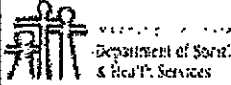


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		Child Fatality Review Childrens Administration - DSHS		Bryce Meining Date of Death: 5/19/2006	
General Information					
REPORT DATE 8/27/2007	REPORT STATUS Closed	REFERRAL NUMBER 1721681	SYSTEM ID 1615	TYPE OF LICENSED FACILITY	
REGION REPORTING 6	OFFICE Vancouver	DIVISION DCFS	CASE STATUS AT TIME OF DEATH History within 12 months , CPS - DCFS		CAUSE OF DEATH Stabbing
Deceased Child Information					
NAME (LAST, FIRST) Meining, Bryce		ROLE(S) Primary Child	DOB - AGE 9/2/2004 -- 1yr-8mo	GENDER Male	
STREET ADDRESS [REDACTED]		CITY [REDACTED]	STATE - ZIP WA 98[REDACTED]	LEGAL STATUS Parental Custody	CAMIS ID 2699444
ETHNICITY White	HISPANIC Unable to Determine	PRIMARY PROGRAM	RESIDENCE TYPE Family home	RESIDENCE COUNTY Clark	DATE OF DEATH 5/19/2006
NATURE OF DEATH Homicide - By Caretaker	SPECIAL CHARACTERISTICS / OTHER ISSUES				
OFFICIAL MANNER OF DEATH Homicide (by Abuse)	DETERMINED BY Medical Examiner	HAS THE CHILD EVER BEEN PLACED IN OUT OF HOME CARE? No			
Summary of How Death Occurred					
<p>Children's Administration first became involved with this family in June 2002. There are three children in the family: [REDACTED] (5 years old), [REDACTED] (3 years old) and Bryce (deceased at 20 months of age). The department had received 7 referrals over the period of time from June 2002 through May 2006, when the referral was received regarding the death of [REDACTED].</p> <p>Bryce's mother, Kelly Meining, had a history of significant mental health issues. She had repeatedly been in and out of mental institutions and had experienced lengthy hospitalizations in an attempt to stabilize her mental health issues. The department received numerous referrals alleging neglect of the children due to the the severe mental health issues, including bouts of hallucinations.</p> <p>On May 19, 2006, Kelly Meining took a large kitchen knife from the counter behind the sink in the kitchen and repeatedly stabbed her son, Bryce, in the stomach and back. The mother reported to law enforcement that she had been playing on the living room floor, when she began to stp him, with the intent to kill him. Kelly told police that she wanted to kill Bryce because she believed that other people were going to kill or torture him. Kelly had been previously diagnosed with bi-polar disorder while she was pregnant with Bryce.</p> <p>During the time that Kelly was with Bryce in the house, Kelly's husband [REDACTED] was outside working on the family boat. After Bryce was stabbed, Kelly proceeded to wash the knife, change</p>					

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her bloody clothes, and went outside to tell her husband she loved him. She then remained outside to watch him work on the boat and was reportedly in a "daze". [REDACTED] discovered his son in the house and proceeded to call 911. Bryce was pronounced dead upon arrival of the medical team. Kelly was immediately arrested, and the two other children were kept with a neighbor pending questioning by law enforcement.

Location Information

RESIDENCE AT TIME OF DEATH Family home	COUNTY RESIDING IN Clark	LOCATION WHERE DEATH OCCURRED Family Home	COUNTY WHERE DEATH OCCURRED Clark
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Incident is NOT Related to a Facility

Birth/Adoptive Parents

NAME (LAST, FIRST) [REDACTED]	ROLE(S) Caretaker, Subject of CA/N Allegations, Birth Parent	GENDER Male	DOB - AGE [REDACTED] 1978	
STREET ADDRESS [REDACTED]	CITY [REDACTED]	STATE WA	ZIP WA	PHONE [REDACTED]

NAME (LAST, FIRST) Meining, Kelly	ROLE(S) Caretaker, Alleged Perpetrator, Present At Death, Subject of CA/N Allegations, Birth Parent	GENDER Female	DOB - AGE [REDACTED] 1975	
STREET ADDRESS [REDACTED]	CITY [REDACTED]	STATE WA	ZIP WA	PHONE [REDACTED]

