Washington State
Department of Social
& Health Services

**Report to the Legislature**

# Quarterly Child Fatality Report

RCW 74.13.640

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# Children's Administration Child Fatality Report

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## INTRODUCTION

This is the first Quarterly Child Fatality Report provided by the Department of Social and Health Services (DSHS) to the Washington State Legislature as required by RCW 74.13.640. Passed during the 2004 Legislative Session, HB 2984 (RCW 74.13.640) requires the department to report on each child fatality review conducted by the department and provide a copy to the appropriate committees of the legislature.

Child Fatality Reviews are conducted when children die unexpectedly and their families had an open case or received services from the Children's Administration within 12 months of their 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 to address the identified issues. A review team can be as few as two individuals on cases where the death is clearly accidental in nature, to a larger multi-disciplinary committee where the child's death may be the result of abuse and/or neglect by a parent or guardian.

The Executive Child Fatality Review is a special review convened by the Children's Administration's Assistant Secretary. The Executive Fatality Review may be requested in cases where a dependent child dies as a result of abuse and/or neglect by their parent or caretaker, or a non-dependent child dies of abuse and/or neglect on an open, active case or in a licensed facility. In the Executive Fatality Review, members of the review committee are individuals who did not have any involvement in the case and represent areas of expertise that are pertinent to the case. Committee members may also include legislators or others as determined by the Assistant Secretary.

It is often many months following the death of a child before the fatality review is completed. This is due to Child Fatality Reviews requiring a multi-agency effort in gathering complete reports and findings. It is necessary to wait until all information is compiled in order to ensure a thorough review of the case, even when this means having an extended timeline for completion.

Since implementation of RCW 74.13.640 in July 2004, 46 child fatality cases have been identified as requiring a review. Of these 46, five reviews have been completed. This report summarizes the five reviews that were completed during the last two quarters of 2004. Four of these fatalities were reviewed by a regional Child Fatality Review Team and one was reviewed by an Executive Child Fatality Review Team.

The reports included discuss fatalities that occurred in the following Regions:

2 reports are from Region 1—Spokane
1 report from Region 2—Yakima
1 report from Region 4—Seattle
1 report from Region 5—Tacoma.

In addition to the Quarterly Child Fatality Reports, CA will be completing an Annual Child Fatality Report which will provide statistical information on child fatalities that occurred throughout the entire year. The issues and recommendations identified in the Child Fatality Reviews from the year will also be discussed in the annual report. The next annual Child Fatality Report will cover the year 2003.

**Child Fatality Review #04-01**
Region 1
Spokane Office

## Case Overview

This 15-year-old boy died on September 18, 2004 after being ejected from the vehicle where he was a passenger. The vehicle, a Ford Bronco, did not have a top on it. The Bronco was towing another car that slid backwards and caused the Bronco to slide over an embankment. The child was ejected, and the Bronco rolled on top of him.

The mother of the child first came to the attention of Child Protective Services (CPS) in 1991. The mother had two children, a girl (DOB 8/7/87) and a boy (the victim, DOB 2/4/89). There are no electronic or physical records that could be located regarding that referral.

Another referral was received on August 19, 1998. The Snohomish County Sheriff's office reported that the mother had been involved in a domestic violence incident witnessed by her children, and the mother was arrested. Follow-up on this referral on August 27, 1998 revealed that the mother and children did not reside in Arlington, Washington but in fact resided in Spokane, Washington.

On March 12, 2000, a referral was made alleging neglect by the mother of her two children who were then ages 11 and 12. The referral stated that the home environment smelled foul, and the children were left home alone in the evenings. A low risk letter was sent to the mother notifying her of the concern.

On May 4, 2000, the mother called requesting voluntary services for her son. The presenting issues were the boy's defiance and aggression. He entered into Children's Hospitalization Alternative Program (CHAP) services with Lincoln County Counseling Services in May of 2000. The boy was diagnosed with Attention Deficit Hyperactivity Disorder for which he received medications. Progress was documented, and he was discharged from services on October 31, 2000.

On July 23, 2002, a report was made to CPS alleging that the live-in paramour had punched the son and held him to the ground. The boy was on probation at the time for a previous assault he committed. The matter was investigated, and the boy stated that the boyfriend had not struck him. The referral was unfounded and closed.

On January 21, 2004, a report was received by CPS that the boy had attempted to hurt the mother with a fireplace poker. When the daughter attempted to call law enforcement, the boy threatened to slit her throat with a knife. This referral was investigated, and the mother was found to be negligent as she failed to protect the daughter and refused to contact law enforcement to intervene. The case was closed on April 21, 2004.

On July 14, 2004, the mother contacted CPS and requested Family Reconciliation Services (FRS) for her daughter. The 15 year old died in the motor vehicle accident while FRS services were being provided to the mother and her daughter.

**Issues and Recommendations**

**I. Practice Issues**

**A. Issue**: No risk assessment or findings were completed on the referral from August 19, 1998.

**B. Recommendation**: *Follow policy for risk assessment within 90 days of receiving the referral and document findings of the investigation.*

## Child Fatality Review #04-04

Region 1
Moses Lake Office

### Case Overview

This two year old Hispanic male was born on August 7, 2001 and died September 2003. The child died due to the physical injuries inflicted on him by his caregivers.

