Children's Administration

Executive Child Fatality Review

Autumn Franks Case

October 2, 2008

Committee Members
Michelle Terry, MD, Medical Consultant Region 5
Kevin Crane, Detective, Bremerton Police Department
Bolesha Johnson, Area Administrator, Division of Children and Family Services (DCFS) Region 4
Kui Hug, CFWS/CHET/Adoption Support Program Manager Supervisor, DCFS Region 6
Michelle Punzel, BSN, RN, Tacoma Pierce County Health Department

Observers
Mary Meinig, Office of the Family and Children's Ombudsman (OFCO)
Paul Smith, Critical Incident Program manager, Children's Administration (CA)
Lynette Young, MSW intern, Division of Children and Family Services Region 5

Facilitator
Bob Palmer, Child Fatality Program Manager, CA Region 5

Table of Contents

Executive Summary

In October 2008, the Children's Administration (CA) convened an Executive Child Fatality Review[1] committee to review the practice and service delivery in the case involving three year old A.F. and her family.

The incident initiating this review occurred on April 30, 2008, when a hospital social worker from Mary Bridge Children's Hospital (MBCH) notified Child Protective Services (CPS) of the impending death of a young child from suspicious injuries. The referrer told CPS the child had been transported to MBCH by ambulance after the girlfriend of the child's biological father was not able to revive A.F. after allegedly being knocked off a couch by a dog. The attending physicians did not believe the story being presented by the girlfriend[2] and the report was accepted for CPS investigation. An initial CT scan showed two skull fractures (including an older skull fracture) with swelling and bleeding in the brain. There were no other broken bones or bruising an older sibling living in the home, was placed into protective custody and was also examined. No injuries were found upon full examination of Later that evening A.F. died after emergent brain surgery. Cause of death was determined to be from blunt force trauma, and manner of death was declared a homicide. Although criminal charges had not been made at the time of the Executive Child Fatality Review or at the time of this report, the CPS investigation resulted in a finding of founded for child maltreatment.

A review of the family's history with Children's Administration notes three previous referrals referencing A.F. and her brother. There were two information only referrals (2005, 2007) involving the biological mother. The biological mother was not a caretaker at the time of the fatality in 2008. A referral was made to CPS on March 18, 2008, alleging physical abuse to A.F. by the biological father's partner L.B. (inconclusive finding). The CPS investigation was still in progress when the child suffered non-accidental trauma which resulted in death.

Committee members included a diverse group of individuals representing the community and Children's Administration (CA). Efforts to secure participation by state legislators on

[1] Given its limited purpose, a Child Fatality Review by Children's Administration should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. A review is generally limited to documents in the possession of or obtained by DSHS or its contracted service providers and the panel may be precluded from receiving some documents that may be relevant to the issues in a case because of federal or state confidentiality laws and regulations. A review panel has no subpoena power or authority to compel attendance and generally will only hear from DSHS employees and service providers. The panel may 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 take personnel action or recommend such action against DSHS employees or other individuals.

[2] Identification of the girlfriend will be by initials only (L.B.) as she has not been charged in connection to the incident as of this report. She is variously referenced in records as "stepmother" and "mother" but should not be confused with the biological mother A.N.

the review panel were not successful. None of the review committee members had any involvement in the A.F. case. Team members were provided case documents consisting of the following: all referrals to CPS involving the family, CPS investigator notes from the pre-fatality abuse investigation and the fatality investigation, medical information (pre-fatality and post-fatality), the initial law enforcement report, and the Pierce County Medical Examiner determination of the cause and manner of death. Additionally, committee members interviewed the CPS social worker who had been investigating the pre-fatality allegations of physical abuse. The worker's supervisor and area administrator were available for interview had the panel desired, but were not called to appear.

Following review of the documents, the case history, and interview of the CPS worker, the review committee made findings and recommendations which are detailed at the end of this report.

