



**OFFICE OF FINANCIAL MANAGEMENT**

# **LOSS PREVENTION REVIEW TEAM**

REPORT TO THE DIRECTOR OF THE OFFICE OF FINANCIAL MANAGEMENT

Department of Social and Health Services  
Children's Administration  
Incident of March 2007

## **LPRT MEMBERS**

**ALAN HENDRICKSON, MD**  
**JILL SELLS, MD**  
**MARGARET A. WEST, PHD, MSW**

## **LPRT PROGRAM STAFF**

**KIM HAGGARD**  
**NANCY HEYEN**  
**DREW ZAVATSKY**

**NOVEMBER 2008**



# Failure to Thrive - Loss Prevention Review Table of Contents

---

<b>Executive Summary .....</b>	<b>1</b>
Context .....	1
Incident Summary.....	1
Review Process .....	1
Findings .....	2
Recommendations.....	3
<b>Review Process.....</b>	<b>3</b>
Team Members.....	3
Acknowledgements.....	4
Review Team Procedure .....	4
<b>Factual Findings.....</b>	<b>5</b>
Scope of Review – Family Services Received Under Voluntary Agreements through Child Protective Services.....	5
SA's Failure to Thrive .....	6
<i>Family History</i> .....	6
<i>Custody of SA</i> .....	7
<i>CPS Contacts with the Abegg/Mitchell Family</i> .....	8
First CPS Contact.....	8
Second CPS Contact.....	9
Third CPS Contact.....	10
<i>SA Is Removed From The Abegg Home</i> .....	13
The Context for the Incident: Neglect and Failure to Thrive are Underreported Nationwide.....	14
<i>Child Neglect Is Underreported Nationwide</i> .....	14
<i>Failure to Thrive and Growth Monitoring</i> .....	17
What is Failure to Thrive, and What Can Cause It?.....	17
How Often Does Failure to Thrive Occur in Children Aged 0-5? .....	18
Washington State Statistics on Failure to Thrive .....	18
Growth Monitoring is the Best Way to Prevent Failure to Thrive in Young Children .....	19
Medicaid Statistics Establish that Many Medicaid-Eligible Children do not Receive Growth Monitoring .....	20
The Effect of Undiagnosed Failure to Thrive on a Young Child is Potentially Severe.....	20
Who Can Detect Non-Organic FTT in Young Children? .....	20
<i>Child Protective Services Investigates Reports of Suspected Neglect</i> .....	22
Possible Agency Actions for Children with Intake Risk Assessments of 0-2 .....	22
Possible Agency Actions for Children with Intake Risk Assessments of 3-5 .....	23

<b>Root Cause Analysis.....</b>	<b>25</b>
Abusive Caregivers were the Root Cause of SA’s Failure to Thrive .....	25
Possible Measures to Reduce Future Occurrences of Failure to Thrive in Washington	26
<i>Growth Monitoring Should be Confirmed when Services are Provided to Young</i>	
<i>Children through a Child Protective Services Voluntary Service Agreement</i>	26
<i>Involve a Medical Professional in Voluntary Agreement Cases with Feeding Issues</i>	
.....	27
<i>Improve Communication in Voluntary Agreement Cases.....</i>	27
<i>Improve Staffing of Voluntary Service Agreement Cases that Involve Feeding</i>	
<i>Issues.....</i>	28
Staffing at the Smokey Point ICW Office .....	28
Statewide Staffing Issues .....	29
 <b>Recommendations .....</b>	 <b>29</b>
 <b>Appendix A – Risk Assessment Decision Making</b>	
<b>Appendix B – Growth Charts</b>	

# Executive Summary

---

## Context

RCW 43.41.370 authorizes the Director of the Office of Financial Management (OFM) to appoint a Loss Prevention Review Team (LPRT) when an incident resulting in death, serious injury to a person, or other substantial loss is alleged or suspected to be caused at least in part by a state agency.

An incident involving serious injury to a child, SA,<sup>1</sup> was discovered on March 7, 2007. The injury was possibly related to the provision of voluntary services to the child's family by the Children's Administration (CA), a division of the Department of Social and Health Services (DSHS). On April 26, 2007, the OFM Director, Victor Moore, determined that this incident should be reviewed by a LPRT.

## Incident Summary

On March 7, 2007, Child Protective Services (CPS) received an anonymous tip that a four-year-old child was being starved by his father (Daniel Abegg) and his father's partner (Marilea Mitchell). CPS requested a welfare check of the child, SA, by law enforcement. Members of the Snohomish County Sheriff's Office conducted a welfare check and found that SA was emaciated, could barely stand up, was suffering from hypothermia and weighed only 24 pounds. Normal weight for SA would have been 32-35 pounds. SA was taken immediately to the hospital for treatment and after weeks of care at Children's Hospital in Seattle was within the normal weight range for his age and height. One month before the welfare check, CPS case workers had stopped providing services to the Abeggs and closed the CPS case file after a service provider reported that the family was "doing fine" and that SA was healthy.

## Review Process

An LPRT uses root cause analysis when conducting a review. Root cause analysis is a rigorous analytical tool that is frequently used to identify and analyze complex situations that may have multiple causes. It is a tool used by analysts in many disciplines, including child death investigations and complex engineering system analysis.

Root cause analysis can reveal more than one cause for an incident under review. It is fact-based and addresses known facts only. Root cause analysis is not based upon speculation and represents a determination of what actually occurred in a particular circumstance.

In this case, the LPRT's task was to review SA's circumstances, evaluate the root cause(s) of the child's injuries, and, if appropriate, make recommendations regarding CPS procedures that might prevent or mitigate future incidents of non-organic failure to thrive (FTT).

---

<sup>1</sup> The child's full name is withheld to preserve his privacy.

The LPRT held its first meeting on June 13, 2007. During the summer and fall of 2007, the LPRT members conducted a series of interviews with DSHS staff regarding CPS and case worker<sup>2</sup> policies and procedures, as well as interviews with experts regarding child health care and health care services in Washington State.<sup>3</sup>

During this review, LPRT members received data and information about the incident from DSHS-CA staff. CA staff also assisted the LPRT by scheduling interviews with pertinent DSHS employees, and assisted with certain LPRT discussions regarding the incident and agency practices.

On July 1, 2008, the LPRT's final draft report was provided to the DSHS-CA, which was given the opportunity to comment on the report. This report incorporates their substantive comments and the LPRT wishes to thank the agency's staff for their courteous and professional assistance.

## Summary of Findings

SA suffered from “non-organic failure to thrive” – that is, he was starving to death due to the actions of his father and his father's partner. Because of insufficient medical information regarding SA's health, it is not possible to determine any other root causes. However, it is likely that similar cases could be detected earlier if CPS consistently develops partnerships with medical professionals<sup>4</sup> when providing services to children and their families under voluntary service agreements where there are issues involving alleged injuries or health concerns.

---

<sup>2</sup> Throughout this report CPS employees that work directly with children in need of services, and their families, are referred to as “case workers” rather than “social workers.” The LPRT makes this designation because the term “social worker” has several distinct definitions.

The term “social worker” is most commonly used to refer to a person who has earned a Masters Degree in Social Work (MSW) from an accredited School of Social Work. Washington State licenses social workers in two categories: social workers that are employed in a clinical or non-clinical setting are in the Licensed Advanced Social Work (LASW) category; social workers who obtain third party reimbursement for their work are in the Licensed Independent Clinical Social Work (LICSW) category. See *generally* RCW 18.225. Both of these licenses require graduation at the Master's or Doctorate level from an educational program accredited by the Council on Social Work Education as well as successful completion of a supervised experience requirement.

While the CA refers to all employees that work directly with children by their job classification of “social worker,” only 15 percent of these workers have a MSW. See *Children's Administration Social Worker Qualifications*, Joint Legislative Audit and Review Committee (JLARC) Report 08-3 (January 9, 2008), at 1, 14. Therefore, the term “case worker” is used to avoid possible confusion as to the background and training of the CA workforce.

<sup>3</sup> In addition, DSHS conducted its own review of the incident and provided its report to the LPRT.

<sup>4</sup> For the purposes of this report, the term “medical professional” refers to physicians, physician assistants, nurse practitioners, registered nurses, and public health nurses.

## Recommendations

1. Confirm that the health status of all children under six years of age served by CPS is monitored by medical professionals.
2. Confirm that all children served by CPS are receiving care in a medical home.
3. For children with medical issues served under voluntary agreements, CPS should consistently use their team service model.
4. In a case where a family agrees to receive voluntary services and where a CPS case worker learns of a growth or feeding issue affecting a child, the case worker should seek medical, as well as behavioral interventions.
5. The CA should train its case workers in how to access data so that they can quickly determine whether a child has actually received medical care.
6. The CA should expand its training program to include training on (a) how to partner with medical professionals, (b) child health and development, (c) child malnutrition, and (d) the impact malnutrition has on a child's health and development.
7. The CA should streamline its process for funding public health services provided to families through local health jurisdictions.
8. The CA should review and streamline its paperwork requirements for CPS case workers.

## Review Process

---

### Team Members

In accordance with RCW 43.41.370, OFM Director Victor Moore is authorized to appoint a LPRT when he decides that an incident involving an agency merits review. On April 26, 2007, Mr. Moore appointed the following LPRT members to review the incident involving SA:

- **Alan Hendrickson, MD**, recently retired after 30 years as a pediatrician with Rockwood Pediatrics in Spokane. Dr. Hendrickson has also been involved in many different organizations that address the prevention of child abuse and neglect, including the Spokane Child Protection Team, the Washington State Child Abuse Consultation Network, and Partners with Families and Children.
- **Jill Sells, MD**, is a clinical associate professor of pediatrics at the University of Washington School of Medicine. She collaborates in systems efforts so that children, parents and caregivers have the information and resources they need to help children be healthy, and ready for success in school and life. Dr. Sells is the Director of Docs For Tots Washington State, the Medical Director of Reach Out and Read Washington State, and has worked extensively with DOH on the development and implementation of Early Childhood Comprehensive Systems/Kids Matter.

- **Margaret A. West, PhD, MSW**, has 40 years of experience working in and with public health, social service, health care, mental health, and educational programs. She has served on the DSHS-CA Advisory Committee for more than 15 years and participated as a team member in Washington State Child Fatality Reviews.

## Acknowledgements

The LPRT acknowledges the useful and effective assistance provided by Sharon Gilbert, MSW, Deputy Director, Field Operations, DSHS-CA, and Sharon Ham, MSW, Practice Consultant, DSHS-CA (retired), in obtaining documents, data, and information for the LPRT during the course of the review.

## Review Team Procedure

The LPRT first met on June 13, 2007. Its initial discussion addressed confidentiality issues, the review process, development of the review plan, and the roles of the team members and LPRT coordinator. DSHS personnel attended the LPRT meeting to discuss the LPRT process and to observe the LPRT develop its review plan. The LPRT met subsequently with DSHS staff on several occasions to develop background information on the CA and CPS procedures.<sup>5</sup> During separate meetings, the LPRT also obtained health care system-related information from DSHS staff. Similar information was developed through interviews with medical professionals in health care services and local health jurisdictions.<sup>6</sup>

The following people were interviewed:

<b>Name</b>	<b>Title/Agency</b>	<b>Interview Date</b>
Nancy Dufraine, M.ED	Indian Child Welfare Program Manager, DSHS	6/25/07
Karen Sporn, MPA	Early Childhood Program Manager, DSHS	9/4/07, 9/11/07
Michelle Bogart	Foster Care Health Program Manager, DSHS-CA	9/4/07, 9/11/07, 9/21/07, 12/7/07, 3/26/08
April Potts	Program Manager, Division of Program and Practice Improvement, DSHS-CA	9/11/07
Barb Putnam	Well-Being Supervisor, DSHS-CA	9/11/07, 3/26/08
Brenda Villarreal, MSW	Screening and Assessment Program Manager, DSHS	9/11/07, 3/26/08

<sup>5</sup> CPS is a branch of the Division of Child and Family Services (DCFS), one of the divisions within the Children's Administration.

<sup>6</sup> Local health jurisdictions are established by statute. See RCW 70.05.060-070. Their role includes enforcement of state public health laws, maintenance of health and sanitation supervision, and other measures necessary to promote public health.

<b>Name</b>	<b>Title/Agency</b>	<b>Interview Date</b>
Lorrie Grevstad, RN, MN	Nurse Consultant, DOH	9/13/07
Don Ashley, MD	Medical Consultant, DSHS-CA	9/18/07
Sharon Gilbert, MSW	Deputy Director, Field Operations, DSHS-CA	9/21/07
Leah Stajduhar	Safety Supervisor, DSHS-CA	9/21/07
Jennifer Sass- Walton, RN, BSN	Public Health Nurse Director, Skagit County	9/26/07, 1/3/08
Nancy Anderson, MD	Chief, Office of Community Services, DSHS- HRSA	10/24/07
Lois Schipper, MPH, BSN	Program Manager III, Parent/Child Health Program (PCH), Public Health-Seattle & King County	10/30/07, 11/5/07
Kathy Carson, RN, BSN	Parent Child Health Administrator, Public Health-Seattle & King County	10/30/07, 11/5/07
Richard Pannkuk	Budget Manager, DSHS-CA	12/7/07
Priscilla Wolfe	Contracts Manager, DSHS-CA	3/26/08
Chris Robinson, MSW	Clinical Director, DSHS-CA	3/26/08

In December 2007 the LPRT began to formulate recommendations. The LPRT finalized this report in November 2008.

## **Factual Findings**

---

### **Scope of Review - Family Services Received Under Voluntary Agreements through Child Protective Services**

The Abegg family was receiving services under a voluntary service agreement with CPS and its Family Preservation Services (FPS) program. The CPS case worker referred the Abegg family for Family Preservation Services (FPS) under a CPS contract with Grayson Associates, Inc., a private, non-profit company. Grayson Associates provides FPS and counseling services to clients, including the Abegg family, who were referred by CPS case workers. This review examines the actions of SA's caregivers and CPS case workers.<sup>7</sup> Because of a lack of information, the LPRT was unable to reach any conclusions about the actions or inactions of the Grayson counselor.

