RCW 74.13.500

RCW 74.13.515

Children's Administration

Executive Child Fatality Review

I.A.

May [redacted] 2011
Date of Child's Birth

September 24, 2011
Date of Child's Death

February 1, 2012
Executive Child Fatality Review Date

Committee Members:
Isaac Pope, M.D., Volunteer Pediatrician
Russ Funk, Program Manager, Cascade Mental Health Center, Centralia
Katie Braee, Social Services Advocate, Human Resources Network, Chehalis
Jamey McGinty, Detective, Lewis County Sheriff's Office
Rebecca Scott, Parent Support Services Coordinator, Centralia College
Debbie Lynn, Area Administrator, Children's Administration

Observers:
Mary Meinig, MSW, Director of the Office of Family and Children's Ombudsman
Paul Smith, Critical Incident Program Manager, Children's Administration

Facilitators:
Bob Palmer, Children's Administration Program Consultant, Region 3 North
Thomas "Kui" Hug, Children's Administration Safety and Well-Being Program Manager, Region 3

Table of Contents:

Executive Summary	page 3
Case Overview	pages 4-5
Committee Discussion	page 5
Findings and Recommendations	pages 5-6

Executive Summary

On February 1, 2012 Children's Administration (CA) convened an Executive Child Fatality Review[1] (ECFR) committee to examine the practice and service delivery in the case involving 4-month-old I.A. and his mother. The incident initiating this review occurred on September 20, 2011, when Centralia CPS intake was notified of the hospital admission of I.A. for severe injuries believed to be the result of non-accidental trauma while in the care of his mother Rachel Bryan[2].

A review of the family's history with CA showed one previous intake from five days prior (September 15) regarding a lump and tenderness to the infant's back. Of noted concern at that time was the reported inappropriate way the mother spoke to the child. This earlier report was assigned for investigation and thus the case was open with CPS at the time of I.A.'s hospitalization for severe injuries from which he died on September 24, 2011.

The ECFR committee included CA staff and community members selected from diverse disciplines with relevant expertise, including representatives from medical, law enforcement, parenting, mental health, and DV/community advocacy. Committee members had no prior direct involvement with the case, although some had limited general knowledge of the situation. Prior to the review each committee member received a chronology of known information regarding the mother and child, un-redacted CA case-related documents, as well as medical and law enforcement records obtained post-fatality incident. Available to committee members at the review were additional documents (e.g., autopsy report), copies of various laws relevant to CA (e.g., legal definitions of abuse and neglect), and several CA policy and practice guides relating to CPS investigations and assessment of risk and safety. During the course of the review, the CPS investigator, CPS Supervisor, and the Area Administrator were available for interviews, but the committee declined as the documentation provided appeared to be sufficiently clear in terms of activities and the basis for decisions made. Committee members were provided with pertinent information gathered during a pre-review interview of the CPS investigator by the ECFR facilitator.

Following review of the case file documents and discussion regarding social work activities and decisions during the CPS investigation, the review committee made findings and recommendations which are detailed at the end of this report.

---

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

[2] The full name of Rachel Bryan is being used in this report as she has been charged in connection to the incident and her name is public record

Case Overview

It is known that the mother moved from Washington State to California in early 2010. She gave birth to her son in California in May 2011. In early September of 2011 Rachel and her infant moved back to Washington State following a domestic violence situation involving her partner (I.A.'s biological father) who was subsequently jailed and then returned to prison (parole violation).

CPS first became aware of I.A. and his mother five days prior to the precipitating incident which resulted in the infant death. On September 15, 2011, a nurse practitioner from a pediatric health center called with concerns following a 4-month-old (new patient) who had been brought in by his mother for a reported lump/tenderness to the child's back. Examination and x-rays revealed no apparent medical explanation and no bruising was found. Observations of the mother's interaction with the infant were of noted concern by health center staff. The mother was described as appearing to be on edge, easily agitated, and very abrupt when talking to the infant - saying things like "stop crying," "you'd better stop crying," "you're irritating me.".

The report was accepted for investigation and the assigned investigator from Centralia CPS made contact with mother, child, referent, and maternal relative within 24 hours. Additionally, the worker consulted with a state Child Protection Medical Consultant[3] who in turn contacted the medical care provider for additional discussion.

A Family Action Plan[4] was developed by the CPS social worker with the parent to help address housing and transportation, to access counseling and medication, to access a parenting class, and to increase the visibility of the child using natural supports. That weekend Ms. Bryan and I.A. moved in with the maternal grandmother. The CPS worker received a voice message the following Monday (September 19, 2011) from the mother confirming the move to her mother's home in the Centralia area. Ms. Bryan also reported she had several appointments set for that week (health; mental health) and had contacted various community and public agencies (Women, Infant, & Children; DSHS).

On the morning of September 20, 2011, I.A. and Rachel were transported to appointments by her "step-father," returning to his home in Thurston County. That afternoon, while the step-father was working outside, Rachel called 911 to report that her baby was not responding as normal and was in distress. Emergency aid arrived to the residence and the child was transported to Centralia Providence Hospital, presenting with possible seizures, hematoma to both eyes, and an arm fracture. The injuries were determined to be due to non-accidental causes. The child was transported to Mary Bridge Hospital in Tacoma as the child's injuries were very severe and

[3] The tasks of the statewide Child Protection Medical Consultants (CPMC) network include providing telephonic consultations, case staffing/case review, training, court testimony, and written consults to CA staff, law enforcement officials, prosecuting attorneys, and physicians regarding child maltreatment cases.

