QUARTERLY CHILD FATALITY REPORT
RCW 74.13.640 JANUARY – MARCH 2019

Washington State Department of
CHILDREN, YOUTH & FAMILIES

Washington State Department of
CHILDREN, YOUTH & FAMILIES

Contents

Nondiscrimination Policy

The Department of Children, Youth, and Families (DCYF) does not discriminate and provides equal access to its programs and services for all persons without regard to race, color, gender, religion, creed, marital status, national origin, sexual orientation, age, veteran's status, or the presence of any physical, sensory, or mental disability.

Executive Summary

This is the Quarterly Child Fatality Report for January through March 2019, provided by the Department of Children, Youth, and Families (DCYF) to the Washington State Legislature. RCW 74.13.640 requires DCYF to report on each child fatality review conducted by the department and provide a copy to the appropriate committees of the legislature:

Child Fatality Review — Report

(1) (a) The department shall conduct a child fatality review in the event of a fatality suspected to be caused by child abuse or neglect of any minor who is in the care of the department or receiving services described in this chapter or who has been in the care of the department or received services described in this chapter within one year preceding the minor's death.

(b) The department shall consult with the office of the family and children's ombudsman to determine if a child fatality review should be conducted in any case in which it cannot be determined whether the child's death is the result of suspected child abuse or neglect.

(c) The department shall ensure that the fatality review team is made up of individuals who had no previous involvement in the case, including individuals whose professional expertise is pertinent to the dynamics of the case.

(d) Upon conclusion of a child fatality review required pursuant to this section, the department shall within one hundred eighty days following the fatality issue a report on the results of the review, unless an extension has been granted by the governor. A child fatality review report completed pursuant to this section is subject to public disclosure and must be posted on the public web site, except that confidential information may be redacted by the department consistent with the requirements of RCW 13.50.100, 68.50.105, 74.13.500 through 74.13.525, chapter 42.56 RCW, and other applicable state and federal laws.

(2) In the event of a near fatality of a child who is in the care of or receiving services described in this chapter from the department or who has been in the care of or received services described in this chapter from the department within one year preceding the near fatality, the department shall promptly notify the office of the family and children's ombuds. The department may conduct a review of the near fatality at its discretion or at the request of the office of the family and children's ombuds.

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

On July 1, 2018, the Department of Social and Health Services (DSHS) Children's Administration (CA) transitioned from DSHS to DCYF. Some of the reviews included in this report were completed before July 1, 2018, therefore, references to DSHS/CA may be cited throughout this report.

This report summarizes information from completed reviews of five (5) child fatalities and one (1) near fatality[1] that occurred in the first quarter of 2019. All child fatality review reports can be found on the Child Fatality & Serious Injury Reports page of the DCYF website.

The reviews in this quarterly report include child fatalities and a near fatality from three of the six regions (DCYF divides Washington State into six regions). Previous quarterly fatality reports reflect three regions when child welfare was administered within DSHS under CA.

DCYF Region	Number of Reports
Region 1	1
Region 2	0
Region 3	0
Region 4	4
Region 5	0
Region 6	1
Total Fatalities and Near Fatalities Reviewed During First Quarter 2019	**6**

This report includes Child Fatality Reviews and Near Fatality Reviews conducted following a child's death or near-fatal injury that was suspicious for abuse and neglect and the child had an open case or received services from the DCYF within the 12 months prior to the child's death or injury. A critical incident review consists of a review of the case file, identification of practice, policy or system issues, recommendations and development of a work plan, if applicable, to address any identified issues. A review team consists of a larger multidisciplinary committee including community members whose professional expertise is relevant to the family history. The review committee members may include legislators and representatives from OFCO.

The following charts provide the number of fatalities and near-fatalities reported to DCYF and the number of reviews completed and those that are pending for calendar year 2019. The number of pending reviews is subject to change if DCYF discovers new information by reviewing the case. For example, DCYF may discover that the fatality or near-fatality was anticipated rather than unexpected, or there is additional DCYF history regarding the family under a different name or spelling.

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

Child Fatality Reports for Calendar Year 2019			
Year	Total Fatalities Reported to Date Requiring a Review	Completed Fatality Reviews	Pending Fatality Reviews
2019	5	1	4

Child Near-Fatality Reports for Calendar Year 2019			
Year	Total Near-Fatalities Reported to Date Requiring a Review	Completed Fatality Reviews	Pending Fatality Reviews
2019	8	2	6

The child fatality reviews referenced in this Quarterly Child Fatality Report are subject to public disclosure and are posted on the DCYF website.

This report includes information from an internal fatality review. This review did not meet the statutory requirements for a review and was conducted at the request of DCYF leadership. Findings and information related to this report are referenced in this first quarter report. However, the full text of this report is not included as this review is not subject to public disclosure and is not included in this report.

Near-fatality reports are not subject to public disclosure and are not posted on the public website.

Notable First Quarter Findings

Based on the data collected and analyzed from the five (5) fatalities and one (1) near-fatality during the first quarter, the following were notable findings:

- Five (5) of the six (6) cases referenced in this report were open at the time of the child's death.
- In five (5) of the six (6) cases referenced, the child was under the age of six months at the time of death.
- Four (4) of the six (6) child fatalities occurred in unsafe sleep environments.
- One (1) child fatality had been closed for four months. This fatality was not the result of abuse or neglect by the parent.
- The one (1) near-fatality case was determined to be an interrupted SIDS event. The mother was impaired and co-slept with her infant son resulting in near-fatal asphyxiation of the child.
- One fatality involved a five-month-old infant dying in an unsafe sleep environment. This child was a twin and his twin sister previously died while co-sleeping with her intoxicated father. The department had an open case when the second child died and had repeatedly educated the parents about the risks of co-sleeping, especially when impaired.
- Safe sleep was discussed with the caregivers prior to the death of the children in their care in each of the infant fatalities.
- Four (4) children referenced in this report were Caucasian, one (1) was African American and one (1) was Hispanic.

- Substance abuse was an identified risk factor in five (5) of the six (6) cases and was a risk factor in all of the unsafe sleep fatalities. Domestic violence, homelessness and cleanliness of the home environment were other significant risk factors identified in several of the cases in this report.
- DCYF received intake reports of abuse or neglect in each of the cases in this report prior to the death of the child. In three (3) of the fatality cases, there were two (2) prior reports made regarding the family. In one (1) fatality case, the department received seven (7) prior reports. In another fatality case, three (3) intake reports were received prior to the child's death. In the one (1) near-fatality case, there was one (1) prior report made regarding the family.
- Due to the small sample of cases reviewed, no statistical analysis was conducted to determine relationships between variables.

Exhibit A

Child Fatality Reviews

The child fatality reviews referenced in this Quarterly Child Fatality Report are subject to public disclosure and are posted on the DCYF website.

Exhibit A contains the following child fatality reviews from the first quarter of 2019:

- C.T. Child Fatality Review
- E.T. Child Fatality Review
- C.P. Child Fatality Review
- C.W-S. Child Fatality Review

WASHINGTON STATE
Department of
Children, Youth, and Families

CHILD FATALITY REVIEW

March 2019

www.dcyf.wa.gov

FULL REPORT

CHILD

- C.T.

DATE OF CHILD'S BIRTH

- [redacted] 2017

DATE OF FATALITY

- April 26, 2018

CHILD FATALITY REVIEW DATE

- October 18, 2018

COMMITTEE MEMBERS

- Erin Summa, MPH, Health Promotion Coordinator, Center for Childhood Safety, Mary Bridge Children's Hospital and Health Network
- Patrick Dowd, JD, Director, Office of Family and Children's Ombuds
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- Kristie Deese, CPS/FAR Supervisor, Department of Children, Youth, and Families

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FACILITATOR

- Bob Palmer, Critical Incident Case Review Specialist, Department of Children, Youth, and Families

CONTENTS

EXECUTIVE SUMMARY

On October 18, 2018, the Department of Children, Youth, and Families (DCYF or Department)[1] convened a Child Fatality Review (CFR) to examine DCYF's practice and service delivery to C.T. and RCW 7 family.[2] Beginning in mid-January 2018, C.T.'s family was receiving Family Assessment Response (FAR)[3] services. The basis for this CFR occurred on April 26, 2018, when, during an unannounced visit to the home, the assigned FAR worker and his supervisor were informed by family members that C.T. had passed away earlier in the day while bed sharing with the father.[4] First responders, law enforcement, and the County Coroner's office finished processing the death scene and departed the home before the arrival of the FAR worker and supervisor. The circumstances of C.T.'s death are similar to those occurring RCW 74. months earlier when C.T.'s RCW 74.1 died.

