Washington State Department of Social & Health Services
CA Children's Administration

Child Fatality Review

J.C.

RCW 74.13.5[redacted] **2010**
Date of Child's Birth

December 22, 2017
Date of Child's Death

April 26, 2018
Date of the Fatality Review

Committee Members
Elizabeth Bokan, Office of the Family & Children's Ombuds
Amy Person, M.D., Health Officer, Benton-Franklin Health District
Ryan Kelly, Sargent, Kennewick Police Department
Dennis Knox, Supervisor, Developmental Disabilities Administration
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Executive Summary

On April 26, 2018, the Department of Social and Health Services (DSHS) Children's Administration (CA), convened a Child Fatality Review (CFR)[1] to assess CA's practice and service delivery to seven-year-old J.C. and [redacted] family.[2] The incident initiating this review occurred on December 22, 2017 when J.C.'s mother reportedly found J.C. in bed and not breathing around 8:00 a.m. J.C.'s mother called 911 and the local Sheriff's office responded and arrived around 8:36 a.m. J.C. was found deceased. J.C. had medically complex issues including diagnoses of [redacted] and [redacted]. [redacted] required a [redacted] and [redacted]. Additionally, [redacted] was [redacted] had [redacted], [redacted], and [redacted]. At the time of [redacted] death, J.C. was residing with [redacted] mother and her paramour, who was not in the home at the time of the child's death.

The CFR Committee included members selected from diverse disciplines within the community with relevant expertise including the Office of the Family and Children's Ombuds, a Developmental Disabilities Administration (DDA) supervisor, a health district director and pediatric medical doctor, a detective sergeant, a CA quality assurance CPS program manager and an area administrator with CA. Neither CA staff nor any other Committee members had previous direct involvement with this family.

Prior to the review, each Committee member received a family genogram, a case chronology, a summary of CA involvement with the family and the 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 chose to interview the CA investigators and supervisor assigned to the case from May 2017 through December 22, 2017, believing that the activities and investigations previously assigned to different investigators were not necessary for the Committee to

[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 death of the 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] The parents are not identified by name in this report as no criminal charges were filed relating to the incident. The names of J.C.'s sibling are subject to privacy law. [Source: RCW 74.13.500(1)(a)].

review. The Committee noted that CA's work prior to May 2017 seemed sufficient, noting the complexity of the child's medical issues and acknowledging CA's efforts to include multiple providers and medical personnel in decision making. Following the review of the case file documents, completion of interviews and discussion regarding department activities and decisions, the Committee discussed possible areas for practice improvement. The Committee identified findings and recommendations related to CA practice as noted at the end of this report.

Family Case Summary

Prior to J.C.'s death, CA received eleven intake[3] reports regarding this family between 2011 and April 2017. CA investigated allegations regarding RCW 13.50.100 by the mother RCW 13.50.100, nutritional-related issues concerning the mother improperly feeding and/or caring for J.C., the mother's RCW 13.50.100, the mother's lack of following medical recommendations for J.C. and the father being unresponsive to the child's medical needs. In 2015, J.C.'s father voluntarily placed RCW 74.13 into the care of a DDA services placement facility as J.C.'s mother had been arrested in Idaho and J.C.'s father could not provide the necessary care for J.C. On January 16, 2017, CA received an intake concerning J.C.'s mother because she was requesting J.C. be placed back into her care and there were concerns related to her ability to provide the necessary medical care for RCW 74.13.5 Between January and April 3, 2017, CA offered intensive services and case monitoring while communicating regularly with multiple medical, state and local providers that were working with the family to assess the mother and her partner's capacity to safely care for J.C. On April 3, 2017, CA closed an investigation related to allegations of RCW 13.50.100 because no safety threats[4] were identified after the social worker visited the home and spoke with the child's medical providers and professional in-home providers.

