Washington State Department of Social and Health Services

Transforming Lives

REPORT TO THE LEGISLATURE

Quarterly Child Fatality Report

RCW 74.13.640

April –June 2018

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Executive Summary

This is the Quarterly Child Fatality Report for April through June 2018, provided by the Department of Children, Youth, and Families (DCYF) to the Washington State Legislature. RCW 74.13.640 requires DCYF 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 ombuds. 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 ombuds.

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 April 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 Ombuds (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.

On July 1, 2018, DSHS Children's Administration transitioned from DSHS to the Department of Children, Youth, and Families (DCYF). The reviews included in this report were completed before July 1, 2018, therefore, references to DSHS / Children's Administration (CA) will be cited throughout this report.

This report summarizes information from reviews completed in the second quarter of 2018 regarding four (4) child fatalities and one (1) near fatality. All child fatality review reports can be found on the DCYF website:
https://www.dcyf.wa.gov/practice/oiaa/reports/child-fatality

The reviews in this quarterly report include child fatalities and a near fatality from three of the six regions (DCYF divides Washington state into six regions). Previous quarterly fatality reports reflect three regions when child welfare was administered within DSHS under Children's Administration.

Region	Number of Reports
1	
2	2
3	1
4	2
5	
6	
Total Fatalities and Near-Fatalities Reviewed During 2nd Quarter 2018	5

This report includes Child Fatality Reviews conducted following a child's death that was suspicious for abuse and neglect and the child had an open case or received services from DSHS Children's Administration within the 12 months prior to the child's death or injury. A critical incident review consists of a review of the case file, identification of practice, policy or system issues, recommendations and 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 include legislators and representatives from the Office of the Family and Children's Ombuds.

The charts below provide the number of fatalities and near-fatalities reported to DCYF, the number of reviews completed, and those that are pending completion for calendar year 2018. The number of pending reviews is subject to change if DCYF discovers new information through reviewing the case. For example, DCYF may discover that the fatality or near-fatality was anticipated rather than unexpected, or there is additional DCYF history regarding the family under a different name or spelling.

Child Fatality Reviews for Calendar Year 2018			
Year	Total Fatalities Reported to Date Requiring a Review	Completed Fatality Reviews	Pending Fatality Reviews
2018	14	2	12

Child Near-Fatality Reviews for Calendar Year 2018			
Year	Total Near-Fatalities Reported to Date Requiring a Review	Completed Near-Fatality Reviews	Pending Near-Fatality Reviews
2018	2	0	2

The child fatality reviews referenced in this Quarterly Child Fatality Report are subject to public disclosure and posted on the DCYF website.
https://www.dcyf.wa.gov/practice/oiaa/reports/child-fatality

Near-fatality reports are not subject to public disclosure and are not posted on the public website and not included in this report.

Notable Second Quarter Findings

Based on the data collected and analyzed from the four (4) fatalities and one (1) near fatality during the 2nd quarter, the following were notable findings:

- Three (3) of the five (5) cases referenced in this report were open at the time of the child's death or near fatal injury.
- Two (2) of the child fatalities in this report resulted from children dying in unsafe sleep environments.
- Safe sleep was discussed with the parents prior to the death of their children in both of the cases involving children who died in unsafe sleep environments.
- In the other two (2) fatality cases, one (1) child died from inflicted injuries and the other from medical issues. In both of these cases the CPS investigations into the children's deaths were closed with founded findings.
- The near fatality case involved a nine-year-old who ingested her mother's prescription medication.
- one (1) child referenced in this report was 12 months old or younger when the fatality occurred.
- Four (4) of the five (5) cases referenced in this report were the result of abuse or neglect by the children's parents or caregivers.
- Three (3) children referenced in this report were Caucasian, one (1) was African American and one (1) was Mexican/Chicano.
- Two (2) of the children referenced in this report were medically fragile; the child referenced in the near fatality case is autistic.
- Domestic violence, substance abuse, mental health and homelessness were significant risk factors identified in several of the cases in this report.
- DSHS Children's Administration received intake reports of abuse or neglect in each of the cases in this report prior to the death or near fatal injury of the child. In two (2) of the fatality cases, there were three (3) prior reports made regarding the family. In the other fatality cases, one had eight (8) reports to the department prior to the child's death and another case had 11 intakes prior to the death of the child. There were 13 prior intakes reported to DCYF prior to the near fatal injury.
- Due to the small sample of cases reviewed, no statistical analysis was conducted to determine relationships between variables.

Child Fatality Review

J.C.

RCW 74.13.510 **2010**
Date of Child's Birth

December 22, 2017
Date of Child's Death

April 26, 2018
Date of the Fatality Review

Committee Members
Elizabeth Bokan, Office of the Family & Children's Ombuds
Amy Person, M.D., Health Officer, Benton-Franklin Health District
Ryan Kelly, Sargent, Kennewick Police Department
Dennis Knox, Supervisor, Developmental Disabilities Administration
Shannon Boniface, Area Administrator, Children's Administration
Lyn Andrews, CPS Quality Assurance Program Consultant, Children's Administration

Facilitator
Cheryl Hotchkiss, Critical Incident Review Specialist, Children's Administration

Executive Summary

On April 26, 2018, the Department of Social and Health Services (DSHS) Children's Administration (CA), convened a Child Fatality Review (CFR)[1] to assess CA's practice and service delivery to seven-year-old J.C. and RCW 74.13.520 family.[2] The incident initiating this review occurred on December 22, 2017 when J.C.'s mother reportedly found J.C. in bed and not breathing around 8:00 a.m. J.C.'s mother called 911 and the local Sheriff's office responded and arrived around 8:36 a.m. J.C. was found deceased. J.C. had medically complex issues including diagnoses of RCW 74.13.520 and RCW 74.13.520. RCW 74.13.520 required a RCW 74.13.520 and RCW 74.13.520. Additionally, RCW 74.13.520 was RCW 74.13.520, had RCW 74.13.520, RCW 74.13.520, and RCW 74.13.520. At the time of RCW 74.13.520 death, J.C. was residing with RCW 74.13.520 mother and her partner, who was not in the home at the time of the child's death.

