# Report to the Legislature

# Quarterly Child Fatality Report

RCW 74.13.640

April – June 2012

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Washington State Department of Social & Health Services

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## Executive Summary

This is the Quarterly Child Fatality Report for April through June 2012 provided by the Department of Social and Health Services (DSHS) to the Washington state Legislature. RCW 74.13.640 requires DSHS to report on each child fatality review conducted by the department and provide a copy to the appropriate committees of the legislature:

***Child Fatality Review — Report***

*(1)(a) The department shall conduct a child fatality review in the event of a fatality suspected to be caused by child abuse or neglect of any minor who is in the care of the department or a supervising agency or receiving services described in this chapter or who has been in the care of the department or a supervising agency or received services described in this chapter within one year preceding the minor's death.*

*(b) The department shall consult with the office of the family and children's ombudsman to determine if a child fatality review should be conducted in any case in which it cannot be determined whether the child's death is the result of suspected child abuse or neglect.*

*(c) The department shall ensure that the fatality review team is made up of individuals who had no previous involvement in the case, including individuals whose professional expertise is pertinent to the dynamics of the case.*

*(d) Upon conclusion of a child fatality review required pursuant to this section, the department shall within one hundred eighty days following the fatality issue a report on the results of the review, unless an extension has been granted by the governor. A child fatality review report completed pursuant to this section is subject to public disclosure and must be posted on the public web site, except that confidential information may be redacted by the department consistent with the requirements of RCW 13.50.100, 68.50.105, 74.13.500 through 74.13.525, chapter 42.56 RCW, and other applicable state and federal laws.*

*(2) In the event of a near fatality of a child who is in the care of or receiving services described in this chapter from the department or a supervising agency or who has been in the care of or received services described in this chapter from the department or a supervising agency within one year preceding the near fatality, the department shall promptly notify the office of the family and children's ombudsman. The department*

*may conduct a review of the near fatality at its discretion or at the request of the office of the family and children's ombudsman.*

In April 2011, SHB 1105 was passed by the legislature and signed into law by Governor Gregoire. The revised child fatality statute (RCW 74.13) became effective July 22, 2011 and requires the department to conduct fatality reviews in cases where a child death is suspected to be caused by abuse or neglect. This eliminated conducting formal reviews of accidental or natural deaths unrelated to abuse or neglect. The revised statute requires the department to consult with the Office of Family and Children's Ombudsman (OFCO) if it is not clear that the fatality was caused by abuse or neglect. The department can conduct reviews of near fatalities or serious injury cases at the discretion of the department or by recommendation of OFCO. The statutory revision allows the department access to autopsy and post mortem reports for the purpose of conducting child fatality reviews.

This report summarizes information from completed reviews of 4 fatalities that occurred in the second quarter of 2012. All of the reviews were conducted as executive child fatality reviews. All prior Child Fatality Review reports can be found on the DSHS website:
http://www.dshs.wa.gov/ca/pubs/fatalityreports.asp.

The reviews in this quarterly report include fatalities from each of the three regions.[1]

| Region | Number of Reports |
|---|---|
| 1 | 1 |
| 2 | 2 |
| 3 | 1 |
| Total Fatalities Reviewed During 2nd Quarter, 2012 | 4 |

This report includes Child Fatality Reviews conducted following a child's death that is suspicious for abuse and neglect and the child had an open case or received services from the Children's Administration (CA) within 12 months of his/her death. Child Fatality Reviews consist of a review of the case file, identification of practice, policy or system issues, recommendations and

[1] DSHS implemented a reconfiguration of the regional boundaries in May 2011. The existing six regions were consolidated into three.

development of a work plan, if applicable, to address any identified issues. A review team consists of a larger multi-disciplinary committee including community members whose professional expertise is relevant to the family history. The review committee members may also include legislators and representatives from the Office of the Family and Children's Ombudsman.

The chart below provides the number of fatalities and near fatalities reported to CA and the number of reviews completed and those that are pending for calendar year 2012. The number of pending reviews is subject to change if CA discovers new information through reviewing the case. For example, CA may discover that the fatality or near-fatality was anticipated rather than unexpected, or there is additional CA history regarding the family under a different name or spelling.

| Child Fatality Reviews for Calendar Year 2012 | | | |
|---|---|---|---|
| Year | Total Fatalities Reported to Date Requiring a Review | Completed Fatality Reviews | Pending Fatality Reviews |
| 2012 | 10 | 0 | 10 |

| Child Near-Fatality Reviews for Calendar Year 2012 | | | |
|---|---|---|---|
| Year | Total Near Fatalities Reported to Date Requiring a Review | Completed Near-Fatality Reviews | Pending Near-Fatality Reviews |
| 2012 | 3 | 0 | 3 |

The fatality reviews contained in these Quarterly Child Fatality Reports are posted on the DSHS website.

**Notable Findings**
Based on the data collected and analyzed from the 4 fatalities reviewed between April and June 2012, the following were notable findings:

- Two (2) of the cases were open at the time of the child's death. Both had open active Child Protective Services (CPS) investigations at the time of the child's death.
- All four (4) children were under the age of 12 months old.
- Two (2) were male and (2) were female.
- Two (2) of the children were Black/African American, one was Caucasian, and one was Native American.

- All of the fatalities were suspicious for abuse or neglect; however, only one of the fatalities was classified as a homicide by a medical examiner.
- In the one fatality listed as a homicide, the child was Black/African American. The child died from blunt force trauma. The perpetrator was the child's father. CA had opened a CPS case on the family 10 days prior to the child's death and was investigating a suspicious skull fracture to this eight-month-old child.
- Children's Administration had intake reports of abuse or neglect in all four child fatality cases prior to the death of the child. Two of the cases had only one intake prior to the death of the child. One case had six prior intakes and another had 21 intakes reported to CPS on the family before the child died. The case with 21 prior intakes was classified by a medical examiner as an accidental death. This child died from being administered an excessive amount of Benadryl.
- Due to the small sample of cases reviewed, no statistical analysis was conducted to determine relationships between variables.

**Table 1.1**

| 2nd Quarter 2012, Child Fatalities by Age and Gender | | | | | | |
|---|---|---|---|---|---|---|
| **Age** | **Number of Males** | **% of Males** | **Number of Females** | **% of Females** | **Age Totals** | **% of Total** |
| <1 | 2 | 50% | 2 | 50% | 4 | 100% |
| 1-3 Years | 0 | - | 0 | - | 0 | - |
| 4-6 Years | 0 | - | 0 | - | 0 | - |
| 7-12 Years | 0 | - | 0 | - | 0 | - |
| 13-16 Years | 0 | - | 0 | - | 0 | - |
| 17-18 Years | 0 | - | 0 | - | 0 | - |
| Totals | 2 | 50% | 2 | 50% | 4 | 100% |

N=4 Total number of child fatalities for the quarter.

