Report to the Legislature

Quarterly Child Fatality Report

RCW 74.13.640

January – March 2014

Children's Administration
PO Box 45050
Olympia, WA 98504-5040
(360) 902-7821

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Executive Summary

This is the Quarterly Child Fatality Report for January through March 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 four (4) child fatalities and three (3) near-fatalities that occurred in the first quarter of 2014. Four of these cases were conducted as executive child fatality reviews. Two fatalities did not meet the statutory requirement for a full executive review. After consulting with the Office of the Children and Family Ombuds (OFCO), CA chose to conduct internal reviews of these cases. A representative from OFCO participated in these reviews. As the reviews were not legally required, no report was written or posted. All prior child fatality review reports can be found on the DSHS website: http://www.dshs.wa.gov/ca/pubs/fatalityreports.asp.

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

Region	Number of Reports
1	1
2	4
3	2
Total Fatalities and Near Fatalities Reviewed During 1st Quarter, 2014	7

[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 provide 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	4	0	4

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	4	0	4

Two (2) of the four (4) fatality reviews referenced in this Quarterly Child Fatality Report are posted on the DSHS website. Two (2) other reviews were not required per statute and are not subject to public disclosure. Near-fatality reports are also not subject to public disclosure and are not included in this report or posted on the public website.

Notable First Quarter Findings

Based on the data collected and analyzed from the four (4) fatalities and three (3) near-fatalities reviewed between January and March 2014, the following were notable findings:

- In one near-fatality case, the child was dependent and was placed in a licensed foster home. He sustained a serious brain injury and multiple other inflicted injuries on his body. The Child Protective Services investigation determined the foster mother inflicted the injuries to this two-year-old and the investigation was closed with a founded finding for physical abuse.
- All seven (7) of the children were under three years of age.
- All seven (7) of the critical incidents occurred while the family had an open case with CA.
- One (1) near-fatality involved a dependent child placed in a licensed foster home.
- One (1) of the fatalities occurred with the child in an unsafe sleep environment. Another child died while co-sleeping with a parent.
- One (1) child died in a car accident; her father was intoxicated at the time of the accident.
- Four (4) children were Caucasian and two (2) were Native American.
- Children's Administration received intake reports of abuse or neglect in all of the child fatality and near-fatality cases prior to the death or near-fatal injury of the child. None of the cases had more than five (5) intakes prior to the critical incident.
- Due to the small sample of cases reviewed, no statistical analysis was conducted to determine relationships between variables.

Child Fatality Review

M.Y.

July 2013
Date of Child's Birth

July 25, 2013
Date of Child's Death

December 4, 2013
Child Fatality Review Date

Committee Members
Meg Cunningham, Thurston County CASA Supervisor
Theresa Malley, Area Administrator, Richland/Walla Walla, DSHS, Children's Administration
Mary Meinig, Director Ombudsman, Office of the Family & Children's Ombudsman
Danielle Murphy, MA-MHP, CDP, BHR Recovery Services
Bonnie Peterson, BSN, PHN, Children with Special Health Care Needs Program, Thurston County Social and Health Services

Observer
Libby Stewart, Critical Incident Case Review Specialist, DSHS, Children's Administration

Consultant
Karen Small, Assistant Attorney General, Thurston County, Attorney General's Office

Facilitator
Robert Larson, Critical Incident Case Review Specialist, DSHS, Children's Administration

Executive Summary

On December 4, 2013, the Department of Social and Health Services (DSHS), Children's Administration (CA) convened a Child Fatality Review (CFR)[2] to review the department's practice and service delivery to a two-week-old male child and his family. The child will be referenced by his initials, M.Y., in this report. At the time of his death, M.Y. was staying in a motel with his father and mother. The incident initiating this review occurred on July 25, 2013 when M.Y. died from probable suffocation related to unsafe sleep practices.

The review was conducted by a team of CA staff and community members with relevant expertise from diverse disciplines. Neither CA staff nor any other committee members had previous direct involvement with the case.

Prior to the review each committee member received a case chronology, a summary of CA involvement with the family and non-redacted 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 the complete case file and relevant state laws and CA policies.

The Committee interviewed the two CA social workers previously assigned to the case.

Following a review of the case file documents, interviews with the CA social workers and supervisor, and discussion regarding department activities and decisions, the Committee made findings and recommendations, which are detailed at the end of this report.

[2] 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.

