CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

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CONTENTS

Full Report

Child

B.M.

Date of Child's Birth

- [redacted] 2019

Date of Fatality

- April 21, 2022

Child Fatality Review Date

- July 20, 2022

Committee Members

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- Cristina Limpens, MSW, Office of the Family and Children's Ombuds
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Facilitator

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Executive Summary

On July 20, 2022, the Department of Children, Youth, and Families (DCYF) convened a Child Fatality Review (CFR)[1] to assess its service delivery to B.M. and [redacted] family.[2]

On April 21, 2022, DCYF learned about B.M.'s death. B.M. died while in transport from a local hospital to [redacted] Hospital. There were several unexplained marks on the child, including bruising, possible burns, a cut on bridge of [redacted] nose, marks on [redacted] back, discoloration on [redacted] lower extremities, bruising on [redacted] lower chin and jaw, and a bruise on the right side of [redacted] head. Law enforcement and medical staff initially reported that it appeared B.M. was severely malnourished and dehydrated. [redacted] had very little body mass. The primary cause of death was septic shock with infection from pneumonia. B.M. had long term and ongoing medical, nutritional, and developmental deficiencies. B.M.'s mother stated she first noticed B.M. was sick on April 17, 2022. The mother observed B.M. was pale, weak, and had spots on [redacted] body. B.M.'s mother did not reach out to B.M.'s doctor or seek medical care or assistance until the day B.M. died. After B.M. died, DCYF learned that the child missed several requested weight checks at [redacted] local doctor's office despite reminder letters and phone calls made by the medical provider to the mother.

The CFR Committee (Committee) included members with relevant expertise selected from diverse disciplines within the community. Committee members did not have any involvement or contact with B.M. or [redacted] family before the fatal incident. The Committee received a case chronology and other relevant documents including, but not limited to, intakes, Child and Family Welfare Services (CFWS), Child Protective Services (CPS) case notes, and other DCYF documents maintained in DCYF's electronic computer system. The Committee interviewed a CFWS caseworker and supervisor, multiple CPS caseworkers and supervisors assigned in 2021 through 2022, and the area administrator for the local office.

Case Overview

For purposes of assessment of this case during the intervention, DCYF identified four fathers. B.M.'s three oldest siblings share a father in common. B.M.'s sibling that is one year older has a father that is not in common with [redacted] or [redacted] other siblings. B.M.'s mother had another child in the [redacted] of 2020. The father to this child is not the father of B.M. or [redacted] older siblings. B.M.'s father was unknown to DCYF until August 2020. This father's DCYF history began in 201 [redacted]

[1] 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)]." RCW 74.13.640(4)(a). Given its limited purpose, a child fatality review (CFR) should not be construed to be a final or comprehensive review of all 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 hears from only DCYF employees and service providers. It does not hear the points of view of the child's parents and relatives, or 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.

[2] No one is named in this report because no one has been charged with a crime in connection with the fatal injuries. See RCW 74.13.500.

RCW 13.50.100 . RCW 13.50.100 . RCW 13.5 .

From September 2012 to March 2022, DCYF received 26 intakes about B.M. and/or RCW 74. siblings in common with RCW 74. mother. Of the 26 intakes, 10 screened out.[3] Eight intakes directly referenced B.M. In 2018, before B.M. was born, DCYF offered the mother voluntary placement[4] and services. B.M.'s siblings were returned to their mother and DCYF noted little progress in services and with behaviors that initiated the voluntary placement intervention. On RCW 74.13.515 2019, a local hospital placed a hold on newborn B.M. because of the mother's substance use. DCYF filed a dependency petition as to B.M. and a motion to place the child in its custody. The court granted DCYF's motion and ordered that B.M. remain in out-of-home care at an initial shelter care hearing. Maternal RCW 74.13.520 use, domestic violence in the home, unaddressed child dental and medical needs, and maternal mental health concerns were some of the allegations cited as the basis for the dependency petition. On Nov. 4, 2019, the court placed B.M. and RCW 74. siblings in a foster care or relative placement. A CFWS caseworker was assigned for ongoing assessment, case service, and court monitoring. On Aug. 18, 2020, DCYF received notice that B.M.'s father's identity and paternity was established. In September 2020, a Family Team Decision Making Meeting (FTDM)[5] was held and B.M.'s father expressed his interest in co-parenting B.M. On Sept. 24, 2020, B.M. and RCW 74. 1-year older sibling were returned to their mother's care in a trial return home (TRH).[6] B.M. was dependent from Nov. 4, 2019, through June 2021. B.M.'s three oldest siblings remained in out-of-home care with their paternal relatives.