**Table 1.2**

| 2nd Quarter 2012, Child Fatalities by Race | |
|---|---|
| Black or African American | 2 |
| Native American | 1 |
| Asian/Pacific Islander | 0 |
| Hispanic | 0 |
| Caucasian | 1 |
| **Totals*** | **4** |

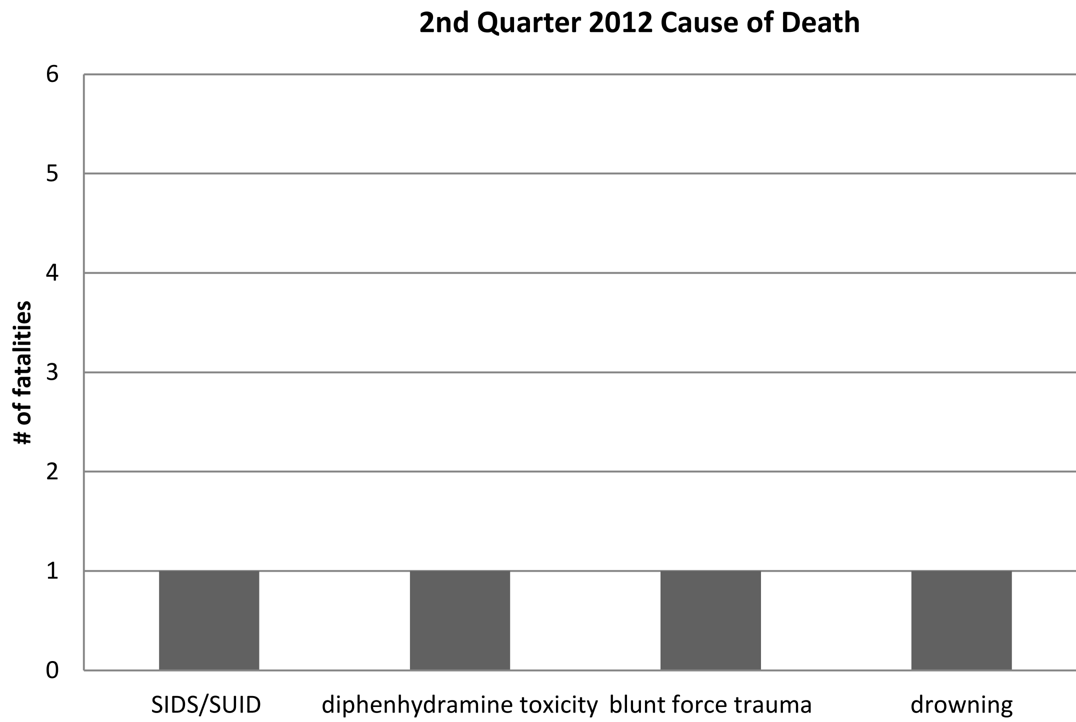
*Children may be from more than one race.

**Table 1.3**

| 2nd Quarter 2012, Child Fatalities by Manner of Death | |
|---|---|
| Accident | 2 |
| Homicide (3rd party) | 0 |
| Homicide by Abuse | 1 |
| Natural/Medical | 0 |
| Suicide | 0 |
| Unknown/Undetermined | 1 |
| **Totals** | 4 |

N=4 Total number of child fatalities for the quarter.

**Table 1.4**




N=4 Total number of child fatalities for the quarter.

**Table 1.5**

| 2nd Quarter 2012<br>Number of Reviewed Fatalities by Prior Intakes | | | | | | |
|---|---|---|---|---|---|---|
| **Manner of Death** | **0 Prior Intakes** | **1-4 Prior Intakes** | **5-9 Prior Intakes** | **10-14 Prior Intakes** | **15-24 Prior Intakes** | **25+ Prior Intakes** |
| **Accident** | - | - | 1 | - | 1 | - |
| **Homicide (3rd party)** | - | - | - | - | - | - |
| **Homicide** | - | 1 | - | - | - | - |
| **Natural/Medical** | - | - | - | - | - | - |
| **Suicide** | - | - | - | - | - | - |
| **Unknown/ Undetermined** | - | 1 | - | - | - | - |

N=4 Total number of child fatalities for the quarter.

## Summary of the Findings and Recommendations

Review committees can make a finding or recommendation regarding the social work practice, policies, laws or system issues following their review of the case history leading up to the child fatality or near-fatal incident. At the conclusion of every case receiving a full team review, the team decides whether they will make any recommendations as a result of issues identified during the review of the case. Recommendations were made in two of the four child fatalities reviewed between April and June 2012.

Findings[2] were made in the four cases reviewed during the quarter. Committees found in two cases that case documentation and practice by the assigned social worker was very good.

In one case involving an infant death, the Committee found that the social worker made reasonable decisions during the prior CPS investigation into a skull fracture to an eight-month-old infant. However, the Committee found that the social worker could have considered other possible scenarios as to how the child sustained the injury. The committee noted that both law enforcement and physicians believed the father's story about how his daughter threw her head back striking the edge of the kitchen table. The committee recommended that the department engage with the CPS medical consultants to consider not only if

[2] A finding is an opinion or a conclusion reached by the Committee. A recommendation is made by the Committee to address an issue with the case or to address deficits they identified in practice or policy. Committees can reach a finding in a case without making a formal recommendation.

the cause of the injury to a child is probable, but also likely given the parent(s)' account.

In the same case, the Committee found that the CPS worker did not do a thorough investigation, specifically in conducting a criminal background check on the parents and completing the Structured Decision Making (SDM®) assessment. The SDM® risk assessment is a tool used by CPS social workers and supervisors to consider when to provide ongoing services to families.

The committee recommended that the department continue to provide a Lessons Learned from child fatalities training to all CA staff.

Another committee found that law enforcement and CA staff should meet to improve communication when both agencies are investigating the same incident.

In two of the reports, the Committees commended the social worker for quality social work practice. Specifically, the Committees acknowledged social worker action leading to permanency for two previously dependent children.

A committee also recognized in one case that policies and procedures were appropriately implemented and there were multiple shared decision making processes utilized throughout the life of the case.

Issues and recommendations that were cited during the child fatality reviews completed during the quarter fell into the following categories:

| 2nd Quarter 2012, Issues & Recommendations | |
|---|---|
| Contract issues | 0 |
| Policy issues | 2 |
| Practice issues | 5 |
| Quality social work | 2 |
| System issues | 1 |
| **Total** | **10** |

# Children's Administration

# Child Fatality Review

## S.R.

**December ██, 2010**
Date of Child's Birth

**December 2, 2011**
Date of Child's Death

**April 23, 2012**
Fatality Review Date

**Committee Members**
Deborah Robinson, Infant Death Investigation Specialist, Criminal Justice Center
Mary Meinig, MSW, Director of the Office of Family and Children's Ombudsman
Rebecca Benson, Public Health Nurse, King County Public Health
Marschell Baker, Child Protective Services Supervisor (CPS), Children's Administration
Randy Hart, Area Administrator, Children's Administration

**Observer**
Paul Smith, Critical Incident Program Manager, Children's Administration

**Facilitator**
Jeff Norman, Children's Administration Program Manager, Region 2

## Executive Summary

On April 23, 2012, Children's Administration (CA) convened a Child Fatality Review[3] (CFR) committee to examine the practice and service delivery in the case involving 11-month-old S.R. On November 27, 2011, S.R. was put into a bathtub with her three-year-old sister. Her mother, C.R., [4] later found her unresponsive in the bathtub. There are multiple conflicting accounts of the circumstances leading up to that moment. The mother told police officers that S.R. was bathing with her three-year-old sister and she took S.R. out of the tub and left to get a towel for S.R. She returned and found S.R. face down in the tub. The mother also told staff at Seattle Children's Hospital that she left S.R. in the tub while she went to get a towel. When she returned from being gone momentarily she found S.R. face down in the tub.

