Report to the Legislature

Quarterly Child Fatality Report

RCW 74.13.640

October – December 2014

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Executive Summary

This is the Quarterly Child Fatality Report for October through December 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 five (5) child fatalities and three (3) near-fatalities that occurred in the fourth quarter of 2014. Five (5) of the eight (8) cases were conducted as executive child fatality reviews. Three of the cases did not meet the statutory requirement for a review. However, after consultation with OFCO it was determined that these cases warranted an assessment by a review committee. All prior child fatality review reports can be found on the DSHS website: https://www.dshs.wa.gov/ca/publications/childrens-administration-child-fatality-reports

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

Region	Number of Reports
1	3
2	2
3	3
Total Fatalities and Near Fatalities Reviewed During 4th Quarter, 2014	8

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

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 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	9	2

Child Near-Fatality Reviews for Calendar Year 2014			
Year	Total Near Fatalities Reported to Date Requiring a Review	Completed Near-Fatality Reviews	Pending Near-Fatality Reviews
2014	8	5	3

Two (2) of the five (5) fatality reviews referenced in this Quarterly Child Fatality Report are subject to public disclosure and are posted on the DSHS website. https://www.dshs.wa.gov/ca/publications/childrens-administration-child-fatality-reports

Three of the child fatality reviews referenced in this report were conducted as internal reviews. These reviews were done in consultation with the Office of the Family and Childrens Ombuds and a representative from OFCO participated in the review. The children's deaths were determined not be caused by abuse or neglect, therefore, per RCW 74.13.500, are not subject to public disclosure and are not included in this report.

Near-fatality reports are not subject to public disclosure and are not posted on the public website or included in this report.

Notable Fourth Quarter Findings

Based on the data collected and analyzed from the five (5) fatalities and three (3) near-fatalities reviewed between October and December 2014, the following were notable findings:

- Seven (7) of the eight (8) cases referenced in this report were open at the time of the critical incident.
- Four (4) of the five (5) child fatalities documented in this report occurred with children five (5) months old or younger.
- Three (3) of the five (5) fatalities occurred in unsafe sleep environments.
- One (1) near-fatality occurred while the child was placed in a licensed foster home. The teenaged youth overdosed on prescription medication.
- One (1) near-fatality occurred with a five-year-old child who sustained serious head trauma inflicted by his mother's boyfriend.
- One (1) fatality was the result of a three-year-old who overdosed on his mother's methadone. Four days prior to his death, police officers responded to a report that the child and his mother were found in a parked car and it appeared the mother was smoking an illicit drug. Children's Administration received a report of this incident less than 24 hours before the child died.
- Seven (7) children were Caucasian, three (3) children listed as Caucasian were also of Hispanic ethnicity. One (1) child was Native American.
- Children's Administration received intake reports of abuse or neglect in seven (7) of the eight (8) child fatality and near-fatality cases prior to the death or near-fatal injury of the child. The one case that had no prior intakes to CPS involved a youth in foster care. The youth was dependent at the time of the near fatal incident. All of the other cases had between three (3) and nine (9) prior intakes before the critical incident.
- The number of fatalities meeting the statutory requirement for review dropped from 15 in 2013 to 11 in 2014.
- The number of near-fatalities meeting the statutory requirement for review dropped from 16 in 2013 to 8 in 2014.

- Due to the small sample of cases reviewed, no statistical analysis was conducted to determine relationships between variables.

Child Fatality Review

K.A.

