Washington State Department of Social and Health Services

Transforming Lives

REPORT TO THE LEGISLATURE

Quarterly Child Fatality Report

RCW 74.13.640

July – September 2017

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Washington State Department of Social & Health Services
Transforming lives

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Executive Summary

This is the Quarterly Child Fatality Report for July through September 2017 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 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.

This report summarizes information from completed reviews of five (5) child fatalities and one (1) near-fatality that occurred in the third quarter of 2017. All child fatality review reports can be found on the DSHS website: https://www.dshs.wa.gov/ca/publications/childrens-administration-child-fatality-reports

The reviews in this quarterly report include child fatalities and near-fatalities from each of the three regions.

Region	Number of Reports
1	2
2	2
3	2
Total Fatalities and Near-Fatalities Reviewed During 3rd Quarter 2017	6

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 the Children's Administration (CA) within 12 months of his/her 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 CA and the number of reviews completed and those that are pending for calendar year 2017. 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 2017			
Year	Total Fatalities Reported to Date Requiring a Review	Completed Fatality Reviews	Pending Fatality Reviews
2017	13	5	7

Child Near-Fatality Reviews for Calendar Year 2017			
Year	Total Near-Fatalities Reported to Date Requiring a Review	Completed Near-Fatality Reviews	Pending Near-Fatality Reviews
2017	6	1	4

The child fatality reviews referenced in this Quarterly Child Fatality Report are subject to public disclosure and are posted on the DSHS website. https://www.dshs.wa.gov/ca/publications/childrens-administration-child-fatality-reports

Near-fatality reports are not subject to public disclosure and are not posted on the public website nor included in this report.

Notable Third Quarter Findings

Based on the data collected and analyzed from the five (5) fatalities and one (1) near fatality during the 3rd quarter, the following were notable findings:

- Four (4) of the six (6) cases referenced in this report were open at the time of the child's death or near-fatal injury.
- Two (2) of the five (5) fatality cases resulted from infants dying in unsafe sleep environments.
- In both of these fatalities, a parent was under the influence of narcotics or alcohol while co-sleeping with their infant children creating an unsafe sleep environment for the child.
- Safe sleep was discussed with the parents in cases involving infants who died in unsafe sleep environments.
- In two (2) of the five (5) fatality cases, medical examiners were unable to determine the cause of death. However, in both cases the child's death was highly suspicious for abuse or neglect.
- The near-fatality case involved a four-year-old child falling from a four story window. She was unsupervised for a considerable time prior to falling.
- In four (4) of the five (5) child fatality cases referenced in this report, the children were 13 months old or younger when the fatality occurred.
- Five (5) of the six (6) cases referenced in this report were the result of abuse or neglect by the children's parents or caregivers.
- Two (2) children in this report were Native American and one (1) was African-American, one (1) was Caucasian and two (2) children were Hispanic.
- Children's Administration received intake reports of abuse or neglect in the each of the cases in the report prior to the death or near fatal injury of the child. In four (4) of the five (5) fatality cases, there was only one (1) intake reported to CA prior to the fatality; in the other fatality case, there were seven (7) intakes prior to the child's death. In the one (1) near fatality case, there were three (3) intakes on the family prior to the near fatal injury incident.
- Due to the small sample of cases reviewed, no statistical analysis was conducted to determine relationships between variables.

Child Fatality Review

K.K.

RCW 74.13.515 2016
Date of Child's Birth

March 17, 2017
Date of Death

May 4, 2017
Child Fatality Review Date

Committee Members
Maureen Sorenson, MSW, Director, Amara Parenting (Pierce County)
Robert Welch, MSW, MHP, LSWAIC, CDPT, Metropolitan Development Council
Patrick Dowd, J.D., Director, Office of Family and Children's Ombuds
Taleema Love, RN/BSN, Tacoma-Pierce County Health Department Nurse Family Partnership Program Public Health Nurse
Amy Boswell, Region 3 Quality Practice Specialist, Children's Administration

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

Executive Summary

On May 4, 2017, the Department of Social and Health Services (DSHS) Children's Administration (CA) convened a Child Fatality Review (CFR)[1] to examine the department's practice and service delivery to RCW 74.13.515 -old K.K. and RCW 74.13.515 family. The incident initiating this review occurred on March 17, 2017 when K.K. passed away from medical complications stemming from critical injuries RCW 74.13.515 suffered on January 17, 2017 at the hands of RCW 74.13.515 father, Daniel Krempl.[2] A Child Protective Services (CPS) investigation had been active since RCW 74.13.515, 2016 in response to a Risk Only[3] intake regarding the birth of K.K. and RCW 74.13.515 twin sibling.

The CFR Committee included CA and community professionals with relevant experiences and expertise in child and family advocacy, child abuse and child safety, chemical dependency, and hospital social work. None of the Committee members had any direct involvement with the family.

In advance of the review, each Committee member received a chronology of the family's brief history of CPS involvement. Relevant un-redacted CA case file documents (e.g., intakes, case notes and assessments of safety and risk) were also provided, along with law enforcement reports regarding the criminal investigation of the initial serious injuries to K.K. and RCW 74.13.515 sibling. Supplemental sources of information (e.g., medical records) and resource materials (e.g., relevant CA policies) were available to the Committee at the time of the CFR.

During the course of the review, the Committee interviewed the CPS worker and her supervisor regarding their involvement with the family. Following review of the case file documents, completion of the interviews and discussion regarding

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

[2] The full name of the father is used in this report because he is charged in an accusatory instrument with committing a crime related to this incident. Neither the mother nor K.K.'s twin sibling are identified in this report due to privacy laws. *See* RCW 74.13.500

[3] CA may investigate intakes that do not allege an actual incident of Child Abuse or Neglect (CA/N), but have risk factors that place a child at imminent risk of serious harm. [Source: CA Practices and Procedures Guide 2200]

department activities and decisions, the Committee made the findings and recommendations presented at the end of this report.

Case Overview

On **RCW 74.13.515** 2016, CA was notified by a hospital social worker that the mother RCW13.50.100 at delivery of K.K. and RCW 74.13.515 twin sibling. K.K. also RCW13.50.100 While intrauterine drug exposure was indicated, the initial assessment at the hospital did not suggest the newborns had been RCW13.50.100 [4] and no hospital/physician hold was initiated.[5] The information provided by the hospital lacked specific allegations of child abuse or neglect as defined in WAC 388-15-009. However, the intake screened in as a CPS Risk Only case due to concerns for RCW13.50.100 and the fact that the father, Daniel Krempl, had previously been identified as having a history of RCW13.50.100.

In-person contact was made at the hospital with the mother, the newborns and the maternal grandmother on **RCW 74.13.515**, 2016. The mother admitted having RCW13.50.100 and was surprised when the doctor discovered the second baby during delivery as she did not realize she was pregnant with twins. She denied any substance abuse issues, reporting her RCW13.50.100 At the time of the initial contact with the mother, the CPS worker reportedly provided various informational packets for later discussion, including materials on infant safe sleep, Plan of Safe Care for Newborns,[6] and various available community resources.

The following day, the assigned CPS worker contacted the mother by phone in an attempt to arrange for a home visit to drop off some purchased baby items for the family, to meet with the twin's father, to discuss a plan for RCW13.50.100and

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[4] RCW13.50.100 . [Source: CA Practices and Procedures Guide Appendix A: Definitions]

[5] RCW 26.44.056; See also RCW 26.44.030(8)

[6] RCW13.50.100 See: The Child Abuse Prevention and Treatment Act section 106(b)(2)(B)(iii)

to discuss the possibility of engaging the family in Family Voluntary Services (FVS).[7] The mother indicated she could not provide the address of her residence because she had just moved and could not remember the address. The worker discussed wanting to do a home visit as soon as the twins were discharged. The worker arranged for the grandmother to pick up the baby items at the local CA office, at which time the grandmother indicated having no concerns for her daughter's ability to parent.

An unsuccessful attempt by the CPS worker to reach the mother occurred on RCW 74.13.515, 2016. Medical records obtained post critical incident show that K.K. and RCW 74.13.515 sibling were seen by their primary care physician for newborn well-child exams on RCW 74.13.515 and no concerns were noted by the medical provider at that time.

Another unsuccessful attempt by the CPS worker to reach the mother occurred two weeks later. The grandmother was contacted and she agreed to try to contact her daughter about calling the CPS worker. Information obtained post critical incident shows that maternal and paternal relatives had in-person contact with the parents and the children in late December and early January and reported having had no concerns about the care or condition of the babies during the times they had seen them.

