Report to the Legislature

Quarterly Child Fatality Report

RCW 74.13.640

October – December 2011

Department of Social & Health Services
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Washington State Department of Social & Health

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Executive Summary

This is the Quarterly Child Fatality Report for October through December 2011 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 by Governor Gregoire. The revised child fatality statue (RCW 74.13) was 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 eliminates 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 Ombudsman (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 recommendation by OFCO. The new law gives 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 17 fatalities and one near-fatality that occurred in the last quarter of 2011. Thirteen of the child fatalities were reviewed by regional Child Fatality Review Teams. Four fatalities and the one near-fatality review were reviewed by an Executive Child Fatality Review team because the fatality or near-fatality was the result of suspected abuse or neglect.

In 2011, the child fatality statute was revised to require the department to post only reviews conducted in child deaths that resulted from child abuse or neglect. The reports from child fatality reviews from non-abuse or neglect related fatalities and the near fatalities are not posted on the public website and are not included in this quarterly report. However, this report includes analysis of data from those reports.

All prior Executive Child Fatality Review reports are 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 each of the three regions.[1]

Region	Number of Reports
1	8
2	3
3	7
Total Fatalities and Near Fatalities Reviewed During 4th Quarter, 2011	18

This report includes Child Fatality Reviews conducted after a child died unexpectedly from any cause and manner, and the child had an open case or received services from

[1] DSHS implemented a reconfiguration of the regional boundaries in May 2011. The existing six regions were consolidated into three.

the Children's Administration (CA) within 12 months of his/her death. Child Fatality Reviews consist 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 can be as few as two individuals (in cases where the death is clearly from a natural cause or accidental), to a larger multi-disciplinary committee where the child's death may have been the result of abuse and/or neglect by a parent or guardian.

Executive Child Fatality Reviews (ECFR) are conducted in cases where the child fatality is the result of suspected abuse or neglect and CA had an open, active case at the time of the child's death or the child received services from the department within 12 months of his/her death. In the Executive Child Fatality Review, members of the review committee are individuals who have not had any involvement in the case and represent areas of expertise that are pertinent to the case. The review committee members may include legislators or representatives from the Office of the Family and Children's Ombudsman.

The chart below provides the number of fatalities and near fatalities reported to CA, and the number of reviews completed and are pending for calendar year 2011. The number of pending reviews is subject to change if CA learns new information through reviewing the case. For example, CA may learn that the fatality or 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 2011			
Year	Total Fatalities Reported to Date Requiring a Review	Completed Fatality Reviews	Pending Fatality Reviews
2011	42	42	0

Child Near Fatality Reviews for Calendar Year 2011			
Year	Total Near Fatalities Reported to Date Requiring a Review	Completed Fatality Reviews	Pending Near Fatality Reviews
2011	1	1	0

The numbering of the Child Fatality Reviews in this report begins with number 11-16. This indicates the fatality occurred in 2011 and is the sixteenth report completed during that calendar year. The number is assigned when the Child Fatality Review report is posted on the Children's Administration website.

The reviews contained in these Quarterly Child Fatality Reports are a summary of the actual report submitted by each region. Confidential and identifying information not

subject to disclosure has been redacted. The executive child fatality review is as it appears on the DSHS website.

Notable Findings

Based on the data collected and analyzed from the 17 deaths and one near fatality reviewed between October and December 2011, the following were notable findings:

- Four of the fatality reviews completed during the 4th quarter required an Executive Child Fatality Review. Two of these child fatalities occurred on an open case. Another case was closed and the family had moved to another state. One of the reviews was conducted at the request of the Office of the Children and Family Ombudsman. The child did not die from suspected abuse or neglect.
- The near fatality review was the first of its kind conducted under the revised statute.
- Of the 18 child fatalities and near fatalities reviewed, 9 were open cases with Children's Administration at the time of the child's death.
- Of these 9 open cases, 4 child fatalities and the 1 near fatality were determined by CA staff to be the caused by abuse or neglect by the children's parent(s).
- Children 11 months or younger accounted for approximately 33% (6) of 18 child fatalities and near fatalities reviewed and 4 of these 6 children were male.
- Of the 18 child fatalities and near fatalities reviewed, 56% (10) were males and 44% (8) were females.
- Of the 17 child fatalities reviewed, 14 of the children were Caucasian, 4 were Native American, 1 was Hispanic, 4 were African American, and 1 was Asian/Pacific Islander. Note that these numbers reflect that some children are identified as being of more than one race.
- In the two fatalities listed as a homicide, both children were Caucasian.
- Natural and accidental deaths, as classified by the medical examiner or coroner, accounted for approximately 59% (10) of the total deaths. The manner of death of the remaining cases was as follows: 12% (2) were the result of homicide, 23% (4) were due to unknown/undetermined causes, and 6% (1) were the result of a suicide.
- In the two fatalities listed as a homicide, one child drowned. The child's father was later convicted of negligent homicide in the death of his son. Another child died from blunt force trauma to her head. The perpetrator was identified as the mother's boyfriend.
- Children's Administration had intake reports of abuse or neglect in all 17 child fatality cases prior to the death of the child. Forty-seven percent (47%) of the child fatalities reviewed had between one and four prior intakes and 24% had between five and nine prior intakes. Six cases (29%) had between 10 and 24 intakes reported to CA prior to the child's death. Of these six child fatalities, four (4) were classified by a medical examiner or coroner as accidental; the other two were undetermined.

- Due to the small sample of cases reviewed, no statistical analysis was conducted to determine relationships between variables.

Table 1.1

4th Quarter 2011, Child Fatalities and Near Fatalities by Age and Gender						
Age	**Number of Males**	**% of Males**	**Number of Females**	**% of Females**	**Age Totals**	**% of Total**
<1	4	40%	2	25%	6	33%
1-3 Years	3	30%	2	25%	5	28%
4-6 Years	2	20%	0	-	2	11%
7-12 Years	1	10%	2	25%	3	17%
13-16 Years	0	-	2	25%	2	11%
17-18 Years	0	-	0	-	0	-
Totals	10	100%	8	100%	18	100%

N=18 Total number of child fatalities and near fatalities for the quarter.

Table 1.2

4th Quarter 2011, Child Fatalities and Near Fatalities by Race	
Black or African American	4
Native American	4
Asian/Pacific Islander	1
Hispanic	1
Caucasian	13
Totals*	**23**

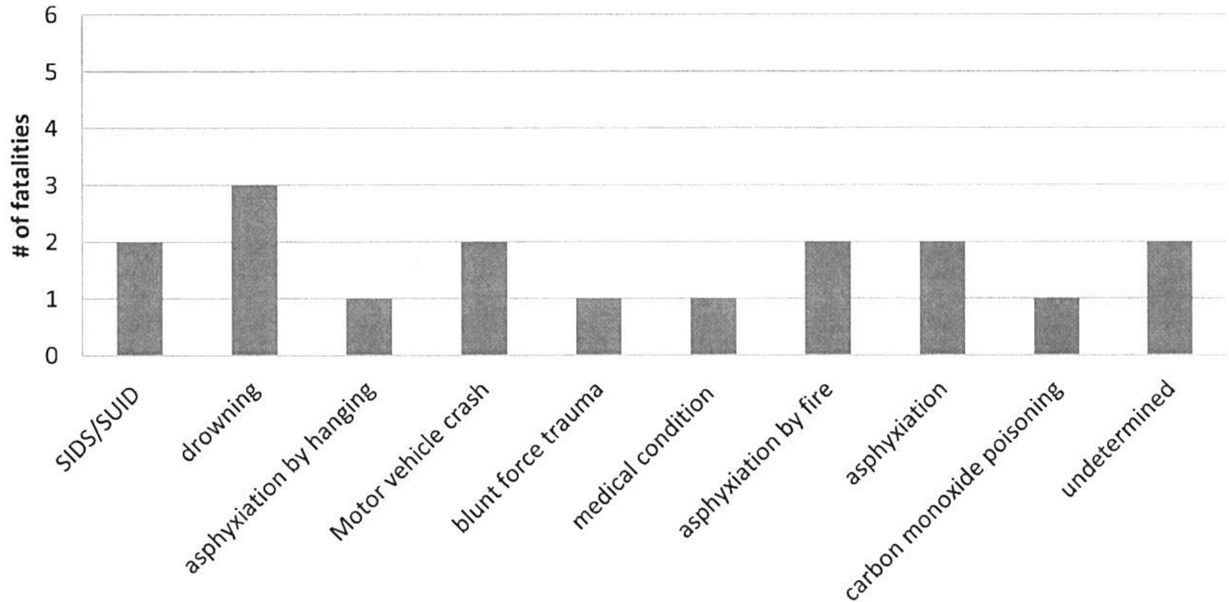
*Children may be from more than one race.