The CFR Committee included members selected from diverse disciplines within the community with relevant expertise including the Office of the Family and Children's Ombuds, a Developmental Disabilities Administration (DDA) supervisor, a health district director and pediatric medical doctor, a detective sergeant, a CA quality assurance CPS program manager and an area administrator with CA. Neither CA staff nor any other Committee members had previous direct involvement with this family.

Prior to the review, each Committee member received a family genogram, a case chronology, a summary of CA involvement with the family and the un-redacted CA case documents (e.g., intakes, investigative assessments and case notes). Supplemental sources of information and resource materials were available to the Committee at the time of the review. These included medical reports, relevant state laws and CA policies.

During the review, the Committee chose to interview the CA investigators and supervisor assigned to the case from May 2017 through December 22, 2017, believing that the activities and investigations previously assigned to different investigators were not necessary for the Committee to review. The Committee noted that CA's work prior to May 2017 seemed sufficient, noting the complexity of the child's medical issues and acknowledging CA's efforts to include multiple providers and medical personnel in decision making. Following the review of the case file documents, completion of

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

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

interviews and discussion regarding department activities and decisions, the Committee discussed possible areas for practice improvement. The Committee identified findings and recommendations related to CA practice as noted at the end of this report.

Family Case Summary

Prior to J.C.'s death, CA received eleven intake[3] reports regarding this family between 2011 and April 2017. CA investigated allegations regarding RCW 13.50.100 by the mother RCW 13.50.100, nutritional-related issues concerning the mother improperly feeding and/or caring for J.C., the mother's RCW 13.50.100, the mother's lack of following medical recommendations for J.C. and the father being unresponsive to the child's medical needs. In 2015, J.C.'s father voluntarily placed RCW 74.13.520 into the care of a DDA services placement facility as J.C.'s mother had been arrested in Idaho and J.C.'s father could not provide the necessary care for J.C. On January 16, 2017, CA received an intake concerning J.C.'s mother because she was requesting J.C. be placed back into her care and there were concerns related to her ability to provide the necessary medical care for RCW 74.13.520. Between January and April 3, 2017, CA offered intensive services and case monitoring while communicating regularly with multiple medical, state and local providers that were working with the family to assess the mother and her partner's capacity to safely care for J.C. On April 3, 2017, CA closed an investigation related to allegations of RCW 13.50.100because no safety threats[4] were identified after the social worker visited the home and spoke with the child's medical providers and professional in-home providers.

On May 4, 2017, CA received an intake report that the family was moving to a rural location in a county outside of the RCW 74.13.520 area. The intake concerns were that J.C. might not have the medical resources and in-home care available to him as this new location has limited medical and community resources that J.C. might need. A CA investigator responded and met with the family in the Everett area, observed J.C. and received information on the family's new address across the state. The case was reassigned in the Tri-Cities area. The case was closed on June 21, 2017, after an in person contact was made with the family and collateral contacts were made with DDA and medical providers. On August 22, 2017 and August 28, 2017, CA received additional reports concerning J.C.'s needs and alleged lack of resources and care. An investigator was assigned and initial contacts with the family were made. The investigators who made contact with the family reported J.C. to be clean and appearing well cared for. The

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[3] An "intake" is a report received by CA in which a person or persons have reasonable cause to believe or suspect that a child has been abused or neglected. A decision to screen out an intake is based on the absence of allegations of child abuse or neglect as defined by WAC 388-15-009.

[4] Safety Assessment is used throughout the life of the case to identify impending danger and determine whether a child is safe or unsafe. It is based on comprehensive information gathered about the family at the time the safety assessment is completed. [Source: CA Practices and Procedures Guide Chapter 1120. Safety Assessment]

family then moved to a very rural and off-the-grid location in a different county in October 2017 without CA's knowledge. Limited case activity occurred on the case from September through early December 2017.

On December 22, 2017, a relative notified CA of the child's death and surrounding circumstances. The deputy that responded to the mother's 911 call said the temperature was 23 degrees outside and felt approximately 32 to 35 degrees inside the residence. The deputy reported the home had no power or running water. The mother reported to law enforcement and the county coroner that she moved to the Stevens County residence three months ago to get away from CPS because "they were hounding" her. J.C.'s cause and manner of death was not determined at the time of the review; however, the coroner had ruled out hypothermia.

Committee Discussion

The Committee heard from the assigned CA supervisor that case staffings occurred during both the May and August 2017 investigations. CA staff also stated they communicated with CA program managers, the CA area administrator, law enforcement and medical providers throughout the assigned 2017 investigations. The Committee noted that there were no documented Family Team Decision Making meetings (FTDM),[5] Shared Planning meetings, consultations with the Assistant Attorney General (AAG) and limited clinical supervisory case staffings from May through early December 2017. The Committee considered the importance of prompt and early case consultation and shared decision making when dealing with complex cases like this one and that CA and the community benefit from such consultations. The Committee believed that information gatheringand assessment and analysis is amplified when CA seeks a medical consultation[6] and communicates with DDA and other DSHS programs, as well as CA staff at all levels in the chain of command.

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

[6] The purpose of the Consultation Network is to provide statewide consultation and training regarding medical findings in cases of alleged child abuse and neglect. It provides quick, cost free access to a physician with expertise in the diagnosis of complex cases of child abuse and neglect to professionals such as CA social workers and supervisor, physicians and other medical providers, prosecutors and Attorney's General, law enforcement, other professionals in child abuse and neglect and tribal social workers. [Source: CA Practices and Procedures Guide Chapter 2331. Child Protective Services Investigation] Child Abuse Consultants are a team of physicians who provide statewide consultation and training regarding medical findings in cases of alleged child abuse and neglect. [Source: Child Abuse Consultation Network for Washington State]
The Child Protection Medical Consultants (CPMCs) are a team of physicians who provide statewide consultation and training regarding medical findings in cases of alleged child abuse and neglect. The tasks of the statewide 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. Secure medical evaluation and/or treatment. The social worker considers utilizing a medical

The Committee members questioned communication and partnership between CA and the medical community from May 2017 until the child's death. The Committee believed that there was a delay on the part of CA to connect with medical providers in each case and that CA could have benefited from promptly utilizing the regional medical consultant to assist in identifying the child's caregiving needs and in the assessment of child safety and parental capacity. The Committee discussed the importance of utilizing the regional medical consultants and child abuse medical consultant team promptly and without delay in such cases as this to assist in determining the parental capacity to safely care for the child. Additionally, the Committee discussed the importance of regular verbal communication with medical professionals involved in the care of J.C. It was apparent to the Committee that prior to May 2017, CA had been communicating and planning with multiple medical staff and providers, but after April 2017, CA did not seem to have sufficient contact with providers or medical staff to assist in determining J.C.'s needs for an accurate and timely safety assessment.

