



STATE OF WASHINGTON

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TO: Drew Zavatsky
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FROM: Randy Hart

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SUBJECT: Failure to Thrive – Loss Prevention Review

Attached is the Children's Administration response to the November 2008 report by the Loss Prevention Review Team. Please direct any questions regarding this response to Sharon Gilbert, Deputy Director of Field Operations for Children's Administration. Sharon can be reached at (360) 902-7822 or gish300@dshs.wa.gov.

cc: Stan Marshburn, Interim Secretary, DSHS
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Children's Administration Response

Office of Financial Management
Loss Prevention Review Team Report
Failure to Thrive – Lost Prevention Review

November 2008



CA Children's Administration

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Children’s Administration – Overview

Our MISSION

The mission of the Children’s Administration is to:

- First, protect abused and neglected children.
- Support the efforts of families to care for and parent their own children safely.
- Provide quality care and permanent families for children in partnership with parents and kin, Tribes, foster parents, and communities.

Our VISION

The vision of Children’s Administration is to:

- Seek to be an organization that provides excellent services, which produce successful safety, well-being, and permanency outcomes for children and families.
- Strive to be innovative, results driven, responsive to changing needs, accountable, and guided by a commitment to professionalism and excellence in the field of child welfare.
- Promote teamwork and embrace our partnerships with parents and kin, Tribes, foster parents, and communities in the design and delivery of child and family services we would be proud to offer our own families.

Over the last decade, Children’s Administration (CA) has received an average of 79,278 reports of suspected child abuse or neglect each year. Of those referrals, an average of 40,728 reports annually met the legal definition of abuse or neglect and initiated a Children’s Administration response.

Of the cases CA accepted for investigation during fiscal years (FY) 2005–2008, there was an average of 35,527 alleged child victims of abuse or neglect (Chart 1.) Of these alleged child victims, 44 percent were between the ages of zero to five-years-old.

Chart 1 – Alleged Child Victims of Abuse or Neglect FY2005-2008

Fiscal Year	0-5 Years		Total*	
	Unduplicated	Duplicated**	Unduplicated	Duplicated**
2005	15,885	19,688	36,214	44,125
2006	15,540	19,003	35,434	42,470
2007	15,483	18,503	34,843	41,280
2008	15,754	18,827	35,617	42,009
Average Total 2005-2008	15,666 (44%)	19,005 (45%)	35,527 (100%)	42,471 (100%)

*Total includes entire population of child victims age 0-17.

** The duplicated count of child population may include children who experienced more than one type or incident of child abuse or neglect.

As stated in the Loss Prevention Review Team report, CPS investigators have 45 calendar days to complete an 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
3. Closure of the CPS case

A voluntary service agreement is used to engage families who are willing to participate in services intended to reduce current and prevent future incidents of abuse or neglect. Voluntary service agreements are short-term; no longer than 180 days. Voluntary services are designed for families that do not require court intervention.

Utilizing CA's current database, it is estimated that CA provides voluntary services to approximately 27 percent of the families CA serves annually. At this time, CA is not able to determine the percentage of children, ages 0-5, served through a voluntary service agreement. CA's new automated child welfare information system, FamLink, implemented in February 2009, will provide more accurate data of this population.

Statutory Authority

Listed below are the pertinent RCW's regarding CA's authority applicable to this case.

RCW 74.13.031(3)

Duties of department-child welfare services.

Investigate complaints of any recent act or failure to act on the part of a parent or caretaker that results in death, serious physical or emotional harm, or sexual abuse or exploitation, or that presents an imminent risk of serious harm, and on the basis of the findings of such investigation, offer child welfare services in relation to the problem to such parents, legal custodians, or persons serving in loco parentis, and/or bring the situation to the attention of an appropriate court, or another community agency. An investigation is not required of non accidental injuries which are clearly not the result of a lack of care or supervision by the child's parents, legal custodians, or persons serving in loco parentis. If the investigation reveals that a crime against a child may have been committed, the department shall notify the appropriate law enforcement agency.

RCW 13.34.050

Court order to take child into custody, when – Hearing.

(1) The court may enter an order directing a law enforcement officer, probation counselor, or child protective services official to take a child into custody if:

(a) A petition is filed with the juvenile court alleging that the child is dependent and that the child's health, safety, and welfare will be seriously endangered if not taken into custody;

(b) an affidavit or declaration is filed by the department in support of the petition setting forth specific factual information evidencing reasonable grounds that the child's health, safety, and welfare will be seriously endangered if not taken into custody and at least one of the grounds set forth demonstrates a risk of imminent harm to the child.