[4] A Family Action Plan (FAP) is a family collaboration tool that can be used to document a family's efforts to identify needs/concerns, to problem solve and develop actions steps, and to identify natural supports. It is not a safety plan per se, but may include steps to maintain safety through increased visibility of the child. [Source: DSHS/CA Practice Guide to Intake and Investigative Assessment – Chapter Seven Family Action Planning]

required immediate medical attention. The prognosis at Mary Bridge was that the child was likely to die as a result of the injuries.

When interviewed by a Thurston County Sheriff's Office detective, Rachel Bryan confessed to physically abusing her infant son. The mother reported I.A. was crying for 20 minutes, and she could not handle it any more. She then forcibly pulled the child up into her shoulder, shook him twice, and then forcefully drove him into the mattress twice. The mother was booked for Second Degree Assault of Child. When the child was pronounced dead on September 24, 2011, charges were amended to Murder in the Second Degree with Aggravating Circumstances.

The CPS investigation was completed in October, with "unfounded" findings regarding neglect but "founded" for physical abuse to her son.

Committee Discussion:

Committee members acknowledged the short time span of CPS involvement in this case, with the first intake being received and accepted for investigation on September 15, 2011 (Thursday), contact being made with medical professionals and the family the following day (Friday), and the second intake regarding severe non-accidental injuries occurring on September 20 (Tuesday) that resulted in the removal from life support of I.A. on September 24, 2011. Committee members reviewed information gathered and social work activities completed by the CPS investigator and supervisor from case assignment to case closure. Committee members engaged in extended discussion as to the CPS worker's response to risk factors and "warning signs" identified early in the case.

Findings:

Intake related

The committee was in full agreement that the decision to accept the September 15, 2011 intake for CPS intervention was appropriate, but was unable to reach complete consensus as to the appropriate designated intake type (i.e., accepting the intake on the basis of allegations or on the basis of Risk Only[5]). There were no associated recommendations specific to intake decisions.

Investigation related

The committee acknowledges good social work practice as evidenced by case file documentation, and recognizes the efforts by the worker to gather information, to assess the family, and to make casework decisions in a short period of time. The committee concludes that the CPS investigative activities and decisions were reasonable and sensible given the information available, and were found to be consistent with current laws and CA policy and practice

[5] CA may investigate intakes that do not allege an actual incident of Child Abuse or Neglect (CA/N), but have risk factors that place a child at imminent risk of serious harm. Many intakes without CA/N allegations will have one or more risk factors. This does not necessarily mean that imminent risk of serious harm is present. The more indicators of CA/N, the more likely it is that a child is being abused or neglected. While many concerning reports are received by CA, most will not rise to the level of imminent risk of serious harm. Careful analysis of the balance of risk and protective factors, combined with good clinical judgment and shared decision making, helps in identifying risk-only intakes. [Source: *DSHS CA Practice Guide to Intake and Investigative Assessment* - Chapter Four Risk Only Intakes]

standards. The worker appears to have been appropriately aware of identified risk factors and "warning signs" suggestive of parental ambivalence[6]. The committee was unable to reach full consensus as to whether the identified concerns sufficiently suggested that I.A. was endangered and therefore should have had a safety plan in place that limited the mother's access to the child as opposed to the Family Action Plan (FAP) that was developed with the parent with family support. The committee does conclude that the FAP did appropriately focus on actions and services that would reasonably be expected to reduce risks and improve parenting and the parent-child relationship. There are no associated recommendations specific to the investigative practice in this case.

Recommendations:

No recommendations emerged that fell within the scope of the Executive Child Fatality Review process.

Miscellaneous Consideration outside the scope of the ECFR:

While not relating to any aspects specific to the circumstances of this particular case, discussion during the review suggested that there may be a need for better communication between CPS and local (Lewis County) law enforcement officers as to placing children into protective custody per RCW 26.44.050[7]. It appears that some CA social workers in Lewis County may be reluctant to provide officers with their opinion as to the need for protective custody so as not to appear to tell law enforcement what to do as the decision rests legally with an officer of the law.

The review committee suggested that the Area Administrator (AA) for the Lewis County DCFS office review and assess the procedures and expectations regarding protective custody that may exist in any written working agreement/protocol with local law enforcement, and to initiate discussion with protocol participants if needed changes are identified. It was further suggested that the AA initiate discussion with Centralia social work staff as to how to effectively communicate with responding officers about identified safety threat issues when protective custody is a consideration while acknowledging that the decision rests with the officer. Such discussions should involve participation by representatives from local law enforcement if possible.

Action Taken: The Area Administrator (AA) for the Lewis County DCFS office has been apprised of the above discussion and has agreed to follow up on the suggestions made to improve communication between workers and responding law enforcement regarding assessed child safety threats.

[6]Parental ambivalence relates to the nurturing and affectionate aspects of a parent-child relationship. It is often identifiable by behavioral or verbal indicators that suggest contradictory attitudes toward the relationship, incompatible expectations and mixed emotions, and self-doubt regarding being able to handle a parent/caretaker role.

[7] A law enforcement officer may take, or cause to be taken, a child into custody without a court order if there is probable cause to believe that the child is abused or neglected and that the child would be injured or could not be taken into custody if it were necessary to first obtain a court order pursuant to RCW 13.34.050.