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

Child Fatality Review

RCW 13.

August 2011
Date of Child's Birth

November 7, 2015
Date of Fatality

March 31, 2016
Child Fatality Review Date

Committee Members
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Oscar Ochoa, Social Services Supervisor, Economic Services Administration
Margo Amelong, Executive Director, Support Center of Okanogan County
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Executive Summary

On March 31, 2016, the Department of Social and Health Services (DSHS) Children's Administration (CA) convened a Child Fatality Review (CFR)[1] to assess the department's practice and service delivery to four-year-old [2] and his family. The incident precipitating this review occurred on November 7, 2015, when died in a relative's home after he had a scheduled operation to remove his RCW 70.02.020 The Grant County Coroner stated the cause of death was RCW 70.02.020 with RCW 70.02.020 as a contributing factor. At the time of death, CA had an open Family Assessment Response (FAR)[3] case with the family.

The CFR Committee included CA staff with expertise in child welfare, law enforcement, domestic violence, child development and a representative from the Office of the Family and Children's Ombuds. No committee members had previous contact or involvement with the family.

Prior to the review, each committee member received a case chronology, a family genogram, a summary of CA involvement with the family and un-redacted case documents including medical records and the medical examiner's report. Supplemental sources of information and resource material regarding caseload data and CA policies were available to the committee at the time of the review. The Committee interviewed the FAR social worker and supervisor who were assigned to the case at the time of the fatality to gain an understanding of FAR practice expectations and decision-making on the case and local office guidelines for community collaboration and law enforcement investigative protocols.

Case Summary

On October 9, 2015, CA received an intake RCW 13.50.100 of six-year-old brother, identified as This intake reported that experienced RCW 70.02.020 and RCW 70.02.020 at school and that his mother, ., was not responsive to the

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

[2] The parents are not identified by name in this report as no criminal charges were filed relating to the incident. The names of and his siblings are subject to privacy law. [Source: RCW 74.13.500(1)(a)].

[3] Family Assessment Response (FAR) is a Child Protective Services alternative response to a screened in allegation of abuse or neglect that focuses on the integrity and preservation of the family when less severe allegations of child maltreatment have been reported. [Source: CA Practices and Procedures Guide 2332]

school's efforts to address the problem. The intake reported that RCW 13.5 resided with his mother, his two younger siblings, RCW 13. and RCW 13. and RCW 13.50.10 father. This intake was assigned to CPS/FAR; the social worker met with the family on October 12, 2015 to discuss the allegations and review the FAR program guidelines. The mother agreed to work with CA voluntarily and consented to take RCW 13.5 to the doctor for evaluation which she did within the week.

On October 15, 2015, the mother took her second oldest child, RCW 13., for a consultation with an RCW 70.02.020 specialist to evaluate his persistent RCW 70.02.020 and RCW 70.02.020 The RCW 70.02 recommended that RCW 13.5 have both his RCW 70.02.020 removed and scheduled this surgery for November 6, 2015. RCW 13 was discharged the same day with a prescription for RCW 70.02.020 for pain.

On November 9, 2015, CA received an intake stating that RCW 1. had died on Saturday, November 7, 2015 at a relative's home. This intake reported RCW 13.50.1 death as accidental but a second intake received on November 10, 2015 provided additional information that alleged that RCW 13. may have died as a result of an RCW 70.02.020. The November 10th intake was accepted for investigation and the matter was referred to law enforcement. In her statements to investigators, RCW 13.50 reported that she had given RCW 13. his prescribed dose of RCW 70.02.020 the night of November 6 and again on the following morning, November 7 at about 8:30 a.m. She reported she gave him another dose on November 7 and allowed him to spend time undisturbed in a bedroom. On the evening of November 7, the mother left RCW 13. at a relative's residence while she went to run errands. At about 7:00 pm that same night, one of the relatives found that RCW 13. had stopped breathing, initiated CPR and called 911. Emergency responders were unable to revive the child and he was pronounced deceased at about 8:25 p.m. The investigating officer noted that 30 ml of RCW 13.50.1 medication was missing from the bottle. The Grant County Coroner's report listed the cause of death as RCW 70.02.020 with RCW 70.02.020 as a risk factor.

Committee Discussion

After discussing case activities, case planning and services to this family from the initial intake on October 9, 2015 through the date of the fatality on November 7, 2015, the Committee found no critical oversights and further found that the social worker appeared to have complied with CA policies, procedures and practice guidelines. The Committee noted that both the social worker and supervisor demonstrated a solid understanding of the case and ability to tell the story of the case in a clear and concise manner. The Committee also noted that

the social worker provided much more information than had been recorded in the case notes and strongly encouraged her to ensure this information is documented.

Although the primary focus of the CFR is to review CA's actions and decision-making prior to the child's death, the Committee was concerned about the lack of information available to CA regarding the investigation of the fatality by law enforcement. As a general practice, CA staff should collaborate with law enforcement agencies to investigate allegations of child abuse and neglect. In cases where the allegations may be criminal in nature or result in criminal charges, law enforcement takes the lead on the investigation as was the case in the investigation of RCW 13.50.1 death. Local CA staff explained to the Committee that the law enforcement agency investigating RCW 13.50.1 death specifically requested that CA staff not interview RCW 13.50.100 mother and relatives regarding the circumstances of the fatality until the investigation had been completed. CA staff informed the Committee that as of the time of this review, four months after RCW 13.50.1 death, this information was still not available to the social worker. The Committee believed that the lack of information significantly impacts the worker's ability to assess safety and risk in this home. Noting that there are two surviving children who may be at risk, the Committee made several recommendations about strategies to address this problem.

Findings

None

Recommendations

1. The Committee believed that the medical examiner's report raised the possibility of risk of neglect by the parent and that further evaluation is needed to assess the safety of the surviving children. The Committee made the following suggestions as possible strategies for the local CA office to consider in order to obtain needed investigative reports.
    - Contact the prosecuting attorney to obtain an updated copy of the investigative protocol, and ensure that law enforcement agencies who are within this office's catchment area have a copy.[4]
    - Consider consultation with the Attorney General's Office to elicit its advocacy to obtain reports needed to assess child safety.

[4] In 1999, the Washington state legislature amended RCW 26.44.180 to require prosecuting attorneys in each county to develop a written protocol for handling criminal child sexual abuse investigations. In 2007, the legislature added RCW 26.44.185 which required prosecuting attorneys in each county to revise and expand their child abuse investigation protocols to include investigations of child fatalities, child physical abuse and criminal child neglect cases.

- Consider working with local law enforcement agencies within the office's catchment area to develop a memorandum of understanding regarding the exchange of information.

2. The Committee recommended that the assigned social worker consult with CA's Regional Medical Consultant in order to better understand the terminology and findings in the medical examiner's report.