Report to the Legislature

Quarterly Child Fatality Report

RCW 74.13.640

January – March 2016

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Washington State Department of Social & Health Services

TABLE OF CONTENTS

Executive Summary 3
A.O. Child Fatality Review 7
K.R. Child Fatality Review 15
L.H. Child Fatality Review 22
D.L. Child Fatality Review 26

Executive Summary

This is the Quarterly Child Fatality Report for January through March 2016 provided by the Department of Social and Health Services (DSHS) to the Washington state Legislature. RCW 74.13.640 requires DSHS to report on each child fatality review conducted by the department and provide a copy to the appropriate committees of the legislature:

> ***Child Fatality Review — Report***
>
> *(1)(a) The department shall conduct a child fatality review in the event of a fatality suspected to be caused by child abuse or neglect of any minor who is in the care of the department or a supervising agency or receiving services described in this chapter or who has been in the care of the department or a supervising agency or received services described in this chapter within one year preceding the minor's death.*
>
> *(b) The department shall consult with the office of the family and children's ombudsman to determine if a child fatality review should be conducted in any case in which it cannot be determined whether the child's death is the result of suspected child abuse or neglect.*
>
> *(c) The department shall ensure that the fatality review team is made up of individuals who had no previous involvement in the case, including individuals whose professional expertise is pertinent to the dynamics of the case.*
>
> *(d) Upon conclusion of a child fatality review required pursuant to this section, the department shall within one hundred eighty days following the fatality issue a report on the results of the review, unless an extension has been granted by the governor. A child fatality review report completed pursuant to this section is subject to public disclosure and must be posted on the public web site, except that confidential information may be redacted by the department consistent with the requirements of RCW 13.50.100, 68.50.105, 74.13.500 through 74.13.525, chapter 42.56 RCW, and other applicable state and federal laws.*
>
> *(2) In the event of a near fatality of a child who is in the care of or receiving services described in this chapter from the department or a supervising agency or who has been in the care of or received services described in this chapter from the department or a supervising agency within one year preceding the near fatality, the department shall promptly notify the office of the family and children's ombuds. The department may conduct a review of the near fatality at its discretion or at the request of the office of the family and children's ombuds.*

In April 2011, SHB 1105 was passed by the legislature and signed into law by Governor Gregoire. The revised child fatality statute (RCW 74.13) became effective October 22, 2011 and requires the department to conduct fatality reviews in cases where a child death is suspected to be caused by abuse or neglect. This eliminated conducting formal reviews of accidental or natural deaths unrelated to abuse or neglect. The revised statute requires the department to consult with the Office of Family and Children's Ombuds (OFCO) if it is not clear that the fatality was caused by abuse or neglect. The department can conduct reviews of near-fatalities or serious injury cases at the discretion of the department or by recommendation of OFCO. The statutory revision allows the department access to autopsy and post mortem reports for the purpose of conducting child fatality reviews.

This report summarizes information from completed reviews of seven (7) child fatalities and one (1) near-fatality that occurred in the first quarter of 2016. Two (2) of the fatality reviews did not meet the statutory requirement for a full review by a committee of community professionals. The deaths of the children in these cases were concerning though not attributed to abuse or neglect. The reviews were done at the request of the regional administrator and included only Children's Administration staff. The reports from reviews are not subject to public disclosure and are not posted on the public website. All other child fatality review reports can be found on the DSHS website: https://www.dshs.wa.gov/ca/publications/childrens-administration-child-fatality-reports

The reviews in this quarterly report include child fatalities and near fatalities from two regions.

Region	Number of Reports
1	4
2	3
3	0
Total Fatalities and Near-Fatalities Reviewed During 1st Quarter 2016	7

This report includes Child Fatality Reviews conducted following a child's death that was suspicious for abuse and neglect and the child had an open case or received services from the Children's Administration (CA) within 12 months of his/her death or injury. A critical incident review consists of a review of the case file, identification of practice,

policy or system issues, recommendations and development of a work plan, if applicable, to address any identified issues. A review team consists of a larger multi-disciplinary committee including community members whose professional expertise is relevant to the family history. The review committee members may include legislators and representatives from the Office of the Family and Children's Ombuds.

The charts below provide the number of fatalities and near-fatalities reported to CA and the number of reviews completed and those that are pending for calendar year 2016. The number of pending reviews is subject to change if CA discovers new information through reviewing the case. For example, CA may discover that the fatality or near-fatality was anticipated rather than unexpected, or there is additional CA history regarding the family under a different name or spelling.

Child Fatality Reviews for Calendar Year 2016			
Year	Total Fatalities Reported to Date Requiring a Review	Completed Fatality Reviews	Pending Fatality Reviews
2016	2	0	2

Child Near-Fatality Reviews for Calendar Year 2016			
Year	Total Near-Fatalities Reported to Date Requiring a Review	Completed Near-Fatality Reviews	Pending Near-Fatality Reviews
2016	6	0	6

Three (3) of the five (5) child fatality reviews referenced in this Quarterly Child Fatality Report are subject to public disclosure and are posted on the DSHS website. https://www.dshs.wa.gov/ca/publications/childrens-administration-child-fatality-reports.

Two (2) child fatalities did not meet the statutory requirement for a review. Children's Administration decided to conduct reviews of these two child fatalities. The reviews were held after consulting with the Office of the Family and Children's Ombuds and a representative from OFCO attended both reviews. The reports of these child fatality reviews are not subject to public disclosure and are not included in this quarterly report.

Near-fatality reports are not subject to public disclosure and are not posted on the public website nor are the reports included in this report.