There were eight Child Protective Services (CPS) reports of child abuse and neglect from August 2000 through September 2003. The first report was made a year before the child was born. Six of the reports were made during the two years of the child's life and the eighth report was made as a result of the child's death.

The eight referrals on this family allege that the mother was using alcohol and drugs during pregnancy and afterwards throughout the history of the case. Later referrals allege that the child had many unexplained bruises and injuries. "DCFS was involved in the child's life since his birth. The agency filed a dependency petition in court and placed the child in foster care a few days after he was reportedly born with drugs in his system. At 10 months of age, he was returned to his parents, while they participated in services. While in his parents' care, the child suffered serious physical injuries including broken bones, skull fractures and burns. Following these injuries, the child was again placed in foster care. In March 2003, at the recommendation of DCFS, the court ordered that the child again be returned to his parents' care. The child and his family remained under DCFS supervision until his death." (2003 Ombudsman Report)

This was an open case at the time of the child's death. This case was reviewed by an Executive Child Fatality Review Team which was convened by the Assistant Secretary of Children's Administration.

### Issues Identified by Review Team

- Age of child and placement history indicate that the child was bonded with foster parents.
- Agency workers lack education of developmental issues.
- Injuries after reunification did not raise an alarm by the agency social worker.
- Chemical Dependency and Mental Health concerns of the parents were unmet.
- The inability of the social worker to use new information and to change direction in case planning was detrimental to the case.
- The relationship and communication between the foster parents and the social worker was not adequate. Communication between social worker and CPT was not objective.
- Social worker bias affected the social worker's judgment and critical thinking.

## Recommendations

Recommendations from this Executive Fatality Review cover each of the following areas:

### Case Management and Practice

1. The department needs to reexamine the application of the KCF concepts and the use of KCF tools by CA social workers. Ongoing training on the concepts of safety as the priority, safety and risk assessment should be required for any worker and supervisor handling cases.
2. Consequences should apply when social workers and supervisors fail to follow policy and protocols in practice manuals, policy, RCW and WAC.
3. The department should develop and administer supervisory training on bias and critical thinking.
4. Supervisors should ensure that social workers receive basic academy training prior to carrying cases or when changing positions into programs that they have not worked in prior.
5. The department should implement a protocol for staffing cases when a family has a case open in two or more CA programs.
6. The department should ensure that a report to law enforcement or the prosecutor's office is made when they learn that a mandatory reporter has failed to report child abuse or neglect.
7. The department should ensure that social workers are trained to flag serious injury, near fatality, high profile referrals so that the appropriate chain of command is alerted.
8. Transition plans should include activities and services that assist children in moving from one cultural experience to another. Biological parents as well as foster parents should receive support and assistance as they negotiate the transition.
9. Child care should be put in place when preschool children are reunifying with their families.

### Child Protective Services

1. CPS should be required to coordinate investigations with law enforcement at the earliest point possible on serious physical abuse cases. The Committee recommends that the department develop a protocol for serious physical abuse cases similar to the county protocols that define and describe coordination of investigations on sexual abuse cases.
2. Medical records of all children in a family, whether they are the identified victim or sibling(s) should be obtained at the earliest point possible in the case.
3. Risk tags on CPS referrals accepted for investigation on any case already open to the department should be assessed at a higher risk.

### Child Welfare Services

1. The department must ensure that CWS social workers understand that assessing safety and risk is part of their job and that they do not focus solely on permanency and reunification.
2. Children who are dependent should have one primary medical provider and this medical provider should be consistent throughout transitions home or in the event of a

return to placement. If this is not a viable plan due to distance and location, the department should ensure that medical records follow children as they change providers.

**Chemical dependency**

1. Social workers need training to learn and understand how to best hold substance using clients accountable to their treatment program. The department should develop joint treatment plans with chemical dependency providers which would assist CA social workers in assessing their clients' sobriety v. their recovery.
2. The department should report chemical dependency treatment providers who do not provide reports per the WAC to the proper monitoring and certification authorities.

**Service Providers**

1. Referrals to service providers from department social workers should always include information of greatest concern and include source documents for provider review.
2. When a review or consult is requested from an outside provider, one consistent source should be used to review all information. This consultation should then be available by speaker phone in the event the information is needed for CPT and/or other staffings.
3. The department should clarify the distinction between psychosocial and psychological evaluations.
4. The department needs to contract with qualified providers for specific violence risk assessment (VRA) in cases where child injury is an element of the case.
5. The department should eliminate the option for contractor self-referral.
6. Annual training of service providers on safety and risk assessment should be required and written into contracts with service providers.