Further, the Committee surmised that CA might have had a better opportunity to gain information and communicate with the family had it partnered with DDA in making home visitations during the investigations post-May 2017. The Committee wondered what expectations CA has in place for staff while assessing safety of children with disabilities or developmental delays. The Committee discussed that CA investigators' knowledge on such topics varies by caseworker depending on previous education, training and practice. The Committee discussed the importance of partnership in such cases as this with DDA to possibly improve resource connections, the quality of assessments, and child safety.

The Committee spent considerable time discussing gaps in gathering sufficient evidence for a global assessment of the family from May through September 2017. The Committee heard from CA workers that the distance to the family home and lack of cell service at the location inhibited their availability to make frequent home visitations. The supervisor supported this explanation for intermittent contact with the family. Understanding that at times there are limitations to accessing residences in rural communities, the Committee noted that the location of the family's residence should not inhibit CA's response to assess child safety or investigate. Further, the Committee discussed a letter written by the CA supervisor that was delivered to the family on September 16, 2017. The Committee wondered if the language in the letter referencing possible legal interventions may have spurred the family to flee rather than encourage partnership or inspire communication with CA as needed for the safety assessment of

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evaluation in cases when the reported, observable condition or the nature and severity of injury cannot be reasonably attributed to the claimed cause and a diagnostic finding would clarify assessment of risk. Social workers may also utilize a medical evaluation to determine the need for medical treatment. [Source: CA Practices and Procedures Guide Chapter 2331. Child Protective Services Investigation]

J.C. Noting that it is not against policy, the Committee maintained that the letter did not reflect best practice and as such should be discouraged. The Committee recognized that CA did not have advance knowledge of the family's plans to move again. However, the Committee discussed how the department may have found out about the move had a health and safety visit[7] been completed in October. The Committee noted that there was limited case activity between September and November 2017 which raised questions about the supervision and investigation of the case.

Findings

The Committee did not find any critical errors on the part of CA, however identified the following findings and recommendations below in hopes of enhancing practice.

The Committee found that gathering information relevant to the May 2017 investigation and safety assessments was not as vigorous as it could have been for a more comprehensive assessment related to the child's medical needs and the caregiver's capacity to ensure safe housing and care. The Committee found this was likely the result of minimal clinical supervision and support to a newly hired worker.

The Committee found a lack of effective supervision and gathering/analysis of information in a timely manner for the August 2017 investigations. The Committee assessed that CA might have included the following for a more in-depth and timely assessment of the family and child safety in the first few months of the May and August 2017 investigations:

- FTDM
- Consultation with an AAG
- Regional medical consultation
- In person home visitations with DDA workers
- Health and safety as required in October

Recommendations

The local area administrator should address clinical supervision with the local supervisor with the goals of amplifying timely and more accurate safety assessments and case planning, and improving supervisory case reviews and collaboration with collateral contacts. The local area administrator might consider encouraging local staff to attend the variety of available trainings for gathering information and safety assessments throughout the region.

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[7] Face-to-face visits with children who have an open case with CA and regular visits with out-of-home caregivers and all known parents provides opportunity for ongoing assessments of the health, safety and well-being of children. Investigators must conduct monthly health and safety visits with children and parents if the case is open longer than 60 calendar days [Source: CA Practices and Procedures Guide Chapter 2331. Child Protective Services Investigations]

CA should make training available to all CA staff regarding the importance of connections and partnering in the field with DDA to assess the safety of children with developmental disabilities.

Child Fatality Review

C.R-M.

RCW 74.13.515 **2016**
Date of Child's Birth

December 21, 2017
Date of Child's Death

May 8, 2018
Date of the Fatality Review

Committee Members
Patrick Dowd, Director, Office of the Family & Children's Ombuds
Dr. Roy Simms, M.D., Acting Chief Medical Director, Coordinated Care of Washington, Primary Care Pediatrician, Yakima Pediatrics, Community Health of Central WA
Jennifer Andrade, Supervisor, Children's Administration
Christina Stretch, CPS Quality Assurance Program Consultant, Children's Administration

Facilitator
Cheryl Hotchkiss, Critical Incident Review Specialist, Children's Administration

Executive Summary

On May 8, 2018, the Department of Social and Health Services (DSHS), Children's Administration (CA), convened a Child Fatality Review (CFR)[8] to assess the department's practice and service delivery to C.R-M. and RCW 74.13.520 family.[9] The incident initiating this review occurred on December 22, 2017, when C.R-M. was taken to a local hospital by RCW 74.13.520 father. At the hospital, the child was pronounced dead. The local coroner ruled that C.R-M.'s death was due to natural causes and cited RCW 74.13.520 health issues (RCW 74.13.520 from birth, RCW 74.13.520, RCW 74.13.520 and RCW 74.13.520) as contributing factors. Medical experts from Seattle Children's Hospital reviewed the coroner's report and disagreed with the findings, noting that the child's death is suspicious for abuse or neglect in part due to the parents' inconsistent statements to police, medical staff and CA regarding where C.R-M. was sleeping leading up to RCW 74.13.520 death and how they found RCW 74.13.520. At the time of RCW 74.13.520 death, C.R-M. was residing with RCW 74.13.520 mother, RCW 74.13.520 father and his twin sibling.

The Review Committee included members selected from diverse disciplines within the community with relevant expertise including the Office of the Family and Children's Ombuds, a pediatric and child abuse medical expert, a CA program manager and a Child Protective Services (CPS) supervisor with CA. Neither CA staff nor any other Committee members had previous direct involvement with this family.

Prior to the review, each Committee member received a family genogram, a case chronology, a summary of CA involvement with the family and un-redacted CA case documents (e.g., intakes, investigative assessments and case notes). Supplemental sources of information and resource materials were available to the Committee at the time of the review. These included medical reports, relevant state laws and CA policies.

