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January 10, 2012

Richard Armstrong
Director, Idaho Department of Health and Welfare
P.O. Box 83720
Boise, ID 83720-0036

Re: *In re Robert Manwill* Blue Ribbon Panel Report and Recommendations

Dear Director Armstrong:

Enclosed with this letter please find the final report and recommendations of the *Manwill* Blue Ribbon Panel. In addition, please find the separate factual addendum summarizing additional facts considered by the panel in its deliberations.

I think I speak for all of the member of the Panel in saying that we applaud your effort to review the operations of the Department in this matter and we hope you find our report helpful.

Sincerely,



Elizabeth Barker Brandt
Associate Dean for Faculty Affairs and
James E. Wilson Distinguished Professor
Chair, *In re Robert Manwill* Blue Ribbon Panel

enclosures

Cc: Deena Layne (with enclosures)



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER - GOVERNOR
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February 29, 2012

Elizabeth Barker Brandt
Chair, *In re Robert Manwill* Blue Ribbon Panel
University of Idaho
PO Box 442321
Moscow, Idaho 83844-2321

Dear Ms. Brandt:

Thank you for committing your time and talent to execute an independent external review of the tragic death of Robert Manwill. I am grateful for the depth and thoughtfulness of this review and your recommendations.

While this case was extremely unique and complex, I appreciate your focus on what lessons we can apply to child protection processes to help prevent injuries to children. This is a daunting task when dealing with lying and manipulative criminal adults working in a democratic system that assumes innocence and reasonable standards of behavior. We are constantly searching for the right balance between parental rights and elevated risks to children. I believe you have provided new definition to the evolution of the tools available to child welfare professionals.

Having completed a thorough review of your recommendations, the included document addresses how DHW will incorporate the changes suggested. Additionally, I will provide you periodic status reports outlining the progress made toward each change.

Once again, please accept my thanks for the contribution of your time, experience, and expertise.

Sincerely,



RICHARD M. ARMSTRONG
Director

RMA/eb

enclosure

In re Robert Manwill
**Blue Ribbon Review Panel Report and Recommendations
including Department of Health and Welfare Response**

Introduction

In response to the death of Robert Manwill, the Director of the Idaho Department of Health and Welfare (“Department”) made a public commitment to conduct a review of the circumstances of Robert’s death for the purpose of determining whether system improvements and reforms within the Department might prevent such a tragic death in the future. In response to this commitment a panel of independent experts was assembled in July, 2011. The Director’s original charge to the Panel is attached to this Report.

The Panel held its first meeting on August 3, 2011 and met five additional times during August, September, November and December 2011. After reviewing the Department’s records and public information about the case, the Panel identified a number of areas of inquiry. It collected information, heard presentations from Department personnel with responsibility in the identified areas, and held discussions utilizing the expertise of the Panel members and Department personnel. The Panel did not have the power to subpoena documents or witnesses. Thus it did not take testimony or engage in “fact finding.”¹ As a result of this process, the Panel developed recommendations for the Department.

Summary Facts

The situation ending in Robert’s death was tragic. At the time, a Child Protective Act (“CPA”) case was pending involving Robert’s half sibling, AE. AE had been removed from the home of his mother, Melissa Jenkins, and her boyfriend, Daniel Ehrlick as a result of a report of physical abuse made by health care workers. When AE was removed from the home, Melissa and her boyfriend falsely executed a Voluntary Acknowledgement of Paternity and filed it with the Idaho Bureau of Vital Statistics. In this Acknowledgment, Daniel and Melissa both stated that Daniel was AE’s biological father, when in fact they knew he was not AE’s biological father.

At the time the CPA case was initiated, the decision was made not to involve Melissa’s other two children, a daughter and Robert, in the CPA case because both children had fathers who had legal custody and who could provide care for them.

The Adjudicatory Hearing in the CPA case was resolved based on Melissa’s stipulation. A case plan was prepared by the Department. Daniel Ehrlick was not treated as a party to the CPA case because there were no facts implicating him in the alleged abuse of AE. Instead, he entered a Voluntary Case Plan with the Department.

