Washington State Department of Social & Health Services

CA Children's Administration

Child Fatality Review

S-I.H.

June 2008
Date of Child's Birth

December 30, 2013
Date of Child's Death

April 9, 2014
Child Fatality Review Date

Committee Members
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RCW 74.13.640

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Executive Summary

On April 9, 2014, 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 5-year-old S-I.H. and his family.[2] At the time of his death, S-I.H. lived with his mother, siblings and mother's boyfriend Tony Goodnow, Sr.[3] The incident initiating this review occurred on December 29, 2013, when S-I.H. sustained fatal injuries during a motor vehicle crash. S-I.H. was an unrestrained passenger in a vehicle driven by Tony Goodnow, Sr. who was allegedly under the influence of alcohol at the time. A month prior to the fatal incident CA had closed a child welfare services case following dismissal of dependencies on S-I.H. and his siblings in King County Juvenile Court.

The review Committee included members selected from disciplines within the community with relevant expertise from diverse disciplines, including mental health and chemical dependency, child advocacy, and public child welfare. No Committee member had previous direct involvement with the family or service providers.

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, investigative assessment tools and case notes). Supplemental sources of information and resource materials were available to the Committee at the time of the review. These included the current case files, relevant state laws, police reports, court documents, King County Family Treatment Court (KCFTC)[4] website material and CA policies.

The Committee interviewed one of the previous CA Family Treatment Court (FTC) case workers and the current supervisor of CA FTC. The current child welfare

[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] S-I.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)]

[3] Mr. Goodnow, Sr. is named due to his current criminal charges of Vehicular Homicide and Reckless Endangerment Domestic Violence.

[4] Family Treatment Court is an alternative to regular dependency court and is designed to improve the safety and well-being of children in the dependency system by providing parents access to drug and alcohol treatment, judicial monitoring of their sobriety and individualized services to support the entire family. [Source: http://www.kingcounty.gov/courts/JuvenileCourt/famtreat.aspx]

social worker for S-I.H.'s biological family was available for consultation had the Committee desired to speak with him.

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

Family Case Summary

The family came to the attention of CA in March 2005 resulting in an alternate response with the Early Intervention Program through public health. Over the course of seven years, CA received nine additional intakes regarding allegations of neglect and physical abuse, with repeated reported concerns regarding illicit drug use by the mother and that the children were exposed to domestic violence in the home. Of the five CPS investigations occurring during that period none resulted in a founded finding. Both CA services and community services (e.g., Early Family Support Services) were offered to the family, but the mother failed to engage. Independent of the department, Family Court became involved in July 2009 and a CASA (Court Appointed Special Advocate) became involved. According to documentation obtained by CA, the CASA made numerous recommendations to the court, including that the mother engage in mental health treatment to address domestic violence issues, submit to random urinalyses (UA),[5] and complete a chemical dependency assessment.

In October 2011, CA initiated a CPS investigation following reports of young children being left alone. The assigned social worker concluded contact with the family on October 26, 2011. According to the investigative assessment completed on January 22, 2012, there was no evidence to support the allegations of negligent treatment. Five days later King County Sheriff Deputies went to the family residence based on information about a convicted felon having access to weapons. At the home, deputies observed the mother and an adult male in the home to be in possession of illicit drugs and that the children were living in a neglectful environment. All adults in the home were arrested and S.-I.H. and his siblings were placed in protective custody. CA initiated dependency actions on the children, who were placed in out-of-home care, eventually in relative care. The allegations of neglect by the mother were determined to be founded[6] and the case was transferred to Child and Family Welfare Services (CFWS).

[5] Urinalysis - The testing of urine for illegal drugs, alcohol or other controlled substances.

[6] CA findings are based on a preponderance of the evidence regarding allegations of child abuse or neglect as defined in RCW 26.44.020, WAC 388-15-009, and WAC 388-15-011. Founded means 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. Unfounded means the determination that, following an investigation by CPS, based on available information, it is more

In May 2012, the mother subsequently was accepted into the King County Family Treatment Court (KCFTC), also known as drug court. While residing in the same sober living environment as Tony Goodnow, Sr., the mother became pregnant. In April 2013, S-I.H.'s biological father petitioned Juvenile Court for placement. A Family Team Decision Making meeting (FTDM) was held and it was agreed by all parties (including S-I.H.'s father) that it would be in the best interests of all the children to be returned to the care of their mother.[7] S.-I.H. and his siblings were returned to their mother's care on May 17, 2013, with in-home services provided by Homebuilders.[8]

At reunification, the mother was living with Tony Goodnow, Sr. Mr. Goodnow was asked to complete a waiver[9] process due to his criminal history which included burglary, assault, drug paraphernalia, and indecent exposure. A safety plan was put in place which directed all contact between Tony Goodnow, Sr. and the children to be supervised by the children's mother. Mr. Goodnow was asked to do random UA testing but failed to comply. The mother gave birth to her fourth child, Tony Goodnow, Sr.'s child, in August 2013. The dependency matters involving S-I.H. and his siblings were dismissed and the case was closed on November 20, 2013.

