Report to the Legislature

Quarterly Child Fatality Report

RCW 74.13.640

October - December 2012

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TABLE OF CONTENTS

Executive Summary

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

> ***Child Fatality Review — Report***
>
> *(1)(a) The department shall conduct a child fatality review in the event of a fatality suspected to be caused by child abuse or neglect of any minor who is in the care of the department or a supervising agency or receiving services described in this chapter or who has been in the care of the department or a supervising agency or received services described in this chapter within one year preceding the minor's death.*
>
> *(b) The department shall consult with the office of the family and children's ombudsman to determine if a child fatality review should be conducted in any case in which it cannot be determined whether the child's death is the result of suspected child abuse or neglect.*
>
> *(c) The department shall ensure that the fatality review team is made up of individuals who had no previous involvement in the case, including individuals whose professional expertise is pertinent to the dynamics of the case.*
>
> *(d) Upon conclusion of a child fatality review required pursuant to this section, the department shall within one hundred eighty days following the fatality issue a report on the results of the review, unless an extension has been granted by the governor. A child fatality review report completed pursuant to this section is subject to public disclosure and must be posted on the public web site, except that confidential information may be redacted by the department consistent with the requirements of RCW 13.50.100, 68.50.105, 74.13.500 through 74.13.525, chapter 42.56 RCW, and other applicable state and federal laws.*
>
> *(2) In the event of a near fatality of a child who is in the care of or receiving services described in this chapter from the department or a supervising agency or who has been in the care of or received services described in this chapter from the department or a supervising agency within one year preceding the near fatality, the department shall promptly notify the office of the family and children's ombudsman. The department may conduct a review of the near fatality at its discretion or at the request of the office of the family and children's ombudsman.*

In April 2011, SHB 1105 was passed by the legislature and signed into law by Governor Gregoire. The revised child fatality statute (RCW 74.13) became effective July 22, 2011

and requires the department to conduct fatality reviews in cases where a child death is suspected to be caused by abuse or neglect. This eliminated conducting formal reviews of accidental or natural deaths unrelated to abuse or neglect. The revised statute requires the department to consult with the Office of Family and Children's 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 3 fatalities and 2 near-fatalities that occurred in the fourth quarter of 2012. All of the reviews are conducted as executive child fatality reviews. All prior Child Fatality Review reports can be found on the DSHS website: http://www.dshs.wa.gov/ca/pubs/fatalityreports.asp.

The reviews in this quarterly report include fatalities and near-fatalities from two regions.[1]

Region	Number of Reports
1	0
2	3
3	2
Total Fatalities and Near Fatalities Reviewed During 4th Quarter, 2012	5

This report includes Child Fatality Reviews and Near-Fatality reviews conducted following a child's death or near-fatal incident 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 chart below provides the number of fatalities and near-fatalities reported to CA and the number of reviews completed and those that are pending for calendar year 2012.

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

The number of pending reviews is subject to change if CA discovers new information through reviewing the case. For example, CA may discover that the fatality or near-fatality was anticipated rather than unexpected, or there is additional CA history regarding the family under a different name or spelling.

Child Fatality Reviews for Calendar Year 2012			
Year	Total Fatalities Reported to Date Requiring a Review	Completed Fatality Reviews	Pending Fatality Reviews
2012	21	11	10

Child Near-Fatality Reviews for Calendar Year 2012			
Year	Total Near Fatalities Reported to Date Requiring a Review	Completed Near-Fatality Reviews	Pending Near-Fatality Reviews
2012	10	4	6

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

Notable Findings

Based on the data collected and analyzed from the 3 fatalities and 2 near-fatalities reviewed between October and December 2012, the following were notable findings:

- One fatality occurred in Idaho after the child was placed with his father during a dependency action filed in Washington. His father was convicted of manslaughter for the death of his son.
- Four (4) of the five (5) cases involved children under three years of age. In 2012, 67% of the fatalities and near-fatalities reviewed were of children who died when they were under the age of three (3).
- Three (3) of the five (5) fatalities occurred while the family had an open case with CA.
- Two (2) of the three (3) fatalities were deemed homicides by a medical examiner or coroner.
- The child victims were male in all five of the cases.
- Three (3) children were Caucasian, one (1) was Black/African American, and one was Native American.
- All of the fatalities and near-fatalities were suspicious for abuse or neglect and all resulted in a founded finding for abuse or neglect by Child Protective Services.
- Children's Administration received intake reports of abuse or neglect in all of the child fatality and near-fatality cases prior to the death or near-fatal injury of the

child. None of the cases had more than five (5) intakes prior to the critical incident.

- Due to the small sample of cases reviewed, no statistical analysis was conducted to determine relationships between variables.

Table 1.1

4th Quarter 2012, Child Fatalities and Near-Fatalities by Age and Gender						
Age	**Number of Males**	**% of Males**	**Number of Females**	**% of Females**	**Age Totals**	**% of Total**
<1	3	60%	0	-	3	60%
1-3 Years	1	20%	0	-	1	20%
4-6 Years	1	20%	0	-	1	20%
7-12 Years	0	-	0	-	0	-
13-16 Years	0	-	0	-	0	-
17-18 Years	0	-	0	-	0	-
Totals	5	100%	0	-	5	100%

N=5 Total number of child fatalities and near-fatalities for the quarter.