Case Overview

Child Protective Services (CPS) history for this family began with a March 18, 2005 referral reporting concerns that biological mother may have slammed a door on who was nearly three years old at the time. The alleged incident did not involve the now deceased child A.F. The referent had no direct knowledge of any actual injury to the child, but had overheard the incident over the phone. The referent indicated that she would be contacting law enforcement for a child welfare check request. No confirmation was made by CPS intake as to whether a child welfare request was made. This referral was taken for information only purposes.

Two years later CPS received information that concerned possible drug use by then primary caretaker . (biological mother) and non-custodial father C.F. It was reported that was allowing her children, ages 2 and 5, to go to their father's home on weekends even though had stated that the father used drugs. According to the referent, the mother admitted to smoking marijuana. The biological mother had also mentioned that her oldest child had been touched by the father's girlfriend on the bottom and "front parts." The referent did not know what was meant by "front parts." Subsequent clarification of this alleged incident was provided by a relative in 2008 who stated that the situation involved hygienic intervention. The report in April 2007 was taken as information only.

On March 18, 2008, a relative reported to CPS intake that three year old A.F. had bruises on her spine and mid-buttock area. The child reportedly stated that "mommy did it" which the referent indicated "mommy" referenced the biological father's girlfriend L.B. It was unclear as to when the bruises were first noticed, but information gathered subsequent to the referral suggests that the alleged injuries may have occurred as much as five days prior to the report to CPS. The report was accepted for investigation and law enforcement was notified the same day.

Prior to conducting an unannounced home visit the assigned CPS worker contacted a Lakewood Police Department (LPD) detective to ask his availability should the CPS investigator go to the home of the biological father and his girlfriend and find the allegations to be accurate. The CPS social worker re-contacted the detective after visiting the home to say that the detective's services would not be needed as only faint bruising was observed on the child.

The home visit by the CPS investigator occurred within 72 hours of the non-emergent referral being accepted for investigation. The "stepmother" L.B. allowed the CPS worker to view the child's back, front, legs, and arms. The CPS worker observed that A.F. had "one very faint and hardly visible bruise smaller than a dime at the base of her back." The child appeared to be a well-nourished healthy child. The social worker documented his observations of the interactions between A.F. and the "step mom" which appeared positive. When interviewed by committee members, the CPS worker recalled that the child was wary of his presence, reluctant to talk, and sought the comfort of the "stepmother." The CPS worker also stated when interviewed that his plan was to find another time when he could attempt to interview the child outside the presence of the father's girlfriend.

The CPS social worker interviewed the alleged subject L.B. who indicated that she did not know how A.F. had become bruised. She stated her discipline did not include spanking. L.B. provided the CPS worker with name of the primary care physician for the child. While at the home the social worker spoke by phone with the father who was at work. He stated that discipline in the home did not currently include spanking. The father also stated that the children's biological mother had called after her last visitation and said the kids had bumps all over. He and his girlfriend L.B. had checked the children and did not see anything. Also during the home visit by the CPS worker the paternal grandmother arrived to the home. She indicated that she saw the children regularly and she had no concerns in regard to their care.

Three days after the initial home visit and face-to-face contact with the alleged victim, a friend of the paternal grandmother contacted the CPS investigator. She stated that she had observed the alleged bruises, indicating having seen three to four bruises just above the butt cheeks and a four inch long narrow bruise on the child's back. The father's partner L.B. had told grandmother's friend that A.F. had fallen while at a local McDonald's restaurant. The caller also indicated that the child had stated that the father's girlfriend ("mommy") did spank. The friend indicated that she had taken photos of the bruises and that she would send them to the CPS worker. The worker never received the pictures which were eventually obtained post-fatality.

On March 26, 2008, the CPS social worker received a telephone call from the biological mother who said that she had also seen the bruises on her daughter's back, describing the same bruises that the paternal grandmother's friend had described to the CPS worker. The mother indicated that the child vacillated when asked about the "stepmother" and the bruises.