February 2011
Date of Child's Birth

May 1, 2014
Date of Fatality

August 14, 2014
Child Fatality Review Date

Committee Members
Mary Meinig, MSW, Director, Office of the Family and Children's Ombuds
Dawn Cooper, MSW, Family Assessment Response (FAR) Project Manager, Children's Administration, Department of Social and Health Services
Jessica Sullivan, Sergeant, Special Assault Unit Supervisor, King County Sheriff's Department
Donna Borgford-Parnell, Children with Special Needs Program Manager, Department of Public Health Seattle/King County

Observers
Paul Smith, Critical Incident Review Program Manager and Practice Consultant, Children's Administration, Department of Social and Health Services
Carolyn Horlor, Planning and Continuous Improvement, Department of Social and Health Services
LaShonda Proby, Quality Assurance Program Specialist, Juvenile Justice and Rehabilitation Administration, Department of Social and Health Services
Lauren Brown, MSW, Supervisor, Children's Administration, Department of Social and Health Services

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

Executive Summary

On August 14, 2014 the Department of Social and Health Services (DSHS), Children's Administration (CA) convened a Child Fatality Review (CFR)[2] to assess the department's practice and service delivery to three-year-old K.A. and his family. K.A. will be referenced by his initials throughout this report.

The incident initiating this review occurred on May 1, 2014 when K.A. was brought to the emergency department by his mother. K.A. was pronounced deceased at the hospital. A medical examiner's report stated K.A.'s manner of death is certified undetermined and the cause of death is acute Methadone[3] and Alprazolam[4] intoxication. Renton Police Department investigated the circumstances surrounding the death of K.A. and the case is currently under review by the King County Prosecutor's Office. At the time of his death K.A. lived with his mother and her boyfriend. Children's Administration (CA) had an open Child Protective Services (CPS) investigation at the time of the fatality.

The Review Committee included members selected from diverse disciplines within the community with relevant expertise including a Public Health Nurse (PHN), a law enforcement sergeant specializing in child related crimes, a Family Assessment Response (FAR)[5] program manager and the Ombuds Office. A representative from the chemical dependency field was originally invited to be a member of the Committee but was sick and unable to participate. Neither CA staff nor any other Committee members had previous direct involvement with this family.

Prior to the review, each Committee member received a case chronology, a summary of CA involvement with the family and unredacted CA case documents (e.g., intakes, investigative assessments, case notes and a law enforcement

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

[3] Methadone is a very strong painkiller. It is also used to treat heroin addiction. [Source: MedlinePlus http://www.nlm.nih.gov/medlineplus/ency/article/002679.htm]

[4] Alprazolam is used to treat anxiety disorders and panic disorder (sudden, unexpected attacks of extreme fear and worry about these attacks). Alprazolam is in a class of medications called benzodiazepines. It works by decreasing abnormal excitement in the brain. [Source: Medline Plus http://www.nlm.nih.gov/medlineplus/druginfo/meds/a684001.html]

[5] Family Assessment Response: a Child Protective Services alternative to investigations of low to moderate risk screened-in reports of child maltreatment. [Source: http://www.dshs.wa.gov/ca/about/far.asp]

report). Supplemental sources of information and resource materials were available to the Committee at the time of the review. These included the current case files, medical examiner's reports, the father's CPS history as a child, material regarding medications referenced in the Medical Examiner's report, relevant state laws and CA policies.

During the course of this review, the Committee interviewed the initial CPS worker, subsequent CPS workers, a Child and Family Welfare Services worker (CFWS) and two CPS supervisors involved in this case. Following the review of the case 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.

Family Case Summary

This family came to the attention of CA on February 25, 2011, when an intake was received regarding the birth of K.A. The information reported did not allege abuse or neglect and therefore it did not meet the legal definitions for abuse or neglect. This referral was screened out. A second intake was received on February 28, 2011, alleging concerns of marijuana use by the father and the mother's refusal to disclose her chemical dependency history. The caller reported the mother fell asleep in a chair while holding K.A. and was counseled regarding the risks of co-sleeping while using medications. This intake was assigned for a CPS investigation.