The mother told law enforcement that she performed CPR and tried to call 911 but got a busy signal so she went to a neighbor's home and had them call 911. S.R. was unresponsive but still alive when police and medics arrived on the scene.

S.R.'s siblings were interviewed and contradicted their mother's account.[5] One of the siblings reported she and S.R. were bathing alone while their mother watched television. In the tub S.R. reached for a rubber duck toy and went under water and was unable to pull herself up. The three-year-old sister never mentioned that her mother was in the bathroom while she and S.R. took a bath. A relative who used to live in the home was interviewed and said it was common practice for the mother to bathe all of her children at the same time without adult supervision.

Police who responded to the scene reported they believe the mother was watching a movie as the volume on the television was very loud when they first entered the home. Police searched the home and found no evidence of drug or

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[3] 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. 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 enquiry 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.

[4] The name of S.R.'s mother is not used in this report as she was not charged criminally for her actions related to her daughter's death. The child's putative father lives in California and has had no contact with his daughter.

[5] The three-year-old male twin was not in the tub with his sisters but may have been in the bathroom at some point after the mother left the room.

alcohol use. There are reports that the tub was full of water, deep enough for an adult to bathe.[6]

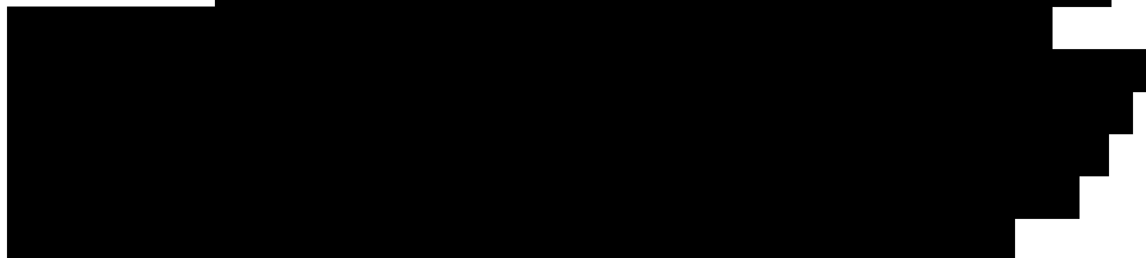
First responders were unable to fully revive S.R. She was still alive when she left the house via ambulance and was transported to Seattle Children's Hospital. Doctors who treated S.R. reported there was no evidence of physical abuse trauma. Doctors also reported that the CPR performed by the mother and neighbors was non-functional.

After several days on life support a determination was made that S.R. had no brain activity and she was removed from life support. She died on December 2, 2011. The King County Medical Examiner determined that the cause of death is anoxic encephalopathy (brain damage due to lack of oxygen) and near-drowning in a bathtub. The manner of death is accidental.

At the time of the incident, law enforcement did not place the other children in the home into protective custody. The mother had a family friend care for them while she was at the hospital with S.R. The department filed dependency petitions on the surviving siblings. The CPS investigation into S.R.'s death was founded for negligent treatment or maltreatment.

Living in the family home at the time of the incident were the mother and five of her children, two daughters, ages eight and five; twins (boy and girl) age three and S.R. The mother has another son, 14-years-old, who resides with his father and was not present when his sister was found unresponsive in the bath tub.

CA did not have an open case on the family at the time of this incident on November 27.



**RCW 74.13.515**

The fatality review committee included CA staff and community professionals selected from diverse disciplines with expertise in infant death investigations and public health. The committee also included a representative from the Office of the Children and Family Ombudsman. The fatality review committee members had no prior direct involvement with the case. The CA staff on the Committee

[6] The mother reported that water level was below S.R.'s chest when she was sitting in the tub.

were not affiliated with the case and were selected from other offices. The community members were selected to participate as their professional expertise is germane to the nature of the case.

During the course of the review, each committee member had available to them CA information regarding the mother and her children, un-redacted CA case related documents, as well as medical and law enforcement records. The committee had a history of intake reports on the family and a CA incident report on S.R.'s death.

The assigned CPS investigator, CPS Supervisor and the Area Administrator were present during the review and discussed the mother's past involvement with the department, the CPS investigation into S.R.'s death and case activity on the family following S.R.'s death.

Following review of the case file documents and discussion regarding social work activities, intake screening decisions, CA's involvement with the family, and decisions during the CPS investigation, the review committee made findings which are detailed at the end of this report. The team also discussed discrepancies in law enforcement response to children not riding in car seats or using seat belts, and how the department screens intakes alleging small children not wearing seat belts while riding in cars.

**Case Overview**

RCW 74.13.515

On November 27, 2011, CPS intake received a report of negligent treatment or maltreatment from Renton Police after 11-month-old S.R. was found unresponsive in a bathtub full of water. She was transported to Seattle Children's Hospital. She was left alone in a bathtub when her mother found her. She was not expected to survive when the initial report was made.

S.R. died on December 2, 2011 from complications of the near drowning. CA filed dependency petitions as to the surviving siblings except for the oldest child who was living with his father. The children were placed in out-of-home care. The dependency petition was dismissed for the three-year-old twins after their father obtained legal custody. Dependency as the other two children was established on April 16, 2012.

**Committee Discussion**

jRCW 74.13.515

Parental Engagement

The CA staff involved with this mother report she has been difficult to engage whenever CA has been involved with her family and particularly since the filing of dependency petitions. She is not participating in services, nor is she visiting her children on a consistent basis. The committee suggested offering bereavement counseling as a way to make a positive connection with her.

**Recommendations**

The committee made no recommendations.

**Action**

RCW 74.13.515

The Bellevue Division of Children and Family Services office changed their procedure in responding to Alternate Intervention cases and is now sending out social workers on all 10-day Alternate Intervention cases in order to have more contact with the family.

RCW 74.13.500

# Children's Administration
# Executive Child Fatality Review

## C.C.-W.

**July ██, 2011**
Date of Child's Birth

**November 28, 2011**
Date of Child's Death

**April 23, 2012**
Executive Fatality Review Date

**Committee Members**
Deborah Robinson, Infant Death Investigation Specialist
Mary Meinig, MSW, Director of the Office of Family and Children's Ombudsman
Megan Sweeney, Domestic Violence Advocate, Lynnwood Police Department
Marschell Baker, Child Protective Services Supervisor (CPS), Children's Administration
Randy Hart, Area Administrator, Children's Administration

**Observer**
Paul Smith, Critical Incident Program Manager, Children's Administration

**Facilitator**
Jeff Norman, Children's Administration Program Manager, Region 2

## Executive Summary

On April 23, 2012 Children's Administration (CA) convened a Child Fatality Review[7] (CFR) committee to examine the practice and service delivery in the case involving 4-month-old C.C.-W. and his mother. The incident initiating this review occurred on November 28, 2011. The Snohomish County Medical Examiner's Office contacted CPS intake to report the death of C.C.-W at the home of his mother's friend in the Arlington area. C.C.-W.'s mother, J.C., found her son in his bassinet in the morning with a plastic grocery bag and a pillowcase over his face.[8] Emergency medical technicians were dispatched to the home and performed CPR.