Table 1.3

4th Quarter 2011, Child Fatalities by Manner of Death	
Accident	8
Homicide (3rd party)	0
Homicide by Abuse	2
Natural/Medical	2
Suicide	1
Unknown/Undetermined	4

N=17 Total number of child fatalities for the quarter.

Table 1.4



N=17 Total number of child fatalities for the quarter.

Table 1.5

4th Quarter 2011, Number of Reviewed Fatalities by Prior Intakes						
Manner of Death	**0 Prior Intakes**	**1-4 Prior Intakes**	**5-9 Prior Intakes**	**10-14 Prior Intakes**	**15-24 Prior Intakes**	**25+ Prior Intakes**
Accident	-	3	1	1	3	-
Homicide (3rd party)	-	-	-	-	-	-
Homicide	-	1	1	-	-	-
Natural/Medical	-	2	-	-	-	-
Suicide	-	1	-	-	-	-
Unknown/ Undetermined	-	1	1	1	1	-

N=17 Total number of child fatalities for the quarter.

Summary of the Recommendations

Of the 17 child fatalities and the one near fatality reviewed between October and December 2011, 12 (67%) identified issues and recommendations during the child fatality review process. Issues and recommendations from fatality reviews impact policy, practice and systems associated with CA. At the conclusion of every case receiving a full team review, the team decides whether any recommendations should result from issues identified during the review of the case by the fatality review team. In most instances where the death was categorized as possibly being preventable, some recommendations were made.

Issues and recommendations that were cited during the child fatality reviews completed during the quarter fell into the following categories:

4th Quarter 2011, Issues & Recommendations	
Contract issues	1
Policy issues	3
Practice issues	16
Quality social work	2
System issues	3
Total	**25**

In three cases, recommendations were made regarding domestic violence. Specifically, the fatality review teams made recommendations for ongoing training for social workers in the area of domestic violence. It was also recommended that a domestic violence advocate be co-located in CA offices for consultation. In two cases, recommendations were made regarding thorough CPS investigations. Issues were raised about timely documentation by social workers and supervisors, delays in notifying the subject of CPS investigations and reporting new abuse and neglect allegations.

In four cases, the review teams identified issues related to case supervision. In one case, the team identified an issue that the monthly supervisory reviews were not completed or documented. The teams made recommendations to provide training on clinical supervision and to revise the curriculum for supervisors at the CA training academy. Teams also recommended that supervisors received monthly reports on open cases in their units.

Review teams identified issues with intake screening in three cases. In one of these cases, the team recommended that low risk or screened out intakes be screened in for investigation if the report is made by a contracted provider who is working with the family. In another case, the team questioned the screening decision of an intake. This issue was addressed through action at the local level and involved more oversight in screening decisions by regional management.

In another case, the review team recommended that headquarters staff create a protocol and provide continuous Peer Support for CA staff impacted by a child death.

This team also recommended closer monitoring of medically fragile children placed in one foster home and training on the placement of medically fragile children.

Refresher training for mandated reporters was recommended in two cases. The training was arranged with the mandated reporters in each case.

RCW 74.13.500

Children's Administration

Executive Child Fatality Review

N.L.

August 14, 2009
Date of Child's Birth

May █, 2011
Date of Child's Death

September 12, 2011
Executive Child Fatality Review Date

Committee Members:
Louisa Hall, Licensed Mental Health Counselor/Coordinator, Sound Mental Health
Bradley Graham, Detective, Tacoma Police Department
Bolesha Johnson, Family to Family Supervisor & Court Service Manager, Children's Administration, Region 2 South
Kellie Rogers, Program Manager, The Children's Domestic Violence Program, YWCA
Kat Scheibner, Child Protective Services (CPS) Supervisor, Children's Administration, Region 3 South

Observers:
Edith Hitchings, Deputy Regional Administrator, Children's Administration, Region 3
Patrick Dowd, Office of the Family and Children's Ombudsman
Mary Meinig, Director, Office of the Family and Children's Ombudsman
Amber Osland, Child and Family Welfare Services (CFWS) Supervisor, Children's Administration, Region 3 North

Facilitators:
Cristina Limpens, Central Case Review Specialist, Children's Administration
Marilee Roberts, Practice Consultant, Office of Risk Management, Children's Administration

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RCW 74.13.500

Executive Summary

On May 9, 2011, Children's Administration (CA) Central Intake (CI) accepted an intake from Pierce County Sheriff's office reporting the death of 20-month old, N.L. The referrer stated that they responded to the family home along with Emergency Medical Technicians (EMT) after receiving a 911 call from the child's mother. N.L.'s mother had been at work at a location close to her home when her boyfriend, Charles Mann[1] called her and informed her that N.L. was in distress. Mr. Mann was caring for N.L. and her two month old half sister, [redacted] Upon returning to the home, the mother found N.L. was not breathing and had vomited. N.L. was brought to Mary Bridge Children's Hospital emergency room by the EMT's who attempted to revive the child however were unsuccessful. Given the condition of N.L. and the unknown origin of her injuries, law enforcement placed [redacted] N.L.'s younger sibling into protective custody.

In an interview with investigating officers, Mr. Mann stated N.L. had apparently drowned while he was attending to the infant, [redacted] in another room. Mr. Mann stated that he attempted to revive N.L. by pumping her stomach to remove water. Following an autopsy on May 10, 2011, the Pierce County Medical Examiner concluded that the manner of N.L.'s death was homicide, and that blunt force trauma to her abdomen caused fatal bleeding. It was the opinion of the medical examiner that N.L. died within three hours of being struck. No water was found in the child's lungs.

After learning of the autopsy results, Mr. Mann changed his account of the incident and subsequently said he accidentally punched N.L. while pretending to box her. On May 10, 2011, Mr. Mann was arrested and charged with second degree murder. The criminal case is pending.

A review of the family's history with CA notes [redacted] intakes prior to N.L.'s death. One intake, dated February 18, 2011, identified N.L., as an alleged victim of child abuse or neglect. [redacted]

[redacted] The [redacted] intake received on February 18, 2011 involved allegations of neglect of N.L. by her mother. This intake was assigned for a CPS investigation; however no finding was made prior to N.L.'s death and the CPS case was open at the time of the child's death.

In September 2011, CA convened an Executive Child Fatality Review[2] (ECFR) committee to review the practice and service delivery in the case of 20-month old N.L. and her family. The fatality review

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[1] The full name of Charles Mann is being used in this report as he has been charged in connection to the incident and his name is a part of public record.

[2] Given its limited purpose, a Child Fatality Review by Children's Administration should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. A review is generally limited to documents in the possession of or obtained by DSHS or its contracted service providers and the panel may be precluded from receiving some documents that may be relevant to the issues in a case because of federal

committee members included CA staff and community members representing disciplines relevant to the case. Committee members had no involvement in N.L.'s case. Committee members received the following case documents prior to the review: a chronology of the case prepared for the review, and historical reports relating to the dependency of N.L.'s older sibling including a 2005 police report, and a 2006 parenting and mental health evaluation of N.L.'s mother. Available to committee members at the time of the ECFR were the un-redacted CA case records, and copies of CA policy regarding child protective services (CPS) investigations. During the course of the review, the CPS supervisor overseeing the February 2011 investigation was interviewed by the committee. The CPS social worker assigned to the investigation was available for questions but the committee declined to interview her.

During the course of the review, committee members discussed issues related to CPS investigative practice and procedures, Pierce West CPS workload, supervision, and availability and access to FamLink[3] reports.

Following review of the documents, case history and consultation with the social worker supervisor, the review committee made findings and recommendations which are detailed at the end of this report.