Table 1.2

4th Quarter 2012, Child Fatalities and Near-Fatalities by Race	
Black or African American	1
Native American	2
Asian/Pacific Islander	0
Hispanic	0
Caucasian	4
Totals*	**7**

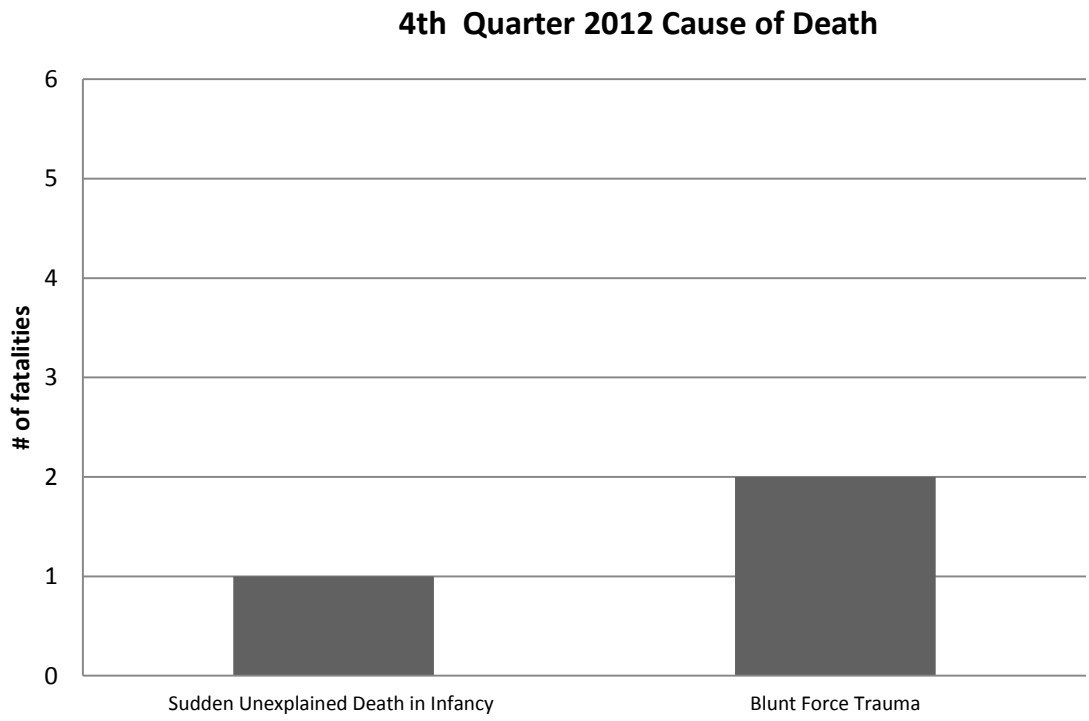
*Children may be from more than one race.

Table 1.3

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

N=3 Total number of child fatalities for the quarter.

Table 1.4



N=3 Total number of child fatalities for the quarter.

Table 1.5

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

N=3 Total number of child fatalities for the quarter.

Summary of the Findings and Recommendations

Review committees can make a finding or recommendation regarding the social work practice, policies, laws or system issues following their review of the case history leading up to the child fatality or near-fatal incident.[2] At the conclusion of every case receiving a full team review, the team decides whether they will make any recommendations as a result of issues identified during the review of the case. Recommendations were made in four of the five child fatalities and near-fatalities reviewed between October and December 2012.

Findings were made in all five cases reviewed during the quarter. In five of the cases reviewed, Committees found overall evidence of good social work practice.

Committees found four instances of prior CPS investigations that were not thorough.

In a case involving an eight-year-old killed by his father, the Committee found that staff did not take enough action to determine the suitability of his father to be a placement for his son. The Committee recognized that the department did not have final decision making on the placement as the case was in dependency action and placement was made by the court; however, the committee concluded that the assigned social worker could have done more exploration of the father's CPS and criminal history in Idaho that could have been shared with the court.

The committee reviewing this case recommended that the department develop guidelines for searching criminal and CPS histories of parents living outside the state. The committee also recommended the department review current policy requirements for vetting parents prior to placing dependent children in their care.

There were two recommendations regarding training of social worker staff. One committee recommended additional training to social workers on safety assessment and planning. Another committee recommended the department offer additional training on substance abuse to include information about methadone use.

Two recommendations were made to require social workers and contracted providers to observe all children in the home, especially infants, during home visits and initial face-to-face contact.

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

Recommendations made during the child fatality and near-fatality reviews completed during the quarter fell into the following categories:

4th Quarter 2012, Recommendations	
Contract issues	0
Policy issues	3
Practice issues	4
Quality social work	0
System issues	1
Training	2
Total	**10**

RCW 74.13.640(d)

Child Fatality Review

A.A.

October 2005
Date of Child's Birth

April 15, 2012
Date of Child's Death

September 13, 2012
Child Fatality Review Date

Committee Members
Lynda Richart, Court Appointed Special Advocate (CASA), Skamania County
Mary Meinig, MSW., Director, Office of Family and Children's Ombudsman
Erinn Havig, MSW., Program Manager for Family Support & Early Learning, Children's Home Society
Maya Brown, MSW. Children's Administration Interstate Compact Unit Supervisor
Kim Lawrence, Foster Parent Liaison/Mentor, Lutheran Community Services Northwest
Darcey Hancock, M.S., Area Administrator Children's Administration, Region 3 (Centralia/Kelso)

Legal Consultant to the Committee
Carrie Hoon Wayno, Assistant Attorney General, Office of the Attorney General

Observer/Facilitator aide
Karin Tracy, Social Worker 4, Vancouver DCFS (Cascade Office)

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

Executive Summary

On September 13, 2012, the Department of Social and Health Services (DSHS), Children's Administration (CA) convened a Child Fatality Review[3] (CFR) to examine the department's practice and service delivery to six-year-old A.A. and his family. On April 15, 2012, A.A. died from blunt force injuries caused by his biological father Anthony Viles,[4] with whom he was living in Bannock County, Idaho.

Prior to going to live with his father in Idaho, A.A. was alleged to be a victim of both neglect and physical abuse by his mother and stepfather[5] in Vancouver, Washington which resulted in his placement in out-of-home care on September 29, 2011 and the subsequent filing of a dependency petition in Clark County Juvenile Court on October 5, 2011. On January 30, 2012, while A.A. was still in foster care but before dependency was established,[6] the court granted Mr. Viles' motion to allow A.A. to temporarily stay with him in Idaho. The court held a review hearing on February 21, 2012, and it placed A.A. with his father in Idaho. The department then dismissed the dependency petition, which ended the department's and the court's legal authority as to A.A.

