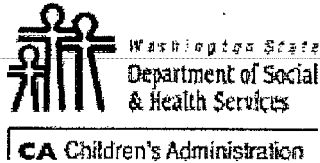

Children's Administration
Child Fatality Review

K.B.

September 2012
Date of Child's Birth

December 11, 2012
Date of Child's Death

May 9, 2013
Child Fatality Review Date

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RCW 74.13.640

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Executive Summary

On May 9, 2013, the Department of Social and Health Services Children's Administration (CA) convened a Child Fatality Review[1] (CFR) to examine the Department's practice and service delivery to 3-month-old K.B. and her family. K.B.'s mother was incarcerated at Washington Correctional Center for Women (WCCW) at the time of K.B.'s birth in September 2012; the infant was discharged by the hospital into the care of the alleged biological father Kevin Boehmer.[2] Mr. Boehmer immediately moved to California with the newborn and on December 11, 2012 K.B. died in Tuolumne County, California as a result of blunt force trauma believed to have been caused by her alleged biological father. Children's Administration had no prior involvement with Kevin Boehmer [redacted] [3]

A CFR was required under RCW 74.13.640(1)(a) because the child's family received services from the Department within a year of the child's death from alleged abuse or neglect. The CFR Committee was comprised of CA staff and community members with pertinent expertise from a variety of fields and systems, including hospital social work, the prison division of the Department of Corrections (DOC), CA intake and child welfare services, parent advocacy, child advocacy, and family preservation. An Assistant Attorney General provided legal consultation to the Committee regarding CA's legal authority, jurisdiction, and other legal issues relevant to the review process. None of the Committee members had any previous direct involvement with the family.

Prior to the review each Committee member received: (1) a brief narrative summary of CA involvement with K.B.'s mother and half-siblings; (2) a chronology covering CA activities from the first mention of the incarcerated mother's pregnancy in March 2012 through post-delivery investigation; (3) unredacted CA case file documents relating to discussions with WCCW prison staff from before K.B. was born; (4) unredacted CA

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

[2] The alleged father's name is used in this report as he was charged by the Tuolumne County District Attorney with Homicide in connection with the child's death. *See* RCW 74.13.500.

[3] The name of K.B.'s mother is not used in this report as she was not involved in the fatality that occurred in California. The names of the half-siblings are also not used in this report due to confidentiality. [*See* RCW 74.13.500]

investigation case file documentation from after K.B. was born; and (5) California CPS documents obtained from Stanislaus County and Tuolumne County. During the review Committee members were provided with a copy of a working agreement from 2000-2001 between WCCW and Pierce County CPS.

During the course of the review two Aberdeen DCFS supervisors and two Aberdeen DCFS social services specialists involved in the case were interviewed. Following review of the case file documents, completion of the staff interviews, and discussion regarding laws and current DOC and CA policies and practices, the Committee made findings and recommendations, which are presented at the end of this report.

Case Overview

K.B. was born in September 2012. However, her mother's history with Children's Administration predates K.B.'s birth by five years.

In March 2012, v , the mother disclosed her third pregnancy and identified California resident Kevin Boehmer as the father. Following the mother's sentencing and transfer to the women's prison, CA responded to several inquiries from WCCW regarding the mother's history with CPS, any known CPS history involving the alleged father, and possible involvement by CPS at delivery of the unborn child since the inmate mother-to-be was not being considered for the parent-child program at the Purdy facility and the child could not stay with the mother in the facility.[4]

In August 2012, WCCW informed CA that the mother had completed a power of attorney that would allow her unborn child to be placed in the custody of Kevin M. Boehmer. The WCCW counselor was advised to contact Child Protective Services (CPS) Intake when the child was born if there were specific concerns about Mr. Boehmer assuming care of the child. In September, an Aberdeen DCFS worker became aware of the birth of K.B. seven days after delivery. Information gathered by the worker suggested that the alleged father and newborn might be staying at the home of a registered sexual offender, which led to

[4] The Washington's Correction Center for Women (WCCW) has a program that allows minimum-security inmates serving less than three years the opportunity to live with their babies in a designated unit. The Residential Parenting Program (RPP) collaborates with Early Head Start to teach the women about parenting and to support healthy attachment, which is critical to an infant's ability to learn.

an intake that screened in as Risk Only (because there were no allegations of abuse or neglect).[5]

A CPS investigation was initiated and the assigned CPS worker and a DOC officer conducted a site visit to the home of the registered sex offender and found no evidence that the child had ever been in the home. Information gathered by the CPS worker indicated K.B. and the alleged father were living in California. The CPS worker confirmed this information from numerous sources and contacted Mr. Boehmer by phone. Following this verification of the child's whereabouts, the CPS worker contacted California CPS and filed a report. The CPS investigation in Washington was closed and Stanislaus County California CPS opened a case, conducted a home visit with the father and child, and offered him services.

In November 2012, Mr. Boehmer moved to Tuolumne County. On December 9, 2012, three-month-old K.B. was admitted to Sonora Regional Medical Center for non-accidental injuries from which she later died. Kevin Boehmer was eventually charged with homicide.

Committee Discussion

The Committee endeavored to follow the prescribed purpose of Child Fatality Reviews by limiting its findings and recommendations to DSHS Children's Administration and not to other public or private agencies involved with the family.