Notable First Quarter Findings

Based on the data collected and analyzed from the six (6) fatalities and one (1) near-fatality during the 1st quarter, the following were notable findings:

- Five (5) of the seven (7) cases referenced in this report were open at the time of the child's death or near-fatal injury.
- Five (5) of the child fatalities referenced in this report occurred when the children were under 2 years of age.
- Five (5) of the six (6) fatalities occurred on open cases.
- Two (2) fatalities were the result of abuse or neglect.
- In four (4) of the six (6) fatalities, the cause of death is Sudden Infant Death Syndrome (SIDS) or Sudden Unexplained Infant Death (SUID). All of these four fatalities were the result of infants in unsafe sleep environments.
- One (1) child fatality was coded as homicide by a medical examiner. This child died from blunt force trauma to the abdomen. The perpetrator was the father's live-in girlfriend.
- Five (5) children were Caucasian and one (1) was Native American and one (1) was Hispanic.
- Children's Administration received intake reports of abuse or neglect in all seven (7) cases prior to the death or near-fatal injury of the child. Of the seven (7) cases, five (5) had three (3) or less intakes reported to CA prior to the critical incident, one had four (4) prior intakes. A fatality case had 9 intakes reported to CA prior to the child fatality.
- Two fatality cases did not meet the statutory requirement for a review. The investigations by police and CPS into the children's deaths did not result in a finding or criminal charge against a parent or caregiver. In both cases, the children died in unsafe sleep environments. There were concerns with the actions taken on the cases and a decision was made to conduct internal reviews with only Children's Administration staff and a representative with OFCO. OFCO was consulted on the decision to review these cases and agreed with this decision. The CA staff on the review committee had no prior involvement with the case and were selected from offices outside the county where the case originated.
- Due to the small sample of cases reviewed, no statistical analysis was conducted to determine relationships between variables.

Child Fatality Review
A.O.

December 2010
Date of Child's Birth

August 18, 2015
Date of Fatality

December 3, 2015
Child Fatality Review Date

Committee Members
Jenna Kiser, MSW, Safety Program Manager, Children's Administration
Steven Bryant, MA, Supervisor, Children's Administration, Pend Oreille County
Cristina Limpens, MSW, Senior Ombuds, Office of the Family and Children's Ombuds
Brian Hamond, Detective, Spokane Police Department
Annabelle Payne, LICSW, CMHS, Director, Pend Oreille County Counseling Services
Mikki Hill, Public Health Nurse, Spokane Regional Health District
Michelle Cutlip, MSW, Practice Coach, The Alliance for Child Welfare

Observers:
Krisana Shrable, MA, Supervisor, Children's Administration, Okanogan County
Sonya Stevens, MA, Licensing Analyst, Department of Early Learning, Eastern Service Area

Facilitator
Susan Danielson, Critical Incident Case Review Specialist, Children's Administration

Executive Summary

On December 3, 2015, The Department of Social and Health Services Children's Administration (CA) convened a Child Fatality Review[1] (CFR) to examine the department's practice and services delivery to four-year-old A.O.[2] and her family. The incident initiating this review occurred on August 18, 2015 when the motor home in which A.O. and her mother were living caught fire. This motor home is located on the property of the deceased child's grandmother in ██████, Washington. At the time of the fatality, CA had an open Child Protective Services (CPS) investigation on this family. A.O. has two siblings who were not involved in the fire and a half-sibling, ███., who lives with her father and who was not part of this investigation. *RCW 13.50.100*

The CFR committee included members selected from disciplines within the community with relevant expertise including representatives from law enforcement, community mental health and chemical dependency treatment, public health, child welfare, the Office of the Family and Children's Ombuds and Children's Administration. Neither CA staff nor any committee members had previous direct involvement with the case management.

Prior to the review, each committee member received a case chronology, a family genogram, a summary of CA involvement with the family and un-redacted case documents including intakes, case notes and assessments, police reports and evaluations. Supplemental sources of information and resource material regarding caseload data and CA policies were available to the committee at the time of the review.

The Committee interviewed the CPS supervisor and investigator who were assigned to the case at the time of the fatality as well as the CPS supervisors who supervised the case in 2014 and after the fire in August 2015. Following a review of the case file documents, interviews with CA staff and discussion regarding department activities and decisions, the Committee made findings and recommendations which are detailed at the end of this report.

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[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 the 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 I the function or purpose of a Child Fatality Review to recommend personnel action against DSHS employees or other individuals.

[2] A.O.'s parents are not identified by name 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 management and information system. The names of A.O.'s siblings are subject to privacy law. [Source: RCW 74.13.500(1)(a)]

Case Summary
This family's history with CA began in 2002 after CA received a report that alleged neglect of M.O.'s oldest child. CA received three additional intakes between 2005 and 2009; in 2007 a dependency was initiated on RCW 13.50.100 oldest daughter 13.50.100., after RCW 13.50.100 was RCW 10.97.050 The dependency was dismissed when 13.50.100 father obtained custody. In 2009, RCW 13.50.100 engaged in voluntary services with the department to address substance abuse and parenting skills issues. From 2012 until 2014, CA received six intakes regarding 13.50.100., A.O. and 13.50.100 alleging substance abuse, lack of supervision and unsanitary living conditions. CA investigators made several attempts to engage RCW 13.50.100 in services throughout this period but she declined to participate. The case was staffed with an Assistant Attorney General (AAG) during this period but no legal action was initiated.

In June 2014, CA received an intake from a citizen who found A.O. and 13.50.100walking alone along US Highway 2 near Elk, Washington attempting to flag down cars. The CPS investigator visited the home to discuss the lack of supervision and was told by 13.50.100 that this was an isolated event. The investigator offered 13.50.100 assistance to obtain housing but the mother declined help and soon moved to the grandmother's home in Chattaroy where she reported sleeping in a motor home in the yard. A decision was made to close the case but prior to closure CA received another intake from law enforcement alleging lack of supervision of 13.50.100 and A.O. Specifically, law enforcement received a complaint on September 29, 2014 that 13.50.100 and her older children were seen at local car racetrack. 13.50.100 appeared to be passed out and her children were unsupervised and had nearly been struck by cars in the pit area of the track. Police responded to the complaint, RCW 10.97.050 released A.O. and 13.50.100 to a family friend. When the CPS investigator made contact with 13.50.100 she denied being under the influence or that her children were in danger. She agreed to do a urinalysis but failed to appear for the appointment. The case was staffed with an AAG but no legal action was initiated.

