QUARTERLY CHILD FATALITY REVIEW
RCW 74.13.640 JULY – SEPTEMBER 2019

Washington State Department of
CHILDREN, YOUTH & FAMILIES

Washington State Department of
CHILDREN, YOUTH & FAMILIES

Contents

Executive Summary

This is the Quarterly Child Fatality Report for July through September 2019, provided to the Washington State Legislature by the Department of Children, Youth, and Families (DCYF or Department). 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 July 2011, SHB 1105 was passed by the legislature and signed into law by Governor Christine Gregoire. The revised child fatality statute (RCW 74.13) became effective July 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.

Quarter Three Roll-Up

This report summarizes information from completed reviews of one (1) child fatality and four (4) near-fatalities[1] that occurred in the third 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 near fatalities from four 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	1
Region 3	2
Region 4	0
Region 5	1
Region 6	0
Total Fatalities and Near Fatalities Reviewed During Third Quarter 2019	**5**

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.

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

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

2019	13	4	9

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	11	5	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 behest of DCYF leadership. 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 Third Quarter Findings

Based on the data collected and analyzed from the one (1) child fatality and four (4) near-fatalities during the third quarter, the following were notable findings:

- Three (3) of the five (5) cases referenced in this report were open at the time of the child's death or near fatal injury.
- In three (3) of the five (5) cases, the children were 2 years old or younger at the time of death or near fatal injury.
- There were no infant fatalities due to unsafe sleep environments during this reporting quarter.
- Two (2) of the near-fatality cases were overdoses. One case involved a 14-year-old who drank a near fatal amount of alcohol, another case involved a 4-year-old who overdosed on opiates.
- One (1) near fatality had been closed for eight (8) months and another closed for three (3) months prior to the near fatal injury. The other three (3) cases were open for services or investigation at the time of the critical incident.
- Three (3) children referenced in this report were Caucasian, one (1) was Filipino and one (1) was Hispanic.
- Substance abuse was an identified risk factor in four (4) of the five (5) cases. Domestic violence and mental health issues were other significant risk factors identified in several of the cases in this report.
- Two cases referenced in this report involved infants who sustained serious inflicted head injuries. One child died from his injuries, the other survived.
- DCYF received intake reports of abuse or neglect in each of the cases in this report prior to the death or near fatal injury of the child. In two (2) of the cases, there was only one (1) prior report made regarding the family. In other case, there were two (2) and five (5) intake reports on the

family prior to the critical incident. In one (1) near fatality case, the department received 26 prior reports.

- 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 third quarter of 2019:

- D.U. Child Fatality Review

CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

June 2019

Washington State Department of
CHILDREN, YOUTH & FAMILIES

Contents

Full Report

Child

- D.U.

Date of Child's Birth

- 74.13.515 2018

Date of Fatality

- January 6, 2019

Child Fatality Review Date

- May 1, 2019

Committee Members

- Kaali Sill MHP, CDP, Northeast Washington Family Counseling Services
- Patrick Dowd, Director, Office of the Family and Children's Ombuds
- Lori Blake, QA CQI Programs Administrator, DCYF

Observer

- Sarah Paukstis, Intern and FAR Social Service Specialist, DCYF

Facilitator

- Cheryl Hotchkiss, Critical Incident Review Specialist, DCYF

Executive Summary

On May 1, 2019, the Department of Children, Youth, and Families[1] (DCYF) convened a Child Fatality Review (CFR)[2] to assess DCYF's service delivery to D.U. and [redacted] family.[3] The child's initials are used throughout this report to maintain confidentiality.