At 11:45 a.m. J.C. placed her son C.C.-W. in his bassinet for a nap. She reported that his head was turned to left and a pillowcase was tucked over and underneath the bassinet pad which acted as a sheet or cover. When C.C.-W. was placed down, a plastic grocery bag was underneath him. The mother reported that she did not see the bag but thought there may have been a bag in the bassinet as she heard the sound of a plastic bag rustling when she put him down for a nap. The bedroom was dark.

At 1:45 p.m. J.C. checked on C.C.-W. in the darkened bedroom and he was okay. At 1:55 p.m. she checked on C.C.-W. again and then found him unresponsive with his face covered by a plastic bag and the pillowcase. J.C. was alone in the home with C.C.-W. when the fatality occurred.

C.C.-W. was taken to Cascade Valley Hospital where he was later pronounced dead.

The assigned detective noted that there were no clear signs of any abuse when C.C.-W. was taken to the hospital. J.C. disclosed that two weeks prior, C.C.-W.

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[7] Given its limited purpose under RCW 74.13.640, 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. 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.

[8] The child's mother is not identified by name in this report as she was not charged with a crime related to her action or inaction in her son's death. The CPS investigation finding was still pending at the time of this report.

was taken to the same hospital after experiencing seizures. This information was not reported to CPS Intake.

The medical examiner completed an autopsy and did not find anything of significance internally and externally concerning C.C.-W.'s body. However, there are concerns about how J.C. initially described the events leading up to C.C.-W.'s death. During the reenactment of C.C.-W.'s death there were discrepancies in the mother's story about whether she knew if a plastic bag was present in the bassinet or not. Her reconstruction account includes a baggie or plastic bag being in front of C.C.-W.'s face and the pillowcase over the top of his head. C.C.-W.'s face was exposed as he was lying on his stomach on top of the pillowcase.

During J.C.'s first recounted version, she said that she heard a crinkle sound when she put her son down in the bassinet and thought it was a zip lock bag underneath the mattress which she cleaned during the previous night. However, after the medical examiner entered the home and J.C. reenacted the events with a doll, she later said that she knew a grocery bag was in the bassinet with the pillowcase that was wrapped around the mattress. J.C. was reportedly alone in her friend's home at the time of the fatality and called 911 at 1:58 p.m.

The detective reported that J.C. has a history of lying in court in addition to lying to law enforcement. She made several inconsistent or false reports to law enforcement about her actions leading up to her son's death. She claimed that C.C.-W. was sick for one month prior to his death. She maintained that she took him to the hospital two weeks prior for febrile seizures, however, the records from the hospital revealed that a spinal tap was conducted and C.C.-W. presented with "nothing remarkable."

C.C.-W.'s putative father, Z.W., describes J.C. as a liar. He had supervised visitation with his son in the weeks before his death and denied that his son had been ill, as the mother previously claimed.

The Snohomish County Medical Examiner has determined the cause of death as sudden and unexpected infant death with risk factors of the sleeping environment. The examiner found the manner of death – whether the death was natural, an accident, or homicide – to be undetermined. Additional testing is being conducted on the bag found in the bassinet. The decision to pursue criminal charges against the mother by law enforcement and the prosecuting attorney are pending the outcome of these tests. The finding of the CPS investigation into C.C.-W.'s death is also pending.

The family's case history with CA was reviewed in preparation for this fatality review. The history included two previous intakes from September 2011 and

November 2011. Neither of the two prior intakes were accepted for investigation by CPS. The first intake alleged domestic violence between C.C.-W.'s parents and the second alleged that C.C.W. came home from a visit with his father with suspicious scratches on his body and with poor hygiene. The most recent report (November 3, 2011) was screened in for Alternate Intervention. A letter was sent to the mother and the case was closed 10 days before the child's death.

The CFR committee included CA staff and community professionals selected from diverse disciplines with relevant expertise and included an infant death specialist, a domestic violence/community advocate and representatives with experience in parenting and child welfare. The committee also included the Director of the Office of the Children and Family Ombudsman. The fatality review committee members had no prior direct involvement with the case. The CA staff on the Committee were not affiliated with the case and were selected from offices other the one that had been assigned to work with this family. The community members were selected to participate as their professional expertise is germane to the nature of the case.

During the course of the review each committee member had available to him or her information regarding the mother, the father and the child, un-redacted CA case related documents, as well as medical and law enforcement records. A petition for a protection order that had been drafted by C.C.-W.'s mother was also available for the Committee's review. Additional documents provided to the Committee included the Lynnwood Police Department's report of a domestic violence incident between the parents, the autopsy report, photographs of the child's sleeping area and a medical assessment of C.C.-W.'s death completed by Dr. Kenneth Feldman, a child abuse and neglect medical consultant with Children's Hospital. The assigned CPS investigator, CPS Supervisor, and the Area Administrator were present during the review and discussed the family's past involvement with the department and the CPS investigation into C.C.-W.'s death.

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

**Case Overview**

C.C.-W. was born to these parents when they were both 17-years-old. [redacted] The issue of C.C.-W.'s paternity was questioned though Z.W. is listed as the father on the birth certificate. **RCW 74.13.500 (1) (d); RCW 74.13.505**

CPS received two reports regarding C.C.-W. and his parents in the months prior to his death. An intake reporting his death was made to CPS.

The first intake was received on September 28, 2011. The intake was screened out for investigation. The regional intake unit received a protection order from District Court. C.C.-W.'s mother, J.C. sought an order of protection for herself and infant son. She alleged that on September 21, 2011, C.C.-W.'s father, Z.W. assaulted her. She asked for his help to care for C.C.-W. while she moved into her new house. He became very angry and shoved her into a wall and yelled at their infant son to "shut up." She left the residence with her son. The committee was able to review a copy of the petition C.C.-W's mother submitted to the court to obtain the petition. The District Court had previously sent CPS Intake the protection order on September 28, 2011 but it did not include the petition which included many more details of alleged abuse of C.C.-W. by his father and domestic violence between the parents.

The restraining order was dismissed on the mother's request on November 9, 2011.

The second intake was received on November 3, 2011 and screened in for Alternate Intervention with a 10-day response. A counselor for C.C.-W.'s grandmother made a report with concerns about C.C.-W.'s condition after he had a four hour visit with his father. Upon his return to his mother's care she changed C.C.-W.'s diaper and found hardened feces and scratches near his penis. She told the child's grandmother of her concerns. The case was assigned to a worker to provide the mother with community resource information. The worker wrote a letter to J.C. with a list of community resources she could access to assist her in the care of her child. The case was closed on November 18, 2011.