A CFR is required under RCW 74.13.640(1)(a) because the child was in the care of the department within a year of his death from abuse. The CFR Committee was comprised of CA staff not connected with the case and community members with pertinent expertise from a variety of fields and systems, including legal, parenting, public child welfare, foster care, and child advocacy. Although some Committee members were aware of the fatality incident, none had any previous direct involvement with the family.

Prior to the review each Committee member received the following information: (1) a summarized chronology of CA involvement with the family that included a

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[3] 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.

[4] The father's name is used in this report because the Bannock County Prosecutor in Idaho charged him with First Degree Murder in connection with his son's death. *See* RCW 74.13.500

[5] The names of A.A.'s mother, stepfather, and half-siblings are not used in this report as they were not involved in the fatality that occurred in Idaho.

[6] *See* RCW 13.34.065

synopsis of Idaho Child Protective Services (CPS) involvement with the mother and the stepfather; (2) non-redacted CA case documents from the initial contact with the family in May 2011 to the court's order placing A.A. with his father in late February 2012; (3) documents from two service providers involved with the family in Washington prior to A.A.'s move to his father's home in Idaho; (4) transcripts from the January 30, 2012 and February 21, 2012 Clark County Juvenile Court hearings; (5) various Idaho media reports regarding the death of A.A.; and (6) a summary of the father's criminal history in Idaho.

During the course of the review CA employees involved in the case were made available to the Committee. Two social workers, a supervisor, and an Area Administrator were interviewed.

Following review of the case file documents, completion of the staff interviews, and discussion regarding department activities and decisions, the Committee made findings and recommendations which are detailed at the end of this report.

Case Overview

The family first came to the attention of the Children's Administration in May 2011 when CPS investigated numerous allegations of neglect and physical abuse of then five year old A.A. by his mother and stepfather. While the allegations were determined to be unfounded,[7] the family's history of previous involvement with Idaho CPS for similar concerns resulted in the department's decision to keep the case open for Family Voluntary Services (FVS). During an unannounced home visit for health and safety monitoring by the assigned FVS worker on September 29, 2011, A.A.'s mother admitted she had put pepper water in her son's mouth for punishment. Following placement into foster care under a Voluntary Placement Agreement, A.A. disclosed other instances of physical punishment by his mother and stepfather which resulted in founded findings of physical abuse by the mother and stepfather.

On October 5, 2011, the department filed dependency petitions as to both A.A. and his half-sibling. A.A.'s biological father Anthony Viles, who had no prior involvement with his son, was contacted in Idaho. Mr. Viles requested and was appointed legal counsel in the dependency proceeding. The father then requested that the court place A.A. with him in Idaho.

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[7] "Unfounded" is defined as 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. RCW 26.44.020(24)
"Founded" is defined as 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." RCW 26.44.020(9)

The father appeared in person on January 30, 2012 in Clark County Juvenile Court for the hearing on his motion for placement of his son. During the hearing, the department's counsel noted that under a 2010 Court of Appeals decision [8] the Interstate Compact on the Placement of Children (ICPC)[9] did not apply to the out-of-state father, as he had not been proven unfit in the dependency proceeding. Counsel stated that if the court placed the child out of state without Idaho's approval in the ICPC process, the department could not ensure the child's safety as it could not monitor the placement or provide transition services, which would have occurred if the placement took place under the ICPC. The mother was not present for the hearing but she was represented by counsel who did not object to A.A.'s placement with his father. The department did not offer evidence that the father was unfit, reported that background checks had been completed on the father and his live-in girlfriend and neither had disqualifying information, and further reported that the father had been cooperative. The court granted the father's motion to allow A.A. to immediately leave for Idaho with his father.

When it ordered that A.A. would leave to stay with his father in Idaho, the court also set a review hearing to occur 30 days after the hearing on the father's motion for placement. In doing so, it ordered the assigned department caseworker and the child's therapist to have frequent contact with both the child and the father during the temporary placement/visit with the father. This review hearing was held on February 21, 2012. At the hearing the court placed A.A. with his father and the department therefore dismissed its dependency petition, which ended the department's and the court's legal authority as to A.A.

On April 12, 2012, during an argument over homework, Mr. Viles allegedly struck his son in the head, knocking the boy to the floor where he hit his head and became unconscious. Two hours passed before Mr. Viles called for an ambulance. A.A. was airlifted to Primary Children's Hospital in Salt Lake City, where he was placed on life support. He died on April 15, 2012, and Mr. Viles was charged with First Degree Murder by the Bannock County Prosecutor in Idaho.

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[8] *In re Dependency of D.F.-M.*, 157 Wn. App. 179, 236 P.3d 961 (2010) (in which the court found that the ICPC did not apply to out-of-state placement with a parent, and stated the following: "[C]ourts can and should demand information about the absent parent's fitness. However, courts, not administrative agencies or individual social workers, are the ultimate evaluators of a parent's ability to care for his child, and the ultimate decision-makers as to whether placement with a fit parent is in the child's best interests." *D.F.-M.*, 157 Wn. App. at 192-93.)

[9] The Interstate Compact on the Placement of Children (ICPC), a uniform reciprocal law enacted in every state, governs the interstate placement of foster children, among other situations (e.g., adoptions). The Compact prohibits states from sending a dependent child to live with an out-of-state caregiver without first obtaining approval from the receiving state's child welfare agency following a home study and other assessments of the caregiver. *See* Chapter 26.34 RCW

Committee Discussion

Committee members reviewed and discussed the documented CA activities and decisions from the initial contact with the family in May 2011 through February 21, 2012, when the court placed A.A. with his father in Idaho. While some discussion occurred as to the CA involvement with the mother and stepfather that resulted in A.A. and his half-sibling being placed in out-of-home care, the primary focus of the review was on the department's activities and decisions in the four-month period from October 2011 to February 2012, during which time A.A.'s father in Idaho emerged as a placement resource.