On April 23, 2008, the CPS worker spoke with the "stepmother" seeking to find out what school the oldest child was attending and whether or not A.F. was in any day care. When interviewed by committee members the CPS worker indicated his intent was to conduct follow-up interviews with the alleged victim and the older sibling. An interview with the sibling did occur on April 23, 2008, at the boy's school in the presence of the school principal. The child gave permission for the interview to be recorded stated during the interview that everything was fine at home and that he and sister did not get in trouble at home. There were no disclosures of child maltreatment. The social worker checked the boy's arms and legs and torso for bruises and found no marks or bruises. When asked about his sister ever getting hurt or having marks on her back stated that his sister had gotten tangled up with the leash of a dog while at the home where his mother lived. When asked by the CPS worker the school principal indicated the school had no concerns about

Five days later the CPS investigator contacted L.B. to discuss the alleged incident at McDonald's whereby A.F. had reportedly gotten hurt. L.B. stated that a week prior to the March referral to CPS that A.F. had been pushed down a slide by another child resulting in marks on her back. The social worker informed L.B. that he intended to do another home visit later in the week. Two days later CPS received information that A.F. had been brought to MBCH with suspicious injuries and was not expected to survive.

Upon receiving notification that A.F. had been admitted to the hospital with serious injuries from suspected non-accidental trauma, CPS initiated an investigation in conjunction with local law enforcement. Extensive medical examination had revealed old and new skull fractures. The older sibling was placed into protective custody by law enforcement and was interviewed at the Tacoma Child Advocacy Center (CAC). When interviewed the boy stated that his sister had been throwing up for several days. He stated that he recently had been in trouble at school and his father had spanked him, indicating he had bruises and his "bones hurt." A medical examination was conducted at the CAC and no injuries were found and he was found to be in good health. A dependency petition was initiated and juvenile court ordered the child to remain in out-of-home placement.

A specialized CPS worker out-stationed at the CAC conducted the investigation of the fatality. While the earlier allegation regarding bruises on A.F.'s back was found to be inconclusive, the investigation of the fatality incident resulted in a determination that more likely than not A.F. had been physically abused by L.B. which led to the child's death. Furthermore, a finding of founded for abuse was made on both L.B. and the father given evidence of a prior skull fracture. Given the medical opinion that the child had suffered the earlier injury which would have been severe enough for both L.B. and the child's father to have noticed and sought medical intervention, a finding of founded was made for negligent treatment/maltreatment on both caregivers. It is unknown whether the subjects of the allegations have sought to overturn the CPS findings.

At the time of the Executive Child Fatality Review and of this report, criminal charges had not yet been filed against either L.B. or the father C.F. The surviving sibling remains in out-of-home care in relative placement.

Findings and Recommendations

The committee made the following findings and recommendations based on interviews, review of the case records including obtained medical documents, department policy and procedures, Child Sexual and Physical Abuse Investigation Protocols for Pierce County Washington, Revised Code of Washington (RCW), and Washington Administrative Code (WAC).

Findings

CPS Intake:

- The report to CPS in March 2005 should have been screened in for investigation rather than taken as information only. Additionally the intake worker should have contacted law enforcement to confirm whether the referent had indeed requested a child welfare check. These noted intake issues were found to have no direct impact upon the child fatality that occurred three years later as the allegation in 2005 involved the biological mother who was not the caretaker of the deceased child at time of the fatality incident.

- The decision at intake to screen-out the report made to CPS in 2007 was found to be reasonable. The referral was not passed onto law enforcement as it was taken for information only. However, because there was a vague reference to possible inappropriate touching of a child by a non-related adult, a minority view among committee members was that consideration could have been made by CPS intake to send the screened out report to law enforcement even if not accepted for investigation by CPS. This issue was determined to have no direct impact upon the child fatality that occurred three years later.

- The physical abuse allegation reported to CPS intake on March 18, 2008, was accepted for investigation and designated for non-emergent field response rather than emergent[3]. The committee was unable to reach full consensus as to which response time was most reasonable given the information provided at the time of the intake and given the lack of clarity as to when the bruises first appeared. Although it appears that the alleged victim may have already returned to her father from visitation with her biological mother, the intake worker might have encouraged the referent (relative) to speak to the non-custodial parent (biological mother) about taking the alleged victim for a medical exam.