Case Summary

M.Y.'s family first came to CA's attention on December 11, 2012 when an intake was received alleging M.Y.'s mother was pregnant and using heroin.[3] M.Y. is his mother's only child. The intake was identified as information only and screened out.[4] On July 11, 2013, CA received an intake reporting the birth of M.Y. The mother told the referrer that she started using drugs when she was 13-years-old; she reported to the referrer that she tested positive for methamphetamine on June 12, 2013. The mother told the referrer that she has the ability to "dupe the system" and hide her drug use. She also stated, "I always want to use, no matter the consequences."

On July 11, 2013, a safety plan was developed to ensure M.Y.'s safety after his discharge from the hospital. The social worker, mother, father, and maternal grandmother all participated in the development of the safety plan. The safety plan required M.Y. and his mother to reside at the maternal grandmother's residence while the mother engaged in chemical dependency treatment, parent education, and public health nursing services. The mother agreed not to reside at her previous residence due to drug use in the home by M.Y.'s father and the maternal grandfather; however, this agreement was not specified in the safety plan.

On July 16, 2013, the maternal grandmother informed the assigned social worker that the mother was in compliance with the safety plan. However, the maternal grandmother expressed concern about the mother relapsing as the maternal grandmother was scheduled to return to work in the next couple of days. The grandmother reported friends and relatives would help check on M.Y. and his mother while she was at work.

On July 19, 2013, the social worker attempted an unannounced home visit at the maternal grandmother's residence. The family was not home at the time of the home visit.

On July 22, 2013, the maternal grandmother reported the mother spent the last several nights at the residence of the father and the maternal grandfather. The maternal grandmother also stated that the maternal step-grandmother smelled alcohol on the mother's breath the previous weekend. The mother returned to

[3] Intakes on Substance Abuse during Pregnancy - Intake Screening Decision: The intake worker will document a pregnant woman's alleged abuse of substance(s) (not medically prescribed by the woman's medical practitioner) in an intake as "Information Only." [Source: CA Practice and Procedures Guide 2552]

[4] Washington state law does not authorize Children's Administration (CA) to screen in intakes for a CPS response or initiate court action on an unborn child.[Source: CA Practice Guide to Intake and Investigative Assessment]

the home on July 22, 2013 and then violated the safety plan again by leaving the home and spending the night at another location.

On July 23, 2013, the mother returned to the maternal grandmother's home. At the request of the social worker, the maternal grandmother informed the mother that she was in violation of the safety plan and needed to comply with the safety plan by staying in her home. The mother again chose to leave the maternal grandmother's residence.

On July 24, 2013, the social worker engaged in joint efforts with law enforcement to locate the mother without success. A dependency petition was filed and the social worker obtained an order to place M.Y. into foster care. The social worker continued efforts to locate the mother throughout the day.

On July 25, 2013, the mother brought M.Y. to the hospital. M.Y. was not breathing, was cool to the touch, and ashen upon arrival. The mother told investigators that she had relapsed on methamphetamine and was attempting to evade Child Protective Services (CPS) by staying in a hotel room in a neighboring county with M.Y.'s father. The mother reported waking up and noticed that M.Y. was aspirating blood and not breathing. M.Y. was sleeping in the bed between the parents at the time of the fatality. CA or law enforcement personnel did not interview the father, as he did not make himself available. The father did not stay at the hospital after dropping off M.Y. and the mother.

Discussion

While the Committee found that there were no apparent critical errors in terms of decisions and actions taken during the involvement by the CPS social worker, the Committee did find instances where additional/different social work activity or decisions may have been considered. However, the absence of these additional activities/decisions was found to have no reasonable discernible connection to the child's death. Thus, the identified issues below serve as noted opportunities where improved practice may have been beneficial to the assessment of the family situation but were not found to be critical oversights that could have prevented the child fatality.

The incident initiating this review occurred on July 25, 2013 when M.Y. died from probable suffocation related to unsafe sleep practices. The Committee noted the social worker had taken the appropriate steps to address unsafe sleep practices by speaking with the parents about safe sleep[5] during their initial meeting at the

[5] Safe Sleep is a nationwide campaign to promote safe sleeping habits for children. Safe sleep practice can reduce the risk of SIDS. According to the National Institute of Child Health and Human Development the top 10 safe sleep guidelines are: 1) Always place your baby on his or her back to sleep, for naps and at night. 2) Place your baby on a firm sleep surface, such as on a safety-approved crib mattress, covered by a

hospital. The Committee also noted the social worker addressed other areas of high-risk to infants including the "Period of Purple Crying."[6] The Committee found the social worker's action regarding safe sleep was proactive and appropriate.