The case remained closed until June 9, 2015 when a family friend reported 13.50.100 had left her children with their aunt and grandmother for the past six months and further reported that the grandmother was a hoarder whose residence was not safe for young children. The referrer reported that the grandmother had left the youngest child, 18-month-old 13.50.100., in the referrer's care after the child had received two black eyes due to unsafe conditions in the grandmother's home. The referrer said that she did not have the financial means to take care of the child or the authority to seek medical care. This intake was initially assigned as a Family Assessment Response (FAR)[3] CPS case

[3] Family Assessment Response (FAR), is a Child Protective Services response to a screened-in allegation of abuse or neglect that focuses on the integrity and preservation of the family when less severe allegations of child

but in an initial case staffing the assigned worker and supervisor concurred that the mother's history of resistance to CA intervention did not make this an appropriate case for the FAR program. Consequently, the case was assigned as an investigative case.

Because the assigned investigator was on annual leave, a co-worker made the initial contact with 13.50.100 at the referrer's home on June 11, 2015. Though the child no longer had visible injuries, credible witnesses reported that a month earlier 13.50.100 had two black eyes. The following evening an afterhours social worker made an initial visit to the grandmother's home, saw the other children and documented concerns about safety both inside and outside of the house. The grandmother and aunt presented themselves to the social worker as the children's primary caregivers and said they had regular contact with 13.50.100

The assigned investigator held a Family Team Decision-Making Meeting[4] (FTDM) on June 17, 2015 to develop a case plan and help assess the family's situation. The grandmother and aunt participated by phone, as did A.O.'s father. The mother did not attend. During the meeting a plan was developed that stated the social worker would assess the conditions in the grandmother's home and the relatives were to complete background checks, take the children to their doctor and supervise them when out of doors.

The day after the FTDM the CPS investigator attempted to assess the grandmother's residence but was met at the driveway by the grandmother and aunt. The grandmother stated that she didn't want to work with CA to make the home safe so she, the aunt and children had moved to a neighbor's home. The investigator observed the neighbor's home and found no safety hazards. The investigator left the residence with the understanding that the relatives and all three children would remain at the neighbor's house and they would complete criminal background checks with the department. Over the next month, the investigator made several unsuccessful attempts to locate the mother through letters and phone calls.

On August 21, 2015, local media reported that A.O. and her mother had died in a fire at the motor home on the grandmother's property. Both mother and child had been sleeping in the motor home when it caught fire, killing them both. 13.50.100 other children were reportedly inside the grandmother's house at the time and were not injured. The department filed a motion to take the surviving children into protective custody and on September 4, 2015 the aunt turned them over to law enforcement. Law

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maltreatment have been reported. Parental engagement and collaboration with CA are essential to the FAR pathway. [Source: CA Practices and Procedures Guide 2332]

[4] Family Team Decision-Making (FTDM) meetings bring people together who are involved with the family to make critical decisions regarding the removal of a child from their home, changes in out-of-home placement, and reunification or placement into a permanent home. [Source: CA Practices and Procedures Guide 1720]

enforcement placed the children into care. 13.50.100 is now in his father's custody and 13.50.100 is in foster care.

Committee Discussion

The majority of Committee discussion centered on CA case activities and decision making that occurred during the investigations in 2014 and 2015. Some discussion occurred as to earlier CA involvement in order to understand the case history and earlier efforts by the department to engage the mother in services. At the completion of the review of the case file documents, staff interviews and discussions regarding CA activities and decisions, the Committee found no critical errors by the department. However, the Committee did identify opportunities where additional reasonable actions by the social worker might have served to enhance the assessment of child safety.

The Committee noted several areas of strength. Committee members felt that the decision to assign the case to CPS investigation rather than CPS-FAR demonstrated good practice and a sound recognition that the more collaborative approach with a CPS-FAR case was not appropriate for this situation. The Committee commended the worker for insisting on assessing the conditions of the grandmother's home herself as well as her recognition of the need to assess the physical conditions in the neighbor's home and request background checks. The Committee also noted that the case notes were well written and easy to follow.

Some initial discussion occurred about CA protocol regarding collaboration with law enforcement on investigations of alleged child abuse and neglect. Though the expectation of notice to law enforcement is clear in cases of alleged physical abuse and sexual abuse, CA staff seemed unaware of the possibility of collaboration with law enforcement in cases of chronic neglect. The Committee noted that it may be helpful to involve law enforcement in investigations when there is a pattern of chronic neglect and this is included as a practice recommendation at the end of this report.

The Committee spent some time discussing the Child Safety Framework,[5] which requires the social worker to gather comprehensive information about family functioning in order to assess safety and risk. As a systems issue, the Committee believed there is additional need for training and clarification about the worker's responsibility when they are faced with complex family arrangements and multiple caregivers in a household. For example, the June 2015 intake identified the mother as the caregiver and subject of the investigation. However, the relatives' statement that they had been

[5] In partnership with the National Resource Center for Child Protective Services (NRCCPS), Washington State 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.

the primary caregivers for the children for several months may have given rise to a need to evaluate the relatives' parental capacities in addition to the mother's for the purpose of more comprehensively assessing child safety. The Committee believed that the June 2015 intake raised questions about the relative's judgment after they left 13.50.100 who was injured at the time, in the care of someone who did not have the means or legal authority to fully provide for or seek medical treatment for this child.

The Committee recognized that this was a complex case with multiple caregivers, multiple parents, and several prior interventions by the department. Because of the complexity of the case, the Committee believed that the social worker may have benefitted from gathering additional information from collateral sources as well as the historic CA file in order to gain insight into family functioning and possibly to gain insight that could help assess the relatives' capacity to protect the children. The Committee recognized that the relatives professed a willingness to reside at a neighbor's home to ensure the children were safe but felt that this temporary arrangement did not effectively alter the family dynamics or provide any protection for the children from their mother if and when she resumed her parental role. The Committee believed that best practice would be to fully assess the relatives' protective capacity and formalize the arrangement to clearly state the department's expectation that they were to remain in the neighbor's home and supervise contact with the mother until more information was gathered to assess the situation.