"Imminent harm" for purposes of this section shall include, but not be limited to, circumstances of sexual abuse, sexual exploitation as defined in RCW 26.44.020, and a parent's failure to perform basic parental functions, obligations, and duties as the result of substance abuse; and

(c) The court finds reasonable grounds to believe the child is dependent and that the child's health, safety, and welfare will be seriously endangered if not taken into custody.

RCW 26.44.050

Abuse or neglect of child -- Duty of law enforcement agency or department of social and health services -- Taking child into custody without court order, when.

Upon the receipt of a report concerning the possible occurrence of abuse or neglect, the law enforcement agency or the department of social and health services must investigate and provide the protective services section with a report in accordance with chapter 74.13 RCW, and where necessary to refer such report to the court.

A law enforcement officer may take, or cause to be taken, a child into custody without a court order if there is probable cause to believe that the child is abused or neglected and that the child would be injured or could not be taken into custody if it were necessary to first obtain a court order pursuant to RCW 13.34.050. The law enforcement agency or the department of social and health services investigating such a report is hereby authorized to photograph such a child for the purpose of providing documentary evidence of the physical condition of the child.

RCW 26.44.056

Protective detention or custody of abused child -- Reasonable cause -- Notice -- Time limits -- Monitoring plan -- Liability.

(1) An administrator of a hospital or similar institution or any physician, licensed pursuant to chapters 18.71 or 18.57 RCW, may detain a child without consent of a person legally responsible for the child whether or not medical treatment is required, if the circumstances or conditions of the child are such that the detaining individual has reasonable cause to believe that permitting the child to continue in his or her place of residence or in the care and custody of the parent, guardian, custodian or other person legally responsible for the child's care would present an imminent danger to that child's safety: PROVIDED, That such administrator or physician shall notify or cause to be notified the appropriate law enforcement agency or child protective services pursuant to RCW 26.44.040. Such notification shall be made as soon as possible and in no case longer than seventy-two hours. Such temporary protective custody by an administrator or doctor shall not be deemed an arrest. Child protective services may detain the child

until the court assumes custody, but in no case longer than seventy-two hours, excluding Saturdays, Sundays, and holidays.

(2) Whenever an administrator or physician has reasonable cause to believe that a child would be in imminent danger if released to a parent, guardian, custodian, or other person or is in imminent danger if left in the custody of a parent, guardian, custodian, or other person, the administrator or physician may notify a law enforcement agency and the law enforcement agency shall take the child into custody or cause the child to be taken into custody. The law enforcement agency shall release the child to the custody of child protective services. Child protective services shall detain the child until the court assumes custody or upon a documented and substantiated record that in the professional judgment of the child protective services the child's safety will not be endangered if the child is returned. If the child is returned, the department shall establish a six-month plan to monitor and assure the continued safety of the child's life or health. The monitoring period may be extended for good cause.

(3) A child protective services employee, an administrator, doctor, or law enforcement officer shall not be held liable in any civil action for the decision for taking the child into custody, if done in good faith under this section.

Loss Prevention Review Team Report Findings - Non Organic Failure to Thrive: Review of Serious Injury Incident

The Loss Prevention Report Team (LPRT) determined the root cause of the maltreatment of the child known as “SA,” was due to the actions by SA’s father and the father’s partner. Due to insufficient medical information, the LPRT could not determine other root causes. Although the LPRT could not determine other root causes, they developed eight recommendations to systematically reduce non-organic failure to thrive cases and specific practices in Children’s Administration, which may or may not be isolated within this case.

Loss Prevention Review Team Report – Recommendations

Outlined below are the eight recommendations made by the LPRT:

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 service 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.

Children's Administration Response

Children's Administration (CA) continues to informally and formally review serious injury, near-fatality, and fatality cases to determine if there are policies, practice, performance, or systemic issues that might have influenced the case outcome.

In the SA case, the question was whether there was legal sufficiency at any point to file a dependency action or whether voluntary services was the most appropriate response to the reports of alleged abuse and neglect. A voluntary service agreement is the preferable response for moderate or moderately high risk cases if caregivers are agreeable to voluntary services that would ameliorate the identified issues.