In an effort to evaluate the reasonableness of decisions made and actions taken by CA, the Committee considered Washington law, CA policy, practice, and system response (including the legal system), as well as CA case documentation and interview responses from the CA staff that occurred during the review.

Three core areas of concern were identified: (1) documentation by the Child and Family Welfare Services (CFWS) worker and supervisor (October 2011 through February 2012); (2) information gathering efforts regarding the father and his partner and her two children; (3) legal and CA policy limitations when the ICPC is not applied in cases involving out-of-state parents seeking placement of their children.

Findings

Documentation

There were obvious violations of CA documentation policy[10] by the CFWS social worker who was assigned the case in October 2011. Almost all case note entries by the worker were entered after the death of A.A. in April 2012, thus many activities were entered into FamLink[11] six months after they reportedly occurred. Information provided to the Committee as to worker caseloads in the Vancouver DCFS office at the time, and in particular the workload associated with the assigned worker's cases at the time he was assigned this case, did not appear to account for the exceptional time delay in the documentation. The worker and his supervisor stated that despite the failure to document case information in FamLink in a timely manner, case related information gathered by the worker

[10] As a means to increase child safety, to ensure quicker availability of electronic information, and to simplify documentation requirements, CA revised documentation timeframes effective July 31, 2010. Variable timeframes were revised depending on specific activity types, and designated as required within 3, 7, or 10 calendar days. [See DSHS/CA Practices and Procedures Guide and CA Operations Manual available online at http://www.dshs.wa.gov/ca/pubs/mnl_pnpg/chapter1.asp]

[11] 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.

was utilized at numerous decision points in the case such as shared planning meetings, monthly supervisory reviews and preparation for court testimony. While there were credible indications the worker kept a log of activities which he later converted into FamLink entries, the Committee found numerous entries that appeared to contain documentation of multiple activities that may have actually occurred on different days but were all entered as having occurred on one particular date. Also, the quality of a case note narrative appeared to vary depending on whether the data was entered timely or not timely (e.g., post-fatality). In sum, while there is no evidence of record falsification, review of the documentation primarily from October 2011 through February 2012, raises questions as to reliability, credibility, and accuracy of the information documented.

Information gathering

The information gathering effort by the CFWS worker as to A.A.'s father and his partner was found to be inadequate and reflective of a significant practice deficit. The committee's concern was not about the information that was gathered, but rather the information that was likely available but was not sought. The Committee heard from several CA staff (field, supervisory, and administrative) who reported being confused as to what information-seeking activities were permissible and expected when the department is considering out-of-state placement with a parent to whom the ICPC is not applied. Under the ICPC, there are clear rules requiring extensive vetting of out-of-state caregivers for placement of dependent children, utilizing information from both the state sending the child and the state receiving the child. In this case, these rules did not apply because the ICPC was not applied to this placement.

The information gathered by the CFWS worker primarily derived from contact with personal references provided by the out-of-state father which overall was positive and did not reveal any obvious indicators that the father was unfit to be a parent. The worker and supervisor relied heavily on this information and in particular relied on a family friend and licensed social worker in Idaho who agreed to provide parenting instruction to the father and his partner. The limited information gathered appears to have been the basis of the department's lack of any objection to the child going to Idaho to stay with his father.

However, the Committee concluded that there was information available but not sought by the worker that may have been sufficient to cause the court to consider slowing down the move of the child. Most pronounced was the lack of any discernible effort by the worker to seek Idaho CPS history on the father or on his domestic partner and her two children. Information provided by Idaho CPS

after the fatality reasonably suggests that had such information been requested and obtained prior to the January 2012 court hearing, and presented to the court, it may have resulted in a decision to slow down the move (as was suggested by the CASA[12]) or court-ordered additional vetting of the father and his live-in girlfriend.

Uniqueness of the case and legal and policy limitations

The situation involving A.A. appears to be unusual in that he was not yet a dependent child and his father from Idaho, whom A.A. had never met, sought placement of him. The department did not have evidence that the father was unfit; thus, under *In re D.F.-M.*,[13] an appellate court decision that is now law, the ICPC did not apply, which resulted in no assistance from Idaho in determining the appropriateness of placing the child with his father. The circumstances of this case do not permit authorized use of the National Crime Information Center (NCIC) database to obtain criminal background information as the database may only be accessed for limited to specific purposes, which likely do not apply in this case.[14] Further, if the child had been dependent, state law would have required a background check (including a criminal and CPS history check) on the parent and the parent's partner.[15] The uniqueness of the situation in this case may have contributed to the confusion reported by the CA staff involved with regard to their authority to pursue more information as to both the father and his partner. As noted previously in this report, the lack of a more substantive inquiry was determined by the Committee to be a serious practice issue in this case.

Recommendations

- It is recommended that at the next Central Case Review scheduled for the Vancouver DCFS office that special focus be placed on evaluating required documentation standards (including timeframes for entry of information into FamLink) as a quality assurance review measure.
- Whereas legal requirements and CA policies are clear as to expected CA activities for gathering information on parents living in Washington who are under consideration for placement of their child who has been placed in out-of-home care, and are clear for out-of-state caregivers in ICPC cases, more guidance is needed for workers with cases involving non-

[12] Court Appointed Special Advocate (CASA) volunteers are community volunteers who are appointed by judges to represent the best interests of a child in dependency proceedings. [Source: RCW 13.34.030(10)]
[13] 157 Wn. App. 179 (2010)
[14] The National Crime Information Center (NCIC) system is a name and date-of-birth based national database of criminal history information operated by the Federal Bureau of Investigations (FBI). Children's Administration is authorized to access this database only for limited purposes: to ensure worker and child safety in CPS investigations; and for emergency placements in out-of-home care. *See* 109 P.L. 248 (Adam Walsh Act); 28 C.F.R. §20.33; *see also* RCW 26.44.240
[15] *See* RCW 13.34.138(2), known as Sirita's law

offending out-of-state parents not under the ICPC but who are placement options for their non-dependent child involved with DCFS. It is recommended that CA, in collaboration with legal consultation with the Attorney General's Office, develop guidelines to provide clarity as to (1) what system search activities are authorized, (2) what other strategies for information gathering may be used (e.g., internet searches, social media sources), and (3) what other criminal and CPS history should be sought.