However, the Committee acknowledged the unique set of complex circumstances of this case, which involved multiple systems each having separate legal authorities, policies, and protocols. The Committee considered various Washington laws, Children's Administration policies and practices, DOC procedures[6] and interagency communication practices between WCCW and CA. These discussions resulted in the Committee's recognition of: (1) limited authority by CA to initiate hospital alerts or share information on cases that are not open with CA (RCW 74.04.060; WAC 388-15-029); (2) specified limits of legal authority for the state to provide Child Protective Services (ch. 388-15 WAC); (3) limits of legal authority for the state to provide Child Welfare Services (RCW 74.13.031(3)); (4) limits of legal authority for the state to intervene in cases involving unborn children (RCW 26.44.020); (5) the right of an inmate at Purdy women's facility not involved in a child dependency matter to designate a caretaker for her newborn,

[5] CA will screen in a CPS Risk Only intake when information collected gives reasonable cause to believe that risk or safety factors exist that place the child at imminent risk of serious harm. In assessing imminent risk of serious harm, the overriding concern is a child's immediate safety. [Source: Children's Administration Practice and Procedure Guide Section 2220]

[6] CFR Committee members were briefed on DOC policy and practices regarding pregnant and delivering mothers incarcerated at WCCW (Purdy), such as the development of an Infant Care Plan, documenting signed power of attorney by an inmate, securing releases of information, and sharing of information with the local Pierce County hospital that provides birthing services for Purdy inmates.

regardless of verified familial relationship; and (6) limits of disclosure of patient health information by health care providers, including hospitals, as established by HIPPA.[7]

While some discussion occurred regarding prior involvement of Children's Administration with the deceased child's mother and half-siblings, the Committee largely focused on the documented activities and decisions from the time of initial disclosure of the pregnancy in March 2012 through K.B.'s birth in September and the subsequent efforts by CPS to locate the newborn and her alleged father.

Findings

- The actions taken and decisions made by Children's Administration appear to have been reasonable based on established Children's Administration practice and the legal constraints for any Children's Administration intervention that were in place at the time. The Committee found the individual work by the Aberdeen CPS investigator to be exceptional in her efforts to locate the newborn, to gather additional information as to the alleged father, to contact and conduct follow-up with California CPS, and to document decisions and activities.
- The Committee was unable to conclude with any substantive level of certainty that had Children's Administration become involved at the moment of K.B.'s delivery that the alleged father could have been prevented from assuming the care of the newborn without evidence that he posed substantial threat of harm to the child. Lack of established paternity would not have been a determinative factor, as the case did not involve a dependency action regarding the child. There was nothing in the records reviewed to suggest any reason to anticipate a fatality incident and the Committee was unable to identify any obvious and legally supportable consideration that would have determinedly changed the course of events in this case.
- During interviews with the Aberdeen Children's Administration staff involved with the case, it was apparent that the workers were unfamiliar with procedures and practices regarding children delivered by inmates at the Purdy facility. Such cases most frequently are handled by Tacoma Children's Administration office as the prison is located in Pierce County, and it appears that workers in other areas of the state are not aware of how such cases are typically handled. The absence of such knowledge was found to have no reasonably discernible connection to the child's later circumstances of death, but was notable.

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[7] The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) established protections for security and privacy of patient health data. HIPAA's broad privacy provisions are intended to protect the confidentiality of patient health records. Broadly worded exceptions to HIPAA's privacy protections permit reporting and disclosure of public health-related case information on child maltreatment and child fatalities to those conducting activities related to "investigation" and "intervention" [See Section 160.203(c)]. In this case there was no investigation or intervention by CPS until several days after the birth.

Recommendations

Children's Administration should convene a workgroup tasked with developing an updated working agreement with the Department of Corrections WCCW similar to the one initiated in 2000 between the then Region 5 CA Regional Administrator and the Superintendent of WCCW. It is recommended that:

- The updated working agreement not be limited to a local agreement, but be a broader inter-department agreement.
- The work group should include not only CA and DOC/WCCW staff, but also include participation by representatives from the Office of Attorney General and attorneys working with clients involved in dependency matters.
- The agreement should cover collaborative protocols for screening of participants eligible for the Residential Parenting Program (RPR) at the Purdy facility as well as procedures for screening pregnant inmates who are not eligible for the program and for which post-delivery caretaking arrangements may or may not need to involve Children's Administration. This might include guidelines regarding use of CA staff to be available to consult with WCCW staff on RPR screening committee meetings and inmate Infant Care Plan development even if not involving a client having an active case with CA to the extent such involvement is authorized by law.
- The workgroup should consider identifying interagency liaisons within CA and DOC that have dedicated responsibilities outlined in the agreement.
- The agreement should provide a clear understanding of roles and responsibilities for both WCCW and CA staff regarding information inquiries, the specific types of information that can be shared within current legal authority, and case staffing protocols. Once a formalized interagency working agreement is completed, it should be made available to all CA staff as an online reference document.

Nondiscrimination Policy

The Department of Social and Health Services does not discriminate and provides equal access to its programs and services for all persons without regard to race, color, gender, religion, creed, marital status, national origin, sexual orientation, age, veteran's status or the presence of any physical, sensory or mental disability.