From December 2020 through April 2021, DCYF received four reports about B.M. regarding ongoing and unexplained bruising, along with development and health concerns. The assigned CFWS and CPS caseworkers worked together to request medical consultations,[7] and to take B.M. to medical appointments. Frequent internal case consultations with regional program managers occurred early in 2021. As part of a statewide performance improvement plan, program staff from DCYF headquarters also reviewed the case twice during 2021. During a dependency review hearing on April 8, 2021, B.M.'s parents agreed B.M. would primarily reside with RCW 74. father and his partner and visit RCW 74. mother three days a week. B.M.'s parents were to work with their attorneys on filing a parenting plan. B.M.'s oldest siblings were returned to B.M.'s mother's care for a TRH. On April 15, 2021, B.M. had a Birth-to-Three assessment for developmental progress, and the providers were pleased with RCW 74. progress. On April 19, 2021, B.M.'s father took RCW 74. to a neurological Magnetic Resonance Imaging (MRI)[8] at RCW 74.13.520 Hospital. B.M. was reported to have made rapid correction with RCW 74. neurodevelopmental progress, and the doctor was very pleased with RCW 74. progress. There were no communicated concerns as to the MRI. A follow up MRI was recommended to occur in a year.

[3] For information about "screened out" reports, see: https://www.dcyf.wa gov/practices-and-procedures/2200-intake-process-and-response
[4] For more information, see: https://www.dcyf.wa.gov/4300-case-planning/4307-voluntary-placement-agreement
[5] For a description of the FTDM process, see: https://www.dcyf.wa.gov/1700-case-staffings/1720-family-team-decision-making-meetings.
[6] For more information, see: https://www.dcyf.wa.gov/4305-permanent-and-concurrent-planning/43051a-trial-return-home
[7] For more information, see CPS investigation policy 2331 (2.g.): https://www.dcyf.wa.gov/policies-and-procedures/2331-child-protective-services-cps-investigation and/or http://insideca.dshs.wa.gov/intranet/pdf/programs/RMC-Medcon.pdf
[8] For more information about MRIs, see: https://www.mayoclinic.org/tests-procedures/mri/about/pac-20384768

All investigations led to unfounded findings.[9] On May 5, 2021, a CPS caseworker and supervisor's investigative assessment[10] was completed as unfounded based on information from medical records and consultations, review of daycare documentation, provider updates, and consultation with the CFWS caseworker on parental progress. The CPS investigation was closed. The caseworker noted that there was no clear evidence of neglect to B.M., but a level of risk associated with B.M.'s mother's ability to appropriately supervise all six of her children remained.

On June 24, 2021, the court dismissed B.M.'s dependency as to RCW 74. mother; dependency as to B.M.'s father was never established, and the court case was closed. From June 24, 2021, to September 2021, the CFWS case involving B.M.'s mother, siblings, and the siblings' fathers remained open. During this time, DCYF continued frequent health and safety visitations with B.M. and monitored RCW 74. and assessed RCW 74. safety.

On Aug. 11, 2021, B.M.'s father was arrested following a domestic violence incident. B.M.'s father and partner were in an altercation and law enforcement determined B.M.'s father was the aggressor. B.M. moved in with RCW 74. mother under a family agreement independent of DCYF's involvement. Between August 2021 and December 2021, DCYF received five reports about B.M. and/or RCW 74. siblings in the mother's care. DCYF opened two interventions; one intervention was specific to B.M. and the domestic violence incident that occurred in RCW 74. father's home. All other reports made concerned B.M.'s siblings and included allegations of lack of supervision, neglect, spanking, and physical abuse.