Case Overview

N.L.'s mother and Mr. Mann both have history with the department . Mr. Mann did not have any prior CPS history as a perpetrator of child abuse and/or neglect.

or state confidentiality laws and regulations. A review panel has no subpoena power or authority to compel attendance and generally will only hear from DSHS employees and service providers. The panel may not hear the points of view of a child's parents and relatives, or those of other individuals associated with a deceased child's life or fatality. A Child Fatality Review is not intended to be a fact-finding or forensic inquiry or to replace or supersede investigations by courts, law enforcement agencies, medical examiners or other entities with legal responsibility to investigate or review some or all of the circumstances of a child's death. Nor is it the function or purpose of a Child Fatality Review to take personnel action or recommend such action against DSHS employees or other individuals.

[3] FamLink – CA's Case Management Information System

RCW 74.13.500

On February 18, 2011 the department received its first intake referencing N.L. as a victim of child abuse and/or negligent treatment. This intake was received from a child care provider who reported that N.L. presented with a black eye in December 2010 or January 2011. According to the child care provider the mother reported N.L. had fallen in the bathtub. The child care provider identified other concerns including N.L. coming to the day care dirty and with diaper rash, the mother asking others for money to purchase food for the home, and concerns regarding the mother having [redacted] and not taking her medication. [redacted] The intake noted that the mother was currently pregnant with her third child. The intake was assigned for investigation. The CPS investigation into the February 18, 2011 intake began on February 19, 2011 and had not yet been concluded when notification of N.L.'s death was received on May [redacted] 2011.

On May [redacted] 2011 CA was notified of N.L.'s death by the Pierce County Sheriff's office. N.L. died from severe trauma resulting from physical abuse reportedly inflicted by Mr. Mann. He was arrested on May 10, 2011 and charged with second degree murder. In charging documents, Mr. Mann maintained that he had found N.L. under water in the bathtub, but when confronted with the autopsy results, he added that he had accidentally struck the child in the abdomen while pretending to box her. It was the medical examiner's opinion that the bruising found on N.L.'s abdomen was not consistent with a single blow from a closed fist.

As a result of N.L.'s death, her infant sibling [redacted] was taken into protective custody by law enforcement and placed in out of home care. A dependency petition was filed in Pierce County Juvenile Court. [redacted] had a full skeletal survey and MRI, and no injuries were noted, and she was found to be in good health. N.L.'s older sibling continues to reside with his maternal great grandmother who retains 3rd party custody of him.

Committee Discussion

The review committee discussed at length, the intake history and related investigations regarding this family. Regarding the investigation related to the February 2011 CPS investigation, the committee noted that the initial face to face contact with the alleged victim, N.L., did occur within the 72 hour required time frame and during this contact, the child was assessed to be safe and free from observable injury. However, the committee noted the lack of a thorough and comprehensive investigation as several investigative standards and requirements were missed. During the discussion it was pointed out that there was minimal investigation of all the allegations identified in the intake; [redacted] There was discussion that an interview with N.L.'s brother was needed and would have added valuable information to support critical decision making on the case. Additionally, the committee identified that the investigation was not completed within 45 days per CA policy. While CA policy does not require children

[4] N.L.'s older brother was having unsupervised visitation with his mother.

to be seen monthly when a case is open for CPS investigation only, and in this case, there was one home visit and one attempted home visit with N.L. by the social worker, the committee discussed that changing family conditions (i.e. the mother due to give birth) may have warranted an additional home visit for a more comprehensive assessment.

The committee members discussed the lack of supervisory oversight on this case as the case remained open past the 45 day mark without a supervisory review to determine what additional investigative activities or actions may have been needed to complete the investigation. The review committee highlighted the importance of the supervisors in reviewing social worker documentation on an ongoing and systematic basis in addition to meeting with the social worker to analyze and discuss information regarding a family.

At the request of the review committee, the social work supervisor met with them to discuss workload and case assignment issues in the Pierce West office at the time this family was referred to the department. The social work supervisor stated to the review committee that they have 18 CPS investigator positions assigned to the Pierce West office. The supervisor reported that she supervises six social workers and her unit handles all of the CPS investigations involving military families, although they also investigate civilian cases.[5] There was some discussion regarding the complexities involved with coordinating investigations with the military, and the supervisor stated the military cases increase the workload for this unit. The supervisor indicated that workload was extremely high in her unit, as well as in the other two CPS units. There was a high number of intakes needing assignment; additionally, the area manager had reported prior to the review that there were at least two vacancies in the CPS section between January and March 2011. Additionally CA was unable to assign full caseloads to two other investigators and this impacted workload for the remaining investigators. The investigative social worker assigned to the February 2011 intake received an average of 13.7 new investigations per month between January and May 2011. The new investigations assigned per month were in addition to the worker's ongoing investigations carried over from the previous month. For investigative workers in child protective services, the Council on Accreditation Standards (COA) recommends that caseloads do not exceed 15 investigations or 15-30 open cases. [6]

Further discussion with the supervisor included challenges to completing investigations within the required 45 days and whether this is a realistic time period given the workload in some offices. The supervisor spoke to the difficulties social workers have, in general, finding the time to complete comprehensive investigations within the 45 day time frame particularly when front end case assignment is high.

The social work supervisor spoke at length with the committee regarding her approach and ability to provide clinical supervision and oversight to the social workers in her unit. She indicated that she struggles to complete monthly supervisory reviews with each of her six workers on all of their cases. She stated that she frequently staffs cases with her workers but does not always have time to document the discussion. She described that each of the three CPS supervisors in the office rotate weekly responsibility for assigning intakes and that this additional responsibility significantly impacts the time she has available to provide direct clinical supervision to her workers.

The social work supervisor described a "second level" of screening of intakes she completes which she

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[5] This was not a military case.

[6] http://www.coastandards.org/standards.php?navView=public&core_id=416

indicated is often necessary to verify information in the intake. The supervisor reported that in addition to assigning and reviewing intakes, she may also be required to attend Family Team Decision Making (FTDM) meetings, thus further impacting her availability. The committee members agreed that other job duties, specifically the social work supervisor's responsibilities around intake assignment and what appeared to be efforts duplicative of the responsibilities of the intake supervisor, need to be reviewed.

In addition to discussing past service delivery to the family and the details of the fatality investigation, the review team also spent some time discussing the issue of domestic violence, including resources and training, as domestic violence was a threat present throughout this case.

Review Committee Findings and Recommendations

The review committee made the following findings and recommendations based on interviews, review of the case records, and department policy and procedure, the Revised Code of Washington (RCW) and Washington Administrative Code (WAC).

Findings

Investigations

The review committee discussed at length the CPS investigations and service recommendations made in this case over the course of the family's involvement with CA. They found the following:

- During February and March 2011, high intake assignment impacted the CPS unit in which the February 2011 intake referencing this family was assigned. Key standards of a CPS investigation required by CA policy[7] did not appear to have occurred. Investigative standards should include:
    - Investigation of all allegations identified in the intake
    - Contact with the referrer to clarify information in the intake
    - Contact with collaterals that were reported to have or may have had firsthand knowledge of the family (e.g., medical providers and other professionals involved with the family, relatives)
    - Completion of the investigation within the required 45 days or an extension of this requirement approved by the supervisor
    - Monthly supervisory review as a means to monitor case progress and to determine if the investigation was not complete and what additional action was necessary
    - Documentation of case activities in a timely manner

- Subsequent to the initial contacts with the alleged victim and mother, there was approximately a 75 day period without any significant investigative follow-up activity or visit by the CPS social worker. During this time, the mother gave birth to another child, which the committee felt may have warranted another visit to the home.

- The review committee confirmed in cases where a child is dependent or a family is receiving voluntary services, CA policy is that each child in the home will be seen monthly. Current CPS investigations policy does not require monthly visits to a home when a case is open 30 or more days for CPS investigation only.

Supervision

- The review committee found after reviewing FamLink data regarding intake assignment in the

[7] CA Practices and Procedures Guide, Section 2331, Investigative Standards

Pierce West office and meeting with the social work supervisor that monthly supervisory consultation or staffings were difficult to maintain due to the unit's workload.