Safety Planning: The Committee discussion noted several areas for system improvements around safety planning that are reflected in the discussion section of this report. The Committee also recommended improved ongoing training regarding safety planning that is reflected in the recommendation section of this report.

Safety Plan Participants

1) The social worker's role in the safety plan was not specified. The Committee believed the safety plan may have been enhanced by the social worker being listed as an active participant in the safety plan and her role in the monitoring of the safety plan clearly specified.
2) The father's role in the safety plan was not specified. The Committee noted all services and safety plan items were specific to the mother. The Committee noted the safety plan failed to address the father's alleged substance abuse or role in the care of M.Y.
3) The Committee noted the grandmother was listed as a participant in the safety plan. The social worker never initiated the background check process on the grandmother as required by CA Practice and Procedure Policy 5512.[7]

Safety Plan Modifications Recommended by the Committee

1) The safety plan may have been enhanced through the timely establishment and monitoring of drug testing for both parents.
2) The safety plan may have benefitted from a relapse plan for the mother due to her lengthy drug use history going back to the age of 13. The

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fitted sheet. 3) Keep soft objects, toys, and loose bedding out of your baby's sleep area. 4) Do not allow smoking around your baby. 5) Keep your baby's sleep area close to, but separate from, where you and others sleep. 6) Think about using a clean, dry pacifier when placing the infant down to sleep, 7) Do not let your baby overheat during sleep. 8) Avoid products that claim to reduce the risk of SIDS because most have not been tested for effectiveness or safety. 9) Do not use home monitors to reduce the risk of SIDS. 10) Reduce the chance that flat spots will develop on your baby's head: provide "Tummy Time" when your baby is awake and someone is watching; change the direction that your baby lies in the crib from one week to the next; and avoid too much time in car seats, carriers, and bouncers.

[6] The Period of Purple Crying is a method of helping parents understand the time in their baby's life where there may be significant periods of crying. During this phase of a baby's life they can cry for hours and still be healthy and normal. The Period of Purple Crying begins at about 2 weeks of age and continues until about 3-4 months of age. [Source: http://www.purplecrying.info/what-is-the-period-of-purple-crying.php]

[7] CA staff must complete the required background check, as defined in this section, of out-of-home caregivers and other adults who will have unsupervised access to a child in their home, including: Complete for safety plan participants per Safety Plan Policy. [Source: CA Practice and Procedures Guide 5512]

Committee suggested the use of language such as: "In the case of a relapse, the mother will leave M.Y. in the care and custody of the maternal grandmother. The mother will not provide care or supervision while under the influence of drugs or alcohol."

3) The Committee suggested the plan may have included language to address the father's care and supervision of M.Y. such as: "The maternal grandmother agrees to supervise all contact between the father and his son until he has demonstrated a 30-day period of sobriety. The social worker agrees to measure the father's sobriety through the immediate initiation of drug testing."
4) The safety plan may have been enhanced through specifying timeframes and defining terms within the safety plan. The safety plan stated, "M.Y. and the [mother] will live with the maternal grandmother upon discharge from the hospital. The maternal grandmother will help ensure the safety of M.Y. to include calling CPS, law enforcement or taking custody if necessary." The Committee noted the mother spent three or four nights at another residence prior to the maternal grandmother contacting the assigned social worker. The Committee believed the safety plan should have specified that the grandmother would immediately call CA upon violation of the safety plan or if she observed any signs of relapse. The Committee believed the term "live with" was insufficiently descriptive and allowed the mother to leave the maternal grandmother's residence and visit the maternal grandfather's residence without restriction. The Committee noted the social worker was aware that the maternal grandfather's residence was a significant risk factor due to the alleged drug use in the home.

On July 23, 2013, the social worker requested the maternal grandmother speak with the mother about her failure to follow the safety plan. The Committee noted the maternal grandmother followed the social worker's direction and spoke with the mother. She informed the mother that she would be out of compliance if she failed to sleep every night at her residence. The Committee expressed concern about the social worker placing the maternal grandmother in the position of confronting her daughter. The Committee believed if the social worker addressed this issue personally it may have enhanced case practice.