A third intake documenting the death of C.C.-W was received on November 29, 2011. The intake screened in for investigation of physical abuse and negligent treatment or maltreatment. The Snohomish County Medical Examiner reported that C.C.-W. died on November 28, 2011 while sleeping in his bassinet at the home of his mother's friend in Arlington. This sleep-related infant death resulted in a complex medical/legal investigation. The sleeping environment was unsafe due to a pillowcase and plastic bag in the bassinet and the child being placed in a prone sleep position. The mother made conflicting statements about the circumstances leading up to the discovery when she found C.C.-W. unresponsive in his bassinet. She reported that the child had recently had seizures but they were not verified by the child's medical providers.

The finding of the CPS investigation is pending at the time of this report. The Medical Examiner has issued his conclusions regarding the child's cause and manner of death. The prosecutor has not made a decision on whether to file charges against the mother.

## Findings

### Intake

The committee members discussed the screening decision of the September 28, 2011 intake and consensus was that based on the information given by the referrer and documented in the intake narrative, the screening decision was appropriate. However, the mother's petition for a protection order detailed allegations of physical abuse of C.C.-W. by his father, Z.W. There was consensus among the Committee members that this information would have warranted an investigation by CPS, if it had been provided to CPS. However, the petition was not sent to CPS. The information in this petition likely would have affected the screening decision for the prior intake and presented a missed opportunity to intervene with this family.

The prior intake dated November 3, 2011 was screened for Alternate Intervention and alleged neglect and suspicious scratches on C.C.-W. The department's response to the Alternate Intervention intake was to send a letter to the child's mother as she was identified as C.C-W.'s custodial parent. The committee questioned why the letter was sent to the mother and not the father who was the alleged subject of abuse.

The committee also discussed the screening decision of the November 3, 2011 intake and concluded that the intake should have screened in for investigation given the injury to an infant.

The committee found the documentation by the assigned social workers to be very good.

### Response to Alternate Intervention Cases

The Everett DCFS office has contracted with a public health nurse to respond to most intakes screened for Alternate Intervention.

Since this event, the Everett DCFS office has changed its practice for Alternate Intervention cases. These changes are as follows:

1. Safe sleep education is given in all cases in which there is an infant in the family regardless of the allegations in the intake.
2. Face-to-face contact will be made with all families for intakes that are screened in for Alternate Intervention.

## Recommendations

No recommendations were made by the Committee.

**RCW 74.13.500**

# Children's Administration

# Executive Child Fatality Review

## L.F.

**December 09, 2011**
Date of Child's Death

**April 19, 2012**
Child Fatality Review Date

**Committee Members:**
Niran Al-Agba, M.D., Pediatrician
Mary Meinig, MSW, Director of the Office of Family and Children's Ombudsman
Russ Funk, Andrea Ryker, MSN, BSN, RN, Field Nursing Supervisor – Tacoma-Pierce County Health Dept.
Lynelle Anderson, Detective, Pierce County Sheriff's Department
Kerry Ann Shaughnessy, MSW, Parenting Instructor, Youth For Christ
Kaaren Jackson, Children's Administration – CPS Supervisor (Kent DCFS)

**Observer/Facilitator's Aide:**
Amber Osland, MSW, Children's Administration - CFWS Supervisor (Pierce East DCFS)

**Facilitator:**
Bob Palmer, Children's Administration Critical Incident Case Review Specialist

## Executive Summary

On April 19, 2012, Children's Administration (CA) convened a Child Fatality Review[9] (CFR) committee to examine the practice and service delivery in the case involving 8-month-old L.F. and her family. The incident initiating this review occurred on the evening of December 7, 2011 when L.F. was admitted to the hospital for severe injuries from which she later died. The injuries were the result of non-accidental trauma while in the care of her father, Ivryee Flowers.[10] Nine days earlier CPS had received notification that L.F. had suffered a minimally displaced left parietal temporal skull fracture (no intracranial bleeding) that appeared to be from accidental trauma. That report was accepted for CPS investigation; the case was open at the time of L.F.'s second hospitalization and subsequent death on December 9, 2011.

The CFR committee included CA staff and community members selected from diverse disciplines with relevant expertise, including representatives from the fields of medicine, public health, law enforcement, parenting instruction and social work. Committee members had no previous involvement with the case. 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 shortly after the fatality incident.

Available to committee members at the review were (1) additional case related documents (e.g., technical-based medical records such as lab tests; recent amended court filings by the county prosecutor), (2) several CA policy and practice guides relating to CPS investigations and assessment of risk and safety, (3) a copy of the *Child Sexual and Physical Abuse Investigation Protocols for Pierce County (2010)* and (4) copies of relevant laws relating to CPS duties, authority to place children, and legal definitions involving child maltreatment. During the

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[9] 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.

[10] The full name of Ivryee Flowers is being used in this report as he has been charged in connection to the incident and his name is public record.

course of the review the CPS investigator and supervisor involved with the case were made available for interview by the CFR committee members.

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

**Case Overview**

Children's Administration first became aware of L.F. and her parents on November 28, 2011 when Central Intake was notified by Mary Bridge Children's Hospital of an 8-month-old infant with a minimally displaced left parietal temporal skull fracture (no intracranial bleeding). The father's story was that on Saturday, November 26, he had been feeding L.F. when she burped and threw up. When he was wiping her face, which she didn't like, L.F. reportedly had thrown her head back and hit it on a table. He reportedly looked at the child's head, did not see any injury and did not mention the incident to anyone. L.F. then spent the night with her maternal grandmother. When L.F. returned home Sunday evening, November 27, the mother noticed a bumpy/boggy area on the child's head. The mother and the child's paternal grandmother took the child to the Emergency Department (ED) at Tacoma General/Mary Bridge Hospital. The ED physician notified the family of his concerns regarding the explanation provided for the injury and the need to admit the child for further examination. Both CPS and local law enforcement were notified.

The intake report was assigned for CPS investigation (emergent 24 hour response) and in collaboration with law enforcement subject interviews were conducted with the parents and the maternal grandmother who had cared for the child during the weekend. An incident re-creation was conducted by law enforcement and CPS at the family apartment. Consultation was sought with a state Child Protection Medical Consultant[11] who, upon review of records and the reported circumstances, presented an overall assessment of "probable accidental trauma." A staffing was held at the Child Advocacy Center[12] of Pierce County on

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[11] 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.

[12] The CAC of Pierce County is a member of the Washington State Chapter of the National Children's Alliance (NCA) which is the accrediting organization. The NCA has established standards for CACs that include: (1) child-focused, child-friendly facilities for children and their non-offending family members; (2) multidisciplinary team case staffing participation by law enforcement, prosecution, medical experts, social work, and advocacy; (3) medical evaluation onsite or through referral; (4) therapy onsite or through referral; (5) onsite forensic interviews; (6) and case tracking. [Sources: Children's Advocacy Centers of Washington www.wsacac.org and CAC of Pierce County website at www.multicare.org/marybridge/childrens-advocacy-center]

December 2, 2011, the same day the infant was seen for follow-up examination by her primary care physician.