In 2022, before B.M.'s death, DCYF received four reports about the family. Three reports were screened in for intervention; two of these reports were assigned for investigation and assessment. On Jan. 28, 2022, two reports alleged B.M.'s older brothers witnessed domestic violence between B.M.'s mother and her paramour and were afraid to be in the home. The caseworker observed B.M. smiling, sitting in a high chair eating meat, and wearing a diaper on Jan. 31, 2022. The caseworker did not observe bruising or marks on B.M. or RCW 74. siblings during the contact. On Feb. 3, 2022, DCYF received a report that B.M.'s 3-year-old sister and 14-month-old sister were bleeding and had pain in their diaper area. On March 7, 2022, the CPS caseworker spoke with the child care provider who provided information on B.M.'s siblings. The provider reported B.M. had not been to the center since Nov. 5, 2021. The CPS caseworker contacted the Early Support for Infants and Toddlers program (also known as Birth-to-Three)[11] provider and a child care provider to refer B.M. and RCW 74. younger sibling for services. DCYF investigated the allegations and determined they were unfounded. On March 15, 2022, DCYF received an intake about B.M.'s 8-year-old brother being lethargic, unable to awake, and sleeping at school for over two hours. The school called the mother, and she told school personnel that she had given him one drop of a naturopathic sleep medication with melatonin. The referent was concerned that B.M.'s mother's explanation did not match the child's symptoms. The report was screened in for a CPS investigation.[12] On March 16, 2022, the CPS supervisor screened out the intake and closed the investigation after reportedly staffing with the Area Administrator. No contact was made with the family or B.M.'s brother about the reported concerns.

[9] RCW 26.44.020(14) defines "founded" as follows: "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(29) defines "unfounded" as follows: "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."

[10] For information about investigative assessments, see: https://www.dcyf.wa.gov/practices-and-procedures/2540-investigative-assessment

[11] For more information, see: https://www.dcyf.wa.gov/services/child-dev-support-providers/esit

[12] For more information, see: https://www.dcyf.wa.gov/policies-and-procedures/2332-child-protective-services-family-assessment-response

On April 21, 2022, B.M.'s mother notified DCYF that she was at the hospital with B.M. and it was "really bad." B.M. was described to have discoloration from head to toe from an undetermined cause at that time. B.M. presented at the hospital with second-degree burns to 40% of [redacted] ring finger and bottom. The doctor identified bruising underneath B.M.'s chin on the left side and bruises on the right side of [redacted] face. [redacted] mother reported the bruises resulted from B.M. falling in the bathtub. The doctor did not identify trauma from physical abuse at this point. B.M. was diagnosed with severe pneumonia in [redacted] left lung and mild pneumonia in [redacted] right. A full skeletal bone scan showed no indication of broken bones. According to the doctor, B.M.'s bottom had a large open wound that appeared to be extremely painful. The doctor explained this wound could be caused by sitting in urine and diarrhea-soaked diapers for hours on end. B.M. was covered in small dark marks that the doctor reported appeared to be the beginning of bed sores and likely the result of B.M. staying in one position for long periods of time. B.M.'s mother provided no additional explanation for the bruises. B.M.'s mother told medical staff that the injuries and discoloration randomly showed up a few days prior. B.M. died on April 21, 2022.

Later, a detective arrived while B.M. was being photographed. The attending doctor was very concerned about B.M.'s bruising. The doctor reported the mother's claim that B.M. got sick a few days prior and that [redacted] condition worsened was a reasonable timeframe for [redacted] sickness to turn into an infection, which subsequently became septic. The detective told the doctor about B.M.'s older sibling's disclosure of her attempt to feed B.M. noodles. B.M.'s head flopped back while [redacted] eyes were open. The doctor reported that the death process had begun for B.M. and explained that average decompensation was 36 hours. B.M. was malnourished and severely dehydrated and already decomposing at 24 hours post mortem. B.M. weighed 17 pounds when [redacted] arrived at the hospital; [redacted] body temperature was 91 degrees and [redacted] white blood cells were 0.8 when they were supposed to be 10-12. B.M.'s mother disclosed that a few weeks prior a medical provider made a home visit and B.M. weighed 21 pounds at that time.

B.M.'s mother reported the diaper rash and other marks did not show up until the day before B.M. died. When explaining why she did not seek medical treatment sooner, she stated that B.M. was a sick child and that this happened all the time and typically cleared up on its own. When discussing malnutrition and dehydration, B.M.'s mother could not provide information about what she fed the child. She stated that she provided B.M. a sippy cup with milk, Pediasure, and water. No sippy cups were located in the home when law enforcement executed a search warrant. B.M.'s older sister stated that the day before B.M. died, she tried to feed [redacted] noodles. Evidence of this was observed by law enforcement. B.M.'s mother reported that B.M. fell asleep in the high chair and woke up vomiting; however, there was no vomit observed on the high chair. A concerned neighbor reported seeing B.M. that afternoon and stated that B.M.'s head was flopping around.