- CA should review the current statutory and policy requirements for vetting parents and their partners prior to placement of dependent children (e.g., Sirita's Law) and consider how these standards might be applied when children who are not yet dependent are placed with an out-of-state parent as occurred in this case. The key aspect of this recommendation is to strengthen practice such that the department identifies the risks associated with placement with an out-of-state parent when the department lacks information about that parent, their partner and/or their living environment, rather than presenting this situation as neutral, with no evidence of unfitness.

RCW 74.13.640(d)

Child Fatality Review

D.M.

March 2012
Date of Child's Birth

April 26, 2012
Date of Child's Death

August 16, 2012
Child Fatality Review Date

Committee Members
Jamie Collins, Detective, Whatcom County Sheriff's Department,
Carmelita Adkins, Supervisor, Children's Administration
Randy Hart, Area Administrator, Children's Administration
Jennifer Sass-Walton, RN, BSN, Child and Family Health Manager, Skagit County Public Health
Corey Wood, Ombudsman, Office of Family and Children's Ombudsman

Observer/Facilitator's Aide
Paul Smith, Critical Incident Program Manager, Children's Administration

Facilitator
Robert Larson, Critical Incident Case Review Specialist, Children's Administration

Executive Summary

On August 16, 2012, Children's Administration (CA) convened a Child Fatality Review[16] (CFR) committee to examine the practice and service delivery in the case involving a one-month-old Caucasian male infant named D.M. and his mother. The incident initiating this review occurred on April 26, 2012 when D.M. was discovered by his mother face down in a crib filled with stuffed animals and other materials. A skeletal survey ordered by the Whatcom County Medical Examiner, Gary Goldfogel, M.D. revealed remote skeletal injuries consistent with inflicted trauma. Dr. Goldfogel certified the cause of death as sudden unexpected infant death (SUID), the manner of death as "undetermined."

The CFR committee included CA staff who had no prior involvement with the family and community members selected from diverse disciplines with relevant expertise, including representatives from the fields of law enforcement, medicine, the Office of the Children and Family Ombudsman and social work. The community committee members also had no previous involvement with the case. Prior to the review each committee member received a chronology of known information regarding the mother and child, un-redacted CA case-related documents, as well as medical records obtained shortly after the fatality incident.

Available to committee members at the review were: (1) additional case related documents (e.g., technical-based medical records such as autopsy, the CA case file on this family), (2) several CA policy and practice guides relating to Child Protective Services (CPS) investigations and assessment of risk and safety, (3) copies of relevant laws relating to CPS duties, legal definitions of child maltreatment. During the course of the review, the mother's public health nurse, the CPS investigator and CPS supervisor were made available for interview by the CFR committee members.

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

[16] 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 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 deceased child's life or death. 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.

Case Overview

D.M. is a male Caucasian child born in March 2012. D.M.'s mother is K.M. who is a 21-year-old Caucasian female. D.M.'s father was not listed on the birth certificate; however, the mother reported that the father of the baby as S.B. The mother stated to the hospital social worker that the father "won't be involved." The father was 21 years old according to the mother.

[redacted]

RCW 74.13.520

On March 22, 2012, D.M. was born at St. Joseph Hospital in Whatcom County. The attending physician expressed concerns about the mother's ability to care for D.M. A hospital social worker was assigned by D.M.'s doctor to assess the mother's ability to care for her child. Hospital records reflect the following information: the mother does "not get" the basic baby care and needs and requires frequent cueing by nurses. D.M. was found with a blanket over his face. K.M. was asked about the blanket and she stated "I didn't do that, he did that himself." The hospital staff provided the mother with information regarding Safe Sleep[17] practices for infants. The hospital social worker wrote that the doctor has "grave concerns" regarding mother's ability to care for her baby. The doctor further reported that the mother had no-showed four to five times for every prenatal appointment she kept. K.M. denied a history of domestic violence (DV); [redacted] She also self-reported three years of sobriety and no history of drug use. The hospital social worker

[17] 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.

determined that "there is not adequate concern for a medical hold." The hospital notes reflect that "CPS was called and planned to follow-up with the mother at home." Before the mother and baby were discharged, the hospital social worker reviewed her notes and spoke to the nurse and doctor to determine whether another CPS report should be made and a medical hold placed on the baby or whether the baby could discharge home with the mother with CPS follow up to be expected. On March 24, 2012, D.M. and his mother were discharged from the hospital.

On March 26, 2012, an intake was received by CA and screened in for investigation. The referrer alleged that K.M. might be slightly mentally delayed. It was also reported that K.M. failed to respond to D.M. when he was screaming and crying and she left the room and went outside to smoke leaving her baby to cry. The doctor expressed concerns that the mother missed multiple appointments during her pregnancy. The mother stated that the baby's father has drug issues and she was not planning to have him involved in her baby's life at the time. According to the referrer the mother sent her baby to the hospital nursery for an entire day prior to discharge. The mother was referred to a Public Health Nurse by hospital staff prior to discharge.

The assigned social worker attempted to contact the family at their residence on March 27, 2012. The family was not home and a second attempt was made on March 28, 2012 when the assigned social worker and another social worker were able to complete an initial face-to-face contact with the family. The mother was reminded to remove items from D.M.'s bassinet to increase child safety related to sleeping. The social worker noted the home was clean and well picked up. K.M. stated that the maternal aunt, grandfather, great grandfather and friends are all available supports. The social worker noted that the mother appeared to have some developmental delays. The mother was offered Family Preservation Services (FPS) and parenting instruction but refused both services. The mother refused to sign a release for medical records.