Neglect and/or Abuse Allegations

WAS THERE AN ALLEGATION OF NEGLIGENCE BY A CARETAKER REGARDING THIS FATALITY IN THE REFERRAL? Yes	WAS AN OFFICIAL FINDING OF NEGLIGENCE BY A CARETAKER DETERMINED A FACTOR IN THIS DEATH? Yes	IF YES, WAS IT PHYSICAL OR MEDICAL? Physical
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The allegation of negligent treatment as to the father is founded due to the fact that law enforcement documented that the children were exposed to unsanitary and unsafe living conditions which were found during the investigation into the fatality. In addition, [REDACTED] was well aware of his wife's mental health issues and had previously been told to not allow her to have any unsupervised contact with the children. In the incident involving the death, [REDACTED] admitted that he was aware that Kelly's recently prescribed medications were not effective in treating her mental health condition, yet failed to provide the level of supervision needed to keep his children safe from their mother.

WAS THERE AN ALLEGATION OF ABUSE BY A CARETAKER REGARDING THIS FATALITY IN THE REFERRAL? Yes	WAS AN OFFICIAL FINDING OF ABUSE BY A CARETAKER DETERMINED A FACTOR IN THIS DEATH? Yes
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Kelly Meining admitted to stabbing her 20 month old son in the stomach and back, with the intent to kill him. Kelly suffered from numerous mental health issues, and was diagnosed with bipolar disorder during her pregnancy with her son Bryce.

The case record reflects that during the interview with [REDACTED] he reported that on the day of the fatality, Kelly and Bryce were in the house while he, [REDACTED] and [REDACTED] were outside working on the boat. He stated that Kelly sat in with him a couple of times while working and told him that

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Bryce was taking a nap. He then stated that he walked into the garage and heard Kelly tell [REDACTED] that she killed Bryce. He immediately went to the bedroom to check up on him. He asked Kelly where Bryce was. He eventually found Bryce in the living room, at which time he called 911 right away. He stated that [REDACTED] and [REDACTED] witnessed this, saw the body, and screamed.

DOMESTIC VIOLENCE INDICATOR? Undetermined		SUBSTANCE ABUSE INDICATOR? Undetermined			
Surviving Siblings Under Age 18					
NAME (LAST, FIRST) [REDACTED]		ROLE(S) Sibling	DOB -- AGE [REDACTED] 2000 -- 5yr-9mo	GENDER Female	RELATION Sibling
STREET ADDRESS [REDACTED]		CITY [REDACTED]	STATE - ZIP WA 98 [REDACTED]	LEGAL STATUS Parental Custody	CAMIS ID 2396066
ETHNICITY White	HISPANIC	PRIMARY PROGRAM	RESIDENCE TYPE Family home	RESIDENCE COUNTY Clark	DATE OF DEATH
NATURE OF DEATH	SPECIAL CHARACTERISTICS / OTHER ISSUES				
NAME (LAST, FIRST) [REDACTED]		ROLE(S) Sibling	DOB -- AGE [REDACTED] 2003 -- 3yr-2mo	GENDER Male	RELATION Sibling
STREET ADDRESS [REDACTED]		CITY [REDACTED]	STATE - ZIP WA 98 [REDACTED]	LEGAL STATUS Parental Custody	CAMIS ID 2549471
ETHNICITY White	HISPANIC	PRIMARY PROGRAM	RESIDENCE TYPE Family home	RESIDENCE COUNTY Clark	DATE OF DEATH
NATURE OF DEATH	SPECIAL CHARACTERISTICS / OTHER ISSUES Prior out of home placement(s)				
Other Non-Sibling Children Residing in the Home at Time of Death: (None Indicated)					
Child Protection / Safety Plans / Licensing Actions					
WHAT ACTION WAS TAKEN TO PROTECT OTHER CHILDREN IN HOME/FACILITY? Remain at Home w Safety Plan			IF THE CHILD REMAINED IN THE HOME/FACILITY, WAS A SAFETY PLAN PUT INTO PLACE? Yes		
DESCRIBE SAFETY PLAN Region 6 after hours field response worker assessed the children's safety in the case of the father and developed a safety plan with the father. The mother was arrested and jailed and does not have access to the children. The safety plan included the following: 1) Father of children will supervise and care for children and obtain help when necessary from friends and grandparents. 2) There will be no contact wither in person or by phone between the children and their mother, 3) Grandparents and Jace will make direct contact in person or by phone on 5/20 and 5/21 and the children to make sure they are okay. 4) The current CPS investigator will check in with the family in person by Tuesday, 5/30/06. 5) The mother is currently in jail facing charges for first degree murderer.					
WHAT LICENSING ACTIONS HAVE OCCURRED AS A RESULT OF THIS DEATH?					
Prior Child Deaths in Family and/or Facility: (None Indicated)					
Adults Living in Home/Facility Where Death Occurred : (None Indicated)					
Caretaker Characteristics					

