Washington State Department of Social & Health Services

Transforming lives

CA Children's Administration

Child Fatality Review
A.H.

RCW 74.13.5 **2014**
Date of Child's Birth

September 12, 2016
Date of Child's Death

December 13, 2016
Date of the Fatality Review

Committee Members
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Annabelle Payne, Director, Pend Oreille County Mental Health Services
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Table of Contents

Executive Summary

On December 13, 2016, the Department of Social and Health Services (DSHS), Children's Administration (CA) convened a Child Fatality Review (CFR)[1] to assess the department's practice and service delivery to 2-year-old A.H. and RCW 74. family[2]. The child will be referenced by the initials A.H. in this report. The family had recently received Family Assessment Response (FAR)[3] services which closed on September 1, 2016. On September 13, 2016, CA was notified by the Spokane County Sheriff's Office of A.H.'s death that occurred a day earlier on September 12, 2016. The Spokane County Medical Examiner determined the cause and manner of death to be a homicide due to blunt force trauma to the abdomen. A.H.'s mother reported to authorities that she left A.H. and her other three children in the care of live-in boyfriend Jason Obermiller[4] who had extensive criminal history for assault and domestic violence.

The review Committee included members selected from diverse disciplines within the community with relevant expertise including the Office of the Family and Children's Ombuds, a mental health treatment provider, a FAR program manager, a CPS supervisor with CA, a Regional Administrator with the Alliance for Child Welfare Excellence and a Department of Corrections supervisor. 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 and case notes). Supplemental sources of information and resource materials were available to the Committee at the time of the review. These included medical reports, relevant state laws and CA policies.

During the course of this review the Committee interviewed the Child and Family Welfare Services (CFWS) worker and the FAR supervisors. The FAR workers who had previously been assigned were not available to be interviewed as one had left employment with the

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[1] Given its limited purpose, a Child Fatality Review (CFR) should not be construed to be a final or comprehensive review of all of the circumstances surrounding the 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 fatal injury. Nor is it the function or purpose of a Child Fatality Review to recommend personnel action against DSHS employees or other individuals.

[2] 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: 74.13.500(1)(a)]

[3] Family Assessment Response (FAR) is a Child Protective Services (CPS) alternative response to an investigation of a screened-in allegation of child abuse or neglect. FAR focuses on child safety along with the integrity and preservation of the family when lower risk allegations of child maltreatment have been reported. [Source: CA Practices and Procedures Guild 2332. Family Assessment Response]

[4] The full name of Jason Obermiller is used in this report because he was charged with committing a crime related to this report of abuse investigated by DSHS. *See* RCW 74.13.500(1)(a).

Department and the other was obligated to participate in another case meeting. Following the review of the case file documents, completion of interviews and discussion regarding department activities and decision, the Committee identified areas for practice improvement and made one related recommendation. The recommendation is at the end of this report.

Family Case Summary

From 2009 through 2013, which is prior to A.H.'s birth in RCW 74.13. 2014, CA received six intakes, four of which resulted in CPS investigations. These early intakes included allegations of RCW 13.50.100 , and concerns regarding RCW 13.50.100 , RCW 13.50.100, RCW 13.50.100, and RCW 13.50.100 of the mother and/or her partners. In December 2013, CA received an intake reporting RCW 13.50.100 in the home. A.H.'s father (who is also father to one older sibling) was in the home against previous Department recommendations due to his RCW 13.50.100, RCW 13.50.100 and history of RCW 13.50.100 The children were RCW 13.50.100 .

Upon A.H.'s birth in RCW 74.13. 2014, CA decided against removing him because the other children were RCW 13.50.100 . A.H.'s mother and father had made progress in services, RCW 13.50.100 . The RCW 13.50.100 on A.H.'s siblings were RCW 13.50.100 , although CA documentation shows continued concerns with the mother's lack of insight regarding the impact her intimate relationships have on her and her children.

Between May 20, 2015 and July 7, 2016, CA received five intake reports, three of which screened in for the FAR pathway and two that screened out. The allegations included RCW 13.50.100 , domestic violence, RCW 13.50.100, RCW 13.50.100, RCW 13.50.100, and the mother's continual contact and relationships with criminally involved and/or dangerous persons. The children's fathers had not been providing care for them, nor did they have contact with the children.

CA received a report on July 17, 2015, that A.H.'s father was RCW 13.50.100 as he was attempting to RCW 13.50.100 with the mother. A.H.'s mother responded by calling law enforcement. The FAR workers did not find sufficient evidence supporting the allegations to warrant further Department intervention or placement of the children. The FAR worker did not observe anyone residing in the home besides the mother and the children during the FAR

[5] RCW 13.50.100

intervention. The FAR case closed on September 1, 2016, with the children remaining in the care and supervision of their mother. Soon after the FAR case closed, the mother allowed Jason Obermiller and two other adults (one with gang affiliation and criminal records) to move into the family home.

On September 13, 2016, CA received an intake from the Spokane County Sheriff's office alleging that A.H. had died while in the care of Jason Obermiller. Several other adults were reported to be in the home at the time of the child's death. Upon examination, there were bruises to A.H.'s head, abdomen, all of [redacted] extremities and throughout the body. The Medical Examiner determined the child's death to be a homicide caused by blunt force trauma to the abdomen. The surviving siblings were [redacted].