The CFR Committee (Committee) included DCYF staff, a representative from the Office of Family and Children's Ombuds, and a child safety educator with expertise in infant safe sleep. None of the participating Committee members had any direct knowledge of the family prior to C.T.'s death. Prior to the review, each Committee member received a chronology summarizing the child welfare involvement with the family, un-redacted DCYF documents (e.g., intakes, risk and safety assessments, and case notes), and law enforcement reports. Supplemental information was also available to Committee members during the review, including death scene photos and the autopsy report involving C.T.'s RCW 74.13. The assigned DCYF worker and supervisor provided verbal information during the Committee's in-person interview process.

PURPOSE OF A REVIEW

A child fatality or near-fatality review completed pursuant to RCW 74.13.640 is subject to discovery in a civil or administrative proceeding, but may not be admitted into evidence or otherwise used in a civil or administrative proceeding except pursuant to RCW 74.13.640(4). Given its limited purpose, a child fatality or near-fatality review (CFR/CNFR) should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. The CFR committee's review is generally limited to documents in the possession of or obtained by DCYF or its contracted service providers.

The committee has no subpoena power or authority to compel attendance and generally only hears from DCYF employees and service providers. It does not hear the points of view of the child's parents and relatives, or of other individuals associated with the child. A CFR/CNFR is not intended to be a fact-finding or forensic inquiry or to replace or supersede investigations by courts, law enforcement agencies, or other entities with legal responsibility to investigate or review some or all of the circumstances of a child's fatal injury. Nor is it the function or purpose of a CFR/CNFR to recommend personnel action against DCYF employees or other individuals. Information discovered through the review may be used in DCYF disciplinary actions such as revocation or suspension of a child care license.

[1] Effective July 1, 2018, the Department of Children, Youth, and Families (DCYF) is the state agency responsible for child welfare and early learning programs (the Department of Social and Health Services Children's Administration was the prior authority). The fatality occurred prior to July 1, 2018, and therefore CA or DSHS may be referenced in this report.
[2] As there are no known criminal charges filed related to the incident, the parents involved are not identified by name in this report. The names of the children are also subject to privacy laws. See RCW 74.13.500.
[3] FAR is a voluntary Child Protective Services (CPS) alternative response to a screened in allegation of abuse or neglect that focuses on the integrity and preservation of the family when less severe allegations of child maltreatment are reported. FAR cases do not require a finding.
[4] Broadly defined, bed sharing is a co-sleeping arrangement in which an infant sleeps on the same surface with another person (e.g., bed, couch, or chair). Due to increased risk for Sudden Unexpected Infant Death (SUID), both the American Academy of Pediatrics (AAP) and the U.S. Consumer Product Safety Commission (CPSC) advise against bed sharing.

CASE SUMMARY

C.T. was born in RCW 74.1 2017. Department-related child welfare history for this family includes two Child Protective Services (CPS) investigations that predated C.T.'s birth. The first investigation occurred in 2013 when CPS initiated an investigation involving allegations RCW 13.50.100 . These allegations were determined to be "unfounded."[5] In September 2014, CPS initiated a second investigation based on RCW 13.50.100 concerns. This investigation originated from a notification that a third party in the home had RCW 13.50.100 . The CPS investigation resulted in a RCW 13.50.100 finding based on the determination RCW 13.50.100 .

January 2018 Intake

On January 19, 2018, a RCW 13.50.100 reportedly disclosed she had been left to watch her sickly RCW old RCW 74.13.515 C.T. when the mother and the baby's father got into a quarrel. The report also included information that C.T.'s RCW 74.13.515 had died RCW 74.1 month earlier (no details were provided). The report was initially screened out as the information provided at the time of intake did not appear to meet the legal definition of child abuse or neglect under WAC 110-30-0030. However, an acting regional intake administrator overrode the screening decision, and the intake was assigned for FAR services. During the FAR worker's interview of the RCW 13.50.100, no disclosures were made with regard to negligent treatment or maltreatment,[6] or feeling unsafe at home. The RCW 13.50.100 15-year old sibling declined to be interviewed. When contacted by phone, the mother denied the allegations. When interviewed in-person, she again denied neglecting any of her children. When asked about the RCW 74.13.515 2017 passing of RCW 74.13.515 , the mother became distraught and indicated the death was related to SIDS (Sudden Infant Death Syndrome). Under the January 2018 FAR case, DCYF initiated a referral for Family Preservation Services (FPS).[7]

March 2018 Intake

While the FAR case was still active, a new FAR intake was accepted on March 22, 2018. Reportedly, the 13-year old half-sibling came home from school to find that C.T. had been left unattended at the home. The assigned FAR worker and another DCYF social worker conducted a home visit. With the exception of C.T.'s father who was later interviewed by telephone, in-person contact was made with all household members. No obvious safety threats were identified other than concerns with C.T.'s sleep environment (e.g., cluttered crib area). These concerns were discussed and addressed with the mother. After meeting with the mother, the Department decided to initiate an investigation of the circumstances of the death of C.T.'s RCW 74.13. which had not been reported to CPS as suspicious.[8] Records obtained from the County Coroner revealed the RCW 74.13.51 death was attributed to Sudden Unexplained Infant Death (SUID), and the manner classified as Undetermined.[9] Law enforcement records confirmed the death occurred

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[5] Findings are determined when the investigation is complete and are based on a preponderance of the evidence standard. **Unfounded** means "the determination following an investigation by the Department that available information indicates that more likely than not child abuse or neglect did not occur, or that there is insufficient evidence for the Department to determine whether the alleged child abuse did or did not occur." **Founded** means "the determination following an investigation by the department that, based on available information, it is more likely than not that child abuse or neglect did occur." RCW 26.44.020.

[6] Included within the definition of child abuse or neglect is the phrase "negligent treatment or maltreatment." Under WAC 110-30-0030(5), negligent treatment or maltreatment is defined as follows: "an act or a failure to act, or the cumulative effects of a pattern of conduct, behavior, or inaction, on the part of a child's parent, legal custodian, guardian, or caregiver that shows a serious disregard of the consequences to the child and creates a clear and present danger to the child's health, welfare, or safety."

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

[8] Child fatalities are not required to be reported to CPS unless there is a reasonable basis to suspect child abuse or neglect caused the death.

[9] Sudden unexpected infant death (**SUID**) is a term used to describe the sudden and unexpected death of a baby less than 1-year old in which the cause was not obvious before investigation. These deaths often happen during sleep or in the baby's sleep area.

during bed sharing (the father and the infant), noting concerns for the sleeping environment (excessive items in the bed) and for possible contribution of alcohol consumption by the father the night of the incident. However, there was insufficient evidence to suggest the situation was anything other than an accidental death.

C.T.'s April 2018 Death

On April 26, 2018, during an unannounced visit to the home, the assigned FAR worker and his supervisor were informed by family members that C.T. had passed away earlier in the day while bed sharing with the father. The circumstances were remarkably similar to the RCW 74.13.515 2017 death of C.T.'s RCW 74.13. In both cases, the mother was not home at the time of death, there was bed sharing by the father, and an infant was in an adult bed cluttered with items. Following the CPS investigation, a neglect founded finding was issued against the father. This finding was based on C.T.'s sleep environment conditions that created "a clear and present danger to [C.T.'s] health, welfare, or safety."[10] Given the indeterminate nature of C.T.'s actual cause of death, the CPS investigator was unable to make a finding regarding parental actions or inactions causing the death. It should be noted that at the time of the CFR, law enforcement had not released the criminal investigative report and the County Coroner's report was still pending toxicology results. Notwithstanding this, the preliminary autopsy suggested the death was a SUID.

COMMITTEE DISCUSSION

During the review process, the CFR Committee explored and discussed a number of issues potentially relevant to DCYF practice, including: intake decisions, investigative practices, infant safe sleep assessment procedures, family engagement and service delivery, and systemic barriers to meeting policy requirements and practice standards in state child welfare work. Not all of the issues discussed and documented in this section resulted in findings or conclusions by the Committee.