Workload

- The committee found after interviewing the social work supervisor, the ability of the CPS social worker to meet practice expectations appeared to be compromised by her caseload. The social worker was experienced. However, due to vacancies in the CPS section and the number of intakes needing to be assigned for investigation, the social worker was getting an average of 13.7 new intakes assigned for investigation between January and May 2011. The social worker had 32 open cases assigned to her at the time of the child's death. The COA standards recommend that a CPS social worker have no more than 30 active cases.

- The supervisor's availability to provide clinical case consultation, monitoring, and feedback to her staff on an ongoing and systematic basis may be impacted by the intake assignment process in the office. CPS supervisors rotate the responsibility of assigning intakes for the section on a weekly basis; much of their time appears to be spent duplicating the efforts of the intake supervisor.

- The supervisor manages a unit that primarily handles military cases, although they do handle civilian cases as well. Coordination with the military can often require additional requirements when conducting investigations, which may increase the investigator's or supervisor's workload.

Recommendations

Practice

- CA may want to consider implementing a monthly visit practice for families who have a CPS case open longer than 30 days. Similar to cases involving dependent children and families receiving voluntary services, children in cases that are open to CPS should be seen monthly.

Supervision

- The review committee recommended that supervisors receive the FamLink report on a monthly basis regarding CPS investigations open for longer than 45 days without an extension as a means to support supervisors in monitoring workload. The committee recommended pulling a statewide report regarding the occurrence of monthly supervisory reviews by office and program area to determine where there may be barriers to completing the reviews.

Workload

- A review of the workflow process from CPS intake to assignment and investigation should occur in the Pierce West and East offices to determine if there are barriers and duplication of job duties.

- A statewide review should occur of the protocols and systemic issues related to coordination of investigations between CPS and the military. Consideration as to whether caseloads involving military cases should be weighted is recommended.

Training/Resources

- The review committee discussed the complexities of cases involving domestic violence. The development of the CA Social Worker's Practice Guide to Domestic Violence in 2010 was identified as a positive step in assisting CA social workers in their work with families

experiencing domestic violence. However, the committee recommended that training be developed in collaboration with community partners and implemented for CA staff regarding the Guide. Recommended training methods such as video or web based training can be developed to effectively and efficiently deliver the training.

- Based on funding availability and partnership with community agencies, a domestic violence advocate should be co-located in CA offices for the purpose of consultation, intervention, and planning on cases involving domestic violence. Research shows that domestic violence often co-exists with child maltreatment.

RCW 74.13.500

Children's Administration
Executive Child Fatality Review

S.R.

November [redacted] 2010
Date of Child's Birth

June 18, 2011
Date of Child's Death

September 23, 2011
Executive Review Date

Committee Members
Laurie Alexander, Area Administrator, Children's Administration, Region 2 North
Mary Meinig, Ombudsman, Office of the Family and Children's Ombudsman
Denise Redford, MS, Pathways for Women, YWCA
Deborah Robinson, Infant Death Investigation Specialist
Robert Thornquist, Supervisor, Children's Administration, Region 2 South
Lori Vanderburg, MS, Children's Advocacy Program Manager, Compass Health
Mae West, Volunteer Guardian Ad Litem, Snohomish County

Observer
Yen Lawlor, Deputy Regional Administrator, Children's Administration, Region 2 North

Facilitators
Marilee Roberts, Practice Consultant, Children's Administration
Toni Sebastian, Practice Consultant, Children's Administration

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Executive Summary

On September 23, 2011, the Department of Social and Health Services (DSHS), Children's Administration (CA) convened an Executive Child Fatality Review (ECFR[1]) of a case involving the death of six-month old, S.R. (DOB: 11[redacted]2010) in her family home. At the time of S.R.'s death the family had an open child protective services (CPS) case and an open child and family welfare services case (CFWS) with CA. A committee that included community professionals and CA staff reviewed the case documents and interviewed staff in an effort to examine child welfare practices, system collaboration, and service delivery regarding this child and her family.

On June 18, 2011 at approximately 2:30 pm Snohomish County deputies contacted the department notifying CA of S.R.'s death earlier in the day. The deputy stated neither law enforcement nor first responders noted any concerns in the home upon arrival. Law enforcement reported that the Snohomish County medical examiner was responding to the scene and would provide additional follow-up after completing an examination and autopsy. After completion of an autopsy[2] the Snohomish County medical examiner listed S.R.'s death as *'Unexpected Infant Death of Undetermined Cause and Manner.'* [redacted]

[redacted] S.R. was the youngest child born in a family of seven children.

[redacted]

A case summary relating to S.R. was prepared and provided to the ECFR committee. A copy of the family's case file was also available to the committee. During the course of the review the committee discussed issues related to service delivery, the significance of patterns in the case including allegations reported to the department, domestic violence, prescription drug use, and parental avoidance of contact with the department.

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[2] Complete autopsy includes toxicology results which often take as much as 12-16 weeks to receive post fatality.

RCW 74.13.500

Following review of the family's history, case records and discussion, the review committee made findings and recommendations that are detailed at the end of this report.

Case Overview

[3] Screening decision is based on the absence of allegations of child abuse or neglect as defined by WAC 388-15-009 What is Child Abuse and Neglect?

CA received four intakes[6] regarding this family beginning in December 2010 following the premature birth of S.R. Issues related to possible substance use and unsafe living conditions in the home prompted CA to be diligent in monitoring the living conditions and the parents' ability to ensure their children's safety. Referrers expressed concern that family living conditions and inconsistent parental behavior would place S.R. at risk of harm once she was released from the hospital. Monthly home visits by the CFWS social worker assigned to the case continued. CPS investigations began in December 2010 after an intake was received reporting the birth of S.R. She was premature and the caller, a medical professional, expressed concerns regarding H. J. and her ability to care for the child. An intake received in February 2011 reported similar concerns and in May 2011 another intake was received and assigned for alternative response.[7] The CPS social worker attempted home visits in May and early June to address issues related to possible drug seeking behaviors on behalf of S.R.'s mother and deteriorating conditions in the home. The family was difficult to contact[8]. When contacted by CA, the mother and father were unwilling to engage with the social worker. The CPS and CFWS cases remained open.

On June 18, 2011, the department received the report of the death of six-month-old S.R. Intake information received stated that S.R. was placed in her bassinet by her mother after being fed. S.R.'s mother reported that she had showered and, afterward, when checking on S.R. she noticed the child had pulled a blanket closer to her and was not breathing. Despite attempts by first responders to revive S.R. she was pronounced dead in the family home at 10:40 am. On June 23, 2011 shortly after S.R.'s death[9] and in collaboration with law enforcement, S.R.'s surviving siblings were placed into protective custody due to ongoing concerns of alleged domestic violence, unsanitary living conditions and their mother's untreated mental health issues. Following a brief stay in foster care the children were placed with a relative and dependency was established in August 2011. At the time of this report the children remain out of home in relative placement and the family continues to be involved in services.

Review Committee Discussion and Findings

To develop a thorough understanding of the family and case, the review committee identified dynamics that appeared to influence decision-making by the department, e.g.) intake screening decisions, placement decisions . The committee requested to meet with the CPS investigator and the CFWS social worker assigned to the case at the time of S.R.'s death. The CPS and CFWS supervisors joined the social workers for their meeting with the ECFR committee.

Patterns: The committee found that a pattern of child abuse and neglect reports to the department had occurred , the presence of multiple risk factors[10] and safety threats are found consistently, creating the need to thoroughly assess the family in order to gain an understanding of the parent's ability to safely parent their children. Diligent efforts in locating, accessing and utilizing information from other sources assists in keeping children safe, identifying family patterns, and influences decision making[11] and case planning.

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[6] Two intakes screened as CPS Risk Only, one for alternative intervention and one screened out.

[7] The committee found the information in the May 6, 2011 intake screened as an Alternative Response (10-day response time) contained information to support screening in the intake for investigation given the family's history.

[8] Case record documentation notes repeated attempts to contact the family without success.

[9] Death determined to be Sudden Unexpected Infant Death of Undetermined Cause and Manner.

[10] Mental health, substance abuse, domestic violence

[11] Decisions such as those made on new intakes or the need for out of home placement or services.

