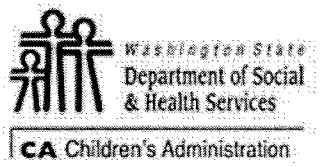
RCW 74.13.500



Child Fatality Review

RCW 74.13.5

February 2014
Date of Child's Birth

July 1, 2014
Date of Fatality

November 20, 2014
Child Fatality Review Date

Committee Members

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Dawn Cooper, MSW, Family Assessment Response Program Manager, Department of Social and Health Services, Children's Administration
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Executive Summary

On November 20, 2014, the Department of Social and Health Services (DSHS), Children's Administration (CA) convened a Child Fatality Review (CFR) to assess the department's practice and service delivery to eight-month-old [redacted] and his family.[1] The child ([redacted] will be referenced by his initials throughout this report.

The incident initiating this review occurred on July 1, 2014, when [redacted]s mother called 911 indicating her child was unresponsive. [redacted] was pronounced dead at his residence. [redacted] lived with his mother and three-year-old sister. [redacted]s father is in the military and stationed in California. The father had been staying at the residence until a few days before [redacted]s death at which time he returned to his post in California.

Law enforcement notified DSHS of the fatality and a CPS investigator was assigned to the case. The CPS worker deferred investigation to the assigned law enforcement detectives. [redacted]s three-year-old sibling was placed in protective custody. She had a brief stay in foster care before she was released to her father. RCW 74.13.500 [redacted]

As of the writing of this report, the cause and manner of [redacted]s death is unknown to the department. The law enforcement investigation is completed and will be reviewed by the prosecuting attorney's office for consideration of criminal charges.

Children's Administration (CA) did not have an open Child Protective Services (CPS) investigation at the time of the fatality nor had any CPS case opened between the birth and death of [redacted] RCW 74.13.500 [redacted]

The review Committee included members selected from diverse disciplines within the community with relevant expertise including mental health, chemical dependency, law enforcement, a Family Assessment Response (FAR)[2] program manager with expertise in CPS investigations, a DSHS/CA supervisor who supervises all case types and the Ombuds Office. Neither CA staff nor any other Committee member had previous direct involvement with this family.

[1] Given its limited purpose, a Fatality Review (CFR) should not be construed to be a final or comprehensive review of all of the circumstances surrounding the near death of a 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 near 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] Family Assessment Response, a Child Protective Services alternative to investigations of low to moderate risk screened-in reports of child maltreatment. [Source: www.dshs.wa.gov/ca/about/far.asp]

Prior to the review, each Committee member received a case chronology, a summary of CA involvement with the family and unredacted CA case documents (e.g., intakes, investigative assessments and case notes). Supplemental sources of information and resource materials were available to the Committee at the time of the review. These included the case file, medical examiner's report regarding the previous fatality in California, the law enforcement report regarding the current fatality, relevant state laws and CA policies.

During the course of this review, the Committee interviewed one CPS worker and CPS supervisor, a supervisor who oversaw Family Voluntary Services (FVS)[3] at the time of a referral to that service, a Child and Family Welfare Services worker (CFWS)[4] and CFWS supervisor, the CPS worker assigned to the fatality and the Area Administrator. There were two previously assigned staff (one CPS investigator and one CFWS worker) who no longer worked for DSHS and therefore were unavailable to be interviewed by the Committee. Following the review of the case documents, completion of staff interviews and discussion regarding department activities and decisions, the Committee made findings and recommendations presented at the end of this report.

Family Case Summary

RCW 74.13.500

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[3] Family Voluntary Services support families' early engagement in services, including working with the family to create Voluntary Service Agreements of Voluntary Placement Agreements and providing ongoing case management services and assessment of safety and risk to children. Voluntary Case Plans are used to engage families willing to participate in services intended to reduce current and future abuse or neglect issues that do not require court intervention. Voluntary services are short-term to help increase parents' protective capacity and manage child safety. Continued assessment of child safety occurs throughout the case. [Source: Children's Administration Practice and Procedure Guide]

[4] CFWS social worker—Child and Family Welfare Services social worker assumes responsibility of a child welfare case after a dependency petition has been filed regarding a child(ren).

RCW 74.13.500

RCW 74.13.500

RCW 74.13.500

RCW 74.13.500

RCW 74.13.500

RCW 74.13.500 . . was born in February 2014.