Four days later the child was medically examined again when she was brought to the emergency room in the late evening of December 6, 2011. The mother reported that her daughter was being “really fussy.” Medical records obtained by CPS show that the attending ED physician was aware of the recent hospital admission for a skull fracture when he conducted the ED exam. X-rays showed that L.F. was very constipated, had no noticeable fractures or other trauma. The infant was discharged home with her parents around 3:00 a.m. on December 7, 2011.

On December 7, at approximately 8:00 p.m., a 911 call was made regarding an unresponsive child. First responders arrived at the home and performed CPR and immediately transported the child to the hospital. Upon hospital arrival, at approximately 8:30 p.m., L.F. was assessed as being cold, cyanotic, without respiratory effort or pulse and only occasional electrical activity. A CT scan showed bi-lateral bleeding in the brain; no other injuries or bruising were noted.

The hospital notified CA Central Intake of the non-accidental trauma and the likelihood that the child would not survive. The intake was assigned for CPS investigation of physical abuse (emergent 24 hour response). Ivryee Flowers confessed to police that he had physically abused his infant daughter causing the severe injuries. He also admitted that he had shaken L.F. on other occasions but denied he had done so at the time of L.F.’s skull fracture in late November. Ivryee Flowers was booked for Assault of a Child in the First Degree. When his daughter was pronounced dead on December 9, 2011, the charges were amended to Murder in the Second Degree and a trial is set for September 2012. The CPS case was closed in late February 2012 and founded for physical abuse of a child.

**Committee Discussion**

Committee members reviewed and discussed the documented social work activities completed by CPS from intake to case closure. As a means to provide structure and context to reviewing social work practice, the Committee members were provided overview information on the Structured Decision Making (SDM®)[13] risk assessment tool, the Child Safety Framework[14] and expected practice risk

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[13] The Structured Decision Making (SDM®) risk assessment is an evidence-based actuarial tool from the Children’s Research Center (CRC) that was implemented by Washington State Children’s Administration in October 2007. It is one source of information for CPS workers and supervisors to consider when making the decision to provide ongoing services to families.

[14] In partnership with the National Resource Center-CPS (NRC-CPS), Washington State Children’s Administration implemented the Child Safety Framework in November 2011. The safety framework is

assessment tool, the Child Safety Framework[15] and expected practice regarding CPS investigations and timelines for completion of work.[16] In this way, committee members were better able to evaluate the reasonableness of actions taken and decisions made by the CPS social worker and supervisor. In addition to reviewing social work practice, discussions occurred around policy issues. These largely focused on two areas, the use of the SDM® as an assessment tool and the criteria used by CA in determining a child to be "medically fragile." Finally, the Committee also discussed system issues relating to criminal and domestic violence background checks and the process of collaboration between CPS and law enforcement.

**Findings**

Based on the information available to the CPS social worker during the short time period between the initial investigation and the fatality incident, the actions taken and decisions made by the social worker appear reasonable. The committee finds no alternative actions that reasonably could have been taken by the CPS social worker that would have likely changed the outcome of the case. However, in examining the broader aspects of the case work, the Committee finds several opportunities where practice could have been improved.

- The Committee recognizes the extra efforts taken by both CPS and the investigating detective to conjointly investigate the circumstances of the first injury to L.F. given the medical consultant's initial opinion that the injury was the result of "probable" accidental trauma. While the injury may have plausibly been accidental the social worker made no additional inquiry as to the degree of probability or actual likelihood that the event was inadvertent rather than intentional.
- The CPS social worker appears to have sought and been provided generalized criminal background information as to the parents but did not seek more detailed records accessible through the local law enforcement

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built on key principles of gathering, assessing, analyzing and planning for a child's safety through (1) collecting information about the family to assess child safety, (2) identifying and understanding present and impending danger threats, (3) evaluating parent/caregiver protective capacities, (4) determining if a child is safe or unsafe, and (5) taking necessary action to protect an unsafe child. http://www.dshs.wa.gov/ca/general/index.asp

[15] In partnership with the National Resource Center-CPS (NRC-CPS), Washington State Children's Administration implemented the Child Safety Framework in November 2011. The safety framework is built on key principles of gathering, assessing, analyzing, and planning for a child's safety through (1) collecting information about the family to assess child safety, (2) identifying and understanding present and impending danger threats, (3) evaluating parent/caregiver protective capacities, (4) determining if a child is safe or unsafe, and (5) taking necessary action to protect an unsafe child. http://www.dshs.wa.gov/ca/general/index.asp

[16] See CA Practices and Procedure: Child Protective Services. http://www.dshs.wa.gov/ca/pubs/manuals.asp

agency. This could have included seeking information as to the criminal backgrounds of the other adults living in the home and information as to any law enforcement responses to the home (non-arrest incidents). Similarly, the social worker could have been more curious about the domestic violence situations self-reported by the parents and appears to have relied on the parents' accounts rather than pursue other sources of information. A more full disclosure of the criminal and domestic violence histories (including juvenile records) may have been beneficial to the multidisciplinary staffing at the Child Advocacy Center.

- The social worker's SDM® scoring does not appear accurate and may have underestimated risk. It does not reflect the number of adults actually living in the home or their history of CPS involvement. Furthermore, the social worker did not identify L.F. as having developmental delays or any disability. When interviewed, the social worker indicated that the basis for his determination was that the infant had been described by medical professionals as "developing normally." While L.F. may have been progressing normally in consideration of her gestational age at delivery, the social worker did not appear to consider the significant developmental issues at hand and the fact that the infant was receiving SSI benefits and was receiving physical therapy. When interviewed the CPS social worker stated that the SDM® scoring had been intended only as an initial inputting of assessment information, with a plan to update the SDM® as more information emerged during the investigation. However, no attempt was made to update or otherwise correct the SDM® prior to completing and closing the assessment.
- L.F. was a "micro preemie"[17] and spent her first few months of life in a Neonatal Intensive Care Unit. At the time CPS became involved L.F. was eight-months-old, no longer requiring intensive medical care and did not meet the current CA criteria for being identified as medically fragile.[18] However, several committee members expressed concern that the

[17] The term "micro preemie" is used in the medical field to refer to the smallest and youngest preterm babies born before 26 weeks gestation or weighing less than 1 pound, 12 ounces (800 grams). "Extreme prematurity" (or extreme preterm) refers to babies who are born before 28 completed weeks gestational age or have a birth weight of less than 1000 grams (about 2 lbs 3 oz). Moderate prematurity (or very preterm) refers to babies who are born 28 to 32 completed weeks of gestational age with a birth weight range between 1000 and 1500 grams (about 2 lbs 3 oz and 3 lbs 5 oz). Mild prematurity (or preterm) refers to babies who are born between 33 and 37 completed weeks gestational age and/or have a birth weight between 1500 and 2500 grams (about 3 lbs 5 oz to 5 lbs 8 oz).