**Child Protection Teams**

1. The team should review the following items which this Committee believes directly impact the overall functioning and efficacy of the CPT.
    - Multi-disciplinary membership, including participation of CDPs
    - Case presentation and sharing of source documents with CPTs
    - Case staffing and continuity of teams and members for subsequent staffings
    - Variability of participation by CPT members
    - Appointment of designated "devil's advocate"
    - Invitation and inclusion of service providers, foster parents and GALs
    - Time allocation and format of case staffings
    - Clarification of CPT member role
    - Resolution of dissent and disagreement by CPT members on recommendations
2. Social workers should provide copies of CPS referrals, evaluations and any pertinent information related to the case on hand. CPTs should be fully informed of all circumstances, services and treatment provided, with progress reports from the providers, recommendations and evaluations from department contracted and non-contracted providers.
3. CA employees should not be members of the CPT.

**Judicial System**

While it is recognized by the Committee that the department cannot change the judicial system, the Committee recommends that the department support the following recommendations.

1. Court Appointed Special Advocates (CASA)/GAL caseloads need to meet the standards set by the National CASA Association and CASA/GALs need proper administrative supervision and support as recommended by the National CASA Association.
2. Judges should receive training on child welfare issues and dependency practice from the Office of the Administrator of the Courts (OAC).
3. Judicial rotations should be extended to allow for the continuity of judicial oversight on dependency cases.
4. Judges should be alert to a pattern of non-contested agreed orders and consider the value of having an in-court hearing so that evidence, recommendations, agreed-upon services and the status of the case can be reviewed on the record.

**Foster Parent**

1. The department should vigorously pursue recruitment and retention of Hispanic foster parents in the Grant County area.
2. The department should ensure that foster parents are invited, with proper notice, to dependency hearings and that they understand their right to provide information to the court.
3. Foster parents should receive proper training before being asked to care for special needs or drug-affected children.
4. The department should ensure that foster parent liaisons are visible and a known resource for the foster parents.

Please see pages 10-18 for the recommendations from the Executive Child Fatality Review.

**Next Steps**

All of the above issues are being addressed through Kids Come First II Initiative accessible at http://www1.dshs.wa.gov/ca/about/imp_kcf2.asp or through other separate actions of Children's Administration headquarters management team. A complete copy of the report can accessed on-line at http://www1.dshs.wa.gov/pdf/ca/gomez.pdf.

# Children's Administration response to the #04-04 Fatality Review Team's recommendations

| Fatality Review Recommendations | CA Response |
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| **Fatality Review Process** | |
| 1. This report should be made available tin English and Spanish and be disseminated to department employees and stakeholders connected to this case. The report should be made easily accessible to any other who are interested in this case. | The report has been made available in English and Spanish to all department employees and stakeholders connected to this case.<br><br>The report in English and Spanish has been posted on the CA internet web site. |
| 2. The Committee requests that the department provide a response to the Committee on plans to follow or not follow recommendations. | CA has complied with this recommendation through this comprehensive response to each recommendation made by the Committee. |
| **Case Management and Practice** | |
| 1. The department needs to reexamine the application of the KCF concepts and the use of KCF tools by CA social workers. The tools may be in need of revision or strengthening in order to be effective decision-making tools. Training on the concepts of safety as the priority, safety and risk assessment should be required for any worker and supervisor handling cases. The CWS social worker did not receive training on the application and use of these tools. Ongoing training is needed to strengthen and emphasize the importance of safety and risk assessment, particularly in cases when children are being reunified with their families. Additional training is needed for social workers on the issue of the competing interests of safety and family preservation. | Children's Administration has provided additional training on safety, risk assessment, reunification, and transition planning to all CPS and CWS social workers and supervisors in the Moses Lake office.<br><br>Children's Administration has completed a review of the KCF concepts, policies and tools and is in the process of revising and strengthening these decision making tools. These revisions are expected to be completed by December 2004.<br><br>Base on these revisions the Children Administration will be providing the following training:<br><br>1. The Academy training for new social workers will be revised to include more classroom and more field placement time on the KCF concepts, policies and application of the tools. This will include training on the critical thinking and the importance of dissenting opinion. The new Academy curriculum will be implemented January 2005. |

