QUARTERLY CHILD REVIEW RCW 74.13.640 APRIL – JUNE 2020

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 April through June 2020, 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:

(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 ombuds 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.

Introduction

In October 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 October 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 Two Report

This report summarizes information from completed reviews of four child fatalities and two near-fatalities 1 that occurred in the second quarter of 2020. All child fatality reviews can be found on the Child Fatality & Serious Injury Reports page of the DCYF website.

The data in this quarterly report includes both 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 the Department of Social and Health Services: Children's Administration.

DCYF Region	Number of Reports
Region 1	1
Region 2	0
Region 3	1
Region 4	2
Region 5	0
Region 6	2
Total Fatalities and Near Fatalities Reviewed During Second Quarter 2020	**6**

This report includes Child Fatality Reviews (Exhibit A) and Near Fatality Reviews (data only) 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 2020. 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 reviews are not subject to public disclosure and not posted on the public website nor are the reviews included in this report.

Child Fatality Reports for Calendar Year 2020			
Year	**Total Fatalities Reported to Date Requiring a Review**	**Completed Fatality Reviews**	**Pending Fatality Reviews**
2020	3	3	0

Child Near-Fatality Reports for Calendar Year 2020			
Year	**Total Near-Fatalities Reported to Date Requiring a Review**	**Completed Near Fatality Reviews**	**Pending Near Fatality Reviews**
2020	12	9	3

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

Near-fatality reports are not subject to public disclosure and are not posted on the public website, nor are the near-fatality reviews included in this report.

Notable Second Quarter Findings

Based on the data collected and analyzed from the four child fatalities and two near-fatalities during the second quarter, the following were notable findings:

- Five of the six cases referenced in this report were open at the time of the child's death or near-fatal injury.
- Two fatality cases involved 15-year-old youth. One committed suicide and the other died from a drug overdose.
- In the other four cases referenced in this report, the children were all less than 12 months old at the time of death or near-fatal injury.
- There was one death and one near-fatal injury of infants in unsafe sleep environments.
- In both cases involving unsafe sleep environments, DCYF caseworkers educated the parents on establishing safe sleep environments for their infants prior to the critical incident.
- There were three incidents this quarter involving children overdosing on narcotics and illegal drugs. Two of the incidents resulted in the death of the children involved. Two of the incidents involved children under 12 months of age. It is also noted that there was a near-fatality case that was due to an overdose of opiates in the most recent quarterly report.
- One near fatality incident involved a CPS case that closed one month prior to the near-fatal injury. All other cases referenced in this report were open when the death or near-fatal injury occurred. One fatality case involved a dependent youth in an open case.
- Three children referenced in this report were White, and three were African American.
- Substance abuse was an identified risk factor in five of the six cases. Pre-natal drug exposure was alleged in two of the cases. Domestic violence, mental health, and neglect (lack of proper nutrition and supervision) were significant risk factors identified in other cases in this report.
- 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 one of the cases involving a dependent youth, there were 18 prior reports made regarding the family. In a fatality case and two near fatality cases, there was one intake report on the family prior to the critical incident. In the one near fatality case, the department received seven 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 second quarter of 2020:

- **L.N. Child Fatality Review**
- **Z.S.E. Child Fatality Review**
- **E.P. Child Fatality Review**
- **R.M. Child Fatality Review**

CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

Washington State Department of
CHILDREN, YOUTH & FAMILIES

Contents

Full Report

Child

- L.N.

Date of Child's Birth

- [redacted] 2019

Date of Fatality

- May 2019

Child Fatality Review Date

- March 4, 2020

Committee Members

- Ruth Wolbert-Neff, Tacoma Pierce County Health Department, Substance Use Disorder Professional Drug and Alcohol Treatment Counselor II
- Jon Pfister, Vancouver Police Department, Detective Sergeant
- Stephanie Frazier, DCYF, Region 6 Safety Administrator
- Kelly Boyle, DCYF, Statewide Intake and Safety Program Manager

Consultant

- Thomas Angier JD, DCYF, Assistant Attorney General

Facilitator

- Libby Stewart, DCYF, Critical Incident Review Specialist

Executive Summary

On March 4, 2020, the Department of Children, Youth, and Families (DCYF) convened a Child Fatality Review (CFR)[1] to assess DCYF's service delivery to L.N. and [redacted] family.[2] [redacted] will be referenced by [redacted] initials throughout this report.

In May 2019, [redacted]-old L.N. died while in the state of [redacted] In mid-January 2020, this author reviewed an [redacted] Department of Human Services [redacted] DHS) Critical Incident Review Team (CIRT) report involving L.N.[3] The report stated that the medical examiner's (ME) toxicology report from L.N.'s autopsy was positive for [redacted]. The ME was unable to determine if the positive toxicology contributed to L.N.'s death. This author recognized some aspects of L.N.'s death based on an Administrative Incident Reporting System (AIRS)[4] notification that was received on May 24, 2019. The AIRS notification was based on an intake called in by [redacted] regarding L.N.'s death. Based on the information contained in the [redacted] DHS CIRT report and the fact that there was an open Child Protective Services (CPS) assessment with DCYF at the time of L.N.'s death, this incident qualified for a DCYF CFR.

The [redacted] DHS CIRT report also stated that L.N. died while bed-sharing with [redacted] mother. The report contained information that L.N.'s mother admitted she drank alcohol the night before L.N.'s death. She also said she regularly used [redacted] and occasionally used [redacted] DHS determined that L.N.'s death was the result of the mother's negligence. No arrests were made regarding L.N.'s death.