On May 4, 2017, CA received an intake report that the family was moving to a rural location in a county outside of the RCW 74.13.515 area. The intake concerns were that J.C. might not have the medical resources and in-home care available to RCW 74.13 as this new location has limited medical and community resources that J.C. might need. A CA investigator responded and met with the family in the RCW 74.13.515 area, observed J.C. and received information on the family's new address across the

[3] An "intake" is a report received by CA 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 WAC 388-15-009.

[4] 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. [Source: CA Practices and Procedures Guide Chapter 1120. Safety Assessment]

state. The case was reassigned in the RCW 74.13.515 area. The case was closed on June 21, 2017, after an in person contact was made with the family and collateral contacts were made with DDA and medical providers. On August 22, 2017 and August 28, 2017, CA received additional reports concerning J.C.'s needs and alleged lack of resources and care. An investigator was assigned and initial contacts with the family were made. The investigators who made contact with the family reported J.C. to be clean and appearing well cared for. The family then moved to a very rural and off-the-grid location in a different county in October 2017 without CA's knowledge. Limited case activity occurred on the case from September through early December 2017.

On December 22, 2017, a relative notified CA of the child's death and surrounding circumstances. The deputy that responded to the mother's 911 call said the temperature was 23 degrees outside and felt approximately 32 to 35 degrees inside the residence. The deputy reported the home had no power or running water. The mother reported to law enforcement and the county coroner that she moved to the RCW 74.13.515 County residence three months ago to get away from CPS because "they were hounding" her. J.C.'s cause and manner of death was not determined at the time of the review; however, the coroner had ruled out hypothermia.

Committee Discussion

The Committee heard from the assigned CA supervisor that case staffings occurred during both the May and August 2017 investigations. CA staff also stated they communicated with CA program managers, the CA area administrator, law enforcement and medical providers throughout the assigned 2017 investigations. The Committee noted that there were no documented Family Team Decision Making meetings (FTDM),[5] Shared Planning meetings, consultations with the Assistant Attorney General (AAG) and limited clinical supervisory case staffings from May through early December 2017. The Committee considered the importance of prompt and early case consultation and shared decision making when dealing with complex cases like this one and that CA and the community benefit from such consultations. The Committee believed that information gathering, assessment and analysis is amplified when CA seeks a

[5] Family Team Decision Making (FTDM) meetings bring people together who are involved with the family to make critical decisions regarding the removal of a child from their home, changes in out-of-home placement, and reunification or placement into a permanent home. [Source: CA Practice and Procedures Guide Chapter 1720. Family Team Decision Making Meetings]

medical consultation,[6] communicates with DDA and other DSHS programs, as well as CA staff at all levels in the chain of command.

The Committee members questioned communication and partnership between CA and the medical community from May 2017 until the child's death. The Committee believed that there was a delay on the part of CA to connect with medical providers in each case and that CA could have benefited from promptly utilizing the regional medical consultant to assist in identifying the child's caregiving needs and in the assessment of child safety and parental capacity. The Committee discussed the importance of utilizing the regional medical consultants and child abuse medical consultant team promptly and without delay in such cases as this to assist in determining the parental capacity to safely care for the child. Additionally, the Committee discussed the importance of regular verbal communication with medical professionals involved in the care of J.C. It was apparent to the Committee that prior to May 2017 CA had been in communication and planning with multiple medical staff and with providers, however after April 2017 CA did not seem to have efficient contact with providers or medical staff to assist in determining J.C.'s needs for an accurate and timely safety assessment.