Intake Decisions

The Committee briefly discussed the screening decisions for the three intakes taken between mid-January 2018 and C.T.'s death in late April 2018. With regard to the January intake, the Committee was undecided about the management decision to override the initial screen-out decision. However, Committee members did agree that C.T. could have reasonably been identified as an alleged victim in that intake. With regard to the April 2018 intake, additional discussion occurred as to whether generating the intake regarding the previous SUID death of C.T.'s RCW 74.1 (RCW 74.13.515 2017) was actually necessary since information about that event had already been documented. The Committee did not reach consensus, but appreciated the fact that the decision to look into the previously unreported death of the RCW 74.1 resulted from shared decision-making.

Information Gathering/Assessment

Some discussion occurred as to the CPS family history that predated the birth of C.T. and RCW 7. The Committee was concerned the FAR worker may not have sufficiently grasped the significance of this prior history as it relates to a possible pattern of the mother's questionable ability to meet the basic health, welfare, and safety needs of her children. However, most of the Committee's focus centered on the more current involvement with CPS and the FAR activities occurring during the three months the case was open before C.T.'s death. The Committee examined worker activities pertaining to the completion of required work (e.g., timelines to conduct various tasks), and the quality of the child welfare work (e.g., sufficiency of collateral

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The three most frequently reported causes for SUID are (1) SIDS, (2) Unknown, and (3) ASSB (accidental suffocation and strangulation in bed).

[10] See "child abuse or neglect" and "negligent treatment or maltreatment" definitions contained in WAC 110-30-0030(5)

contacts and corroboration of information, level of investigative curiosity, critical thinking/analysis). The Committee also compared the initial efforts by the worker in January 2018 to connect with the family, versus subsequent efforts to gather additional information or corroborate additional information reported by family members (e.g., the nature of the prior death of the RCW 74.1[redacted]).

The Committee also discussed that during the three months the case was open before C.T.'s death, the information gathered by the FAR worker was incident-focused instead of assessment-focused. For example, the FAR worker appeared attentive to the allegations originating from the RCW 13.50.100, but the case file did not contain substantive documented information about C.T. until C.T. was identified as an alleged victim in the March intake. Despite living in the home, very little information regarding the father surfaced until the FAR worker spoke to him by phone in early April 2018. The Committee also considered whether the worker should have explored the discrepancies between what one of the older siblings had reportedly told others about what was going on in the home, and what she disclosed to the worker when interviewed. The Committee considered how missing but obtainable information may have significantly impacted the accuracy of the assessment tools used to evaluate safety and risk and determine the service needs of the family.

Infant Safe Sleep

Taking into consideration the unusual, if not suspicious, circumstances of two apparent SUID deaths in the same family just months apart, the Committee was given statistical data related to national infant mortality rates, mortality rates for RCW 74.13.5[redacted] including SUID/SIDS deaths, and current frequency estimates for multiple infant deaths in a family. The Committee also looked at risk reduction recommendations for infant safe sleep promoted by the American Academy of Pediatrics and the National Institute of Child Health and Human Development,[11] and the DCYF infant safe sleep policy.[12] The Committee also considered the nature and extent of the infant safe sleep assessment, education, and intervention activities conducted by DCYF staff before C.T.'s death. The Committee looked at efforts by the FAR worker and his co-worker to address basic infant safe sleep with the mother during a visit to the home. There was also discussion about the "wedge" sleep positioner[13] allegedly recommended by C.T.'s doctor for reflux reduction but never verified by the worker. The Committee discussed missed opportunities for improved safe sleep education and intervention with other caregivers in the home (the father, the teen half-siblings, the grandmother). This issue seemed particularly relevant given the fact that the father was the adult involved in the bed sharing SUID of C.T.'s RCW 74.13.515. While all Committee members were familiar with DCYF's commitment to address infant safe sleep in policy and training opportunities for staff, some questioned how reasonable it is to expect DCYF staff to have anything more than basic knowledge about infant safe sleep.

Family Engagement/Services

The Committee reviewed and discussed the FAR worker's efforts to connect with the family and offer services beyond providing the family with a FAR brochure[14] and County Resource Guide. The Committee considered the fact that the FAR worker had very limited follow-up contact with the family for a two-month period, and no in-person interactions with the father prior to C.T.'s death. As previously noted, the Committee had concerns the worker may not have had sufficient

[11] https://safetosleep.nichd.nih.gov/
[12] https://www.dcyf.wa.gov/1100-child-safety/1135-infant-safety-education-and-intervention
[13] A sleep positioner is a readily available product used to keep babies on their backs while sleeping. Some are flat mats with side bolsters, and others are inclined (wedge) mats with side bolsters. Many types of sleep positioners claim to help reduce the risk of SIDS by keeping babies on their backs, help with food digestion and reflux, ease colic, and prevent flat head syndrome. The U.S. Consumer Product Safety Commission (CPSC) and the U.S. Food and Drug Administration (FDA) have issued warnings to consumers to stop using infant sleep positioners as they pose a suffocation risk. Similarly, the American Academy of Pediatrics (AAP) advises caregivers to avoid using commercial devices marketed to reduce the risk of SIDS. https://www.cpsc.gov/Newsroom/News-Releases/2010/Deaths-prompt-CPSC-FDA-warning-on-infant-sleep-positioners/
[14] https://www.dshs.wa.gov/sites/default/files/SESA/publications/documents/22-1534.pdf

comprehension of family functioning and individual functioning within the family to inform how to proceed with service delivery. For example, the Committee discussed whether the referral to FPS was the appropriate service given there did not appear to be a substantial risk of placement and the FPS referral was very non-specific with regard to targeted services. There was some indication the FPS referral may have been the result of the "best service available" in the family's community at the time.

Possible Systemic Barriers

The Committee looked at possible systemic barriers that may have contributed to the FAR worker not meeting some policy requirements and practice standards (e.g., timely documentation and timeframes for completion of work). The Committee considered the worker's caseload, his years of experience in the field, and, based on interview responses from the worker and supervisor, the quantity and quality of supervision provided to the worker on a regular basis. While noting the worker's caseload appeared to exceed the state average as well as the recommended standards of national child welfare organizations,[15] it was unclear to the Committee what specific impact the high caseload may have had on meeting expectations.

Post-Critical Incident Activities

Given that the task of the Committee is to review and evaluate recent DCYF service delivery occurring prior to a suspicious child death, there was only limited discussion about the post-critical incident activities and findings. With the cause and manner of C.T.'s death being undetermined at the time of the CFR, the Committee discussed the challenges with regard to making a finding that the death was the result of child maltreatment. However, because the death scene investigation showed evidence of an unsafe sleeping environment, the Committee took no issue with the CPS investigative finding that the parent failed to provide a reasonably safe sleeping environment for an infant irrespective of C.T.'s death. Finally, the Committee speculates that the worker and supervisor seemed reluctant to continue family engagement soon after C.T.'s death, possibly persuaded by the family's decline for further services.

FINDINGS

The Committee did not identify any critical errors by the Department in this case. In part, this was due to the unknown nature of what caused C.T.'s death. However, the Committee noted the following missed opportunities for reasonably improved practice – issues that may be important for consideration for statewide DCYF practice.

- Although there was documentation that the infant safe sleep assessment and safe sleep discussion occurred in the family home with the mother present, there did not appear to be any significant infant safe sleep discussions occurring with C.T.'s father, the paternal grandmother, or C.T.'s teenage half-siblings – all of whom had caretaking responsibilities for the infant. There was no follow up with C.T.'s doctor who reportedly recommended the use of a crib wedge due to reflux issues. As a part of the infant safety education process, the FAR worker may not have been aware that DCYF workers are to review materials with parents and caregivers that include the Infant Safe Sleep Guidelines (DSHS 22-1577). These guidelines contain the recommendation for caregivers to "avoid wedges, positioners or other products unless prescribed by your baby's doctor."[16]
- Information gathered by the FAR worker during the three months the case was open before C.T.'s death appeared to be limited, concrete, and incident-focused instead of assessment-focused. The worker may not have had a substantive understanding of

[15]For child protective services, the Council on Accreditation recommends that caseloads do not exceed 15 investigations or 15-30 open cases. http://coanet.org/standards/standards-overview/ The Child Welfare League of America recommends a caseload size of 12 intake reports per month per worker. See http://www.cwla.org/wp-content/uploads/2014/05/DirectServiceWEB.pdf
[16] https://www.dshs.wa.gov/sites/default/files/SESA/publications/documents/22-1577_0.pdf

family and individual functioning, resulting in flawed assessment of service needs, and missing numerous opportunities to address parental chemical dependency issues.