¹ In addition, the Child Protective Act and Idaho Court Administrative Rules restrict disclosure of court records and any information contained therein with limited exceptions. The Panel conducted its review without reference to protected Child Protective Act court records.

Pursuant to the case plan and the voluntary case plan, the Department worked toward its state and federal statutory mandates to reunify AE with Melissa. The plans provided for a number of activities: 1) assessments of Daniel and, primarily, Melissa, were undertaken; 2) intensive in-home parenting education was provided to both Daniel and Melissa; 3) visitation between Melissa and Daniel and AE, under the supervision of Department Contractors, was undertaken so that the family relationships between Melissa, Daniel and AE could be maintained.

In April, Melissa pled guilty to a reduced charge pursuant to I.C. §18-1501(2), a misdemeanor count of Injury to a Child, and was sentenced to 180 days of jail and placed on two years' supervised probation. The jail term was suspended to 30 days with work release.

Once Melissa was released from jail, the Department continued its efforts to reunify AE with Melissa. Toward the end of May, intensive, in-home parenting education began.

During the time in-home services were being delivered, Robert disappeared from the Jenkins/Ehrlick home. Melissa and Daniel were later criminally charged and convicted in regards to Robert's murder.

Recommendations

The Panel's review of Robert's death has discovered some systemic gaps or quality concerns with the Department's approach to child protection cases. It has provided the opportunity for the Panel to make focused recommendations to assist the Department. These recommendations are aimed at tightening and improving Department procedures in the future. The recommendations are as follows:

- 1. Jurisdiction over "another child living or having custodial visitation in the same household."**

Idaho Code § 16-1603 provides that if a court has taken jurisdiction over a child under the CPA, the court also may take jurisdiction over "another child living or having custodial visitation in the same household" if the court finds, among other things, that the other child "has been exposed to or is at risk of being a victim of abuse, neglect or abandonment." This report will refer to such children as "contact children."

Prior to Robert Manwill's death, AE, Robert's half-brother was removed from the home of Melissa Jenkins and Daniel Ehrlick. Robert, Melissa's son from a prior marriage, was in the primary physical custody of his father, Charles Manwill, and had visitation with Melissa at the Jenkins/Ehrlick home at the time of AE's removal. Robert was not present at the time of AE's injuries. CPA jurisdiction was not asserted over Robert who was primarily living with his father, Charles, in a different community pursuant to the terms of custody orders entered as part of Melissa's divorce from Charles Manwill.²

²See *Manwill v. Manwill*, Case No. CV-DR-2002-01646 (Ada County)(Stipulation to enter Order and Judgment July 11, 2008). Charles Manwill was made aware of the CPA case involving Melissa and AE during the week of

Instead of bringing Robert into the CPA case, the recommendation was made to Charles that Robert should not have unsupervised visitation with Melissa. Because there had been no allegations of abuse related to Robert, this recommendation was based on informal inquiry and verbal communications regarding Robert's situation. Robert's situation was not monitored as the case regarding AE progressed.

Initially, during the pendency of the CPA case involving AE, Robert had supervised visitation in the Jenkins/Ehrlick home for limited time periods and with the knowledge of Department social workers. As the case progressed, Robert continued to visit the Jenkins/Ehrlick home, often for longer periods and often without the knowledge of the Department social workers. Because Robert was not named in the formal CPA action, he was not the focus of attention by the Department social workers. The Department did not closely monitor Robert because he was not the subject of a CPA action.

The facts known to social workers at the time the decision was made that Robert should not become part of the CPA case, and at the time supervised visitation with Melissa was permitted in the Ehrlick/Jenkins home, supported both decisions.

The following recommendations are made to improve the decision process and to facilitate appropriate safety planning for contact children whenever possible.

Recommendation: The Department should develop guidelines to assess the risks of abuse, neglect, or abandonment to a contact child and to assist in the decision process regarding his or her removal from the home. This decision process should contain, among other things: a) an evaluation of the ability of another parent³ to protect the safety of the contact child; and b) an evaluation of whether the other parent of the contact child has the legal authority to carry out the safety plan. Thus, for example, the Department should obtain a copy of any custody/visitation order(s) governing the care and control of a contact child whenever possible.