During the course of this review, the Committee interviewed the CPS investigator, supervisor and area administrator. Following the review of the case file documents, completion of interviews and discussion regarding department activities and decisions, the Committee discussed possible areas for practice improvement while recognizing the

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

[9] Family members are not named in this report because they have not been charged in an accusatory instrument with committing a crime related to a report maintained by the department in its case and management information system. [Source: RCW 74.13.500(1)(a)]

limited time CA was involved prior to the incident. The Committee did not make any findings or recommendations related to CA's response or CA systems.

Family Case Summary

Prior to C.R-M.'s death, CA received three intake[10] reports regarding the child, two of which screened in[11] for investigation on June 3, 2017 and September 8, 2017. The first report included allegations of physical abuse and negligent treatment. C.R-M. was reported to have had multiple injuries to vulnerable areas of RCW 74.13.520 body at different stages of healing. CA received a confirming report that C.R-M. had verified fractures with no explanation by the parents for the cause of the injury. C.R-M. parents were named as alleged perpetrators of physical abuse and negligent treatment. A CA investigator was assigned and learned that C.R-M. was RCW 74.13.520 at birth, causing numerous health issues including RCW 74.13.520, RCW 74.13.520, RCW 74.13.520 and needing RCW 74.13.520. Additionally, C.R-M. has been diagnosed with RCW 74.13.520. Some of the medical professionals involved with C.R-M. believed the injuries reported in the first intake were concerning for abuse, especially the injuries to RCW 74.13.520 ribs. However, the medical professionals could not reach consensus about how the child's injuries likely occurred. C.R-M.'s primary care physician believed the injuries might have been inflicted by physical therapy (performed by various providers as well as the parents) while other medical professionals disagreed, believing C.R-M. would have had previous injuries identified from x-rays that were completed prior to June 2017. The CA investigator collaborated with all of the professionals involved with the family and ultimately was unable to find that the parents were responsible for C.R-M.'s injuries. The investigator referred the family for in-home services and helped the family find licensed childcare.

On September 8, 2017, CA was notified by C.R-M.'s therapists that the parents did not seem to understand RCW 74.13.520 therapeutic needs due to missing some appointments. The parents explained to CA that C.R-M. had been ill and missed a few therapy appointments. The parents ensured C.R-M.'s attendance to all of the therapy appointments after the complaint was made. The parents agreed to communicate with the therapists in the future in order to have shared decision making regarding therapy cancellations. The allegations were investigated and determined to be unfounded. The case was closed October 18, 2018.

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[10] An "intake" is a report received by CA in which a person or persons have reasonable cause to believe or suspect that a child has been abused or neglected. A decision to screen out an intake is based on the absence of allegations of child abuse or neglect as defined by WAC 388-15-009.

[11] Intake social workers determine program response type and response times (emergent or non-emergent) for an investigation.CA intakes fall into three categories: CPS involves a child who is allegedly abused, neglected, or abandoned and includes child abuse allegations. CPS Risk Only involves a child whose circumstances places him or her at imminent risk of serious harm but does not include child abuse allegations. Non-CPS involves a request for services for a family or child.

On December 21, 2018, C.R-M.'s father reportedly put C.R-M. down for a nap around 10:00 a.m. and checked on RCW 74.13.520 around 2:00 p.m. The father reported to hospital staff that he was caring for C.R-M. alone and the mother was not home. The father stated that he found C.R-M. unresponsive at around 2:00 pm and took RCW 74.13.520 to the hospital, where C.R-M. was pronounced dead. Hospital staff wondered why the father had not called 911 and why the baby reportedly had been unattended and not checked on for four hours. Law enforcement later interviewed the parents. Law enforcement informed CA that both parents stated that they were both at home during the incident and reported C.R-M. to have been put down in the crib around 10:00 am and checked on at 2:00 pm. The mother reported that C.R-M. slept more during the day than at night. Law enforcement questioned why the parents did not call 911 and why the mother did not join the father in going to the hospital with C.R-M. The mother reported that it was routine for the father to transport C.R-M. to the hospital rather than call 911. Later, the parents reported to the CA investigator that they had all fallen asleep on the bed during the day and had placed C.R-M. next to the headboard of the bed. When the parents woke up they stated C.R-M. was unresponsive.

Committee Discussion

The medical expert on the Committee agreed with the RCW 74.13.515 Hospital SCAN Team's concerns about physical abuse to C.R-M. based on the type and location of injuries. The Committee discussed the challenges CA faces working with multiple medical professionals with varying opinions and uncertainty regarding injuries and suspicion for physical abuse. The Committee noted that regardless of the challenges, the assigned CPS investigator responded appropriately and efficiently to assess child safety and sort information for assessment and services. Further, the Committee noted that the investigator swiftly secured appropriate services for the family. The Committee appreciated the investigators skills and knowledge related to the family's culture and language believing that it benefitted the investigator in sorting out information for a global assessment. The Committee agreed with the investigator's assessment of child safety based on information that was available at the time of the investigation, adding that the investigator's actions were purposeful, tenacious and well thought out.

The Committee discussed the possibility that the family's primary language being Spanish may have impacted their reports to the various professionals (outside of CA) surrounding the circumstances of C.R-M.'s death. The Committee believed that the father's response in transporting the child to the hospital without calling 911 could have been a normal response based on his culture and routine practice in seeking care for C.R-M. The Committee discussed that many cultures or persons residing in rural areas may not be accustomed to having emergency services available. The Committee did not consider the parent's response to the hospital, rather than calling 911, out of the ordinary based on the information that was available.

Understanding CA's inability to remedy or oversee protocols of outside agencies, the Committee discussed the differing opinions between the coroner's written findings on the nature of C.R-M.'s death and the RCW 74.13.515 Hospital medical experts' assessment. The medical expert on the Committee agreed with the RCW 74.13.515 Hospital medical expert's assessment concerning abuse or neglect to C.R-M. The Committee medical expert added that the coroner's report did not meet the standards necessary for a quality death investigation and agreed with the RCW 74.13.515 Hospital medical expert that some of the notations in the report were generalized and inaccurate. The Committee discussed that an autopsy was not ordered by the Coroner, which the Committee speculated might reflect a disparity in the healthcare system's treatment of children with complex medical needs such as C.R-M. The Committee believed that CA is put in a difficult position when receiving conflicting reports from community professionals while also being responsible for conducting thorough investigations and assessing surviving children's safety.