<sup>7</sup> The report does not address the foster care system, as SA was not referred for either an in-home or an out-of-home dependency proceeding.

## SA's Failure to Thrive

This section of the report describes the harm to SA, and also discusses the larger context in which that harm occurred, which is presented in two parts: (a) the prevalence of child neglect (FTT is one example of such neglect), and (b) how social service systems identify and then address cases of child neglect.

These findings are based upon written reports of DSHS-CA contacts with all of the family members. There were multiple files on the family. Due to the different ways in which family members were reported to CPS, files were opened at different times on Mr. Abegg, KA (the child's biological mother), and the three Abegg children, JA, SA, and HA. The files, taken together, contain more than 2,000 pages of documents that were not integrated into a single timeline. The LPRT took considerable time to create a timeline of events regarding SA's history.

Because of pending litigation, family members were not interviewed by the LPRT. In addition, the Grayson counselor, who has since left the company, refused to be interviewed. What follows is an overview of the events based on the available information.

### *Family History*

SA was born in October 2002 in Auburn, Washington. The chart below shows the members of his family at the time of his birth:

<b>Name</b>	<b>Relationship to SA</b>	<b>Native American Tribal Affiliation</b>
Danny Abegg	Father	None
KA <sup>8</sup>	Mother	Kotzebue, Alaska
JA (dob 1999)	Brother	Kotzebue, Alaska

SA joined a young and troubled family. When SA's older brother JA was born, Danny Abegg was 19 years old and KA was 18 years old. The family had already been engaged with both the legal system and the California Child Protective Service (CCPS).

On May 22, 2001, when JA was about a year and a half old (and about a year and a half before SA was born), Mr. Abegg was convicted of a misdemeanor assault on KA in Riverside, California. Almost a year later, on April 2, 2002, CCPS received a call that alleged that KA "uses meth daily and is not supervising her child... there are dirty diapers, dog feces, and trash everywhere" in their home. Then, on May 16, 2002 (after a CCPS investigation), a Riverside County Court removed JA from his parents' custody:

Mother and father have a history with Riverside County CPS due to substantiated allegations of general neglect on behalf of [JA]... the parents have failed to benefit from services thereby placing [JA] at risk of

---

<sup>8</sup> The names of adults (such as SA's biological mother) who are not involved in this review are confidential and each is identified only by his or her initials.

suffering harm... [their residence] was found to be [a] health and safety hazard... The father abuses controlled substances.

However, by October 2002, KA had recovered custody of JA and moved to Washington State in order to live with her parents in Federal Way. SA was born a short time later, but his biological father, Mr. Abegg, remained in California.

### *Custody of SA*

In May 2003, when SA was seven months old, KA and the two boys moved in with KA's boyfriend, JC, who lived in Kingston, Washington. The chart below shows the members of the family in contact with the children at the time:

<b>Name</b>	<b>Relationship to SA</b>	<b>Native American Tribal Affiliation</b>
KA	Mother	Kotzebue, Alaska
JC	Boyfriend of KA	Chickasaw Nation, Oklahoma
JA (dob 1999)	Brother	Kotzebue, Alaska
SA (dob 2002)		Kotzebue, Alaska
PC	JC's mother	Chickasaw Nation, Oklahoma
SDC	JC's stepfather	None

On August 8, 2003, CPS investigated an allegation that JC physically abused JA. JA had extensive bruising on his face and his buttocks; SA was not injured. As a result, JA and SA were placed with JC's mother, PC.

By October 17, 2003, KA regained custody of the boys, in part because she was employed and had stable housing. Over the next year, the boys continued to visit with PC and her husband, SDC.

On September 14, 2004, PC and SDC filed a request for a temporary restraining order against the boys' mother, KA. The petition to the court alleged that KA physically abused SA, sought to prevent KA from having any contact with her sons, and asked the court to give custody of the boys to PC and SDC. Soon afterwards, KA, JA and SA disappeared from their home in Tacoma, and the police could not find them.

However, on October 30, 2004, police officers found KA, JA and SA living in a van in Longview, Washington. The van had no heating or car seats. JA told a CPS worker that his mother, "would lock [us] in the van and leave [us] until after dark. She would leave [us] nothing to eat or sometimes a sandwich." Apparently, at the time they were found both boys were 25-30 percent under their normal body weight and were severely dehydrated.<sup>9</sup> The children were placed back with PC and SDC.

On November 3, 2004, CPS received a referral alleging that SDC sexually abused his own children and was not allowed unsupervised contact with them. Although the investigation results were inconclusive, on November 30, 2004, SDC agreed to a safety

<sup>9</sup> See Family Preservation Services Closing Report, (9/25/06), at 6 (Bates #001715).

plan that barred him from having any contact with the boys. By February 2005, PC had legally separated from SDC.

By August 2005, the boys had moved in with Mr. Abegg, who lived at the time in Lynnwood, Washington. The chart below shows the members of this household:

<b>Name</b>	<b>Relationship to SA</b>	<b>Native American Tribal Affiliation</b>
Danny Abegg	Father	None
Marilea Mitchell	Partner of SA's Father	None
JA (dob. 1999)	Brother	Kotzebue, Alaska
SA (dob. 2002)		Kotzebue, Alaska
HA (dob. 2005)	SA's Half Sister	None

Beginning in late spring 2006, CPS began investigating the Danny Abegg/Marilea Mitchell household.

### ***CPS Contacts with the Abegg/Mitchell Family***

#### **First CPS Contact**

On May 1, 2006, a witness reported to CPS that both boys appeared to be underfed; they would “wolf down” large amounts of food when visiting the witness. The witness also believed that Ms. Mitchell (Mr. Abegg’s partner) “resents having to give any time, attention, or resources to” JA and SA. The CPS intake risk assessment (created when the witness contacted CPS) stated, “the neglect elements and the ages of the two boys support the [assessment] of moderately high [risk].”<sup>10</sup>

The case was referred to the Indian Child Welfare Unit (ICW) of the Smokey Point CPS Office, in Arlington.<sup>11</sup> A case worker (case worker #1)<sup>12</sup> made a home visit on May 3, 2006, to investigate. Case worker #1 noted that “both boys appear to have a good relationship with both parents.” Mr. Abegg told case worker #1 that JA had a tendency to gorge on food, asserting that JA had not been regularly fed when he had been in KA’s care in the past.

On June 5, 2006, case worker #1 interviewed JA at school with his school counselor. JA told case worker #1 that he “always has enough to eat at home.” The school counselor told case worker #1 that he had no concerns about JA’s health or welfare. On June 6, 2006, case worker #1 closed the case, finding that the allegation of neglect was unfounded.<sup>13</sup>

---

<sup>10</sup> Bates 002041.

<sup>11</sup> In some regions, CA has specialized units that serve Native American children and families, based on state and federal laws designed to protect and preserve their cultural heritage. Several laws provide added protections to Native American children that are abused and/or neglected. See, e.g., 25 USC 1901, et seq.; WAC 388-15-025; and DSHS-CA *Indian Child Welfare Manual* (located at [http://www.dshs.wa.gov/CA/pubs/manuals\\_ICW1.asp](http://www.dshs.wa.gov/CA/pubs/manuals_ICW1.asp)).

<sup>12</sup> This is the first of three separate Smokey Point case workers involved with SA.

<sup>13</sup> An “unfounded” finding means that based on available information, it is more likely than not that the alleged abuse or neglect did not occur. RCW 26.44.020(19).

**Second CPS Contact**

On June 22, 2006, a neighbor confronted the Abeggs at a store, and told the boys that she knew that their “parents beat you.”<sup>14</sup> A deputy sheriff investigated because SA had a bruise on his forehead. The deputy did not place SA in protective custody because the bruise appeared to be healing. The matter was referred to CPS for investigation.<sup>15</sup>

On June 23, 2006, case worker #1 interviewed the family. Both parents were cooperative with the interviews. Neither child appeared to be afraid of the parents. In addition, both “children told [case worker #1] that either [Ms. Mitchell] or dad make the meals. They have plenty to eat.”<sup>16</sup> Based on the investigation, case worker #1 completed a safety assessment with the following responses:

Questions	Indicated	Not Indicated
Is there a pattern of neglect/incidents/injuries involving any child in the family, which is escalating in severity?		X
Is there any other concern that places a child in this home at risk of serious and immediate harm?	X	

Case worker #1 explained:

This is the second recent referral alleging that the children are physically abused and have bruising. Although the parents have a reasonable explanation for the injury and the children made no disclosure, there is concern over lack of supervision, and underlying concern that maybe there is physical abuse occurring but the children are not disclosing it.<sup>17</sup>

No referral was made for a medical evaluation of the children. However, case worker #1 referred the Abeggs to FPS for assistance because it appeared that the “parents could benefit from training on parental disciplinary techniques.” FPS provided services to the Abeggs under a voluntary service agreement that they see a Grayson employee for counseling services approximately once a week over a period of three months.<sup>18</sup>

On July 26, 2006, the case was transferred to case worker #2. At the three month review in September 2006, the Grayson counselor recommended that the FPS services should end and that the Abegg case should be closed. Under the counselor’s analysis the risk to the children had decreased to an acceptable level.<sup>19</sup> The counselor assessed several Caretaker Risk Factors in arriving at his opinion:

---

<sup>14</sup> Bates 001879.

<sup>15</sup> Bates 001867.

<sup>16</sup> Bates 001579.

<sup>17</sup> Bates 001940-41.

<sup>18</sup> The Abeggs saw the Grayson counselor for a total of 38 hours, consisting of two-hour sessions on June 28, July 3, 7, 11, 14, 18, 25, and three-hour sessions on July 31, August 7, 15, 22, 29, and September 7, 14, and 21, 2006.

<sup>19</sup> Bates 001720.

Caretaker Risk Factors <sup>20</sup>	Risk levels at:	
	Entry*	Exit**
Substance abuse	4	1
Mental, Emotional, Intellectual, or Physical Impairments	4	1
Parenting Skills / Expectations of Child	4	3
Empathy / Nurturance / Bonding	4	3
History of Violence or Sexual Assault of Caretakers (towards peers, and/or children)	0	0
Protection of Child by Non-Abusive Caretaker	4	3
Recognition of Problem / Motivation to Change	5	4
History of CA/N as a Child	1	1
Level of Cooperation	4	3

\* Provided by the DCFS Intake case worker

\*\* Assessed by the Grayson counselor

To assess the counselor's recommendation, case worker #2 visited the Abegg home and observed:

Both [SA] and [JA] were eager and willing to talk to the social worker ... All 3 of the children looked clean, healthy, and had a healthy color to them... Danny said that the boys were getting better about [hoarding] food. He said they are starting to realize that they will have food and drinks when they need them.<sup>21</sup>

At that time, Mr. Abegg worked full time while Ms. Mitchell stayed home with the children. On October 5, 2006, case worker #2 decided to close the investigation.<sup>22</sup>

### Third CPS Contact

On October 16, 2006, JA arrived at school crying and visibly upset, with "extreme bruising to both sides of his head" and ears, as well as a bruise on his forehead. School staff could not calm him down and had to call his parents to take him home.<sup>23</sup> A referral was made to CPS.

JA went to school the next day, October 17. While he was at school, case worker #2 interviewed Mr. Abegg by telephone. He did not give an explanation for how the injuries happened, but speculated that JA might have hurt himself while in his room.

Case worker #2 then went to interview JA at his school and saw JA's bruises, which had turned a greenish color. JA claimed that he got the injuries when he tripped and fell. When asked how he is disciplined at home, JA said, "I go to my room or I [lose] my snack." JA said that SA was punished in the same way. When asked if he was afraid of anyone at home, JA "replied very quietly, slowly shaking his head and said 'no.'"<sup>24</sup>

<sup>20</sup> See Bates #001711. Risk levels are graded as follows: 0 = No Risk, 1 = Low Risk, 2 = Moderately Low Risk, 3 = Moderate Risk, 4 = Moderately High Risk, 5 = High Risk.

<sup>21</sup> Bates 001586.

<sup>22</sup> Bates 001587.

<sup>23</sup> Bates 001589.

<sup>24</sup> Id.

A sheriff's deputy arrived and also interviewed JA at the school, and decided he would not put JA into protective custody; it appeared to the deputy there was no immediate threat to the child, and JA did not seem to be nervous during the discussion. Case worker #2 deferred to the deputy's decision. However, the deputy was concerned that Mr. Abegg had not taken JA to a doctor for the injuries. There is no medical record that shows that JA was taken to the doctor.

On October 18, case workers #1 and #2 made a home visit and again asked how the injury happened. This time, Mr. Abegg claimed that the bruising was caused when JA fell while playing with a friend. He also speculated that school bullies "might have been hitting [JA] in the head."<sup>25</sup> Case worker #2 confronted Mr. Abegg about his changing story. Mr. Abegg replied that he was "confused and upset that they had another referral on them."<sup>26</sup>

Case worker #2 also physically examined SA, who had a small bruise on his forehead. There were no other marks or bruising on SA, who was very talkative during the examination. The case workers also were able to see HA's body during a diaper change and saw no bruises or other visible marks on the baby. Both SA and HA looked otherwise "healthy and well fed." The parents agreed to resume seeing the same Grayson counselor, and to take JA to see a doctor. Mr. Abegg also told the case workers that he was considering sending JA to stay with Mr. Abegg's mother in California, "to see if he will behave better with her."<sup>27</sup>

Case worker #2 completed a Safety Assessment and noted:

Questions	Indicated	Not Indicated
Is there a pattern of neglect/incidents/injuries involving any child in the family, which is escalating in severity?		X
Is there any other concern that places a child in this home at risk of serious and immediate harm?	X	

Case worker #2 completed a safety plan with the Abeggs that stated, in part, that "Danny and Marilea agree to take the children to medical services to ensure their well child exams are current and shots are up to date."<sup>28</sup> Case worker #2 also told Mr. Abegg that he must take JA in to be examined by a doctor. Subsequent investigation has not located any medical records that show that either child was examined by a doctor in response to the case worker's instructions.