On December 29, 2013, Tony Goodnow, Sr. was alleged to be driving under the influence of intoxicants. S-I.H. was in the vehicle as was one of his siblings. The sibling was restrained but S-I.H. was not. Tony Goodnow, Sr. lost control of the vehicle and the vehicle hit a tree. S-I.H. was ejected from the car and incurred fatal injuries.

Committee Discussion

While the Committee's primary focus was on the actions and decisions made by the department during the period of the child's dependency (January 2012-November 2013), the entire CA history of involvement with the family was reviewed and discussed.

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likely than not that child abuse or neglect did not occur, or there is insufficient evidence for the department to determine whether the alleged child abuse did or did not occur. Inconclusive means that based on available information following an investigation, a decision cannot be made that more likely than not child abuse or neglect did or did not occur. Inconclusive as a finding option was discontinued for any CPS investigation occurring on or subsequent to October 1, 2008.

[7] Family Team Decision Making meeting (FTDM) is a meeting that occurs whenever a placement decision needs to be made. Typical participants include the parents, the child (as appropriate), relatives, family friends, neighbors, caregivers, community stakeholders, service providers, and Children's Administration social workers. The purpose of the meeting is to develop an appropriate course of action to keep the child safe by creating a detailed case plan.

[8] Homebuilders is a contracted intensive family preservation program through DSHS.

[9] As part of determining character, competence and suitability of prospective out-of-home caregivers and other individuals to have unsupervised access to children, Children's Administration (CA) is required to conduct background checks (including criminal history and Child Abuse and Neglect or CA/N history) pursuant to RCW 43.43, RCW 74.15.030, WAC 388-06 and PL 109-248. [Source: Children's Administration Operations Manual Section 5510]

The Committee spent considerable time reviewing Solution Based Casework (SBC),[10] the current practice mode of CA, as well as the CA Child Safety Framework,[11] and Sirita's Law.[12] These discussions served to provide an essential framework for looking at key aspects of CA policy, practice, and service delivery to the family in an effort to evaluate the reasonableness of decisions made and the actions taken by CA at reunification and prior to the fatality.

To a limited degree, the Committee also reviewed non-CA agency aspects of service delivery to the family. This included discussing the differences, depending on the county involved, for Juvenile Court CASAs or Guardians ad Litem (GAL) to request a parent or care provider to provide an unobserved UA on the spot. While such considerations are generally outside the scope and purpose of the CFR, they served to generate discussion on inter-agency collaboration including that between CA and KCFTC partners. The Committee suggested that CA consider initiating discussions with the CASA/GAL programs regarding their willingness and ability to request on demand UAs of parents involved in dependency actions.

The Committee inquired as to workload issues or other systemic barriers to meeting CA policies and practice expectations. When interviewed, the CA FTC supervisor indicated to the Committee that his worker's cases are capped at 12 per social worker, but FTC cases are unique due to significant travel time related to where the families are living, where children are placed, and multiple staffings and court hearings that are required.

[10] SBC is the over-arching framework for the theory and practice for social workers within DSHS/CA. The model seeks to: (1) prioritize partnership to ensure safety by building a consensus with the family and service providers around the primary safety and risk concerns, (2) locate the problem(s) within the everyday life of the family and identify the individual with the high risk behavior that led to maltreatment through an assessment, (3) help families identify cycles of maltreatment and utilize relapse prevention techniques to prevent further maltreatment, (4) develop co-constructed plans with the family that target the primary area of safety and risk by sorting out information into family and individual level objectives, (5) develop tasks to achieve outcomes that are skill-based and not just measured by compliance, and (6) celebrate and document even the smallest success and progress made by the family, and note when improvements have not been made.

[11] The Child Safety Framework is the foundation for assessing child safety throughout the life of a case. It looks for present and impending safety threats.

[12] Substitute House Bill 1333, also known as Sirita's Law, was passed into law in 2007. It requires the department to identify any persons who may act as a caregiver for a child in addition to the parent with whom the child is being placed and determine whether such persons are in need of any services in order to ensure the safety of the child, regardless of whether such persons are a party to the dependency. The department may recommend to the court and the court may order that placement of the child in the parent's home be contingent on or delayed based on the need for such persons to be engaged in or complete services to ensure the safety of the child prior to placement. If services are recommended for the caregiver, and the caregiver fails to engage in or follow through with the recommended services, the department must promptly notify the court.