In reviewing medical records, DCYF learned that B.M.'s weight significantly declined through 2021. B.M.'s last visit with [redacted] primary doctor was on Dec. 16, 2021, during a CPS intervention. B.M.'s weight was noted to be in the second percentile.[13] B.M. was recommended to have weight checks after the December appointment, but B.M.'s mother did not take [redacted] to any further doctor appointments. The last time B.M. was seen by [redacted] primary care doctor was on Dec. 16, 2021.

Committee Discussion

The Committee recognized the amount of work that went into the assessments and services offered and monitored during this case through the CFWS assignment and CPS interventions. The committee highlighted

[13] For more information, see: https://www.cdc.gov/healthyweight/assessing/bmi/childrens_bmi/about_childrens_bmi.html:

and recognized the difficult and, at times, unenviable task DCYF had in assessing and monitoring families with multiple children and parents. The Committee noted that the assigned caseworkers tried to assess six children with multiple behavioral and physical needs, along with four parents with a variety of co-occurring behaviors and barriers, while simultaneously incorporating service and medical providers' information for assessment. The Committee added that the COVID-19 pandemic and related restrictions added a component of difficulty for DCYF and community providers in the provision of services.

The Committee discussed the medical community's responsibility in assessing B.M. and RCW 74. condition. The Committee discussed the unfortunate reality that DCYF was often tasked with trying to gather and analyze medical records and reports. The Committee discussed the medical providers' role in failing to assess B.M.'s medical needs effectively because of RCW 74. ongoing medical anomalies, unexplained bruising, and documented weight and developmental decline. The Committee noted the difficulty for DCYF caseworkers to notice subtle weight loss in a child, but believed a three-pound loss would have been apparent in a child with such a small frame. The Committee noted that a possible reason why the weight loss was not obvious to the DCYF caseworkers was because the child sat in a high chair or seat during most DCYF visits and a different worker had been assigned at each intervention.

The Committee discussed the difficulty in obtaining consistent medical care, especially due to COVID-19 impacts in 2020 through 2021. The Committee believed DCYF's assessment and care of B.M. may have improved with an additional medical consultation during the winter of 2021. The Committee believed an updated consultation with medical experts that included all of the case file information on B.M.'s bruising, weight, MRI results, and local office interpretations could have provided an opportunity to address B.M.'s condition and understand its root cause. The Committee noted that the assigned workers contacted medical providers and accessed records, but believed additional consultation could have improved the medical community's response. The Committee believed that additional statewide or regional medical consultant involvement could assist DCYF in advocating for access to medical services for children.

The Committee discussed the time between B.M.'s initial placement in out-of-home care and dismissal of the dependency at the end of June 2021. The Committee learned there were multiple reports made by the child care provider about bruising on B.M. and concerns about RCW 74. siblings. The Committee opined that the child care provider was a protective factor for B.M. and RCW 74. siblings and a source for DCYF's assessment of the children and parental functioning. The Committee discussed the CFWS caseworker talking with B.M.'s mother about B.M.'s lack of attendance at childcare on May 27, 2021. B.M.'s mother told the CFWS caseworker that she was not sending B.M. to child care because she wanted to spend more time with RCW 74.1 She agreed to take B.M. to child care the following day. The Committee also noted that in September 2021, a DCYF CPS caseworker learned B.M.'s mother stopped sending B.M. to child care. B.M.'s mother told the assigned CPS caseworker that she had not been sending B.M. to child care for fear of ongoing reports being made to DCYF and the trauma it caused her children. In January 2022, a CPS caseworker learned from the child care provider that B.M. had not been to child care since Nov. 5, 2021. The Committee appreciated the CPS caseworker making a referral to child care in March 2022. Between August 2021 and B.M.'s death, the Committee believed DCYF missed opportunities to facilitate a meeting with medical providers, child care providers, community services providers, and parents and program managers to communicate and collaborate on B.M.'s health, along with the health and well-being of RCW 74. siblings, after they all returned to the mother's home and care. The Committee believed that when DCYF was notified of B.M.'s failed attendance at child care and medical appointments, a shared planning meeting might have benefited planning efforts and monitoring of

B.M.'s health and safety. The Committee believed a shared planning meeting could have been an opportunity for DCYF to advocate for a consistent medical care provider and increased monitoring of B.M.'s health.