CA has limited authority when working with families under voluntary service agreements. CA workers *may* ask a family to take certain measures to address a child's safety, health, or welfare, but unless the safety, health or welfare issue rises to the threshold outlined in RCW 13.34.050 (1) or RCW 26.44.050, workers do not have the authority to mandate that a family participate in recommended services.

There was an average of 15,666 alleged child abuse or neglect victims, per year between the ages of 0-5 during the period fiscal year 2005-2008. This is 44 percent of the overall child population that CA investigates annually. Children's Administration estimates the number of children and families that received voluntary services through a voluntary service agreement at 27 percent of all CPS cases accepted for investigation. The services and programs available to voluntary service cases differ from cases that involve placement of a child into out of home care. These include the availability of publicly funded health care coverage. In addition, the specific voluntary service agreement must be tailored to address the primary safety or risk issue that impacts child safety.

As outlined in the LPRT report, there are two types of failure to thrive (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."

The Department of Health (DOH) statistics in the LPRT report show an average of 602 organic and non-organic FTT cases a year (during the years 2002-2006) where children were hospitalized. DOH was not able to provide the number of cases that were organic vs. non-organic as Washington does not have a universal health care reporting system. The LPRT stated that the DOH data provided in their report, "inaccurately reflects the true prevalence of non-organic FTT in Washington State and is likely a significant underestimate of this form of abuse."

CA's new automated child welfare information system, FamLink, provides department staff with the ability to document and track children diagnosed as FTT. Like DOH's reporting system, FamLink provides a total number of all FTT cases and does not distinguish organic vs. non-organic FTT.

Children's Administration has been examining ways to expand social worker's understanding and knowledge about children's physical and social development. This includes the topic of failure to thrive and other issues that may compromise a child's health and development. However, failure to thrive is a medical condition that requires evaluation and diagnosis by a medical professional. Social workers are advised to refer the child to their primary care physician for a complete medical assessment.

Recommendation 1 – *“Confirm that the health status of all children under six (0-5) years of age served by CPS is monitored by medical professionals.”*

Response: Children's Administration (CA) social workers often address children's health care issues by involving public health nurse services where they are available or by referring families to their primary care physician. Social workers attempt to determine if a child has been seen regularly for well-child exams which monitor physical growth indicators (e.g., height, weight and head circumference). Some families served through a voluntary service agreement may not have health care insurance and CA social workers and service providers often assist families in accessing publicly funded health care coverage.

For dependent children in foster care or relative placement, the department consults with physicians on staff in addressing any health care issues.

Implementation Impact and Resource Limitations: CA estimates the number of children and families that received voluntary services through a voluntary service agreement could be 27 percent of all CPS cases accepted for investigation. As noted above, many children served through voluntary service agreements may qualify for federal and state funded health care coverage, but not all children involved in voluntary service agreements. The lack of health care coverage could impact the ability of parents to access routine health care for their children. As there is not funding to have health care insurance for all children, CA must consider what requirements are made of all families involved in CA services.

Recommendation 2 – *“Confirm that all children served by CPS are receiving care in a medical home.”*

Response: CA workers discuss the importance of having a primary care physician with parents and caregivers. They also ask if a child has regularly attended their well-child exams where their physical growth indicators (e.g., height, weight and head circumference) are monitored. However, CA workers are not required to have this discussion during a CPS investigation. Children served through voluntary service

agreements do not necessarily have health insurance to cover routine health care services. In these cases, CA does not have authority to require children to have a medical home. CA social workers and service providers do take steps to assist families in accessing other available services including publicly funded health care coverage; however, the focus of a service plan is on the issues that present the greatest risk to the child's safety, which may or may not include health care.

Implementation Impact and Resource Limitations: Between fiscal years 2005 – 2008, there was an average of 35,527 alleged child victims between the ages of 0-17, of abuse or neglect reported and investigated annually by CA. Children's Administration estimates that 27 percent of all CPS cases accepted for investigation were served by a voluntary service agreement. The implementation of CA's new information system, FamLink, should provide better information for the agency to assess the workload and financial impact in the future.