Further, the Committee surmised that CA might have had a better opportunity to gain information and communicate with the family had it partnered with DDA in making home visitations during the investigations post-May 2017. The Committee wondered what expectations CA has in place for staff while assessing safety of children with disabilities or developmental delays. The Committee discussed that CA investigators' knowledge on such topics varies by caseworker

[6] The purpose of the Consultation Network is to provide statewide consultation and training regarding medical findings in cases of alleged child abuse and neglect. It provides quick, cost free access to a physician with expertise in the diagnosis of complex cases of child abuse and neglect to professionals such as CA social workers and supervisor, physicians and other medical providers, prosecutors and Attorney's General, law enforcement, other professionals in child abuse and neglect and tribal social workers. [Source: CA Practices and Procedures Guide Chapter 2331. Child Protective Services Investigation] Child Abuse Consultants are a team of physicians who provide statewide consultation and training regarding medical findings in cases of alleged child abuse and neglect. [Source: Child Abuse Consultation Network for Washington State]
The Child Protection Medical Consultants (CPMCs) are a team of physicians who provide statewide consultation and training regarding medical findings in cases of alleged child abuse and neglect. The tasks of the statewide 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. Secure medical evaluation and/or treatment. The social worker considers utilizing a medical evaluation in cases when the reported, observable condition or the nature and severity of injury cannot be reasonably attributed to the claimed cause and a diagnostic finding would clarify assessment of risk. Social workers may also utilize a medical evaluation to determine the need for medical treatment. [Source: CA Practices and Procedures Guide Chapter 2331. Child Protective Services Investigation]

depending on previous education, training and practice. The Committee discussed the importance of partnership in such cases as this with DDA to possibly improve resource connections, the quality of assessments, and child safety.

The Committee spent considerable time discussing gaps in gathering sufficient evidence for a global assessment of the family from May through September 2017. The Committee heard from CA workers that the distance to the family home and lack of cell service at the location inhibited their availability to make frequent home visitations. The supervisor supported this explanation for intermittent contact with the family. Understanding that at times there are limitations to accessing residences in rural communities, the Committee noted that the location of the family's residence should not inhibit CA's response to assess child safety or investigate. Further, the Committee discussed a letter written by the CA supervisor that was delivered to the family on September 16, 2017. The Committee wondered if the language in the letter referencing possible legal interventions may have spurred the family to flee rather than encourage partnership or inspire communication with CA as needed for the safety assessment of J.C. Noting that it is not against policy, the Committee maintained that the letter did not reflect best practice and communication and as such should be discouraged. The Committee recognized that CA did not have knowledge of the family's plans to move again. However, the Committee discussed how the department may have found out about the move had a health and safety visit[7] been completed in October. The Committee noted that there was limited case activity between September and November 2017 which raised questions about the supervision and investigation of the case.

Findings

The Committee did not find any critical errors on the part of CA, however identified the following findings and recommendations below in hopes of enhancing practice.

The Committee found that gathering information relevant to the May 2017 investigation and safety assessments was not as vigorous as it could have been for a more comprehensive assessment related to the child's medical needs and the caregiver's capacity to ensure safe housing and care. The Committee found

[7] Face-to-face visits with children who have an open case with CA and regular visits with out-of-home caregivers and all known parents provides opportunity for ongoing assessments of the health, safety and well-being of children. Investigators must conduct monthly health and safety visits with children and parents if the case is open longer than 60 calendar days [Source: CA Practices and Procedures Guide Chapter 2331. Child Protective Services Investigations]

this was likely the result of minimal clinical supervision and support to a newly hired worker.

The Committee found a lack of effective supervision and gathering/analysis of information in a timely manner for the August 2017 investigations. The Committee assessed that CA might have included the following for a more in-depth and timely assessment of the family and child safety in the first few months of the May and August 2017 investigations:

- FTDM
- Consultation with an AAG
- Regional medical consultation
- In person home visitations with DDA workers
- Health and safety as required in October

Recommendations

The local area administrator should address clinical supervision with the local supervisor in hopes to amplify timely and more accurate safety assessments, case planning and to improve supervisory case reviews and collaboration with collateral contacts. The local area administrator might consider encouraging local staff to attend the variety of available trainings for gathering information and safety assessments throughout the region.

CA should make training available to all CA staff regarding the importance of connections and partnering in the field with DDA and assessing safety of children with developmental disabilities.