The CPS worker met the family at the hospital and the family agreed to a Public Health Nurse (PHN) referral. Per CA case notes, the PHN was challenged at times to maintain communication with the family due to the parents not making themselves available or returning phone calls. The PHN provided positive remarks regarding the family to the CPS worker after she did make contact and interacted with the family. The CPS investigation resulted in an unfounded finding and closed on June 30, 2011.[6]

On February 15, 2013, CA received an intake alleging drug use by the mother and drug sales out of her home. The caller also reported that the mother's drug paraphernalia was within reach of K.A. The caller reported the paternal grandparents conducted a drug test on K.A.'s diaper and it was positive for heroin. This intake was assigned for a CPS investigation. The assigned CPS worker made contact that same day with K.A. and his mother at their home. The allegations were not substantiated at that time. However, due to workload issues

[6] 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

the CPS worker did not complete the investigation. Due to high caseload counts a CFWS worker was assigned to complete this investigation. A CFWS worker completed the investigation and the Investigative Assessment (IA).[7] Before the completion of that CPS investigation another intake was received on March 1, 2013. The allegations were reportedly documented in the February 15, 2013 intake and therefore the March 1st intake was not assigned for an investigation.

During the February 15, 2013 investigation the CFWS worker made three unannounced home visits and two phone calls in an attempt to meet and speak with the mother and K.A. in person. The mother would not make herself or K.A. available to the CFWS worker. The CFWS worker completed the IA as unfounded for the February 2013 intake.

On April 26, 2014, two law enforcement officers were dispatched to a call alleging that a passerby observed the mother smoking something off tinfoil while K.A. was in the backseat of the vehicle. The vehicle was parked on the side of the road with a male passenger in the front seat. When law enforcement arrived they found the mother and K.A. in the car. The responding officers did not find any drugs or drug paraphernalia in the car and were unable to re-contact the reporting party. The officers contacted the mother's boyfriend who came and took the mother and K.A. home. This report was mailed to CA intake and received on April 30, 2014. This intake was assigned for a CPS investigation on the same day it was received.

On May 1, 2014, the CPS worker arrived at K.A.'s home. She was met by law enforcement officers who were outside the residence. K.A. had been taken to an emergency department by his mother only hours before the CPS worker's arrival. K.A. was pronounced dead upon medical examination at the hospital. When K.A. arrived at the hospital, he had visible physical trauma. Law enforcement asked the CPS worker to not speak with the mother or others related to this case until further notice.

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

Committee Discussion

The Committee discussion focused on CA policy, practice and system responses in an effort to evaluate the reasonableness of decisions made and actions taken by the department. Discussions occurring as to the family involvement with non-CA agencies was considered outside the purpose and scope of the CFR but served to generate discussion on interagency collaboration as well as collateral resource gathering.

The Committee noted the department did not obtain collateral information in order to conduct a thorough CPS investigation. The Committee noted there were many opportunities for the assigned department staff to obtain and verify allegations if the department had conducted collateral contacts during investigations. The department staff did not seek out or request medical records, criminal history, court records or contact extended family members. The lack of collateral information was noted by the Committee to have negatively impacted the accurate completion of the Structured Decision Making® tool, which informs the department when services may or must be offered.[8]

On the day before the review the department received medical records from the investigating law enforcement agency. The medical records indicated K.A. had been evaluated and treated by a local hospital for ingesting Suboxone[9] on February 7, 2012. K.A. had also been treated on March 9, 2014 for a head injury which required sutures. Neither medical intervention was reported to either law enforcement or CPS.

Staff interviews informed the Committee there were many changes to this local office starting shortly before the department received referrals regarding K.A. and his family. There have been three Area Administrators, significant turnover of senior CPS staff and a Central Case Review which recommended practice improvements regarding child safety.

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[8] Actuarial risk assessment is a statistical procedure for estimating the probability that a critical event will occur at some future time. Structured Decision Making® (SDM®) uses factors associated with higher rates of abuse and neglect to identify families who are most likely to experience a future event of child abuse or neglect. SDM® supports Children's Administration staff in making decisions about the highest risk families who should receive intervention. [Source: http://www.dshs.wa.gov/ca/pubs/sdm.asp] 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]

[9] Subutex (buprenorphine hydrochloride) and Suboxone tablets (buprenorphine hydrochloride and naloxone hydrochloride) are approved for the treatment of opiate dependence. Subutex and Suboxone treat opiate addiction by preventing symptoms of withdrawal from heroin and other opiates. [Source: U.S. Food and Drug Administration http://www.fda.gov/drugs/drugsafety/postmarketdrugsafetyinformationforpatientsandproviders/ucm191520.htm]