Between 2020 and B.M.'s death in April 2022, there were documented concerns from caregivers, providers, DCYF staff, as well as B.M.'s mother about a lack of attachment or bonding between B.M. and [redacted] mother. When discussing stressors with DCYF caseworkers, B.M.'s mother continued to revisit the idea of having B.M. cared for by alternative caregivers. The Committee wondered if the desire for B.M.'s mother to succeed in caring for her children overshadowed her lack of attachment or ability to meet B.M.'s medical needs in conjunction with all of her other children's daily needs and parental stressors. The Committee recognized the benefit of hindsight while reviewing a case, noting it was easier to piece indicators together during a review as opposed to the reality workers face while they attempt to assess, document, and communicate massive amounts of information on multiple cases at a time.

The Committee discussed that DCYF staff was not formally trained in recognizing bonding and attachment cues or physical development and malnutritional indicators in children. The Committee discussed the difficulty in evaluating children for malnutrition and bonding or attachment without consistent medical care and interpretation by providers or professionals with expertise. For DCYF caseworkers, the Committee believed that knowledge on child development, bonding, attachment, and malnutrition was likely subject to personal and educational experiences. One Committee member noted a different fatality review recommended that DCYF provide an online resource for caseworkers and supervisors to assist them in identifying bonding and attachments, as well as nutritional and physical development milestones. The Committee recognized DCYF's limited role involving these topics, but believed a minimal education and understanding was necessary for completing accurate assessments.

The Committee learned that the CPS supervisor assigned after the fall 2021 incident was new to the supervisory position. The Committee noted that from August 2021 until the critical incident, there were three different CPS workers assigned to reports received about the family. The Committee believed an internal case consultation during this timeframe could have assisted the new supervisor and assigned caseworkers with critical thinking and comprehensive assessments. The Committee discussed that the amount of previous internal consultation and oversight by regional and headquarters program staff may have been viewed as extraneous to the assigned caseworkers and supervisors. The Committee learned that one regional program manager provided mentorship, consultation, and completed case documentation at one point, in addition to the casework by the CFWS and CPS caseworkers. The Committee discussed the inter-office dynamics that occurred between the caseworkers and program staff. The Committee heard from caseworkers and supervisors that due to the involvement of program managers, it seemed confusing at times who was responsible for making decisions on the case. The Committee believed that due to previous internal case staffings and possibly professional disagreement about the case, the continued use of internal case consultation later in 2021 through the 2022 interventions may have been limited.

The Committee heard from the supervisor that the reports received from 2021 up until the incident involved concerns related to B.M.'s siblings. The supervisor noted that the primary focus was on allegations pertaining to B.M.'s siblings, but added that DCYF assesses all children in the home for safety. The Committee agreed that DCYF was responsible for assessing the safety of all children in the home when investigating or providing services to families, but believed the assessments could have benefited from additional supervisory guidance and internal case consultation to provide opportunities for expanded critical thinking and collaboration with medical providers about B.M.'s ongoing, deteriorating, and unaddressed medical condition.

The Committee discussed the March 2022 report. The Committee learned that the CPS supervisor discussed the intake and received approval to screen out the intake. The Committee learned that the CPS supervisor and Area Administrator believed at the time of the intake that the report should screen out because the reported concerns did not rise to the level necessary for intervention. The supervisor also told the Committee that DCYF had seen all of the children and closed a case the week before. The Committee heard from the supervisor that he believed there was not an immediate concern for B.M.'s sibling because the school did not call the paramedics. The Committee disagreed with the CPS supervisor and the Area Administrator's decision to screen out the intake. The Committee noted the allegations as to B.M.'s sibling were new and that should have elevated DCYF's response to assess the children's safety in light of the extensive concerns previously reported as well as the legal intervention. Some Committee members noted the children were last documented as being seen in early February 2022. The Committee believed that this incident may have been an example of DCYF's possible bias as to the mother's parental capabilities.

Recommendations

The Committee recommended that DCYF create a small online reference or resource guide for staff regarding malnutrition, bonding and attachment, and child development. The resource should be somewhat short and provide information on what to look for in relation to child size and development, nutrition, and bonding or attachment.

The Committee believes DCYF should advocate for consistent medical care for children with special health care needs that are receiving DCYF services. The Committee believes that cases with prior court involvement and unresolved child/ren's medical issues should be elevated for response and advocacy for continuity of medical care. With this in mind, the Committee recommended that DCYF hold a meeting with the regional medical consultant and child's medical providers in all cases involving children with ongoing and unexplained bruising, poor physical development, and/or poor weight gain over a period of time.