NAME (LAST, FIRST) Meining, Kristofer	ROLE(S) Caretaker, Subject of CA/N Allegations, Birth Parent	GENDER Male	DOB - AGE [REDACTED] 1978
STREET ADDRESS [REDACTED]	CITY [REDACTED]	STATE WA	ZIP WA
PHONE [REDACTED]			
NAME (LAST, FIRST) Meining, Kelly	ROLE(S) Caretaker, Alleged Perpetrator, Present At Death, Subject of CA/N Allegations, Birth Parent	GENDER Female	DOB - AGE [REDACTED] 1975
STREET ADDRESS [REDACTED]	CITY [REDACTED]	STATE WA	ZIP WA
PHONE [REDACTED]			

Family Referrals

NUMBER OF REFERRALS PRIOR TO DEATH 6	DATE OF FIRST REFERRAL 6/6/2002	DATE OF LAST REFERRAL 5/19/2006
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The Meining family consists of Kelly, the mother, [REDACTED], the father and three children: [REDACTED] (5), [REDACTED] (3) and Bryce (deceased at 20 months). Over the life of the department's involvement with this family there were seven referrals, including the referral regarding the death of Bryce. The six referrals previous to the death involve numerous allegations of neglect and lack of supervision. The majority of the referrals involve incidents where Ms. Meining's mental health was not stable, and she was hallucinating. Ms. Meining has had repeated involuntary hospitalizations for her significant mental health history. In June 2002 the referral alleged that then 18 month old child [REDACTED] was outside by the road for at least an hour and a half without supervision. After repeated attempts to get someones attention in the home, with the front door wide open, the referrent took the child to her child care center, and the father did not find her for another 20 minutes. In the same referral, the reporter also stated the mother, Kelly, had left the father two weeks previous due to severe domestic violence. Kelly reportedly had bruises on both sides of her face and neighbors indicated the fight was really bad. The police department was not called but they had been in the past. The case was closed on July 3, 2002 with a finding of inconclusive.

On July 28, 2003 a referral was received alleging that the mother left her 4-month old baby [REDACTED] in the middle of the parking lot at the public library. Mother put the baby there, then got in her car and drove off. The referrent stated the police did a mental health transport on the mother on July 9, 2003. She was in Memorial Hospital for the weekend on that occasion. The baby was placed with maternal grandparents. Grandfather stated they have been taking care of the baby, his sister, and the mother over the last week. The grandfather said they have noticed a change in mother's behavior over the last 3 weeks. Mother will answer questions with a delayed action. The mother said that someone had put 'meth in their water supply', and some friends had given her a baby seed contaminated with meth. The case was investigated and allegations of neglect were founded. Following this referral, a shelter care motion and dependency petition was filed. The department entered into a voluntary service agreement with the family on 8/20/03. The shelter care/dependency hearing was continued to 11/21/03.

Kelly admitted herself into psychiatric care at Providence Hospital on October 17, 2003 as a voluntary patient. She became agitated, required restraint and was later placed on a hold as she was identified as a danger to herself an others. She was further described as psychotic, depressed and had auditory hallucinations. [REDACTED] the father to [REDACTED] and [REDACTED], obtained custody of the children and set up visitations with their mother Kelly. The case was closed with Children's

Administration in April 2004.