- The Committee believes there were missed opportunities for the supervisor to adjust his supervisory skills to meet the needs of the FAR worker, and to recognize where the worker may have needed more guidance. This includes more guidance with regard to activity completion, next steps follow-up, and identifying the need to initiate collateral contacts to corroborate information. The Committee acknowledged the significant challenges facing DCYF to maintain a high level of practice during a time of significant workload increases, significant staff turnover rates, reliance on workers with relatively limited experience in child protection, and the inability to provide an essential level of consistent supervision.

RECOMMENDATIONS

There are no specific recommendations emerging from this review. However, the Committee encourages DCYF to continue its efforts to promote infant safe sleep with families through continued policy enhancements and staff training.

WASHINGTON STATE
Department of
Children, Youth, and Families

CHILD FATALITY REVIEW

December 2018

www.dcyf.wa.gov

FULL REPORT

CHILD

- E.T.

DATE OF CHILD'S BIRTH

- RCW 74.15.515 2017

DATE OF FATALITY

- July 2018

CHILD FATALITY REVIEW DATE

- October 18, 2018

COMMITTEE MEMBERS

- Mary Moskowitz, JD, Ombuds, Office of the Family and Children's Ombuds
- Amy Boswell, Child Protective Services (CPS) Program Manager, Department of Children, Youth, and Families
- Melanie Terrill, CPS/Family Assessment Response Supervisor, Department of Children, Youth, and Families
- Melanie Robinson, Sexual Assault Unit Detective, Kent Police Department

FACILITATOR

- Libby Stewart, Critical Incident Review Specialist, Department of Children, Youth and Families

CONTENTS

EXECUTIVE SUMMARY

On October 18, 2018, the Department of Children, Youth, and Families[1] (DCYF or Department) convened a Child Fatality Review (CFR)[2] to assess the Department's practice and service delivery to E.T. and [redacted] family.[3] [redacted] will be referenced by [redacted] initials throughout this report.

On July 7, 2018, the Department received a telephone call from a hospital alleging E.T. was neglected by [redacted] mother and her boyfriend. Paramedics brought E.T. to the hospital where [redacted] was declared deceased. E.T.'s mother reported that in the morning, shortly after she awakened, she observed E.T. and determined [redacted] was unresponsive. The mother's boyfriend started chest compressions and called 911. The mother shared details of the events from the previous evening and that morning. The mother stated she felt something was wrong because she did not check on her child before bedtime. Law enforcement was contacted and started an investigation. This intake was assigned for a Child Protective Services (CPS) investigation. At the conclusion of the CPS investigation, the Department issued founded findings for negligent treatment or maltreatment to both the mother and her boyfriend.

At the time of [redacted] death, E.T. lived with [redacted] mother, maternal grandfather, maternal step-grandmother, and the maternal step-grandmother's teenage child. There had been two recent CPS/Family Assessment Response (FAR) assessments regarding E.T.[4] On May 10, 2018, those assessments were approved for closure.

The CFR Committee (Committee) included members selected from diverse disciplines within the community with relevant expertise including individuals from the Office of the Family and Children's Ombuds, law enforcement, and child welfare. Extensive efforts were made to include a person from the deaf and hard of hearing community to also sit on the Committee. Those efforts were unsuccessful. The Committee members did not have any involvement or contact with E.T. or [redacted] family.

The Committee interviewed the CPS worker, the CPS supervisor, and the area administrator. Due to the Committee's responsibility to focus on events prior to the critical incident, the Committee chose not to interview the CPS worker who investigated the fatality. When the first intake was received, the CPS worker was supervised by an interim supervisor. This person did not have any recollection of the case and was not asked to attend the review. At the time of the second intake, the CPS worker's primary supervisor had returned and was present throughout the conclusion of the case.

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[1] Effective July 1, 2018, the Department of Children, Youth, and Families (DCYF) replaced the Department of Social and Health Services (DSHS) Children's Administration (CA) as the state agency responsible for child welfare (and early learning programs).

[2] Given its limited purpose, a CFR should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. The CFR Committee's review is generally limited to documents in the possession of or obtained by DCYF or its contracted service providers. The Committee has no subpoena power or authority to compel attendance and generally only hears from DCYF employees and service providers. It does not hear the points of view of the child's parents and relatives, or of other individuals associated with the child. A CFR is not intended to be a fact-finding or forensic inquiry or to replace or supersede investigations by courts, law enforcement agencies or other entities with legal responsibility to investigate or review some or all of the circumstances of a child's fatal injury. Nor is it the function or purpose of a CFR to recommend personnel action against DCYF employees or other individuals.

[3] E.T.'s parents and the mother's boyfriend are not named in this report because they have not been charged in an accusatory instrument with committing a crime related to a report maintained by the Department in its case and management information system. [Source-Revised Code of Washington 74.13.500(1)(a)]

[4] https://www.dcyf.wa.gov/practices-and-procedures/2332-child-protective-services-family-assessment-response.

FAMILY CASE SUMMARY

On April 8, 2018, the Department received an anonymous call reporting that E.T.'s mother was using RCW 13.50.100 in the presence of her RCW 74.15.313 -month old child. The caller reported the mother drives with the baby after she RCW 13.50.100 and the caller is concerned for the baby's health and safety. The caller also said the father does not use drugs and does not want the mother RCW 13.50.100 around the baby. The caller reported the mother does not comfort the baby when RCW 74 cries and expects the father to do all of the work when he is home. The father told the caller he is overwhelmed. The caller also reported the parents often engage in verbal altercations but there is no physical violence. This intake was screened in for a 72-hour CPS/FAR assessment.

The assigned CPS worker called the mother's phone number and left a message requesting the mother return her call. The CPS supervisor assisted the worker in looking up an alternative telephone number for E.T.'s maternal grandfather. The CPS worker called the grandfather. He provided information, including the fact that the mother and child lived with him and the fact that the mother is deaf. The grandfather told the CPS worker he is the one who takes care of the child. The CPS worker requested from the department that a sign language interpreter be present for the initial face-to-face meeting with the mother, which was scheduled for April 10, 2018. The CPS worker did not receive a response to her request.

On the morning of April 10, 2018, the following persons were present when the CPS worker arrived for the face-to-face meeting: E.T., both of RCW 74. parents, the maternal grandfather, his wife (maternal step-grandmother), and her teenage child. The maternal step-grandmother provided sign language interpretation. The worker discussed Period of Purple Crying, safe sleep, and the allegations. The CPS worker told the mother that she had been referred for a urinalysis test. The CPS worker observed a diaper change and reviewed the child's sleeping environment. The family shared that E.T. was up to date with RCW 74. medical needs and discussed RCW 74. routine care. The grandparents provided the mother with a sleeping monitor that vibrates and flashes, through an application on her phone, if E.T. rolls over while RCW 74 is sleeping. The step-grandmother stated she is purchasing a bracelet that the mom can wear that will vibrate if the baby moves. The family explained how they meet E.T.'s needs when RCW 74 cries. They said E.T. is allowed to cry for five minutes before they respond. This plan is to allow the mother time to respond. If the mother does not respond, then one of the other family members will assist with E.T.'s immediate needs. The mother denied current RCW 13.50.100 use.

After the worker completed contact with the mother and her family, the worker followed the father to his residence. The father lives with his mother. The worker discussed safe sleep if E.T. stays at his home. The mother's family indicated that the father visits at the maternal grandparent's home only. The family has not allowed E.T. to leave their home with only RCW 74. father. The paternal grandmother did not speak English and was not utilized as a collateral contact.

The worker contacted the pediatrician's office and verified E.T. was up to date on RCW 74. immunizations. The worker also sent an email to the mother and her stepmother providing a description of available resources and services. The worker made sure the resources could provide services utilizing American Sign Language (ASL). The worker also reviewed the Department's computer records system to determine whether the father, mother, maternal grandfather, or maternal step-grandmother have a record of any documented history with the Department. The worker also emailed the father with information about resources for fathers.

At the time the worker referred the mother for a urinalysis, the worker was unaware that she had to specifically request the urine be tested for RCW 13.50.100 The Department had previously

removed RCW 13.50.100 from the regular testing panel. Therefore, the negative urinalysis provided by the mother did not test for RCW 13.50.100 use. This was not known to the worker until after the case was closed on May 10, 2018.