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| 3. The department should develop and administer supervisory training on bias and critical thinking. This training should include stressing the importance and value of a "devil's advocate" or dissenting opinion and how to accept challenges to pre-conceived or developed briefs. | CA will address this recommendation through the steps outlined in response to recommendation #1 above. |
| 4. Supervisors should ensure that social workers receive basic academy training prior to carrying cases and when social workers change positions bringing them into programs that they have not worked in prior. | This is a current CA policy requirement.CA will clarify for all supervisors the training requirements when social workers change positions and provide services in program areas which are new to them. This policy clarification will be undertaken in September 2005. |
| 5. The department should implement a protocol for staffing cases when a family has a case open in two or more CA programs. | CA will develop and implement a statewide protocol to address this recommendation. The protocol will be implemented in early 2005. The Area Administrator for the Moses Lake office is now participating in staffings, including Child Protection Team staffings, and consulting on cases that require a new CPS investigation on a case currently opened for CWS service.<br><br>This recommendation is addressed in the Kids Come First (KCF) II plan: Safety 4.1.1 |
| 6. The department should ensure that a report to law enforcement or the prosecutor's office is made when they learn that a mandatory reporter has failed to report child abuse or neglect. | CA will review with the office of the Attorney General the legal issues and feasibility of implementing this recommendation. |
| 7. The department should ensure that social workers are trained to flag serious injury, near fatality, high profile referrals so that the appropriate chain of command is alerted. | The CA computerized case management system (CAMIS) includes a serious injury and fatality check box. When either box is checked the social workers chain of command is automatically notified. CA will enhance the case management system to include a check box for "injury on open case". The completion of this check box will provide automatic notification to the chain of command of such incidents.<br><br>Training and instruction has been provided to the Moses Lake Intake supervisor and social workers regarding the flagging of serious injury, near fatality, and high profile referrals in order to alert the chain of command to these situations on a timely basis. |
| 8. Transition plans should include activities and services that assist children in moving from one cultural experience to another. These activities and services should address daily routines, food and diet, language, etc.<br><br>Plans should also include how attachment will be transitioned. | The revisions to the KCF tools (see response to recommendation #1 above) will include changes to the transition plan as outlined in these recommendations. Training on the revised KCF tools will be implemented as outlined in the response to recommendation #1. |

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| Children, particularly those placed at birth, need time to attach to their new caregivers (even when those caregivers are their own parents) and time to separate from their last caregiver. Attachment to biological parents upon reunification should not be assumed. Biological parents as well as foster parents should receive support and assistance as they negotiate the transition. | |
| 9. Child care should be put in place when young children are reunifying with their families. This provides the child with additional care from a caregiver who can independently monitor the child's safety and development. | CA recognizes the value of child care services in supporting child safety and reunification. However, CA believes that child care should be provided based on the assessed needs of the child rather than automatically in all cases. CA will address the need for child care to support safety and reunification in the revisions to the transition plan outlined in the response to recommendation # 8 above. |
| **Child Protective Services** | |
| 1. CPS should be required to coordinate investigations with law enforcement at the earliest point possible on serious physical abuse cases. The Committee recommends that the department develop a protocol for serious physical abuse cases similar to the county protocols that define and describe coordination of investigations on sexual abuse cases. "Serious physical abuse cases" are defined by the Committee as those children who come to the attention of medical providers because of their injuries. | CA will work with representatives from the office of the Attorney General and law enforcement to develop a protocol, similar to the current sexual abuse protocols, to support a coordinated investigation of serious physical abuse cases.<br><br>Coordinating investigations with law enforcement will also be a component of the new "Advanced Investigation Training" training to be implemented in early 2005. (See response to Case Management and Practice recommendation #1.) |
| 2. Medical records of all children in a family, whether they are the identified victim or sibling(s) should be obtained at the earliest point possible in the case. | CA will include this requirement in its Academy Training program for new CA staff, and in the new "Advanced Investigation Training" training to be implemented in early 2005. (See response to Case Management and Practice recommendation #1.) In the case of siblings who are not identified as victims, consent to release of information is required under HIPAA. Without this consent CA is not able to obtain such medical records.<br><br>The KCF II plan: Child and Family Well-being 16.1.1 includes an integration of the pre-passport and passport programs to provide more effective documentation and sharing of children's medical records. |
| 3. Risk tags on CPS referrals accepted for investigation on any case already open to the department should be assessed at a higher risk. | CA will implement this recommendation as part of its revisions to the KCF concepts, policies and tools. (See response to Case Management and Practice recommendation #1.) |

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| | Moses Lake Intake social workers and supervisors have received additional training regarding the assessment of risk on referrals related to open CWS cases. |
| **Child Welfare Services** | |
| 1. The department must ensure that CWS social workers understand that assessing safety and risk is part of their job and that they do not focus solely on permanency and reunification. The Gomez, Nobles and Grace cases all demonstrate the failure of CWS social workers to adequately assess safety and risk. The department must examine the content of training delivered specifically to CWS social workers and ensure that there is proper emphasis on safety and risk assessment. | CA will address this recommendation through revisions to the KCF concepts, policies and tools, and the additional training to be provided to all social workers and supervisors. (See response to Case Management and Practice recommendation #1.)<br><br>Additional training on safety and risk assessment has been provided to Moses Lake CWS staff. (See response to Case Management and Practice recommendation #1.) |
| 2. Children who are dependent should have one primary medical provider and this medical provider should be consistent throughout transitions home or in the event of a return to placement. If this is not a viable plan due to distance and location, the department should ensure that medical records follow children as they change providers for continuity of care. | A new work unit focusing on Child Well-Being has been established in the Division of Program and Policy. This work unit will address the health care outcomes for children. Through its Child Well-Being unit, CA will review and revise its current policy dealing with medical services to and medical records for dependent children to address this recommendation. CA will also work with the Medical Assistance Administration within DSHS to address issues related to continuity of medical care for children within a managed care program. |
| **Substance Abuse** | |
| 1. Social workers need training to learn and understand how to best hold substance using clients accountable to their treatment program. The department should develop joint treatment plans with chemical dependency providers which would assist CA social workers in assessing their clients' sobriety v. their recovery.<br><br>The department should explore establishing or strengthening partnerships with chemical dependency providers or perhaps the Division of Alcohol and Substance Abuse (DASA) in order to increase the availability of expertise and the accessibility of chemical | CA has now completed a Memorandum of Agreement (MOA) with DASA. This MOA includes funding of a special program manager to implement the provisions of the MOA. The MOA itself includes:<br>-review and enhancement of the current training on chemical dependency provided to CA social workers, supervisors and foster parents<br>-development of joint treatment/service plans<br>-joint research initiatives related to CPS/chemical dependency issues<br>-joint policy development<br><br>The special program manager has now been appointed and work is beginning on the |