The Committee was made aware, by all of the staff interviewed, of high staff turnover within the office during both the 2011 and 2013 investigations. The Committee was told of a decision by the office to utilize workers from other program units as well as other King County Children's Administration offices to help complete open CPS investigations as a means to close out the large number of open CPS investigations. However, the decision included utilizing staff who were not trained in CPS investigations to complete this work. While considering the staff turnover issue the Committee believed it was not an appropriate decision. The Committee also discussed concerns that a majority of the CPS workers had less than one year experience and were assigned high risk cases.[10] The office also struggled with a lack of experienced CPS supervisors to help mentor and guide the new CPS investigators.

Below are the findings and recommendations made as a result of the staff interviews and discussion regarding K.A. and his family's involvement with CA.

Findings

- The Committee found the department failed to conduct a home visit after K.A. was discharged home after his birth with his parents and before the investigation was closed. This was documented as a directive by the CPS worker's supervisor but it was not completed by staff.
- The department utilized the Public Health Nurse as the only collateral contact for the February 2011 investigation. The Committee found that collateral contacts were lacking in both the 2011 and 2013 investigations. The Committee agreed best case practice would have been to contact other sources such as extended family and mother's medical provider, obtain prenatal records, follow up with K.A.'s pediatrician to verify adequate post natal care and request a urinalysis from the mother to make sure the prescribed medications were the only ones being used by the mother. Collateral contacts are a way to verify if information contained in an intake and during an investigation are accurate.
- The Committee was concerned about the inaccuracies in the SDM® and whether the lack of risk identified through proper use of this instrument negatively influenced this as well as the next investigation and subsequently led to an early closure of the case. Neither SDM® was completed in a timely manner.[11]

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

[11] Complete the Structured Decision Making Risk Assessment® (SDMRA®) no longer than 60 days after the intake was received and following the Safety Assessment and prior to a determination to offer ongoing services or a case

- The Committee found the department did not conduct background checks on the alleged subjects of the intakes as well as others who lived in the home with the family. During the two investigations prior to K.A.'s fatality the department did not request any background checks. The Committee considered this a worker safety issue as well as leading to an inaccurate completion of the SDM® during the February 2013 investigation.
- The Committee found there was too long of a time lapse between the assignment of the February 2013 investigation and the completion by the CFWS worker three months later.
- During the February 2013 investigation, the department did not utilize the Guidelines for Reasonable Efforts to Locate Children and/or Parents (DSHS 02-607).

Recommendations

- Children's Administration should further evaluate providing, either through funding or donations, CPS investigators with mobile electronic equipment beyond what is currently available. Specifically, the Committee noted a tablet or related item could be used to take photographs, access DSHS programs such as FamLink, ACES and other available databases which would help workers utilize their time in the field in a more cost-effective manner and could aid in worker safety and investigations.
- Children's Administration should discuss the value of continued use of the SDM®. The Committee found that the SDMs® completed on both the February 2011 and February 2013 investigations were inaccurate and not completed in the recommended time frames. They were approved by the supervisor where they should be checked for accuracy. During the Committee discussion this was identified as a statewide issue and not specific to this particular office. The Committee questions the benefits that continued use of the SDM® provides.
- An administrative representative from the Kent office will speak with the law enforcement agency regarding the decision to mail the April 26, 2014 report rather than calling CA intake. The Committee believed the report should have been called in to intake rather than mailed. An administrative representative from the Kent office should also speak with the medical facility that did not report the February 7, 2012 incident involving K.A. accessing and ingesting methadone.

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transfer to another program area. Supervisors may extend the completion date of the SDMRA® with reason. [Source: CA, Practices and Procedures Guide 2541]

Child Fatality Review

M.E.