On April 13, 2018, the father called to speak with the worker. The father was very distressed. Ultimately the worker called the father back after giving him time to calm down. The father told the worker that they all lied to her. He stated they lied about the mother's and maternal grandparents' RCW 13.50.100 use. He also told the worker that the mother slept with E.T. in the same bed. The worker again encouraged the father to seek services for possible counseling, parenting classes, and custody related legal advice or assistance from the Divine Alternatives for Dads Services.[5]

The day after speaking with the father, the RCW 13.50.100 called in an intake. The intake's allegations were based on the April 13, 2018, statements made by the father to the worker. The allegations stated that the maternal grandparents RCW 13.50.100 and drive with the baby in the car, and that it is a big secret and no one wants to talk about it. The allegations also allege the mother fails to adequately protect E.T. This intake was assigned as a CPS/FAR assessment. This intake was assigned to the current CPS/FAR worker.

The CPS/FAR worker and her supervisor conducted an unannounced home visit. When they arrived, they shared the information in the intake. The family once again denied the allegations. The CPS worker and supervisor conducted a walk-through of the home. The case was closed after the unannounced home visit.

On July 7, 2018, the Department received a telephone call from a hospital reporting that E.T. had been brought by ambulance to a hospital and was declared deceased. On the evening of July 6, 2018, E.T. had been with RCW 74. mother and her boyfriend at an event and they stayed the night with friends. This intake was assigned for a CPS investigation; and as of the writing of this report, remains an open law enforcement investigation. After a CPS investigation, the Department issued founded findings against the mother and her boyfriend for the negligent treatment or maltreatment of E.T. that resulted in RCW 74. death.

[5] https://www.aboutdads.org/

COMMITTEE DISCUSSION

After interviews were completed with Department staff, the Committee discussed the case further. The Committee briefly discussed the Department's current policies pertaining to CPS investigations and FAR. The Committee also discussed the fact that CPS investigations and FAR are functions of CPS, with child safety being the paramount concern under both functions. The Committee discussed that one way to create a more fluid approach to policies for CPS investigations and CPS/FAR assessments would be for them to be contained in a shared policy heading.

The Committee also talked about whether the documentation throughout the case could have been more thorough. The Committee noted that the first intake was the first case assigned to the CPS worker, and as such, the CPS worker did a very good job for her first assessment. However, there were areas the Committee believed could have been bolstered by guidance from the CPS worker's supervisor. This is further discussed in the findings section below.

The Committee discussed the need for the Department to provide staff training regarding working with clients who speak ASL. Sometimes, cases that involve ASL speaking clients can provide a more complex case situation and require a deeper knowledge of how to assess child safety. This topic is further discussed in the recommendation section below.

When the area administrator addressed the Committee, she said that she believes it would have been best practice to have requested urinalyses tests from the grandparents based on the allegations in the second intake. The Committee agrees with this statement. The Committee discussed that while a urinalysis is only a snapshot in time, it is a tool that is readily used by Department staff for situations involving allegations of substance use and abuse.

FINDINGS

The Committee did not identify any critical errors made by DCYF during the two CPS/FAR assessments. However, the Committee discussed areas not related to E.T.'s passing in which Department practice could be improved. Those recommendations are addressed below.

The Committee identified the intent and training by the Department has been for department staff to exclude the use of family members to provide sign language interpretation. Department staff normally require certified ASL interpreters when interacting with hearing impaired clients. In this case, the CPS worker requested an ASL interpreter for the initial face-to-face contact but one was not available and a family member was used instead. This approach is consistent with policy 4330.[6] Subsequent contact did not include a request by Department staff for an interpreter until the investigation of E.T.'s death. The Committee believes that each time the Department had planned contact with the mother, there should have been a request for an ASL certified interpreter. The Committee also noted that utilizing a family member for interpretation services may compromise clear and impartial communication between the client and Department staff.

Taking into consideration this case was the first case assigned to the CPS worker, the Committee believes the work completed by her was well done. However, the Committee identified areas of her investigation that were lacking in information that are normally necessary to assess child safety. The Committee also believes the areas that were lacking detail should have been caught and corrected by the supervisor during supervisory review and at case closure. For example, the CPS supervisor went with the CPS worker when she met with the mother and her family to assess the April 14, 2018, intake. The Committee noted that this contact could have been an opportunity for the supervisor to demonstrate a more in-depth gathering of details to assist with assessing the overall safety and risk to E.T.

The CPS worker did work to assess the substance abuse allegations by requesting a urinalysis from the mother, but not other household members. Utilizing results from random urinalysis testing is one tool Department staff have to assess the use or abuse of substances. Also, the maternal step-grandmother has a teenage daughter who lives in the same home. That person was not included in the household constellation (in the electronic case file) and was not interviewed as a part of the investigation. After the review and during a discussion with the CPS worker, she shared that she started to put information about the household into the system but was told by a supervisor (who is no longer employed by the Department) she could not do this. The CPS worker is now aware she can and should add all persons that live in the residence.

The April 14, 2018, intake (second intake) did not include the grandparents as subjects, though they are discussed in the body of the intake. The supervisor could have shown the assigned worker how to add the grandparents to the intake, which would have also allowed them to be included in urinalysis testing to aid in determining the validity of the allegations.

The second and third intakes did not identify the mother's primary language as ASL. Even though the third intake clearly identified this in the body of the allegation section and there was a note on the first page of the intake, it still needed to be appropriately identified under the language tab for E.T.'s mother.

[6] https://www.dcyf.wa.gov/4300-culturally-relevant-services/4330-serving-persons-disabilities

RECOMMENDATIONS

DCYF should create a Quick Tip to remind staff about policy 4320 requiring the use of interpreters.

DCYF should also create or obtain a training for staff that work with or may work with ASL speaking clients. The Committee discussed that when department staff assess child safety for clients that are deaf, there may be additional areas to consider as it relates to parenting and daily functions based on many differing aspects for that family (i.e. who is deaf, were they born deaf, is there exposure for children of deaf parents to spoken language, etc.). The Committee suggests a voluntary training be made available to staff, such as an easy to access e-learning.

The Department should review policy 4320 and 4330 and evaluate if changes can be made to make the policies consistent with each other, and to state that staff must first try to utilize certified interpreters in all situations, including cases involving hearing impaired clients. A revised policy should also provide guidance to the worker with regard to what should be done if an ASL certified interpreter is unavailable, or if the hearing impaired client refuses to use a certified ASL interpreter and instead wants a family member or friend to interpret. When this evaluation has been completed the Department should communicate clarifications regarding interactions with ASL speaking clients to all staff to comply with state and federal requirements.

WASHINGTON STATE
Department of
Children, Youth, and Families

CHILD FATALITY REVIEW

January 2019

www.dcyf.wa.gov

FULL REPORT

CHILD

- C.P.

DATE OF CHILD'S BIRTH

- [redacted] 2018

DATE OF FATALITY

- August 2018

CHILD FATALITY REVIEW DATE

- November 15, 2018

COMMITTEE MEMBERS

- Patrick Dowd, JD, Director, Office of the Family and Children's Ombuds
- Amy Boswell, Child Protective Services/Family Assessment Response Program Manager, Department of Children, Youth, and Families
- Ruth Wolbert-Neff, CDP, Drug and Alcohol Treatment Counselor 1, Tacoma-Pierce County Health Department
- Melanie Terrill, CPS/FAR Supervisor, Department of Children, Youth, and Families

FACILITATOR

- Libby Stewart, Critical Incident Review Specialist, Department of Children, Youth, and Families

CONTENTS

A child fatality or near-fatality review completed pursuant to RCW 74.13.640 is subject to discovery in a civil or administrative proceeding, but may not be admitted into evidence or otherwise used in a civil or administrative proceeding except pursuant to RCW 74.13.640(4).

Given its limited purpose, a child fatality review (CFR) should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. The CFR committee's review is generally limited to documents in the possession of or obtained by DCYF or its contracted service providers. The committee has no subpoena power or authority to compel attendance and generally only hears from DCYF employees and service providers. It does not hear the points of view of the child's parents and relatives, or of other individuals associated with the child. A CFR is not intended to be a fact-finding or forensic inquiry or to replace or supersede investigations by courts, law enforcement agencies, or other entities with legal responsibility to investigate or review some or all of the circumstances of a child's fatal injury. Nor is it the function or purpose of a CFR to recommend personnel action against DCYF employees or other individuals.