On RCW 74.13.515, 2017, CA central intake was contacted by RCW 74.13.515 Children's Hospital regarding RCW 74.13.515 -old twins who had been admitted for serious injuries. K.K. was in grave condition with devastating neurologic injuries, multiple fractures (including skull) and other compromising conditions for which risk of mortality was high. Additionally, there appeared to be genital trauma which was concerning for sexual abuse. K.K.'s twin sibling, RCW13.50.100 The infants had been discovered in their mother's basement apartment by a neighbor after a 911 response regarding their mother, who had died outside of the apartment building. Cause of death regarding K.K.'s mother was later determined to be from a bacterial infection.[8]

Daniel Krempl was subsequently arrested, charged and jailed for suspicion of two counts of first degree child assault. A CPS investigation was founded as to Daniel

[7] FVS is a child welfare services program for families not involved in dependency matters. Parents are offered services designed to reduce the safety threats while the children remain in the care and custody of their parent(s).

[8] In Washington state a death certificate is a public record and a legal statement of the cause and manner of death.

Krempl for negligent treatment and physical abuse of both children and for sexual abuse of K.K.

Dependency petitions were filed on both children. While K.K. remained hospitalized, RCW 74.13.515 sibling was placed into RCW13.50.100 On January 26, 2017, Do Not Resuscitate (DNR) and Do Not Intubate (DNI) orders were signed in Pierce County Juvenile Court regarding K.K., largely based on the recommendations of the child's medical team. Eight days later, the presiding judge signed an order to allow for Comfort Care Measures.[9] On February 13, 2017, K.K. was placed in a facility for medically complex and fragile children. One month later, K.K. succumbed to a multitude of complications stemming from the injuries RCW 74.13.515 suffered in mid-January.

Committee Discussion

As part of the review process, the Committee explored and discussed a number of issues potentially relevant to CA's delivery of services to the family and system responses to the needs of the family. This included issues relating to investigative practices (e.g., information gathering), assessment, worker caseload, worker experience, etc. It should be noted that not all the issues discussed and documented in this Discussion Section resulted in tangible presumptions or conclusions by the Committee. Those issues that were determined by the Committee to have significant consideration for CA practice are noted in the Findings Section of this report.

The Committee briefly discussed the screening decision for the RCW 74.13.515 2016 intake. It was noted that hospitals in Washington are encouraged to report to CPS RCW13.50.100 , but that such information, in and of itself, is not an allegation of abuse or neglect.[10] CA policy directs intake to screen in reports as Risk Only when there is no child abuse or neglect allegation but the newborn is RCW13.50.100 and risk factors indicate imminent risk of serious harm.[11] While an argument was made that the risk factors identified at intake were not unequivocally indicative of imminent risk of

[9] Comfort Care Measures refers to medical treatment of a dying person where the natural dying process is permitted to occur while assuring maximum comfort. It is in contrast to other levels of intervention such as removal of all support modalities and long-term full care (intensive care support, mechanical life-support, multiple surgeries).

[10] *See* Washington State Department of Health Guidelines for Testing and Reporting Drug Exposed Newborns in Washington State

[11] "Imminent Risk of Serious Harm" as used in Risk Only Intakes and coordination with law enforcement: Imminent - Having the potential to occur at any moment, or there is substantial likelihood that harm will be experienced. Risk of Serious Harm - A high likelihood of a child being abused or experiencing negligent treatment or maltreatment that could result in death, life endangering illness, injury requiring medical attention, and/or substantial risk of injury to the physical, emotional, or cognitive development. [Source: CA Practices and Procedures Guide Appendix A: Definitions]

serious harm, the Committee did not take issue with the intake screening decision.

Committee members discussed the investigative and assessment activities occurring prior to the mid-January critical incident, as reflected in case file documentation and in the recollections of the worker during the Committee interview. The CPS worker appeared to have met or was the in process of meeting basic investigative practice requirements per policy, with the exception of case note entry (timeline) policy violations. While belated case note entries were of some concern, with the exception of one Committee member, these were not viewed as significant oversights in terms of case outcomes and as such were not specifically included in the Findings Section of this report.

The Committee primarily looked at activities involving information gathering and assessment, key components of both the Child Safety Framework[12] and the Structured Decision Making Risk Assessment (SDMRA)[13] tool used by CA. The Committee recognized the worker's initial efforts in RCW 74.13.515 2016 to try to connect with the family as well as the worker's intentions to do more in depth information gathering and have additional discussions with the parents. This included the worker's plan to discuss infant safe sleep[14] and to offer resources available in the community that might benefit the family. However, the information actually gathered by the worker appeared to be very limited.

The Committee noted that, excluding the initial contact shortly after the birth of the twins in RCW 74.13.515, the worker had no further observations of the infants until after the critical incident in mid-January. While it later became known that the infants had been seen by others during that span of time, the worker had essentially no updated information on K.K. and RCW 74.13.515 sibling. The worker had just one follow-up conversation with the mother (by phone) and was unable to reach the father despite multiple attempts to contact both parents.

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[12] CA's Child 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.

[13] The SDMRA® is an evidence-based actuarial tool from the Children's Research Center (CRC) 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. The tool is a household-based assessment heavily influenced by family history. [Source: Structured Decision Making® Procedures Manual]

[14] Current CA policy requires CA staff to conduct a safe sleep assessment when placing a child in a new placement setting or when completing a CPS intervention involving a child aged birth to one year, even if the child is not identified as an alleged victim.

The Committee looked at other sources of available information that were not tapped by the worker. These sources included exploring what options the worker had to locate the address of the family, such as using information from hospital admission records and inquiring with apartment managers at the street intersection given by the mother. The Committee also looked at possible sources the worker could have pursued to confirm the mother's assertion that she had previously been prescribed [redacted] RCW13.50.100 K.K.'s mother had revealed to the worker that Daniel Krempl had spent time incarcerated in a federal penal facility (unspecified) and was on parole/probation. The Committee discussed what reasonable options the worker had to hasten criminal background checks.[15] Even if additional and/or clarifying information been gathered, the Committee was unable to say how such information would have impacted child safety decisions. However, the Committee felt that a relatively swift gathering of such information could have impacted decisions as to service referrals, such as a Public Health Nurse (PHN), Maternity Support Services,[16] and possibly Birth to Three.[17]

The Committee deliberated on the SDMRA® tool currently used by CA, which is an actuarial instrument based on empirical evidence and primarily provides prescribed, structured guidelines for assessment and practice in child welfare. The Committee discussed the limitations of the SDMRA® which does not allow for clinical judgments, including consensus-derived (non-actuarial derived) risk factors that could be considered in terms of combinations and interactions of risks. Questions arose as to whether a more expansive clinical-based assessment tool would have been more beneficial in this case.[18] While the Committee

[15] CA is authorized to access the National Crime Information Center (NCIC) database for subjects of CPS investigations and other adults related to the investigations. The Purpose Code C check allows the social worker to assess the safety of children in the home and the safety of CA staff conducting the investigation. Purpose Code C checks are based on name and date-of-birth information and are a point in time check. Purpose Code C checks are not required and are completed at the discretion of the investigating social worker. Information from NCIC Purpose Code C checks and summary forms may not be printed out, placed in case files, or shared with parties outside of DSHS. [Source: CA Operations Manual 5518 NCIC Checks for CPS Investigations - Purpose Code C]

[16] Maternity Support Services are preventive health and education services to help improve birth outcomes. Services can begin any time during the pregnancy, delivery or postpartum period.

[17] Birth to Three services are intended to help families build knowledge and skills to meet the developmental and health needs of a child, birth to three years old, with special needs. Most of the infants and toddlers served by Birth to Three Developmental Center qualify for services under the Individuals with Disabilities Education Act (IDEA).

[18] In an effort to improve decision-making in child protective services (CPS), most states have implemented one of two types of risk assessment – either a theoretical-empirical (consensus/ecological) based or an actuarial based model. The Theoretical-Empirically Guided Approach is based on an established set of theoretical and empirically based risk factors and the "clinician" formulates an overall assessment of risk based on observed combinations of risk factors. A key is the interaction of risk factors associated with the child, caregiver, caregiver/child interaction, family factors and factors related to the larger social context

appeared to be generally supportive of the idea of CA re-evaluating the use of the SDMRA®, the Committee did not reach consensus about a better screening method and therefore no specific recommendation was included in the Recommendation Section of this report.

At the time of first contact with K.K. and RCW 74.13.515 family in RCW 74.13.515 2016, the assigned CPS worker had a caseload of approximately 15 active investigative assignments.[19] The Committee was made aware that the worker was assigned 12 new intakes in the month of RCW 74.13.515. At the time of the second intake on this family in RCW 74.13.515, the worker had 20 total cases assigned. The caseload did not appear dramatically outside the standards for CPS as recommended by national associations or as statistically indicated for Washington state.[20] However, the Committee also considered the limited number of work days available for the worker to cover all the families on her caseload during this period of time. While this span of time equated to 41 calendar days, the Committee was aware that, accounting for non-work days (i.e., weekends, 3-day holidays and several days of worker leave time), the actual amount of available work days was about 20. CA documentation shows casework activities on this case occurred on four of those available days.