Case worker #2 decided that evidence of alleged negligent treatment or maltreatment and physical abuse of the children was "inconclusive." Case worker #2 referred the family back to the Grayson counselor because:

Both parents seem unwilling to change their behaviors to help improve the behaviors of the children. The expectations of these parents toward the

<sup>25</sup> Bates 001936.

<sup>26</sup> Id.

<sup>27</sup> Bates 001934.

<sup>28</sup> Bates 001933.

children are not always age appropriate; they tend to expect the children to just stop learned behavior.<sup>29</sup>

On October 27, the family sent JA to live with Mr. Abegg's mother in California. About a week later, they started meeting again with the Grayson counselor.

On November 13, case worker #2 discussed the case with the Grayson counselor, who said he was "unaware of all the details [of the October 16<sup>th</sup> allegations] before now."<sup>30</sup> They discussed the fact that Ms. Mitchell might be depressed, and that she needed "an outlet to get out of the home once in a while to help her from becoming so overwhelmed."<sup>31</sup>

On November 15, during a home visit, case worker #2 noted that:

The children... were clean, free of any noticeable marks or bruises. Both looked healthy, their color and appearance were good... [SA] came out of his room to ask his dad for a snack, he was very polite saying please and thank you, promptly went back into his bedroom.<sup>32</sup>

Case worker #2 wrote a safety plan with Mr. Abegg and Ms. Mitchell. One of the goals was "to ensure the safety and wellbeing of the children within the parents' care... by providing adequate meals."<sup>33</sup> Both parents signed the agreement.

On November 30, case worker #2 transferred the case to case worker #3, who contacted Mr. Abegg on December 8. Mr. Abegg reported that the family was doing well. Case worker #3 spoke with the Grayson counselor on December 12, who confirmed that the family was continuing to attend counseling with him and were doing well. The Grayson counselor claimed that a native tribe was involved in obtaining services for the Abegg family, and "that the Department [DSHS-CA] could close their case."<sup>34</sup>

The department did not close the case. Instead, on January 17, 2007, case worker #3 and another case worker made a health and safety check on the Abegg children, who appeared to be healthy. However, during the visit, SA did not come out of his room. Case worker #3 spoke with SA in his bedroom and away from his parents. The child was quiet, very friendly, and polite. He did not seem to be afraid of the case worker. He did appear to be afraid of being overheard, although when case worker #3 pointed out her observation, SA denied it. SA said that he was sent to his room or made to stand in a corner when he was punished for misbehavior.

Case worker #3 was concerned that SA did not seem to interact with his parents. During the discussion on this topic, Ms. Mitchell admitted that she had "separated herself from the child and father after CPS became involved in the family, because she

---

<sup>29</sup> Bates 002006-009.

<sup>30</sup> Bates 001597.

<sup>31</sup> Bates 002016.

<sup>32</sup> Bates 001597.

<sup>33</sup> Bates 002029.

<sup>34</sup> Bates 002021.

was afraid that she was going to lose her baby [HA].<sup>35</sup> In addition, although the case workers had previously recommended it, SA had not been taken to a counselor to address the various separations in his life (from his brother, from his biological mother, and from the mother's "stepmother" PC). Both parents said that they were afraid of sending SA to counseling because "he lies a lot and they are afraid they will get into trouble."<sup>36</sup>

Case worker #3 told Mr. Abegg and Ms. Mitchell that it was very important to get SA to counseling and that they would have nothing to fear if they were not abusing him or neglecting his care. She also encouraged the Abeggs to enter counseling themselves, and to include SA more in their day-to-day family activities.<sup>37</sup> However, there is no evidence that SA actually went to see a counselor.

On January 25, case worker #3 made a referral to a mental health provider for SA, and told Ms. Mitchell about the appointment. Ms. Mitchell told the case worker that they had seen the Grayson counselor the previous day, and that "everything was good with the family."<sup>38</sup> There is no record that Ms. Mitchell actually took SA to a mental health provider.

Case worker #3 recommended that the case should be closed based upon the Grayson counselor's assurance that his counseling services would be ongoing through a native tribe.<sup>39</sup> On February 6, 2007, the case was closed after review by case worker #3's supervisor even though they did not reassess the risk factors associated with the Abeggs and SA, and did not confirm that a tribe would oversee the Abegg family counseling.<sup>40</sup>

### ***SA Is Removed From The Abegg Home***

On March 7, 2007, CPS received an anonymous phone call that reported concerns about SA's welfare. The caller described two separate events.

The first event occurred during Christmas 2006. The caller said that SA appeared to be skinny, had pale lips, circles under his eyes, and had protruding ribs. The caller had confronted Mr. Abegg and Ms. Mitchell about SA's physical condition, and they agreed to take SA to the doctor.

The second event occurred on March 6, 2007. The caller reported that a relative babysat for SA on March 6, and that SA still seemed to be undernourished. The babysitter also told the caller that SA was sick with "flu-like" symptoms and that SA's father was not seeking any medical care for the boy.<sup>41</sup>

---

<sup>35</sup> Bates 002023.

<sup>36</sup> Bates 002022.

<sup>37</sup> Bates 002022-023.

<sup>38</sup> Bates 002024.

<sup>39</sup> Bates 002021, 002025.

<sup>40</sup> Bates 002003, 002027.

<sup>41</sup> Bates 000931-32, 001221, 2068-69. The LPRT did not find any record that shows that SA saw a physician between August, 2005 (when he moved into the Abegg home) and February, 2007.

Based on the anonymous call, CPS contacted the Snohomish County Sheriff's Office and requested a welfare check. When officers arrived at the Abegg home, they knocked repeatedly at the door to gain entry. After five minutes, someone answered the door. After the officers went into the house, Mr. Abegg tried to hide SA from the officers' view.<sup>42</sup>

Officers examined SA, who appeared to be dangerously underweight. They took him immediately to the hospital. While in the emergency room, SA asked the nurses not to tell anyone that he was eating, "because he may get in trouble." Doctors found that SA suffered from severe malnutrition, was hypothermic, and weighed 11 kg (or 24.25 pounds).<sup>43</sup> By contrast, at his 18-month-old well-child checkup on March 22, 2004, SA weighed 27.0 pounds.<sup>44</sup> Thus, he weighed nearly three pounds less than he had weighed *three years* previously. Based on his height at that time, SA should have weighed between 32-35 pounds in March 2007.<sup>45</sup>

After being transferred to Children's Hospital for several weeks of treatment, SA has since regained weight, is in the healthy weight and height range for his age, and is receiving regular medical care. He is currently living in foster care.

After the medical examination, Danny Abegg and Marilea Mitchell were arrested. On December 19, 2007, they were both convicted of the crime of first degree criminal mistreatment.

## The Context for the Incident: Neglect and Failure to Thrive are Underreported Nationwide

SA suffered from a form of child abuse/neglect: non-organic FTT. This section briefly discusses (a) child neglect in general; (b) specific considerations regarding non-organic FTT; and (c) the systems in place in Washington State that can detect child neglect.

### *Child Neglect Is Underreported Nationwide*

Neglect is the most common form of child maltreatment, yet it "frequently goes unreported and, historically, has not been acknowledged or publicized as greatly as child abuse."<sup>46</sup> Difficulties in measuring the frequency of child neglect can include underreporting, different definitions of neglect, changes in community standards (i.e., evolving ideas of corporal punishment), and whether community resources are available to accept referrals for cases of neglect.

In 2004, nearly 3 million referrals were made to CPS nationwide, involving approximately 5.5 million children. CPS investigations determined that about 872,000

---

<sup>42</sup> Bates 001049, 001221, 001985.

<sup>43</sup> Bates 001006.

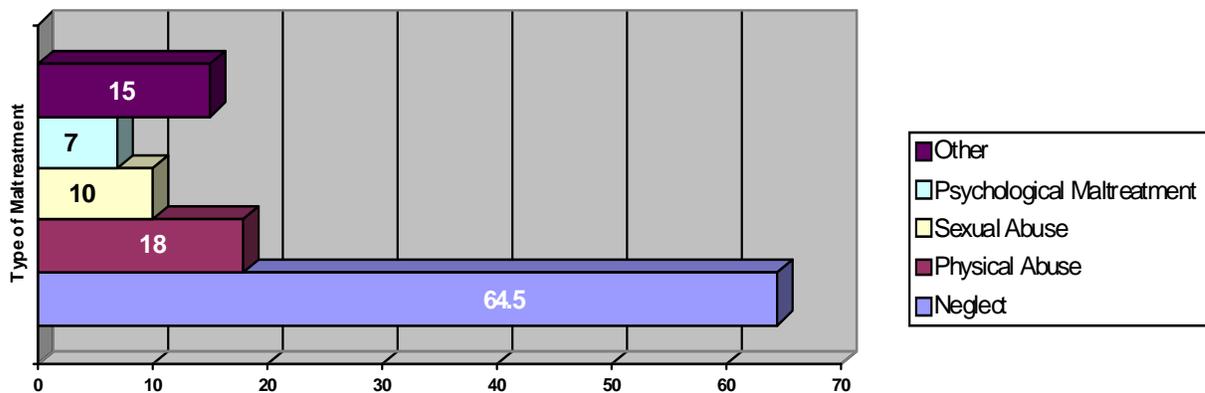
<sup>44</sup> Bates 003752.

<sup>45</sup> Bates 005384.

<sup>46</sup> DePanfilis, D., *Child Neglect: A Guide for Prevention, Assessment, and Intervention* (2006), U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, Office on Child Abuse and Neglect, at 9.

of these children were maltreated.<sup>47</sup> The types of maltreatment are displayed in the accompanying graph. However, experts believe maltreatment is grossly under-reported and estimate that “less than one-third of child abuse and neglect cases are reported to CPS.”<sup>48</sup>

2004 Nationwide Child Maltreatment Statistics



% of Children with Findings, N = ~872,000  
 (total >100% because some findings were of multiple types of maltreatment)

In 2004, approximately 1,490 children were reported to have died of maltreatment nationwide. Unfortunately, when a child dies due to neglect, there are generally very few obvious clues as to who caused the death and even how the death happened, making it very difficult to determine exactly how many child deaths result from neglect. “One study estimated that 85 percent of child maltreatment fatalities are not recorded as such on death certificates.”<sup>49</sup> One estimate of the overall cost of child abuse and neglect, calculated in 2007 dollars, exceeds \$103 billion.<sup>50</sup>

Fatalities by type of maltreatment are shown in the next chart. Taken together, the national statistics in these two charts show that neglect is the leading cause for both child maltreatment and fatality cases.

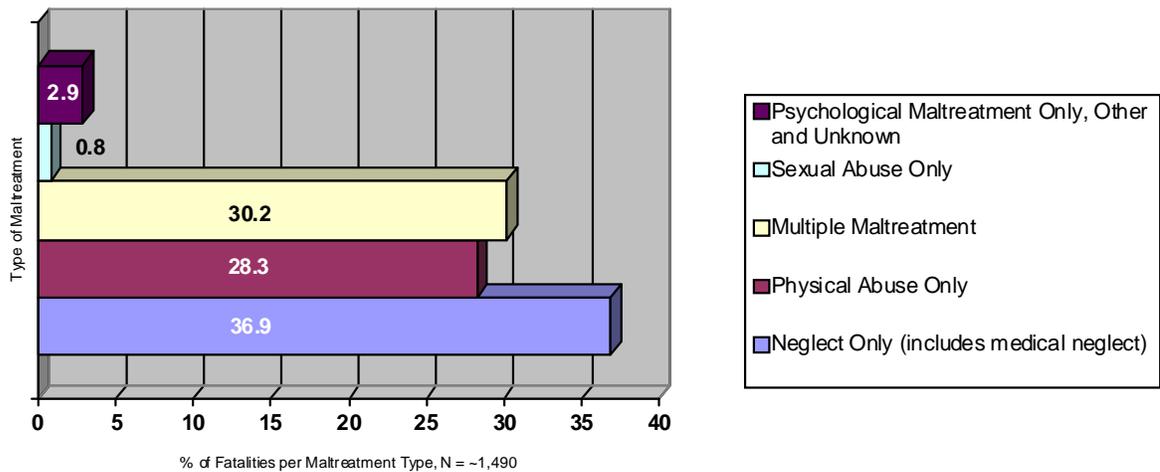
<sup>47</sup> *Id.*, at 16 (citing *Child Maltreatment 2004*, National Child Abuse and Neglect Data System (NCANDS), Children’s Bureau, Administration on Children and Families, U.S. Department of Health and Human Services). NCANDS is a voluntary national data collection and analysis system created in response to the requirements of the *Child Abuse Prevention and Treatment Act* (CAPTA) (Public Law 93-247).

<sup>48</sup> *Id.*, (citing the *Third National Incidence Study of Child Abuse and Neglect* (1996)).

<sup>49</sup> *Id.*, at 18.

<sup>50</sup> “Total Estimated Cost of Child Abuse and Neglect in the United States,” Wang, C. & Holton, J. (2007). These costs were based on calculations of direct costs (i.e., hospitalization, mental health care system costs, child welfare system costs, law enforcement costs) and indirect costs (i.e., special education costs, juvenile system costs, mental health and health care costs, adult criminal justice system costs, and lost productivity to society).

## 2004 Nationwide Child Fatality Statistics



As mentioned above, one reason that neglect is not measured accurately is that there is no single definition of “child abuse and neglect.” Federal law defines it as:

any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm... or an act or failure to act which presents an imminent risk of serious harm.<sup>51</sup>

Washington State law defines it as:

injury of a child by any person under circumstances which cause harm to the child’s health, welfare, or safety... or the negligent treatment or maltreatment of a child by a person responsible for or providing care to the child.<sup>52</sup>

Washington State DSHS administrative rules define it as:

Negligent treatment or maltreatment means an act or failure to act, or the cumulative effects of a pattern of conduct, behavior, or inaction, on the part of the child’s parent... that shows a serious disregard of the consequences to the child of such magnitude that it creates a clear and present danger to the child’s health, welfare, or safety... [including failure] to provide adequate food... for a child’s health, welfare, or safety.<sup>53</sup>

<sup>51</sup> 42 U.S.C. 5106g (CAPTA) (1974). CAPTA was amended most recently by the *Keeping Children and Families Safe Act* of 2003.