Department Response: By June 2012, the Department will review its standard regarding Safety, Comprehensive, and Ongoing Assessment and modify to include the process of gathering custody/visitation orders and assessing safety of children who do not reside in the home on a permanent basis. Additionally, by June 2012, the Department will request technical assistance from the National Resource Center for Child Protective Services to develop or gather safety decision

October 21, 2008 and was advised not to permit Robert to have unsupervised contact with Melissa. Charles Manwill did not seek a modification of this custody order after initiation of AE's CPA case. The Department was not a party to the private child custody case between Charles and Melissa except for the limited purpose of seeking enforcement of child support. It did not have standing in the case to seek alteration or suspension of the visitation order between Charles and Melissa.

³ The focus of this recommendation is on a parent who is not implicated in the child protection case. Usually such a parent was not residing in the home where the abuse occurred.

making tools to evaluate the protective capacities of both caretakers in the home as well as caretakers who may not reside in the home.

Recommendation: To the extent possible given the limits of jurisdiction, the safety of contact children should be closely monitored on a continuing basis during the pendency of a CPA case.

Department Response: In January 2011, the Department revised its standard regarding contact between the social worker, the child, the family, and foster parent(s). It clarified the requirement for ongoing contact with children who are visiting non-custodial parents, short term (such as weekend or for one or two weeks). It also made revisions to the requirement for ongoing contact with children who remain in the family home when a sibling is removed. Additionally, the Child and Family Services Program has a continuous quality improvement process, which involves an audit of 210 cases each year. Part of this process includes an examination of whether the safety of all the children in the home was assessed. By June 2012, the Department will modify its standard in reference to service planning to specifically address all contact children who may be present in the household. Each contact child will be addressed in the family's service plan, regardless of whether the Department has jurisdiction over that child. Custody and visitation orders will be reviewed and included in the service plan development.

Recommendation: The Department should convene a panel of experts to consider legislation providing for limited investigative and monitoring authority over contact children and providing authority for the court in the CPA case to realign custody orders governing such contact children to ensure their continued safety.

Department Response: The Department will forward this recommendation to the Idaho Supreme Court Child Protection Committee for its consideration. The committee includes magistrates from each judicial district, CASA, public defenders, prosecuting attorneys, representatives from the Attorney General's Office, juvenile probation, Behavioral Health, and Child Welfare Services.

Recommendation: The Department should develop guidelines to ensure that *all* case plans include specific provisions governing the terms and conditions for the visitation of any contact children in the home.

Department Response: By June 2012, the Department will convene a committee, including representatives from Child and Family Services, the court, and the CASA program, to develop a process and protocol for considering this requirement and to potentially modify the current visitation standard of the Department.

2. **Relationship between the Department and service contractors.** Pursuant to its internal practices and standards, the Department relies on contractors to provide direct services to families in the child protection system. In the Ehrlick/Jenkins situation, a contractor was providing intensive services in the home aimed at facilitating the reunification of AE with Melissa and Daniel. The Department social worker and the employees of the contractor had regular formal and informal communication regarding interactions with the family. During June and July of 2009, the contract employees and the social worker reported at least 8 “staffings” regarding the AE case in addition to numerous documented email and voicemail exchanges.

There was frequent and extensive communication between the Department social workers and employees of the Department’s contractors regarding the delivery of services. Nonetheless, one of the Department’s contractors did not supply complete and timely notes to the Department regarding its interactions with the family until the criminal trial.

Recommendation: The Department should develop clear, short guidelines to regularize detailed, swift and accurate communication between Department and its contractor(s) regarding the changes in family structure as well as the family’s progress and the ongoing situation in the home.

Department Response: Through years of budget constraint and reduction of staff, the Department must depend on contractors to perform a variety of duties. By June 2012, the Department will review each in-home service contract and work with the providers to develop clear guidelines related to timely and accurate information exchange on daily case compliance. These guidelines will be incorporated into the practice standard of the Department for in-home family preservation services.

Recommendation: Details regarding all children living or having custodial visitation in the home (in addition to the child(ren) of concern) should be documented and should be communicated between the Department and contractors.