EXECUTIVE SUMMARY

On November 15, 2018, the Department of Children, Youth, and Families[1] (DCYF) convened a Child Fatality Review (CFR) to assess DCYF's practice and service delivery to C.P. and [redacted] family.[2] [redacted] will be referenced by [redacted] initials throughout this report.

On August 9, 2018, DCYF received a call stating C.P. had passed away while bed sharing with [redacted] parents. DCYF was told that the parents woke up just before 2:00 p.m. and discovered that their [redacted] was unresponsive. Emergency services responded to the scene after being called by the parents. Emergency services declared C.P. deceased at the scene. No resuscitative measures were taken by the responding emergency services personnel. Law enforcement observed drug paraphernalia in the bedroom where C.P. passed away as well as in the living room. The residence was known to law enforcement because of prior drug activity. The August 9, 2018, call to DCYF resulted in a child protective services (CPS) investigation. There had already been an open CPS/Family Assessment Response (FAR) assessment in progress at the time of C.P.'s passing. The same CPS worker assigned to the CPS/FAR assessment conducted the investigation related to C.P.'s death. As a result of the CPS investigation, founded findings for negligent treatment or maltreatment were entered against both parents.

The CFR Committee (Committee) included members selected from diverse disciplines within the community with relevant expertise, including individuals from the Office of the Family and Children's Ombuds, substance abuse, and child welfare. A law enforcement detective previously agreed to attend and participate as a Committee member. However, on the morning of the scheduled review, her circumstances changed and she was unable to attend or participate. The Committee members did not have any involvement or contact with C.P. or [redacted] family.

The Committee interviewed the CPS worker and her supervisor. The Committee also reviewed a packet of information provided to them which included DCYF intakes, case notes, and assessments/investigation materials. The Committee also received the following information on the day of the scheduled review:

- Historical DCYF records about [redacted]
- Historical DCYF records about [redacted]
- Medical records pertaining to C.P.'s birth that were obtained after [redacted] death
- A law enforcement report regarding the fatality
- A 2014 [redacted] County Superior Court document regarding [redacted]

[1] Effective July 1, 2018, the Department of Children, Youth, and Families (DCYF) replaced the Department of Social and Health Services (DSHS) Children's Administration (CA) as the state agency responsible for child welfare (and early learning programs).
[2] C.P.'s family members are not named in this report because they have not been charged in an accusatory instrument with committing a crime related to a report maintained by the Department in its case and management information system. [Source-Revised Code of Washington 74.13.500(1)(a)].

FAMILY CASE SUMMARY

Between October 2004 and July 2018, there were 13 intakes received by DCYF regarding C.P.'s mother and her children. The intakes' allegations included RCW 13.50.100 by the parents, RCW 13.50.100, RCW 13.50.100 of the mother, RCW 13.50.100, and RCW 13.50.100 . None of the 13 intakes assigned for investigation resulted in a founded finding. C.P. has four half-siblings. Three of RCW 74 half-siblings share the same father. Those children were in the care and custody of their maternal grandmother at the time of C.P.'s passing. C.P.'s oldest half-sibling has been in the care and custody of her father since 2001.

During the CPS investigations prior to C.P.'s birth, DCYF conducted Child Protection Team (CPT)[3] staffing on September 22, 2011, and March 3, 2012. Both times the CPTs recommended case closure. Services were not offered to the family until the March 2012 CPS investigation. However, the parents failed to engage in the offered in-home services, and it was noted in the Investigative Assessment[4] that the maternal grandparents intervened and took physical custody of the three children. At the time of the grandparents' intervention, they indicated an intent to file for legal custody.

On RCW 74.13.515, 2018, another intake was created. This intake was based on a report that C.P.'s mother had given birth to a baby RCW 74.13 and the mother was RCW 13.50.100 for the unnamed child (later named C.P.). The mother disclosed RCW 13.50.100 but said she RCW 13.50.100 . The RCW 13.50.100 . This intake was screened out.

Another intake was received on July 30, 2018. This intake reported that the mother, her boyfriend, and five children all resided together. The caller also reported that the mother's oldest child disclosed that the mother and family did not have a stable place to live, both the mother and her boyfriend were using RCW 13.50.100 the mother admitted she is "RCW 13.50.100 ," that the child RCW 13.50.100, and C.P. is neglected by RCW 74 parents. This intake was screened in for a CPS/FAR assessment.

On August 2, 2018, the CPS/FAR worker contacted the mother. Upon the worker's arrival to the mother's location, the mother's sister stopped the worker in the parking lot. The worker explained the reason for her visit and the mother's sister assisted with getting the mother to speak to the worker. The mother was described as defensive. She stated that C.P. is the only child living with her, and the other children are living with the maternal grandmother in RCW 74.13.515. During this visit, the worker was able to see C.P. and did not observe any concerns. The mother's sister shared that the mother and C.P. lived with her at her residence. The sister said that she did not have any concerns about the mother, that she appeared to be doing well with C.P., and when she is at her home she knows there is no drug use occurring. The worker learned that C.P.'s father is married to a different woman and that woman has a positive relationship with C.P.'s mother. The father's wife sometimes provides care for C.P.

After the meeting with the mother, the worker contacted the maternal grandmother. The maternal grandmother confirmed that she has custody of three of C.P.'s siblings. She said she was recently in Washington to see C.P. and did not have any concerns regarding RCW 74 care while with RCW 74 mother at the aunt's home. The worker also reached out to RCW 74.13.515 CPS. There was no information found for the maternal grandmother and the children. The worker requested a health and safety check to confirm that the children residing with the maternal grandmother were safe.

[3] https://www.dcyf.wa.gov/1700-case-staffings/1740-child-protection-teams-cpt
[4] https://www.dcyf.wa.gov/practices-and-procedures/2540-investigative-assessment

On August 9, 2018, DCYF received an intake stating that the Medical Examiner's office was working with the sheriff's office regarding the death of C.P. The mother stated she went to bed between 4:00 - 4:30 a.m. and at some point C.P.'s father joined them. She woke just before 2:00 p.m. and found that C.P. was unresponsive. Emergency services were called but C.P. was declared deceased at the residence. The investigating officers found drug paraphernalia in the bedroom and living room and stated the home was a known residence for drug use. This intake was assigned for a CPS investigation. At the conclusion of the investigation, C.P.'s parents received a founded finding for negligent treatment or maltreatment.

COMMITTEE DISCUSSION

The Committee discussed with the worker and supervisor the reasons for not asking the mother and father to provide a urinalysis during the August 2, 2018, contact. The CPS worker and supervisor stated the worker was trying to build trust based on the mother's presentation at the initial contact and due to the long history the mother had with DCYF. Other factors that influenced the decision to not request a urinalysis included the fact that the mother appeared to be coherent and did not appear to be under the influence, the home was in order, and the mother's sister provided positive information regarding safety. The Committee concluded the explanation given to be an appropriate basis for not requesting a urinalysis.

There was also a discussion about whether DCYF can "flip" (transfer) an intake from CPS/FAR to CPS investigations. It was determined that the answer to this question is yes. However, each office has a different CPS unit structure. Some CPS units are FAR units only and some CPS units contain investigative workers and FAR workers that conduct both CPS functions. The CPS supervisor reported she has struggled with some FAR staff who are resistant to taking cases that need to move to investigations because the staff are reluctant to conduct investigations related to more serious allegations. The Committee discussed that this is an issue facing other CPS units around the state. The Committee also discussed new DCYF staff must be informed that they may be required to interact with and handle cases involving significant trauma. New staff must also be informed that even though a case may come in as a FAR assessment, there are frequently other more significant traumas that may be revealed during the assessment process.

The Committee also expressed concerns about the mother's extensive history involving prior drug use and mental health needs. The CPS worker and supervisor were aware of this history and were clearly mindful of this in the approach taken with the family before the fatality. Notwithstanding this, with regard to the RCW 74.13.515, 2018, intake the Committee was concerned that the mother's prior history demonstrated a need for a CPS investigation as compared to a FAR assessment.

FINDINGS

The Committee found there were no critical errors made by DCYF during the assessment that pertains to C.P. There were no other findings related to this review.