On March 29, 2012, the Public Health Nurse (PHN)[18] contacted the mother. She noted that D.M.'s hood was "up around the baby's face." K.M. reported that the baby does not nurse well.

On April 2, 2012, a letter and pamphlet about Sudden Infant Death Syndrome (SIDS)[19] and Safe Sleep was mailed to the mother by the assigned social worker.

[18] Public Health Nurses (PHN) are nurses who provide individuals and families with health guidance. In this case, the PHN provided the mother with guidance related to the basic needs of herself and her child.

The PHN attempted to meet the mother at her home on April 3, 2012, as scheduled, but the mother was not home. The PHN attempted further contacts by phone on April 4, 2012 and April 17, 2012. The PHN did not receive a return call from the mother. The PHN was able to make phone contact on April 25, 2012 and scheduled an appointment for May 2, 2012.

The PHN spoke to the Children's Administration's (CA) Early Intervention Program (EIP)[20] coordinator on April 18, 2012, and notified the coordinator of K.M.'s inability to track and understand the baby's needs and the baby's hood being located around his face.

Due to the PHN's concerns the social worker attempted to make contact at the family's residence on April 23, April 24, and April 25, 2012. The mother and baby were not home during any of these attempted contacts.

On April 26, 2012, D.M. was found unresponsive in a crib. D.M.'s listed time of death was 11:58 a.m. K.M. reported last seeing D.M. alive at 6:30 a.m. D.M.'s mother gave him pediatric Tylenol for a cough and runny nose. D.M. was also fed a bottle of formula by his mother and was placed into a crib that "barely [had] room for the child" according to Dr. Goldfogel. Dr. Goldfogel also noted that the mother "made an appointment [for] the day prior to death for the child's cold but failed to show for the appointment. She also failed to appear for a well-baby check and scheduled circumcision appointments."

The autopsy listed the cause of death as sudden unexpected infant death (SUID). The autopsy opinion section reads, "The decedent is a one month old Caucasian male infant discovered face down in a crib essentially filled with stuffed animals and other materials. Skeletal survey reveals remote skeletal injuries consistent with inflicted trauma. Forensic autopsy reveals no evidence of congenital anomaly, infection or other anatomical explanation of the infant's demise. Based on circumstances surrounding the death, as currently known, the manner of death is certified as undetermined."

Committee Discussion

Committee members reviewed and discussed the documented social work activities completed by Children's Administration from intake to case closure. As a means to provide structure and context to reviewing social work practice, the

[19] Sudden infant death syndrome (SIDS) is the unexpected, sudden death of a child under age 1 in which an autopsy does not show an explainable cause of death.

[20] Early Intervention Program (EIP) offers services to help families build knowledge and skills to meet the developmental and health need of the child from birth to three years of age. Helps families with practical and emotional challenges related to care of their child. Helps families identify and use community resources and services.

committee was provided a case summary and had access to D.M's case file. In this way, committee members were able to evaluate the reasonableness of actions taken and decisions made by the Children's Administration. In addition to social work practice, discussions occurred around policy issues. The discussions largely focused on the following areas: the March 26, 2012 intake, the initial face-to-face contact, social work practice related to the initial investigation, and the gathering of medical records after an intake is received from the hospital.

The Committee interviewed the CPS social worker regarding her actions related to the CPS investigation. The social worker completed her initial contact with the mother and D.M. within policy time frames. The social worker observed the mother had placed too many items in the crib and asked the mother to remove the items. The Committee was informed by the social worker that she had asked the mother to demonstrate a safe sleeping arrangement. The mother was able to appropriately demonstrate that she was able to create a safe sleeping environment. The Committee determined the social worker had completed a thorough interview as the social worker was able to provide significant details about the mother's daily routine, mental health history, and general ability to care for D.M. In addition, the social worker addressed the primary areas of concern in the referral.

The Committee wanted to know how resistant the mother was to services. The social worker informed the Committee that the mother was offered Family Preservation Services (FPS),[21] but she refused. The social worker informed the mother of the benefits of FPS including the financial assistance that is offered as part of the service. The mother continued to refuse FPS. The mother was also offered parenting instruction, but she also refused this service and stated that she had completed a Love and Logic[22] class recently. The social worker asked the mother to sign a release of information for medical records in an effort to gather more information about the missed appointments. The mother refused to sign the release of information and denied no-showing for medical appointments. The mother told the social worker, "my medical information is private." The social worker told the Committee that she chose to keep the case open and she also

[21] Family Preservation Services (FPS) are short-term, family-based services designed to assist families in crisis by improving parenting and family functioning while keeping children safe.

[22] Love and Logic: According to the Love and Logic website it is a philosophy of raising and teaching children which allows adults to be happier, empowered, and more skilled in the interactions with children. Love allows children to grow through their mistakes. Logic allows children to live with the consequences of their choices. Love and Logic is a way of working with children that puts parents and teachers back in control, teaches children to be responsible, and prepares young people to live in the real world, with its many choices and consequences.

informed the mother at the time of the initial face-to-face contact that she would be doing regular checks on her progress.

The committee asked the social worker if she had completed an NCIC[23] criminal background check. The social worker stated that she did not believe the client's history indicated a need for an NCIC criminal background check. The Committee discussed how the NCIC may not have provided any additional information, but the completion of a NCIC background check has the potential to provide social worker's with additional valuable information and is an additional method of protection for the social worker as it could potentially inform the social worker of dangerous individuals.

The social worker informed the Committee about her attempts at gathering additional information. She completed an ACES[24] check to confirm the mother's address and check for additional information. The social worker reported that the ACES narrative report had very limited information. The social worker also reported leaving a voicemail with the hospital social worker; however, she did not receive a call back. The social worker stated she was very busy at the time of this investigation and was unable to document every contact and action including the phone message to the hospital social worker. The social worker stated she had received 14 intakes to investigate between March 26, 2012 and April 26, 2012. During this same time period she also placed four children in out-of-home care from three different families.