Based on a review of the case documents and interviews with staff, the Committee did not find any critical errors made by department staff directly linked to the child's death. The Committee did not have any findings or recommendations. The Committee commended the investigator for her efforts and assessment.

Child Fatality Review

J.S.

RCW 74.13.515 **2017**
Date of Child's Birth

December 2017
Date of Fatality

March 29, 2018
Child Fatality Review Date

Committee Members
Cristina Limpens, MSW, Senior Ombuds, Office of the Family and Children's Ombuds
Stephanie Frazier, Child Protective Services Program Manager, Children's Administration
Jennifer Gaddis, MSW, Region 3 Safety Administrator, Children's Administration
Karen Irish, Victim Advocate, Seattle City Attorney's Office

Observers
Dave Voelker, Fatality Review Program Manager, Adult Protective Services
Kirk Snyder, Central Intake Supervisor, Children's Administration
Mary Rogers, Central Intake Supervisor, Children's Administration

Facilitator
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Executive Summary

On March 29, 2018, the Department of Social and Health Services (DSHS), Children's Administration (CA) convened a Child Fatality Review (CFR)[12] to assess the department's practice and service delivery to J.S. and RCW 74.13.515 family.[13] The child will be referenced by RCW 74.13.515 initials in this report.

On December 13, 2017, CA received an intake from the RCW 74.13.515 County Medical Examiner's Office stating RCW 74.13.515 -month-old J.S. passed away. J.S.'s mother put RCW 74.13.515 face down on her bed which had clothes and blankets on it. She later checked on RCW 74.13.515 and RCW 74.13.515 was not breathing.

Law enforcement placed J.S.'s sister in protective custody. The Medical Examiner found no outward signs of trauma at the scene. The cause of death was determined to be Sudden Infant Death Syndrome (SIDS) and the manner of death was deemed natural. After the child's death, CA learned that J.S. was living with RCW 74.13.515 mother and sister. CA had closed the most recent Child Protective Services (CPS) investigation seven days prior to J.S.'s death with the understanding that J.S. and RCW 74.13.515 sister were living with their maternal grandmother.

The Committee included members selected from diverse disciplines within the community with relevant expertise including individuals from the Office of the Family and Children's Ombuds, domestic violence and crime victims advocate as well as child welfare. There were two observers from CA and one observer from another DSHS administration. None of the Committee members or observers had any involvement or contact with this family.

Prior to the review, each Committee member received a summary of CA involvement with the family and un-redacted CA case documents (e.g., intakes, investigative assessments and case notes). Supplemental sources of information and resource materials were available to the Committee at the time of the review. These included the law enforcement report, relevant state laws and CA policies.

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

[13] J.S. mother is not named in this report because she has not been charged in an accusatory instrument with committing a crime related to a report maintained by the department in its case and management information system. [Source: RCW 74.13.500(1)(a)]

The Committee interviewed one CPS worker and two CPS supervisors. The CPS worker assigned to the case, which closed on December 6, 2017, was not available to be interviewed by the Committee.

Family Case Summary

On September 12, 2016, CA received an intake regarding J.S.'s then four-year-old sister. Between September 12, 2016 and August of 2017, there were six intakes received alleging RCW 13.50.100 to J.S.'s sister, RCW 13.50.100 and RCW 13.50.100 by the mother. Three of the six intakes were screened in for CPS/Family Assessment Response (FAR)[14] and one intake was screened in for a CPS Risk Only[15] assessment.

During a FAR assessment that was open in eastern Washington, CA learned that the mother and daughter had moved to western Washington in August of 2017. On September 1, 2017, an intake was received providing historical allegations of RCW 13.50.100 as well as stating that the mother RCW 13.50.100. The intake further alleged that RCW 13.50.100 That intake was assigned for a CPS investigation.

On RCW 74.13.515, 2017, while CPS was investigating the September 1, 2017 intake, another intake was received stating the mother had given birth to J.S. The intake stated that J.S. RCW 74.13.520 and that he had been RCW 74.13.520 in the first few months of the pregnancy. This intake was screened in for a Risk Only CPS assessment. On October 12, 2017, an intake was received stating that J.S.'s sister was RCW 13.50.100. This intake was screened out. The decision to close this intake was stated as not having met the sufficiency guidelines for a CPS investigation. The case was closed on December 6, 2017. At the time of the case closure, CA believed that J.S. and RCW 74.13.515 sister were in the physical care of their maternal grandmother. At the time of the case closing, CA believed that the mother had obtained RCW 13.50.100 treatment for herself and RCW 13.50.100 services for her daughter.

On December 13, 2017, J.S. passed away. RCW 74.13.515 was found by RCW 74.13.515 mother not breathing on her bed, after she laid RCW 74.13.515 down on RCW 74.13.515 stomach for a nap. According to the Medical Examiner, the bed had clothing and blankets on top of it. Based on the repeated education on safe sleep environments provided to J.S.'s mother by CA staff and the hospital staff where J.S. was born, a founded finding for neglect was given to the mother regarding the death of J.S. A criminal investigation regarding J.S.'s

[14] Family Assessment Response (FAR) is a Child Protective Services (CPS) alternative response to an investigation of a screened-in allegation of child abuse or neglect. FAR focuses on child safety along with the integrity and preservation of the family when lower risk allegations of child maltreatment have been reported. [Source: CA Practice and Procedures Guide 2310. Child Protection Services Initial Face-to-Face Response]

[15] CPS Risk Only reports when a child is at imminent risk of serious harm and there are no CA/N allegations. [Source: CA Practices and Procedures Guide2200. Intake Process and Response]

death was initiated based on the education provided to the mother regarding safe sleep and statements that the maternal grandmother made about prior incidents where J.S.'s ability to breathe were interrupted. After J.S.'s death, CA RCW 13.50.100 as to J.S.'s sister and she was briefly placed in out-of-home care. However, the court shortly thereafter chose to return the child to the mother, against the department's objection and while the criminal investigation continued.