The Committee also spent time discussing the worker's length of CPS experience for the worker and the supervisor's length of supervisory experience. The Committee acknowledged the challenges faced by CA to maintain a high level of practice during a time of significant workload, staff turnover and reliance on workers with relatively limited experiences in child protection.[21] While both the worker and supervisor had advanced degrees in social work, the Committee pondered how the limited CPS experience by the worker (1½ years), and the limited supervisory experience by the supervisor (less than 2 years), may have

within which the family lives. [Child Welfare League of America: *A Comparison of Approaches to Risk Assessment in Child Protection and A Brief Summary of Issues Identified from Research on Assessment in Related Fields*]

[19] Caseload and workload are not synonymous. While a worker's caseload generally equates to the number of assigned cases, workload involves the complexity of cases requiring intensive intervention and additional administrative requirements. [Source: U.S. Department of Health & Human Services, Administration for Children & Families, Child Welfare Information Gateway]

[20] For investigative workers in child protective services, the Council on Accreditation recommends that caseloads do not exceed 15 investigations or 15-30 open cases. The Child Welfare League of America (CWLA) recommends a caseload size of 12 intake reports per month per worker. In Washington state, the average caseload size for investigation caseworkers ranged from 16.4 to 19.3 intakes per month in calendar year 2015 [CA/CPS 2016 Supplemental Budget report]

[21] DSHS Strategic Plan Metrics – Children's Administration (April 2014): "It takes an average of two years for an investigator to become proficient. It takes an average of 3 months to hire a new CPS investigator. The high turnover rate also impacts staff that remain. They are burdened with higher caseloads and mentoring new staff."

been a barrier to understanding the connections and interactions of risk factors in this case, particularly those risk factors not accounted for within the SDMRA®.

The Committee briefly discussed current mentoring, training and supervision within CA. This discussion was in the context of looking at whether the worker was given the tools necessary to do the work and the supervisor given the training to provide sufficient supervision. During the interview with the supervisor, the Committee learned of several changes to practice initiated by the local office following the critical incident under review. An FVS position was developed to help deal with the increased number of RCW13.50.100 infants coming into the system through Risk Only intakes. Routine use of a Plan of Care for newborns who are RCW13.50.100 was put into practice. Extra emphasis was given to focusing on home visits for infants, preferably prior to release from hospitals. Specific database training was provided so workers could better access and locate missing parents. Training from RCW13.50.100 and RCW13.50.100 programs was provided to reinforce practice regarding RCW13.50.100 by parents. CPS supervisors in the office are now scheduled twice a month with the Area Administrator to address CPS-specific needs.[22] While such training and practice changes were viewed positively, the Committee could only speculate as to what difference these activities would have made in this case had they been initiated prior to the case being opened with CPS.

Findings

With the exception of one member, the Committee found no critical errors in terms of decisions and actions taken by CA, particularly given the fact that the initial investigation was still in progress at the time of the critical incident. Based on the information known at the time, the critical incident did not appear to be predictable. Even had information gathered post critical incident been known earlier, the majority of the Committee concluded that it would likely not have resulted in a decision by CA to legally intervene prior to the critical incident.

The Committee did identify instances where additional or alternative social work activity may have been beneficial to the assessment of the family situation. The majority of the Committee members struggled with assigning particular value to missed practice opportunities in terms of singular or collective significance to the

[22] Note: Subsequent to this review, the Region 3 Administrator implemented additional supports for new staff that had been in development for about a year. This included New Employee Support Training (NEST) that provides additional one-on-one practice supports to staff (individuals, units, offices) and the development of a new employee desk guide. This desk guide is a quick reference source for resources and tools designed to support practice. A similar source for Region 3 new supervisors is also in development at this time.

subsequent critical incident and possible prevention of such an event. The Committee collectively viewed the below issues as sufficiently noteworthy in terms of identifying areas where practice could have been better in this case.

- The information actually gathered by the worker prior to the critical incident appeared to be very limited. The worker missed opportunities to more actively probe in terms of seeking and verifying information (particularly as to the father's criminal history) and more aggressive in locating and meeting with the parents at the residence and having follow-up contact with the twins.
- The Committee questioned whether or not the SDMRA® was accurately scored, with one Committee member arguing that it clearly had underestimated risk. The SDMRA® was completed within the 60-day timeline required by CA policy but completed after the critical incident and may have been moderated due to a lack of information in a number of areas utilized by the tool. If the SDMRA® had been done earlier in the investigation and included more corroboration of information, the worker likely would have had a better comprehension of the family service needs and expedited appropriate community referrals such as PHN, Maternity Support Services and/or Birth to Three.

Recommendations

- CA should consider requiring a home visit to be conducted within some short period of time after an accepted intake involving a newborn. The Committee discussed various time periods including three days of the intake, within one day of discharge from a hospital or within a week. This requirement would be separate from current policy requirements for initial face-to-face contact that may occur outside the home (e.g., hospital). This recommendation would require an immediate assessment of the home and infant sleep environment within a specified time frame not currently set in policy.
- The Committee recommends that CA evaluate the potential of using shared planning meetings, such as an FTDM or CPT,[23] on cases involving Plans of Safe Care for newborns. While the Plan of Safe Care form (DSHS 15-491/December 2016) includes a section documenting any referrals to resources such as Public Health Nurse and Maternity Support Services,

[23] A Family Team Decision-Making meeting (FTDM) is a facilitated team process, which can include birth/adoptive parents, guardians, extended family members, youth (as appropriate), community members, service providers, child welfare staff and/or caregivers. These meeting are held to make critical decisions regarding the placement of children. A Child Protection Team (CPT) provides confidential, multi-disciplinary consultation and recommendations to the department on cases where a Family Team Decision Making (FTDM) meeting will not or cannot be held, there is a risk of serious or imminent harm to a young child, or when there is dispute as to the appropriateness of an out-of-home placement.

shared planning around such resources may beneficially expedite and streamline the process.

- The Committee recommends that CA explore the possibility of re-initiating the Chemical Dependency Professional (CDP) liaison program, which provided CA field offices with "in-house CDPs" that were available for substance abuse related consultation, informational resources, guidance for client engagement and community resources. The Committee is aware that current state budget constraints may pose a barrier to this recommendation.
- CA should consider expanding current substance abuse training to include information and discussion regarding typical behavior patterns displayed by users of specific types of drugs (e.g., heroin, methamphetamine, heavy marijuana use). This training would provide workers with the potential to better assess the caregiver's situation as it relates to child safety.
- CA is encouraged to continue ongoing evaluation of formal mentoring of new child welfare workers beyond Regional Core Training (RCT).[24] This would include looking to replicate formalized mentoring programs from other disciplines (such as law enforcement) that have sought to increase in-field competency.

[24] Regional Core Training (RCT) is a structured learning program developed for new employees to gain knowledge and skills identified as foundation level competencies. RCT is the initial, intensive, task-oriented training that prepares newly hired Social Service Specialists to assume job responsibilities.

Washington State Department of Social & Health Services
CA Children's Administration

Child Fatality Review

T.K.

May 2007
Date of Child's Birth

Unknown
Date of Fatality

February 16, 2017
Child Fatality Review Date

Committee Members
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Jessica Sullivan, Captain, King County Sheriff's Office
Cammy Hart-Anderson, Division Manager, Snohomish County Human Services
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Libby Stewart, Critical Incident Review Specialist, Children's Administration

Executive Summary

On February 16, 2017, the Department of Social and Health Services (DSHS), Children's Administration (CA) convened a Child Fatality Review (CFR)[25] to assess the department's practice and service delivery to T.K. and her family.[26] The child will be referenced by her initials in this report.

On October 29, 2016, the Snohomish County Sheriff's Office placed two of T.K.'s siblings in protective custody. A third sibling was believed to be living out of the county. The children were placed in protective custody due to a law enforcement investigation regarding T.K.

The children were placed in protective custody after law enforcement requested the mother produce T.K. The mother provided a container to law enforcement indicating the remains in the container were that of T.K. Due to the condition in which the body was found, a date of death has not been determined. No other information has been shared with CA regarding a cause or manner of death as of the writing of this report.

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, chemical dependency and mental health, law enforcement and child abuse and child safety. No Committee member had previous involvement with this family.

Prior to the review, each Committee member received 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 the most recent volumes of the case, relevant state laws, and CA policies.