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| 3. The department should clarify the distinction between psychosocial and psychological evaluations and ensure social workers and supervisors understand the difference between the two so that they may make better informed choices about the evaluation they recommend. | CA will respond to this recommendation through the protocol/practice guideline described in response to recommendation #1 above. |
| 4. The department needs to contract with qualified providers for specific violence risk assessment (VRA) in cases where child injury is an element of the case. Content of VRAs should be contractually defined with specific tests or instruments identified. This should be updated or reviewed annually. The department will need to establish specific provider credentials for contractors providing VRAs. | CA will respond to this recommendation through the protocol/practice guideline described in response to recommendation #1 above. |
| 5. The department should eliminate the option for contractor self-referral. | CA will implement this recommendation where there are adequate community resources in place to do so. CA notes that in small communities often the service provider who provides the assessment is the only provider of services. This is especially the case related to chemical dependency assessment and treatment. CA will address this issue through the development of protocols/practice guidelines regarding assessment and service provision as outlined in the response to recommendation #1 above. CA will continue to expand the array of services and programs available to children and families. Strategies for expanding the array of services are identified in the KCF plan: Array of Services |
| 6. Annual training of service providers on safety and risk assessment should be required and written into contracts with service providers. | CA in cooperation with major service providers is developing a strategic training plan for service providers. This training plan will include training on safety and risk assessment. Initial implementation of the training plan is expected in early 2005.<br><br>This recommendation is addressed in the KCF II plan: Quality Assurance 41.1 |
| **Child Protection Team** | -identification of persons contracted to provide such assessments<br>-management of potential conflicts of interest related to contractor self-referral |
| 2. When a review or consult is requested from an outside provider, | CA will respond to this recommendation through the external review of Child Protection Teams |
| 1. The Committee is troubled by the serious flaws in the CPT system and recommends a statewide review of the process by a multi-disciplinary team including internal and external stakeholders. The team should review the following items which this Committee | CA will establish a multi-disciplinary work group to conduct a comprehensive review regarding the Child Protection Team program. The work group will include both internal and external stakeholders. The terms of reference for the review will include all of the items identified by the Fatality Review Committee. The multi-disciplinary work group will be established by |

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| believes directly impact the overall functioning and efficacy of the CPT.<br><br>· Same case, same team<br>· Variability of participation by CPT members<br>· Appointment of designated "devil's advocate"<br>· Multi-disciplinary membership<br>· Lack of expertise of membership<br>· Sharing of source documents with CPTs<br>· Format of staffings, time allotment for case staffings<br>· Participation of service providers, foster parents and GALs<br>· Sharing of case information with CPTs prior to meeting<br>· Clarification of CPT member role<br>· Dissent and disagreement by CPT members on recommendations | October 2004 and is expected to make its recommendations by early 2005.<br><br>This recommendation is addressed in the KCF II plan: Safety 4.4.1 |
| 2. Social workers should provide copies of CPS referrals, evaluations and any pertinent information related to the case on hand. CPTs should be fully informed of all circumstances, services and treatment provided, with progress reports from the providers, recommendations and evaluations from department contracted and non-contracted providers. Such information should be provided to the CPT members in advance of the CPT meetings so members can have the time to absorb and digest the information on which they would base their recommendation. | This recommendation will be addressed through the comprehensive CPT review outlined in response to recommendation #1 above. |
| 3. CA employees should not be members of the CPT. | This recommendation will be addressed through the comprehensive CPT review outlined in response to recommendation #1 above. |
| 4. The department should ensure that foster parents are invited to participate when CPTs staff cases on the children living in their homes. Foster parents should receive proper notice of the CPT staffing time and place so that they can adjust their schedules as needed in order to attend. | Current policy requires foster parents to be notified and encouraged to participate in CPT's. When foster parents are unable to attend in person they are encouraged to provide written information for CPT consideration.<br><br>This recommendation will be addressed through the comprehensive CPT review outlined in |