A search of the home by law enforcement revealed a [redacted] in the mother's bedroom. A.H's mother was founded[7] for negligent treatment or maltreatment of A.H. The mother was incarcerated in Spokane County [redacted]. Jason Obermiller was arrested and incarcerated and charged with 2nd degree murder.

Discussion

The Committee briefly discussed the 2009-2014 public child welfare involvement with the family that occurred prior to A.H.'s birth. For some Committee members, such a historical accounting helped to provide a necessary background for understanding patterns of chronic neglect (e.g., failure to protect). In the process of evaluating these early CA intervention efforts, as well as subsequent ones, some generalized discussion occurred regarding chronic neglect, consistent environmental chaos and dysfunction, and persistent multiple risk factors (*e.g.*, domestic violence, criminal issues, mental health, unsafe caregivers, drug and alcohol issues, and poverty). The Committee found the staff interviews helpful in understanding how CA assesses the impact of chronic neglect on the safety and well-being of children.

[6] RCW 26.44.050: A law enforcement officer may take, or cause to be taken, a child into custody without a court order if there is probable cause to believe that the child is abused or neglected and that the child would be injured or could not be taken into custody if it were necessary to first obtain a court order pursuant to RCW 13.34.050.

[7] CA findings are based on a preponderance of the evidence. Child Abuse or Neglect is defined in RCW 26.44, WAC 388-15-009, and WAC 388-15-011. Findings are determined when the investigation is complete. Founded means the determination that, following an investigation by CPS, based on available information: it is more likely than not that child abuse or neglect did occur. Unfounded means the determination that, following an investigation by CPS, based on available information: it is more likely 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. CPS findings in Washington State follow a preponderance of evidence standard rather than "clear and convincing evidence" or "reasonable doubt" standards of proof. In this way "Founded means the determination following an investigation by the department that, based on available information, it is more likely than not that child abuse or neglect did occur." [See: RCW 26.44.020(9)] Findings are determined when the investigation is complete and are based on a preponderance of the evidence standard. **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. **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. [Source: RCW 26.44.020]

The Committee specifically discussed CA's involvement occurring shortly after A.H. was born in [redacted] 2014. This included exploring the reasons CA did not file a dependency petition on newborn A.H. [redacted]. CA and Alliance[8] staff provided clarification regarding placement decisions for newborns [redacted]. This included consideration of the status of the [redacted], the current functioning and progress of the parents with services, and assessment of active safety issues in the home that may be managed with a safety plan. In this case, [redacted]. Some Committee members expressed concern that the CFWS worker may not have fully assessed or articulated safety threats or issues to the court but understood the challenges of communicating the difference between progress and compliance. The Committee noted that one service goal during the CFWS assignment (mother's ability to acknowledge or have insight to the impact her relationships have had on her children) was not achieved [redacted]. The Committee was unconvinced that, at the time of [redacted], the mother truly understood her role in protecting her children from unsafe persons or situations —especially unstable relationships with partners with violence histories.

Committee discussions centered on the written and verbal accounts regarding the FAR case activities and decisions from May 2015 through early September 2016. The Committee considered information about early implementation of FAR and subsequent changes to this program (e.g., screening policies). Under current policy[9] any screened in report within 12 months of a closed dependency will be screened into the CPS investigative pathway rather than the CPS FAR pathway. The Committee noted the intake supervisor's decision to override the intake worker's initial screen out decision on March 16, 2016[10] and assign for FAR intervention.

Of particular interest to the Committee was the quality of inquiry, seeking collateral contacts for information, and corroboration of information. The Committee noted instances of good practice such as documenting the children's general appearance, contacting school staff, and obtaining medical records related to the children. However, there were missed opportunities for collateral contacts such as: relatives, the mother's medical provider, intake referents, past persons in the home, and law enforcement. These untapped sources of information may have provided a rationale for further safety analysis and intervention. In particular, the Committee felt that the September 2016 FAR response could have evidenced more substantive curiosity about others living or frequenting the home. The lack of documentation that the workers

[8] The Alliance for Child Welfare Excellence is a program through the University of Washington, in partnership with DSHS, to provide regular training to CA staff. The Alliance provides the Regional Core Training (RCT) that all new CA case carrying employees must complete before they can be assigned cases.

[9] Screen in for CPS Investigation when a dependency action involving the child victim or household was closed within the previous 12 months [CA Practices and Procedures Guide 2200 1. iii. A. III. Ii]

[10] An "intake" is a report received by Children's Administration in which a person or persons have reasonable cause to believe or suspect that a child has been abused or neglected. A decision to screen out an intake is based on the absence of allegations of child abuse or neglect as defined by Washington Administrative Code (WAC) 388-15-009.

utilized FAMLINK[11] to assess all persons identified as having recently resided in the home or been in caretaking roles for the children was concerning. The Committee believed that a FAMLINK or MODIS[12] and criminal history search on such persons is essential in assessment of household functioning and child safety.