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

[26] T.K.'s 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)]

The Committee interviewed three staff who had direct involvement with the June 2016 investigation.

Family Case Summary

RCW 13.50.100 [redacted]

RCW 13.50.100 [redacted] While the case notes indicate the case was to transfer to a voluntary services Indian Child Welfare unit, the case was closed after the CPS investigation.

While no father was listed on T.K.'s birth certificate, the mother identified two possible birth fathers that did not include the man to whom she was married. That man assumed care and custody of T.K. at varying times and paid child support through Division of Child Support, and thus for the purposes of this report is considered to be T.K.'s father.

[redacted] In each intake, T.K. was listed as a participant as were the other siblings.[27] The inclusion of a child on the list of household participants would require the child to be included in a CPS investigation.

RCW 13.50.100 [redacted] This intake was closed with a referral to an alternate intervention.[28] RCW 13.50.100 [redacted]

[27] Participant refers to a section of the CA intake listing all household members and the referent. All children in the household should be included in the CPS investigation.

[28] (Pre-Family Assessment and Response) Alternate Intervention—CA must respond within 10 calendar days to an alternate intervention intake. The CA social worker may send a letter, make a phone call to the caretakers(s), or make a brief home visit. CA may send the intake to an Early Family Support Service or other community agencies which are willing to accept the intake for services and/or monitoring. DLR/CPS may not use alternate intervention.

[redacted] All of the children were listed on the intake under participants.

RCW 13.50.100 [redacted] The intake was screened out.[29]

RCW 13.50.100 [redacted]

RCW 13.50.100 [redacted]

RCW 13.50.100 [redacted]

RCW 13.50.100 [redacted]

RCW 13.50.100 [redacted]

[29] An intake screens out if it does not meet the legal definition of child abuse or neglect under RCW 26.44.030.

[30] CA Practices and Procedures Guide Chapter 2541. Structured Decision Making Risk Assessment®

[31] Findings are determined when the investigation is complete and are based on a preponderance of the evidence standard. Unfounded means the determination that, following an investigation by CPS, based on available information: it is more likely than not that child abuse or neglect did not occur, or there is insufficient evidence for the department to determine whether the alleged child abuse did or did not occur. Founded means the determination that, following an investigation by CPS, based on available information: it is more likely than not that child abuse or neglect did occur. [Source: RCW 26.44.020]

[redacted]

RCW 13.50.100 [redacted]

The next intake CA received regarding the family was on June 6, 2016. RCW 13.50.100 [redacted] The Snohomish County Sheriff's Office conducted a criminal investigation at the same time as CA's investigation regarding this allegation.

A second intake was received 13 days later RCW 13.50.100 [redacted] T.K. was listed on both intakes as a participant. The assigned social worker made repeated inquiries into T.K.'s whereabouts to arrange an interview. The mother provided numerous differing statements regarding the whereabouts of T.K. The CPS investigator asked the assigned detective to assist with locating T.K. but the case was closed prior to locating the child.

On October 29, 2016, the Snohomish County Sheriff's Office notified CA that they had placed T.K.'s siblings in protective custody. Law enforcement took possession of a container that the mother advised held the remains of T.K. Law enforcement provided the container to the medical examiner's office for investigation.

Committee Discussion

For purposes of this review, the Committee mainly focused on case activity from the time T.K. was born until the time CA was made aware that her body was provided to law enforcement.

RCW 13.50.100 [redacted]

[redacted]

RCW 13.50.100 [redacted]

The Child Protective Services investigator documented that he told the mother that if she did not produce T.K. for assessment purposes he would conduct a Family Team Decision Making[33] (FTDM) meeting and/or pursue legal intervention. The Committee discussed that, often times, child welfare work is supported by the utilization of shared staffings or multi-disciplinary team (MDT) staffings which can include other partnering agencies such as law enforcement. This case may have benefited from utilization of an MDT, child protection team staffing or Family Team Decision Making meeting before closing out the case in September of 2016. The Committee believes it would have been appropriate for the CPS investigator to have followed through with the stated options.

The Committee also acknowledged that in order to comply with best case practice standards as well as policies, CPS workers may have to utilize legal interventions if a parent is refusing to produce a child for assessment purposes. The hope is that less intrusive actions such as an FTDM would lead a family to produce the child but if this fails, then CA must make all efforts to locate that child and assess for safety. One of the CPS investigators told the mother that these two options may become necessary if she did not produce T.K.; however, neither were utilized prior to the closure of the case.

A brief discussion occurred surrounding the issue of adequate pay as it pertains to recruitment and maintenance of consistent and well-trained staff. Also shared during this conversation was the ongoing issue of vacancies and movement within the agency that impacts stability within the offices.

Lastly, the Committee noted a lack of consideration during each of the investigations as it pertained to the parent's history RCW 13.50.100 [redacted] Incident-focused investigations may lead to incomplete

[32] FamLink is the case management information system that Children's Administration implemented on February 1, 2009; it replaced CAMIS, which was the case management system CA had used since the early 1990s.

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

investigations, possibly leaving children in unsafe situations. The Committee understood that it can be challenging to find the time to read a family's history in FamLink or MODIS (CA's archived case file system). However, it is imperative that staff understand the history of a family is important in assessing its current functioning and ability to provide for the safety of the children. The Committee also struggled with the period between 2010 and 2016 when there were no referrals. The Committee believes it would have been appropriate to ask the family as to what was working well for the family or where the children were during that time period. This curiosity can aid staff in conducting a more fruitful investigation.

Findings

The Committee identified areas where alternative choices or case practice by CA may have benefited the family. While no critical errors were identified, the Committee identified the findings below as areas for improved practice.

The Committee believed that the intake from July 22, 2010 should have screened in for an investigation. The Committee discussed the appropriateness of calling the mother and utilizing her statements in the decision to close out the intake at screening. Prior notes entered under T.K.'s father's case indicated that the mother told the case worker the child was RCW 13.50.100 that she denied to the intake worker therefore providing conflicting information.

There was a lack of comprehensive assessment regarding the children's needs and safety throughout both the mother's and father's cases. The Committee believes the mother's lack of cooperation during RCW 13.50.100 refusal to produce T.K., should have caused more curiosity by CA. CA could have taken the legal steps available to it through the juvenile court to have T.K. produced and filed a missing child report with law enforcement.

The Structured Decision Making Risk Assessment tool used by CPS to assess future risk of harm to the children. The Committee noted that the SDMRA was completed without including T.K.

The case was closed prior to an assessment of or contact with T.K. Policy states that prior to the completion of the Safety Assessment, face-to-face contact is required for all children who are not identified as victims but are related to the household.[34]

[34] CA Practices and Procedures Guide Chapter 2310. Initial Face to Face Response Time

Recommendations

CA should consider having all case carrying staff attend training related to open source searching. These trainings aid investigators who are searching for people through free sources on the internet. While it is particularly pertinent in this case, it would be beneficial in other cases where children may be on the run or missing from care.

RCW 13.50.100 . The Committee participants have identified that the loss of RCW 13.50.100 professionals stationed within DCFS offices may have decreased staff's engagement with families regarding RCW 13.50.100 issues. The Committee recommends that CA reconsider this partnership.

Washington State Department of Social & Health Services
CA Children's Administration

Child Fatality Review

G.K.

RCW 74.13.515 2015
Date of Child's Birth

January 20, 2017
Date of Child's Death

April 19, 2017
Date of the Fatality Review

Committee Members
Cristina Limpens, Office of the Family & Children's Ombuds
Sharon Ostheimer, CPS Program Consultant, Children's Administration
Patricia Erdman, Administrator, Alliance for Child Welfare Excellence
Ryan McCain, Detective, Moses Lake Police Department

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

Executive Summary
On April 19, 2017, the Department of Social and Health Services, Children's Administration (CA) convened a Child Fatality Review (CFR)[35] to assess the

[35] 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 a child. The CFR Committee's review is generally limited to documents in the possession of or obtained by DSHS or its contracted service

department's practice and service delivery to an infant child and RCW 74.13.515 family.[36] The child is referenced by RCW 74.13.515 initials, G.K., in this report. At the time of RCW 74.13.515 death, G.K. had been residing with RCW 74.13.515 mother. The incident initiating this review occurred on January 20, 2016, when G.K. died while in RCW 74.13.515 mother's care due to undetermined circumstances.

The CFR Committee included CA and community professionals with relevant expertise in child abuse and child safety, domestic violence and law enforcement. None of the Committee members had any previous direct involvement with this family.

Prior to the review, each Committee member received a detailed case summary, a family genogram, un-redacted case documents including case notes, referrals for services, assessments and medical records. The hard copy of the file was available at the time of the review. Supplemental sources of information and resource materials were also available to the Committee, including state laws and CA policies relevant to the review.