Recommendation 3 – *“For children with medical issues served under voluntary service agreements CPS should consistently use their team service model.”*

Response: Children's Administration supports and values training and utilization of a team service model with staff and community partners. Although the team service model approach taken in the SA case involved a Family Preservation Services provider, it did not involve other community professionals as provided in the above recommendation. The Administration is actively training staff in the academy and statewide through individual tracks (e.g., Intake, Child Protective Services, Family Voluntary Services, etc.) about the importance of shared decision making and community partnership. Child Protection Team meetings are required in some cases and are available for cases where this type of staffing is beneficial. Family team decision meetings are occurring in many offices and involve family and community resources when placement decisions or options are being developed.

Implementation Impact and Resource Limitations: CA agrees that the utilization of a team service model does have a positive impact on child outcomes. Each CA office has a child protection team, some of which have physician participation. These are multi-disciplinary teams available for consultation on cases where the risk of serious harm to a child is present and there are children in the home under six years of age or when there are complex cases where consultation will help improve a case outcome. Social workers also have access to the medical consultation network if physicians who have expertise in child abuse and neglect issues.

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.”*

Response: Children’s Administration agrees with this recommendation. The Administration believes that in most cases where there are concerns reported about a child’s growth or feeding, public health or primary care physicians are consulted. CA will attempt to determine if this issue is isolated to this case or if this is a broader practice issue.

Implementation Impact and Resource Limitations: CA will review the new curriculum with the academy and track trainings (e.g., Intake, Child Protective Services, Family Voluntary Services, etc.) to examine whether there is sufficient emphasis on the involvement of a medical professional in cases involving a growth or feeding issue. There may be limitations to the ability to access medical interventions in all voluntary service cases because some families may not be eligible for publicly funded health care insurance. If there are serious risks to the health of a child, steps other than voluntary services would be pursued.

Recommendation 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.”*

Response: Foster Care Public Health Nurses, Child Health and Education Screeners, and social workers have access to the MMIS billing data. They consistently use the information to guide efforts to secure appropriate placements and health care for children placed in out-of-home care with the department. The Foster Care Public Health Nurses have the ability to update information in CHILD Profile and recently CA negotiated read-only access for social workers and CHET Screeners. It is important to note that the data system will not include information on children who are covered by private health insurance and that for some children the data that is available may not contain detail.

Implementation Impact: Read-only access to CHILD Profile is new and CA is still in the process of identifying training needs for workers. However, social workers will not be trained or expected to use CHILD Profile until FamLink is active and in-place.

Recommendation 6 – *“The CA should expand its training program to include training on:*

- 1. How to partner with medical professionals,*
- 2. Child health and development,*
- 3. Child malnutrition, and*
- 4. The impact malnutrition has on a child’s health and development.”*

Response: CA agrees with this recommendation. CA has been reviewing and

updating its current curriculum to include these topics. In addition, Children's Administration is implementing a practice model which will emphasize the role of clinical supervision by supervisors. The clinical consultation that occurs with CA social workers will provide additional opportunities for social workers to receive support and information from their supervisor following academy training.

Implementation Impact and Resource Limitations: While CA is looking at ways to address these topics in academy and post-academy training, CA is also facing funding reductions that could impact the length of the social worker academy as well as the number and frequency of post-academy trainings. CA must balance the training needs with the available resources for training. CA believes that additional support provided through supervisory clinical consultation will be helpful to the social worker training approach.

Recommendation 7 – *“The CA should streamline its process for funding public health services provided to families through local health jurisdictions.”*

Response: Most public health services for which CA contracts are funded with federal grants. Federal funds have specific funding and eligibility requirements which are different for each contract and local health district. At this point, a single contract is not practical for the variety of services and contracts CA has with the Department of Health.

Implementation Impact and Resource Limitations: See above response.

Recommendation 8 – *“The CA should review and streamline its paperwork requirements for CPS case workers.”*

Response: With the implementation of the FamLink information system, CA will be implementing a uniform Family Assessment and Assessment of Progress that examines the status of a family, each caregiver, and each child. This information is documented in FamLink and covers both strengths and needs that the family has as a whole and that individual family members may have. The assessment information also includes information that on the child's health. Child health information will now be documented in a specific location in the information system which will reduce the need to search through case note records to identify the medical status of the child. For voluntary service cases, an assessment of progress is conducted on the family and child 90 days after the initial Family Assessment.

Implementation Impact and Resource Limitations: CA will begin requiring Family Assessments for each new case. This requirement will go into effect 60 days after February 2, 2009. Cases that are currently open as of February 2, 2009 will not require a Family Assessment in FamLink immediately to accommodate the transition to a new automated child welfare information system.