**RCW 74.13.640(d)**

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

# Department of Social and Health Services
# Children's Administration
# Child Fatality Review

**N.S.**

**March 2010**
Date of Child's Birth

**March 30, 2012**
Date of Child's Death

**August 15, 2012**
Child Fatality Review Date

**Committee Members:**
Tracey Goncalves, LICSW, Good Samaritan Hospital (Puyallup)
Andrea Ryker, M.S.N., B.S.N., R.N., Public Health Nurse Supervisor/Maternal Child Health, Tacoma-Pierce County Health Department
Nancy Shattuck, Domestic Violence Victim Advocate, Puyallup City Attorney's Office
Lori Linenberger, B.A., National Certified Addictions Counselor II, MOMS/Women's Recovery Center

**Medical Consultant to the Committee**:
Dr. Michelle Terry, M.D. Department of Pediatrics – University of Washington School of Medicine

**Observers:**
Victoria Bennett, LICSW, Children's Administration Supervisor, Pierce South Division of Children and Family Services
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**Executive Summary**

On August 15, 2012, the Department of Social and Health Services (DSHS), Children's Administration (CA) convened a Child Fatality Review[1] (CFR) to review the department's practice and service delivery to 2-year-old N.S. and his family whose Child Protective Services (CPS) investigation for alleged neglect had been closed nine months prior to the March 30, 2012 death of the child. On the day of his death the child's mother Aleesha Walker[2] called 911 to report she had killed her son. Tacoma Police Department (TPD) officers and emergency medical services (EMS) found the child unresponsive and without a pulse. The child was transported to Mary Bridge Children's Hospital where he was pronounced dead. The Pierce County Medical Examiner later determined the manner of death to be a homicide.

The CFR Committee included community members selected from diverse disciplines with relevant expertise, including representatives from public health, domestic violence advocacy, chemical dependency treatment and hospital social work. Representatives from the Office of the Family and Children's Ombudsman and local law enforcement were scheduled to participate on the committee but due to unanticipated circumstances were unable to attend. Although some committee members were aware of the fatality incident through various media reports, none had any previous direct involvement with the family.

Prior to the review each committee member received a summarized chronology of CA involvement with the family and non-redacted CA case documents (e.g., intakes, case notes, safety assessments, Child Protective Services investigative reports). Committee members also received a brief written summary by Dr. Michelle Terry, pediatric consultant to the committee, regarding the health care N.S. received during his life.

Supplemental sources of information and resource materials were made available to the committee at the time of the review. These included: (1) additional documents obtained post-fatality (e.g., N.S.'s medical records, Aleesha Walker's petition and granted Order for Protection from her estranged partner, initial police reports regarding the fatality incident); (2) CA practice guides relating to Child Protective

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

[2] The full name of Aleesha Walker is used in this report because she was charged with committing a crime related to this report of abuse investigated by DSHS. *See* RCW 74.13.500(1)(a).

Services (CPS) investigations, assessment of risk and safety and CA response to domestic violence; and (3) copies of state laws and CA policies relevant to the review.

During the course of the review the CPS investigator was not available for an interview. However, the CPS supervisor involved with the case was made available to the committee for interview.

Following review of the case file documents 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 2010 when CA's Child Protective Services (CPS) received an allegation of neglect regarding N.S's care. The intake was accepted for alternate intervention and referred to the local health department's Early Family Support Services (EFSS) program.[3] A Family Support Worker from a local Family Support Center (FSC) conducted a home visit with the mother and child and observed no signs of abuse or neglect. The Family Support Worker discussed available community services including parenting resources which the mother declined. The alternate intervention was closed in June 2010.

Eight months later on February 25, 2011, CA received a neglect report alleging unsanitary conditions in the home and concerns for possible intimate partner violence. Following a request by CPS for a child welfare check, local law enforcement went to the home and could not confirm any of the reported concerns. The subsequent CPS investigation resulted in an unfounded finding[4] regarding the allegations of negligent treatment of N.S. While the case was still active CA received an allegation that N.S. may have been exposed to a serious domestic violence (DV) incident[5]. Prior to CPS contact regarding the allegations, Aleesha Walker removed herself and her child from the domestic violence situation, connected with local DV services and filed a Temporary Order for Protection against her partner, N.S.'s father. The CPS investigation resulted in an unfounded finding due to lack of evidence that

[3] Children's Administration has an alternate intervention program for low risk and moderate low-risk families that are referred to Children's Administration. Where available, CA Intake can refer the family to a contracted alternate intervention, called Early Family Support Services (EFSS). *See DSHS/*CA Practice and Procedures Guide – Section 2332.