Furthermore, the Committee discussed whether the workers had a clear understanding of the mother's physical health and mental health and their impact on her ability to make safe decisions for her children. While the worker obtained information from a RCW 13.50.100 provider, the Committee believed a deeper inquiry could have been beneficial in developing an intensive aftercare planning (e.g., wrap around services) with available community resources. The Committee however did not reach consensus as to specific findings or recommendations around this issue. The Committee recognized that the July 2016 FAR worker obtained the mother's medical and health records, and discussed whether utilizing the CA Medical Consultant network[13] would have been helpful in assessing family and child safety. The Committee noted limitations for a formal CA medical consult relating to adult records, which would require a signed consent form.

Given indications that the FAR worker may have believed CPS referrals were made in retaliation against the mother, the Committee discussed the possibility of confirmatory bias[14] by the worker. Such bias may have resulted in the failure to recognize the mother's regression to previous patterns of behavior, lack of insight and inability to protect her children from harm, as well as an incomplete assessment of the household, parental functioning and child safety.

Consideration was given to the possibility that the historical pattern of failing to protect on the part of the mother could have been more fully assessed and applied to the safety assessment[15] for both the CFWS and FAR interventions. While the committee discussed concepts of immediate harm versus ongoing risk[16] to the children it did not reach a full consensus as to whether or not there was an identifiable safety threat[17] during either the CFWS or FAR cases.

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[11] FamLink is the case management information system that Children's Administration implemented on February 1, 2009, and it replaced CAMIS, which was the case management system CA had used since the early 1990s.

[12] MODIS is CA's digital case archiving system. Closed files are stored in this system so that workers are able to view the case history on their computers

[13] 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.

[14] The tendency to search for, interpret, focus on and remember information in a way that confirms one's preconceptions.

[15] Safety Assessment is used throughout the life of the case to identify impending danger and determine whether a child is safe or unsafe. It is based on comprehensive information gathered about the family at the time the safety assessment is completed. A Safety Assessment is completed at key decision points in a case to identify impending danger and to inform and implement safety plans with families to control or manage those threats. Source: [Source: CA Practices and Procedures Guide] https://www.dshs.wa.gov/ca/practices-and-procedures-guide/1100-child-safety

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

[17] A threat of danger is a specific family situation or behavior, emotion, motive, perception or capacity of a family member that threatens child safety. The danger threshold is the point at which family functioning and associated caregiver performance becomes perilous enough to be perceived as a threat or produce a threat to child safety. The Safety threshold determines

Findings

Based on a review of the case documents and interviews with staff, the Committee did not find any critical errors made by Department staff directly linked to child's death. However, the Committee identified missed opportunities for global assessment of the parental functioning and household function that might have provided CA information for a more thorough safety assessment. The Committee believed that the FAR responses met the minimum requirements but did not fully address the mother's current RCW 13.50.100 functioning in conjunction with the historical patterns of her lack of insight and allowing dangerous persons or situations around her children. The Committee identified the following areas of practice that could have been improved during CA's intervention on this case:

- Verification that progress with Family Preservation Services[18] (FPS) goals during the CFWS case plan were documented and assessed, specifically related to the goals around the mother's ability to protect her children. The case was dismissed with an uncorrected parental deficiency related to the mother's inability to protect and lack of acknowledgement of the impact her relationships have had on her children. There was no documented progress with the FPS provider on that specific goal during the dependency.
- The Committee felt that the 2015 and 2016 FAR responses were incident-focused and that there was a lack of curiosity and assessment about who frequented the home and the pattern of multiple/varying roommates or persons living in the home (chronic issues for this family). The FAR responses were limited in relation to seeking information about the mother's current mental health, current physical health, loss of employment, use of available child care resources and not fully incorporating historical CA involvement into the current assessments.

Recommendations

In response to concerns that the 2015-2016 contacts were overly incident-focused at times, CA should develop or enhance currently available training for social workers and supervisors statewide on global assessment of families involved with CA. This training should emphasize and focus on the following:

- Assessing other adults in the home, interviewing clients and verifying statements, obtaining consultation or interpretation of records (specifically medical, mental health and chemical dependency) and how to incorporate and analyze historical CA records into current assessments.

impending danger. Safety threats are essentially risk influences that are active at a heighten degree and greater level of intensity. Safety threats are risk influences that have crossed a threshold in terms of controllability that has implications for dangerousness. Therefore, the safety threshold includes only those family conditions that are judged to be out of a caregiver's control. Retrieved from: http://www.dshs.wa.gov/pdf/ca/SafetyThresholdHandout.pdf

[18] FPS is an Intensive home-based intervention for children at imminent risk of placement or who are in placement where services can manage threats in the family home. The expected outcome is centered around the increased ability of the parent's to safely care for their children as well as connecting the families to community resources.

- Use of clinical supervision at the 30-day case review[19] to identify and address gaps in information gathering and assessment, assess for bias, and include development of case plan and the social workers next steps.

[19] CA policy requires that social work supervisors conduct monthly supervisory case reviews with each assigned social worker and document each case review in the client's electronic case file. [CA Practices and Procedures Guide 46100 Monthly Supervisory Case Reviews]