Department Response: The Department will incorporate a requirement for sharing information regarding all individuals residing in or having visitation in the home into the guidelines referenced in the previous response.

3. **Establishment of Paternity.** Idaho Code § 7-1106 provides for the execution of a Voluntary Acknowledgement of Paternity by the mother and biological father⁴ of a child who are not married at the time of the child’s birth. When such an Acknowledgment is executed and properly filed with the Vital Statistics Unit of the Idaho Bureau of Vital

⁴ The biological father is defined as the “father” for purposes of the Paternity Act. Idaho Code § 7-1103(4).

Records and Health Statistics, the statute provides that it “shall constitute a legal finding of paternity.” The statute does not dictate the content of the acknowledgment in detail. Although the statute defines the term father, it is ambiguous regarding what facts are required before a man may “acknowledge” *paternity*. Affidavits developed by the Vital Statistics Unit to implement the statute require the man executing the document to acknowledge that he is the “biological father” of the subject child. Idaho Code § 39-273 provides penalties for furnishing false information affecting a vital record.

In his criminal trial Daniel Ehrlick testified that he signed a Voluntary Acknowledgment of Paternity of AE, although he knew at the time that he was not AE’s biological father.

Recommendation: The Department should convene a panel of experts to determine whether Idaho Code § 7-1106 should be revised to clarify the underlying facts required for an Acknowledgment and/or to otherwise address the validity of Acknowledgments based on false information.

Department Response: Within the Department, various divisions use paternity to execute very different legal obligations. This includes the Child Support program, Vital Records, and Child Protection. There are unintended consequences when defining father, biological father, voluntary acknowledgment of paternity, responsible party, etc., for each of these programs. Furthermore, conflicts exist between federal and state law. The Department is currently mapping its processes and, through an interdepartmental team, setting up a single paternity tracking site. After full examination of the issues, the Department will propose appropriate change of Idaho statute. The Department will also forward this recommendation to the Idaho Supreme Court Child Protection Committee for its consideration and assistance.

Recommendation: The Department should provide training to social workers and department staff regarding how to address the provision of false information in a certificate, record or report governed by the Vital Statistics Act.

Department Response: Beginning in February 2011, Department staff from the Division of Family and Community Services began meeting with representatives from the Bureau of the Vital Records and Health Statistics, and representatives from the Bureau of Child Support to identify potential cases where paternity may be an issue. As a result, a process was developed including regular meetings to resolve paternity issues that impact more than one program. The purpose of this process is to rectify paternity information within the current legal framework. By June 2012, the Department will provide statewide training to child welfare social workers via video conferencing.

4. **Reunification Safety Planning.** Pursuant to practices and standards of the Department and pursuant to Idaho and federal law, reunification of children with families is one of the

principal goals of the child protection system.

Often, when a CPA case is accompanied by a parallel criminal proceeding against a parent, the parent stipulates to CPA jurisdiction rather than risk incriminating her/himself at the adjudicatory hearing under the CPA. If the parent later enters a plea arrangement in the criminal case, no trial regarding the parent's conduct takes place either in the criminal case or in the CPA case.

In the Ehrlick/Jenkins situation, Melissa admitted that she caused AE's injuries and pled guilty to a criminal charge of injury to a child. The initial explanation for the injury (that Melissa hit AE's head on a table while feeding him) was rejected by medical experts. Nonetheless, the exact facts and behaviors leading to AE's injury were never established when the plea was entered or in a CPA adjudicatory hearing. Within this vacuum, the social workers were required to move forward with a case plan to address the safety issues that led to AE's injuries as they emerged in the plea arrangement and in the CPA stipulation, while providing the least disruptive environment for AE and preserving the family system.

Recommendation: The Department should continue to seek ways to ensure that the details of the factual context that brings a child into care are developed as much as possible and that case plans directly address the full range of safety issues that brought the child into care even where a parent stipulates to jurisdiction and parallel criminal proceedings focus only on limited aspects of the overall safety situation.

Department Response: In the fall of 2009 and winter of 2010, Department Child and Family Services staff received advanced training on safety assessment and safety planning. In the fall of 2011, the Department implemented new court reports that emphasize the assessment and resolution of existing safety concerns.