The Committee discussed the value of the shared decision making process. In this case, the Committee believed CA practice may have benefitted from the completion of a Family Team Decision-Making (FTDM) meeting.[8] The Committee

[8] Family Team Decision-Making Meeting (FTDM) is a facilitated team process which can include birth/adoptive parents, guardians, extended family members, youth (as appropriate), community members, service providers, child welfare staff and/or caregivers. These meetings are held to make critical decisions

believed the FTDM process may have provided the social worker with an opportunity to further explore the strengths and areas of concern regarding the family.

Workload is often cited as a challenge of casework and a barrier to quality practice. The Tumwater CA office was undergoing a period of significant staff turnover around the time of the fatality. The assigned social worker had six years' experience at the time of the fatality. However, all other remaining CPS investigators in the Tumwater office had less than one year experience. Additionally, the assigned social worker had 32 open investigations at the time of the fatality and received 17 CPS investigative assignments during the month of the fatality.

Findings

1) The Committee believed the social worker should have initiated drug testing immediately as drug use by both parents was the primary concern identified on this case.
2) The Committee noted the safety plan insufficiently addressed the safety concerns around plan member participation, parental drug use, child supervision, and clearly specifying timeframes and terms.
3) The Committee believed DSHS policy 1720 required the completion of a FTDM.[9]

Recommendations

1) The Committee recommends social workers receive and demonstrate a strong understanding of the safety planning process prior to carrying of cases and completion of Regional Core Training (RCT). [10]
2) The Committee recommends social workers receive an annual refresher training regarding safety planning.

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regarding the placement of children following an emergent removal of child(ren) from their home, changes in out-of-home placement, and reunification or placement into a permanent home. There may be instances when a FTDM can be held prior to placement if there is not an immediate safety threat such as a child who is on a hospital hold and a FTDM could provide placement options. Permanency planning starts the moment children are placed out of their homes and are discussed during a Family Team Decision-Making meeting. A Family Team Decision-Making meeting will take place in all placement decisions to achieve the least restrictive, safest placement, in the best interest of the child. By utilizing this inclusive process, a network of support for the child(ren) and adults who care for them is assured. [Source: Washington State Family Team Decision-Making Meeting Practice Guide]

[9] The social worker shall conduct a FTDM meeting prior to removing a child and anytime out-of-home placement of a child is being considered. [Source: CA Practice and Procedures Guide 1720]

[10] Regional Core Training (RCT) is the initial, intensive, task-oriented training that prepares newly hired Social Service Specialists to assume job responsibilities. RCT starts on the first day of employment and lasts for 60 days, or the first two months of employment. Competencies are used to assess learning needs and to identify a developmental plan for the new workers.

3) The Committee noted a significant amount of documentation was entered into FamLink following the fatality. The Committee believed the documentation accurately reflected case activity and met all policy requirements; however, the Committee questioned CA's practice of destroying handwritten case notes after the information is entered into FamLink. The Committee believes CA would benefit from a policy that requires the retention of all handwritten case notes that exist at the time of the fatality. The Committee specifically stated that this recommendation should not change the requirement that hand written case notes be entered into FamLink.

Washington State Department of Social & Health Services

CA Children's Administration

Child Fatality Review

N.A.

May 2012
Date of Child's Birth

August 16, 2013
Date of Child's Death

November 13, 2013
Child Fatality Review Date

Committee Members
Renea Bloom, CADC, Chemical Dependency Professional, Merit Resource Services
Mary Meinig, Director Ombudsman, Office of the Family & Children's Ombuds
Christy Stretch, MSW, Child and Family Welfare Services Supervisor, Spokane, DSHS, Children's Administration
Jan Wahl, Domestic Violence/Sexual Assault Advocate, Lower Valley Crisis and Support Services

Observers
Tina Musgrove, Child and Family Services Supervisor, Wenatchee, DSHS, Children's Administration

Facilitator
Robert Larson, Critical Incident Case Review Specialist, DSHS, Children's Administration

Executive Summary

On November 13, 2013, the Department of Social and Health Services (DSHS), Children's Administration (CA) convened a Child Fatality Review (CFR)[11] to review the department's practice and service delivery to a 15-month-old female child and her family. The child will be referenced by her initials, N.A., in this report. At the time of her death, N.A. shared a home with her father and mother. The incident initiating this review occurred on August 16, 2013 when N.A. died from injuries related to a car accident. N.A.'s father was intoxicated and driving at the time of the accident; N.A. was the only passenger in the car. The mother was at the family residence at the time of the accident.