<sup>52</sup> RCW 26.44.020(12).

<sup>53</sup> WAC 388-15-009(5). The Washington Legislature recently confirmed:

It is the intent of the legislature that the department of social and health services be permitted to intervene in cases of chronic neglect where the health, welfare, or safety of the child is at risk. One incident of neglect may not rise to the level requiring state intervention; however, a pattern of neglect has been shown to cause damage to the health and well-being of the child subject to the neglect.

See Chapter 512, Laws of 2005, §2.

One commentator describes the following range of responses to maltreatment based upon the degree of neglect:

- **Mild neglect** usually does not warrant a report to CPS, but might necessitate a community-based intervention (e.g., a parent failing to put the child in a car safety seat).
- **Moderate neglect** occurs when less intrusive measures, such as community interventions, have failed or some moderate harm to the child has occurred (e.g., a child consistently is inappropriately dressed for the weather, such as being in shorts and sandals in the middle of winter). For moderate neglect, CPS may be involved in partnership with community support.
- **Severe neglect** occurs when severe or long-term harm has been done to the child (e.g., a child with asthma who has not received appropriate medications over a long period of time and is frequently admitted to the hospital). In these cases, CPS should be and is usually involved, as is the legal system.<sup>54</sup>

This view is not universal, however, and the lack of a common definition of neglect continues to be a barrier to accurate reporting. An additional barrier arises from different definitions used in various professions that serve maltreated children (such as doctors, nurses, case workers, etc.). Furthermore, a professional's assessment of neglect will likely vary depending upon a child's developmental stage.<sup>55</sup>

Regardless of how frequently neglect occurs, child welfare experts generally describe neglect as existing within several specific (though broad) categories, including: "physical neglect; medical neglect; inadequate supervision; environmental, emotional and educational neglect; and newborns addicted or exposed to drugs."<sup>56</sup> Failure to thrive is a type of neglect that falls within the category of physical neglect.<sup>57</sup>

### *Failure to Thrive and Growth Monitoring*

#### **What is Failure to Thrive, and What Can Cause It?**

The National Institutes of Health (NIH) define "Failure to Thrive" (FTT) as a descriptive term for "children whose current weight or rate of weight gain is significantly below that of other children of similar age and sex."<sup>58</sup> There are several different medical causes

---

<sup>54</sup> DePanfilis, D., at 10 (citing English, D. (1999), "Evaluation and risk assessment of child neglect in public child protection services," in Dubowitz, H. (Ed.), *Neglected children: Research, practice, and policy* (2000) at 191-210).

<sup>55</sup> *Id.*, at 9-11.

<sup>56</sup> *Id.*, at 11.

<sup>57</sup> *Id.*, at 12.

<sup>58</sup> On-line Medical Dictionary, National Institutes of Health (NIH), "Failure to Thrive," located at: <http://www.nlm.nih.gov/medlineplus/ency/article/000991.htm>.

for FTT, which include genetic disorders, diseases, or injury.<sup>59</sup> Various cultural and/or social factors may contribute to a child's under nutrition, including social isolation, depression, repeated loss experiences (psychological trauma), and financial hardship.<sup>60</sup> FTT can also occur due to caregiver neglect or abuse.<sup>61</sup>

### How Often Does Failure to Thrive Occur in Children Aged 0-5?

Although records are kept nationally on reported child abuse and neglect, there is no uniform national system for reporting when abuse or neglect also results in FTT. At best, national statistics approximate how often FTT occurs.<sup>62</sup> No current national studies have been conducted to assess the prevalence of children under the age of six that fail to thrive due to caregiver neglect or abuse.<sup>63</sup>

### Washington State Statistics on Failure to Thrive

In Washington State, hospitals report FTT cases to the DOH, which recognizes two types of FTT: organic and non-organic. Organic FTT is defined as “acute or chronic illness that interferes with nutritional intake, absorption, metabolism, excretion and energy requirements.” Non-organic FTT is defined as FTT that occurs as a symptom of neglect or abuse. DOH statistics derived from Washington hospital reports of FTT cases where children were hospitalized are shown below.<sup>64</sup>

Failure to Thrive, ICD-9 CM 783.41						
Age	2002	2003	2004	2005	2006	Total
0	421	369	452	416	387	2,045
1	132	103	115	99	147	596
2	33	36	53	40	33	195
3	18	14	13	16	11	72
4	8	6	13	11	12	50
5	12	9	4	15	12	52
<b>Total</b>	<b>624</b>	<b>537</b>	<b>650</b>	<b>597</b>	<b>602</b>	<b>3,010</b>

<sup>59</sup> Medical causes can include gastrointestinal issues (i.e., chronic diarrhea or liver disease, or cystic fibrosis); a chronic illness or medical disorder (i.e., cleft palate, or cardiac disorders); or infections (i.e., parasites, tuberculosis). See [http://www.kidshealth.org/parent/nutrition\\_fit/nutrition/failure\\_thrive.html](http://www.kidshealth.org/parent/nutrition_fit/nutrition/failure_thrive.html).

<sup>60</sup> Sturm, L. and Gahagan, S., “Cultural Issues in Provider-Parent Relationships,” in Kessler, D.B., & Dawson, P. (Eds.), *Failure to Thrive and Pediatric Undernutrition* (1999), at 353.

<sup>61</sup> *Id.* DSHS-CA acknowledges these concerns in their policy manual regarding risk assessment for cases reported to CPS, which states: “Failure to thrive may be caused by an underlying medical disorder; by caregiver actions or inactions; or may be a combination of the two situations.” DSHS-CA, *The Practice Guide to Risk Assessment* (2006), at 27.

<sup>62</sup> See Casey, P. H., “Diagnostic Coding of Children with Failure to Thrive,” in Kessler & Dawson, at 281-86.

<sup>63</sup> See Kessler, D. B., “Failure to Thrive and Pediatric Undernutrition: Historical and Theoretical Context,” in Kessler & Dawson, at 6. One 1988 study found that “26 percent of abused children in a large case series experienced growth impairment.” Sherry, B., “Epidemiology of Inadequate Growth,” in Kessler & Dawson, at 32 (citing Taitz, L.S., & King, J.M., “Growth patterns in child abuse,” *Acta Paediatrica Scandinavica*, 343 (Suppl.), at 62-72).

<sup>64</sup> Data Charts prepared by Ann Lima, Center for Health Statistics, Washington State DOH (November 8, 2007). Sources include: the DOH Comprehensive Hospital Abstract Reporting System (CHARS); Veterans Administration Hospital Records, Madigan Army Medical Center, and Navy Hospital Bremerton; and Oregon records of hospitalizations for Washington State Residents from the Oregon State Inpatient Database (SID), Oregon Healthcare Cost and Utilization Project (HCUP), and the Oregon Agency for Healthcare Research and Quality. Although the data may contain some duplications (certain children are hospitalized multiple times), statewide totals may be higher than listed in the charts because not all instances of FTT are reported to hospitals, or are properly diagnosed.

It is not possible under current Washington State reporting guidelines to discern how many of these 3,010 reported cases involve neglect or abuse, as the hospital reporting codes do not distinguish between organic and non-organic FTT. It is unclear whether all Washington hospitals report instances of non-organic FTT when child patients are victims of multiple forms of abuse.<sup>65</sup> Furthermore, many children with less severe cases of FTT are treated in emergency rooms and/or outpatient clinics – and are therefore never admitted to the hospital. Thus, the data in this chart inaccurately reflect the true prevalence of non-organic FTT in Washington State and is likely a significant underestimate of this form of abuse.

Part of the difficulty with obtaining accurate data on FTT statewide is the lack of any universal health care reporting system; no single source of health care-related data exists regarding all children in the state. The lack of such a reporting system means that the LPRT was unable to evaluate the adequacy of health screening of various populations in Washington.

### **Growth Monitoring is the Best Way to Prevent Failure to Thrive in Young Children**

The National Institutes of Health state that the “best means of prevention [of Failure to Thrive] is by early detection at routine well-baby examinations and periodic follow-up.”<sup>66</sup> Such examinations include tracking a child’s growth by monitoring weight, height, and head circumference.<sup>67</sup> Even for physicians, early detection of FTT requires more than a visual inspection of the child:

Because a diagnosis of pediatric under nutrition involves much medical and nutritional information, the initial data gathering must be focused in this area. Information that should be collected includes past medical history, birth records, growth records... and data from programs, such as the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), and professionals, such as visiting nurses, case workers, occupational therapists, and speech-language pathologists... The basic nutrition evaluation, including feeding observation and record of food intake, is also very important.<sup>68</sup>

However, not all children in Washington receive growth monitoring.

---

<sup>65</sup> For example, if a child is abused by a caregiver that has broken the child’s ribs and who also starved the child, it is unclear whether all hospitals will code the incident as broken ribs **and** non-organic FTT.

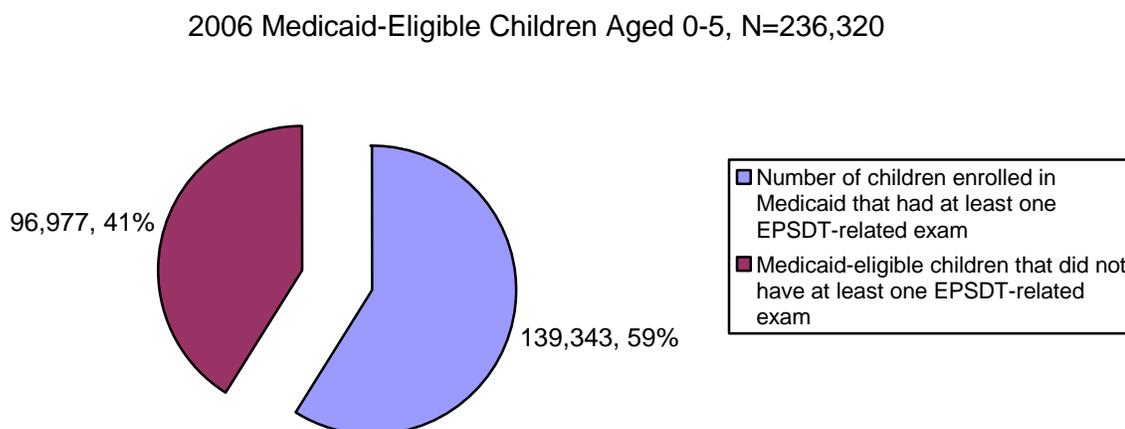
<sup>66</sup> On-line Medical Dictionary, “Failure to thrive,” *supra*.

<sup>67</sup> The health tracking funded through Medicaid is called the Early and Periodic Screening, Diagnosis and Treatment (ESPDT) program, which is designed to screen Medicaid-eligible clients (that are under 21 years of age) for physical and/or mental health problems. The data retained by Medicaid includes only billing records.

<sup>68</sup> Claxton, N. & Sirotnak, A. P., “Child Protective Services,” in Kessler & Dawson, at 427.

## Medicaid Statistics Establish that Many Medicaid-Eligible Children do not Receive Growth Monitoring

In 2006, about 236,320 children between the ages of 0-5 years old were eligible for Medicaid.<sup>69</sup> Of these Medicaid-eligible children, only about 139,343, or about 59 percent, actually received at least one physical examination that likely tracked their growth.<sup>70</sup> This data is shown in the chart below:



While lack of EPSDT well child exams likely means that a child's growth was not measured, it is unknown how many of the 96,977 children (or 41 percent) eligible for Medicaid were in fact measured to track their growth.

### The Effect of Undiagnosed Failure to Thrive on a Young Child is Potentially Severe

The impact of non-fatal FTT on a child's physical and psychological health and development is the subject of numerous ongoing studies. Overall long-term effects of under nutrition can include an increased risk that a child will develop long-term behavior problems.<sup>71</sup> In addition, several physical deficits may occur, such as reduced physical growth, reduced hormonal functions, decreased immune system development and functioning, and inhibited vital organ development.<sup>72</sup>

### **Who Can Detect Non-Organic FTT in Young Children?**

A report that a child is undernourished may come from many different people in the child's life. The first group that might report a child's FTT is family members, who typically would have the most consistent, extensive interactions with the child. Members of the community, church or day care center as well as government workers

<sup>69</sup> Data assembled by Dan Conlon, Financial Service Specialist, Health and Recovery Services Administration (HRSA), Washington State DSHS (January 3, 2008). HRSA administers the Washington Medicaid program.

<sup>70</sup> *Id.*

<sup>71</sup> See Black, M. M., Berenson-Howard, J. and Cureton, P. L., "Home-Visiting Intervention for Families of Children Who Experience Growth Delay," in Kessler & Dawson, *supra*, at 385-86.

<sup>72</sup> See Metallinos-Katsaras and Gorman, K. S., "Effects of Undernutrition on Growth and Development," in Kessler & Dawson, at 37-38.

also may report a child's under-nutrition. Detection may occur "in a variety of settings, including pediatric inpatient wards and outpatient clinics; early intervention centers; Special Supplemental Nutrition Programs for Women, Infants and Children (WIC) nutrition clinics; and social services agencies."<sup>73</sup>

Medical Providers - Pediatricians and Family Physicians are some of the primary sentinels for child neglect. Under Washington law, they are "mandatory reporters" – that is, they are required to report neglect and abuse to law enforcement and CPS officials.<sup>74</sup> As a part of their duties attending to a child's physical well-being, primary medical providers will monitor physical growth indicators (i.e. height, weight, head circumference). One study suggests the following list of risk factors that can suggest the possibility of FTT caused by neglect:

- parental depression, stress, marital strife, divorce
- parental history of abuse as a child
- mentally challenged parents and parents with psychological abnormalities
- young and single mothers without social supports
- domestic violence
- alcohol or other substance abuse
- previous child abuse in the family
- social isolation and/or poverty
- parents with inadequate adaptive and social skills
- failure to adhere to medical regimens
- lack of knowledge of normal growth and development
- infant with low birth weight or prolonged hospitalization<sup>75</sup>

Publically Funded Services - Many programs that are funded by federal, state, and/or local governments offer services that include growth monitoring, which can lead to detection of FTT.<sup>76</sup> The federal Special Supplemental Nutrition Programs for Women, Infants and Children (WIC), administered in Washington by the DOH, provides funding to local health jurisdictions (LHJs), which offer services that include monitoring growth. Through LHJs, WIC provides funding for food and health services to qualifying families with children less than six years of age, and participants are required to have their children's height and weight measured by LHJ staff. If FTT is diagnosed, families are offered interventions designed to improve the child's health.