February 2013
Date of Child's Birth

July 1, 2014
Date of Fatality

November 20, 2014
Child Fatality Review Date

Committee Members
Mary Meinig, MSW, Director, Office of the Family and Children's Ombuds
Dawn Cooper, MSW, Family Assessment Response Program Manager, Children's Administration
Wally Stefan, Homicide Detective, Vancouver Police Department
DeDe Sieler, Behavioral Health Program Manager, Clark County Department of Community Services
Lisa Carpenter, LICSW and CMHS, Executive Director, Family Solutions
Erin Miller, Supervisor, Children's Administration

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

RCW 74.13.500

Executive Summary

On November 20, 2014, the Department of Social and Health Services (DSHS), Children's Administration (CA) convened a Child Fatality Review (CFR)[12] to assess the department's practice and service delivery to eight-month-old [redacted]. and his family. The child ([redacted] will be referenced by his initials throughout this report.

The incident initiating this review occurred on July 1, 2014 when [redacted].'s mother called 911 indicating her child was unresponsive. [redacted] was pronounced dead at his residence. [redacted]. lived with his mother and three-year-old sister. [redacted].'s father is in the military and stationed in California. The father had been staying at the residence until a few days before [redacted]'s death at which time he returned to his post in California.

Law enforcement notified DSHS of the fatality and a CPS investigator was assigned to the case. The CPS worker deferred investigation to the assigned law enforcement detectives. [redacted].'s three-year-old sibling was placed in protective custody. She had a brief stay in foster care before she was released to her father. [redacted]

As of the writing of this report, the cause and manner of [redacted].'s death is unknown to the department. The law enforcement investigation is completed and will be reviewed by the prosecuting attorney's office for consideration of criminal charges.

Children's Administration (CA) did not have an open Child Protective Services (CPS) investigation at the time of the fatality nor had any CPS case opened between the birth and death of [redacted]

The Review Committee included members selected from diverse disciplines within the community with relevant expertise including mental health, chemical

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

dependency, law enforcement, a Family Assessment Response (FAR)[13] program manager with expertise in CPS investigations, a CA supervisor who supervises all case types and the Ombuds Office. Neither CA staff nor any other Committee member 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, and case notes). Supplemental sources of information and resource materials were available to the Committee at the time of the review. These included the case file, medical examiner's report regarding the previous fatality in California, the law enforcement report regarding the current fatality, relevant state laws and CA policies.

During the course of this review, the Committee interviewed one CPS worker and CPS supervisor, a supervisor who oversaw Family Voluntary Services (FVS)[14] at the time of a referral to that service, a Child and Family Welfare Services worker (CFWS)[15] and CFWS supervisor, the CPS worker assigned to the fatality and the Area Administrator. There were two previously assigned staff (one CPS investigator and one CFWS worker) who no longer worked for the department and therefore were unavailable to be interviewed by the Committee. Following the review of the case 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.

Family Case Summary **RCW 74.13.500**

[redacted]

[13] Family Assessment Response is a Child Protective Services alternative to investigations of low to moderate risk screened-in reports of child maltreatment. [Source: http://www.dshs.wa.gov/ca/about/far.asp]
[14] 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: CA Practice and Procedure Guide Section 2441]
[15] CFWS social worker--Child and Family Welfare Services social worker assumes responsibility of a child welfare case after a dependency petition has been filed regarding a child(ren).

[16] 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. [Source: WAC 388-15-005]
[17] Negligent Treatment or Maltreatment means an act or omission that evidences a serious disregard of consequences of such magnitude as to constitute a clear and present danger to the child's health, welfare,

[redacted] On July 1, 2014, five-month-old M.E. died while at home with his mother and three-year-old sister.

Committee Discussion

The Committee discussion focused on CA policy, practice, and system responses in an effort to evaluate the reasonableness of decisions made and actions taken by the department. Discussions occurring as to the family involvement with non-CA agencies was considered outside the purpose and scope of the CFR but served to generate discussion on inter-agency collaboration as well as collateral resource gathering. **RCW 74.13.500**

The Committee heard staff discuss challenges they faced while they were involved with this family. One major challenge was the lack of cooperation by San Diego County Child Protective Services in California regarding the request for records [redacted] A history check with Oregon Department of Human Services was conducted which resulted in no history found. The office also struggled with maintaining adequate staffing levels for CPS during this time.