On [redacted], 2018, D.U. was born prematurely. D.U. was on a strict feeding schedule due to the premature birth and diagnosis of [redacted].[4] On January 6, 2019, D.U. died. DCYF was notified of the death on the same day. Initially, the coroner's office and law enforcement suspected the cause of death to be sudden infant death syndrome (SIDS). Neither the coroner nor law enforcement initially reported any abuse or neglect suspicions. D.U.'s body was transported to [redacted] County for an autopsy, and on January 10, 2019, the coroner reported that D.U. had disturbing injuries, including significant skull fractures on both sides of [redacted] head. The skull fracture on the left side measured five inches. In addition to the skull fractures, D.U. had brain swelling and bleeding. It was determined the fractures caused D.U.'s death and were only hours old at the time of death. It was also determined the fractures were indicative of physical abuse. Accordingly, after an internal consultation, a Child Protective Services (CPS) investigation was initiated. This investigation is pending. D.U.'s mother and maternal uncle resided in D.U.'s home at the time of [redacted] death.

The Review Committee (Committee) included members selected from diverse disciplines within the community with relevant expertise including working for the Office of the Family and Children's Ombuds, a licensed chemical dependency specialist, and a DCYF CPS program administrator who has field experience as a DCYF supervisor. None of the Committee members had any previous direct involvement with this family.

Prior to the review, each committee member received a family genogram, a case chronology, a summary of DCYF involvement with the family, and the un-redacted DCYF case documents (e.g., intakes, investigative assessments, and case notes). At the time of the review, supplemental sources of information and other resource materials were available to the Committee. These included medical reports, relevant state laws, and DCYF policies.

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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] 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) or child near fatality review (CNFR) should not be construed to be a final or comprehensive review of all circumstances surrounding the death or near 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 or CNFR is not intended to be a fact-finding or forensic inquiry to replace or supersede investigations by courts, law enforcement agencies, or other entities with legal responsibility to investigate or review some or all the circumstances of a child's fatal injury or near fatality. Nor is it the function or purpose of a CFR or CNFR to recommend personnel action against DCYF employees or other individuals.

The restrictions do not apply in a licensing or disciplinary proceeding arising from an agency's effort to revoke or suspend the license of any licensed professional based in whole or in part upon allegations of wrongdoing in connection with a minor's death or near fatality reviewed by a child fatality or near fatality review team. RCW 74.13.640(4)(d).

[3] D.U.'s parents and relatives 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. RCW 74.13.500(1)(a).

[4] [redacted]

During the course of the CFR, the Committee interviewed the CPS assigned worker and supervisor who previously worked with the family. The Committee was told there was a personal conflict preventing the Family Assessment Response (FAR) supervisor from working on the case. Accordingly, another supervisor in the office was assigned. Following the review of the case file documents, completion of interviews, and discussion regarding department activities and decisions, the Committee discussed possible areas for practice improvement. The Committee's findings, conclusions, and recommendations are included at the end of this report.

Case Overview

On 74.13.515, 2018, D.U. was born in a 74.13.515 County hospital about three hours from 74.13.5 mother's primary residence. 74.13.5 was born prematurely at 74.13.520 At birth, D.U. was diagnosed with 74.13.520. At the time of D.U.'s birth, the mother denied consuming any harmful substances but did test positive for 74.13.520. In October 2018, the mother also tested positive for a substance at another hospital. However, DCYF was not provided with information pertaining to the substance type. On December 17, 2018, a rural eastern Washington DCYF office received an intake report[6] that screened in for a CPS response.

On December 18, 2018, a 74.13.515 CPS worker responded to the hospital to complete initial contacts with the mother and child. The mother admitted that due to the pain she was experiencing she took un-prescribed "74.13.52." The mother explained the "74.13.52" caused a positive 74.13.520 finding in her system. The worker disagreed with the mother's explanation and told her that an "74.13.52" would not cause a positive 74.13.520 finding. Regarding the 74.13.520 the mother admitted someone gave her a pill and that she also ingested a 74.13.520 prior to D.U.'s birth.