On May 20, 2004 a referral was received reporting concerns about the mental health of Kelly Meining and her ability to care for her children. The referral was screened as an information only referral, and no action was taken. The referral stated that Kelly marches in her yard, stops, and salutes the house. In past referrer reports Kelly went to a neighbors home at 3:00 AM and stated someone was in her home with a knife, police responded and no one was there. Referrer also reported concerns that Kelly and her husband [REDACTED] use meth.

On July 8, 2004 a referral was received reporting that Kelly Meining was admitted to the hospital for involuntary treatment on 7/6/04 for unspecified psychotic disorder. Kelly's drug screen was negative. Husband [REDACTED] reports Kelly has a history of mental health issue that appear to be increasing since the birth of their son [REDACTED] in 2003. Referrer reported Kelly assaulted [REDACTED], who appears to be primary caretaker of [REDACTED] and 3 year old [REDACTED]. Referrer reported both grandparents appear supportive of family. Referrer reported concerns as Kelly is pregnant, due 9/13/04, but was seen at birthing center due to pre-term labor and has had sporadic prenatal care. Referrer reports Kelly has an upcoming court date and believes she will be in hospital for some time. The referral was screened as an information only referral. No action was taken.

On September 3, 2004, a referral was received reporting that Kelly gave birth to a healthy baby boy. The referent stated she was concerned about mother's mental health status and its possible affect on parenting. Referent stated the mother has reported a diagnosis of depression, but also has gone into episodes of psychosis. Referent states in July, mother was brought in for mental evaluation and reportedly attacked a nurse and bit a staff member. Referent stated that the mother suffers from hallucinations and may still have pending assault charges against her. The referent further stated the family is under a lot of stress because of her mental health issues, but they also have a lot of support from the grandparents, who watch the children often. The referent also stated the father is very appropriate, but appears to be under a lot of stress from mother's condition. The referent stated the family does not qualify for maternity support services, and also stated that it appears that possibly with the last CPS case, part of the safety plan was not allowing the mother to be alone with the children. Referent states the family has been somewhat successful, but mother admitted to referent there are times when she is alone with the kids. The investigation was closed as inconclusive for neglect.

On January 23, 2005, a referral was received reporting that on 1/20/05, Kelly was brought to Southwest Washington Medical Center by law enforcement (LE) after a 911 call from Kelly's counselor. Kelly had made statements regarding suicidal ideations and she made statements of a homicidal nature regarding "taking her children with her." The father of Kelly's children, [REDACTED], requested that the SW call and report the situation and ask if there is anyway that CPS could help to provide care in the home for the children when Kelly goes home. The Investigative Assessment indicated that the mother had told her counselor she was suicidal, and thought of taking her children with her. As a result, daycare services were offered to support the family. Case was closed by the worker in April 2005. Supervisory review did not occur until September 2005.

On May 19, 2006, Central Intake (CI) received several telephone calls from Media requesting information about a child, Bryce 20 month old who was stabbed to death by his biological mother, Kelly. CI SW contacted Clark County Sheriff's Department who stated the following: "At 16:56 there was a 911 call from the father [REDACTED] indicating that Bryce had been stabbed and he was requesting assistance. At 16:58 the first Deputy arrived on the scene and they

attempted to resuscitate the child, but all efforts were futile. The child was transported to SW Medical Center where Bryce was announced dead and is currently with the Clark County Medical Examiner."