The review is conducted by a team of CA staff and community members with relevant expertise from diverse disciplines. Neither CA staff nor any other committee members had previous involvement with the case.

Prior to the review each committee member received a case chronology, a summary of CA involvement with the family and non-redacted 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 the complete case file and relevant state laws and CA policies.

The Committee interviewed two CA social workers and a CA supervisor previously assigned to the case.

Following a review of the case file documents, interviews with the CA social workers and supervisor, and discussion regarding department activities and decisions, the Committee made findings and recommendations, which are detailed at the end of this report.

[11] 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.

Case Summary

N.A. and her family first came to the attention of Children's Administration (CA) on June 14, 2013. Law enforcement responded to the family home on June 14, 2013 following a car chase where the father was reported to have driven drunk and eluded police. Law enforcement officers used the vehicle's license plate number to track the vehicle to the family home where they found the mother and father engaged in a loud verbal altercation. Law enforcement attempted to gain entry into the family home by knocking on the door. Law enforcement was forced to kick in the door after the parents failed to respond to their requests to enter the residence. Upon entering the responding officers drew their weapons after observing blood splattered around the living room. The father responded by picking up N.A. and placing her between himself and law enforcement. Law enforcement records indicate the father was using N.A. as a shield. The father eventually surrendered himself to police custody. N.A. was then placed into foster care and a dependency petition was filed.

On June 18, 2013, the court ordered the return of N.A. to her mother's care following a Local Indian Child Welfare Advisory Committee (LICWAC) staffing where reunification was recommended.[12] The social worker supported the reunification of N.A. with her mother. Case records reflect the mother was engaged in her court ordered services and demonstrating the ability to meet her daughter's basic physical needs. The father was incarcerated when N.A. was reunified with her mother. It should also be noted that the father had a no contact order in place from a May 2013 domestic violence incident which prohibited the father from having contact with the mother until May 10, 2021.

The father's no contact order was dismissed on July 19, 2013 for reasons unknown to CA social workers. On July 26, 2013, the father was released from jail. On August 1, 2013, the social worker arranged for a visit between the father and N.A. in the family home. The mother was also present and in agreement with the visit.

After the father was released from jail, the social worker reminded the parents that the father may not be in the family home outside of the agreed upon visitation plan. The parents agreed to abide by this condition. On August 16, 2013, the mother canceled the father's visit as she was sick. At approximately 4:00 p.m., the father arrived at the family home without the knowledge or approval of the social worker and took N.A. out to dinner with her mother's

[12] A LICWAC is a body of volunteers, approved and appointed by Children's Administration (CA), who staff and consult with the department on cases of Indian children. The LICWAC team acts as a multi-disciplinary team for CA in the development of culturally relevant case plans. A LICWAC may review the social worker's assessment of potential risk factors and makes appropriate recommendations to ensure the safety of each Indian child. [Source: Indian Child Welfare Manual 10.01]

permission. The father was involved in a car accident and N.A. was killed from injuries related to the accident. The father was under the influence of alcohol and methamphetamine at the time of the accident.

Discussion

The Committee discussed the process of gathering and assessing information during a child abuse and neglect investigation. The Committee believed the social workers might have benefitted from the gathering of additional information related to the family's past domestic violence (DV) history. This included law enforcement records, criminal background checks, and information regarding the no contact order that prevented the father from knowingly coming within 500 feet of the mother. The no contact order was initially set to expire on May 10, 2021 and was entered by the Yakima Municipal Court on May 10, 2013. The Committee noted the social workers did not gather police reports regarding the no contact order and the May 10, 2013 DV incident. The Committee believed the social workers could better assess the mother's protective capacity if they had this additional information.

The Committee noted the no contact order was dismissed on July 24, 2013. The Committee believed it was important for the social worker to gather information regarding the court's reasoning for the dismissal of the no contact order. The Committee noted the assigned social worker did a good job of verifying the dismissal of the no contact order but did not know the basis for the dismissal.

The Committee members requested the child fatality review report reflect how critical the safety planning process is to child safety. The Committee believes each CA social worker should be an expert in the development of strong safety plans. The Committee discussion noted several areas for system improvements around safety planning that are reflected in the findings section of this report. The Committee also recommended improved ongoing training regarding safety planning that is also reflected in the recommendation section of this report.