The Committee interviewed the previously assigned CPS investigator and CPS supervisor. Following the review of the case file documents, completion of staff interviews and discussion regarding CA activities and decisions, the Committee made findings and recommendations that are presented at the end of this report.

Case Summary

The mother was alleged to have RCW 13.50.100 on November 25, 2016, when a RCW 13.50.100 by her father and grandmother. RCW 13.50.100 was taken to the RCW 13.50.100 who then notified law enforcement. The mother admitted that she had RCW 13.50.100 Law enforcement contacted CPS to report the incident. Through conversation with the responding law enforcement officer; the father, the mother and the maternal grandparents verbally agreed that the children would stay with the maternal grandparents through the weekend and until CPS could gather sufficient information necessary to assess risk and safety of the children in parental care,

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.

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

assess for parental deficiencies and offer services if necessary. During the course of the CPS investigation, the mother and father both agreed to be involved in services and have their case remain open through Family Voluntary Services.[37] The father more actively participated in services than the mother. He attempted to RCW 13.50.100 The CPS investigator made a determination that the allegation of RCW 13.50.100 against the mother was unfounded.[38]

On January 20, 2017, RCW 74.13.515-month-old G.K. and G.K.'s mother arrived at the hospital at approximately 2:00 a.m. Emergency department staff attempted to resuscitate G.K. without success and RCW 74.13.515was pronounced dead. Hospital staff contacted law enforcement at 2:18 a.m. The mother originally told the hospital staff and law enforcement that she woke up to use the restroom and noticed a blanket on top of G.K., who was in RCW 74.13.515crib. The mother said that she attempted cardiopulmonary resuscitation(CPR) even though she has no training in CPR. After a few attempts at CPR, she picked up the child and ran from her home with both of her children to the emergency department. G.K.'s mother initially reported to the hospital staff that she had carried the child to the hospital as it was nearby her residence. The mother's story changed when questioned by law enforcement and the medical examiner. The mother admitted that she was dishonest initially about the location of the incident. She was not at home as initially reported but was actually at a friend's home out in the county with her children and boyfriend. Children's Administration (CA) was made aware of G.K.'s death by local law enforcement. The autopsy additionally revealed rib fractures on G.K. that were in a state of healing possibly two weeks to a month or more old. The cause of death was documented as undetermined. Factoring into this determination was the coroner's inability to complete the toxicology screens as the sample was lost in the mailing system utilized by the local coroner.

[37] Family Voluntary Services (FVS) support families' early engagement in services, including working with the family to create Voluntary Service Agreements or Voluntary Placement Agreements and providing ongoing case management services and assessment of safety and risk to children. Voluntary case plans are used to engage families willing to participate in services intended to reduce current and future abuse or neglect issues that do not require court intervention. Voluntary services are short-term to help increase parents' protective capacity and manage child safety. [Source: CA Practices and Procedures Guide, Chapter 3000]

[38] Unfounded means the determination following an investigation by the department that available information indicates that, more likely than not, child abuse or neglect did not occur, or that there is insufficient evidence for the department to determine whether the alleged child abuse did or did not occur. 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. [Source: RCW 26.44.020]

Committee Discussion

For purposes of this review, the Committee primarily focused on case activity occurring prior to G.K.'s death.

The Committee noted that the safety assessment[39] identified that the children were "safe" on the safety assessment but that a safety plan[40] was still developed. Although a technicality, the Committee noted that it is not CA's procedure to develop a safety plan without an identified safety threat[41] according to CA's safety framework.[42] The Committee wondered about the assessment of risk and safety and the accuracy of the assessment. The Committee noted that the safety plan lacked specific safety tasks that would protect the children. Further, the Committee was concerned that at the time of the Family Team Decision Making meeting[43] (FTDM), CA did not utilize its safety framework as designed and relied

[39] 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].

[40] The Safety Plan is a written agreement between a family and CA that identifies how safety threats to a child will be immediately controlled and managed. The Safely Plan is implemented and active as long as threats to child safety exist and caregiver protective capacities are insufficient to protect the child. A safety plan is required for all children where there is a safety threat(s) indicated on the safety assessment. The safety plan is written arrangement between a family and CA that identifies how safety threats to a child will be immediately controlled and managed. Note: when creating an in-home safety plan, the following criteria must be met: 1) there is at least one parent/caregiver or adult in the home; 2) the home is calm enough to allow safety providers to function in the home; 3) the adults in the home agree to cooperate with and allow an in-home safety plan; 4) sufficient, appropriate and reliable resources are available and willing to provide safety services/tasks. [Source: CA Practices and Procedures Guide, Chapter 1130]

[41] A threat of danger is a specific family situation or behavior, emotion, motive, perception or capacity of a family member that threatens child safety. The danger threshold is the point at which family functioning and associated caregiver performance becomes perilous enough to be perceived as a threat or produce a threat to child safety. The safety threshold determines impending danger. Safety threats are essentially risk influences that are active at a heighten degree and greater level of intensity. Safety threats are risk influences that have crossed a threshold in terms of controllability that has implications for dangerousness. Therefore, the safety threshold includes only those family conditions that are judged to be out of a caregiver's control. [Source: Safety Threshold]

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

[43] A Family Team Decision-Making meeting (FTDM) is a facilitated team process, which can include birth/adoptive parents, guardians, extended family members, youth (as appropriate), community members, service providers, child welfare staff and/or caregivers. These meetings are held to make critical decisions regarding the placement of children following an emergent removal of child(ren) from their home, changes in out-of-home placement and reunification or placement into a permanent home. There may be instances when an FTDM can be held prior to placement if there is not an immediate safety threat such as a child who is on a hospital hold and an FTDM could provide placement options. Permanency planning starts the moment children are placed out of their homes and are discussed during a Family Team Decision-Making meeting. An FTDM will take place in all placement decisions to achieve the least restrictive, safest placement in the best interests of the child. By utilizing this inclusive process, a network of support for the

on law enforcement's verbal agreement from the previous weekend to keep the children with the relative caregivers. Although the parents agreed to the children remaining in the relatives' care while services were offered, the Committee would have preferred CA offer a Voluntary Placement Agreement (VPA)[44] or filed a dependency petition if the children were not safe to return to their parents. The Committee also wondered to what extent the mother actually voluntarily agreed to the plan and services.

The Committee discussed the necessity of collateral contacts in conducting a comprehensive investigation and in assessment of risk and safety. The Committee believed that the assigned CA staff focused primarily on the initial RCW 13.50.100 incident with RCW 13.50.100 and could have more thoroughly assessed and verified the mother's statements about the incidents, her family's daily life and the caregiving of her children. The Committee noted missed opportunities to gather additional clarifying information from other sources within the family's community, including the mother's partner, the family members and neighbors. The Committee engaged in limited contextual discussion as to the unfounded finding for the RCW 13.50.100 allegations to RCW 13.50.100 Some Committee members believed greater consideration should have been given for a founded finding[45] based on the mother's admissions surrounding the incident. Consensus about the finding was not reached by all Committee members.

The Committee felt that a more complete assessment of the mother's partner needed to have occurred in order for a more accurate safety assessment. The Committee believed that the mother's partner should have been interviewed and assessed further, as he was listed as a subject in the initial investigation. The Committee acknowledged that the assigned worker gathered a significant amount of information; however, analysis of the information, including the impact of possible domestic violence, substance use and daily functioning on the mother's and her partner's ability to safely care for the children was limited early on in the investigation. The Committee opined that the FTDM process may have had some influence on the development of the plans and safety assessment. The Committee discussed that had the department better understood the day-to-day functioning of the caregivers, their substance use and the impact of potential

child(ren) and adults who care for them are assured. [Source: Family Team Decision-Making Meeting Practice Guide]

[44] A Voluntary Placement Agreement (VPA) safely supports a time-limited plan for a short-term removal and placement in out-of-home care for a child who cannot safely remain in the parent or legal guardian's home. [Source: CA Practice and Procedures Guide, Chapter 4307]

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

domestic violence, a more functional and successful safety assessment and plan could have been developed to manage any identified safety issues in the home.

The Committee discussed the CPS investigator's documentation and discussions of safe sleep[46] with the caregivers in this case. The Committee heard from the CA worker that policy was met with the primary caregivers but the Committee would have liked to have seen clear documentation that the workers observed the safe sleep practices by all of the caregivers as well as identification of who cares for or has responsibility for the children on a daily or frequent basis.