RECOMMENDATIONS

The Committee discussed that DCYF is inconsistent statewide with regard to CPS assignments and investigative findings pertaining to unsafe sleep incidents. The Committee recommends that DCYF discuss this issue with the Attorney General's Office and work to find a consistent directive for field staff regarding this issue.

The Committee identified the need for more trauma-informed care that should be made available to staff that experience a critical incident, such as a fatality or near-fatality. The Committee believes there should be a person or team of people that can be dispatched to the impacted DCYF office to provide onsite emotional support immediately or within 24 hours of a critical incident. This is beyond how the current Peer Support model currently functions. The Committee also believes that staff should be treated similarly to other first responders by relieving them from taking new assignments and possibly case responsibilities for a specified period of time after the incident. The Committee also believes they should be given paid leave to support their emotional well-being.

The Committee does not agree with the current standard for assessing intakes regarding a family's chronicity and whether the case is a CPS investigation or FAR assessment. The Committee believes DCYF should re-evaluate this and take into consideration the entirety of a family's chronicity as opposed to just considering the last 12 months.

WASHINGTON STATE
Department of
Children, Youth, and Families

CHILD FATALITY REVIEW

March 2019

www.dcyf.wa.gov

FULL REPORT

CHILD
- C.W.S.

DATE OF CHILD'S BIRTH
- RCW 74.13 2018

DATE OF FATALITY
- September 2018

CHILD FATALITY REVIEW DATE
- December 13, 2018

COMMITTEE MEMBERS
- Mary Moskowitz, JD, Ombuds, Office of the Family and Children's Ombuds
- Ginny Jenkins, Court Appointed Special Advocate, Snohomish County Juvenile Court
- DJ Rivera, Chemical Dependency Professional, Catholic Community Services
- Ly Dinh, MSW, Quality Practice Specialist, Department of Children, Youth, and Families
- Tarassa Froberg, Family Voluntary Services/Child and Family Welfare Services Program Manager, Department of Children, Youth, and Families

OBSERVER
- Heather Moss, Deputy Secretary Operations and Infrastructure, Department of Children, Youth, and Families

FACILITATOR
- Libby Stewart, Critical Incident Review Specialist, Department of Children, Youth, and Families

CONTENTS

EXECUTIVE SUMMARY

On December 13, 2018, the Department of Children, Youth, and Families[1] (DCYF) convened a Child Fatality Review (CFR) to assess DCYF's service delivery to C.W.S. and RCW 74 family.[2] Initials of the child are used throughout this report to maintain confidentiality.

On September 6, 2018, an intake was received stating C.W.S. passed away at RCW 74 home the previous night. C.W.S. lived with RCW 74 parents, brother, and maternal grandparents. The death was under investigation with law enforcement but there was no evidence of trauma or neglect. This intake was assigned for a Child Protective Services (CPS) investigation. At the time of C.W.S.'s death, the family had an open Family Voluntary Services (FVS) case with DCYF.

During the CPS investigation regarding the fatality, DCYF learned that C.W.S. had been fed and was then placed face down onto a bed by RCW 74 father. The maternal grandmother later checked on C.W.S. and RCW 74 was unresponsive. Emergency services were contacted. The father admitted to law enforcement he used RCW 13.50.100 and had been doing so during the family's open FVS case. The father also said he believed the mother was using RCW 13.50.100 and that she was RCW 13.50.100 After the intake, a RCW 13.50.100 with regard to C.W.S.'s brother who is still residing in the family home. With regard to C.W.S.'s death, DCYF entered a founded finding against the father for negligent treatment or maltreatment.

The CFR Committee (Committee) included members selected from diverse disciplines within the community with relevant expertise including individuals with the following backgrounds: an Ombuds from the Office of the Family and Children's Ombuds, a chemical dependency professional, a juvenile court advocate, and child welfare. The Committee members did not have any involvement or contact with C.W.S. or RCW 74 family.

The Committee interviewed the CPS investigator, the FVS worker, their supervisor, and the area administrator.

PURPOSE OF A REVIEW

A child fatality or near-fatality review completed pursuant to RCW 74.13.640 is subject to discovery in a civil or administrative proceeding, but may not be admitted into evidence or otherwise used in a civil or administrative proceeding except pursuant to RCW 74.13.640(4). Given its limited purpose, a child fatality or near-fatality review (CFR/CNFR) should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. The CFR committee's review is generally limited to documents in the possession of or obtained by DCYF or its contracted service providers.

The committee has no subpoena power or authority to compel attendance and generally only hears from DCYF employees and service providers. It does not hear the points of view of the child's parents and relatives, or of other individuals associated with the child. A CFR/CNFR is not intended to be a fact-finding or forensic inquiry or to replace or supersede investigations by courts, law enforcement agencies, or other entities with legal responsibility to investigate or review some or all of the circumstances of a child's fatal injury. Nor is it the function or purpose of a CFR/CNFR to recommend personnel action against DCYF employees or other individuals. Information discovered through the review may be used in DCYF disciplinary actions such as revocation or suspension of a child care license.

[1] Effective July 1, 2018, the Department of Children, Youth, and Families (DCYF) is the state agency responsible for child welfare and early learning programs (the Department of Social and Health Services Children's Administration was the prior authority).
[2] C.W.S.'s parents are not named in this report because they have not been charged in an accusatory instrument with committing a crime related to a report maintained by DCYF in its case and management information system. [Source-Revised Code of Washington 74.13.500(1)(a)].

CASE SUMMARY

On April 18, 2018, DCYF received an intake stating that because of RCW 13.50.100 pertaining to RCW 13.50.100, C.W.S.'s mother was admitted to a hospital. At the hospital, the mother RCW 13.50.100 and admitted to RCW 13.50.100. The hospital also reported that the mother received RCW 13.50.100. The mother has a long history of substance abuse. The mother and her boyfriend have a 2-year-old son and recently moved into her mother's home. This intake was screened out.

On RCW 74.13.515, 2018, C.W.S. was born and the hospital called to report concerns related to the mother's substance abuse. The mother's substance abuse history dates from 2009 to present, and she recently RCW 13.50.100. Due to RCW 74.13.520 displayed by C.W.S. after RCW 74.1 was born, C.W.S. remained in the hospital for observation. The mother reported that C.W.S.'s father, who is also the father of her older child, uses illegal substances. This intake was assigned for a Risk Only assessment.[3]

While at the hospital, the assigned CPS worker made contact with the parents. Both parents discussed their substance abuse history and housing issues. They said the maternal grandmother knows about their past substance abuse history but does not know about their current use. The parents also reported that the grandmother provides the mother with RCW 74.13.520 when the mother experiences RCW 13.50.100 issues. The mother previously possessed a prescription for RCW 74.13.520 but allowed it to expire. From this original prescription, the grandmother saved the remaining RCW 74.13.520. Because of the maternal grandmother's concerns pertaining to her daughter's substance abuse, the maternal grandmother has provided the mother with home urinalysis tests. The parents said the grandfather does not know about the father's substance abuse history or recent substance abuse by the mother. If he was aware of this the parents believe he would not allow them to live in the home.

A Family Team Decision Meeting (FTDM)[5] was held on May 11, 2018. The parents, maternal grandmother, C.W.S.'s brother, medical staff, and DCYF staff were present at the FTDM. At the conclusion of the FTDM, the parents agreed to engage with FVS and signed safety and action plans. The action plan includes substance abuse assessments for the parents, urinalysis tests for the parents, and a walk-through of the family home by the CPS worker. The parents agreed to be honest with DCYF to ensure child safety and safety plan participants agreed to adhere to the safety plan.

After the FTDM on May 11, the CPS worker conducted a walk-through of the parents' home, observed C.W.S.'s sleep environment, and reviewed with the mother the safe sleep practices and procedures. The CPS worker reviewed with both parents the Period of Purple Crying (PPC).[6] The CPS worker had a private conversation with the father. He provided details about his family, history of RCW 13.50.100, and substance use history. That same day, the CPS worker contacted the hospital and provided approval for C.W.S. to be discharged to RCW 74 parent's care after C.W.S.'s feeding issues resolved. The CPS worker also requested medical records for C.W.S.