The Committee discussed the challenges of developing a strong case plan when working with a family struggling with the impacts of domestic violence. As mentioned previously, the Committee noted the importance of gathering reasonably available records (such as police records, court records) related to past domestic violence. The Committee learned through interviewing the previously assigned social workers that the mother may have had a history as both a perpetrator and victim of domestic violence. The Committee expressed concern that the social worker was unable to provide further details about the mother's alleged history as a perpetrator.

The Committee believes the social worker should not have offered the father visits in the family home. The Committee believes the father had not demonstrated progress in the areas of concern that caused his incarceration and the placement of N.A. into foster care. The areas of concern included substance abuse and domestic violence. The Committee noted the father was released from jail and then reintroduced back into the family home via visits without demonstrating the ability to maintain a drug and alcohol free lifestyle. The Committee noted that the mother self-reported a correlation between the father's substance abuse and the escalating domestic violence episodes. The Committee believes the mother lacked the ability to set limits on the father once he was reintroduced back into the family home.

The Committee noted the mother and father demonstrated a willingness to disregard the existing no contact order by allowing the father into the family home on June 18, 2013. The social worker's referral for Family Preservation Services (FPS) dated July 1, 2013 highlights the social worker's concerns about domestic violence at the time of reunification. The referral reads, "There is evidence of escalating domestic violence between the parents. There is a no contact order in place through 2021, but both parents have continually and apparently voluntarily broken this order on an ongoing basis." The Committee believes the parents' history of violating the previous no contact order might have warranted a delay in reunification.

The Committee expressed concern that the social worker placed the mother in a position of power over the visitation plan given the history of domestic violence. The mother stated on July 10, 2013, "That she thinks this separation is for the best, they both need to get better individually before they can try to be together." The social worker engaged the father in a conversation about visitation upon his release from jail. The social worker documented, "We [father and social worker] agreed that this social worker will call [the mother] to see if an arrangement [for visits] can be made for tomorrow from 3-5 with this social worker present." The social worker then spoke with the mother and documented, "Social worker spoke with [the mother], she was in agreement with the visit, she stated that she felt "kind of nervous." This social worker restated that if she didn't want to do it [in-home visits] she had the right to say so and other arrangements could be made." The Committee believed the social worker and her supervisor should have taken on the responsibility of setting the parameters around the visits and that the visits should have continued out of the home until the father and mother had both demonstrated a period of progress with services.

The Committee acknowledged areas of strength that included quality documentation and the strong engagement skills of the social workers assigned to this case.

Findings

1) The Committee believes Children's Administration staff did not gather sufficient information regarding the pattern of domestic violence in the family home prior to making critical decisions about reunification and visitation.
2) The Committee noted several concerns regarding the safety plan initiated on June 18, 2013. The first concern was related to the reliance on a grandmother with her own concerning Child Protective Services (CPS) history. The Committee believes the grandmother's history should have precluded her from being considered a safety plan participant. In addition, the Committee noted the CPS social worker and Child and Family Welfare Services (CFWS) supervisor were aware of the grandmother's CPS history; however, they failed to notify the assigned CFWS social worker who was unaware of the grandmother's CPS history. The Committee believes strong communication about the safety plan is critical when a case is transferred between social workers. The grandmother's history was a critical piece of the Committee discussion because she was a key participant who agreed to help monitor for safety concerns. Second, the Committee noted the safety assessment was created at a time when the safety plan participants believed the father would not be returning to the home due to his incarceration. The Committee believes the safety plan needed to be reevaluated and updated following the father's release from jail.
3) The Committee noted the mother and father failed to comply with the May 10, 2013 no contact order. For this reason, the Committee believed reunification should have been delayed until the mother had demonstrated the ability to maintain appropriate boundaries.
4) The Committee believes the social worker should not have introduced in-home visits prior to the father demonstrating a period of compliance and progress with services.

Recommendations

1) The Committee recommends all social workers read and discuss the *Social Worker's Practice Guide to Domestic Violence* prior to the completion of the Regional Core Training (RCT).[13]

[13] Regional Core Training is the initial, intensive, task-oriented training that prepares newly hired Social Service Specialists to assume job responsibilities. RCT starts on the first day of employment and lasts for 60 days, or the first two months of employment. Competencies are used to assess learning needs and to identify a developmental plan for the new workers.

2) The Committee recommends social workers receive and demonstrate a strong understanding of the safety planning process prior to the carrying of cases and the completion of RCT.
3) The Committee recommends all CA social workers receive an annual refresher training regarding safety planning.