---

<sup>73</sup> Sturm, L. and Dawson, P., "Working with Families: An Overview for Providers," in Kessler & Dawson (*supra*), at 65.

<sup>74</sup> RCW 26.44.030.

<sup>75</sup> "Failure to Thrive as a Manifestation of Child Neglect," *Pediatrics* Vol. 116, No. 5, (2005), at 1235. The authors conclude that "for infants with FTT who are suspected to be victims of abuse and neglect, aggressive multidisciplinary intervention is required." *Id.*, at 1236.

<sup>76</sup> Community Health Clinics also can provide similar detection and intervention services along with many Faith-Based and Charitable organizations. Many of these organizations also contract with DOH or DSHS to deliver services.

## *Child Protective Services Investigates Reports of Suspected Neglect*<sup>77</sup>

Law enforcement and CPS are the two groups that investigate reports of alleged neglect and abuse of children. CPS becomes involved in an investigation of alleged child neglect or abuse when an intake worker receives a report of alleged abuse or neglect of a child. The basic question for CPS Intake is whether the allegations meet the statutory definition of abuse or neglect (RCW 26.44.020 and WAC 388-15-009) or that the child is at imminent risk of abuse or neglect.<sup>78</sup>

Intake risk assessment is an analysis that results in a rating by the intake worker that ranges from “zero” (meaning no risk) to “five” (“high risk”).<sup>79</sup> The following chart displays possible agency actions based on the risk assessment under current policies:

Risk Assessment	Agency Action
0 – No Risk	Assigned for Alternate Intervention
1 – Low Risk	Assigned for Alternate Intervention
2 – Moderately Low Risk	Assigned for Alternate Intervention
3 – Moderate Risk	Assigned for CPS investigation
4 – Moderately High Risk	Assigned for CPS investigation
5 – High Risk	Assigned for CPS investigation

### **Possible Agency Actions for Children with Intake Risk Assessments of 0-2**

When a CPS report is identified to have no risk, low risk, or moderately low risk (0-2) at intake, the department may provide one of the following Alternate Interventions:

1. Assign the CPS report to a Children’s Administration case worker, or
2. Make a referral to an Alternative Response System (ARS – contracted program) or other community agencies which are willing to accept the referral for services and/or monitoring (these may or may not be contracted agencies).

The assigned case worker may send a letter to the family, make a phone call to the caretaker(s), or make a brief home visit with the family to provide some or all of the following depending upon the particular circumstances in the referral:

- Notification that CPS has accepted a CPS report for Alternate Intervention,
- Information included in the referral regarding allegations of child abuse or neglect,
- Information on the local DCFS telephone number/contact,

---

<sup>77</sup> CPS conducted its own Executive Review of this incident, with a purpose distinct from the purpose of this review: “The purpose of the [CPS] review was to look at how the department was involved throughout the lives of SA and his older brother, JA, and to evaluate service delivery by the department.” Thus, the CPS Executive Review focused on its service delivery to SA, rather than the root causes of the incident.

<sup>78</sup> See Appendix A, *Risk Assessment Decision Making* (displays the CPS process of risk assessment).

<sup>79</sup> See fn. 20, *supra*.

- Information on community resources which may be available to address the needs of the family (i.e., information and referral), and
- Notification that no further action will take place in response to the CPS report.

### **Possible Agency Actions for Children with Intake Risk Assessments of 3-5**

When a CPS report is identified to have moderate to high risk (3-5) at intake, the department must assign the report to be investigated. This assignment requires CPS Investigators to conduct a new, more thorough risk assessment of the alleged child victim and their family. CPS investigators have 45 calendar days to complete their investigation. Based upon a safety assessment, the new risk assessment, and other evidence collected during the investigation, there are three possible case outcomes for a CPS investigation:

1. A written voluntary service agreement with the family signed by the participants,
2. A dependency action filed in juvenile court, or
3. Closure of the CPS case.

Outlined below is an overview of each outcome.

1. **Voluntary Service Agreement (VSA)** – The VSA is used to engage families who are willing to participate in services intended to reduce current and future abuse or neglect issues. Voluntary services are designed for families that do not require court intervention. The CPS investigator and CPS supervisor will review the information gathered from the Safety Assessment, initial interviews, case history and risk assessment to determine if a VSA is appropriate, based on the following factors:
  - The level of risk and safety concerns,
  - The protective factors that exist within the family and their support system,
  - The temporary nature of the family crisis,
  - The family's ability and willingness to engage in services and achieve their goals within the time period specified,
  - The service(s) being offered to the family are likely to help maintain or restore a safe, stable family environment,
  - Safety and protection of the child does not appear to require court intervention, and
  - The Voluntary Service Agreement is in the child's best interest.

Examples of voluntary services that may be offered to a family under a VSA include, but are not limited to:

- Drug and alcohol evaluation
  - Mental health evaluation
  - Family Preservation Services (FPS) or Intensive Family Preservation Services (IFPS) –FPS and IFPS services are remedial services offered to prevent out-of-home placements. If a family does not cooperate with these services or fails to complete these services, it is likely that a child may be removed from the home and placed in out-of-home care (e.g., this may include foster care, relative placement or placement with a suitable person).
  - Voluntary Placement Agreement (VPA) – A VPA may be used when one of the following conditions exists:
    1. A parent is requesting a short term (i.e. no longer than 180 days) placement of a child (age 0-18).
    2. A dependent youth, age 18 is signing him- or herself back into care to complete their education or vocation program.
    3. A judge oversees a court hearing where the parent/guardian of a Native American child is requesting a short term (i.e. no longer than 180 days) placement of a child (age 0-18).
2. **Dependency Action Filed in Juvenile Court** – A worker may file a dependency petition when a child is determined to be at serious and immediate harm, or is not safe to remain in the home and requires out of home placement. A worker may also file a dependency petition (in-home dependency) to place court structure and intervention around a child and the family, when circumstances allow the child to remain safely within their family home under court supervision and monitoring.
3. **Closure of the CPS Case** – Following the completion of the CPS investigation, CPS will close a case when:
- The family does not require services,
  - The risk has been reduced or eliminated through provision of services and no longer requires CPS intervention, or
  - The family requires services, refuses services, and there is not legal sufficiency to file a dependency petition.

# Root Cause Analysis

---

After completing incident-related interviews and research, Loss Prevention Review Teams use the root cause analysis process to find out why and how an incident happened and to document the root causes of an injury. Sharing the results of this analysis helps agencies to design and implement changes that can better prevent such harm in the future. The purpose of the review is to improve the delivery of services that agencies provide to the citizens of Washington.

This LPRT report addresses the root cause(s) of SA's FTT.

## Abusive Caregivers were the Root Cause of SA's Failure to Thrive

The LPRT performed a comprehensive root cause analysis in this case and determined that the primary root cause for the injuries to SA is the behavior of SA's father, Daniel Abegg and Mr. Abegg's partner, Marilea Mitchell.

On December 19, 2007, Mr. Abegg and Ms. Mitchell were convicted of first degree child mistreatment. The prosecutor concisely said why each adult was the root cause of SA's starvation: "They made a decision every day. At lunchtime, at dinner time, at snack time, at breakfast: We're all eating and [SA] isn't."<sup>80</sup>

Mr. Abegg and Ms. Mitchell had been warned that SA had food- and feeding-related issues. On August 9, 2006, the Grayson counselor reported:

The largest issue for [SA and his brother, JA has] been the trauma they endured while they were with their mom [KA]. The boys have a severe fear of lack of food... they steal and horde food from the rest of the family. While they were with their mother they would go for days without food; they never knew when the next time [was that] they would be getting something to eat. [The Grayson counselor] is working with Danny and [Ms. Mitchell] about the food problem... the family has agreed to leave food out all the time so the boys can eat at will – let them realize that there is always food available. Danny and [Ms. Mitchell] are working on parenting skills to help the boys with their food issues.<sup>81</sup>

Mr. Abegg and Ms. Mitchell concealed SA's medical condition by not taking the boy to a doctor between the date that CPS first investigated them (in June 2006) and the day that SA was removed from their home (March 7, 2007).<sup>82</sup> Because medical professionals are typically the only service providers who receive training in early detection of FTT, Mr. Abegg and Ms. Mitchell effectively prevented detection of SA's condition until he was severely malnourished.

---

<sup>80</sup> See "Couple convicted of denying food to 4-year-old," *Seattle Times* (12/20/07), located at [http://seattletimes.nwsources.com/html/localnews/2004083767\\_abegg20m.html](http://seattletimes.nwsources.com/html/localnews/2004083767_abegg20m.html).

<sup>81</sup> Bates 001887.

<sup>82</sup> In addition, during the welfare check on March 7, 2007, Mr. Abegg tried to hide SA's body from the investigating officers' view. Bates 001221.

Typically, root cause analysis reveals more than one cause for an incident under review. Root cause analysis is fact-based and addresses known facts only. It is not based upon speculation and represents a determination of what actually occurred in a particular circumstance.

In this case, it has been extremely difficult to discern additional root causes due to the complex diagnostic issues raised in this FTT case. Because there was no growth monitoring of SA for the years before his near starvation, and because the Abeggs did not take SA to a medical professional for regular medical care, it is impossible to tell specifically *when* Mr. Abegg and Ms. Mitchell began to starve him.<sup>83</sup> The LPRT has found no evidence that shows whether or not additional actions by the case workers would have prevented the Abeggs from starving SA.

There are no records from the Grayson counselor regarding his follow-up with the family after CPS closed its case. The Grayson counselor refused to be interviewed by LPRT members. Thus, there is insufficient evidence in the record to be able to determine whether the Grayson counselor's actions (or failures to act) were a root cause of SA's injuries. Certainly, the Grayson counselor is not a trained medical professional.

It may be tempting in such a tragic case to speculate about different outcomes; it is easy, in retrospect, to ask, "what if?" However, speculation does not establish an actual cause of an event, and is therefore rejected in root cause analysis.

Even though the root cause analysis process does not identify additional root causes for the injuries to SA, there are certain measures that can be taken to increase the likelihood that service providers could detect FTT early and prevent such incidents from occurring in the future. We provide this analysis below.

## Possible Measures to Reduce Future Occurrences of Failure to Thrive in Washington

### ***Growth Monitoring Should be Confirmed when Services are Provided to Young Children through a Child Protective Services Voluntary Service Agreement***

Growth monitoring is the essential method for early detection of FTT in children aged 0-5 years. Currently, medical professionals are the only service providers that are adequately trained to properly measure, monitor, and assess a child's growth. The CA acknowledges the importance of such monitoring by medical professionals in the foster care system when it requires the Administration to track the health of all foster children.<sup>84</sup>

---

<sup>83</sup> The deputy prosecutor who convicted Mr. Abegg and Ms. Mitchell reported that one of the witnesses for the State was a medical expert from Harborview Medical Center in Seattle. The expert testified that SA's physical condition when he was removed from the Abegg home indicated that his parents had not provided adequate nutrition to the boy for at least two, and possible six, months. The expert indicated it was not possible to give a more precise estimate for the timeframe of the abuse. *Interview with Snohomish County Deputy Prosecutor Mark Roe*, March 18, 2008.

<sup>84</sup> See *Strategic Plan 2007-2011*, DSHS-CA, at 11 (description of Passport Program).

There is no statewide system for health care monitoring of children served under CPS voluntary service agreements.<sup>85</sup> Certain local health jurisdictions (such as in King County) have coordinated services with the regional CA offices so that, where relevant, children served under voluntary service agreements also receive health-related services.<sup>86</sup>

### ***Involve a Medical Professional in Voluntary Agreement Cases with Feeding Issues***

None of the case workers who worked with the Abeggs received training that could have allowed them to detect FTT in its early stages. Overall, there is no program in place that requires every CPS case worker to receive training on child growth or FTT.

In the circumstances of this case, SA did not have a “medical home” (i.e., the child did not have a physician or nurse who was tracking his overall health and development). There is no evidence that SA regularly saw a medical professional while he lived in the Abegg home. The case workers’ efforts to provide services to SA did not confirm any involvement by someone trained to monitor SA’s growth.

There was no interdisciplinary team approach to review SA’s case. Most of the work of both the case workers and the Grayson counselor focused on the behavior of both SA and the Abeggs. There was no corresponding focus on verifying that SA was seen by a physician and monitoring the actual health and physical development of the child. It would be unreasonable to expect case workers to have medical expertise. Thus, the inclusion of a medical professional appears to be a necessary step in developing an appropriate service model for voluntary agreement cases involving health issues.

The case workers did not benefit from a medical professional’s advice regarding SA’s food- and feeding-related issues (i.e., hoarding food); the case workers’ case management and discharge decisions were uninformed by any input from medical professionals. Therefore, the case workers were unable to detect FTT in its early stages and were particularly vulnerable to the Abeggs’ manipulation.

Inclusion of a medical professional in a team review of the case would have made it probable that a team would monitor the child’s health and physical development. The fact that no medical professional was involved in monitoring SA’s physical growth meant that health-related information was not included in the case workers’ risk assessment of SA’s welfare.