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| | response to recommendation #1 above with a view to identifying strategies to strengthen foster parent participation in CPT's |
| 5. The department should ensure that when a child has a GAL, that the GAL receives proper notice and are invited to CPTs. | The child's GAL and/or CASA are invited to participate in CPT's. When they are unable to participate in person they are encouraged to provide written information for CPT consideration. This recommendation will be addressed through the comprehensive CPT review outlined in response to recommendation #1 above with a view to identifying strategies to strengthen GAL/CAS participation in CPT's |
| **Judicial System** | |
| While it is recognized by the Committee that the department cannot change the judicial system, the Committee recommends that the department support the following recommendations. | |
| 1. Court Appointed Special Advocates (CASA)/GAL caseloads need to meet the standard set by the National CASA Association. CASA/GAL need administrative supervision and support. | CA will support this recommendation |
| 2. Judges should receive training on child welfare issues and dependency practice from the Office of the Administrator of the Courts (OAC). | CA will support this recommendation<br><br>This recommendation is addressed in the KCF II plan: Consultation and Collaboration 33.1 |
| 3. Judicial rotations should be extended to allow for the continuity of judicial oversight on dependency cases. | CA will support this recommendation<br><br>This recommendation is addressed in the KCF II plan: Consultation and Collaboration 33.1 |
| 4. Judges should be alerted when there is a pattern of non-contested agreed orders and consider the value of having an in-court hearing so that evidence, recommendations, agreed-upon services and the status of the case can be reviewed on the record. | This recommendation will require careful and thorough review by Office of the Administration of the Courts (OAC), the office of the Attorney General, and the Public Defender's office. CA will participate in any process developed by OAC to address this recommendation. |
| **Foster Parents** | |
| 1. The department should vigorously pursue recruitment and retention of Hispanic foster parents in the Grant County area. | In July 2003 the Moses Lake office completed a needs assessment related to foster home recruitment. The needs assessment identified a need for additional Hispanic foster homes and |

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| | homes available for sibling placement. As a result of this needs assessment 16 additional foster homes were licensed including four bi-lingual, bi-cultural Hispanic homes.<br><br>CA is currently preparing an extensive RFP for improved foster home recruitment across all regions of the state. The RFP identifies the type of foster homes required. The resultant contracts will be performance based and focused on efforts to recruit foster homes based on local and regional needs assessments. The RFP is expected to be published in September 2004.<br><br>This recommendation is addressed in the KCF II plan: Resource Family Recruitment and Retention 24.1 |
| 2. The department should ensure that foster parents are invited, with proper notice, to dependency hearings and that they understand their right to provide information to the court. | CA will collaborate with the courts and foster parents to develop strategies for ensuring foster parent notification and participation in dependency hearings. It is expected that these strategies will be developed in late 2004 and implemented in early 2005. Implementation will include training for foster parents on presenting information to the courts on children in their care.<br><br>This recommendation is addressed in the KCF II plan: Permanency 7.5.1 |
| 3.4. Foster parents should receive proper training before being asked to care for special needs or drug-affected children. | CA has an extensive pre-service and in-service training program for foster parents. Training is currently available regarding drug affected children and some special needs children. CA will develop a policy regarding mandatory in-service training for foster parents. This policy will address the definition of "special needs" and specify the training required for caring for special needs or drug affected children.<br><br>CA plans to require Division of Licensed Resources (DLR) social workers to make quarterly contact with foster parents and conduct an annual evaluation of foster parents. This evaluation will include an assessment of the training needs of the foster parent. The results of the annual evaluation will be utilized to develop the foster parent training program.<br><br>This recommendation is addressed in KCF II Resource Family Recruitment and Retention 23.1.7 and 23.1.8. It is also addressed in the KCF II plan: Quality Assurance 40.1, 40.2, 40.3 |
| The department should ensure that foster parent liaisons are visible and a known resource for foster parents. | Currently a pamphlet outlining the roles and availability of foster parent liaisons is provided to foster parents at the point of licensing and whenever a licensing investigation is commenced. CA will make this pamphlet available to foster parents at the time of any placement. In |

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| | addition, CA will ensure an up-to-date list of foster parent liaisons is posted on the CA foster parent training web site and the Foster Parents Association of Washington State (FPAWS) web page. |

## Child Fatality Review #04-06

Region 2
Yakima Office

**Case Overview**

This 9-year-old girl died on July 3, 2004 due to head trauma and internal injuries as a result of a motor vehicle accident.

On July 3, 2004, the aunt of the child was driving a gray Plymouth Voyager van west bound on State Route 22. She had a total of five passengers that included her daughter and four nieces; 9-year-old (daughter—who died in the crash); 2-year-old (niece); 9-year-old (niece—who died in the crash); 6-year-old (niece); 3-year-old (niece). They had been attending a family outing in Toppenish and were returning home. The aunt had reached the entrance to the mobile court and was stopped waiting for traffic to clear before attempting to turn left. An on-coming vehicle traveling at approximately 55 MPH was approaching when the aunt's vehicle started to turn left. The on-coming vehicle struck the van. Both deceased children were on the right side of the vehicle where it was struck. One of the deceased children was not wearing a seat belt. Per the Washington State Patrol, failure to yield by the aunt to the on-coming vehicle was the causing factor in the collision.

On December 1, 2003, a report was received indicating domestic violence had occurred in this family home. The father became angry at the children and stood up to go after them. The mother intervened. During the struggle the mother lost one of her fingers. The children were in the home when this incident occurred. The case was assigned; the child was interviewed and did not disclose any abuse or neglect. The case was closed.