On December 20, 2018, the hospital informed the primary worker that D.U. would not be discharged until after the holiday (after December 25). Notwithstanding this, on December 24, the hospital changed its plan and told the primary DCYF worker that the child would be discharged that same day. Also on that same day, the primary worker held a Family Team Decision Making Meeting (FTDM)[7] in which the mother participated by telephone while she was at the hospital. The mother and family agreed to participate in Family Voluntary Services (FVS) services and a caretaking plan that would go into effect after the FTDM. The maternal grandmother reportedly agreed to move into the mother's home where D.U.'s maternal uncle also resides. The documentation does not clearly describe the extent of the living arrangements and agreement. On December 24, DCYF was unaware of the scope of the paternal uncle's daily caretaking role or the extent of his disabilities. On December 24, D.U. was discharged to 74.13.5 mother who returned to her residence in rural eastern Washington.

On December 26, 2018, the primary worker and FVS worker unsuccessfully attempted to conduct two home visits. On December 27, 2018, the same workers went to the home with local law enforcement and were able to make contact with the mother and D.U. With regard to the uncle, law enforcement provided collateral information to the primary worker. The worker learned the uncle held a job in the

[5] 74.13.520.
[6] https://www.dcyf.wa.gov/practices-and-procedures/2200-intake-process-and-response.
[7] 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.

community and volunteered throughout the week at the local fire station. As it relates to D.U.'s caretaking and safety, the worker did not receive information about the household's daily functioning or routine.

On December 28, 2018, the primary worker received a urinalysis sample that was collected on 74.13.515. The sample tested positive for 74.13.520 (prescribed), 74.13.520 and 74.13.520 The worker consulted with a DCYF medical consultant about the mother's urinalysis, and D.U.'s daily care needs due to the 74.13.520. The primary worker believed DCYF should file a dependency petition due to the mother's dishonesty about her active and illicit drug use in combination with D.U.'s vulnerability as an infant and extra caretaking needs due the 74.13.520. The primary worker and supervisor staffed the case with internal consultants. Taking into consideration the totality of the circumstances and attempts to establish that reasonable efforts were being made by DCYF to remedy the mother's parental deficiencies and not remove D.U. from her care, the supervisor directed the primary worker to attempt to engage the mother into services. Further, the worker was directed to adjust the safety plan to include specific timeframes for chemical dependency services to be completed. The primary worker proceeded as directed regardless of professional disagreement about filing a petition. The primary worker and FVS worker met with the mother at her home and provided her with a copy of a proposed plan for services DCYF was willing to provide. The proposed plan contained the following requirements:

1. Provide urine samples for drug analysis (UAs);
2. Obtain a chemical dependency assessment by January 8, 2019, and follow all recommendations;
3. Attend and participate in a parenting education course;
4. Attend and participate in a Birth to Three program; and
5. Cooperate with the FVS program.

The mother agreed to the proposed plan and signed an agreement that would implement the plan. The primary worker attempted to engage the paternal uncle in conversation but his verbal ability was limited and D.U.'s mother answered for him.

The primary worker was notified on January 6, 2018, that D.U. had died.

Committee Discussion

The Committee found the staff interviews helpful to understand how the local DCYF office functions and works to achieve policy measures and gather information for child safety. The Committee heard from the primary worker and supervisor that information was frequently communicated by the worker to the supervisor. For purposes of this case, the Committee wondered about clinical supervision. The Committee discerned that although case information was frequently passed along, it seemed that further clinical assistance to the primary worker may have been beneficial. The Committee noted the worker's supervisor on this case was a substitute supervisor specific to this case. The Committee speculated the primary worker, who was considered a novice employee, may not have felt qualified when there was professional disagreement to request an administrative review of the case decisions.

The Committee noted the diligence and amount of effort the primary worker put into her investigation prior to D.U.'s death. The Committee distinguished between the value of interviewing the assigned staff and receiving a verbal recollection of case activity because much of the information relayed to the Committee was not found in the DCYF case record.

