Child Fatality Review

L.R.

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

October 16, 2017
Date of Fatality

February 1, 2018
Child Fatality Review Date

Committee Members
Elizabeth Bokan, Ombuds, Office of the Family and Children's Ombuds
Jenna Kiser, M.S.W, Intake, Safety and Domestic Violence Program Manager, Children's Administration
Joshua Jewell, Supervisor, Children's Administration
Debi Keenan, King County Court Appointed Special Advocate

Observers
Esther Shin-Kirkendall, Central Intake Area Administrator, Children's Administration
Tom Soule, Central Intake Supervisor, Children's Administration

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

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Executive Summary

On February 1, 2018, the Department of Social and Health Services (DSHS or Department), Children's Administration (CA) convened a Child Fatality Review (CFR)[1] to assess the Department's practice and service delivery to L.R. and [RCW 7] family.[2] The child will be referenced by [RCW 7] initials in this report.

On October 16, 2017, CA received an intake stating L.R. had passed away. L.R.'s mother reported she placed [RCW 74.1] face down on the bed where she was also sleeping. She woke in the morning to find [RCW 74.13.515] unresponsive. The referent reported that the mother's statements regarding the death were inconsistent, but no additional detail was provided by the referent. Law enforcement was present at the scene but did not place L.R.'s surviving sibling into protective custody. At the time of L.R.'s death, [RCW 7] lived with [RCW 7] mother and older sister. CA closed a Family Voluntary Services (FVS) case on September 19, 2017, after the mother completed services.

The Child Fatality Review Committee (Committee) included members selected from diverse disciplines within the community with relevant expertise including individuals from the Office of the Family and Children's Ombuds, a Court Appointed Special Advocate (CASA) as well as child welfare. There were two observers from CA. Neither the Committee members nor observers had previously been involved with or had contact with this family.

Prior to the review, each Committee member received a case chronology, a summary of CA involvement with the family and unredacted 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 relevant state laws and CA policies.

The Committee interviewed a Child Protective Services (CPS) supervisor, the FVS worker and the FVS worker's supervisor during the last round of FVS services.

<u>Family Case Summary</u>

The CA case history for this family includes ten intakes received between May 2010 and February 2013 pertaining to the mother's first child. The majority of allegations in those ten intakes were regarding [RCW 13.50.100]. On February 24, 2016, and June 8, 2016, CA received intakes

[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 near 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] L.R.'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-Revised Code of Washington 74.13.500(1)(a)]

regarding L.R.'s sister. The allegations in these two intakes included RCW 13.50.100 by the mother to RCW 13.50.100, concerns regarding the mother's RCW 13.50.100 as well concerns about the RCW 13.50.100.

There was a CPS investigation pertaining to the February 24, 2016, intake as to L.R.'s sister, which resulted in the mother agreeing to work voluntarily with CA. During the time that the FVS case was open the mother and L.R.'s sister RCW 13.50.100. There were multiple other service providers from other agencies working to support the mother and her child. The FVS worker referred the mother for Family Preservation Services (FPS).[3] After the completion of the FPS services the case closed in July of 2016.

Another intake was received on February 8, 2017. The intake alleged the mother was living with her two children, an RCW 74.13.515 old daughter and a RCW 74.13.515 old son, L.R. The allegations included neglect and lack of supervision. A CPS/Family Assessment Response (FAR) worker was assigned to complete an assessment.[4]

During that assessment, another intake was received on March 21, 2017. The intake alleged neglect, concerns for bed sharing and concerns that the mother is RCW 13.50.100 but noted the mother has had some appropriate interactions with the children and is working with a housing advocate. This intake was screened in for a CPS/FAR assessment.

On April 6, 2017, three more intakes were received. These intakes had new allegations of neglect including leaving her children unattended in the emergency shelter, bed sharing and RCW 13.50.100 of L.R.'s sister. Two of the intakes were screened in for CPS investigation.

The mother was referred to and engaged with FPS, housing advocates and was attending school. Collateral contacts provided positive feedback and did not identify any safety threats to the children. The mother failed to attend a family team decision making meeting but she did ultimately accept an offer to engage again in FVS.

There was a staffing to discuss whether it was appropriate to legally intervene and possibly remove the children. A determination was made that based on the mother's willingness to engage in voluntary services, that legal intervention was not appropriate at that time.