**Issues and Recommendations**:

No issues or recommendations identified.

## Child Fatality Review #04-07

Region 4
Seattle Office

**Case Overview**

This 17-year-old girl died on June 19, 2004 due to a motor vehicle accident. She was on a motorcycle with her boyfriend. The couple was stopped by the police for a traffic violation and tried to run away from the police. The couple hit a tree and died. They were driving 85 to 90 miles per hour. Law enforcement indicated that they found what appeared to be methamphetamine, as well as a scale in the seat of the motorcycle. The child's mother lives in Spokane, and the father in Black Diamond. This child has a history of running away.

There are 19 prior referrals on this family. There are Child Protective Services (CPS) referrals, seven of which were 'information only' referrals indicating that there were no specific allegations of abuse. There were eight Family Reconciliation Services (FRS) referrals requesting services for their daughter.

This family first came to the attention of CPS on April 11, 1994. The parents of this child had three children, a boy (DOB 1/27/83), a girl (DOB 7/28/88), and the victim (DOB 9/14/86). The mother was reporting that the children came from visiting their father's home smelling of marijuana. Mother indicates that the father has sold marijuana in the past. This referral was not assigned due to the absence of allegations of abuse.

On March 12, 1999, a referral was received alleging that the father's house was unsafe due to dirty clothes and garbage in the house. The mother was again calling on her ex-husband. This referral was assigned as a low risk case. A letter was sent to the family and the case was closed.

On August 25, 1999, it was reported that the children's step-father had thrown the victim around the house and smashed her against the sink resulting in bruising to the child. These incidents reportedly occurred when the mother was not around. This case was assigned to CPS for investigation and was closed as a moderate low risk case.

On October 7, 1999, a FRS referral was received indicating that a 13-year-old girl had run away from home. It was found that the case was still open to CPS and it was transferred to the CPS unit. The case was closed to FRS and turned over to CPS due to a prior referral on the family. Child Protective Services investigated the case and referred the family to FRS counseling services. The case closed.

On November 2, 1999, the mother called requesting FRS. Counseling services were provided and focused on better communication within the family. The case was closed after counseling was completed.

On November 8, 1999, a referral alleged the mother had slapped the child across the face. This information was reported during the intake for the previous referral. The referral was taken as 'information only' and was not assigned.

On September 19, 2000, a FRS referral was received, indicating that the child had been on the run recently. Stress in the family is due to the mother taking care of the grandmother. An At-Risk-Youth petition was mailed to the family for review and to discuss with the daughter. This referral was 'information only' and no action was required.

On September 26, 2000, a FRS referral was received stating that the youth had been on the run several times. A run report was referred to law enforcement and she was eventually picked up. The youth was placed out of the home during the night. An At-Risk-Youth petition was filed with the court. The petition was dismissed. The family was referred for more family counseling and the case closed.

On October 4, 2000, a CPS referral was received indicating that the mother was using crank. This referral was 'information only' and was not assigned. The case was still open to FRS when this referral came in. The child had been a resident of SKYS and an At-Risk-Youth petition had been filed.

On November 10, 2000, a CPS third-party report was taken. The child was indicating that she had sex with a 24-year-old man. This information was referred to law enforcement.

On January 22, 2001, the mother requested FRS indicating that the child had run from the home on several occasions. The mother was interested in filing an At-Risk-Youth petition. The previous petition had been dismissed due to the mother not attending a hearing. The mother states the child is smoking marijuana and running away. The mother failed to follow through and the case was closed.

On April 4, 2001, the youth called requesting to explore services and a Child-in-Need-of-Services (CHINS) petition. She stated she wanted to go live with her aunt due to her mother being strung out on crank. The child filed petition and was placed with her aunt. The case was closed.

On April 4, 2001, same date as above referral, a CPS referral was received alleging that the child had been thrown out of her house by her mother. After telling her daughter to leave, the mother reportedly passed out on the bed. The child packed her things and called her aunt. The child was formally placed with her aunt and the case was closed.

On May 16, 2001, a report was received indicating that the court commissioner ordered FRS to provide the court with a reunification plan for the child. The case was assigned to FRS. The mother was requested to complete a drug and alcohol assessment. The child was returned home to her mother in August 2001. The case remained open for services.

On January 23, 2002, a report was received indicating that the CWS case was being closed, and the FRS worker did an intake with the aunt and child. The child relates that both parents are using drugs and that she would like to live with aunt in a safe environment. The child denied sleeping with men for drugs. A Family Reconciliation Services case was opened. Arrangements were made for a CHINS petition to be filed, and the case was closed.

On January 28, 2002, a report was made by the aunt indicating that the parent's of this child were drug addicts. The referral was informational as the case was already open to FRS and no allegations of abuse were noted.

On February 20, 2002, a report was received indicating that there is emotional abuse to the teenage child. The report was called in by the aunt. A CHINS petition had been filed, but the mother failed to serve the daughter so she was in contempt. The child is currently with the aunt. This was an 'information only' CPS report.