[3] An intake designated for emergent response requires a worker to conduct initial face-to-face contact with any alleged victim within 24 hours from the time of the referral. This was implemented by CA in April 2005. An intake designated for non-emergent response requires a worker to conduct initial face-to-face contact with any alleged victim within 72 hours from the time of the referral. This practice was implemented by CA in August 2005.

CPS Investigative Activities (pre-fatality):

- While recognizing the fact that the investigation was still in process when the child fatality occurred, the interviews of the caretakers as conducted and documented by the CPS worker appear to be deficient. The only contact with the biological father was a brief phone contact occurring while conducting the initial home visit (father was at work). After the initial interview of the father's partner (L.B.) at the home, the worker received additional information that would suggest a need to re-interview her. There is some indication in the case record that the CPS worker had intended to re-interview the girlfriend but that plan was interrupted when the child fatality incident occurred. There was also minimal contact with the biological mother. While the mother was a non-custodial parent at the time, there were indications in the case documentation that suggest she could have been a source of more specific information regarding suspected non-accidental injuries to A.F.

- Subsequent to the initial contacts with the alleged victim and the family, there was a 30 day period without any significant investigative follow-up activity by the CPS worker. This included a delay in interviewing the sibling and re-interviewing the alleged subject of the allegations. The worker's ability to meet best practice expectations appear to have been compromised by his case load at the time.

- The CPS worker might have considered giving the family information on available community services such as the local Family Support Center and/or making a referral for Public Health Nursing services.

- The CPS worker did conduct an informal criminal court history check on the child's caretakers (biological father and his girlfriend). Although it was later determined that neither caretaker had any significant criminal history, the worker might have considered checking with local law enforcement for a more in depth local criminal history check earlier in the case.

- The CPS worker should have put forth a more assertive effort to get photographs of bruises on A.F. that had reportedly been taken. It is noted that the person who initially offered the photos to the CPS worker stated in a post-fatality e-mail to the CPS worker that she had decided not to send the photos fearing the children would be taken away and placed with strangers. On March 21, 2008, when the CPS investigator saw the child, there was no significant bruising observed. The photographs obtained post-fatality, which had been taken on March 14, 2008, did show observable bruising.

- After considering the family history, interviewing the pre-fatality CPS worker, and reviewing all available documents the committee reached consensus that the subsequent death by abuse did not appear to be predictable in any obvious way. However, the issue of preventability of the outcome does allow for conjecture and

rests on not having obtained the photos from mid-March 2008. Had the worker seen the photographs, it is possible that the caretakers would have been asked by the CPS worker to have A. F. examined. It is unknown as to whether such a medical examination by the child's PCP or other professional would have led to a recommendation for full body radiographs which then may have identified an old skull fracture.

Workload:

- As noted, the ability of the CPS worker to meet both basic and best practice expectations appeared to be compromised by his case load. The worker was experienced and typically was assigned the most serious physical abuse and sexual abuse cases through his out-stationed position at the local Child Advocacy Center[4]. Due to unit vacancies, social workers attending CA Academy Training (and unable to be assigned cases), and the number of referrals needing to be assigned for investigation, the worker was getting as many as four assigned cases a week, some of which would have normally gone to regular (non-CAC) CPS workers in the unit had workers been available. Thus while working numerous exceptionally serious child maltreatment cases which required intensive investigative activities, the worker was also assigned more routine cases such as this case. At the time of assignment it was the ninth case assigned to him that month, with three more assigned by the end of March. Total number of active cases being worked by the CPS investigator was 26 at the end of March. Additionally, the worker received 11 new investigative assignments in April 2008, ending the month with 30 total active cases.

Recommendations

Intake:

- CA should continue efforts to standardize intake decisions across the state to promote better consistency. The development of an intake "decision tree" as part of FamLink, the new CA data management system which is due for implementation in December 2008, should improve consistency. However, within the first six months post implementation of FamLink, CA should conduct a review of intakes to evaluate if the implementation of the intake "decision tree" improved consistency across the state.
- It is recommended that CA consider adding at intake the task of asking referents who report physical abuse of a child as to the existence of any known photographs of marks, bruises, or injuries.