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While the mother appeared cooperative with the CFWS social worker, she avoided contact with CPS social workers attempting to complete investigations. Noted in the record were the department's unsuccessful efforts to contact the family through unannounced home visits and phone calls. This pattern of behaviors and events, verifiable through collateral sources, raise questions about the mother's credibility and apparent willingness to work with the department.

Domestic Violence (DV): After closely reviewing the case information and meeting with the assigned social workers the committee identified domestic violence as a reoccurring theme in this family. The committee found that managing the domestic violence in this case was challenging given H.J. was often the single source of information.

The committee found that by utilizing historical information[13] and accessing collateral information from law enforcement , mental health professionals, and domestic violence agencies, CA can gain insight into the family dynamics to support intervention and planning. Understanding how to identify domestic violence perpetrators, how they think, how other family members respond within the home and how to effectively work with victims and perpetrators can only be gained when employing a collaborative planning effort among experts.

Critical Thinking/ Shared-Decision Making: While the committee was convened to review the death of S.R. in 2011, They found complex cases call for a gathering of information from additional sources and is essential in understanding the family's dynamics.

The committee found examples in which gathering additional information and not relying on a single source, such as H.J., would have provided a better understanding of this family's situation. For example, CA received conflicting information from two psychological evaluations on S.R.'s mother in 2010; and continued reports of unsafe and unhealthy living conditions. The committee also noted that the department did not follow-up on critical pieces of information

CA received four intakes beginning in December 2010. The committee noted the referrers making reports were all professionals within the community who had insights into this family. The review committee

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found the family was evasive with CA during this time and when the opportunity to meet with the family occurred CA relied heavily on information from S.R.'s mother and did not always seek corroborating information from second sources (e.g. law enforcement reports, medical examiner, referrer, etc.) regarding allegations or present family circumstances.

The review team found fully understanding a family should result in as complete a picture of a family as possible and will come from a variety of sources[14]. Critical thinking and shared decision making helps to build an understanding of a family and can take into account several areas such as family strengths and respective challenges, which supports developing intervention strategies and case planning.

The committee noted this case could have benefitted from a critical review and analysis of all information received (e.g. clinical supervision, case staffings, child protection teams and multi-disciplinary team staffing). A multi-disciplinary team staffing in particular can provide a comprehensive review and assessment of a complex child abuse and neglect case such as in this family. The collaborative staffing opportunity can support development of case plans that serve individual family members and support child safety.

Given the dynamics in this family the review team found utilizing a multi-disciplinary team decision making approach may have resulted in increased objective recognition and understanding of the family patterns.

Recommendations

Patterns: During the review, the committee learned about CA's implementation of a new Child Safety Framework in November 2011 that supports and assists social workers in assessment, identification, and management of safety threats throughout the life of a case. The patterns of child abuse and neglect reports, domestic violence, and avoidance of department staff would be identified in the new assessment, moving the practice away from incident-focused work to a comprehensive assessment of how this family functioned. The Child Safety Framework also supports the verification of information gathered by contacting collaterals and other child welfare partners working on a case.

Domestic Violence: In February 2010 CA released a Social Worker's Practice Guide to Domestic Violence. The 88 page guide provides social workers with information regarding domestic violence which includes legal considerations, routine screening, domestic violence assessment, case decisions and case planning. The committee commended CA in this effort. However, the committee found that regardless of how valuable the guide, supporting it with a training program that includes direction for supervisor consultation can provide guidance and information to front line staff in assessing and planning around domestic violence.

Given the complexity regarding domestic violence the committee recommended on-going training and regular consultation on domestic violence. A training curriculum that addresses the broad spectrum of domestic violence and includes topics such as perpetrator assessment and accountability, treatment recommendations, understanding patterns and cycles, and safety planning is recommended. Training could be conducted in person or through on-line resources.

Critical Thinking/Shared Decision Making: It is recommended when multiple agencies and service providers over time have worked or are working with a family or have referred them for intervention,

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[14] Sources include medical professionals, law enforcement, schools, community services agencies to include other state agencies, etc.

CA convene a multi-disciplinary team. While the primary purpose may typically be to help team members resolve difficult cases, MDT teams may fulfill a variety of additional functions. They can promote coordination between agencies; provide a 'checks and balances' strategy to ensure the interests and rights of all concerned parties are addressed; and identify service gaps and breakdowns in coordination or communication between agencies or individuals. MDTs can enhance the professional skills and knowledge of individual team members by providing a forum for learning more about the strategies, resources, and approaches used by various disciplines.

RCW 74.13.500

Children's Administration

Executive Child Fatality Review

Leo Mathis III Case

Date of Birth: 10[illegible]/2007
Date of Death: 06/22/2011
Date of Review: 11/16/2011

Committee Members
Jennie Lindberg, Chemical Dependency Professional, Evergreen Manor
Cleveland King, Child Protective Services Supervisor, DCFS, Region 2 South
Megan Sweeney, Domestic Violence Coordinator, Lynnwood Police Department
Bill Barrett, Area Administrator, DCFS, Region 2 South
Paul Smith, Critical Incident Program Manager, Children's Administration Headquarters

Facilitator
Kara Rozeboom, Safety Program Manager, Region 2 North, Children's Administration

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Executive Summary

On June 22, 2011, Leo Mathis Jr. was carrying his then three-year-old son Leo Mathis III across the Prickly Pear Creek near Helena, Montana. Mr. Mathis tripped and fell, dropping Leo III into the creek. The child was swept downstream and was found about 18 minutes later. Leo III fell into the water at around 7:15 p.m. Witnesses saw him go into the water and immediately called 911. An aid crew with East Helena Fire Department found him about a half mile down the creek. Rescue workers found Leo III at 7:38 p.m. and immediately began administering CPR. He was taken by an ambulance to St. Peter's Hospital in Helena. He was pronounced dead at 8:56 p.m. The Lewis and Clark County Coroner reported that Leo III died from drowning.

On June 24, 2011, Leo Mathis Jr. was arrested on a charge of negligent homicide in connection with his son's death. Police officers reported Mr. Mathis was intoxicated when he attempted to carry his son across the creek eventually dropping him into the water.

Mr. Mathis has pleaded not guilty to negligent homicide. He was still in the Lewis and Clark County Detention facility awaiting trial when this report was written.

Police reported that Leo Mathis Jr. moved to Montana from Oak Harbor just days prior to Leo's death. L.D., Leo's mother, moved with Leo III to Montana in December 2010.

Children's Administration has history on this family from November 2010. At that time, Oak Harbor Police officers stopped Mr. Mathis after he was observed stumbling down the street in Oak Harbor with his young son Leo in his arms. Mr. Mathis was intoxicated at this time. A Child Protective Services (CPS) case was opened on the family. The investigation was completed and the case was closed in December 2010 shortly after L.D and Leo III moved to Helena, Montana.

Leo Mathis Jr. participated in drug/alcohol treatment in September 2010, prior to CPS involvement with this family. His participation in drug/alcohol treatment was a condition of his probation. Mr. Mathis was court ordered into substance abuse treatment because of two DUI arrests and convictions in 2009.

On November 16, 2011, CA convened a multi-disciplinary committee to review adherence to policy and the social work practice in this family's case.[1] The fatality review team was

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represented by disciplines associated with the case and had no involvement or limited involvement with this family. The fatality review team members included a community representative working with victims of domestic violence and a chemical dependency professional. The team also included CA staff who had no direct connection to the case. An invitation was sent to the Office of the Children and Family Ombudsman.

Relevant case documents were made available to the fatality review team. These documents included: law enforcement reports, family history including intake information, a chronology of the case upon assignment of the case on November 20, 2010 and media reports on the tragic death of Leo Mathis III.[2]

Following review of the case history, case records and law enforcement records, the review team discussed the case and any issues and recommendations. The issues and recommendations are detailed at the end of this report. The team also discussed intake screening criteria when cases allege domestic violence between parents.

Case Overview

The CPS history on this family, prior to Leo III's death, consists of one intake received on November 20, 2010. This intake was accepted for investigation by Child Protective Services.