Recommendation: The Department should continue to provide services to the family that directly address the safety issues that brought the child into care.

Department Response: With our revised court reports, the Department will continue to provide the court with pertinent information related to the existing safety concerns. By August 2012, the Department will conduct service planning training in each region facilitated through its regional embedded trainers. The service planning training will emphasize the importance of linking the service and safety plans with identified safety concerns.

- 5. Social Worker Home Visits.** The Department has developed protocols and guidelines for home visits by a social worker. These guidelines provide for meaningful monthly contact and at least one home visit per month. The decision of whether to announce a visit in advance is made by the social worker based on the facts of the case, the needs of

the child, and other specifics of the family situation. The social worker must balance the need to know details of the home situation against the desire to join with the family to create a trusting environment for service delivery and thereby facilitate family reunification.

In the Jenkins/Ehrlick situation, pursuant to these guidelines and in the context of delivering services, the primary social worker and employees of the Department had extensive contact with the Jenkins/Ehrlick family in the home (far beyond the amount of contact required by Department protocols). During June and July social workers from the Department and Department contractors were in the home at least three times per week delivering services. Most, if not all of these social worker and contractor visits were scheduled. Despite this level of frequency, testimony at Daniel Ehrlick's criminal trial indicated that the home situation was staged for the visits to disguise developing issues.

Recommendation: The Department should develop guidelines for determining whether home visits should be announced or unannounced.

Department Response: By June 2012, the Department will examine current best practice literature and develop a guideline containing factors to consider when determining whether to schedule an announced or unannounced home visit. The Department will then modify its current standard regarding contact between the social worker, the child, the family, and resource parent(s), to include a requirement when unannounced home visits should occur.

Recommendation: The Department should develop guidelines for reporting on observations and events during home visits. Reports pursuant to this guideline should be shared in a timely fashion with all social workers and/or contractors visiting the home.

Department Response: The Department currently has a standard for case documentation. By June 2012, Department staff will review this standard and revise it to include guidelines for documenting specific observations related to safety concerns made during home visits. As previously stated, within the next six months the Department will review each in-home service contract and will work with the providers to develop clear guidelines related to timely and accurate information exchange.

- 6. Assessment Services.** As part of the process of developing a case plan, the Department often relies on assessment services provided by third parties regarding, among other things, substance abuse, mental health, and family violence. Prior to Robert's death, Daniel Ehrlick agreed to participate in a "Risk to Child" assessment and an anger management assessment as part of the Voluntary Case Plan in AE's CPA case. Although commonly used throughout the country, anger management assessments have been the subject of criticism.

In the Jenkins/Ehrlick situation the assessments appear to be thorough, thoughtful and focused on child safety.

Recommendation: The Department should regularly re-evaluate the quality of the assessment tools and services it utilizes in light of the most recent research in the field. Although forensic assessment may be required as part of the adjudicatory process, the Department should endeavor to emphasize clinical assessment when developing the case plan.

Department Response: The Department will continually evaluate the quality of the assessments community providers complete. It will refer families to providers who can offer the most thorough assessment and services to reduce safety threats. The Department will continue to seek best-practice evaluations of tools and assessments used in other states and jurisdictions and will attempt to incorporate these tools into its practice.

Recommendation: The Department's court reports should emphasize child safety in addition to reporting on progress in addressing the issues that arise in clinical assessment.

Department Response: As previously stated, the Department has revised all of its court reports with a specific focus on child safety. The Department began utilizing these new reports in the fall of 2011. With the revised court reports, the Department will continue to provide the court with pertinent information related to the safety concerns that brought the family to the attention of the Department as well as any new safety concerns that may have arisen.

- 7. Child Mortality Review Process.** The Department's commitment to convene the Blue Ribbon Panel was made in the absence of any statutory or regulatory authority for such a review. The Department has its own internal quality assurance and review processes, but does not have any mandate to convene an outside panel of experts. The support of the Department for the Panel's review has been unwavering. Likewise the participation of experts from other state and local agencies was extensive and thoughtful. The consensus of the Panel participants was that the review process was useful and appropriate.