The Committee heard from the Area Administrator. She informed the Committee there had been a strong emphasis placed on closing out cases where no safety threat currently existed due to a high number of open cases in their dependency court. This information was shared in part due to the concern regarding dismissing a case right before a new baby is born into the family. The Area Administrator also stated she has been able to stabilize her CPS work force and

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and safety. The fact that siblings share a bedroom is not, in and of itself, "negligent treatment or maltreatment." [Source: RCW 26.44.020; CA Case Services Policy Manual Appendix A: Definitions]

this has added to consistent, adequate, and timely CPS investigations. During the time of this case the county split from one office into two different offices. The two offices remain in the same building and are not divided by area or zip code.

The Committee noted the department missed opportunities to obtain collateral information and to conduct a thorough CPS investigation which led to incident focused investigations.[18]The lack of requested collateral information was noted by the Committee to have negatively impacted the accurate completion of the Structured Decision Making® tool, which informs the department when services may or must be offered, as well as provide a clear understanding regarding the fathers' needs for supportive or educational services.[19] The Committee discussed at length the lack of information gathered regarding the fathers.

The mother asked for supportive services regarding her alcoholism and mental instability. The Committee believes the mother's alcoholism was not viewed as significantly as it should have been. The mother was referred for a chemical dependency assessment as part of the plan to transfer her case to voluntary services but before this was completed the case was closed and sent to an alternate community intervention without communication with the mother. When the decision was made to file a dependency petition, the mother admitted to the CPS worker at court that she had relapsed. The CPS worker is unsure if he informed the court worker and ultimately the court of the mother's continued abuse of alcohol thus raising the risk of a two-year-old child in her care.

The Committee discussed that the assigned CPS worker did not adequately provide the mother with services to address her mental health needs. The mother completed a GAIN-SS on December 14, 2012, which by its results indicated a need to refer the mother to a Crisis Line or Designated Mental Health Professional (DMHP) because the mother indicated yes to the question [redacted]

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

[19] Actuarial risk assessment is a statistical procedure for estimating the probability that a critical event will occur at some future time. Structured Decision Making® (SDM®) uses factors associated with higher rates of abuse and neglect to identify families who are most likely to experience a future event of child abuse or neglect. SDM® supports Children's Administration staff in making decisions about the highest risk families who should receive intervention. [Source: http://www.dshs.wa.gov/ca/pubs/sdm.asp] The Structured Decision Making Risk Assessment® (SDMRA®) is a household-based assessment focused on the characteristics of the caregivers and children living in that household. By completing the SDMRA® following the Safety Assessment, the worker obtains an objective appraisal of the risk to a child. The SDMRA® informs when services may or must be offered. [Source: CA Practices and Procedures Guide Section 2541]

[redacted]"[20] After the mother completed this document she was later given a telephone number to call to access mental health services. The Committee noted best case practice would have been to call a crisis line or DMHP immediately after the mother completed the document.

The CFWS worker who had the case when the mother missed her UA and provided diluted UAs no longer works for CA. However, the supervisor stated during her interview with the Committee that the worker failed to provide accurate information regarding the UAs to the supervisor when they staffed the case. In fact, the CFWS worker provided all positive information during her monthly supervisory reviews. The supervisor stated, had she been given the correct information, she would have directed the worker to utilize a Child Protection Team (CPT) before considering dismissal of the case.[21]

The Committee understood that the fatality investigation was not as urgent based on the fact that there were no other children remaining in the mother's custody. However, the Committee believes the CPS worker should have requested more information from the detectives to aid in her investigation before it was closed. The Committee felt strongly that a new referral alleging child abuse and/or neglect should have been made based on the CPS worker's knowledge of the mother changing her account of the fatality as well as knowing that law enforcement found alcohol in the apartment. While understanding that a finding of founded for child abuse or neglect does not keep a child safe, an adequate and complete investigation regarding a child's fatality can be beneficial if there were to be any future allegations of abuse or neglect. **RCW74.13.500**

Below are the findings and recommendations made as a result of the staff interviews and discussion regarding [redacted]. and his family's involvement with CA.