On Saturday, November 20, 2010, the Oak Harbor Police Department called Central Intake looking for assistance in placing three-year-old Leo Mathis III in protective custody. Police officers had decided to place him into protective custody after receiving a call that Leo's father, Leo Mathis Jr., was observed walking down a street in Oak Harbor, very intoxicated and stumbling with his son in his arms. Police responded and made contact with Mr. Mathis. He was belligerent and combative with police officers. Officers initially planned to return Leo III to his mother's care, but Mr. Mathis refused to tell police officers where she was located.

Police reported they transported Mr. Mathis to the police station, but when they arrived, he jumped out of the car and ran.

A police officer contacted an after hours social worker to arrange for a transfer of custody to place Leo III in out of home care. The after hours social worker was dispatched from Bellingham but was unable to respond in a timely manner due to treacherous road conditions.[3]

Police were later called to the home of a friend of L.D. L.D. and Leo III were staying at this friend's home. After fleeing from the police, Mr. Mathis went to the home of L.D's friend. Oak Harbor Police responded to a call by the mother's friend when Mr. Mathis arrived at her

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legal responsibility to investigate or review some or all of the circumstances of a child's death. Nor is it the function or purpose of a Child Fatality Review to take personnel action or recommend such action against DSHS employees or other individuals.

[2] The criminal case was pending at this time of the fatality review; therefore limited information regarding the criminal investigation is contained in this report to preserve the criminal proceedings of this case. A request for records was made to law enforcement in Montana, but no records were produced. A request was also made for records from Montana Child & Family Services Division. Again, no records were produced as the case was open at the time of the review.

[3] A winter storm resulted in snow and compacted ice on roads.

apartment still intoxicated, verbally abusive, and was refusing to leave the apartment. Oak Harbor Police found Leo's mother there and explained that her son was in protective custody. L.D. had a warrant for her arrest for a misdemeanor domestic violence assault. The victim of the assault was not Mr. Mathis or her son. There were no other suitable relatives in the area available to take Leo; Oak Harbor Police agreed to release Leo III to his mother if she agreed to appear in court the following Monday to have the warrant quashed.

Mr. Mathis was unable to walk and due to his state of intoxication, an ambulance was called and he was transported to Whidbey General Hospital. He spent the night at the hospital and had to be physically restrained due to his behavior that included verbally threatening hospital staff and threats of harm. Mr. Mathis was discharged the next morning.

L.D. reported Leo was with his father on a visit during the day. She spoke to Mr. Mathis around 3:00 p.m. and he did not appear intoxicated. L.D. acknowledged there was a No Contact Order barring Leo Mathis Jr. from seeing his son following a domestic violence (DV) dispute. L.D. told the assigned social worker that she had moved in with her friend after Mr. Mathis broke her rib about three weeks prior. She said she did not call the police after Mr. Mathis assaulted her.

L.D. said she planned to move to Helena, Montana where her father, brother, and several aunts and uncles lived.

L.D. went to court and had the warrant quashed. She and Leo III moved in with Leo's paternal grandmother in Marysville. The grandmother had arranged to drive them to Montana just prior to the Christmas holiday where the mother planned to relocate. This occurred around December 17, 2010.

The CPS investigation was closed with a founded finding for negligent treatment or maltreatment against Leo Mathis Jr. The CPS investigation was closed with an unfounded finding for negligent treatment or maltreatment against Leo III's mother, L.D.

There had been considerable domestic violence in the relationship between Leo Mathis Jr. and L.D. There were five different No Contact Orders in place during the course of their relationship. A No Contact Order was in place in November 2010 when the CPS investigation was conducted. This information had not been forwarded to Children's Administration staff. L.D. informed the assigned social worker of the No Contact Order during the course of the CPS investigation.

Issues Identified by the Review Team

The review team discussed actions taken by law enforcement and Children's Administration's after hours staff regarding the November 20, 2010 intake. The team acknowledged the excellent social work practice evidenced in the case file after the case was assigned to a local CPS social worker. The findings include the following:

- The team discussed law enforcement's initial contact with Leo Mathis Jr. and questioned why he was not arrested when he was stopped by police.

- Police were aware of Leo Mathis' extensive criminal history and the history of domestic violence and No Contact Orders between Mr. Mathis and L.D. No reports were made to CPS intake.
- According to L.D., there was a No Contact Order barring Leo Mathis Jr. from having contact with his son.
- The review team felt that Leo III should have been placed in care to give the assigned CPS social worker more time to assess his safety with both parents.

Recommendation

- The review team recommended that contact be made with Oak Harbor Police Department by CA staff and offer to provide training regarding Mandated Reporting and provide them with phone numbers to call when a No Contact Order is violated and there is a child in the home.

Children's Administration
Executive Child Fatality Review

M.S.

September [redacted] 2009
Date of Child's Birth
July 2, 2011
Date of Child's Death
October 27, 2011
Executive Review Date

Committee Member
Penny Bell, Chemical Dependency Professional, First Step Community Counseling Services
Brent Borg, Area Administrator, Children's Administration, Region 1 North
Sgt. Bob Brockman, Patrol Sergeant, Benton County Sheriff's Office
Erinn Gailey, Shelter Services Director, Domestic Violence Services Benton/Franklin Counties
Mary Meinig, Director, Office of the Family and Children's Ombudsman
Frank Murray, Yakima County Juvenile Court CASA & Diversion Supervisor, Yakima County Superior Court
Sharon Ostheimer, Social Worker 4 Supervisor, Children's Administration, Region 1 North

Facilitator
Marilee Roberts, Practice Consultant, Field Operations, Children's Administration

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Executive Summary

On October 27, 2011, the Department of Social and Health Services (DSHS), Children's Administration (CA) convened an Executive Child Fatality Review (ECFR)[1] of the case involving the death of 21-month old, M.S. (DOB: 09-[redacted]-2009; DOD: 7-2-11). M.S. was a dependent of the state at the time of her death. She had recently returned home on trial return home on June 7, 2011. A committee that included community professionals and CA staff reviewed case documents and interviewed CA staff to examine child welfare practices, system collaboration, and service delivery to M.S. and her family.

On July 3, 2011 the Guardian ad Litem (GAL) supervisor assigned to M.S.'s dependency case reported to CA's Central Intake office that she had been notified by the child's family that M.S. drowned in the family's above ground pool on the evening of July 2, 2011. The referrer reported she was told the child's mother was on a cell phone when she saw M.S. go outside the family home. M.S.'s mother, E.S., assumed she was being supervised by her father who was outside with their other child at the time. However, according to the referrer, M.S.'s father (R.A.) was in another part of the yard playing with M.S.'s brother not near the above ground pool and unaware M.S. was outside unsupervised. The referrer reported the family's above ground pool has an attached ladder that the parents report is usually put up when the pool is not in use; however had been left attached the evening of July 2, 2011 and was accessible to M.S. The referrer reported the family called 911 and law enforcement and emergency medical technicians responded, performed CPR at length, but were unable to revive M.S.

An autopsy was performed at the request of Yakima County Coroner's Office noting *Cause of Death – Probable Fresh Water Drowning – Asphyxia, Manner: Accidental.*

The family's CA history includes 13 intakes of child abuse and neglect. The incident which led to M.S. and her sibling being placed in out-of-home care occurred in May 2010. On May 12, 2010 M.S. was transported to Sacred Heart Hospital in Spokane after being left unsupervised in the bathtub and the victim of a near-drowning. As a result of this incident law enforcement officials placed M.S. and her older sibling into protective custody and upon release from the hospital M.S. was placed in the same foster home as her sibling. A dependency was established in July 2010. Following a year in out-of-home care and services provided by CA, M.S. and her brother were returned home on trial return home in June 2011.

A case summary relating to M.S. and her family was prepared and provided to the ECFR committee. A copy of the family's case file was also available to the committee. During the course of the review the committee discussed issues related to service delivery, the significance of patterns identified in the case regarding allegations reported to the department, domestic violence, and substance abuse.