However, in the absence of formal authority the Panel encountered a number of difficult obstacles. The Department, courts and other institutional participants in the child protection process are subject to stringent federal and state confidentiality and disclosure provisions. In the absence of statutory authorization, the Department and the Panel did not have clear guidance regarding whether and when the Panel could obtain access to information relevant to the case. In addition the Department and the Panel lacked clear guidance as to what information could be included in the report of the Panel and/or made public as part of the review process. Other entities in the child protection system were constrained to share information with the Panel.

Finally, Idaho is the only state in the country that has no formal child mortality review process.⁵

Recommendation: The Department should convene a working group of stakeholders in the child protection system to develop policy and legislation to implement a regular, child mortality review process for the State of Idaho.

Department Response: A formal child mortality review process reaches beyond the scope and legal jurisdiction of the child protection system. A child mortality review evaluates all children's deaths, which includes deaths that are natural, accidental such as car accidents or drownings, suicides, or from abuse or neglect. The Department will forward this recommendation to the Idaho Governor's Task Force on Children at Risk for consideration.

In the child protection system, the Department has engaged various stakeholders to establish a protocol for a Director's Panel Review. Under the existing authority of the Director ongoing reviews will be authorized.

⁵ See National Center for Child Death Review Policy and Practice <http://www.childdeathreview.org/spotlightID.htm> (last visited November 29, 2011)

In re Robert Manwill Blue Ribbon Review Panel Detailed Factual Addendum

The situation ending in Robert's death was tragic. At the time, a Child Protective Act ("CPA") case was pending involving Robert's half sibling, AE.

In October 2008, AE was removed from the home of his mother, Melissa Jenkins, and her boyfriend, Daniel Ehrlick, after emergency health care providers contacted police because they suspected that AE had been physically abused. The removal occurred when a declaration of imminent danger was made by a Boise City Police Officer who responded to the report of suspected abuse. As a result of the removal, a CPA proceeding was initiated on October 23, 2008.

Shortly after AE's removal from the home, Melissa and Daniel falsely executed a Voluntary Acknowledgement of Paternity and filed it with the Vital Statistics Unit of the Idaho Bureau of Vital Records and Health Statistics. In this Acknowledgment, both Melissa and Daniel stated under oath that Daniel was AE's biological father, when in fact they each knew he was not AE's biological father.

At the time the CPA case began, Melissa's other two children, a daughter and Robert, were not declared in imminent danger or otherwise made part of AE's case. The fathers of both children were consulted by the Department social worker assigned to Melissa's case. It appeared that the safety of both children could be protected by fathers who had legal custody and who could provide care for them. The Department social worker cautioned each father not to permit unsupervised visitation with Melissa who was free on bail and living in her residence with Daniel.

On October 23, 2008, Melissa appeared and waived the Shelter Care Hearing. Daniel was also present on October 23 and had a copy of the completed Voluntary Acknowledgment of Paternity. A week later, Melissa, with a criminal case pending against her, waived the Adjudicatory Hearing and stipulated to legal custody of AE with the Department. Melissa requested AE be placed in her home under Daniel's care. Her request was not acted upon, and AE remained in foster care where he had been placed upon his initial removal from the home.

In late November of 2008, the court granted legal custody of AE to the Department.

The Department's case plan for Melissa included the following tasks: completion of a parenting education class, completion of a Risk to Child evaluation, maintenance of safe and stable housing, completion of individual and family counseling, participation in Family Preservation Services, resolution of pending legal issues, participation in the development of a permanency plan for AE, participation in and Infant/Toddler Evaluation for AE, and attendance at all medical and developmental appointments for AE.

Daniel, by virtue of the Voluntary Acknowledgement of Paternity, was treated as AE's father and entered into a Voluntary Case Plan with the Department. Daniel's plan was voluntary

because, at the time, no facts indicated that Daniel was the perpetrator of, or was implicated in the abusive conduct toward AE. In this voluntary plan, Daniel agreed to complete parenting education classes, participate in a Risk to Child Assessment, maintain safe and stable housing for himself and AE, maintain weekly contact with AE's case manager, participate in family and individual counseling, participate in Family Preservation Services, participate and provide information to AE's Infant/Toddler program, and attend all medical and developmental appointments for AE.