During the second round of FVS, another intake was received and screened out. The intake on June 1, 2017, did not provide any current allegations of child abuse or neglect and was therefore closed at screening. On September 19, 2017, CA closed the FVS case. Prior to the

[3] Family Preservation Services, http://apps.leg.wa.gov/RCW/default.aspx?cite=74.14C.010, Definitions (3)a, b, c

[4] Family Assessment Response (FAR) is a Child Protective Services (CPS) alternative response to an investigation of a screened-in allegation of child abuse or neglect. FAR focuses on child safety along with the integrity and preservation of the family when lower risk allegations of child maltreatment have been reported.

closure, the mother obtained independent housing, engaged in services with a public health nurse, was connected to Women Infants and Children (WIC), the children were up to date with medical care and the mother was involved with a local church for added support. Before the case was closed, the FVS worker discussed safe sleeping and risks of bed sharing with the mother on multiple occasions.

On October 16, 2017, CA received a call from the Medical Examiner's office indicating L.R. had passed away. The details surrounding the events of that evening were inconsistent. Law enforcement was notified and on scene but did not place L.R.'s sister in protective custody. CA RCW 13.50.100 for L.R.'s sister shortly after L.R.'s death, and the RCW 13.50.100 . She was RCW 13.50.100 .

Committee Discussion

For purposes of this review, the Committee mainly focused on case activity from the time L.R. was born until RCW 7 passed away. The Committee discussed the CA case file content prior to L.R.'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 L.R.

During the RCW 13.50.100 as to the mother's oldest child, there was mention of the mother having RCW 74.13.520 The Committee speculated that further assessment and corroboration regarding this medical condition may have assisted CA in understanding the mother's stability and ability to make adequate parenting decisions regarding her children. Fully understanding how untreated or inconsistent treatment of RCW 74.13.520 can affect the cognitive stability of a parent may be beneficial when assessing for child safety.

There was a discussion that CA should have made increased collateral contacts to include relatives, fathers of the children and sharing information with mental health providers. The Committee speculated that this may have provided a clearer understanding of the mother's needs regarding parent education and her ability to provide safe and adequate care for her children either independently or through a network of natural supports.

The Committee identified that the CA staff involved in this case provided good insight into what could have been done differently and had prepared well for the interviews. The professionalism, empathy and vulnerability shown by CA staff during this review was acknowledged by the Committee.

The Committee also identified that the FVS worker's continued discussion and education with the mother regarding safe sleep based on the eldest child's small size and bed sharing with the mother went above and beyond the expectations outline by CA's policies.

Findings

Based on the review of the case documents and interviews with staff, the Committee did not identify any critical errors that contributed to the death of L.R. The Committee did identify

missed opportunities within the assessment and case work with this family as well as a systemic barrier to consistent supervision and case practice.

The Committee discussed that the history relating to the care that L.R.'s mother provided to children born before L.R. was not consistently included in decisions made regarding the safety of L.R. and RCW 7 sister. Had full inclusion of the history been considered, CA staff may have identified the need for more in-depth collateral contacts and corroboration of information provided by the mother regarding concerns for substance abuse and mental health needs and how those interacted with the mother's ability to safely care for her children. The Committee noted that the mother's prior RCW 74.13.520 provided information regarding RCW 74.13.520 issues that were relevant to her ability to provide independent, safe care to children as well as RCW 13.50.100 that could inform future engagement and service needs for the mother. By not including historical information and utilizing curiosity regarding the pattern of information shared in prior intakes, the CPS interventions became incident focused.

After reviewing the records and listening to the staff interviews, it appeared as though staff believed the mother was trying hard to make positive changes in her life, and staff focused on providing in-home services and supports. There were some concerns about confirmation bias and the workers trying so hard to support keeping the children in the mother's care that prior history was given less weight than current impressions of the mother. Her desire to complete college, obtain independent housing and employment as well as the mother's presentation to staff led staff to conclude that the mother had made significant improvements and could safely parent.

The Committee also identified that the consistent turnover of staff within CA, including the office involved in this review, is a systemic barrier to consistent supervision for field staff. The Committee discussed how newer staff need guidance and mentoring from established staff and/or supervisors, and this cannot occur if CA continues to have such a high staff turnover. Without consistent supervision and with large spans of supervision, the Committee discussed how staff are often not afforded sufficient time to discuss their assigned cases, which can lead to more incident-focused assessments and investigation as well as missed opportunities to provide comprehensive assessments of child safety.

Recommendations

CA should consider developing a training for both Assistant Attorney Generals (AAG's) and field offices regarding legal sufficiency for intervention, identification of safety threats, CA's Domestic Violence Guide and how it directs staff to interact with families when domestic violence is alleged or identified. This training could be a joint endeavor between CA and the Alliance and delivered to all CA and AAG field offices.

CA headquarters and the AAG's headquarters office should consider creating a training regarding communication between the staff of each agency when staffing cases for legal sufficiency, preparing for testimony and presentation and expectations at dependency hearings.