### ***Improve Communication in Voluntary Agreement Cases***

The Abegg family was served by three different case workers between June 2006 and February 2007. The fact that the case files regarding members of the Abegg family

---

<sup>85</sup> However, a Legislative Committee has recognized that one emerging public health trend involves home visits from public health nurses to promote healthy practices and habits in families, which can “produce social and health benefits for both . . . mothers and their children.” See *Findings*, Joint Select Committee on Public Health Finance (November 14, 2006), at 4.

<sup>86</sup> For example, CPS has contracted with Public Health – Seattle & King County to provide Alternative Response System services.

contain over two thousand pages of materials increased the likelihood that important facts regarding the abuse and neglect of SA would be overlooked. None of the files contained brief summaries of SA's case history, his medical history, or a timeline of meaningful events in SA's case. It is informative that the foster care system includes in each case file a form listing essential information regarding a child that includes a summary of the child's medical history. No such form exists for voluntary service agreement cases.

By necessity, a case worker that receives a new or transferred case has the task of becoming familiar with the details of the child and/or family involved. If the case file or files contain(s) thousands of pages, the worker must spend a large amount of time learning the pertinent details, and a complete review is impossible considering their workload. In the absence of a meaningful condensed case summary and timeline, relevant information would likely not be communicated. This is particularly true where, as in the Abegg case, the file was transferred several times in a period of five months. These issues are exacerbated when case workers are relatively inexperienced and have high caseloads.

Additional challenges arise when information about children and families must be transferred between states and between state and tribal entities. This exchange of information may be delayed, incomplete or not accomplished. In this case, transfer of information between states (California and Washington) and between counties within Washington, as well as with various tribal programs presented challenges to ensuring appropriate services were provided to SA.

### ***Improve Staffing of Voluntary Service Agreement Cases that Involve Feeding Issues***

#### **Staffing at the Smokey Point ICW Office**

The three case workers assigned to the Abeggs were all relatively inexperienced; by the time they worked with the Abegg family, case worker #1 had been a case worker for 16 months, while case workers #2 and #3 had been case workers for one month each.<sup>87</sup> Their supervisor was also new, beginning her first supervisory duties in September 2006. None of the staff ever consulted with a medical professional about the case.

Because of understaffing, each case worker, as well as their new supervisor, was under severe pressure due to their high workload and relative lack of experience. For example, in December 2006, case worker #3 was assigned approximately 40 cases – and that month, had been working as a case worker for less than two months. In April 2006, the state average was a total of 24 cases per case worker. The state average included all case workers, regardless of how long they had worked for the CA.<sup>88</sup>

---

<sup>87</sup> Data Chart prepared by Sharon Ham (since retired), DSHS-CA (August 6, 2007).

<sup>88</sup> *Strategic Plan 2007-2011*, DSHS-CA, at 41. In 2004, more than half of the case workers employed by the Division of Child and Family Services had more than 3 years of experience. See "Social Work Supervisor Survey: Summary of Survey Questions and Answers," Miller, M.G., Washington State Institute for Public Policy (February, 2004), at 3.

The CA has responded to the Smokey Point staffing situation. All vacant Smokey Point case worker positions have now been filled and the office is fully staffed with a mix of both experienced and new employees.

### **Statewide Staffing Issues**

In November 2007, the CA completed a workload study that analyzed what could be done to address, in part, certain “gaps in Child Welfare service delivery.”<sup>89</sup> The study established Constructed Standards for child case worker duties, which reflected “the expected amount of time necessary to perform a service for a case in a month, if all federal and state law, policy and good practice” requirements are fulfilled.<sup>90</sup>

The report analyzed the statewide average time that a case worker actually spends on each case and compared these averages with the study’s Constructed Standards.<sup>91</sup> The study recommended additional overall staffing, or efficiencies that could result in workload reduction that would allow service per case to increase by approximately 58 percent.<sup>92</sup>

The Legislature began addressing these issues in July 2005 by providing additional funding and staff to DSHS-CA. This funding increased the pay levels for case workers, and has allowed the CA to hire over 400 additional case workers, supervisors, and staff by May 2008.

## **Recommendations**

---

Each of the LPRT’s recommendations is consistent with the state’s acknowledgment that child welfare depends fundamentally upon preserving a child’s safety and a child’s health.<sup>93</sup> The LPRT applauds the overall success of the CA in promoting child safety. The recommendations are designed to enhance the CA’s ability to initially identify possible FTT cases, monitor and promote the health of children served under voluntary contracts in an equitable manner throughout the state.

***Recommendation 1: Confirm that the health status of all children under six years of age served by Child Protective Services is monitored by medical professionals.***

When a voluntary service agreement is created to provide services to children and families, there is no systematic method through which case workers can confirm that

---

<sup>89</sup> *Washington State Children’s Administration Workload Study*, Walter R. McDonald & Associates, Inc. (2007), at vii.

<sup>90</sup> *Id.*, at ix.

<sup>91</sup> *Id.*, at xii.

<sup>92</sup> *Id.*, at xi (Figure E.2). The addition of 58 percent of case worker time spent on the Abegg case could have resulted in improved risk assessment and analysis of the safety of SA.

<sup>93</sup> See, e.g., RCW 13.34.020 (“child’s health and safety shall be the paramount concern” of the Juvenile Court Act); RCW 43.20A.870 (DSHS must annually report on “outcomes regarding health and safety of children in the children’s services system”); RCW 74.14C.005(1) (in support of FPS, “the legislature believes that protecting the health and safety of children is paramount”); RCW 74.15.010(1) (foster care system must “safeguard the health, safety, and well-being of children”).

medical professionals are routinely monitoring a child's growth. In addition, there is a distinct need to improve state case worker training programs regarding child health care issues.

Fundamentally, the system should be able to answer the following basic and essential questions regarding the health of a young child (i.e., a child between 0-5 years old):

- How is the child growing?
- How is the child developing?
- Does the child have any medical problems?
- Does the child have health insurance?
- Does the child have a regular doctor/medical provider?
- Is the child receiving well child (i.e., preventive) care?
- Are the medical needs of the child being met?
- Is the family able to meet the child's health and medical needs?

These questions can only be answered in conjunction with a medical professional. In many instances, partnership with a public health provider<sup>94</sup> can help address these questions, monitor health status, and assure access to a primary care provider. Thus, CPS should monitor the growth of children less than six years of age who they serve under voluntary service agreements.

Health monitoring can be accomplished by implementing the following initiatives:

- Prioritize monitoring of child health, including growth, within CPS voluntary service agreement cases involving children aged birth to five years old;
- Partner with medical professionals so that all such children receive regular health care within a medical home, including monitoring of growth and development; and
- Partner with local public health providers as needed to help assess child health needs, connect the child with a medical home, and to monitor and treat growth or other health concerns in partnership with the child's medical home.

***Recommendation 2: Confirm that all children served by Child Protective Services are receiving care in a medical home.***

The Legislature has begun to increase state-level investments in Medical Home and Early Learning systems. The expansion of medical home and early learning services creates partnership opportunities that can benefit both CPS and the families it serves.

Funding for these systems has increased because there is widespread agreement that all children should have access to health care within a medical home, and to high quality early learning experiences. Together, high quality health care and early learning services support families, and help assure children can be healthy and ready for success in school and in life. Within these efforts, there is a focus on addressing

---

<sup>94</sup> The term "public health provider" refers to either a public health nurse, nurse practitioner, or a doctor working in a local health jurisdiction. Public health providers are discussed, *infra*, in the text accompanying Recommendation #3.

disparities or inequities among children, both in terms of access to services as well as desired health and educational outcomes.

Children and families served by CPS represent many of Washington's citizens who are the most at risk for poor health, developmental delays, and poor educational outcomes. Therefore, the LPRT believes that these children need to be among the first to be served by existing and new services to support children's health and development/learning. By partnering with agencies such as the Department of Early Learning, DOH, DSHS/HRSA, and the Council for Children and Families (formerly known as the Washington Council for the Prevention of Child Abuse and Neglect) – the agencies most involved with Medical Home and Early Learning efforts – CPS will be better able to assist with the improvement of all children's health in Washington, and to help families obtain necessary health- and education-related services.

This recommendation does not require CPS to directly provide every service a family might need. Instead, the focus of this recommendation is to facilitate the appropriate connection of a child and/or family to needed services, through the active creation of – and support for – cross-discipline partnerships. The ability to implement and sustain effective multi-system partnerships (Health Care, Mental Health, Drug and Alcohol

Substance Abuse, Legal, Domestic Violence, and other social service partners) to improve outcomes for children at risk of abuse or neglect is the shared responsibility of all such partnerships.

***Recommendation 3: For children with medical issues served under voluntary agreements, Child Protective Services should consistently use their team service model.***

The LPRT recognizes that partnership with various professional specialists is frequently essential and always helpful in accomplishing best outcomes for children who receive services through CPS. Case workers are ideally positioned to establish teams that optimize the child and family's chances for success.

A leading commentator notes:

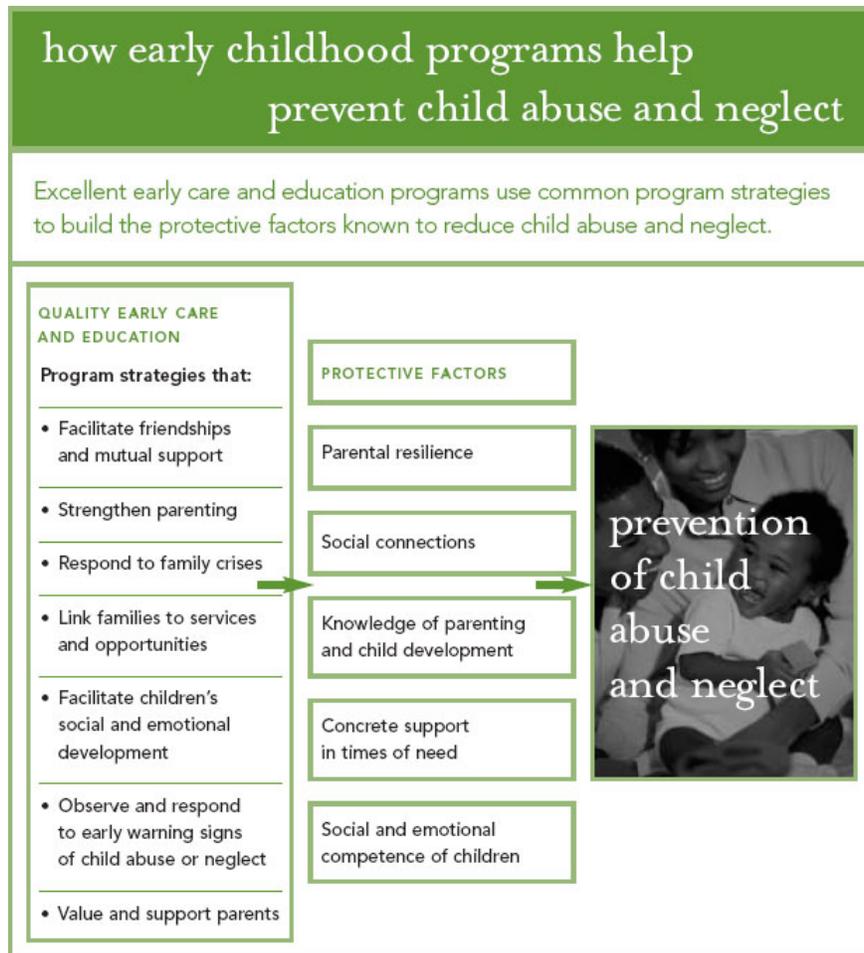
Treatment of undernourished, neglected children requires work in several areas, including nutrition, medicine, social services and mental health... This involves multiple professionals and invites the formation of a team... Communication between the [CPS] worker and the other professionals should address the specific nature of the growth and development problems, medical care needs, and necessary follow-up plan of care. The medical passport system developed by many state agencies can be used for this purpose.<sup>95</sup>

---

<sup>95</sup> Claxton & Sirotnak, *supra*, at 430.

Several opportunities for effective and beneficial partnerships currently exist.<sup>96</sup> For example, joint problem solving of non-organic FTT issues could involve “public health agencies, hospitals and medical clinics, feeding and nutrition services, child care agencies, social services... [WIC and] mental health centers . . .”<sup>97</sup>

Best practices for preventing child abuse and neglect include creating partnerships between early care and education programs, and child welfare agencies.<sup>98</sup> As the accompanying chart<sup>99</sup> illustrates, a positive relationship between child welfare agencies with families and their support groups facilitates child abuse and neglect prevention:



The need for such partnerships, at least for certain cases of child abuse or neglect, was recognized in 1987, when the Legislature created Child Protection Teams (CPTs), which “consist of at least four persons, selected by [DSHS], from professions which

<sup>96</sup> The LPRT acknowledges that for many areas in the state, certain populations do not currently receive sufficient necessary medical care and in some locations, cannot obtain health care. Recently, however, the state Legislature acted on this issue and ESSB 1441, Chap. 279, Laws (2005) was designed to provide all children in the state with health insurance and access to care within a medical home by the year 2010.

<sup>97</sup> McWilliam, P.J., “Coordination of Services,” in Kessler & Dawson, at 481

<sup>98</sup> *Strengthening Families, A Guidebook for Early Childhood Programs*, Center for the Study of Social Policy, <http://www.cssp.org/uploadFiles/handbook.pdf> (2007), at pages 4-17 through 4-24.

