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
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Table of Contents

Executive Summary

On April 19, 2017, the Department of Social and Health Services, Children's Administration (CA) convened a Child Fatality Review (CFR)[1] to assess the department's practice and service delivery to an infant child and [redacted] family.[2] The child is referenced by [redacted] initials, G.K., in this report. At the time of [redacted] death, G.K. had been residing with [redacted] mother. The incident initiating this review occurred on January 20, 2016, when G.K. died while in [redacted] 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 [redacted] on November 25, 2016, when a [redacted] by her father and grandmother. [redacted] was taken to the [redacted] who then notified law enforcement. The mother admitted that she had [redacted]. Law enforcement

[1] Given its limited purpose, a Child Fatality Review (CFR) should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of 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.

[2] 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)].

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, 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.[3] The father more actively participated in services than the mother. He attempted to RCW 13.50.100 [redacted]. The CPS investigator made a determination that the allegation of RCW 13.50.100 against the mother was unfounded.[4]

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 74.1 was 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 74.1 crib. 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

[3] 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]

[4] 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]

coroner's inability to complete the toxicology screens as the sample was lost in the mailing system utilized by the local coroner.

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[5] identified that the children were "safe" on the safety assessment but that a safety plan[6] 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[7] according to CA's safety framework.[8] 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[9] (FTDM), CA did not utilize its safety framework as designed and relied

[5] 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].

[6] 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]

[7] 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]

[8] 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.

[9] 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

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)[10] 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 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 Some Committee members believed greater consideration should have been given for a founded finding[11] 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

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

[10] 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]

[11] 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[12] 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.[13]
- 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.

[12] 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]

[13] 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.