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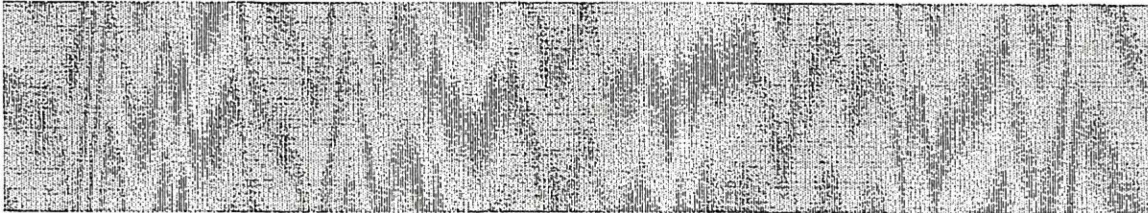
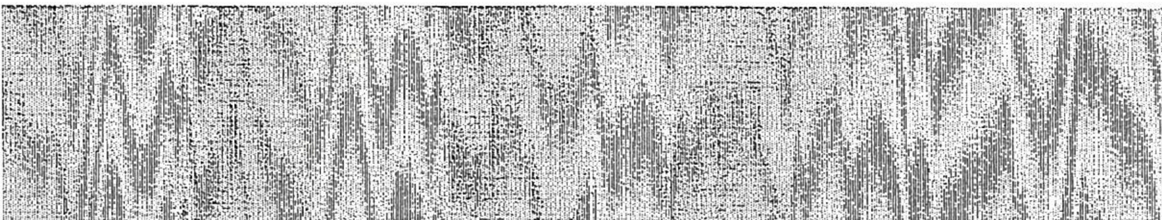
Committee members interviewed the GAL supervisor and the social worker assigned to the case at the time of M.S.'s death. The committee's discussion addressed issues related to the coordination of communication between service providers, critical thinking, shared decision making, and case elements.[2] Following a review of the family's history, case records and discussion, the committee made findings and recommendations that are detailed at the end of this report.

Case Overview

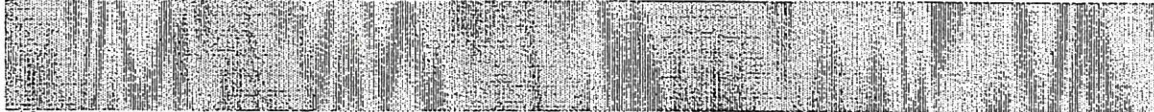




R.A. is associated with 4 intakes (beginning in May 2010) referencing M.S. and her sibling (an older brother)[8]; 2 in which he is identified as a subject of abuse and neglect that resulted in founded findings for neglect and negligent treatment.

In May 2010 CA initiated an investigation in collaboration with law enforcement into allegations of neglect (lack of supervision) after it was reported M.S. had nearly drowned in the family bathtub. It was reported her father had placed M.S. in the bathtub while her mother was outside with their other child. M.S.'s father then left to take the garbage out while seven-month-old M.S. remained in the bath tub. It was reported M.S.'s parents proceeded to argue in the front yard when they realized M.S. was left unattended in the bath tub. Collaterals provided a consistent explanation to the incident and M.S.'s father took responsibility for the incident. As a result of this incident a founded finding was made and a petition to remove M.S. and her brother from the family home was filed in court due to continuing concerns for their safety. Upon release from the hospital, medical staff expressed concern about developmental delays noted during M.S.'s hospitalization that were not related to the drowning

[2] Activities conducted according to CA Practice and Procedure Manual and Case Services Manual e.g.) Monthly Social Worker Visits, Documentation, Investigation Criteria, Intake Decisions, etc.



[5] Source: WAC 388-15-009 What is Child Abuse and Neglect?

[6] FamLink is Children's Administration's management information system.

[8] M.S. has three brothers; one who lives with his father who is not a dependent, and two others; one older who was part of the May 2010 dependency matter and a younger brother born during the dependency who was not placed in out of home care.

incident but more likely to ongoing neglect of M.S. by her caregivers. The shelter care hearing was held on May 17, 2010, and the court ordered the children to remain in out-of-home care until services could be provided to address safety threats and parental protective capacities. Dependency for both children was established in July 2010.

CA provided services during the dependency process which included drug and alcohol assessments, individual counseling, domestic violence, anger management and visitation. Service providers reported although the parents were slow to engage in services, they did begin to comply in their attendance and noted some progress in addressing issues related to parenting, substance use,[9] and relationship issues. Disclosure of domestic violence was made by M.S.'s mother in December 2010, however recanted shortly thereafter. Follow up regarding possible domestic violence in the home was included in services addressing anger management and relationship issues; however a referral or consultation with a domestic violence program was not noted in the case record.

During the course of the dependency and prior to return home of the children, CA received three intakes following visits in the parental home. The referrer (foster parent) reported concerns regarding bruises to the children and hygiene issues following visits. Following investigation of the three intakes, unfounded findings were made. In May 2011, as required by policy prior to returning children home, the case was staffed with the local Child Protection Team[10] (CPT). The CPT, after consultation with the assigned social worker and GAL, agreed that return home was an appropriate plan with the condition the case remain open for a minimum of six months and the family continue to participate in any identified services (domestic violence referral was recommended). The children were returned home following court approval on June 7, 2011. The assigned social worker conducted a monthly health and safety visit on June 10, 2011 according to CA Policy[11] noted no concerns, and the children were doing well in the family home. CA policy requires two health and safety visits each month for children returned home on a trial return home for the first 120 days.

On July 3, 2011 CA received the intake noting M.S.'s death. CA and Grandview Police Department initiated an investigation into the death and determined M.S., then 17 months old, was outside the family home unsupervised and accidently drowned in the above ground pool located on the family property.[12] The Yakima County Coroner determined cause and manner of death: probable fresh water drowning – asphyxia, accidental. CA's fatality investigation resulted in a founded finding of neglect/negligent treatment against M.S.'s mother. Following CA's intervention and with the assistance of law enforcement based on concerns for child safety and the parents' ability to supervise their children, the surviving siblings[13] were placed in out of home care[14] on July 4, 2011.

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[9] Case documentation notes both parents participated in random urinalyses during the course of the dependency. Attendance and follow through in recommended treatment was sporadic.

[10] Source: CA Practice and Procedures Manual Chapter 2500 Section 2562 (2) (b) (iii) Child Protection Teams CPT consultation is required: *"In all cases prior to return home or dismissal of dependency, when the child is age six or younger and any risk assessment has resulted in a risk level of moderately high or high risk."*

[11] Source: CA Practice and Procedures Manual Chapter 4420 Social Worker Monthly Health and Safety Visits

[12] The family property included several mobile homes and one fixed dwelling. During the investigation it was noted the above ground pool located on the back of the family property could not be seen from M.S.'s family home.

[13] M.S.'s older brother, already a Washington dependent and a third child born during the course of the dependency (November 2010) were placed in protective custody.

Review Committee Discussion and Findings
To develop a thorough understanding of the family and case, the review committee identified dynamics that appeared to influence decision-making by the department, e.g.) intake screening decisions and investigations, identification and assessment of family dynamics and how they affected parenting, service delivery and progress, and placement decisions. The committee requested and met with the Child Family Welfare Services (CFWS) social worker assigned to the case at the time of M.S.'s death and the GAL's supervisor.

Casework: The committee discussed at length the CPS investigations and CFWS case management decisions made in this case over the course of the family's involvement with CA. They found the following:

- **Intake screening decisions:** Intakes received on January 28, 2009, March 18, 2009 and August 9, 2009 were screened out recommending no need for intervention by CA. Allegations referenced illicit substance use by M.S.'s mother while pregnant and concern for safety of other children while she was using. The intakes did not note allegations of child abuse or neglect as defined by WAC 388-15-009. However the committee found based on the mother's documented substance abuse history and previous founded findings the intakes merited intervention and recommended they should have screened in as CPS Risk Only.[15]

- **Investigation and case management elements:** The committee found some case elements required by CA policy did not occur. Investigative and case management standards should include:
    - Collaborating with law enforcement when parallel investigations are occurring (especially in cases of a child fatality) as defined by the respective county's established protocol.[16]
    - A review of the family history to gain an understanding of previous interventions and as a means to identify patterns of parental behaviors that affect child safety.
    - Obtain sufficient collateral information which may include a child's medical records, and interviews with sources familiar with the family.
    - Seek and document information obtained from service providers that address behavioral progress in services not just compliance. Committee members found case documentation was minimal which affected decision making.
    - Social worker monthly health and safety visits occurred both in the family home and while the children were in out-of-home placement throughout this case according to policy. Current policy[17] includes observations of the home environment shall be completed at the time of the visit. However, the committee found current policy does not recommend observations of the areas outside the home to check for safety hazards.