<sup>99</sup> *Logic Model for Strategies that Build Protective Factors for Children*, Center for the Study of Social Policy, [http://www.cssp.org/doris\\_duke/logicModel.html#programmatic](http://www.cssp.org/doris_duke/logicModel.html#programmatic) (2007).

provide services to abused and neglected children..."<sup>100</sup> In 1995, the Governor required CPTs to be used:

- a. In all child protection cases in which the risk assessment results in a "moderately high" or "high" risk classification, and the child is age six years or younger;
- b. In all child protection cases where serious professional disagreement exists about a risk of death or serious injury;
- c. In all child protection cases that are opened on the basis of "imminent harm"; and
- d. In all complex child protection cases where such consultation will help improve outcomes for children.<sup>101</sup>

Partnerships with local public health providers could greatly enhance the ability of CPS to preserve the health of the children that the agency serves.<sup>102</sup> Some partnerships already exist (such as with Public Health-Seattle & King County). The efficacy of such partnerships was established by a study regarding FTT and parental depression, reflecting the comprehensive approach required to address child growth issues:

...a child who is identified with poor weight gain should be treated clinically as part of the mother-child dyad, and the mother should be screened for [post-natal depression]... Similarly, the child of a mother who presents with [post-natal depression] should have weight gain checked... The ongoing management of both faltering growth in the child and depression in the mother needs to emphasize supervision and advice on feeding with reinforcement of positive parenting skills rather than repeat weight measurements.<sup>103</sup>

Local public health providers report that for the Foster Care Passport Program, the CA has employed a public health nurse who is a central contact point between the jurisdictions and the CA. This system streamlines administration of the Program, and should be a feature of the statewide partnership program between local health jurisdictions and the CA. Currently, it appears that not every local health jurisdiction has such partnerships.<sup>104</sup>

The CA currently has in place policies and guidelines for Child Protection Team staffing requirements, Family Team Decision-Making staffing requirements, and Multi-

---

<sup>100</sup> RCW 74.14B.030.

<sup>101</sup> Executive Order 95-04. Also see WAC 388-15-033 ("When will CPS involve local community resources?").

<sup>102</sup> One example of a successful partnership is located in Philadelphia. Their *Starting Young* program provides an interdisciplinary team to conduct extensive pediatric developmental evaluations, which includes assessment of physical growth. The team includes medical professionals and social service caseworkers. See [http://cbexpress.acf.hhs.gov/nonissart.cfm?issue\\_id=2005-11&disp\\_art=1059](http://cbexpress.acf.hhs.gov/nonissart.cfm?issue_id=2005-11&disp_art=1059).

<sup>103</sup> "Postnatal Depression and Faltering Growth: A Community Study," *Pediatrics*, Vol. 113, No. 5 (2004), at 1246-47. It is noteworthy that the case workers noticed that after she gave birth to her daughter, Ms. Mitchell appeared to grow distant from SA and to become depressed.

<sup>104</sup> Currently, the DOH tracks access-to-service performance measures in order to assess whether Washington citizens are able to obtain critical health services. The data is shared with local health jurisdictions in order to identify barriers to accessing critical health services, and to close gaps in providing such services to citizens. See *Standards for Public Health in Washington State* (2007), at 15-16.

disciplinary Team staffing. However, in this circumstance, the case workers did not use these team methods. Therefore, the LPRT believes that case workers should receive training on how to facilitate the establishment of a child protective team that includes medical professionals. Creating such a team should be an essential requirement in every case where medical and/or nutritional issues, including concerns about growth and a child's physical development, are involved.

The LPRT recommends the statewide creation of service partnerships between CA case workers and public health providers. This will necessitate training in best practices, possibly using the experiences in local health jurisdictions that already use such partnerships as models for instituting such programs. The benefits of such partnerships are obvious: enhanced ability to monitor children's health and growth; ensuring that medical professionals and public health providers treat children in need; and more efficient coordination of state and federal resources.

***Recommendation 4: In a case where a family agrees to receive voluntary services and where a CPS case worker learns of a growth or feeding issue affecting a child, the case worker should seek medical, as well as behavioral interventions.***

Case workers are not medical providers and thus should not be expected to detect and/or address potentially complex food and/or feeding issues on their own, even with the training recommendations outlined here. This recommendation is a corollary to Recommendation #3, and encourages CPS – where appropriate – to create and rely upon a team service approach that includes medical professionals and public health providers.

***Recommendation 5: The Children's Administration should train its case workers in how to access data so that they can quickly determine whether a child has actually received medical care.***

The Children's Administration currently has a data sharing agreement with the Department of Health (DOH) for access to the CHILD Profile Immunization Registry. Foster Care Public Health Nurses can access the Registry to obtain certain medical information about the children they serve. In addition, the Children's Administration has a real-time interface with the Medicaid Management Information System (MMIS) operated by the DSHS Health and Recovery Services Administration (HRSA). MMIS retains billing data that can be accessed by case workers who need information on open cases.

Although MMIS billing data does not contain a complete medical history, it can be used to obtain anecdotal information that can confirm whether a child has received medical treatment. Thus, training case workers on how to access data within the CHILD registry

and MMIS would give case workers the ability to quickly determine whether a child has actually received medical care.<sup>105</sup>

***Recommendation 6: The Children’s Administration should expand its training program to include training on (a) how to partner with medical professionals, (b) child health and development, (c) child malnutrition, and (d) the impact malnutrition has on a child’s health and development.***

There are three primary means by which CPS case workers receive training: (a) by the CA through formal classes in their initial academy and post academy training; (b) through on-the-job training and supervision; and (c) through formal education programs offered by universities. Case worker academy, post academy trainings, supervisor training and statewide conferences provide instruction regarding subjects and special topics commonly needed by social workers to provide competent social work practice, e.g., Indian Child Welfare, cultural responsiveness, mental health, chemical dependency, safety assessment, permanency planning, engagement with families, teaming as well as an introduction to legal processes.

Recommendation #3 addressed the first two training methods with regard to fostering a team approach to casework that includes medical professionals. A complementary initiative should be undertaken with university training.

Currently in Washington State, the CA partners with the graduate Schools of Social Work in Washington State to focus on strengthening the academic preparation of graduate students with a special interest in child welfare work. The LPRT recommends that the CA, in partnership with the Schools of Social Work, include a focus within their curricula on (a) how to establish partnerships with health care systems and health care providers in the context of providing services to children aged birth to five, and (b) a requirement for studying early child growth and development. Students who gained this knowledge and expertise as part of graduate education would more likely be able to implement the recommendations in this report. In addition, new employees with this training would be able to provide models of effective partnership with medical professionals and public health providers that might influence co-workers, which would have the benefit of strengthening the capacity of CA to detect and serve cases of neglect and FTT.

***Recommendation 7: The Children’s Administration should streamline its process for funding public health services provided to families through local health jurisdictions.***

Both federal and state governments provide funding for early child health care to Washington’s 35 local health jurisdictions (LHJs). Agencies that distribute these funds include DOH and DSHS.<sup>106</sup>

---

<sup>105</sup> Similar benefits could occur through streamlining information sharing with the DOH and its WIC program, which could allow case workers to learn whether a child is receiving nutrition services.

<sup>106</sup> In a recent study, the Joint Legislative Audit and Review Committee (JLARC) analyzed the consistency of public health delivery among the local health jurisdictions. JLARC concluded:

The DOH coordinates delivery of several different types of funds, including WIC. The disparate funding sources are distributed under a single contract to which all 35 LHJs are parties.<sup>107</sup> Since 2004, the DOH Finance Committee has also worked on ways to equitably streamline allocation and dispersal of these funds.<sup>108</sup> DSHS does not have a similar funding system and instead every year requires each LHJ to enter into separate contracts for each type of funding source (e.g. for the Alternative Response Systems).

Some LHJs report that the administrative cost of seeking funding from DSHS exceeds the benefits of funding they would receive from the agency. Some of the jurisdictions have stopped seeking available funding. The LPRT therefore recommends that the CA should adopt a more streamlined process, perhaps using the DOH system as a model. In the alternative, it may be preferable to provide the funds through the DOH local health jurisdiction funding system.

An example of an evidence-based program that could be funded through local health jurisdictions is home visiting. Home visits by medical professionals appear to be an effective means of preventing child neglect. Such home visits have four common objectives: abuse/neglect prevention, improving child health, optimizing child functioning and development, and enhancing parents' care-giving ability. Studies have shown that home visit programs can reduce child neglect by nearly 40 percent.<sup>109</sup> In 2004, the Washington State Institute for Public Policy reported that, for Home Visiting Programs for At-risk Mothers and Children, every dollar invested yielded approximately \$2.24 of societal benefits. The same study found that the Nurse Family Partnership for Low Income Women program yielded approximately \$2.88 of benefits for each dollar spent.<sup>110</sup>

***Recommendation 8: The Children's Administration should review and streamline its paperwork requirements for CPS case workers.***

When a CPS file or files for a child and/or a family include thousands of pages of records, it is very difficult to discern critical facts affecting the family without some form of data summaries that provide an immediate overview of the issues faced by the family.<sup>111</sup> As previously discussed, a newly assigned case worker currently uses a

---

Standardized information is not currently available to paint a complete picture of the choices being made at the local level for public health service delivery. Information that is available shows wide variation in public health expenditures (both in total and per person) and in local jurisdictions' ability to meet the minimum public health standards.

*Review of Washington's Public Health System*, JLARC Report 07-8 (May 30, 2007), at 2, 27-31.

<sup>107</sup> See <http://www.doh.wa.gov/msd/OFS/2005rs/Revsum.htm>.

<sup>108</sup> *Public Health Improvement Plan*, Washington Department of Health, at 28-29 (2004).

<sup>109</sup> See "Interventions to Prevent Child Maltreatment," Daro, D., in *Handbook on Injury and Violence Prevention Interventions*, Doll, L., Mercy, J., Hammond, R., Sleet, D., & Bonzo, S. (Eds.) (2007), at 146. Home visit programs are evidence-based services that promote the prevention of child abuse and neglect, and are funded by the Council for Children & Families (formerly the Washington Council for the Prevention of Child Abuse and Neglect). See <http://www.wcpcan.wa.gov/documents/policybrief2008-homevisiting.pdf>.

<sup>110</sup> See *Benefits and Costs of Prevention and Early Intervention Programs for Youth*, Washington State Institute for Public Policy Report (September 17, 2004), at 6.

<sup>111</sup> Several forms in use at DSHS could serve as models for information to include in a data summary cover sheet for voluntary agreement cases. See, e.g., DSHS forms 10-083 (EPSDT Assessment); 10-254 (Public Health Nurse Evaluation/Recommendations, Workfirst); and 10-339 (Nursing Care Consultant Assessment).

substantial amount of time learning the contents of a file, time which might be more efficiently used either with the family members themselves, or obtaining and/or confirming additional services that the family could be using.

The LPRT members spent nearly 100 hours in order to make a meaningful summary of the case, as well as a meaningful timeline. There is currently no means of creating such summaries in a consistent manner within CPS. The LPRT suggests that some form of meaningful case summaries should be developed for use in voluntary service cases. For example, files for each child in voluntary agreement cases could include summary face sheets that provide brief overviews of the critical issues faced by the family, including growth charts<sup>112</sup> and medical home information. The LPRT recognizes that this is a substantial undertaking.

---

<sup>112</sup> Appendix B contains sample growth charts.

# **Appendix A**

## **CPS Risk Assessment Decision Making**

# Appendix A

## Risk Assessment Decision Making



This chart<sup>113</sup> describes the stages of possible CPS involvement once a report of child neglect or abuse is received by CPS Intake workers.

<sup>113</sup> Excerpted from DSHS "Risk Assessment Report for FY 2002," located at <http://www.dshs.wa.gov/pdf/EA/GovRel/leg1002/RAR.pdf>.

# **Appendix B**

## **Growth Charts**

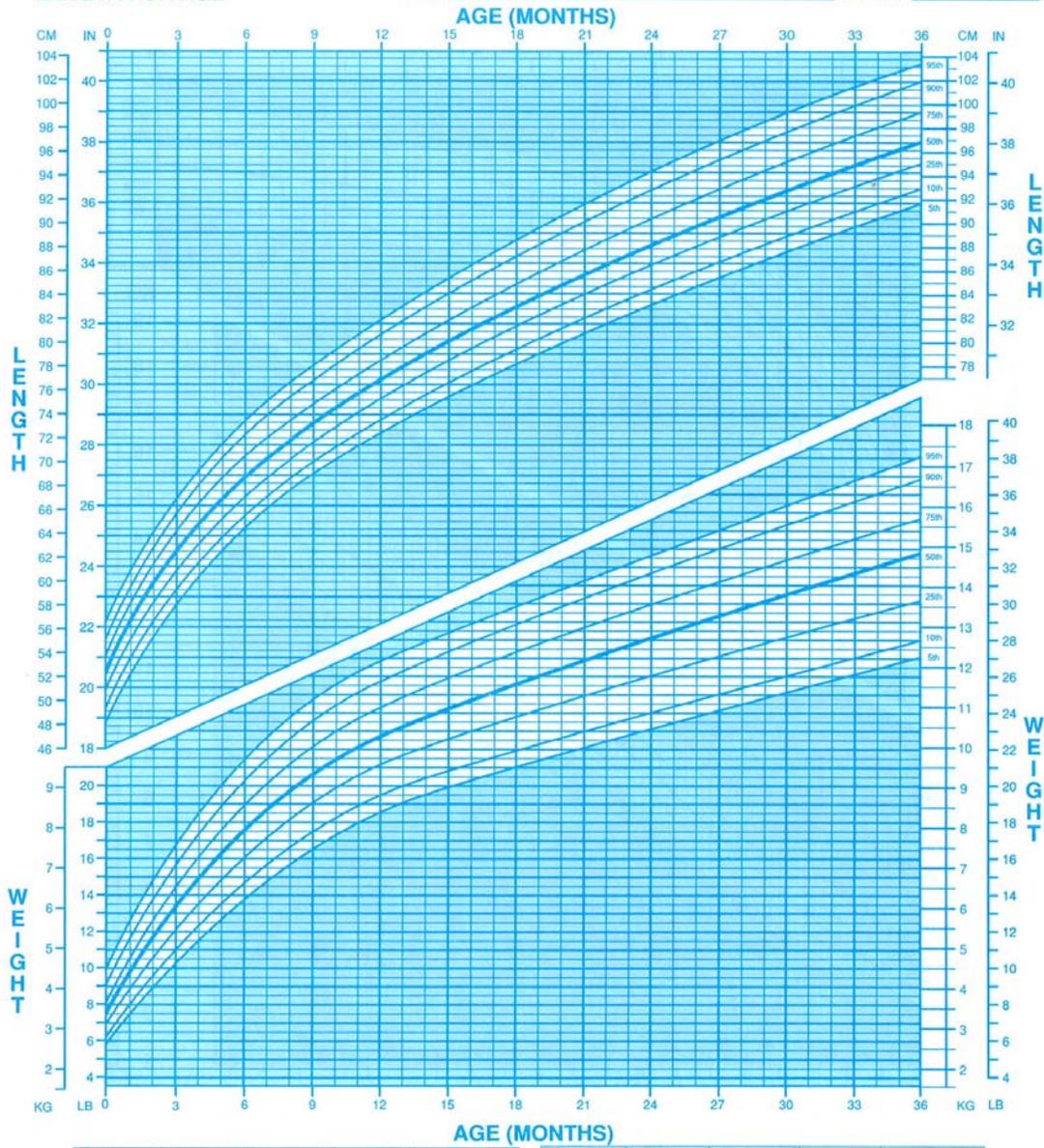
## **Appendix B - Growth Charts**

Growth charts are age- and gender-specific guides that help medical providers follow growth patterns for children. Measurements at specific ages are helpful, but it is more important to follow growth over time, and to compare height (length) percentiles with weight percentiles. Interpretation of growth abnormalities requires knowledge of medical and genetic factors in addition to possible social concerns. Examples of growth charts are provided on the following pages.

