how progress was being defined. When interviewed, the CA staff stated they did not believe there should have been more detailed information sought as the parent had a right to privacy and that privacy aided a more positive client practitioner relationship. While recognizing rights of privacy of the parent, the Committee felt the provider, who was contracted by CA, should have provided a more detailed written report and that the one session a month was questionable in assessing compliance and progress by the mother.

System Issue – Drug Court

- The Committee found the limited reliance on drug court related shared planning; at the expense of other resources such as CPT (Child Protection Team)⁴⁸ or SBC staffing, limited critical thinking regarding case planning for this family and resulted in a singular groupthink⁴⁹ mentality focused on the FTC team preferred positive and supportive outcomes. That is, drug court teams in general may be predisposed towards only a parent’s sobriety and fail to recognize a wider perspective that includes more global considerations regarding safe parenting that would balance support with accountability.

Recommendation

- The Committee recommends CA discuss the concern of groupthink and the possible pitfalls of such, with CA staff who participate on drug court teams across the state.

⁴⁸ Child Protection Teams provide confidential, multi-disciplinary consultation and recommendations to the department on cases where there will not be an FTDM, and there is a risk of serious or imminent harm to a young child and when there is dispute if an out-of-home placement is appropriate. [Source: [CA Practices and Procedures Guide 1740](#)]

⁴⁹ Groupthink is unquestioning conformity: conformity in thought and behavior among the members of a group, especially an unthinking acceptance of majority opinions [Source: Bing Dictionary]