The Committee discussed the intake and medical reports with the social worker. The social worker stated, and the Committee agreed, that the referral did not rise to a level where she was concerned about imminent harm to D.M. The initial home visit went well and the mother was able to show her how to meet the babies basic needs. She stated that she would normally gather the birth records, but she was very busy at the time of this referral due to the high volume of referrals. The Committee reviewed the prenatal and birth records that were obtained post-fatality and did not feel that they would have impacted or changed the outcome of the case; however, the Committee felt the gathering of birth records immediately after a referral from the hospital should be considered best practice and reviewed as soon as possible.

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[23] NCIC: CPS Investigators may request a NCIC Purpose Code C on subjects of CPS investigations and other adults related to the CPS investigation. This information is used to assess child and worker safety. Requests for NCIC checks for CPS investigations are made in accordance with federal and state law (RCW 26.44.030 & PL109-248). **Purpose Code C may only be requested during a CPS investigation for the purpose of assessing child and worker safety as it relates to the CPS investigation.**

[24] ACES is the computer system used by the community services offices of the Department of Social and Health Services to determine eligibility for public assistance.

The Committee discussed the differences between the March 26, 2012 intake report and the hospital social worker's records that were received post-fatality. The Committee noted that the medical notes included more details and concerns regarding the mother than the March 26, 2012 intake. The Committee was unable to determine the cause for the differences but did note that it is not unusual for a referrer to provide an abbreviated summary of concerns. The medical records from March 23, 2012 indicated that CPS had previously been contacted; however, there are no additional records within Children's Administration that indicate CPS had been called and no knowledge about a previous contact according to Bellingham CPS staff. In addition, the Committee discussed the timing of the referral. The Committee noted that the referral was called into Children's Administration on March 26, 2012. The mother and D.M. were discharged from the hospital on March 24, 2012. The Committee determined that it would have been beneficial to both the investigator and Committee to have an audio recording of the referral as routinely done by 911. Some Committee members felt the recording of all referrals would be good practice for CA while other Committee members expressed concern that some referrers would not call if they knew the call would be recorded. The Committee did not come to a consensus on the recording of future intakes.

Findings

1. The social worker demonstrated quality practice by initiating a complete and thorough face-to-face interview within policy timeframes. She offered the mother reasonable services and asked detailed and relevant questions. The social worker would have been within policy to close the case following the refusal of services, but the Committee felt she appropriately informed the mother that she would keep the case open and follow-up with in-home checks. The PHN appropriately communicated her concerns to CA when the mother demonstrated a pattern of failing to make herself and her child available for PHN services. The social worker then appropriately acted by attempting to make contact with the family the three days preceding D.M.'s death.
2. Two practice concerns were noted by the Committee. The Committee believes it would have been beneficial to the investigation to have completed a criminal background check, though it was not required by policy. Second, the investigative process would have benefited from the gathering of the birth records immediately after the receipt of the referral. The Committee noted that the birth records would not have been sufficient reason for further court intervention and would not have led to more services as the mother had refused all offered services.

Recommendations

1. The Bellingham Children's Administration office should develop a plan to increase communication with the local hospital following an intake regarding abuse and/or neglect originating at a hospital.
   Action Taken: The Bellingham Children's Administration office contacted the local hospital and a meeting was facilitated by a CPS Supervisor on July 8, 2011. A follow-up meeting between the Bellingham Children's Administration office and local will be scheduled by December 31, 2012.

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RCW 74.13.640(d)

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

Child Fatality Review

C.T.

November 2011
Date of Child's Birth

May 13, 2012
Date of Child's Death

September 6, 2012
Child Fatality Review Date

Committee Members
Carmelita Adkins, Supervisor, Children's Administration
Karen Burke, Director, Domestic Violence and Sexual Assault Services (DVSAS)
Jamie Collins, Detective, Whatcom County Sheriff's Department,
Randy Kaui, LMHT, CPT Team Member, LIBC
Mary Meinig, MSW, Director, Office of Family and Children's Ombudsman
Patty Turner, Area Administrator, Children's Administration
Betsy Tulee, ICW Program Manager, Children's Administration

Observers/Facilitator's Aides
Laurie Alexander, Area Administrator, Children's Administration

Facilitator
Robert Larson, Critical Incident Case Review Specialist, Children's Administration

Executive Summary

On August 7, 2012, Children's Administration (CA) convened a Child Fatality Review[25] (CFR) Committee to examine the practice and service delivery in the case involving 6-month-old C.T. and her family. The incident initiating this review occurred on May 13, 2012 when C.T.'s father called 911 to report his daughter was not breathing. A medical exam showed C.T. was discovered in cardio-respiratory arrest. C.T. was resuscitated but did not regain consciousness and expired approximately four hours later. C.T. suffered from blunt cranial trauma and anal sexual trauma according to the autopsy.

The Child Fatality Review Committee included CA staff and community members selected from diverse disciplines with relevant expertise, including representatives from the fields of local law enforcement, domestic violence, Indian child welfare policy, the Office of the Children and Family Ombudsman, and social work. All committee members had no previous involvement with the case with the exception of Randy Kaui. Mr. Kaui is an active Lummi Nation Child Protection Team (CPT)[26] member and he participated in multiple meetings about C.T. preceding the fatality. Prior to the review each committee member received a chronology of known information regarding the family and un-redacted CA case-related documents.

Available to committee members at the review were (1) additional case related documents (e.g., records, court records and case file) and (2) copies of relevant laws relating to CPS duties and legal definitions involving child maltreatment. The CPS investigators and Lummi Children's Services Assistant Program Manager/Child Welfare Supervisor were made available for interview as part of the review process.

Following review of the case file documents, interview of CPS investigators, interview of the Lummi Children's Services Assistant Program Manager/Child

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

Welfare Supervisor, and discussion regarding social work activities and decisions, the review committee made findings and recommendations which are detailed at the end of this report.