The Committee recognizes the short time span between the December 17, 2018, intake assignment and D.U.'s January 6, 2019, death. The Committee also recognizes the primary worker's positive practice and appreciates the worker's diligence in seeking information from the medical consultant and collateral sources. The Committee agrees the worker had very little time during business hours to gather information. The Christmas and New Year holidays also made gathering such information more difficult. Due to the holidays, establishing contact with the family was also more difficult. The Committee believes DCYF was further limited in what information could have been gathered prior to the infant's discharge from the hospital due to the abrupt change in discharge date.

The Committee discussed whether there had been an active safety threat[8] that could not be managed in the home and if DCYF could have pursued a petition for out of home placement. The Committee did not come to a consensus but acknowledged the mother did not display blatant behavioral indicators that would alert DCYF or hospital staff to her incapability to provide care for her infant [redacted] The Committee recognizes the challenges faced by DCYF caseworkers to fully assess clients for current chemical dependency issues, such as in cases where clients may intentionally minimize their drug use or need for treatment even in the presence of illicit drug use evidence. The Committee noted there was little to no evidence outside of the mother's illicit drug use, and deception about her use, to indicate an inability to provide care to D.U. The Committee discussed that without behavioral evidence related to the impacts of child safety, DCYF's ability to legally intervene to obtain an out of home placement is limited.

The Committee noted the safety assessment[9] found that the child was "unsafe" and that a safety plan[10] was developed that only identified services. The safety plan did not provide for specific time frames for safety tasks to be completed that may have protected the child in the home. According to DCYF's safety framework,[11] it is not appropriate to develop a safety plan that does not identify specific tasks or persons responsible for the child's safety in the home when the safety threat[12] is active. The Committee

[8] A threat of danger is a specific family situation or behavior, emotion, motive, perception or capacity of a family member that threatens child safety. The danger threshold is the point at which family functioning and associated caregiver performance becomes perilous enough to be perceived as a threat or produce a threat to child safety. The Safety threshold determines impending danger. Safety threats are essentially risk influences that are active at a heighten degree and greater level of intensity. Safety threats are risk influences that have crossed a threshold in terms of controllability that has implications for dangerousness. Therefore, the safety threshold includes only those family conditions that are judged to be out of a caregiver's control. Retrieved from: https://dcyf.wa.gov/sites/default/files/pdf/SafetyThresholdHandout.pdf

[9] Safety Assessment is used throughout the life of the case to identify impending danger and determine whether a child is safe or unsafe. It is based on comprehensive information gathered about the family at the time the safety assessment is completed. [Source: DCYF Practices and Procedures Guide, Chapter 1000].

[10] The Safety Plan is a written agreement between a family and Children's Administration (CA) that identifies how safety threats to a child will be immediately controlled and managed. The Safely Plan is implemented and active as long as threats to child safety exist and caregiver protective capacities are insufficient to protect the child. A safety plan is required for all children where there is a safety threat(s) indicated on the safety assessment. The safety plan is written arrangement between a family and CA that identifies how safety threats to a child will be immediately controlled and managed. Please note that when creating an in-home safety plan, the following criteria must be met: 1) there is at least one parent/caregiver or adult in the home; 2) the home is calm enough to allow safety providers to function in the home; 3) the adults in the home agree to cooperate with and allow an in-home safety plan; 4) sufficient, appropriate and reliable resources are available and willing to provide safety services/tasks. [Source: DCYF CA Practices and Procedures Guide, Chapter 1000.

[11] In partnership with the National Resource Center – CPS, (NRC-CPS), Washington State Children's Administration implemented the Child Safety Framework in November 2011. A key concept of this model is that the scope of child welfare work is not defined by determining the presence or absence of injuries or incidents, but rather in identifying present or impending safety threats, and working with families to mitigate those threats.