[18] A child is considered "medically fragile" when meeting the following criteria: (1) Child has medical conditions that require the availability of 24-hour skilled care from a health care professional or specially trained family or foster family member; (2) These conditions may be present all the time or frequently occurring; (3) If the technology, support, and services provided to a medically fragile child are interrupted or denied, the child may, without immediate health care intervention, experience death.

definition of medically fragile as currently used by CA (including within the SDM® tool) may be too narrow in not considering the medical vulnerability common to preterm infants even if not evaluated as having pervasive medically intensive needs.

**Recommendations**

- While admittedly having only brief introduction to the SDM® risk assessment tool used by CPS, the Committee concludes that the SDM® appears to have limited usefulness and CA should consider eliminating the tool.
- CA should engage the state Child Protection Medical Consultant (CPMC) group in a discussion about improving communication with department social workers when consulting on child injury cases. Specifically, this would be to look at going beyond determinations of "possible" or "plausible" for causes of injuries, and offering more detailed estimated probability that would include a statement as to "how likely" an injury was accidental or non-accidental. This would increase the ability of social workers to understand and assess the safety needs of the child as well as support investigative findings that are based on a "more likely than not" standard of proof.[19]
- Although it is recognized that the criteria for medically fragile status as used by CA is consistent with that of the Washington State Developmental Disabilities Council Policy 109 (1990),[20] it is suggested that CA consider expanding the criteria to include medically vulnerable preterm infants who have substantial needs although not medically intensive needs.
- CA should consider offering training to social workers on preterm ("preemie") babies. Given the increased number of preterm deliveries nationally and the increasing research regarding short and long term

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[19] CPS findings in Washington state follow a preponderance of evidence standard rather than "clear and convincing evidence" or "reasonable doubt" standards of proof. In this way "Founded means the determination following an investigation by the department that, based on available information, it is more likely than not that child abuse or neglect did occur." [See: RCW 26.44.020(9)]

[20] WSDDCP: Medically fragile individuals are those who have medically intensive needs. Their chronic health-related dependence, continually or with unpredictable periodicity, necessitates a 24-hour a day skilled health care provider or specially trained family or foster family member, as well as the ready availability of skilled health care supervision. Further, if the technology, support and services being received by the individual are interrupted or denied, he or she may, without immediate health care intervention, experience irreversible damage or death. Medically fragile also includes individuals who are at risk for medical vulnerability. These individual's chronic health-related dependence does not require 24-hour supervision by a skilled health care provider, but they do experience unpredictable life threatening incidence. Without appropriate monitoring and the availability of licensed, certified or registered providers, their condition could deteriorate and the intensity of their medical needs increase.

health and disability risks,[21] awareness of the subject may be beneficial to those providing public child welfare services. It is suggested that such training could be offered in a web-based format that could be blended with other related training (e.g., infant safe sleep).

- CA should consider reaching out collaboratively with state law enforcement to support the introduction of new legislation that would require law enforcement officers to promptly notify Child Protective Services whenever a child is present or in close proximity to a situation involving domestic violence of a parent or caretaker regardless of any observable harm to the child. Such notification could then be retained by CA in FamLink, the statewide child welfare information system. This would be similar to the efforts made in 2010 in enacting RCW 46.61.507 which requires law enforcement to notify CPS of DUI situations whereby a child is present and the operator of the vehicle is a parent, custodian or caretaker.
- CA should continue with statewide presentations of Lessons Learned from Child Fatalities that would be available annually by a variety of venues and formats (in person training, web-based training, web casts). It is suggested that future presentations consider including the following lessons: (1) Social workers should try to verify information provided by parents such as relating to their domestic violence and criminal history. This might include a request with law enforcement contacts to search data bases available to their agency that may have information beyond arrest, charges or conviction data. (2) While consultation with medical professionals is often critical to gathering information for investigation and assessment, medical opinion should not be the only source of information when assessing risk or safety or making a finding decision. (3) In cases where the medical opinion may be that an injury is "plausibly accidental," social workers should ask for a more specific estimate of probability (e.g., "how likely" is it that the injury was accidental or non-accidental?).

[21] The rate of premature births has increased by 36 percent since the early 1980s and currently in the U.S. about 12.8 percent of babies (more than half a million a year) are born prematurely. Sources: World Health Organization and March of Dimes [www.marchofdimes.com].

# Children's Administration
# Executive Child Fatality Review

## L.W.

RCW 13.50.100

**November ██, 2011**
Date of Child's Birth

**December 28, 2011**
Date of Child's Death

**May 11, 2012**
Executive Review Date

**Committee Members**

Honorable Judge Paul Bastine, Spokane County Superior Court, retired
Patrick Donahue, CASA/GAL Program Coordinator, Spokane County Juvenile Court
Jenna Kiser, Child Protective Services Program Consultant, Children's Administration, Region 1 South
Connie Lambert-Eckel, Deputy Regional Administrator, Children's Administration, Region 1
Tim Nelson, Implementation and Quality Assurance Program Consultant, Children's Administration, Region 1
Susan Schultz, Program Manager, Spokane Regional Health District
Dr. Katherine Whipple, MD, Internal Medicine and Pediatrics[22]

**Invitee**

Representative from the Coeur D'Alene Tribe[23]

**Facilitator**

Nicole LaBelle, Regional Programs Administrator, Children's Administration, Region 1

[22] Dr. Whipple is a descendent of the Spokane Tribe and member of the Association of American Indian Physicians.
[23] L.W's father was an enrolled member of the Coeur D'Alene Tribe. L.W. was not eligible for enrollment. A representative of the Tribe declined participation with this Executive Child Fatality Review.

**RCW 13.50.100**

## Executive Summary

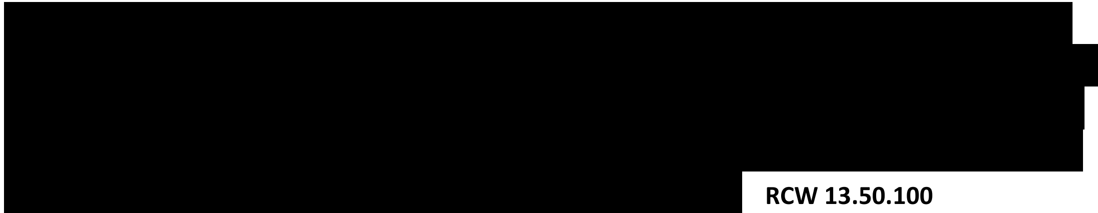
On May 11, 2012, the Department of Social and Health Services' (DSHS) Children's Administration (CA) convened an Executive Child Fatality Review (ECFR) Committee to review the death of a 5-week-old boy, L.W. L.W. was in the care and custody of his mother at the time of his death in Spokane, Washington. Prior to his death a Child Protective Services investigation was initiated from an intake in November 2011. The investigation was being concluded and the family was receiving services from CA at the time of L.W's death. CA conducts fatality reviews to identify practice strengths and challenges as well as systemic issues in an effort to improve performance and better serve children and families. The Committee reviewed case documents and interviewed CA staff to examine child welfare practices, system collaboration and service delivery to L.W. and his family. [24]

On December 28, 2011, L.W.'s mother contacted the CA assigned social worker and reported that earlier that morning she had found L.W. unresponsive beside her in bed. L.W.'s mother called 911 and emergency responders transported L.W. to the hospital. Resuscitation attempts were unsuccessful and L.W. was pronounced dead at the hospital.