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[14] Children were placed in licensed foster care as there were no relatives deemed available at the time for placement.

[15] Source: CA Practice Guide to Intake and Investigative Assessment, Chapter 4, page 25: CPS Risk Only intakes are defined as intakes that do not allege child abuse and neglect as defined by WAC 388-15-009, but have risk factors that place a child at imminent risk of serious harm.

[16] Source: RCW 26.44.185 County protocols referencing child fatalities, child physical abuse and chronic neglect cases.

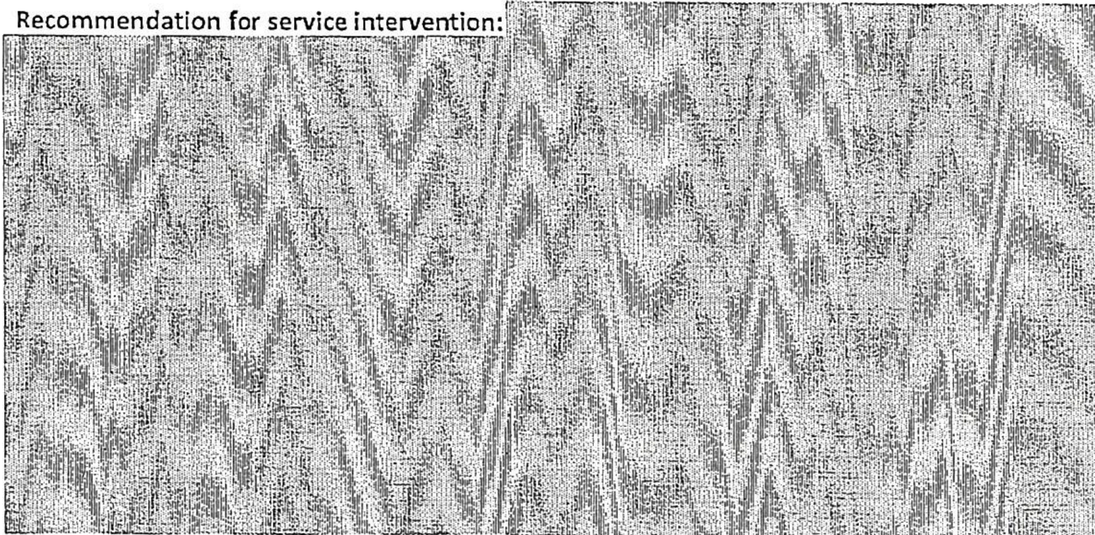
[17] Source: CA Practice and Procedures Manual Chapter 4420 (B) (1) Social worker visits with child

RCW 74.13.500.

RCW 13.50.100

- CA policy requires a Family Team Decision Making (FTDM)[18] meeting will be held when considering reunification. Committee members noted a Child Protection Team (CPT) staffing occurred as required by policy; however a FTDM was not scheduled prior to return home in June 2011.

- Recommendation for service intervention:



Patterns: The committee observed that a pattern of child abuse and neglect reports to the department had occurred from 2008-2011 (13 intakes in 3 years). The presence of multiple risk factors and safety threats existed throughout the record consistently, creating the need to thoroughly assess the family in order to gain an understanding of the parents' ability to safely parent their children. When assessing for present and impending danger for a child, CA policy directs that staff be aware of the heightened risk to children when the parent shows a pattern of failing to meet the child's physical, medical, educational and emotional needs (e.g. repeated disclosures of domestic violence, supervision issues and illicit substance abuse[20]).

Intakes and inconsistent compliance in services noted in this case demonstrated a pattern in parental behavior directly impacting the health and safety of their children. The committee found recognizing and understanding the pattern of behaviors and events, verified through collateral sources, can support intervention (taking action) and subsequent decision making to increase child safety while assessing a parent's ongoing progress in improving their protective capacities. Diligent efforts in locating, accessing and utilizing information from other sources assists in keeping children safe and identifying family patterns can affect decision making,[21] service needs and case plans.

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[18] Source: CA Practice and Procedures Manual Chapter 4302 Family Team Decision Making Meetings

[19] Family Voluntary Services are voluntary and the family has no court involvement. CA and the family develop a time-limited agreement based on the family's needs that outlines the services offered to improve their child's health and safety.

[20] Substance abuse and domestic violence was identified as major issues in this case. The committee observed the parents' follow through with these issues was inconsistent throughout involvement with CA staff.

[21] Decisions such as those made on new intakes or the need for out of home placement or services.

Service Needs and Follow Through: The committee observed that CA staff accurately identified substance abuse and domestic violence issues in this case which directly impacted parenting capacities. Information provided by the social worker and the GAL supervisor indicated that although no significant defining event had occurred in this family following the children's out of home placement in May 2010, it appeared the family minimized the impact domestic violence and substance use had in meeting their children's safety needs. Recommendations and referrals for services were appropriately generated to support the family in developing an understanding as to how these issues operated in their home and what safety tasks and services were needed to increase their children's health and safety.

CA staffs consult with subject matter experts[22] to assist in providing services and effecting behavioral change in families. Consistent communication should not rely exclusively on written reports, but can include telephone contact and providers inclusion in any identified staffing, which contacts must subsequently be documented according to CA policy.[23] Information shared should focus on a parent's treatment progress rather than just attendance.

Recommendations

Casework: The committee noted CA practice and procedures provide guidance to assist social workers in fulfilling case requirements. The committee confirmed the need to gather and verify information provided by a parent through the use of collateral sources, direct observation and communication, shared planning meetings, supervisor consultation and collaborating with subject matter experts. This collaboration and communication assists in completing a thorough assessment of a family

In referencing social worker monthly health and safety visits the committee recommends enhancement to the existing policy to include an outside perimeter assessment of a home. It was recommended CA could utilize information contained in the C-POD Guidelines[24] (Collaboration, Preservation, Observation and Documentation) used by first responders when responding to child fatalities and serious physical injury cases. The *observation* component includes information on how to assess both the outdoor and indoor environment of a home/facility.

Patterns: During the review, the committee learned about CA's implementation of a new Child Safety Framework in November 2011 that supports and assists social workers in assessment, identification, and management of safety threats throughout the life of a case. The patterns in this case of child abuse and neglect reports, domestic violence, and substance abuse would be thoroughly identified in the new assessment, moving the practice away from incident-focused work to a comprehensive assessment of how this family functioned. The Child Safety Framework also stressed the importance of verifying information gathered (from parents) by contacting collaterals and other child welfare partners working on a case.

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[22] In this case domestic violence and substance abuse providers.
[23] Shared Planning Meetings, Family Team Decision Making meetings, MDTs, etc.
[24] Source: Washington Criminal Justice Training Commission's C-POD Guidelines for First Responders.

The framework also suggests critical thinking and shared decision making through clinical supervision and multidisciplinary team staffings assists in understanding family patterns and helps to mitigate bias in casework.

Service Needs and Follow Through: The committee found that given the complexity regarding domestic violence and substance abuse it is recommended on-going training and regular consultation regarding these issues occur for staff. Assessment of parental issues and deficiencies is critical in developing case plans and improving child safety within families. A domestic violence training curriculum that addresses the broad spectrum of domestic violence to include topics such as perpetrator assessment and accountability, treatment recommendations, understanding patterns and cycles, and safety planning is recommended. A substance abuse training curriculum that assists social workers in understanding the progress of addiction as well as recovery would be beneficial. Training could be conducted in person or through on-line resources.

Supervisor Consultation: CA policy[25] supports supervisors conducting monthly case reviews with their staff and documenting in FamLink. The committee found that while thorough guidance is provided in the policy, additional direction and training would be beneficial to front line supervisors for the purposes of case consultation and supervision. The committee identified the 3 week Academy for supervisors provides an introduction to supervision, however recommended follow up training for supervisors that would address topics such as coaching, mentoring, counseling, interaction, and clinical supervision. It was recommended that CA program managers consider researching the Criminal Justice Training Commission's supervisory course curriculum as a follow up training to Supervisors Academy.

[25] Source: CA Practice and Procedures Manual Chapter 46100(B)(1-3): Monthly Supervisor Case Reviews