On May 20, 2002, a CPS third party report was filed alleging that the husband of the aunt threw the child against the wall and hurt the child's back. Since this was third party, no assignment was made. This was an 'information only' CPS report.

On February 24, 2003, a FRS report was received stating that younger sister of the child was needed to have an At-Risk-Youth petition filed. The mother came to the office, but then changed her mind, and was going to contact law enforcement to have the child returned home. The case was closed.

On January 12, 2004, a CPS 'information only' report was received stating that child's younger sibling wants to remain living with her father. Allegations were made that the father does not maintain a clean house.

On June 22, 2004, a report was received stating the child had died in an accident.

**Issues and Recommendations**

No issues or recommendations identified.

## Child Fatality Review #04-08

Region 5
Tacoma Office

### Case Overview

This two-year-old boy died on July 13, 2004 after wandering out of the daycare home to Lake Tapps. The day care provider was attending to several other children when this child opened the bolted door and wandered to the lake. He was found about 40 minutes after he disappeared under a dock. The child was taken to Mary Bridge Hospital where he was pronounced dead.

This licensed provider had only one prior referral due to not giving her tax ID number to a parent for a tax report. There were no prior allegations of abuse and/or neglect on the daycare provider or the parents. The licensed home voluntarily closed their daycare, and the license was subsequently revoked.

### Issues and Recommendations

### I. Practice Issue

**A. Issue:** The Child Fatality Review (CFR) panel concluded after review and discussion of the licensing file, that the department had no knowledge of any incidents or pattern of incidents relating to lack of supervision at the licensed child care home, neither specific to the deceased child nor for any children attending the day care. Statements collected post-fatality, however, did indicate that the deceased child was known to open the front door, locked or unlocked. During the most recent home visit by the licensor in March 2004 (prior to fatality), clarification was given to the day care provider regarding the fire code regulations which require the ability for persons to be able to exit the residence. This was documented in SER by the licensor.

**B. Recommendations**: None. Comment: Practice standards for licensing activities were followed.

### II. Policy Issue

**A. Issue**: Laws, licensing requirements, departmental policies, etc., sufficient to protect the safety of children in licensed child care, already exist in the State of Washington. The responsibility for the death of this child was determined by the CFR panel to fall solely with the licensee who did not follow current requirements in place which were sufficient to protect the child. That is to say, the day care provider failed to provide sufficient supervision as described in licensing requirements.

**B. Recommendations**: None

## III. Exceptional Social Work

**A. Post-Fatality response by DLR/CPS and DCCEL:** The teaming between the DCCEL licensor and the DLR/CPS investigator was immediate and responsive to the situation. The DLR/CPS investigation was substantive, complete, and the documentation appears to be exceptional. The finding of "Founded for Negligent Treatment/ Maltreatment" appears reasonable given the documentation.

**B. Recommendation**: None. Comment: The DLR/CPS investigator, DLR/CPS supervisor, DCCEL licensor, and DCCEL supervisor were present.

## IV. Policy

**A. Post-Fatality response by DCCEL:** Suspension and Revocation notifications to DCCEL licensees are generally presented at the same time. In this case the suspension notification preceded the revocation by about three weeks due to the sensitivity of the circumstances. Upon discussion of this issue by the CFR panel, it was determined that the decision was within policy and was appropriate under the circumstances.

**B. Recommendations**: None

## V. Policy

**A. Post-Fatality issue not related to the fatality itself**: There appears to be no "Traumatic Incident Policy" within DCCEL that addresses issues relating to critical incidents such as child deaths occurring in licensed day care homes.

Such policy can offer guidelines for departmental de-briefing, supervisory and administrative support for licensors and for attaining services through Employee Advisory Services (EAS) which is in policy. Discussion also occurred as to having such a policy to include providing the licensees/providers with support following a traumatic event in their licensed day care home or day care center. The CFR panel members were in agreement that it was not the role of the licensor to work with providers on grief and loss or post-traumatic responses.

**B. Recommendations**: None. Comment: Consideration could be made by DCCEL to develop a "Traumatic Incident Response" policy that gives specific guidelines for responding to employees and providers who may experience such incidents as child fatalities. This policy could allow for supportive intervention to be offered to providers and their staff (either by specified program staff or contracted from without the agency) following such events.

## VI. System Issue

**A. Post-Fatality discussion on increased preventability through changes in WAC:** The CFR panel spent time discussing possible additional requirements in the licensing WACs which could reduce the probability of similar incidents occurring. This included requiring five foot fences around some yet determined yardage for any day care near a water source (lake, river, pond) or high vehicle traffic area. The problem would be that some areas have residential covenants that do not allow fencing of front yards. Another idea was to suggest requiring laser alarms or other types of door alarms that go off whenever someone enters or exits a day care home or center.

While these discussions were well-intentioned, the CFR panel concluded that fences and alarms still cannot take the place of adequate supervision. In the case under review, the issue is clearly "supervision" which is already sufficiently outlined in WAC and MLR.

**B. Recommendations**: None