Findings

After a review of the case chronology, interviews with staff and discussion, the Committee did not identify any critical errors linked to the death of G.K. The Committee reached consensus on the findings and recommendations below:

- At the FTDM, CA should have utilized the safety framework as designed and offered the family a VPA, filed a petition or the children should have returned home. CA should not have relied on an outside agency's (police) verbal agreement to have the children remain out of their parent's care.
- During the initial investigation, a subject interview with the mother's partner did not occur as required by CA Practices and Procedures Guide Chapter 2334.[47]
- The Committee found that the initial investigation and safety assessment seemed incident-focused. CA might have conducted a more in-depth initial analysis and gathered additional information from collateral sources to have improved CA's assessment of risk and safety and in order to utilize the safety framework as designed.

[46] Safe Sleep is a nationwide campaign to promote safe sleeping habits for children. Safe sleep practice can reduce the risk of SIDS. According to the National Institute of Child Health and Human Development the top 10 safe sleep guidelines are: 1) always place your baby on his or her back to sleep, for naps and at night. 2) Place your baby on a firm sleep surface, such as on a safety-approved crib mattress, covered by a fitted sheet. 3) Keep soft objects, toys, and loose bedding out of your baby's sleep area. 4) Do not allow smoking around your baby. 5) Keep your baby's sleep area close to, but separate from, where you and others sleep. 6) Think about using a clean, dry pacifier when placing the infant down to sleep, 7) Do not let your baby overheat during sleep. 8) Avoid products that claim to reduce the risk of SIDS because most have not been tested for effectiveness or safety. 9) Do not use home monitors to reduce the risk of SIDS. 10) Reduce the chance that flat spots will develop on your baby's head: provide "Tummy Time" when your baby is awake and someone is watching; change the direction that your baby lies in the crib from one week to the next; and avoid too much time in car seats, carriers, and bouncers. [Source: National Institute of Child Health and Human Development]

[47] Interviewing Subjects: The CA caseworker must conduct individual and face-to-face interviews of each subject or FAR participant. If he or she refuses to be interviewed, consult with the supervisor and document in FamLink. [Source: CA Practice and Procedures 2334]

Recommendations

- The Committee recommends that the local office supervisors, social workers and FTDM facilitators who assess for child safety and placement attend the available Safety Boot Camp trainings or a unit in-service training on safety assessment and planning by January 2018 if they have not completed a safety assessment training in 2016.
- The Committee recommends that all social workers and supervisors in the local office attend the available two-day domestic violence training or domestic violence trainings by June 2018.

Washington State Department of Social & Health Services

CA Children's Administration

Child Fatality Review

D.S.

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

March 8, 2017
Date of Fatality

July 15, 2017
Child Fatality Review Date

Committee Members

Cristina Limpens, Senior Ombuds, Office of the Family and Children's Ombuds
Candy Hamilton, Director of Indian Child Welfare, Stillaguamish Tribe of Indians
Kym Castenada, Shelter Manager, Domestic Violence Services of Snohomish County
Stephanie Frazier, Child Protective Services Program Manager, Children's Administration
Alex Fitzstrawn, Child Protective Services and Family Voluntary Services Supervisor, Children's Administration
Pam Hubbard, LMHC CDP, Outpatient Counselor Supervisor, Evergreen Recovery Center
Shannon Finn, Social Worker, Stillaguamish Tribe of Indians

Facilitator

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

Executive Summary

On June 15, 2017, the Department of Social and Health Services (DSHS), Children's Administration (CA) convened a Child Fatality Review (CFR)[48] to assess the department's practice and service delivery to D.S. and her family.[49] The child will be referenced by RCW 74.13.515 initials in this report.

On March 8, 2017, CA received an intake from law enforcement stating five-month old D.S. passed away. D.S. lived with RCW 74.13.515 mother and father. RCW 74.13.515 had two older, maternal, half-sisters who visited. D.S. was in the care of RCW 74.13.515 father at the time of RCW 74.13.515 death.

During the law enforcement interviews, the mother stated she put D.S. in RCW 74.13.515 crib when RCW 74.13.515 left the motel. The mother did not return right away after dropping off her daughters and instead went to a casino to avoid arguing with D.S.'s father. Shortly after midnight, D.S.'s father fed RCW 74.13.515 a bottle of formula then brought RCW 74.13.515 into the same bed with him. When he woke, D.S. was nonresponsive and cold to the touch. He then called the mother who was on her way back to the motel room. The mother called 911 who responded to the scene. The mother admitted to RCW 13.50.100 within the last 24 hours and the father admitted to RCW 13.50.100 within the last 24 hours. Both parents state when they would RCW 13.50.100, they would use them in another room, then wash their hands before handling D.S. The mother admitted to smoking cigarettes in the same room as D.S.

The medical examiner's report states the pathological diagnoses included sudden unexpected infant death with the contributory factor of unsafe sleep environment consisting of co-sleeping with an RCW 74.13.520 However, the report states the concentration of methamphetamine smoke detected in D.S.'s body did not contribute to 74.13.515 death. The manner of death was stated as undetermined.

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[49] D.S.'s 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)]

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, domestic violence victims advocate, and experts in infant safe sleep, child abuse and child safety. There was one CA staff member who observed the review. The two Committee members representing the 74.13.515 Tribe had prior contact with the family. However, no other Committee members had prior involvement or contact with the family.

Prior to the review, each Committee member received 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 a law enforcement report, medical examiner's report, relevant state laws and CA policies.

The Committee interviewed the CPS investigator who conducted the investigation at the time of D.S.'s birth, as well as that worker's supervisor.

Family Case Summary

Between May 9, 2004 and June 17, 2016, CA received nine intakes regarding allegations of neglect, RCW 13.50.100 by parents, RCW 13.50.100and RCW 13.50.100. Of those nine intakes, six were assigned for investigations or assessment. At one point, D.S.'s older sisters were RCW 13.50.100 was initiated. However, RCW 13.50.100 . Neither parent was cooperative during the CPS investigations.

On RCW 74.13.515 2016, CA received an intake stating the mother had given birth to D.S. The information contained in the intake stated the father was affiliated with the RCW 13.50.100Tribe and that the mother planned to live with her two older daughters and their father, who is not the father of D.S. The caller reported there was past RCW 13.50.100between D.S.'s mother and the father of the older girls and that both adults have past RCW 13.50.100issues. This intake was assigned for a CPS risk only investigation.[50]

During this CPS investigation the mother provided a urinalysis which was RCW 13.50.100 . The mother indicated the RCW 13.50.100 . Neither the mother nor the father of the two older girls were cooperative with the investigation. The adults would not allow the CPS workers to enter the home and observe the living environment or sleep

[50] CA Practices and Procedures Guide Chapter 2200 Intake Process and Response

environment. D.S.'s biological father would not cooperate with the CPS worker's attempt to speak with him regarding the intake.

On September 29, 2016, the mother met with the CPS worker and the director of Indian Child Welfare from the RCW74.13.515 Tribe at the DCFS office. The mother stated any RCW 13.50.100with the father of her older children occurred a long time ago and denied any current RCW 13.50.100issues. The CPS worker discussed the Period of Purple Crying,[51] safe babies/safe moms and safe sleep during this meeting.[52]

The CPS worker requested medical records for all three children and met with the two older children as part of the investigation. The CPS worker also spoke with the school counselors for the older girls; neither reported any concerns. D.S.'s father failed to respond to any of the CPS worker's attempt to speak with or meet with him. The investigation was closed on November 23, 2016.

On March 8, 2017, CA received the intake regarding the death of D.S. This intake was assigned as a risk only investigation. A subsequent intake was received on May 8, 2017, from the medical examiner's office stating that during their investigation test results showed that D.S. had RCW 74.13.520 in her system at the time of RCW74.13.515 death. This intake was screened out. The intake area administrator documented that there was already a current investigation regarding the death and this was not a new incident.

The CPS worker investigating the death altered the investigative assessment to include allegations of negligent treatment or maltreatment. Both parents were founded for these allegations as to D.S.

Committee Discussion

For purposes of this review, the Committee mainly focused on case activity from the time D.S. was born until RCW74.13.515 passed away. The Committee did discuss the content prior to D.S.'s birth but the focus of the review was to evaluate the contact and service delivery to the family between the birth and passing of D.S.

The Committee noted that the CPS investigators were met with hostility which in turn made successful interventions challenging at best. The CPS worker who conducted the investigation stemming from the RCW74.13.515, 2016 intake worked diligently to collaborate with the tribe and requested tribal assistance in connecting with D.S.'s father. However, even with this collaboration it was

[51] What is the Period of Purple Crying?

[52] CA Practices and Procedures Guide Chapter 1135 Infant Safety Education and Intervention.

difficult for the CPS worker to have a comprehensive understanding of this family.