Findings

- The Committee found that collateral contacts were lacking throughout this case. The mother referenced court requirements for one of the fathers when speaking with the assigned social worker. However, no further follow up questions or records request followed. Both fathers were enlisted in the military and therefore, military social work staff could have

[20] Tool used to screen parent, guardians or legal custodians and youth, age 13 and over to identify need for further chemical dependency, mental health or co-occurring assessment by a community professional and make appropriate referrals. [Source: http://ca.dshs.wa.gov/intranet/policy/gain-ss.asp]

[21] Child Protection Teams provide confidential, multi-disciplinary consultation and recommendations to the department on cases where there will not be a Family Team Decision-Making Meeting, 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 Section 1740]

been contacted. In an intake it was alleged that the mother had been hospitalized due to suicidal expressions and had been drinking for twenty-four hours. The caller reported when the mother was discharged it was recommended to begin therapy, medication management, and support groups. Records regarding this information could have been requested to assist in assessing the mother's current treatment needs. Despite having information about the mother's past issues and the fact that one of the children had special needs, the social worker did not document the child's needs and if or how that was impacted by the mother's actions, addiction, and mental health. There was consensus that the investigations and case in general, lacked a thorough social summary and was incident focused. The social summary would allow for a more comprehensive assessment of the needs for the children as well as what services and supports for all parents would have been appropriate for the family to stabilize.

- The Committee believed the third intake from December 2012 met screening criteria and should have resulted in a CPS investigation.
- The Committee was concerned about the inaccuracies in the completed SDM® risk assessment and whether the failure to complete it correctly negatively impacted services being offered during the first investigation. The fathers were not included in the completion of the SDM® risk assessment.[22]
- A shared planning meeting should have occurred prior to dismissal.[23] The Committee believes best case practice would have been to hold a Family Team Decision Making meeting prior to the attempted transfer to FVS in 2012 and prior to the filing of the dependency petition.[24]
- The safety plan was not completed correctly. It included a service and did not clearly address the safety of the children in the home. There were not adequate supports included in the plan. **RCW 74.13.500**
- The second assigned CFWS worker failed to conduct twice monthly health and safety visits with [redacted]'s sister seven out of the eight months the case was assigned to her.[25]

Recommendations

- Children's Administration should discuss the value of continued utilization of the SDM®. During the Committee discussion, this issue was identified as

[22] Source: http://ca.dshs.wa.gov/intranet/pdf/practicemodel/SDMRiskManual.pdf
[23] Source: RCW 13.34.145
[24] Family Team Decision Making meetings (FTDM) bring people together who are involved with the family to make critical decisions regarding the removal of child(ren) from their home, changes in out-of-home placement, and reunification or placement into a permanent home. [Source: CA Practices and Procedures Guide 1720 Purpose Statement]
[25] Source: CA Practices and Procedures Guide 4420A

statewide and not specific to the local office. The Committee questions the benefit that continued use of the SDM® provides. If Children's Administration continues use of the SDM®, the Committee strongly suggested ongoing refresher trainings for all CPS staff. After the review was completed the Area Administrator informed this writer that the office recently held training for all CPS workers on the SDM® because she was aware of the challenges of accurate completion of this tool.

- Children's Administration should have regular, ongoing safety assessment training for all staff.
- The local office should reassess their practice of not reassigning CPS intakes to the previously assigned social worker. The Committee believes it can be positive for a worker to have the personal history of a family when assessing a new intake but acknowledged that the practice must be balanced with keeping an open mind during each investigation. The Committee discussed the pitfalls of reassigning a case to the previous worker as the investigator may not recognize safety threats and risk when becoming too familiar with a family. It is the hope of the Committee that the assigned supervisor can provide objective oversight to make sure an appropriate assessment is completed.
- The Committee believes that staff statewide would benefit from ongoing training regarding alcohol abuse. The Committee expressed concern that some CA staff may have a bias regarding alcohol abuse and lethality.