**BOYS BIRTH TO 36 MONTHS**  
**WEIGHT FOR AGE &**  
**LENGTH FOR AGE**

NAME \_\_\_\_\_

RECORD # \_\_\_\_\_

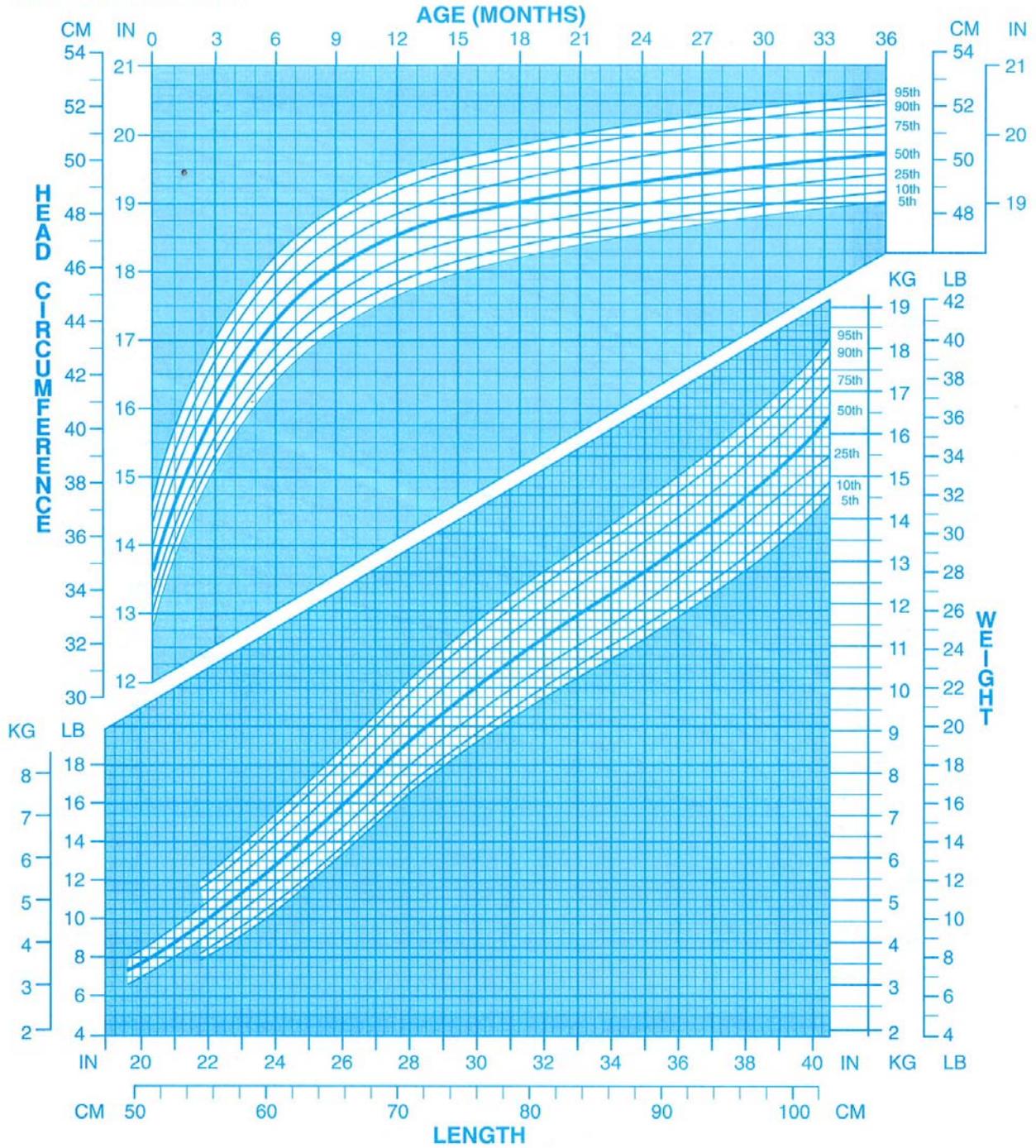


Date	Age in Months	Recumbent Length	Weight	Head Circumference

Department of Health, Education, and Welfare, Public Health Service  
 Health Resources Administration, National Center for Health Statistics, and Center for Disease Control

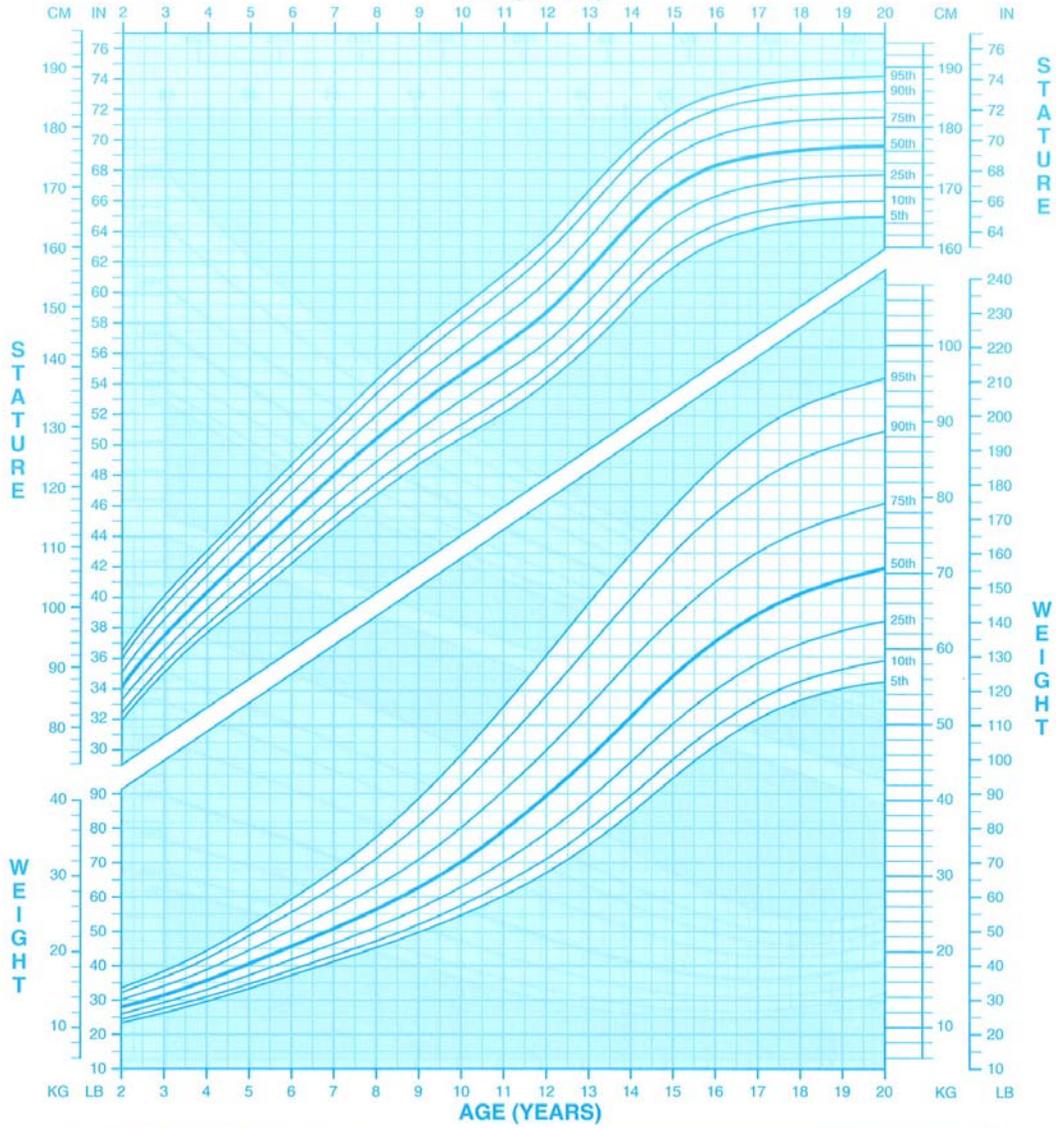
**BOYS: BIRTH TO 36 MONTHS**  
 HEAD CIRCUMFERENCE FOR AGE &  
 WEIGHT FOR LENGTH

NAME \_\_\_\_\_ RECORD # \_\_\_\_\_



**BOYS: 2 TO 20 YEARS**  
 STATURE FOR AGE &  
 WEIGHT FOR AGE

NAME \_\_\_\_\_ RECORD # \_\_\_\_\_  
**AGE (YEARS)**



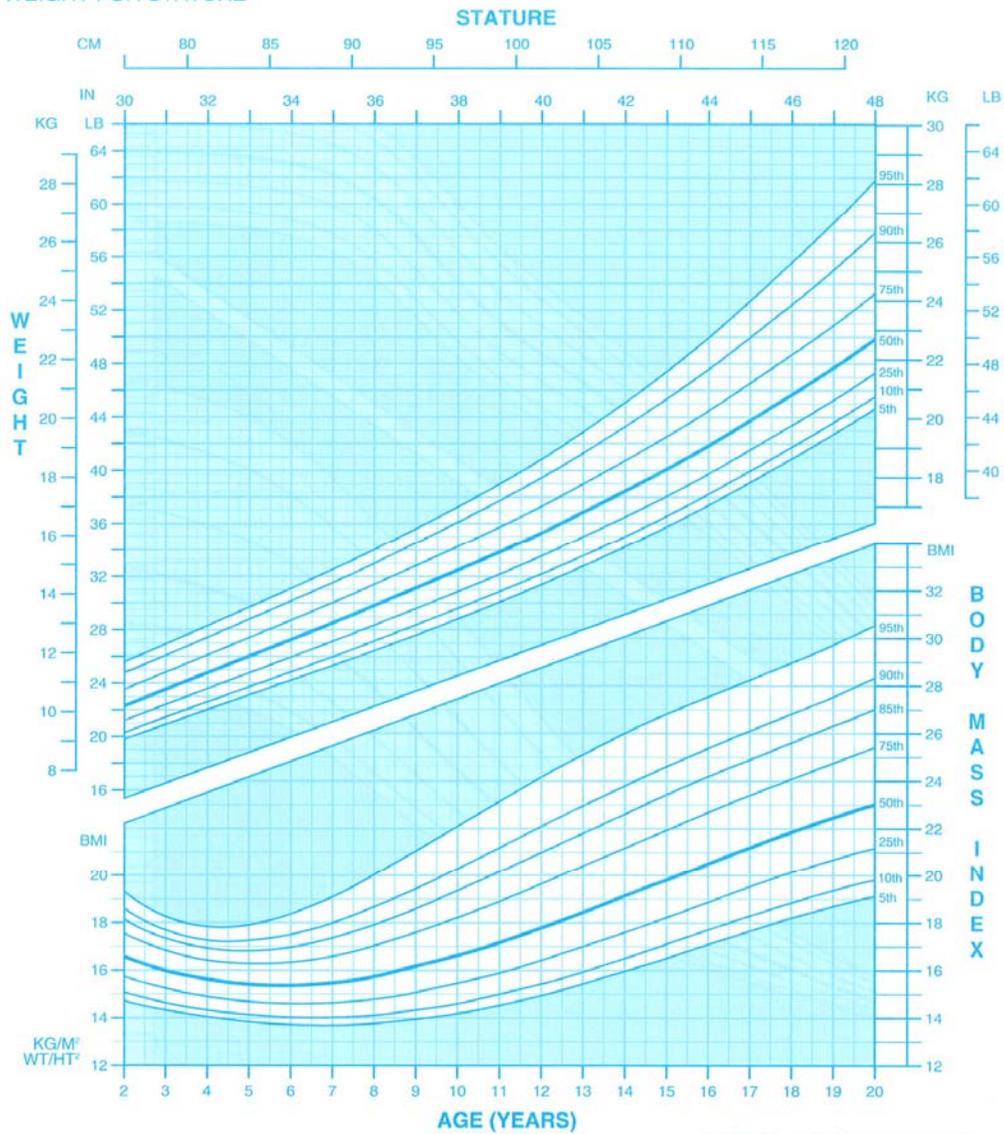
Date	Age	Stature	Weight	BMI

Date	Age	Stature	Weight	BMI

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, CENTERS FOR DISEASE CONTROL AND PREVENTION, NATIONAL CENTER FOR HEALTH STATISTICS, 2000.

**PRE-PUBERTAL BOYS:  
2 TO 11½ YEARS  
WEIGHT FOR STATURE**

NAME \_\_\_\_\_ RECORD # \_\_\_\_\_



**BOYS: 2 TO 20 YEARS  
BODY MASS INDEX FOR AGE**

Provided Courtesy of