[4] CAC refers to the Children's Advocacy Center of Pierce County, a child-friendly facility in Tacoma, made up of representatives from law enforcement, prosecution, CPS, medical, mental health, advocacy, and other disciplines within Pierce County. The team's primary goal is to coordinate efforts to offer a comprehensive and collaborative approach to the investigation, prosecution, and treatment of child victims of alleged sexual and severe physical abuse.

- While the FamLink system includes a chronically referred family indicator[5] for intake, consideration should be made by CA to establish specific criteria for additional intake review when a family has multiple "information only" but not multiple accepted referrals. This recommendation does not derive specifically from elements of this case, but from a general discussion occurring among the committee members during the fatality review regarding "red flags" for child maltreatment for which a pattern of report history is an important consideration.

Training/Practice:

- CA should consider developing a basic checklist guideline ("cheat sheet") that would be available to all CPS investigators in the state. This would include listing both what is required by law, policy and best practice for conducting CPS investigations. It would include noting such activities as contacting the child's doctor, seeking child medical records, seeking any photographs that may be available, consideration for consultation with the Child Abuse Medical Consultant, and other practice guidelines. Such a one-page tool could serve as a task-reminder to workers in the field as well as serve as a supervisory review tool. It is recognized that such efforts have been made previously by individual CA offices across the state as well as by CA program staff, and it is strongly recommended that this be revisited.
- CA should continue the current practice of conducting state-wide "Lessons Learned" presentations that address issues surfacing during Child Fatality Reviews. This includes continuing to present issues relating to non-biologically related caretakers and social worker bias.

Workload

- CA social worker caseloads need to be reduced in order for workers to meet current basic practice expectations. CA should consider putting a cap on the number of cases a CPS investigator can be assigned per month and can have active at any point. This should be in the range of no more than 2-3 new investigative assignments per week, 8-10 new cases per month, and no more than 18 at any given time for a CPS caseload. It is understood that smaller CA offices across the state most often have social workers with mixed case loads (CPS, FVS, adoption). It is further understood that meeting such recommendation would be contingent upon exceptional budgetary considerations that would need to be approved by the state legislature.
- The documentation requirements for social workers, which currently involves time consuming "desk time" by social workers while inputting case notes into the CA data management and information system, could be lessened by making

[5] The Chronically Referred Person Indicator will be incorporated into the new CA data management web-based system called FamLink due to go on-line in December 2008. An indicator will automatically be triggered when a participant in a case meets any of the following criteria: (1) three accepted CPS referrals in the prior year; (2) four accepted CPS referrals in the prior two years; (3) five accepted CPS referrals in the prior three years; (4) two or more founded allegations in the past two to six CPS referrals.

available dictation devices, transcription services, and subsequent entry into the CA data base by support/clerical staff. CA should continue to seek improvement and/or new technology that may help support less time consuming data processing by case carrying social workers.

Access to law enforcement and court data bases

- CA should continue pursuing measures to give workers simple ready access to the numerous information management systems used by various law enforcement and court jurisdictions.
- Although RCW 26.44.030[6] authorizes law enforcement and CPS to exchange information on cases being investigated for child maltreatment, there is a need for clarity regarding any limits to what information can be provided and if such information can be provided "informally" by law enforcement without violation of rights of privacy or other rights of protection under the law. This would include whether information such as criminal histories of members of a household (including arrests that did not involved convictions) or prior child welfare checks on a residence can be provided routinely to CPS informally by law enforcement officers. It is recognized that some law enforcement jurisdictions may require formal requests while others may provide such information informally on a routine basis and may be doing so at risk of violation of rights of privacy. CA, in conjunction with the Attorney General's Office should review this issue, and if deemed necessary, pursue changes in the current RCW that would clarify authority and limits of authority.

[6] Section 12 of RCW 26.44.030 states that "In investigating and responding to allegations of child abuse and neglect, the department may conduct background checks as authorized by state and federal law."