L.W. was the youngest of six children born to the mother.

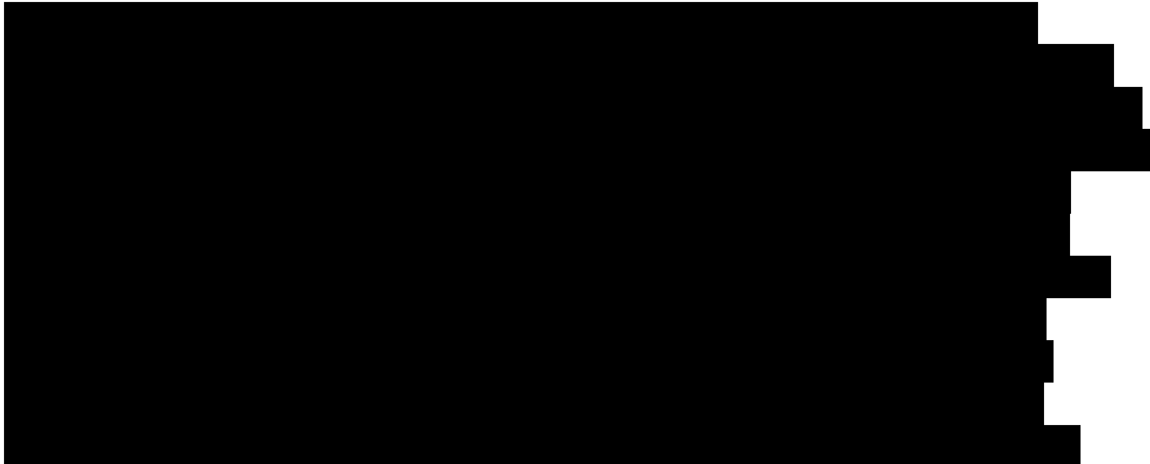
An autopsy was performed by the Spokane County Medical Examiner's Office noting cause of death as diphenhydramine toxicity; manner, accidental. CA learned of the Medical Examiner's conclusion on April 4, 2012.

[24] Given its limited purpose, an Executive Child Fatality Review should not be construed as a final or comprehensive review of all of the circumstances surrounding the death of a child. The ECFR 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 may not hear the view of the child's parents and relatives, or of other individuals associated with a deceased child's life or death. An Executive 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 an ECFR to recommend personnel action against DSHS employees or other individuals.


RCW 13.50.100

The ECFR Committee members included CA staff and community members representing disciplines associated with the case. Committee members had no involvement in L.W.'s case. A chronology of the intakes, investigations and conclusions, legal history, and services offered and provided to the family was prepared and provided to the ECFR Committee. A copy of the family's case file and L.W.'s autopsy report were also available to the Committee. Committee members interviewed the social worker, supervisor and Area Administrator assigned to the case at the time of L.W.'s death. During the course of the review the Committee discussed the legal proceedings the family had been involved in, issues related to services provided to the family and service provider progress reports and summaries to CA. There was also discussion related to safe sleep practices with infants, shared decision making, and case elements.[27] Following a review of the family's history, case records and discussion, the Committee made findings and recommendations that are detailed at the end of this report.

**Case Overview**



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[25] Source: CA Practice Guide to Intake and Investigative Assessment, Chapter 4, page 25: CPS Risk Only Intakes are defined as intakes that do not allege child abuse and neglect as defined by WAC 388-15-009, but have risk factors that place a child at imminent risk of serious harm.
[26] The two intakes were screened out because neither contained an allegation of child abuse nor neglect that under the definition of child abuse and neglect. WAC 388-15-009. The intakes were documented in Children's Administration's management information system, however, CA is not authorized to act on screened out intakes.
[27] Activities conducted according to CA Practice and Procedure Manual and Case Services Manual e.g., Monthly Social Worker Visits, Documentation, Investigation Criteria, Intake Decisions, etc.
[28] FamLink is Children's Administration's management information system.

**RCW 13.50.100**

**RCW 13.50.100**

**RCW 13.50.100**

[29] Executive Order 95-04 mandates the use of Child Protection Teams (CPTs). The purpose of Child Protection Teams are to provide consultation and recommendations on all cases where there is a risk of serious harm to the child and/or where there is dispute over whether out-of-home placement is appropriate.

RCW 13.50.100

she was pregnant with L.W. and gave birth to him on November 20, 2011. The hospital contacted CA at the time of birth after the mother reported she had an open case with CPS. The intake was screened as information only.

There were no additional reports regarding L.W. or his family between the time of his birth and his death. The CPS worker was preparing the case for closure when L.W. died.

**Review Committee Discussion and Findings**

To develop a thorough understanding of the family and case the review committee identified dynamics that appeared to influence decision-making by CA, e.g., intake screening decisions and investigations, identification and assessment of family dynamics and how they affected parenting, service delivery and progress and placement decisions. The review committee also considered the facts and information presented in the court proceedings that led to removals, reunifications and parental relinquishment. The committee requested and met with the CPS social worker, supervisor and Area Administrator assigned to the case at the time of L.W.'s death.

**Casework:** The committee discussed the CPS investigations, placement interventions, voluntary services delivery and dependency case management decisions made in this case over the course of the family's involvement with CA. The committee identified and acknowledged quality social work practices that encouraged the continued engagement of L.W.'s mother especially in the wake of CA's interventions

RCW 13.50.100

All of the social workers that managed any element of this case also documented active and ongoing efforts in the identification and inclusion of each child's father.

CA policies and procedures appeared to be appropriately implemented and there were multiple shared decision making processes utilized throughout the life of the case to include court processes, CPT, Shared Planning meetings,[30] supervisory reviews and requested case consultations with the Area Administrator and an Assistant Attorney General.

**Service Needs**: The committee observed that CA staff accurately identified the issues in this case which directly impacted parenting capacities. Recommendations and referrals for services were appropriately generated to support the family in developing an understanding of issues and dynamics operating in the home. RCW 74.04.060

There were two separate psychological evaluations as to L.W.'s These evaluations were conducted in the context of determining the mother's employability and any barriers she faced in living independently The committee identified that a referral for and completion of a psychological evaluation for the purposes of identifying challenges or barriers in parental capacity may have been helpful in this case.

The committee also identified that the mother and each sibling received some level of service from Public Health through a home visiting nurse model. Following L.W.'s birth the mother did not receive this service as it is limited through Public Health and she was not eligible when L.W. was born. The committee explored the possibility that the mother may have received more support and education regarding safe sleep practices as well as appropriate medication dispensing to her infant if she was provided services through a home visiting nurse intervention following L.W.'s birth.

## Recommendations

A resource recommendation was made by the Committee pertaining to increasing state funding and resources for Public Health Nursing services to serve a broader population than currently available.

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[30] Policy 4301: Shared Planning Meetings bring individuals together to help make decisions for children about safety, permanency and well-being.