Family Referral History

REFERRAL DATE 1/23/2005	REFERRAL ID 1586033	SUBJECT Meining, Kelly/Kristofer	PROGRAM CPS	DECISION Accepted
ALLEGATIONS Case Closure		CA/N CODES Negligent or Maltreatment		FINDING Unfounded
REFERRAL DATE 9/3/2004	REFERRAL ID 1547668	SUBJECT Meining, Kelly	PROGRAM CPS	DECISION Accepted
ALLEGATIONS Service Plan		CA/N CODES Negligent or Maltreatment		FINDING Inconclusive
REFERRAL DATE 7/8/2004	REFERRAL ID 1534569	SUBJECT Meining, Kelly	PROGRAM CPS	DECISION Information Only
ALLEGATIONS Case Closure		CA/N CODES		FINDING
REFERRAL DATE 5/20/2004	REFERRAL ID 1520106	SUBJECT Meining, Kelly	PROGRAM CPS	DECISION Information Only
ALLEGATIONS Case Closure		CA/N CODES		FINDING
REFERRAL DATE 7/28/2003	REFERRAL ID 1436735	SUBJECT Meining, Kelly	PROGRAM CPS	DECISION Accepted
ALLEGATIONS Case Closure		CA/N CODES Negligent or Maltreatment		FINDING Founded
REFERRAL DATE 6/6/2002	REFERRAL ID 1323811	SUBJECT Meining, Kelly	PROGRAM CPS	DECISION Accepted
ALLEGATIONS Case Closure		CA/N CODES Negligent or Maltreatment		FINDING Inconclusive

Services Offered To Family

MENTAL HEALTH Offered/Accepted	CHILD CARE Offered/Accepted	BUS PASS Offered/Accepted
<p>Kelly Meining has had a lengthy history of mental health problems. She has seen a therapist on a regular basis, and has had numerous voluntary and involuntary hospitalizations for her mental health issues. In addition to mental health services, the department provided child care assistance to the family from January to April 2005 while Kelly was recovering from another hospitalization. In addition, a bus pass was provided for Kelly.</p>		

Facility Referrals (Not Applicable)

Factual Summary Of The Child / Family Case

The Meining family has been involved with Children's Administration since June 2002, when the first referral was received. There are three children in this family: (5), (3) and Bryce

(deceased at 20 months). All of the referrals involving the children in this family were related to the mental health issues of the mother and concerns about her ability to care for her three children. Following one referral in 2003 where the mother left the baby [redacted] in the library parking lot, a shelter care and dependency petition were filed. They were later dismissed when the father was granted custody through a 2610 in family court. The order for custody stated that the mother was not to have contact with the children. Dependency was never established on either parent.

After numerous referrals, as outlined in the referral section of this report, the final referral involved the untimely death of the 20 month old baby Bryce Meining, at the hands of his mother. The two older children were in the home when this happened, and discovered their brother had been killed. The mother was incarcerated, and the father entered into a safety plan agreement with the department. Due to being incarcerated, the mother did not have any further contact with the children. She was later transferred to Western State Hospital.

The maternal grandparents have been a support for this family, and worked closely with the department to supervise contact between the mother and the children prior to the children being returned to the care of the father. The two older children are enrolled and actively involved in individual counseling and a program focusing on grief and loss for children. There have been no further referrals involving this family since the death of Bryce.

Factual Summary Of Facility Licensing History (Not Indicated)

Participants in Review Process

NAME (LAST, FIRST)	TITLE	CITY	PHONE
Serafin, Denise	Social Work Supervisor	Vancouver	
Hitchings, Edith	Deputy Regional Administrator	Tumwater	
Bailey, Nancy	Social Worker	Vancouver	
Paresa, Bill	Social Work Supervisor	Vancouver	
Heard, Sonja	Regional Supervisor	Tumwater	
Gilmorc, Marian	Area Administrator	Vancouver	

Information Used in Review Process

DCFS CASE FILE / SUMMARY OF FILE Used in Review	AUTOPSY REPORT Used in Review	LICENSING FILE / SUMMARY OF FILE Not Applicable	LAW ENFORCEMENT REPORTS Used in Review
DLR/CPS FILE / SUMMARY OF FILE Not Applicable	MEDICAL RECORDS Not Available	PROSECUTOR'S OFFICE REPORTS Not Available	DEATH CERTIFICATE Not Available
CORONER'S OFFICE REPORTS	CRIMINAL HISTORY	RECORDS OF CONTRACTED PROVIDER	CPS RECORD CHECK

Used in Review	Not Applicable	Not Applicable	Used in Review
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For purposes of this review there was an enormous amount of information to be reviewed, including the case record, police records, autopsy, and medical examiner report. The prosecuting attorney information was not available at the time of the review or at the time of the summarizing of the review.