[4] "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).

[5] There is a high co-occurrence of domestic violence in cases of child abuse and neglect. However, a child's exposure to domestic violence, in and of itself, does not constitute child abuse and neglect. Domestic violence which physically harms a child or puts a child in clear and present danger would constitute an allegation of child abuse. *See* DSHS/CA Practices and Procedures Guide – Section 2220.

N.S. had been placed in clear and present danger[6] and due to Aleesha Walker prioritizing her child's safety by separating from the alleged DV perpetrator.

Prior to the CPS case closing at the end of June 2011, CPS received allegations of poor health and hygiene of the child and possible reuniting of Aleesha Walker with the alleged DV perpetrator. None of the allegations were confirmed and the mother and child were found to be living in a stable and protective environment. The investigator contacted the child's primary care physician and the mother's DV advocacy staff. They also did not support the reported alleged concerns. The case was closed.

Nine months later on March 30, 2012, two-year-old N.S. was killed and his mother arrested. A CPS investigation was initiated in collaboration with local law enforcement. The manner of death was ruled a homicide. The CPS investigation resulted in a finding of "founded for physical abuse" against the mother for causing the death of her son.

**Committee Discussion:**
Committee members reviewed and discussed the documented CA activities and decisions from the alternate intervention response in 2010 through the multiple CPS investigations conducted between February and June 2011. Committee discussions focused on CA policy, practice and system response to the family in an effort to evaluate the reasonableness of decisions made and actions taken by CA. In this way the committee considered case documentation, information provided on CA policy and interview responses from the CPS supervisor on expected practice (e.g., assessing domestic violence, mental health and substance abuse; considerations made for case closure). Review of post-fatality CPS activities was limited primarily to the information obtained by CA during the brief CPS fatality investigation in March 2012. Actions taken by non-CA agencies were briefly discussed but considered outside the scope of this review in terms of generating any findings or recommendations.

Given the fact that no information is known as to the situation of N.S. and his family for the nine months between CA case closure and his fatality, the committee found it difficult to derive any tangible conclusions. While there were no apparent critical errors in terms of decisions and actions taken during the CA involvement, the committee did find instances where additional social work activity could have been considered. However, the absence of these additional activities was found to have no reasonably discernible connection to the child's death. Thus the identified issues below serve as noted opportunities where improved practice may have been beneficial to the assessment of the family situation but were not found to be critical oversights.

[6] Negligent treatment is defined as "as act or a failure to act, or the cumulative effects of a pattern of conduct, behavior, or inaction that evidences a serious disregard of consequences of such magnitude as to constitute a clear and present danger to a child's health, welfare, or safety…" RCW 26.44.020(14).

**Findings:**

- While recognizing the fact that the CPS investigator made numerous collateral contacts during the investigations (e.g., referrer, relatives, the primary care physician, law enforcement, DV staff), several additional sources of information available at the time were not pursued. The worker did not contact some witnesses reported to have been present during domestic violence incidents. The worker did not seek clarification as to why the mother did not have care or custody of an older biological child and the worker might have considered contacting the custodial parent of that child. The worker might have considered doing follow up with the mother's mental health provider or at least seeking a release from the mother to contact the provider.
- In addition to questioning whether the worker had sufficient understanding of the mother's history of mental health issues, the committee raised doubt as to whether the worker adequately understood the domestic violence situation between N.S.'s parents. The worker appeared to be satisfied with the fact that the mother eventually sought DV services as evidence of child safety.
- Similarly, the potential impact of the mother's confirmed use of marijuana, in combination with her mental health history and domestic violence victimization, may not have been sufficiently understood by the worker. That is, the worker appeared to view substance abuse, mental health and domestic violence in isolation rather than as an interactive group of risk and safety factors.

**Recommendations:**

- Due to the high co-occurrence of domestic violence and child maltreatment and the importance of accurate assessment for child safety purposes, DV training for Children's Administration (CA) staff is recommended on an on-going basis as an adjunct to the CA Social Worker's Practice Guide to Domestic Violence.
- CA should incorporate the following practice issues into any future "Lessons Learned from Child Fatalities" presentations for CA staff: (1) making purposeful effort to find out why a parent does not have care and/or custody of other biological children, including making contact with the custodial parent or relative caregivers; (2) giving deliberate consideration to referring a marijuana using parent for substance abuse assessment when that parent has any past diagnoses for substance abuse/chemical dependency issues, especially if they co-occur with mental health and domestic violence issues.
- CA should consider exploring a "continuing education" requirement system whereby social work staff would be required to receive training on mental health, domestic violence and chemical dependency every few years rather than only offering optional training.