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[3] Screen in CPS Risk Only reports when a child is at imminent risk of serious harm and there are no CA/N allegations. https://www.dcyf.wa.gov/practices-and-procedures/2200-intake-process-and-response

[4] RCW 74.13.520

[5] Family Team Decision Making (FTDM) meetings follow the Shared Planning Meeting model of engaging the family and others who are involved with the family to participate in critical decisions regarding the removal of child(ren) from their home, placement stabilization and prevention and reunification or placement into a permanent home. https://www.dcyf.wa.gov/1700-case-staffings/1720-family-team-decision-making-meetings

[6] The *Period of PURPLE Crying* begins at about two weeks of age and continues until about 3-4 months of age. There are other common characteristics of this phase, or period, which are better described by the acronym *PURPLE*. All babies go through this period. It is during this time that some babies can cry a lot and some far less, but they all go through it. http://www.purplecrying.info/what-is-the-period-of-purple-crying.php

On May 11 and May 17, the father provided random urinalysis samples. Both samples tested RCW 13.50.100. The mother's random urinalyses for the same dates were RCW 13.50.100

On May 14, 2018, the FVS worker conducted a health and safety visit at the family's home. Both parents and both children were present. Multiple phone contacts were attempted between this date and June 13, 2018, when the next health and safety visit occurred. During the June 13 health and safety visit, the father expressed frustration with the fact that the case remained open. The FVS worker told the father that despite numerous DCYF attempts to contact (phone calls and texts) the parents, the parents did not respond. The FVS worker discussed concerns with the parents about child safety and parental substance use. At that time, the mother admitted to using again. The mother said she and the father left the children with the maternal grandmother and did not return home until the following day. The mother also said she missed her substance abuse evaluation and rescheduled it for June 21. The FVS worker spoke with the mother about triggers for using, postpartum depression, and the Parent-Child Assistance Program (PCAP).[7]

During the next health and safety visit on June 21, the mother admitted to missing her second substance abuse evaluation. There was further discussion regarding the mother's ambivalence with regard to abstaining from RCW 13.50.100. The FVS worker also discussed supportive resources within the community. The next in-person contact occurred on June 26. The mother was ill so the FVS worker met with the father and children. The FVS worker discussed, among other issues, that if another urinalysis tested positive the case would need to change from voluntary to legal intervention.

On July 13, the FVS worker met with the parents and children at a park. During this health and safety visit, the FVS worker specifically documented a discussion with both parents regarding safe sleep. They also discussed the parents' continued drug use. The parents stated that when they use they are leaving the children with the maternal grandmother. The FVS worker discussed PCAP and a chemical dependency evaluation for the mother. The father said he does not find meetings or other typical recovery supports helpful but prefers to read books. The FVS worker indicated she would try to purchase books for the father. The FVS worker and father discussed the father's mental health needs, including the fact that the worker thinks the father is using drugs as a way to cope with his unmet mental health needs. There was also discussion about the possibility that DCYF may file a dependency petition.

The next in-person meeting was on July 24 at the family home. The same topics were addressed as had been discussed during the previous contacts. The paternal grandfather died between the July 24 visit and the next visit on August 28. After the grandfather's death, the parents did not make themselves available for an in-person meeting until August 28.

On August 28, the FVS worker exchanged text messages with the parents. The FVS worker told the parents she would be at their home that morning. Instead, the parents said they would meet the FVS worker at her office later that afternoon. The parents failed to appear for the scheduled meeting.

On August 19, the worker called the father and asked that the parents submit to a urinalysis. The father said the test would be positive because both parents used drugs. An FTDM was scheduled for the following day. However, the meeting did not occur until August 30. Attendees at the meeting included the parents, the maternal grandmother, the children, the FVS worker, and FVS supervisor. After discussing the case and engaging the grandmother in the discussion about the parents continued drug use, the parents were given another opportunity to voluntarily

[7] https://depts.washington.edu/pcapuw/ .

engage in services. After the August 30 meeting, the FVS worker attempted numerous times to contact the parents by calling and texting them. However, they did not respond until September 5 when the father stated he could only text her.

On September 6, DCYF received an intake from the Medical Examiner's (ME) office reporting that C.W.S. had passed away the previous night. Law enforcement was involved but there did not appear to be any trauma or neglect identified by law enforcement or the ME's investigator. This intake was assigned for a CPS investigation.

At the conclusion of the CPS investigation, the father was issued a founded finding for negligent treatment or maltreatment based on his placement of C.W.S. in an unsafe sleep environment. After learning more about the extent of the parents' drug use from the law enforcement investigation DCYF also RCW 13.50.100 with regard to C.W.S.'s brother.

COMMITTEE DISCUSSION

The Committee is aware that DCYF policy does not require social worker discussions about the Period of Purple Crying and safe sleep with all adults or caregivers in the home. The Committee believes it may have been appropriate for this discussion to have occurred between the social worker and grandparents. This is the case because the maternal grandmother was identified as a care provider for the children when the parents were using drugs. She was providing more care than just intermittent babysitting.

The Committee struggled with balancing assigned casework and the need for training. The Committee believes line staff do not have enough time to attend trainings on a regular basis if they are also required to comply with policy and practice expectations. While the Committee considered the idea of case carrying staff attending Safety Framework training on a regular basis, the decision was made to recommend supervisors attend the training because the supervisors are the individuals that decide to approve or disapprove case transfers and closures.

The Committee also discussed that despite the fact that the FVS worker is obtaining her chemical dependency credentials and is becoming knowledgeable about substance abuse, most of the staff are not receiving such training. There was also discussion about the fact that staff previously had access to co-housed chemical dependency professionals (CDP). However, this access is no longer available. In the past, it was helpful to have the co-housed CDPs' immediate availability to discuss case questions or situations with staff, and in some cases, respond in the field with staff. That in-field response removed many barriers for parents who were struggling with substance abuse issues.

The Committee discussed a missed opportunity to have a more robust discussion with the family during the second FTDM. During the meeting, there may have also been a missed opportunity to share with the family a written case plan about appropriate next steps. However, the Committee recognizes that with the substantial number of children assigned to the FVS worker it is understandable that these actions did not occur. The Committee also recognizes that more likely than not those actions would not have had any impact on the fatality.

During the staff interviews, staff identified barriers to accomplishing certain case tasks within the community. Staff reported there are no local sites that offer random urinalysis on Fridays and there are no locations for color based random urinalysis. Meaning, that without the color based random urinalysis system, staff must create a random system for each case and make contact with the clients each time. On the other hand, the color system allows a color to be assigned to each client. The client then calls in each morning to the urinalysis site to see if their color is

randomly called for that day. Staff also reported it is challenging to find substance abuse assessment providers for clients. This issue was not as significant when there were co-housed CDPs. The staff also discussed a lack of locally available in-home providers for other supportive services connected with DCYF.

FINDINGS

The CFR Committee found no critical errors. However, there were areas identified for improved case practice. Those areas are noted below:

- DCYF missed an opportunity to assess the family further by not including the maternal grandfather. The maternal grandfather was not included in the FTDMs or as a collateral contact.
- The Committee believes additional collateral contacts could have enhanced the assessment of the case. The Committee identified thorough reading of the hospital records, talking with the maternal grandfather, checking in with the maternal grandmother with regard to the safety plan, and attempting to talk with C.W.S.'s brother may have provided more information about the family's situation. The staff stated they asked the family for contact information for other relatives at the FTDMs, but the family stated there were not any.
- The Committee believes the FVS worker had too many children assigned to her caseload. The FVS worker had 55 children assigned to her the day C.W.S. passed away. The Committee believes the FVS worker did a very good job with her documentation based on the size of her caseload.

RECOMMENDATIONS

The Committee made the following recommendations:

- DCYF should consider providing substance abuse training that includes information about typical behavior patterns displayed by users of specific types of drugs (e.g. heroin, methamphetamine, heavy marijuana use, etc.). This training may provide workers with the potential to better assess the caregiver's situation as it relates to child safety. The Committee recommends this training be provided by a subject matter expert from the substance abuse field.
- DCYF employees should attend updated Safety Framework training once they have been promoted to a supervisory position. Likewise, they should also receive updated Safety Framework training if they change disciplines within supervision, such as moving from CPS to CFWS.
- For purposes of caseload calculations, FVS caseloads should be calculated based on the number of children, not by family.
- DCYF should consider changing DCYF Policy No. 1135 (Infant Safety Education and Intervention) to require all adults residing in the home receive PPC and safe sleep education. This education requirement should also apply to anyone within the home who is providing care for the child or children that are also involved with DCYF. This would not include situations such as a homeless shelter, residential treatment centers, etc.