The following areas should be considered when answering the above questions. Intake policies and procedures; required time frames; required contacts; staffing and shared decision making requirements; supervisory reviews; legal authorities and requirements; risk assessment policies and procedures; documentation; other policies, practice, and systems issues appropriate to the case. Any specific personnel actions related to this case as a result of this review are not documented in this report.

Identified Issues and Recommendations

CATEGORY PRACTICE ISSUE DESCRIBED	RECOMMENDATION
In September 2004, the previous social worker entered a note in the case file that he was retiring and that the next social worker assigned would need to follow-up to make sure that the mother was receiving the appropriate mental health services. The next social worker was assigned the case but did not attempt to make contact with the family until December 2004. The first meeting between the new worker and the family was January 2005.	The local management team should develop a process for how to re-assign cases in a timely manner when a worker leaves the agency.

CATEGORY PRACTICE ISSUE DESCRIBED	RECOMMENDATION
There were numerous referrals in the file alleging neglect of the children by the mother, due to being incapacitated by her mental health issues. It did not appear that the mother was asked to sign a release of information or that efforts were made to ascertain copies of her mental health records from her treating physicians or hospitalizations. This information may have been useful in providing services to the family and protection for the children.	The Area Administrator has initiated meetings with the county mental health agency to revise the MOU. In addition, work was initiated to set up regular meetings with the county mental health agencies to conduct staffings and promote communication. It is recommended that the Area Administrator continue to work on these two processes and complete the MOU with the county mental health agency. The local staff need to be reminded to coordinate with mental health to obtain the proper records of parents when they pertain to the care and welfare of their children.

Summary of Review and Recommendations

The review for this fatality was conducted on 10/11/06. Due to the criminal investigation, it took a longer period of time to get the necessary information. This case revealed several areas of practice that could be improved, in addition to positive case practice that needs to be recognized. The Vancouver DCFS office prides itself on utilizing relative resources whenever possible. In this case, although one child had been in placement for a while, they were always placed with the relatives. In an attempt to keep this family together, there were many efforts to provide in-home services. Unfortunately the mental health issues of the mother were far more in-depth than the agency was aware of. Local mental health providers had been working with this mother for several years as well.

In the case file there was an Investigative Risk Assessment for each of the cases that were

investigated. The Investigative Risk Assessment includes a summary of the history of child abuse and/or neglect, the description of the most recent child abuse and neglect, and an assessment of the risk levels of the caregivers and the children. The Investigative Risk Assessment was utilized inconsistently in this case. The rankings for the individual risk ratings were not consistent with the overall level of risk. In many areas there would be indications of high risk in certain categories, but then the overall rating would be low. This tool is a very subjective tool, and has not been shown to have very high inter-rater reliability.

In October 2007, the entire Children's Administration will be stopping the use of the Investigative Risk Assessment, and will be moving to use the new evidence based tool: Structured Decision Making (SDM). This tool is more concise and will not require a worker to enter individual risk categories for each characteristic for the caretaker and child, but will ask the worker to answer a series of questions related to the circumstances of the case. The overall result will be a computer generated score which will help the social worker determine what cases will need to be opened for services.

Summary of Review and Recommendations (Not Indicated)

DOES THE REVIEW TEAM RECOMMEND A WORK PLAN BE DEVELOPED? No	WORK PLAN DUE DATE
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Review Approval

APPROVED BY	TITLE
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Given its limited purpose, a Child Fatality Review by Children's Administration should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. Review is generally limited to documents in the possession of or obtained by DSHS or its contracted service providers and the panel may be precluded from receiving some documents that may be relevant to the issues in a case because of federal or state confidentiality laws and regulations. A review panel has no subpoena power or authority to compel attendance and generally will only hear from DSHS employees and service providers. The panel may not hear the points of view of a child's parents and relatives, or those of other individuals associated with a deceased child's life or fatality. A Child Fatality Review is not intended to be a fact-finding or forensic enquiry or to replace or supercede investigations by courts, law enforcement agencies, medical examiners or other entities with legal responsibility to investigate or review some or all of the circumstances of a child's death. Nor is it the function or purpose of a Child Fatality Review to take personnel action or recommend such action against DSHS employees or other individuals.

Staff Authorized to Access Incident

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