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

[6] Negligent Treatment or Maltreatment means an act or omission that evidences a serious disregard of consequences of such magnitude as to constitute a clear and present danger to the child's health, welfare, and safety. The fact that siblings share a bedroom is not, in and of itself, "negligent treatment or maltreatment." RCW 26.44.020 [Source: DSHS, CA, Case Services Policy Manual Appendix A: Definitions]

RCW 74.13.500 On July 1, 2014, five- month-old RCW74.13.50 died while at home with his mother and three-year-old sister.

Committee Discussion

The Committee discussion focused on CA policy, practice and system responses in an effort to evaluate the reasonableness of decisions made and actions taken by the department. Discussions occurring as to the family involvement with non-CA agencies was considered outside the purpose and scope of the CFR but served to generate discussion on inter-agency collaboration as well as collateral resource gathering.

The Committee heard staff discuss challenges they faced while they were involved with this family. One major challenge was the lack of cooperation by San Diego County child protective services in California, regarding the request for records RCW 74.13.500 A history check with Oregon Department of Human Services was conducted which resulted in no history found. The office also struggled with maintaining adequate staffing levels for CPS during this time.

The Committee heard from the Area Administrator. She informed the committee there had been a strong emphasis placed on closing out cases where no safety threat currently existed due to a high number of open cases in their dependency court. This information was shared in part due to the concern regarding dismissing a case right before a new baby is born into the family. The Area Administrator also stated she has been able to stabilize her CPS work force and this has added to consistent, adequate and timely CPS investigations. During the time of this case, the county split from one office into two different offices. The two offices remain in the same building and are not divided by area or zip code.

The Committee noted the department missed opportunities to obtain collateral information and to conduct a thorough CPS investigation which led to incident focused investigations.[7] The lack of requested collateral information was noted by the Committee to have negatively impacted the accurate completion of the Structured Decision Making tool, which informs the department when services may or must be offered, as well as provide a clear understanding regarding the fathers' needs for supportive or educational services.[8] The Committee discussed, at length, the lack of information gathered regarding the fathers.

[7] In partnership with the National Resource Center-CPS (NRC-CPS), Washington State Children's Administration implemented the Child Safety Framework in November 2011. A key concept of this model is that the scope of child welfare work is not defined by determining the presence or absence of injuries or incidents, but rather in identifying present or impending safety threats, and working with families to mitigate those threats.

[8] Actuarial risk assessment is a statistical procedure for estimating the probability that a critical event will occur at some future time. SDM® uses factors associated with higher rates of abuse and neglect to identify families who are most likely to experience a future event of child abuse or neglect. SDM® supports Children's Administration staff in making decisions about the highest risk families who should receive intervention. [Source: www.dshs.wa.gov/ca/pubs/sdm.asp]; The Structured Decision Making Risk Assessment (SDMRA) is a household-based assessment focused on the characteristics of the caregivers and children living in that household. By completing the SDMRA following the Safety Assessment, the worker obtains an objective appraisal of the risk to a child. The SDMRA informs when services may or must be offered. [Source: DSHS, CA, Practices and Procedures Guide 2541]

The mother asked for supportive services regarding her alcoholism and mental instability. The Committee believes the mother's alcoholism was not viewed as significantly as it should have been. The mother was referred for a chemical dependency assessment as part of the plan to transfer her case to voluntary services, but before this was completed the case was closed and sent to an alternate community intervention without communication with the mother. When the decision was made to file a dependency petition, the mother admitted to the CPS worker at court that she had relapsed. The CPS worker is unsure if he informed the court worker and ultimately the court, of the mother's continued abuse of alcohol thus raising the risk of a two-year-old child in her care.

The Committee discussed that the assigned CPS worker did not adequately provide the mother with services to address her mental health needs. The mother completed a GAIN SS on December 14, 2012, which by its results indicated a need to refer the mother to a Crisis Line or Designated Mental Health Professional (DMHP) because the mother indicated yes to the question "RCW 74.13.520 ".[9] After the mother completed this document, she was later given a phone number to call to access mental health services. The Committee noted best case practice would have been to call a crisis line or DMHP immediately after the mother completed the document.

The CFWS worker who had the case when the mother missed her UA and provided diluted UA's, no longer works for CA. However, the supervisor stated during her interview with the Committee that the worker failed to provide accurate information regarding the UA's to the supervisor when they staffed the case. In fact, the CFWS worker provided all positive information during her monthly supervisory reviews. The supervisor stated, had she been given the correct information, she would have directed the worker to utilize a Child Protection Team (CPT) before considering dismissal of the case.[10]

The Committee understood that the fatality investigation was not as urgent based on no other children remaining in the mother's custody. However, the Committee believes the CPS worker should have requested more information from the detectives to aid in her investigation before it was closed. The Committee felt strongly that a new referral alleging child abuse and/or neglect should have been made based on the CPS worker's knowledge of the mother changing her account of the fatality as well as knowing that law enforcement found alcohol in the apartment. While understanding that a finding of founded for child abuse or neglect does not keep a child safe, an adequate and complete investigation regarding a child's fatality can be beneficial if there were to be any future allegations of abuse or neglect.