Findings

Pre-fatality CPS Investigations

- As evidenced in statements made in the investigative assessment by the CPS social worker conducting investigations of two intakes in late 2005, there appears to have been over reliance on another CPS involved family on the caseworker's caseload to report any concerns about S-I.H.'s family.[13] As a protective factor and safety monitoring source, the Committee found such reliance to be questionable.
- Based on statements found in the April 2011 investigative assessment, which was completed three days into the investigation, the Committee believed the worker blamed the alleged child victim for the injuries she sustained and failed to accurately assess all the injuries sustained by the child. The Committee also found a lack of collateral contacts resulted in insufficient information that compromised an accurate assessment of child safety and findings of the investigation.
- For the CPS investigation initiated in October 2011, the Committee found a lack of sufficient collateral contacts and no indication in the investigative assessment that the worker was familiar with the family's extensive referral history and pattern of similar allegations over time. The Committee found the investigative activities to be insufficient and lacked the information needed for the social worker to assess child safety. Case practice would have been significantly enhanced had these been strengthened, particularly in regards to the decision to close the case. The Committee questioned how the circumstances within the home could have changed so drastically in such a short period of time from the conclusion of the CPS investigation and the placement of the children in protective custody by the King County Sheriff's Department that resulted in dependency of the children.

Reunification Decisions (prior to fatality)

- As noted previously, the Committee believed case decisions would have been significantly enhanced had workers and supervisors conducted a more thorough review of documented CA history and case file information that identified ongoing parental deficiencies. From this perspective, the

[13] The social worker shall complete an investigative risk assessment on all investigations of child abuse and neglect upon completion of the investigation within 60 calendar days of Children's Administration receiving the intake. [Source: CA Practices and Procedure Guide 2520] For reports of alleged abuse or neglect that are accepted for investigation by the department, the investigation shall be conducted within timeframes established by the department in rule. In no case shall the investigation extend longer than ninety days from the date the report is received, unless the investigation is being conducted under a written protocol pursuant to RCW 26.44.180 and a law enforcement agency or prosecuting attorney has determined that a longer investigation period is necessary. At the completion of the investigation, the department shall make a finding that the report of child abuse or neglect is founded or unfounded.[Source: RCW 26.44.030]

Committee was concerned that risks and child safety were not fully assessed as to the mother's partner, Tony Goodnow, Sr., prior to reunification. Had the workers known Tony Goodnow, Sr.'s history both as a child and as an adult, the department may have presented a more assertive argument in court with the support of the full FTC team to require compliance by Mr. Goodnow in services, such as UA testing.

- Although not documented in the report to the court, both the social worker and supervisor indicated to the Committee that the FTC team was, on more than one occasion, made aware of Tony Goodnow, Sr.'s failure to engage in requested random UAs. The Committee voiced concern about the lack of compliance given Mr. Goodnow's criminal history, history of substance abuse issues, lack of documented completion of chemical dependency treatment, cohabitation with a person who also struggled with sobriety, and the fact that he provided care for the children involved in a dependency action.
- With the understanding that most dependency cases are dismissed after six months of court supervision following a return home, the Committee felt this case would have warranted a request for extended court supervision and in-home services based on the lack of compliance with random UAs by Tony Goodnow, Sr., on the mother's continued use of prescribed narcotic pain medications (without required UA testing) following the birth of her fourth child, and concerns identified by in-home providers.
- The Committee identified working with a hospital at the time of a child's birth during an open dependency case as vital. Even if the baby being born is not be part of a legal dependency action as in this case, assessing the baby's health should have included discussions with hospital staff as to the newborn's health and requesting a UA for both mother and child soon after delivery.
- The Committee agreed it would have been appropriate for CA to persistently request a comprehensive psychological evaluation of the mother to assess the mother's capacity for safe parenting. This is based on the mother's documented lengthy history of aggression and mental health issues. The Committee believed that consideration for reunification necessitated the worker having a clear understanding of the mother's mental health issues and sharing such information with the CA FTC team members involved in the case. Case file documents regarding her mental health treatment during the dependency process were extremely limited. The Committee believed the worker should have attempted to obtain more detailed reports from the mother's mental health treatment provider as to the treatment plan, treatment goals, and how progress was being defined.

When interviewed, the CA staff stated they did not believe there should have been more detailed information sought as the parent had a right to privacy and that privacy aided a more positive client practitioner relationship. While recognizing rights of privacy of the parent, the Committee felt the provider, who was contracted by CA, should have provided a more detailed written report and that the one session a month was questionable in assessing compliance and progress by the mother.

<u>System Issue – Drug Court</u>

- The Committee found the limited reliance on drug court related shared planning; at the expense of other resources such as CPT (Child Protection Team)[14] or SBC staffing, limited critical thinking regarding case planning for this family and resulted in a singular groupthink[15] mentality focused on the FTC team preferred positive and supportive outcomes. That is, drug court teams in general may be predisposed towards only a parent's sobriety and fail to recognize a wider perspective that includes more global considerations regarding safe parenting that would balance support with accountability.

Recommendation

- The Committee recommends CA discuss the concern of groupthink and the possible pitfalls of such, with CA staff who participate on drug court teams across the state.

[14] Child Protection Teams provide confidential, multi-disciplinary consultation and recommendations to the department on cases where there will not be an FTDM, and there is a risk of serious or imminent harm to a young child and when there is dispute if an out-of home placement is appropriate. [Source: Children's Administration Practices and Procedures Guide 1740]

[15] Groupthink is unquestioning conformity: conformity in thought and behavior among the members of a group, especially an unthinking acceptance of majority opinions [Source: Bing Dictionary]