As the case moved forward, criminal charges were pending against Melissa and AE was placed in foster care. Both Daniel and Melissa began participating in the Case Plan and Voluntary Case Plan activities. Melissa and Daniel both had regular, supervised visitation with AE. This visitation was supervised by a Department contractor and took place both at the contractor's place of business and at the Jenkins/Ehrlick residence. By March 2009, when a review hearing was held, both Melissa and Daniel had completed many of the tasks required by their respective plans.

During this period of time from the end of October 2008 through March 2009, Robert lived with his father and had three supervised visits with Melissa -- one in December 2008 and two in March 2009. These visitations took place with the knowledge and agreement of the Department. The first visit was on Christmas Eve and was supervised by Melissa's mother. Both visits during March 2009 were supervised by Daniel. The visits in March involved overnight stays.

In addition to the three visits approved by the Department, testimony at Daniel's criminal trial indicated that Robert was present at AE's birthday with the Jenkins/Ehrlick families in February 2009 and may also have had additional visits in March. The additional visits were not approved in advance by the Department and may not have been supervised.

During this same time from late October, 2008 through March 2009, the Department social worker and department contractors had frequent and continuing contact with Daniel, Melissa and AE through home visits to the Jenkins/Ehrlick home, telephone contact and through regular supervised visitation between Daniel, Melissa and AE.

In March 2009, Melissa's criminal charges were resolved when she pled guilty to a reduced charge pursuant to I.C. §18-1501(2), a misdemeanor count of Injury to a Child, and was sentenced to 180 days of jail and placed on two years' supervised probation. The jail term was suspended to 30 days with work release. She began her jail sentence at the end of April 2009.

After March 2009, as the CPA case progressed, the Department, pursuant to its state and federal statutory mandates, continued its efforts to reunify AE with Melissa and Daniel. As part of this process the Department undertook a number of tasks: 1) assessments of Daniel and, primarily, Melissa, were undertaken; 2) intensive in-home parenting education was provided to both Daniel and Melissa by the Department contractor; and 3) visitation between Melissa and AE, under the supervision of a Department contractor, was continued.

On May 1, 2009, AE was placed in a parental placement with Daniel Ehrlick. As part of the safety plan Melissa was not yet permitted to live in the home full time. However she was required to visit the home regularly to participate in reunification services and to visit AE under the supervision of Daniel. To facilitate visitation with AE, Melissa was permitted to be in the home for up to forty-eight hours without court order as long as Daniel was in the home supervising her contact with AE. Melissa regularly requested that the Department allow her to move back into the home full time with her family. Yet, her request was not approved by the Department. This situation continued through the end of July, 2009.

During June and July of 2009, it appears that Robert was regularly present at the Jenkins/Ehrlick home. The Department records indicate that this visitation was neither formally requested by Melissa and/or Daniel and was not approved by the Department. The Department contractors were aware of Robert's presence, although the Department social worker was not informed that Robert was visiting.

As indicated previously, the Department had sometimes known of and granted permission for Robert's visitation earlier in the case. Yet, Robert was not subject to the Department's jurisdiction. His contact with Melissa was governed by the private custody arrangement between Melissa and Charles Manwill. In addition, given the progress Melissa and Daniel appeared to have made in AE's case, visitation by Robert in the Jenkins/Ehrlick home likely would not have been a source of significant concern for the Department or its contractors. The Department records indicate that Daniel and Melissa had made substantial progress towards reunification of their family. AE was living full time with Daniel and prior visitations with Robert under Daniel's supervision had been uneventful.

During the time in-home services were being delivered, Robert disappeared from the Jenkins/Ehrlick home. Melissa Jenkins and Daniel Ehrlick were later criminally charged and convicted in regards to Robert's murder.

WORKING TOGETHER TO PREVENT UNEXPECTED CHILD DEATHS

Blue Ribbon Panel Review – In Re: Robert Manwill

Goals and Objectives:

Every child death is a tragedy for the family of the deceased and the community as a whole. Understanding the circumstances surrounding a child's unexpected death is one way to make sense of the tragedy. In addition, reviews can help identify systemic changes that could prevent other deaths of children in the future.