Committee Discussion

The Committee discussed how the mother's presentation, as described by the staff who participated in this review, led to a biased approach in CA staff's interactions with her. There were recurring instances of staff taking the mother's statements as fact rather than verifying the information through other sources. Collateral contacts, such as mental health providers and substance use disorder treatment providers, could have provided a more thorough and unbiased assessment regarding the family's safety and stability.

The Committee struggled with the ongoing issue of turnover and CA's struggle to maintain consistent staff. This issue of turnover and vacancies leaves supervisors with a substantial workload. One specific area that proves to be a struggle is the supervisor's reliance on their staff to provide accurate and comprehensive details regarding cases during monthly supervision staffings. The Committee discussed how supervisors do not have the time to read through each and every case assigned to their staff to make sure there are no gaps in the information provided to them by their staff. This can lead to supervision that lacks critical thinking and support to the families CA is involved with. There were periods of time where supervisory reviews were not documented on this case.

The Committee also thought CA could have utilized other supports and shared decision-making by cross reporting the September 1, 2017 intake to law enforcement. This intake contained allegations RCW 13.50.100 to J.S.'s sister that the mother allegedly admitted to.

One Committee member discussed that RCW 74.13.515 County has a Domestic Violence Best Practices Group that meets on a monthly basis. The group consists of service providers in RCW 74.13.515 County and CA staff. The purpose is to staff cases involving DV and for shared decision-making and next steps. Also discussed was the fact that CA did not have a DV policy at the time of the allegations in this case. Since that time, a policy has been implemented which outlines how to handle assessments of DV within the families that CA interacts with.

The Committee discussed the placement of J.S. and RCW 74.13.515 sister with their grandmother. Due to the identification of the children as unsafe with their mother and

then the mother making the decision to place with the maternal grandmother, this was considered an informal placement. The Committee discussed that the issue of informal placements has been a statewide issue for some time. The Committee is hopeful that this issue will be addressed in the upcoming policy roll out July 1, 2018.

Findings

Based on the review of the case documents and interviews with staff, the Committee did not identify any critical errors made by CA that contributed to the death of J.S. The Committee did identify missed opportunities within the assessment and casework with this family, as well as systemic barriers to consistent supervision and case practice.

The Committee identified there were various points during the case where the assessment of safety was not accurately completed. There were missed opportunities to engage collateral contacts such as relatives and service providers. This included the need to adequately assess the maternal grandmother based on differing statements regarding her suitability and stability for providing care fulltime to her grandchildren. There was also a missed opportunity to assess for the safety and well-being of J.S. and RCW 74.13.515 sister in the month of November prior to the case closing. CA did not conduct a health and safety visit during November or December 2017.

The Committee noted that the assessments of safety throughout this case were incomplete. The Committee believed that there were times where the household circumstances changed and there was not a new assessment completed. The Committee discussed that CA did not thoroughly assess the safety of J.S.'s sister regarding the mother's boyfriend and allegations of RCW 13.50.100 . The mother denied RCW 13.50.100 and told CA the child was safe; there was reliance upon the mother's statements as fact.

The Committee noted that during the September 2017 assessments, CA staff believed J.S. and RCW 74.13.515 sister were not safe in their mother's care. The CA staff allowed the mother to choose to have the children stay with the maternal grandmother as an informal placement. The Committee believed it would have been appropriate for CA to discuss this with an Assistant Attorney General or possibly formalize this placement decision based on the unsafe status of the children with their mother. As part of this formalized placement, CA would have conducted a thorough assessment of the maternal grandmother's suitability for placement. Instead, CA relied upon a revocable document indicating the mother was allowing the children to live with and be cared for by the maternal grandmother.

The Committee believed that the mother had unmet mental health needs based on her statements that she was RCW 13.50.100, experienced the RCW 13.50.100, was a

RCW 13.50.100. The Committee noted that it may have been beneficial for CA to have referred the mother to her own mental health assessment.

Recommendations

CA needs to address the issue of coverage for supervisors and line staff based on the high turnover rates within the agency.

The RCW 74.13.5 Southeast and Southwest offices should receive training regarding safety throughout the life of a case to include informal placements, safety framework and safety threshold.

Child Fatality Review

M.H-A.

RCW 74.13.5 **2015**
Date of Child's Birth

December 3, 2017
Date of Fatality

March 29, 2018
Child Fatality Review Date

Committee Members
Mary Moskowitz, JD, Ombuds, Office of the Family and Children's Ombuds
Jenna Kiser, MSW, Intake, Safety and Domestic Violence Program Manager, Children's Administration
Silvia Johnson, MSW, Area Administrator, Children's Administration
Yolanda Duralde, MD, Medical Director at MultiCare Child Abuse Intervention Department and Children's Administration Medical Consultant
Ashley Robillard, Sexual Assault Unit Detective, Tacoma Police Department

Facilitator
Libby Stewart, Critical Incident Review Specialist, Children's Administration

Executive Summary

On March 29, 2018, the Department of Social and Health Services (DSHS) Children's Administration (CA) convened a Child Fatality Review (CFR)[16] to assess the department's practice and service delivery to M.H-A. and RCW 74.13.5 family.[17] The child will be referenced by RCW 74.13.5 initials in this report.

On November 30, 2017, CA received a call on behalf of a physician with a local hospital's child abuse team with concerns for possible abuse to M.H-A. The allegations involved a facial injury to the child. A week prior, on November 22, 2017, M.H-A. was hospitalized for an infection on RCW 74.13.5 face. RCW 74.13.5 was released on November 25, 2017 and brought back on November 29, 2017 for a follow-up examination. The initial diagnosis at the time of the child's admission to the hospital was a possible infection. Upon returning to the hospital for the follow-up examination, the dermatologist and a physician who specializes in child abuse believed that the underlying injury leading to the infection was a possible immersion burn. M.H-A. was allowed to leave the hospital with RCW 74.13.5 mother after the follow-up examination and a call was made to CA intake the following day.