One area the Committee felt needed further assessment was the mother's RCW 13.50.100status and an understanding of the mother's RCW 13.50.100 which are commonly prescribed for RCW 13.50.100. The suggestion by the Committee was that the CPS worker could have reached out to discuss these issues with the RCW 13.50.100and the mother's RCW 13.50.100 to gain a better understanding of the mother's current mental status. Understanding a parent or care provider's RCW 13.50.100 status can be a vital part of assessing child safety.

The Committee discussed with the CPS investigator the answers contained in the Structured Decision Making Risk Assessment® tool (SDMRA).[53] The Committee questioned whether the SDMRA was completed correctly as it related to RCW 13.50.100, RCW 13.50.100and RCW 13.50.100. The CPS investigator indicated there was no evidence to prove an indicated response to those areas. This response was countered by the Committee noting that a lack of cooperation by the parents and lack of gathering corroborating evidence does not make the statements untrue, just unanswered. The tool also allows for comments at the end and the ability to raise the risk level which would require further actions such as a child protection team staffing to assess the need for further CA intervention.

RCW 13.50.100 between D.S.'s mother and the father of the older girls was reported on multiple occasions prior to the birth of D.S. One intake stated that the mother's RCW 13.50.100; however, this fact was never discussed with the mother. The Committee noted this was a missed opportunity to further explore RCW 13.50.100.

Findings

While the Committee identified two areas where practice could have been improved, they also indicated there were no critical errors by CA. The identified areas below are stated as a way to suggest improvement in practice, but not indicative of relation to the critical incident.

[53] The Structured Decision Making Risk Assessment® (SDMRA) is a household-based assessment focused on the characteristics of the caregivers and children living in that household. By completing the SDMRA following the Safety Assessment, the worker obtains an objective appraisal of the risk to a child. The SDMRA informs when services may or must be offered. [Source: CA Practices and Procedures Guide Chapter 2541 Structured Decision Making Risk Assessment®]

The Committee noted a more thorough investigation could have included collateral contacts such as the RCW 13.50.100for the mother's RCW 13.50.100which the mother indicated was RCW 13.50.100. Another collateral could have included obtaining the mother's prenatal records. This may have allowed for a more global understanding of any RCW 13.50.100or RCW 13.50.100issues for the mother.

CA policy states staff should observe the sleeping environment of all children under the age of one year. While the mother and her ex-boyfriend were not cooperative with showing the CPS worker the home or sleep environment on the first contact with the residence, the Committee agreed that further attempts should have been made. The Committee understood that D.S.'s father was nonresponsive to the CA worker. And while the Committee understands that educating care providers and parents does not stop them from bed sharing, the CPS worker could have attempted to provide that education to the father by sending him the appropriate documents or pamphlets with information regarding safe sleep and Period of Purple Crying. The CPS worker could also have gone directly to the motel to attempt contact.

The Committee did not make any recommendations related to this case.

Washington State Department of Social & Health Services

CA Children's Administration

Child Fatality Review

B.T.

RCW 74.13.515 2017
Date of Child's Birth

February 24, 2017
Date of Death

July 27, 2017
Child Fatality Review Date

Committee Members
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Cristina Limpens, MSW, Senior Ombuds, Office of Family and Children's Ombuds
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Executive Summary

On July 27, 2017, the Department of Social and Health Services (DSHS) Children's Administration (CA) convened a Child Fatality Review (CFR)[54] to examine the department's practice and service delivery to RCW 74.13.515 -day-old B.T. and RCW 74.13.515 family.[55] The incident initiating this review occurred on February 24, 2017 when B.T. was discovered unresponsive by her mother who had fallen asleep with the infant in her arms after a feeding. Emergency responders were unable to revive the infant who was declared deceased at a local hospital. A Child Protective Services (CPS) investigation had been active since RCW 74.13.515, 2017 in response to a Risk Only[56] intake regarding the birth of B.T. in Yakima. At the time, a Child and Family Welfare Services (CFWS) case was open in the Lakewood office relating to a RCW 13.50.100 .

The CFR Committee included CA and community professionals with relevant experiences and expertise in child and family advocacy, child abuse and infant safe sleep. Efforts to secure a chemical dependency professional to sit on the Committee were unsuccessful. Neither the Children's Administration CFWS Program Manager nor the Permanency Planning Program Manager was able to attend the review. None of the Committee members had any direct involvement with the family.

In advance of the review, each Committee member received a summarized chronology of the family's history of CPS involvement. Also provided were un-redacted CA documents specific to the initial Risk Only investigation and the investigation of the fatality, as well as death scene law enforcement reports. Supplemental sources of information (e.g., medical records) and resource

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

[55] The names of the parents are not used in this report as neither have been identified in an accusatory instrument with committing a crime related to this incident. B.T.'s siblings are not identified in this report due to privacy laws. *See* RCW 74.13.500

[56] CA may investigate intakes that do not allege an actual incident of Child Abuse or Neglect (CA/N), but have risk factors that place a child at imminent risk of serious harm. [Source: CA Practices and Procedures Guide 2200 Intake Process and Response]

materials (e.g., relevant CA policies) were available to the Committee at the time of the CFR.

During the course of the review, the Committee interviewed the Lakewood CFWS worker and her relatively new supervisor regarding their involvement with the family. The Committee was also provided with information from the Yakima CPS worker who had been interviewed by one of the CFR facilitators prior to the review. Following review of the case file documents, completion of the interviews, and discussion regarding department activities and decisions, the Committee made several findings and one recommendation presented at the end of this report.

Case Overview

The family had CPS involvement prior to B.T.'s birth in 2017. In 2011, CPS legally intervened on behalf of the mother's first child who RCW 13.50.100 later adopted by a relative. In RCW 13.50.100 2015, a second child was born and CPS again became involved due to RCW 13.50.100 and RCW 13.50.100 . In late February 2016, RCW 13.50.100 The mother continued to have RCW 13.50.100

In December 2016, the RCW 13.50.100 Subsequently, the CPS investigation into allegations of RCW 13.50.100 and RCW 13.50.100 were determined to be unfounded.[58]

In early RCW 74.13.515 2017, RCW 74.13.515 before the mother was due to give birth to B.T., the CFWS worker was notified that the mother was being RCW 13.50.100 due to the mother's RCW 13.50.100

[57] RCW 13.50.100 [Source: Medscape]

[58] Findings are determined when the investigation is complete and are based on a preponderance of the evidence standard. Unfounded means the determination that, following an investigation by CPS, based on available information: it is more likely than not that child abuse or neglect did not occur, or there is insufficient evidence for the department to determine whether the alleged child abuse did or did not occur. Founded means the determination that, following an investigation by CPS, based on available information: it is more likely than not that child abuse or neglect did occur. [Source: RCW 26.44.020]

[redacted] The mother was otherwise [redacted] RCW 13.50.100 [redacted] The CFWS worker electronically contacted legal representatives for the department and for the mother, to discuss the possibility of placing a hospital hold when the mother delivered and filing a dependency petition. None of those actions occurred.

On RCW 74.13.515 , 2017, a hospital social worker notified CA that the mother RCW 74.13.520 [redacted] The newborn (B.T.) initially appeared to be showing signs of being drug affected[59] but no hospital/physician hold was initiated.[60] At the time, the mother was RCW 74.13.520 [redacted]

The information provided by the hospital lacked specific allegations of child abuse or neglect as defined in WAC 388-15-009. However, the intake screened in as a CPS Risk Only case due to concerns over the mother's RCW 13.50.100 history, having had RCW 13.50.100 [redacted] recently being RCW 13.50.100 [redacted]

A Yakima CPS worker made in-person contact with the mother and B.T. at the hospital on RCW 74.13.515 . The newborn was discharged to mother's care after five days of medical monitoring RCW 74.13.520 [redacted]. The hospital reported concerns to the CFWS worker, based on observations of the mother, that the mother may not have sufficient parenting abilities.

On February 16, the Lakewood CFWS worker and the GAL for the RCW 13.50.100sibling met at a Yakima shelter where the mother and baby were

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59 " RCW 13.50.100 [redacted]. [Source: CA Practices and Procedures Guide – Appendix A: Definitions]

60 RCW 26.44.056; *See also* RCW 26.44.030(8)

RCW 13.50.100 [redacted] [Source: PubMed Health]

residing. During that visit, the mother was reminded about infant safe sleep during a safe sleep assessment, including caution against bed sharing.[63]

On February 24, 2017, CA intake was notified of the death of B.T. Reportedly the mother had fallen asleep with her infant during feeding and awoke to find the child unresponsive. The hospital Emergency Department attending physician who declared the death noted no evidence of injury or trauma to the infant. Post-mortem findings concurred - no evidence of trauma or wedging. Cause of death, as determined by the Yakima County Coroner's Office, was "probable positional asphyxia." The manner of death was classified as accidental. Law enforcement declined to pursue any criminal investigation. The CPS investigation regarding the circumstances of the fatality resulted in the allegations being unfounded.