The Committee expressed concern about several systems issues that arose during the discussion. Specifically, they learned that this unit is generally assigned to CPS-FAR cases and that they were handling this case to assist the CPS investigations unit, which was experiencing a staff shortage. As a result, this complex case was assigned a worker with relatively little experience conducting CPS investigations. The Committee appreciated the teamwork in sharing workload among units to meet the department's mission. However, it also acknowledged that not every worker is an expert in every program and when a worker is assigned to a case that is out of his or her primary area, there is an increased need for strong clinical supervision to provide the social worker with expertise to help ensure the thoroughness of investigations.

Findings

1. Child Safety Framework: The Committee believes that insufficient information was gathered to do a comprehensive assessment of child safety. The investigation appeared to be incident-focused and did not include a comprehensive assessment of all children and adults in the household.
    a. The Committee could not find documentation that comprehensive interviews occurred with the children and the adult caregivers regarding

the specific allegations, the family dynamics or the cause of the youngest child's injuries.

  b. The Committee believed that given the potential seriousness of the youngest child's injuries, a medical assessment was warranted. Though the relatives were asked to take all the children for well-child exams, CA did not follow through to ensure this had occurred or seek information from medical providers to specifically assess this child for injury.
  c. The Committee believed there were missed opportunities to gather and document additional information from collateral sources such as local police reports, TANF records and historic reports in the family file.
  d. The Committee felt that the plan developed at the FTDM could have enhanced child safety by including provisions for ongoing monitoring and re-evaluation of the family's compliance with the plan.

2. Health and Safety Visits: The children in the household did not receive private, individual, face-to-face health and safety visits every calendar month as is required when the case has been open beyond 45 days.
3. Supervision: Though monthly supervisory reviews were documented as having occurred regularly and timely, the content lacked clinical direction to provide guidance, critical thinking and feedback to ensure a thorough and timely investigation of the allegations.

Recommendations

1. The Committee recommended that the department continue to provide training on the Child Safety Framework specifically aimed at assessing child safety. The Committee identified the need for training on the mechanics of childhood injuries, the importance of gathering information throughout the life of a case and guidance about how to assess caregivers when there are multiple adults in a caregiving role in the household.
2. Noting that one of the challenges in this case was that the relatives did not cooperate with efforts to conduct background checks, the Committee recommended that the department expand worker access to databases like LexisNexis so that more workers can use this to assess caregivers in cases where program restrictions do not allow access to NCIC.[6]
3. In cases where there is extensive history indicating neglect, the Committee recommended that CA consider collaborating with local law enforcement for consideration of criminal charges of child neglect.

[6] The National Crime Information Center (NCIC) database is a name and date-of-birth based national database of criminal history information operated by the Federal Bureau of Investigation (FBI). Children's Administration is authorized to access this database only for limited purposes: to ensure worker and child safety in CPS investigations, and for emergency placement in out-of-home care.

4. The Committee recommended that this unit receive training on how to access historic CA case information in MODIS.[7] Note: Action has already been taken on this identified training need for this unit.

[7] Management Operation Document Imaging System (MODIS) is CA's electronic archival storage system. All closed cases are uploaded to MODIS and available to workers.

Child Fatality Review
K.R.

June 2015
Date of Child's Birth

August 25, 2015
Date of Fatality

January 21, 2016
Child Fatality Review Date

Committee Members
Patrick Dowd, Director, Office of the Family and Children's Ombuds
Meg Gallagher, RN, Whitman County Health Department
Molly Rice, Child Protective Services Program Manager, Region One
Cameron Norton, CPS Supervisor, Children's Administration, Spokane
Lori Eastep, MSW, LICSW, Grassroots Therapy Group
Pete Martin, Whitman County Coroner

Observer
Paul Smith, Critical Incident Practice Consultant, Children's Administration

Facilitator
Susan Danielson, Critical Incident Review Specialist, Children's Administration

Executive Summary

On January 20, 2016, the Department of Social and Health Services Children's Administration (CA) convened a Child Fatality Review[8] (CFR) to examine the Department's practice and service delivery to eleven-week-old K.R.[9] and her family. The event precipitating this review occurred on August 26, 2015 when K.R.'s mother, RCW 13.50.100 found K.R. unconscious and unresponsive in her bed. Emergency personnel who responded to the parents' 911 call were unable to resuscitate the child. RCW 13.50.100 and her partner, RCW 13.50.100., reported they had placed K.R. in an infant bouncer chair on their bed the night before and during the night she had fallen out of the chair landing face-down on the bed. The cause of death was listed as Sudden Unexpected Infant Death (SUID),[10] with risk factors related to sleeping conditions. At the time of RCW 13.50.100.'s death the family had an open Family Voluntary Services (FVS)[11] case. There are four older surviving children in the home.

The CFR committee was comprised of Children's Administration staff, a representative from the Office of the Family and Children's Ombuds and community members with expertise in public health and family therapy. Neither CA staff nor any committee members had direct involvement with the family prior to the critical incident.

Prior to the review each committee member received a case chronology, a family genogram, a summary of CA involvement with the family and un-redacted case documents including intakes, case notes and assessments, police reports and evaluations. Supplemental sources of information and resource material regarding

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[8] 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 the 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.

[9] K.R.'s parents are not identified by name 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 management and information system. The names of K.R.'s siblings are subject to privacy law. [Source: RCW 74.13.500(1)(a)].

[10] SUID: The United States Centers for Disease Control (CDC) defines SUID as "Deaths in infants less than 1 year of age that occur suddenly and unexpectedly, and whose cause of death are not immediately obvious prior to investigation." According to the CDC, the 3 most frequently reported causes of SUID are SIDS, Unknown, and ASSB (accidental suffocation and strangulation in bed). [Source: Centers for Disease Control and Prevention]

[11] 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 mange child safety. Continuous assessment of child safety occurs throughout the case. [Source: CA Practices and Procedures Guild 2440]

caseload data and CA policies were available to the Committee at the time of the review.