On November 30, 2017, CA assigned a Child Protective Services (CPS) worker to investigate the allegations of abuse to M.H-A. The CPS worker was unable to locate the family because CA did not have a current address for them. The CPS worker made numerous attempts to locate the child and family between November 30 and Friday, December 1. Based on the lack of a current address for the family, the CPS worker was unable to request an after-hours response for Saturday.

On December 3, 2017, CA received a call from a RCW 74.13.5 County Medical Examiner stating M.H-A. died in RCW 74.13.5 home and D'Andre Glaspy was the only other person present at the time of death. D'Andre Glaspy was arrested and charged with Murder in the Second Degree. M.H-A.'s mother was not home when the child died.

The CFR Committee included members selected from diverse disciplines within the community with relevant expertise including individuals from the Office of the Family

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[17] M.H-A.'s mother is not named in this report because she has not been charged in an accusatory instrument with committing a crime related to a report maintained by the department in its case and management information system. The mother's boyfriend, D'Andre Glaspy, has been charged with Murder in the Second Degree in connection with the death of M.H-A. [Source: RCW 74.13.500(1)(a)].

and Children's Ombuds, law enforcement and child welfare. The Committee also included a medical professional who specialized in child abuse. The Committee members did not have any involvement or contact with this family.

Prior to the CFR, each Committee member received a summary of CA involvement with the family and un-redacted CA case documents (e.g., intakes, investigative assessments and case notes). Supplemental sources of information and resource materials were available to the Committee at the time of the CFR. These included the Medical Examiner's report, relevant state laws and CA policies.

The Committee interviewed the CPS supervisor for the April 2017 investigation and the CPS supervisor and worker on the November 20, 2017 investigation. The CPS worker who investigated the April 2017 intake terminated his employment with the department prior to this CFR.

Family Case Summary

On April 7, 2017, CA received an intake alleging physical abuse to M.H-A. by RCW 74.13.515 mother's boyfriend, D'Andre Glaspy. The report also stated the mother was made aware of the concerns by the caller and continued to allow D'Andre Glaspy to physically harm M.H-A. The intake states the child had scratches to RCW 74.13.515 face and a bruise on RCW 74.13.515 neck. This intake was screened in for a CPS investigation.

The intake was cross-reported to law enforcement who did not assign the case for investigation. The CPS worker made numerous attempts to contact the family between April 7 and April 13. The worker reached the mother by phone on April 13. On April 14, 2017, the CPS worker met the mother, M.H-A. and another adult female at a local library. The mother denied the allegations of physical abuse to M.H-A. by her boyfriend and the CPS worker did not see any injuries on M.H-A.

A second intake was received on April 21, 2017 from the prior referent with new allegations of a burn to the child's hand and that the mother and D'Andre Glaspy were using RCW 13.50.100. This intake was screened out, with the screening decision notes indicating that the allegations were documented in the previous intake. That same day, the referent spoke with the CPS worker; a case note documented the same information regarding the burn to the child's hand and allegations of RCW 13.50.100 use.

On May 22, 2017, the CPS worker walked through the residence where M.H-A. and RCW 74.13.515 mother were staying. The family friend whose house they were staying at told the CPS worker that D'Andre Glaspy gave her a "bad vibe" and that he "has a weird persona." The family friend stated she would not put the accusations of abuse towards M.H-A. past D'Andre Glaspy and would not leave D'Andre alone with M.H-A.

The CPS worker made a collateral contact with M.H-A.'s pediatrician and confirmed that M.H-A. was up to date on RCW 74.13.515 medical needs.

M.H-A.'s mother requested assistance in obtaining child care; the CPS worker sent M.H-A.'s mother a letter indicating she could obtain child care by calling the phone number provided in the letter.

The CPS worker mailed a letter to the last known address for D'Andre Glaspy. The letter was an attempt to contact him and discuss the allegations in the intake. The CPS worker had attempted to call D'Andre Glaspy but was unable to reach him. There was no other documentation in the case file on efforts to locate D'Andre Glaspy.

The CPS investigation of the April 7th referral was closed as unfounded on June 2, 2017. On June 7, 2017, the family friend where the mother and M.H-A. were residing called the CPS worker and left a voicemail message. The CPS worker documented receiving the voicemail in a case note with no further details; the CPS worker did not return the family friend's call.

On November 30, 2017, CA received an intake stating M.H-A. was admitted to the hospital on November 22 for an infection to RCW 74.13.515 face, discharged on November 25, and brought back in on November 29 for a follow-up examination. After the examination, M.H-A. left with RCW 74.13.515 mother. The infection had resolved but the dermatologist indicated it appeared there was an underlying burn around the child's mouth involving the chin, cheeks and lips. The dermatologist consulted with another physician at the hospital who is a child abuse expert; it was determined that the injury may have been an immersion burn which became infected.

On November 30, 2017, the intake was assigned to a CPS worker for an investigation. The CPS worker reviewed the CA history of both the mother and D'Andre Glaspy and then sent a copy of the intake to law enforcement. The CPS worker called law enforcement twice to ask for a detective to go out to locate the family but was told no one was available. The CPS worker did not request a patrol officer to accompany her when she attempted to visit the family. The CPS worker then called the referring physician and discussed the intake.

The CPS worker went to the address listed on the intake the next day but no one answered the door. She then called the phone number listed for the child's mother. She ended up speaking with the maternal grandmother who said she would have the mother call the CPS worker. The grandmother denied knowing the whereabouts of M.H-A. The CPS worker then received a call from an aunt of the mother stating the grandmother often watches M.H-A. when the child's mother is working. The aunt did not know the mother's current address or where M.H-A. was currently at. The CPS

worker spoke with one of the physicians who consulted on M.H-A.'s case. The physician provided some historical information including knowing that the family had recently moved but that a current address was not obtained by hospital staff prior to the mother and M.H-A. leaving the hospital on November 29.

On December 2, 2017, CA received a call from a RCW 74.13.515 County Medical Examiner stating M.H-A. had been found deceased by RCW 74.13.515 mother's boyfriend, D'Andre Glaspy. There were no other people in the residence when the child died. The Medical Examiner's final report listed the cause of death as multiple blunt force injuries and the manner of death was homicide. The autopsy identified multiple acute injuries as well as prior injuries. There were multiple fractures in various states of healing which were consistent with non-accidental trauma. M.H-A.'s mother has not been charged in relation to RCW 74.13.515 death or prior injuries. At the conclusion of the CPS investigation, the mother received a founded finding for negligent treatment for failing to protect her RCW 74.13.515 from abuse by D'Andre Glaspy. D'Andra Glaspy received a founded finding for physical abuse.