A review of the circumstances surrounding a child's death, like that of Robert Manwill, is an opportunity for citizens, as well as local and state systems, to identify how they might better assess and serve families. This review is intended to identify risk factors that may lead to changes and improvements in strategies, policies, practices, processes, communication, and interventions that may ultimately prevent or lessen the risk of unexpected child deaths. Our hope and expectation is that we will learn valuable lessons from this case which will lead to recommendations for improvements in the child protection system, state and local. These suggested improvements could include changes to statute, rule, policy, practice, process, communication, or procedure, as well as increased public awareness and education.

Underlying Operating Principles:

- The death of a child is a community responsibility.
- A death review requires multidisciplinary participation from the community.
- A death review should be comprehensive and broad.
- A death review should lead to an understanding of risk factors.
- A death review should focus on effective recommendations and actions to prevent childhood deaths and to keep children healthy, safe, and protected.

Through a multidisciplinary team approach, the panel will conduct a comprehensive, systemic review of Robert Manwill's death and develop a full understanding of the facts. That information will be used to produce recommendations intended to improve the child protection system in Idaho. In particular, the panel will perform the following functions:

- (1) perform an in-depth review of the facts and develop a full understanding of the circumstances which led up to the death of Robert Manwill; and
- (2) develop written recommendations for improvements to the child protection system, state and local, that may help prevent or lessen the risk of other childhood deaths in the future.

This review is intended to lead to positive action that will safeguard and promote the health, safety, and welfare of children. It is intended to increase knowledge about the death of Robert Manwill, which in turn, may lead to systemic improvements at the local and state level, as well as improve citizen assistance that could reduce the incidence of preventable childhood deaths. This review is not a mechanism for criticizing or second-guessing any family or agency decisions, actions, or inactions. Rather it is a forum for sharing and discussing information essential to the improvement of the child protection system's ability to protect children in Idaho. The critical question being asked is not "Could this death have been prevented?" but rather "How can we prevent a death like this from occurring again?" As such, this review will not address or determine whether a person, group of persons, agency or department could have prevented this fatality or was otherwise guilty of negligence or at fault.

Membership:

It is anticipated that the team will include the following individuals who represent the following professions, disciplines, departments, agencies, and organizations:

Elizabeth Brandt, Associate Dean, College of Law, University of Idaho, Chairman

Dr. Paul McPherson, Board Certified Pediatrician, CARES, Boise, Idaho

Dr. Kenny Bramwell, Board Certified Emergency Medicine Physician, Boise, Idaho

Jane Smith, Administrator, Division of Health, Department of Health and Welfare

Shirley Alexander, Program Manager, Child Welfare, Division of Family and Community Services, Department of Health and Welfare

Brian Taylor, Canyon County Prosecutor, Caldwell, Idaho

Annie Cosho, Ada County Public Defender, Boise, Idaho

John Buck, Gem County Coroner, Emmet, Idaho

Bill Bones, Detective Commander, Boise City Police (designee pending)

Lt. Erik Skolund, Nampa City Police Department

Nancy Thiemert, Attorney, State Guardian Ad Litem Coordinator ("CASA") (pending)

Kirt Naylor, Attorney, Governor's Task Force Children at Risk, Boise, Idaho

Gary Harvey, Public at Large

Sources of information:

- Death certificate
- Death investigation reports, including, scene reports, and interviews
- Autopsy reports
- Medical and health information
- Information on the social services provided to the family or child

- Information from court proceedings or other legal proceedings conducted as a result of the death
- Law enforcement investigation reports
- Prosecuting Attorney's reports
- Coroner and medical examiner reports
- Emergency Medical Services report
- Mental health and drug treatment reports
- Child Protective Services (CPS) and other Department records, reports, or abstracts
- Public Health Records
- School records, school counselor report
- Medical and hospital records

Meetings of the Panel: Meetings and discussions of the panel will be closed to the public.

Report and Recommendations: The panel's report and recommendations will be made public.