The Committee interviewed the CPS supervisor and social worker who were assigned to the case at the time of the fatality. Following a review of the case file documents, interviews with CA staff and discussion regarding department activities and decisions, the Committee found no critical errors by the department but made findings and recommendations which are detailed at the end of this report for purposes of practice improvement.

Case Overview

This family has an extensive history with Children's Administration dating back to 2006 when RCW 13.50.100 oldest child, RCW 13.50.100 was born. Between 2006 and 2009, CA investigated three intakes alleging substance abuse, domestic violence and negligent treatment by RCW 13.50.100 None of these investigations resulted in founded findings. In 2013, the department screened in four intakes alleging abuse and neglect of RCW 13.50.100 children centering on lack of supervision, substance abuse in the home, lack of stability and negligent treatment. These investigations were unfounded.

In July 2014, CA received an intake from law enforcement alleging that RCW 13.50.100 was in a conflict RCW 13.50.100 and was so inebriated she was unable to take care of her children. A second intake received the next day alleged that RCW 13.50.100 had assaulted her oldest daughter, RCW 13.50.100 causing her to "see stars." A CPS investigator made a determination that the children were not safe and developed a safety plan with the family. The family was referred for Family Preservation Services (FPS) to address family conflict and safety concerns in the home. During August, September and October 2014, CA received four more intakes alleging lack of supervision, substance abuse and domestic violence between RCW 13.50.100 and her partner RCW 13.50.100 Though these intakes were not accepted for investigation, the investigator met with RCW 13.50.100 to discuss the allegations and try to engage the family in services. The investigator was not able to engage the family in services and the investigation closed in November 2014 after the case was reviewed by the Child Protection Team.[12] RCW 13.50.100 was given a founded finding for negligent treatment of all four of her children based on the July 2014 intake. Shortly after the case was closed, an anonymous source reported concerns that RCW 13.50.100 was pregnant, using RCW 13.50.100 and leaving her children with a variety of caregivers. This was not accepted for investigation.

The case was reopened in January 2015 after CA received two intakes alleging physical abuse and negligent treatment of her older two children. The intakes also alleged

[12] Child Protection Teams provide confidential, multi-disciplinary consultation and recommendations to the department on cases where there will be an FTDM and there is a risk of serious or imminent harm to child under the age of 6 as to whether an out-of-home placement is appropriate. [Source: CA Practices and Procedures Guide 1740]

substance abuse in the home and domestic violence between RCW 13.50.100 and RCW 13.50.100 A new CPS investigator was assigned and held a Family Team Decision-Making Meeting[13] (FTDM) to discuss the allegations and assess the need for out-of-home placement. The FTDM was attended by RCW 13.50.100. and RCW 13.50.100. as well as members of the extended family, CA staff and service providers. At the FTDM, RCW 13.50.100 and RCW 13.50.100 agreed to participate in random urinalysis and Intensive Family Preservation Services (IFPS);[14] they agreed to cooperate with ongoing, regular monitoring by the department. Both parents RCW 13.50.100 and indicated they were not willing to change this habit.

In March 2015, the investigator authorized Family Preservation Services (FPS)[15] to provide ongoing services in the home. In April 2015, RCW 13.50.100

Though RCW 13.50.100 did not perceive herself as a RCW 13.50.100, the social worker referred her to a domestic violence advocacy center so that she could gain insight into the dynamics of domestic violence and the impact it could have on her family. The social worker met regularly with the family between March and May 2015 and attended several of their family sessions with their FPS provider. Though both parents were authorized to have regular urinalysis, RCW 13.50.100 participated minimally and RCW 13.50.100 did not participate at all. The results of RCW 13.50.100 positive RCW 70.02.0200

In May 2015, CA received an intake alleging that RCW13.50.100 had missed several scheduled prenatal appointments. This intake was not accepted for investigation though the investigator addressed the allegations with RCW13.50.100. who explained that lack of transportation impacted her ability to attend the appointments. In preparation for the new baby's birth, the social worker and family therapists met with RCW13.50.100 to prepare for the new baby's birth. The social worker collaborated with RCW 42.56.230 (5) for the home.

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[13] Family Team Decision Making (FTDM) meetings bring people together who are involved with the family to make critical decisions regarding the removal of a child from their home, changes in out-of-home placement, and reunification or placement into a permanent home. [Source: CA Practices and Procedures Guide 1720]

[14] Intensive Family Preservation Services (IFPS) are short-term, family-based services designed to assist families in crisis by improving parenting and family functioning while keeping children safe. IFPS is generally authorized for 30 days. [Source: CA Practices and Procedures Guide 4502]

[15] Family Preservation Services (FPS) are short-term, family-based services designed to assist families in crisis by improving parenting and family functioning while keeping children safe. FPS is aimed at preventing out of home placements for children and is generally authorized for a limited period. [Source: CA Practices and Procedures Guide 4502]

The RCW 42.56.230 (5) worker agreed to meet regularly with the family to monitor the situation and assist the family in accessing services.

When K.R. was born in June 2015, hospital staff contacted CA to report concerns about RCW13.50.100's daily use of RCW 70.02.020 and her admission that she had used RCW 70.02.020 early in her pregnancy. A RCW 70.02.020 test done at K.R.'s birth was positive for RCW 70.02.020. RCW 70.02.020 but released her on June 12, 2015, noting that K.R. was in good health. Following K.R.'s release from the hospital, the family continued to work with their FPS provider, the DSHS financial worker and CA staff. The investigator visited the family home weekly and spoke with the family at each visit about the importance of a safe sleep environment for the baby. In August 2015, the family completed FPS. The social worker notified the family that their case would close noting that their situation had stabilized and that they were engaged in ongoing case management with DSHS financial workers.

On August 26, 2015, CA was notified that K.R. died at her parents' home. RCW13.50.100 reported to law enforcement that she had placed K.R. unsecured in a baby bouncer on top of her own bed. She reported she accidentally fell asleep and RCW13.50.100. joined her sometime in the night. She woke up at about 4:00 a.m. and found K.R. lying face down, unconscious and unresponsive on the bed. There were no signs of trauma. The cause of death is listed as Sudden Unexpected Infant Death with risk factors related to the sleeping conditions.

