Department of Social and Health Services
Children's Administration
Child Fatality Review

T.H.

November 2004
Date of Child's Birth

November 21, 2013
Date of Child's Death

March 26, 2014
Child Fatality Review Date

Committee Members
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Executive Summary

On March 26, 2014, the Department of Social and Health Services (DSHS), Children's Administration (CA) convened a Child Fatality Review (CFR)[1] to review the department's practice and service delivery to a nine-year-old female child and her family. The child will be referenced by her initials, T.H., in this report. At the time of her death attawai[2] T.H. shared a home with her mother, her mother's boyfriend (M.S.), and her four siblings. T.H. is the second oldest of the five siblings. The incident initiating this review occurred on November 21, 2013, when T.H. and her family were involved in a single vehicle rollover accident. T.H. and a seven-year-old brother were ejected from the car and T.H. died at the scene. The brother was hospitalized for one day for minor injuries and was discharged. The mother is alleged to have been drinking and driving at the time of the accident.

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

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

Prior to the review, each committee member received a case chronology, a summary of CA involvement with the family and unredacted CA case documents (e.g., intakes, safety assessments, investigative assessments, provider records, law enforcement records, and Child Protective Services investigative reports).

Supplemental sources of information and resource materials were available to the Committee at the time of the review. These included copies of state laws and CA policies relevant to the review and the complete case file.

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

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

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

Case Summary

CA received seven intakes from 2011 to 2013 regarding T.H.'s family prior to the fatality. Two of the intakes were investigated by Child Protective Serives (CPS) and determined to be unfounded, two of the intakes were founded and three intakes did not have a finding as they were screened out[3] or assigned to alternative response.[4],[5] T.H.'s family first came to Children's Administration's (CA's) attention on October 12, 2011 when an intake was received alleging unsafe living conditions, neglect, and chronic head lice. The family was offered and initially accepted Family Preservation Service (FPS) services. FPS services were

[3] CA will generally screen-out the following intakes: 1) Abuse of dependent adults or persons 18 years of age or older. Such services are provided by the Adult Protective Services (APS) section; 2) Third-party abuse committed by persons other than those responsible for the child's welfare; 3) Child abuse and neglect (CA/N) that is reported after the victim has reached age 18, except that alleged to have occurred in a licensed facility; 4) Child custody determinations in conflictual family proceedings or marital dissolution, where there are no allegations of CA/N; 5) Cases in which no abuse or neglect is alleged to have occurred; 6) And alleged violations of the school system's Statutory Code, Administrative Code, statements regarding discipline policies.

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

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

ended after multiple unsuccessful attempts by the FPS provider to engage the mother. The CPS case was closed as unfounded on April 5, 2012.[6]

On April 18, 2012, CA received an intake alleging T.H. had a bloody nose as a result of her mother slapping her in the face. The CPS investigation was completed with a founded[7] finding and a safety plan created.[8] The case was closed on June 19, 2012 after the mother refused further services. On November 6, 2012, CA received an intake alleging the children were continuing to come to school dirty, without appropriate clothing, and with chronic head lice. The allegations were investigated and the case closed as unfounded on December 20, 2012. On April 11, 2013, CA received a telephone call alleging the children's odor was so significant that it overwhelmed the classroom. The allegations were determined to be founded. On April 25, 2013, the case was closed due to the mother's refusal of services. No further case activity took place prior to the fatality on November 21, 2013.

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

Discussion

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

[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.

[7] Founded--The determination that, following an investigation by CPS, based on available information: it is more likely than not that child abuse or neglect did occur. WAC 388-15-005

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

planning meetings. Committee discussion also focused on CA activity as it relates to Yakama Nation tribal members and investigations on tribal land.

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

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

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

The Committee noted the nature of the intakes was consistent in identifying neglect as a concern throughout 2011, 2012, and 2013, with the exception of the one intake that alleged physical abuse. The intakes primarily identified T.H. and one of her siblings as the alleged victims. The Committee noted two of the

children were not school-aged and may have been less likely to be included in an intake due to their lack of visibility within the community.

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

The Committee believed this case might have benefitted from the shared planning meeting process.[9] The Committee believed Executive Order 12-04 supported the use of a Child Protection Team (CPT)[10] staffing to assist the agency in case and safety planning due to the age of the youngest child chronicity and severity of the neglect and the resistance of the mother. The Committee also believes any shared planning meeting should have involved Yakama Tribal members as they might have provided additional insight or resources for engaging the family.

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[9] Shared Planning Meeting--All staffings engage parents in the shared planning process to develop family specific case plans focused on identified safety threats and child specific permanency goals. Working in partnership with families, natural supports, and providers helps identify parents' strengths, threats to child safety, focus on everyday life events, and help parents build the skills necessary to support the safety and wellbeing of their children. The shared planning process integrates all CA staffings. Source: http://www.dshs.wa.gov/CA/pubs/mnl_pnpg/chapter1.asp

[10] The Department of Social and Health Services shall consult with a Multidisciplinary Community Protection Team, established pursuant to RCW 74.14B.030 as follows: 1) In all child abuse or neglect investigation cases in which the assessment requires the Department of Social and Health Services to offer services, and a Family Team Decision Making (FTDM) meeting will not or cannot be held, and the child's age is six years or younger; 2) In all child abuse and neglect cases where serious professional disagreement exists regarding a risk of serious harm to the child and where there is a dispute over whether out-of-home placement is appropriate; and additionally, the Department of Social and Health Services may consult with a Multidisciplinary Community Protection Team in any case where the Department of Social and Health Services believes such consultation may assist it in improving outcomes for a particular child. Source: http://www.governor.wa.gov/office/execorders/eoarchive/eo_12-04.pdf

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

1) The home is calm enough to allow safety providers to function in the home.

   The Committee believed the social worker had not gathered sufficient information to determine if the home was calm.

2) The adults in the home agree to cooperate with and allow an in-home safety plan.

   The Committee noted the mother denied the allegations and was openly hostile during prior CA intervention attempts. For this reason, the Committee believed the mother would not have been cooperative.

3) Sufficient, appropriate, reliable resources are available and willing to provide safe services and tasks.

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

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

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

Findings

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

Recommendations

1) The Committee recommends CA establish a lower Klickitat County CPT/LICWAC that meets a minimum of one time per month. The purpose of this CPT/LICWAC would be to provide a local staffing resource with knowledge of the local community and people.
2) The Committee recommends the Goldendale CA office work with the Yakama Nation to clarify agreements and protocols regarding investigations on Yakama Nation land.[11]

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

Nondiscrimination Policy

The Department of Social and Health Services does not discriminate and provides equal access to its programs and services for all persons without regard to race, color, gender, religion, creed, marital status, national origin, sexual orientation, age, veteran's status or the presence of any physical, sensory or mental disability.