Case Overview

C.T. is a female member of the Lummi Nation who was born in November 2011. C.T. was born into a family that consisted of her mother, father, and sister. C.T.'s mother is R.W. She is a descendent of the Lummi Tribe and was 23-years-old when C.T. died. C.T.'s father is L.T. He is also a descendent of the Lummi Tribe and was 22-years-old when his daughter died. C.T.'s sibling, [redacted] was born in [redacted] and [redacted] was 18-months-old at the time of C.T.'s death.

RCW 74.13.520

RCW 70.02.020

[redacted]

[27] When an allegation is "Unfounded" it means that CPS investigated the allegation and, based on the information available, determined that it was more likely than not that the alleged abuse or neglect did not occur, or that there was insufficient evidence to determine whether the abuse did or did not occur. RCW 26.44.020(24)

[redacted]

C.T. was born in November 2011. The social worker had completed the Lummi CPT requirements and was preparing to close the case. [redacted] The mother agreed to work with Lummi Children's Services (LCS). The Lummi Housing Department also [redacted]

On January 1, 2012, the Lummi Nation Police called CPS to report concerns of domestic violence (DV)[28] between the mother and father. The maternal grandfather was attempting to intervene when law enforcement responded to the home. The intake was screened in for investigation. The assigned social worker and LCS contacted the family. The two social workers met with the mother at her house and again at the LCS office. The social workers wanted to provide the mother with an opportunity to talk in a safe environment away from L.T. The mother admitted that she had an altercation with L.T., but denied any ongoing domestic violence. The mother reported that she had thrown the object that had resulted in a broken window. The social worker documented that the mother blamed the maternal grandfather for spreading rumors. The case was staffed with the Lummi CPT who recommended case closure.

On May 13, 2012, the Lummi Nation Police called an intake to report a pending fatality due to sexual and physical abuse. C.T. passed away at 11:58 a.m. from the injuries. The manner of death according to the County Medical Examiner was homicide. The County Medical Examiner reported, "The decedent is a six-month-old Native American female discovered in cardio respiratory arrest by the father. The child was resuscitated but did not regain consciousness and expired approximately four hours later. The child suffered from blunt cranial trauma and anal sexual trauma. From pattern of the cranial injuries, I suspect elements of both crushing/squeezing and impact against a surface."

[28] Domestic Violence (DV) *behavioral definition* "a pattern of assaultive and coercive behaviors, including physical, sexual, and psychological attacks, as well as economic coercion, that adults or adolescents use against their intimate partners".

The father admitted to causing the physical injuries that resulted in C.T.'s death, but denies sexually abusing C.T. The sibling of C.T. was placed into protective custody and a dependency petition was filed. C.T.'s sibling remains in foster care as of September 2012.

Committee Discussion

Committee members reviewed and discussed the documented social work activities completed by Children's Administration from intake to case closure. As a means to provide structure and context to reviewing social work practice, the Committee was provided a case summary and had access to C.T's case file. In addition, the Committee was provided with information on policy and procedure as it relates to the investigation of child abuse and neglect so committee members were better able to evaluate the reasonableness of actions taken and decisions made by Children's Administration social workers. In addition to social work practice, discussions occurred around policy issues. The discussions largely focused on the following areas: the initial intake and how CPS investigators investigated the child's injuries, the ongoing concerns of domestic violence, the use of investigative tools, the intake decisions, and services provided to the family. **RCW 74.13.520**

C.T.'s family was offered services throughout this case; however, the family refused services from the state. The family reported that they were able to receive services through the Lummi Nation and this was evidenced through their utilization of the housing program, chemical dependency services and mental health services. The Committee discussed the family's Lummi heritage and how it is not unusual for a tribal member to seek services through their own tribe. Overall, the Committee noted that active efforts were completed by the assigned social workers. The Committee also noted that the family had two young children and determined it would have been beneficial for the family to receive Public Health Nurse (PHN) services. The Committee could not determine if the family was receiving PHN services at the time of the fatality.

Children's Administration learned through their contact with the Lummi Tribe, community members, family members, and law enforcement that DV was an underlying concern with C.T.'s family. The CPS investigators both noted during their interview that they spoke with the mother separately from the father and that she denied any domestic violence. The CPS investigators noted that they remained concerned about domestic violence, but they could not locate significant evidence supporting the presence of domestic violence. The lack of significant evidence and the parents' denial of domestic violence was a significant barrier to domestic violence related services. The Committee discussed how the mother may have benefitted from the receipt of an informational DV brochure and the official offer of DV victim services. **RCW 74.13.520**

Three different state social workers were assigned to this case from August of 2011 until the fatality in May of 2012. The second social worker reported she was unable to complete all of her documentation due to work demands before she left for an anticipated extended leave. Some documentation was inputted approximately six months late. The Committee discussed the significant amount of paperwork and activities involved in an investigation regarding child abuse. The Committee determined that the agency would continue to benefit from streamlining the investigative tools.

RCW 74.13.520

[redacted]

Committee Findings

1. The Committee determined that the safety concerns and risks associated with this case were adequately assessed by the worker. After review, it was determined that there was no way of predicting the eventual abuse to C.T.
2. The assigned social workers used the available community resources in their investigation and efforts to assist the family including law enforcement, Lummi Tribal contacts, and CPT. The Committee noted the positive and productive relationship between the Lummi Nation and the Bellingham Children's Administration office.

[redacted]

Committee Recommendations

1. [redacted] The Committee recommends that it is best practice for all Children's Administration social workers to take photographs whenever reasonably possible for documentation purposes to prove a child was or was not injured. The Committee believed photographs should be taken even when a mark is not present. The Committee determined that the use of photographs would help with future investigations and case reviews. In addition, the Committee stated that each social worker should have quick access to a camera and/or phone with a camera. The camera should include the ability to quickly upload the photograph into FamLink.
2. Children's Administration should conduct a review of the FamLink investigative tools in an effort to decrease the impact on workload due to possible duplication of documentation related to the investigative tools.