Washington State Department of Social & Health Services

CA Children's Administration

Child Fatality Review

M.B.H.

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

June 29, 2016
Date of Fatality

October 20, 2016
Child Fatality Review Date

Committee Members
Mary Moskowitz, J.D., Senior Ombuds, Office of the Family and Children's Ombuds
Ralph C. Jefferson Jr., J.D., Juvenile Court Services Director, Lummi Nation
Stan Atkins, NCC-AP1 Chemical Dependency Professional, Stillaguamish Tribe
Jana Bouzek, Detective, Bellingham Police Department
Heidi Kennedy, M.S.W., Child Protective Services/Family Assessment Response Supervisor, Children's Administration

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

Facilitator
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Executive Summary

On October 20, 2016, the Department of Social and Health Services (DSHS), Children's Administration (CA) convened a Child Fatality Review (CFR)[1] to assess the department's practice and service delivery to RCW 74.13.515-old M.B.H. and RCW 74 family.[2] The child will be referenced by RCW 74 initials in this report.

On June 29, 2016, CA received an intake stating M.B.H. died while bed sharing with RCW 74 mother. The mother, father and M.B.H. stayed in a small travel trailer on the maternal grandmother's property. The mother awoke that morning and found M.B.H. unresponsive. Law enforcement was contacted. According to the police report, RCW 13.50.100 were located in the trailer as well. The medical examiner's report stated the death was an accident but a contributing factor may have been an unsafe sleep environment. The CPS investigation into the death was completed as unfounded for abuse or neglect and there were no criminal charges related to the incident.

At the time of the fatality, there was an open child protective services investigation involving M.B.H.'s RCW 13.50.100 who lives with the RCW 13.50.100 . There were no allegations of alleged abuse or neglect related to M.B.H. or RCW 74 next eldest half-brother.

Since RCW 74 discharge from the hospital after RCW 74 birth, M.B.H. lived with both of RCW 74 parents. However, RCW 7 was often cared for by other maternal relatives, mainly RCW 74 maternal grandmother. M.B.H. was healthy and up to date with RCW 74 medical care at the time of RCW 74 death.

The Review Committee included members selected from diverse disciplines within the community with relevant expertise including the Office of the Family and Children's Ombuds; and a Lummi Nation tribal member with employment experience in law enforcement, who previously worked as an attorney and is currently the director of juvenile court with the Lummi Nation. The Committee also included a chemical dependency professional who specializes in opiate

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

replacement therapies, a child abuse detective and a child protective services supervisor. There was also an observer who is a critical incident review specialist with CA. No Committee member or the observer had previous involvement with this family.

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

The Committee interviewed the previously assigned Family Voluntary Service worker (FVS)[3] and the CPS worker on the two most recent investigations and their supervisor.

Family Case Summary

The history involving M.B.H., RCW 74 siblings and parents includes allegations relating to the mother's history of RCW 13.50.100, including alleged RCW 74.13.520, RCW 74.13.520 and RCW 74.13.520 Also alleged, was RCW 13.50.100 by the parents and relatives where the parents have resided on and off with the children. There were a total of 10 intakes received prior to the fatality alleging RCW 13.50.100 and RCW 13.50.100 by the parents and relatives; RCW 13.50.100 by the mother's husband to the RCW 13.50.100, resulting in a criminal conviction; failure to comply with a RCW 13.50.100 between the RCW 13.50.100 and RCW 13.50.100; and RCW 13.50.10. There was one founded finding relating to the RCW 13.50.100 of the RCW 13.50.100 by the RCW 13.50.100

Due to the RCW 13.50.100 between the RCW 13.50.100 and RCW 13.50.100, the RCW 13.50.100 became a RCW 13.50.100 for the RCW 13.50.100. This arrangement has since become a permanent court order for placement and care.

The mother was involved with RCW 74.13.520 during the entire time she was pregnant and parenting M.B.H. The mother's husband also has a history of RCW 13.50.100 and began to receive RCW 74.13.520. At the time CA opened an investigation in March of 2015 for RCW 13.50.100 to the RCW 13.50.100, the parents were in compliance with their

[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]

RCW 74.13.520. However, the mother RCW 74.13.520 .

A risk only assessment was initiated at the time of M.B.H.'s birth. That assessment resulted in the opening of a FVS case that closed on March 25, 2016. During the FVS case, both parents remained in compliance with their RCW 74.13.520

At the time of the fatality, M.B.H. was cared for primarily by RCW 74 parents and maternal grandmother. The RCW 13.50.100 was in the temporary care of the RCW 13.50.100 and the RCW 13.50.100 was cared for on and off by the mother and RCW 13.50.100. The fathers for the RCW 13.50.100 were not involved in their care. M.B.H. and RCW 74 parents lived in a travel trailer near the maternal grandmother's home on the RCW 74.13.515.

The mother is an enrolled member of the RCW 74.13.515. M.B.H.'s father does not identify as Native American, nor does he claim any Native American heritage. During each investigation and throughout the life of the FVS case, CA worked closely with RCW 74.13.515 Tribal social workers. The collaboration between CA and the RCW 74.13.515 Nation was confirmed during interviews with Tribal child welfare staff.

Committee Discussion

For purposes of this review, the Committee mainly focused on case activity from the time M.B.H. was born until RCW 7 passed away. There was some discussion regarding history prior to RCW 74 birth and regarding the death investigation. There was significant discussion surrounding the family's RCW 13.50.100 issues and struggle with RCW 13.50.100. That coupled with the historical issues surrounding government child welfare involvement and how such involvement may be felt and perceived by tribal families can create a difficult path towards engagement between CA and tribal families.

The Committee discussed the work by the FVS worker to engage with the family and continue to gather collateral information. The worker faced resistance at times but balanced the resistance against the information she gathered, which indicated there was no imminent risk of harm to the children at the time she closed both cases.

CA staff often struggle with the idea of asking a parent to provide a urinalysis shortly after their child has passed away when there are allegations of parental substance abuse. However, it has been repeatedly recommended as best case practice to help provide proof that a parent may or may not have been under the influence at the time of the incident. A positive urinalysis alone is not enough to

conclude that child abuse or neglect has occurred; however, it is taken into consideration along with all of the other information gathered during an assessment. The Committee agreed with the CPS investigator and her supervisor that it would have been ideal to have obtained a urinalysis of both parents at the time of the fatality. The CPS investigator could not locate the parents until three days after the fatality. A urinalysis taken that far after M.B.H.'s death would not have been beneficial in assessing a parent's sobriety three days prior.

Findings

The Committee did not identify any findings related to missed opportunities or failure to adhere to CA policies. The Committee did identify positive practice by CA.

The Committee noted that FVS cases per policy are to remain open for 90 days. However, the Bellingham office identified that this family was in need of support beyond the 90-day closure date. There was an appropriate assessment and collaboration with the RCW 74.13.515 Nation and the case remained opened for an extended 90 days. It appeared to the Committee that all child welfare workers and the supervisor involved balanced the need for case closure and active efforts to ameliorate the need for future involvement with this family.