Committee Discussion

The Committee discussion focused on CA policy, practice and system responses to evaluate the reasonableness of decisions made and actions taken by the department. Committee members primarily focused on CA involvement during 2015 when the family engaged in voluntary services, though some discussion occurred regarding the department's prior interventions with the family in 2014.

The Committee spent considerable time discussing risk factors[16] noted throughout CA's involvement with this family. Persistent risk factors included alleged substance abuse, domestic violence, unstable housing and struggles with parenting. The Committee noted the challenge posed by attempting to impact multiple risk factors within the relatively short intervention period that is allowed by the FVS model. The Committee noted that considerable resources were used in meeting the family's basic needs either directly by CA or through collaboration with community providers. The Committee discussed whether the parent's lack of compliance with recommended RCW 70.02.020 and substance

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[16] Allegations of child abuse or neglect assert specific events, incidents, patterns and conditions defined by law and policy as child abuse and neglect. Allegations always describe past events, incident and conditions. Risk factors include all other information that lacks assertions of abuse or neglect but which are relevant to assessing the likelihood of future child abuse and neglect.

abuse evaluations was of sufficient weight to warrant legal intervention based on the chronicity of alleged abuse and neglect in the family. Though there was no consensus about whether or not the department should have intervened legally, the Committee felt that best practice would have been to consider holding another FTDM to evaluate the situation with the family.

The Committee utilized staff interviews to provide additional sources of information for consideration. This included discussions about caseload and workload size, the general makeup of the unit in terms of worker experience and staff turnover. The office has experienced a high turnover in staff due to transfers within the agency and as a result, the office experienced vacancies during this period. The Committee acknowledged the challenges faced by CA to maintain a high level of practice during a time of significant staff turnover and commended the office on managing to maintain regular, ongoing contact with this family in spite of the challenges.

The Committee noted several areas of quality practice during the 2015 intervention. The case notes were clear, thorough and timely. The social worker did an exceptional job in addressing safe sleep guidelines with the parents during every home visit. The use of regular, unannounced visits to the family home reflected strong commitment to child safety as well as good engagement with the parents. The social worker was resourceful in accessing community partners to meet the family's basic needs and in gaining their collaboration to help monitor the family's situation.

Findings

At completion of the review of the case file documents, staff interviews and discussions regarding CA activities and decisions, the Committee found no critical errors by the department. However, the Committee identified several missed opportunities in the 2014 investigations for improved practice that were determined to be worthy of inclusion in this report. Specifically, the Committee believed that the investigation conducted in 2014 could have more comprehensively assessed child safety and parental functioning in several key areas.

- The child interviews could have more fully assessed or explored the allegations.
- The parent interviews could have been more comprehensive with regard to either the allegations or the risk factors alleged in the intakes.
- The investigative assessment lacked collateral contacts that may have enhanced the assessment of child safety
- The safety plan developed by the social worker in 2014 did not address the specific safety threat and could have been enhanced by the inclusion of additional monitoring of the children's well-being.

Recommendations

1. Children's Administration should consider offering training in how to effectively deal with secondary trauma or compassion fatigue to offices whose staff have experienced critical incidents.
2. The Committee recommended that the Region One Practice Consultant review with the staff in this office the benefits of conducting an FTDM when a family is not compliant with Family Voluntary Services.

Child Fatality Review

L.H.

June 2015
Date of Child's Birth

September 21, 2015
Date of Fatality

December 3, 2015
Child Fatality Review Date

Committee Members
Mary Moskowitz, J.D., Office of the Family and Children's Ombuds
Robert Welch, MSW, MHP LSWAIC, CDPT, Behavioral Health Specialist, Metropolitan Development Council
Stephanie Frazier, Child Protective Services and Family Voluntary Services Program Manager, Department of Social and Health Services, Children's Administration
Tim Kelly, Program Manager, Department of Social and Health Services, Children's Administration
Chad Harty, Family Voluntary Services Supervisor and Child and Family Welfare Services, Department of Social and Health Services, Children's Administration

Observer
J. Christopher Graham, Ph.D., Senior Reports and Data Developer/Designer, Children's Administration Data Management and Reporting Section

Consultant
Shea Hopfauf, Social and Health Program Consultant Region 2, Department of Social and Health Services, Children's Administration

Facilitator
Libby Stewart, Critical Incident Review Specialist, Department of Social and Health Services, Children's Administration

Executive Summary
On December 3, 2015, the Department of Social and Health Services (DSHS), Children's Administration (CA) convened a Child Fatality Review (CFR)[17] to assess the department's practice and service delivery to three-month old L.H. and his family.[18] The child will be referenced by his initials, L.H., in this report.

At the time of his death, L.H. lived with his mother and a roommate. L.H.'s father lived in a separate residence. On September 21, 2015, L.H. was found to be unresponsive after taking a nap. The circumstances surrounding where L.H was sleeping or if he co-slept with anyone remains unclear. Kent Police responded to the home as did an investigator from the King County Medical Examiner's Office. There were no observable signs of injury. At the time of the fatality, the family had an open Family Voluntary Services case with Children's Administration. There was also a visiting public health nurse working with the family.

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, a Child Protective and Family Voluntary Services program manager with CA, an Evidence Based Services program manager with CA, a co-occurring therapist[19] with a community chemical dependency agency and a FVS/Child and Family Welfare Services supervisor with CA. There was a consultant and one observer from CA. Neither CA staff nor any other Committee members 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 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 medical reports, law enforcement reports, relevant state laws, and CA policies.

During the course of this review the Committee interviewed the public health nurse, FVS worker and supervisor and CPS investigator of the fatality.