Committee Discussion

The Committee discussed at length the need for mandatory reporters to follow RCW 26.44.030, which outlines mandatory reporting responsibilities. There were multiple points documented in the medical records indicating that the injury to M.H-A.'s face may have been an infection but that it may also have been a result of non-accidental trauma, yet an intake was not called in until after the child had been discharged from the hospital. There was enough concern that the Committee contacted the Suspected Child Abuse and Neglect (SCAN) team at the hospital where the child was previously treated to review their records. The Committee noted, based on the documented concerns regarding the etiology of the injuries, that it would have been appropriate for medical professionals to call law enforcement or CA prior to discharging M.H-A. on November 25, 2017.

The Committee discussed how children under 2 years old are often given a full skeletal survey as part of an assessment for possible abuse or neglect because often times children this young are unable to verbally describe how they received an injury. A full skeletal survey is a tool to assist in this evaluation process. M.H-A. was just over that age cut-off. However, D'Andre Glaspy's history with two similarly aged children, and those children's injuries, may have provided the added component necessary to consider whether a full skeletal survey would have been appropriate for this assessment.

The Committee noted that between April 7 and April 13, 2017, the CPS worker made numerous efforts to locate M.H-A. and RCW 74.13.515 mother. Those efforts were impressive, especially since the family did not have a consistent residence. However, after the contact was made, there did not appear to be the same fervor to locate D'Andre Glaspy

in order to fully assess the situation and interview all subjects of the investigation. There were indications that D'Andre Glaspy could have been located via social media, but the CPS worker did not attempt to find him this way.

The Committee discussed how the CPS worker assigned to the April 2017 investigation provided the mother with a letter in response to her request for childcare assistance. The Committee discussed that it may have been beneficial to have a follow-up conversation with the mother to help her obtain this service as opposed to a short letter only containing an informational phone number. It is often seen as a positive support to have other persons, especially mandatory reporters such as childcare providers, have ongoing contact with children.

The Committee discussed how neither a Multi-Disciplinary Team (MDT) nor Child Assessment or Abuse Center (CAC) was used on this case. It was the Committee's understanding that a CAC is available through one of the hospitals in RCW 74.13.515 County, but this was not confirmed. The ability for CA staff to discuss a case with a multifaceted team such as an MDT or CAC allows for shared decision making as well as critical thinking to occur from differing disciplines. The Committee believed these types of support in shared decision making and staffing would be beneficial to all staff in RCW 74.13.515 County as well as specifically for this case.

Findings

Based on the review of the case documents and interviews with staff, the Committee did not identify any critical errors made by CA that contributed to the death of M.H-A. The Committee did identify missed opportunities within the assessment and casework with this family as well as systemic barriers to consistent supervision and case practice.

This intake was assigned on April 7, 2017. On May 1, 2017, the assigned CPS worker was given a new supervisor; the new supervisor had been with CA for 18 months prior to his promotion to a supervisory position. By July 2017, this supervisor was managing two units and continue to manage both units for eight months. A majority of this time, the area administrator was out on leave. While there was an area administrator for the other office located in the same building, and at times the area administrator's supervisor was in the office, this often left the new supervisor to access only peers as a way to receive support and guidance. The Committee believed the issue of retention and longevity of staff prior to promotion to a supervisory position are ongoing statewide issues.

The Committee believed that the April 21, 2017 intake should have screened in for a CPS investigation as opposed to being screened out. The alleged burn to M.H-A.'s hand and alleged RCW 13.50.100use by the mother and D'Andre Glaspy while caring for the child were not previously reported. The concern about this particular screening decision

has already been addressed by the field office through a training by the CA Intake Program Manager on April 18, 2018 with the intake location and their staff.

Collateral contacts are utilized by CA staff for a better understanding of a family's situation, needs and dynamics. The Committee identified the need for more collateral contacts in this case. Some examples were following up with the family member that the mother and M.H-A. lived with and who said she would not leave the child alone with D'Andre Glaspy. That same person also left a voice message for the CPS worker days after his investigation into the April 7th referral was closed, but the CPS worker did not call her back. The Committee also suggested that the department could have requested an evaluation by M. H-A.'s primary physician. Due to the time lapse between the initial screened-in intake and the time that the CPS worker saw M.H-A., any possible injury may have resolved. Requesting a urinalysis from the mother and D'Andre Glaspy would have been another resource to assess the allegations of RCW 13.50.100use.

Another avenue that is often considered a collateral contact is the history available to CA staff within our own FamLink computer system. Regarding this case, the CPS worker for the April 7, 2017 intake stated he reviewed the history of the mother and D'Andre Glaspy as adults only. He indicated that there were no founded findings of abuse or neglect against either adult. However, the CPS worker on the November 30, 2017 intake reviewed the history of the mother as a child and adult and looked further at the investigation involving D'Andre Glaspy with two other young children. Those two actions provided the CPS worker with more details surrounding RCW 13.50.100; details regarding historical, child welfare issues related to the RCW 13.50.100 as allegations, though no founded findings, of physical abuse to similarly-aged boys as M.H-A. by D'Andre Glaspy.

Recommendations

CA should have a Child Abuse Medical Consultation Network (MedCon) discuss mandatory reporting responsibilities with RCW 74.13.515 Hospital. This case highlighted a need for more urgency regarding the need for mandatory reporting which can be made to law enforcement or CA. Law enforcement often has the ability to respond immediately as opposed to CA's response time. The Committee also wanted MedCon to discuss that CA cannot place children in protective custody. Placement in protective custody by law enforcement, a court order for removal through a dependency case, or a hospital hold by a treating physician are the only means to immediately remove a child from the home legally.

CA should consider reminding offices that utilizing regional supports such as Safety Administrators, Quality Practice Specialists, program managers or headquarters staff as well as MDTs and CPTs are good resources for shared decision making.

CA should create a policy regarding the use of social media as it pertains to communication between CA staff and clients.