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[9] Tool used to screen parent, guardians or legal custodians and youth, age 13 and over to identify need for further chemical dependency, mental health or co-occurring assessment by a community professional and make appropriate referrals. [Source: http://ca.dshs.wa.gov/intranet/policy/gain-ss.asp]

[10] Child Protection Teams provide confidential, multi-disciplinary consultation and recommendations to the Department on cases where there will not be an FTDM, and there is a risk of serious or imminent harm to a young child and when there is dispute if an out-of home placement is appropriate. [Source: DSHS, CA, Practices and Procedures Guide 1740]

Below are the findings and recommendations made as a result of the staff interviews and discussion regarding [redacted] and his family's involvement with CA.

Findings

- The Committee found that collateral contacts were lacking throughout this case. The mother referenced court requirements for one of the father, when speaking with the assigned social worker. However no further follow up questions or records request followed. Both fathers were enlisted military and therefore military social work staff could have been contacted. In an intake, it was alleged that the mother had been hospitalized due to suicidal expressions and had been drinking for twenty-four hours. The caller reported when the mother was discharged it was recommended to begin therapy, medication management and support groups. Records regarding this information could have been requested to assist in assessing the mother's current treatment needs. Despite having information about the mother's past issues and the fact that one of the children had special needs, the social worker did not document the child's needs and if or how that was impacted by the mother's actions, addiction and mental health. There was consensus that the investigations and case, in general, lacked a thorough social summary and was incident focused. The social summary would allow for a more comprehensive assessment of the needs for the children as well as what services and supports, for all parents, would have been appropriate for the family to stabilize.
- The Committee believed the third intake from December 2012 met screening criteria and should have resulted in a CPS investigation.
- The Committee was concerned about the inaccuracies in the completed SDMs and whether the failure to complete it correctly negatively impacted services being offered during the first investigation. The fathers were not included in the completion of the SDMs.[11]
- A shared planning meeting should have occurred prior to dismissal.[12] The Committee believes best case practice would have been to hold a FTDM prior to the attempted transfer to FVS in 2012 and prior to the filing of the dependency petition.[13]
- The safety plan was not completed correctly. It included a service and did not clearly address the safety of the children in the home. There were not adequate supports included in the plan
- The second assigned CFWS worker failed to conduct twice monthly health and safety visits with [redacted]'s sister, seven out of the eight months the case was assigned to her.[14]

[11] http://ca.dshs.wa.gov/intranet/pdf/practicemodel/SDMRiskManual.pdf

[12] RCW 13.34.145

[13] Family Team Decision Making (FTDM) meetings bring people together who are involved with the family to make critical decisions regarding the removal of child(ren) from their home, changes in out-of-home placement, and reunification or placement into a permanent home. [Source: CA, DSHS Practices and Procedures Guide 1720 Purpose Statement]

[14] DSHS, CA Practices and Procedures Guide 4420 A

Recommendations

- Children's Administration should discuss the value of continued utilization of the SDM. During the Committee discussion, this issue was identified as statewide and not specific to the local office. The Committee questions the benefit that continued use of the SDM provides. If Children's Administration continues use of the SDM, the Committee strongly suggested ongoing refresher trainings for all CPS staff. After the review was completed, the Area Administrator informed this writer that the office held a training for all CPS workers on the SDM recently because she was aware of the challenges of accurate completion of this tool.
- Children's Administration should have regular, ongoing safety assessment training for all staff.
- The local office should reassess their practice of not reassigning CPS intakes to the previously assigned social worker. The Committee believes it can be positive for a worker to have the personal history of a family when assessing a new intake, but acknowledged that practice must be balanced with keeping an open mind during each investigation. The Committee discussed the pitfalls of reassigning a case to the previous worker as the investigator may not recognize safety threats and risk when becoming too familiar with a family. It is the hope of the Committee that the assigned supervisor can provide objective oversight to make sure an appropriate assessment is completed.
- The Committee believes that staff statewide would benefit from ongoing training regarding alcohol abuse. The Committee expressed concern that some CA staff may have a bias regarding alcohol abuse and lethality.