<u>Family Case Summary</u>
The mother first came to the attention of CA on June 18, 2015, when an intake was received stating L.H. was born. Both mother and child tested positive for opiates. The mother told the hospital staff she used leftover pain medication from a prior automobile accident during her pregnancy when she started to feel bad. The report included that the mother did not start

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[17] Given its limited purpose, a 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 near fatal injury. Nor is it the function or purpose of a Child Fatality Review to recommend personnel action against DSHS employees or other individuals.
[18] No criminal charges have been filed relating to the incident and therefore no names are identified. [Source: RCW 74.13.500(1) (a)].
[19] Formerly known as dual diagnosis or dual disorder, co-occurring disorders describe the presence of two or more disorders at the same time. For example, a person may suffer substance abuse as well as bipolar disorder. [https://www.psychologytoday.com/conditions/co-occurring-disorders]

prenatal care until she was twenty-four weeks pregnant and the baby was born prematurely at 35.6 weeks. The report stated the baby was showing signs of withdrawal and was being monitored.

The CPS worker contacted the mother and maternal grandmother as part of the assessment. At the time of his birth, there were two alleged fathers. One of the alleged fathers contacted the CPS worker and reported that the other alleged father was an intravenous drug user. The hospital referred the family for a public health nurse. The case was accepted for FVS services and a transfer staffing was held on July 1, 2015.

On July 2, 2015, a safety plan was written and agreed to between CA, the mother and maternal grandmother. The grandmother agreed to make daily, in-person contact with the child and mother. The mother agreed to voluntary services including random urinalysis, a parenting class and a public health nurse referral. It is unclear how many times the mother and alleged father were requested to provide random UA's. There were only two urinalyses submitted by the mother. The first urinalysis was shortly after the birth of the child. The second urinalysis was on September 2, 2015. The second urinalysis was diluted. The mother failed to regularly engage with the FVS worker. The public health nurse reported to CA that the mother and baby were doing well and she did not see any signs of drug use.

Committee Discussion

For purposes of this review, the Committee focused on case activity from the day L.H. was born up until the day of the fatality. The CPS investigation regarding the fatality was briefly discussed; however the focus of the review was CA's involvement prior to the fatality.

The Committee discussed actions CA could have taken to provide a more comprehensive assessment of this family. Based on the mother and child's positive urinalyses and the mother's admission to improper use of prescribed medications, an immediate chemical dependency assessment would have offered CA a clearer picture as to the mother's chemical dependency needs. There was discussion regarding the term "pseudo addiction". This term relates to inadequate pain management, which can lead to addiction of pain medication. This could also have been assessed through a chemical dependency assessment.

Another action CA could have taken was to conduct a family team decision meeting. This meeting would have allowed the parents, family supports, service providers and CA to come together and discuss the families strengths, needs and barriers to ameliorating the circumstances which brought the family to the attention of CA.

The mother stated that she was prescribed pain medication due to an injury as a result of an automobile accident. The consensus was that it would have been appropriate for the CPS investigator to verify the mother's statement. Verifying her statement could have included a two-pronged approach: First, the worker could have requested NCIC to see if the automobile accident was listed and if not, attempted to track down a police report, if there was one, of the

accident to verify its occurrence. Second, the CPS investigator could have reached out to the prescriber to speak with him or her and to verify the mother's prescription.

The Committee noted CA missed an opportunity to comprehensively assess the mother through a chemical dependency assessment, an immediate referral for random UAs, and timely follow-up regarding the mother's diluted UA. It also felt that CA missed an opportunity to comprehensively assess the child's alleged fathers for suitability and child safety.

FINDINGS

The Committee identified positive case practice during this case. Those positive actions included having a meet-and-greet between the CPS investigator, FVS worker and the mother and the referral for the PHN through the Early Intervention Program at the CA office.

The Committee did not find any critical errors and did not make any recommendations. The Committee identified an area where case practice could improve. There was a lack of comprehensive assessment related to substance abuse regarding the mother and the alleged fathers. This lack of assessment led to a failure to fully assess the safety of L.H. while in the care of his mother. The Committee noted there was a lack of verification by the assigned caseworkers regarding the mother's statements, maternal grandmother's observations during her daily contact per the safety plan and collateral contacts to fully assess the allegations.

Nondiscrimination Policy
The Department of Social and Health Services does not discriminate and provides equal access to its programs and services for all persons without regard to race, color, gender, religion, creed, marital status, national origin, sexual orientation.

Child Fatality Review

D.L.

April 2014
Date of Child's Birth

September 27, 2015
Date of Fatality

December 10, 2015
Child Fatality Review Date

Committee Members
Cristina Limpens, MSW, Senior Ombuds, Office of the Family and Children's Ombuds
Yolanda Duralde, MD, Medical director of the Child Abuse Intervention Department at Mary Bridge Children's Hospital/MultiCare and the Pierce County CAC
Jenna Kiser, Intake and Safety Program Manager, Children's Administration
Jessica Sullivan, Sergeant, King County Sheriff's Office
Meagan Cordova, MSW, Social and Health Program Consultant/Quality Practice Specialist Region 2 North, Children's Administration
Kristy Suydam, MSW, Child Protective Services Supervisor, Children's Administration

Observer
Diane Shimizu, Social and Health Program Consultant/Quality Practice Specialist Region 2 South, Children's Administration

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

Executive Summary

On December 10, 2015, the Department of Social and Health Services (DSHS), Children's Administration (CA) convened a Child Fatality Review (CFR)[20] to assess the department's practice and service delivery to 17-month-old D.L. and his family.[21] The child will be referenced by his initials, D.L., in this report.

At the time of his death, D.L. lived with his father, his father's girlfriend Alicia Goemaat and Ms. Goemaat's son.[22] D.L.'s mother did not live with or have contact with him at the time of his death. On September 27, 2015, CA received a call from the King County Medical Examiner's Office stating D.L. was pronounced dead at his father's residence. The Medical Examiner's Office reported that D.L.'s death was unattended as he had been placed down for a nap and was later found unresponsive. The intake indicates that several bumps and bruises were found on D.L.'s body. The father stated that D.L. sustained these injuries while roughhousing with his sibling (Alicia Goemaat's son, not biologically related). At the conclusion of the autopsy, it was found that D.L. died of blunt force trauma consistent with non-accidental trauma. Additionally, Alicia Goemaat made admissions to law enforcement regarding her assault of D.L.