Committee Discussion

While the primary focus of the child fatality review was centered on actions and decisions made by the department during the RCW 74.13.515 of B.T.'s life, the Committee briefly looked at the mother's CA history involving her older children. This history provided an important context for understanding the mother's pattern of parenting deficiencies and struggles with RCW 13.50.100and RCW 13.50.100.

Largely through the interview process with the CFWS worker assigned to the RCW 13.50.100case involving B.T.'s sibling, the Committee considered information regarding the mother's RCW 13.50.100and her RCW 13.50.100 . This included exploring what information the worker had gathered about drug testing and treatment program compliance and progress, and what discussions the CFWS worker had had with the mother regarding the pregnancy and postnatal planning for the baby.

Some discussion occurred about the December 2016 CPS investigation of the RCW 13.50.100 The only witnesses to indications that the child had been RCW 13.50.100 . The Committee noted that while the RCW 13.50.100 was interviewed by three CA workers

[63] Current CA policy requires CA staff to conduct a safe sleep assessment when placing a child in a new placement setting or when completing a CPS intervention involving a child age birth to one year, even if the child is not identified as an alleged victim.

[64]Supervised visits require someone designated to be within direct line of sight and sound of the child and all parties to the visit at all times. Monitored visits require periodic check-ins with the visiting parties. Unsupervised visits do not require any oversight other than at drop off and pick up of the child.

about the incident, RCW 13.50.100 was never interviewed. The Committee was not able to determine how significant the lack of contact with RCW 13.50.100 was in terms of the results of that investigation. The Committee did inquire with the CFWS worker as to any impact that incident had on her assessment of the mother's ability to safely parent her RCW 13.50.100 child as well as B.T., who would be born less than RCW 74.13.515 later. The worker indicated that after the RCW 13.50.100 incident she became less enthusiastic about the request by the mother's attorney for the department to begin looking at RCW 13.50.100 .

The Committee devoted significant time looking at the RCW 13.50.100 abrupt and unexpected notification to the CFWS worker of the RCW 13.50.100 of the mother RCW 74.13.515 before she was to give birth. Prior to the notification the worker understood the mother was continuing to make RCW 13.50.100 At RCW 13.50.100, the mother maintained her participation in the RCW 13.50.100 and continued to do so even after delivery of B.T. The RCW 13.50.100 Summary Report, not completed and released by the RCW 13.50.100 until a week after B.T. was born, assessed the mother's RCW 13.50.100 The report also indicated that the mother had completed her RCW 13.50.100 plan in January. The CFWS worker, when interviewed, did not appear to have knowledge of the specifics of that plan.

The Committee examined the actions taken and decisions made by the department in reaction to the mother's abrupt RCW 13.50.100 Clearly the CFWS worker was challenged with an immediate need to help find alternative living situations for the mother, to find available RCW 13.50.100 resources and to prepare for B.T.'s birth. The CFWS worker recalled having electronically contacted the Assistant Attorney General assigned to the mother's case, the mother's attorney and the RCW 13.50.100 child's GAL,[65] to discuss the situation. A copy of an email corroborates this.

The Committee was interested in the basis for the decision to not file a dependency petition for B.T. upon RCW 74.13.515 birth. The Committee considered the mother's prior history, status of the RCW 13.50.100 on the older sibling, the mother's 7 RCW 13.50.100 and the sudden escalation RCW 13.50.100

[65] A Guardian ad Litem (GAL) is an individual appointed by the court to represent the best interests of a child or incapacitated person involved in a case in superior court. [Source: Washington Courts]

[redacted]. The Committee deliberated as to how conducting an FTDM[66] before or even after the birth of B.T. might have been beneficial to case decisions and case planning. Such a meeting might have afforded the opportunity for improved assessment of the mother's ability to meet the needs of her newborn.

The Committee then discussed the department's response to the Risk Only intake reporting B.T.'s birth. This discussion involved looking at the activities of the office assigned to the already open case (Lakewood) and the office (Yakima) conducting the courtesy face-to-face contact with the mother and newborn at the hospital. The Yakima worker's case note was brief with limited description. The Committee was made aware that the worker had, in a pre-review interview, admitted she had not documented more in depth discussions with the mother and her father (maternal grandfather of the newborn) regarding the postnatal plans for caring for the infant.

The Committee considered both the documentation and additional recollections provided to the Committee by the CFWS worker who, in the company of the sibling's GAL, met with the mother and newborn at a shelter in Yakima two days after hospital discharge. Discussions with the mother as to infant safe sleep and dangers of bed sharing, as well as about service planning, were documented. The worker covered Plan of Safe Care areas at that meeting, although a formal plan was not found in the case file.[67] Some debate occurred among Committee members as to whether a Plan of Safe care was required in this case, as the medical records indicated RCW 74.13.520 but did not confirm B.T. had been RCW 74.13.520

The Committee also discussed whether the Lakewood and Yakima staff understood their respective roles and responsibilities per CA policy regarding Risk

[66] Family Team Decision-Making meeting (FTDM) is a facilitated team process, which can include birth/adoptive parents, guardians, extended family members, youth (as appropriate), community members, service providers, child welfare staff and/or caregivers. These meeting are held to make critical decisions regarding the placement of children following and emergent removal of child(ren) from their home, changes in out-of-home placement and reunification or placement into a permanent home. There may be instances when an FTDM can be held prior to placement if there is not an immediate safety threat such as a child who is on a hospital hold and an FTDM could provide placement options. [Source: Family Team Decision-Making Meeting Practice Guide]

[67] Children's Administration caseworkers must complete a "Plan of Safe Care" as required by the Child Abuse Prevention and Treatment Act (CAPTA) when a newborn is identified as substance-affected by a medical practitioner. The plan must address the health and substance use disorder treatment needs of the infant and family, and include monitoring of the plan to determine whether and how local entities are making referrals and delivering appropriate services to the infant and affected family or caregiver. [Source: CA Practice and Procedures Guide 1135 Infant Safety Education and Intervention]

Only intakes on open CFWS cases.[68] In review of the inter-office communications and coordination between Lakewood and Yakima offices, there appeared to be some confusion as to the roles and responsibilities for completion of work. Most pronounced was the apparent delayed awareness by the Lakewood office that it was their responsibility to do the safety, risk, and investigative assessments associated with the Risk Only investigation. This may have been further muddled when a new CPS investigation was assigned to the Yakima office following the child fatality incident.

Finally, the Committee briefly discussed the fact that information contained in a psychological and parenting evaluation, initiated in October 2016, was not completed until after B.T.'s birth and not made available until March (post fatality). Based on a battery of personality and parenting inventories, the clinician had assessed similar concerns about the mother's RCW 13.50.100 as reported by the mother's RCW 13.50.100 and the hospital staff when B.T. was born. Having such information earlier in the case would likely have provided an opportunity for additional considerations for case planning such as RCW 13.50.100. It should be noted that the report from the clinical psychologist indicated that, RCW 13.50.100 .

Findings

The Committee found no critical errors in terms of decisions and actions taken by CA. However, the Committee did find instances where additional or alternative social work activity may have been beneficial to the assessment of the family situation. While these noted practice areas did not have clear significance to the apparent accidental death, the Committee deemed them worthy of consideration for improved practice.

- Conducting an FTDM before, or even after, the birth of B.T. might have been beneficial to case decisions and case planning. Such a shared planning venue might have afforded the opportunity for improved analysis of the mother's abilities to safely meet the needs of her newborn and other risks.
- Based on information provided by the CFWS worker during the Committee interview, there appeared to be instances where some contacts were

[68] Assign CPS Risk Only intakes on an open case to the assigned CPS Family Assessment Response (FAR), CPS investigation, FVS or Child and Family Welfare Services (CFWS) caseworker to complete the CPS investigation; including the initial face-to-face contact with the child, safety, risk and investigative assessments. [Source: CA Practices and Procedures Guide 2331 CPS Investigation]

either not documented or could have been more detailed. This included consultations regarding case planning.

- That the case was active in Lakewood, but the mother had been residing in Yakima for seven months, presented a number of challenges for the worker. The challenges were increased when new intakes were generated out of Yakima, necessitating intra-office cooperation, collaboration and communication. The Committee found some deficiencies in these areas that served as barriers to completed work.

Recommendation

CA should review the current policies regarding active CFWS cases involving RCW 13.50.100 and RCW 13.50.100 children as occurred in this case. Consideration should be given to improving guidance to workers and supervisors on how to proceed with completing a comprehensive, ongoing assessment of children who are not a part of an open case yet are under the care of a parent who has other RCW 13.50.100 children. This could include guidance on cases that involve multiple offices.