[12] A threat of danger is a specific family situation or behavior, emotion, motive, perception or capacity of a family member that threatens child safety. The danger threshold is the point at which family functioning and associated caregiver performance becomes perilous enough to be perceived as a threat or produce a threat to child safety. The safety threshold determines impending danger. Safety threats are essentially risk influences that are active at a heighten degree and greater level of intensity. Safety threats are risk influences that have crossed a threshold in terms of controllability that has implications for dangerousness. Therefore, the safety threshold includes only those family conditions that are judged to be out of a caregiver's control. Retrieved from: https://dcyf.wa.gov/sites/default/files/pdf/SafetyThresholdHandout.pdf

wondered about the risk and safety assessments and the accuracy of such assessments. The Committee's safety and service plan discussion led to a larger discussion about statewide practice and challenges DCYF management has with regard to the implementation of the safety framework. The Committee discussed the variance within DCYF staff implementing policy, and understanding the difference between a safety plan and a service plan. The Committee observed that supervisors and line staff have had multiple trainings related to the safety framework and questioned whether the staff and administrators are held accountable to policy and procedure requirements. Although the accuracy of the assessment was considered, the Committee noted the primary worker was still in the process of gathering information for the investigation and ongoing safety assessment.

The Committee discussed whether there was a missed opportunity at the FTDM meeting to understand the daily functioning in the home and the caregivers' ability to care for the child. The Committee observed there was limited information gathered about the uncle in the home, or his ability to safely care for, interact with, or protect the child. The Committee speculated additional information may have been available to DCYF to evaluate whether the mother's substance use and uncle's disabilities impacted D.U.'s safety.

The Committee considered the FTDM meeting.[13] DCYF did not identify specific timeframes or provide detailed roles and responsibilities for family members. The FTDM participants left the meeting with ambiguity in relation to roles and expectations. The Committee recognizes the challenges workers have when attempting to facilitate a telephone meeting. When meetings are held telephonically the Committee believes the workers' ability to interact and assess the parent's behavior is limited. This is especially the case if alleged drug use is an issue. If drug use is an issue, an in-person observation to assess possible drug use is beneficial. Overall, the Committee understood the investigation was not yet complete before D.U.'s death, and further time may have allowed for additional information gathering for assessment and understanding of household functioning.

Findings

Based on a review of the case documents and interviews with staff, the Committee did not find any critical errors made by DCYF staff directly linked or attributed to the child's death. The Committee found that the safety plan did not include specific safety tasks in the home.

[12] RCT is the initial, intensive, task-oriented training that prepares newly hired Social Service Specialists to assume job respons bilities. RCT starts on the first day of employment and lasts for 60 days, or the first two months of employment. Competencies are used to assess learning needs and to identify a developmental plan for the new workers.

[13] Family Team Decision-Making meeting (FTDM) is a facilitated team process, which can include birth/adoptive parents, guardians, extended family members, youth (as appropriate), community members, service providers, child welfare staff and/or caregivers. These meeting are held to make critical decisions regarding the placement of children following an emergent removal of child(ren) from their home, changes in out-of-home placement, and reunification or placement into a permanent home. There may be instances when a FTDM can be held prior to placement if there is not an immediate safety threat such as a child who is on a hospital hold and a FTDM could provide placement options. Permanency planning starts the moment children are placed out of their homes and are discussed during a Family Team Decision-Making meeting. Am FTDM will take place in all placement decisions to achieve the least restrictive, safest placement in the best interests of the child. By utilizing this inclusive process, a network of support for the child(ren) and adults who care for them are assured.
https://www.dcyf.wa.gov/sites/default/files/pdf/FTDMPracticeGuide.pdf

Recommendations

In an attempt to address inconsistencies pertaining to the accurate use of the safety framework, the Committee encourages DCYF to continue to consider alternative methods of implementing practice standards, perhaps through the state and regional Program Improvement Plans.

In cases of professional disagreement, the Committee encourages DCYF to consider an avenue for line staff to seek consultation from upper management outside of their direct supervisor. The Committee believes the ideal process should be normalized so that consultation may occur quickly and without retaliation or stigma.