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, a Child Protective Services supervisor with CA, a sergeant with the King County Sheriff's Office, a contracted medical consultant with CA who specializes in child abuse, an intake and safety program manager with CA and a quality practice specialist with CA. Also present was an observer from CA. Neither CA staff nor any other Committee members 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

[20] Given its limited purpose, a 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 near fatal injury. Nor is it the function or purpose of a Child Fatality Review to recommend personnel action against DSHS employees or other individuals.

[21] D.L.'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)]

[22] Alicia Goemaat is named in this report due to her current criminal charges of Second Degree Murder.

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 the assigned CPS worker and her supervisor as well as the CPS worker who investigated the fatality. Both CPS workers' supervisor had taken positions outside of CA.

Family Case Summary

On January 27, 2015, CA received a call regarding D.L.'s mother. The intake alleges the mother appeared to be RCW 70.02.020 when she arrived at the RCW 70.02.020. The caller was concerned due to the fact that the mother was reportedly caring for six-month-old D.L. This intake was screened out as there was no indication the mother was providing care for that child and she was not the custodial parent.

The second intake was received on September 21, 2015. A person called on behalf of Dr. Kenneth Feldman, a contracted medical consultant with CA who works at Seattle Children's Hospital. Dr. Feldman expressed concern for D.L. based on photographs taken the previous day that showed bruises and abrasions not consistent with common toddler injuries. Dr. Feldman expressed concern for the child's safety in the home. Dr. Feldman had not personally observed the child; rather, the photographs were taken while the child had been in the hospital the previous day. D.L. had been seen at the hospital due to an RCW 70.02.020 abuse to another child living in the home. The alleged offender of the RCW 70.02.020 assault was another adult living in the home. This intake was assigned for a 24-hour CPS investigation.

On September 21, 2015, the assigned CPS worker contacted the Children's Protection Program at Children's Hospital and requested a copy of the Suspected Child Abuse and Neglect (SCAN) consultation and the four photographs that were taken of D.L. She learned that a detective with Seattle Police Department had been assigned. The worker attempted contact at the family residence but was unable to enter the building.

The next day, the CPS worker contacted SPD and was advised to wait until the end of the week before making contact with the family. The CPS worker stated that she was told the detectives were all busy working to support security while the President of China was in Seattle. The CPS worker stated she made a second attempt to contact the family after having been advised to wait for the detective to contact her. The CPS worker stated she knew she had to meet the face-to-face timeframes per policy. This second attempt at the family home was not documented.

On September 27, 2015, D.L.'s body was found unresponsive at the father's home. The medical examiner reported he was declared dead at the scene and had visible bruises and bumps on his body. Alicia Goemaat had been providing care for him that day. The King County Medical Examiner's Office determined the resulting injuries led to his death.

Committee Discussion

For purposes of this review, the Committee focused on case activity prior to the fatality. The CPS investigation regarding the fatality was briefly discussed.

The majority of the Committee's discussion centered on the lack of urgency related to D.L.'s injuries as observed by medical personnel on September 20, 2015. While the Committee is charged with assessing the actions or inactions of CA, there was also a discussion surrounding the actions and inactions of medical personnel and law enforcement. The intake call and statements contained in the intake report indicate that Dr. Feldman expressed concern and urgency regarding the injuries. The Committee felt it would have been appropriate for the attending physicians to have called law enforcement when they observed the injuries. This led to a conversation regarding a concern for lack of child abuse training for physicians.

The second area where urgency was not overtly expressed was during the interview with the assigned social worker and supervisor. The Committee noted that the assigned CPS investigator and supervisor stated they were not concerned about the child's safety because the child had been released by the hospital. However, the Committee believed the fact that Dr. Feldman was calling with concern based on his review of the pictures as well as the age of the child and D.L.'s lack of verbal skills to describe how he was injured all indicated a higher risk necessitating more urgency in CA's actions.

During her interview, the CPS investigator stated she called SPD and spoke with the administrative assistant for the lieutenant in charge of assigning cases to detectives. That person is the one who indicated to the CPS worker that she should wait to contact the family. The Committee noted that the CPS worker could have taken the next step to ask to speak with the lieutenant directly or to call and ask for a patrol officer to accompany her to the home.

Findings

The Committee did not find any critical errors that directly resulted in the fatality. However, the Committee identified areas where practice could improve.

The Committee noted a lack of critical thinking by the worker. Taking into consideration the case was open for six days before D.L. was killed, there were

actions that could have been taken in order to allow for a more thorough assessment of D.L.'s safety. While trying to work within the agreed boundaries and in collaboration with law enforcement, there are times when CA must see a child before the assigned detective is available. This case highlighted that need. The Committee believes CA staff should have realized the urgent need to assess the safety of a 17-month-old child with what appeared to be non-accidental injuries and staffed the case with their area administrator to discuss the next steps.

The Committee also noted that Dr. Feldman was not contacted by CA staff. They understood that Dr. Feldman did not directly call CA; rather, someone called on his behalf. The question that could have been asked to help provide more urgency could have been, "What type of follow up does Dr. Feldman hope will occur?" The answer to this question may have provided the CPS worker a timeframe and structure necessary for law enforcement intervention and intervention by CA.

Recommendations

When an intake is assigned that includes alleged injuries to a child under three years of age and that requires an extension or exception to meeting the face-to-face timeframe, the case should be staffed with the area administrator prior to granting the extension. This staffing should be documented in a case note.

The Committee believes that a MedCon[23] should reach out to Seattle Children's Hospital to conduct child abuse identification and subsequent mandatory reporter training.

CA should provide a training to educate its staff on MedCon which should include when, why and how to use them. This training should also include skills training on how to converse with and professionally question a professional within the medical community regarding his or her assessment of a child or situation. An integral piece of the training should also include the dynamics of child abuse. This training should be offered every two years for all staff regardless of how long they have been employed by CA.

CA should develop ongoing supervisor training to discuss the dynamics of child abuse, working with community partners and critical thinking. This training should include all supervisors regardless of how long they have been employed by CA.

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[23] Medical Consultation Network