The CFR Committee (Committee) includes members with relevant expertise selected from diverse disciplines within the community. Committee members have not had any involvement or contact with L.N. or [redacted] family. The Committee received relevant documents including intakes, case notes and other DCYF documents maintained in DCYF's electronic computer system.

The Committee interviewed the CPS case worker who assessed the May 7, 2019 intake, her supervisor and the area administrator. The Committee also spoke with an assistant attorney general (AAG).

Case Overview

On May 7, 2019, DCYF received a report alleging that L.N.'s mother was intoxicated and tried to run over L.N.'s father while L.N. was in the vehicle. The allegations also stated the mother drank heavily, and while intoxicated would often bed share with L.N. The father reportedly tried to discuss these concerns with the mother, but she continued her behavior. This intake was assigned for CPS/Family Assessment Response (FAR) assessment.

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[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)]." 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.

[2] No one has been criminally charged related to L.N.'s death; therefore, no one is named in this report.

[3] This CIRT report can be found at: https://www [redacted].

[4] See: https://www.dcyf.wa.gov/6000-operations/6302-administrative-incident-reporting

On May 7, 2019, the CPS case worker called L.N.'s father. The father said the mother had a long-time drinking problem and drank during her pregnancy with L.N. He said the mother's family brought her alcohol to the hospital when she delivered L.N. The father also said he struggled with alcohol use in the past but had control over his use. He stated he had a family history of alcoholism as well.

The father said that on April 21, 2019, the mother was drunk and tried to run him over while their 74.13.515 was in the car. The father did not call police but said he had a video of the event. He also stated that a few days later, the mother called him to pick up L.N. The father stated that when he arrived he was assaulted by the mother's boyfriend.

The father also said he has two other children. Neither child lived with him. One child is being raised by the father's grandmother and the other child is being raised by that child's mother.

Due to the mother living in Washington State yet frequenting 74.13.515 State, the CPS worker requested police reports from two agencies in 74.13.515 (74.13.515 County and 74.13.515 Police Bureau) and two agencies in Washington State (74.13.515 County and 74.13.515 Police Department).

On May 8, 2019, the CPS worker contacted 74.13.515 DHS to see if it had any history regarding this family. The CPS case worker was told there was an open CPS case. The DCYF CPS case worker contacted the 74.13.515 DHS CPS worker and was told there was an allegation of 13.50.100 .

On May 9, 2019, the assigned CPS worker made an unannounced home visit to the mother's Washington home. The CPS case worker observed the home to be clean and orderly and did not observe any behaviors that caused concern the mother was intoxicated. The CPS case worker observed a portable crib and discussed safe sleep with the mother. The mother shared that at times L.N. would take naps on the mother's bed. The mother denied ever bed-sharing with 74.13.515 after she had been drinking or when she was under the influence of any substance. The mother denied the allegations in the intake as well as the information the father shared during his telephone call with the CPS case worker. The mother also said the father was a drug dealer, confidential informant for law enforcement, pimp and affiliated with gangs. The mother identified family in 74.13.515 that supported her and stated she 13.50.100 . She told the CPS case worker she was rarely in 74.13.515 and planned to move back to 74.13.515 74.13.515 soon.

On May 10, 2019, the CPS worker made a referral for a crib and mattress for the mother. The CPS case worker was not sure whether L.N.'s mother picked up the items.

On May 24, 2019, L.N.'s father contacted DCYF and said that L.N. died while in the care of 74.13.51 mother in 74.13.515 The father said the mother called him around 1:00 that morning and sounded intoxicated. She wanted to see him and said she was going to drive. He told the mother he would send an Uber to pick up her and the baby. The father heard the baby crying in the background. The mother said she had been babysitting while her friend and sister were out. Later that same morning, the father received a call from a hospital stating his 74.13.515 had died. The mother's friend told the father that when she walked into the room (where they were staying), she saw blood coming from L.N.'s mouth and the mother asleep next to 74.13.515 This intake was screened in for a DCYF CPS investigation.

Also on May 24, 2019, DCYF created an intake regarding an event reported to law enforcement. The event occurred and was reported to law enforcement on May 7, 2019. The law enforcement report

stated that the father reported the mother was drunk and tried to run him over with a car while their 74.13.515 was in the car. The report stated the father showed the police officer video footage of the incident. The officer documented that he could see from the video that L.N. was in the car while the mother was driving. This intake was screened out as the allegations were already reported.

The May 7, 2019 intake was closed out after L.N.'s death. DCYF closed out the May 24, 2019 investigation without a finding. This decision was made because the death occurred in 74.13.515 During the time the investigation was open, law enforcement told the assigned CPS case worker there was an 74.13.520 found during the autopsy and that it was believed this contributed to or caused L.N.'s death. The DCYF investigation was closed prior to receiving the medical examiner's toxicology report. It is only upon review of the 74.13.515 DHS CIRT report that DCYF learned the 74.13.520 did not contribute to or cause L.N.'s death

Committee Discussion

The Committee appreciated how well prepared the CPS worker was for the review. The Committee identified that the CPS case worker asked good questions of the parents during her contact, requested records from appropriate sources early in the assessment, made timely and appropriate contact with 74.13.515 DHS and addressed safe sleep multiple times with the mother.

The Committee discussed the screening decision regarding the May 9, 2019 intake. There was some thought that the allegations constituted imminent risk and should have been assigned as a CPS investigation. The Committee discussed that the CPS case worker more than likely would have approached the case in the same manner and that the screening decision would have impacted only the time between the assignment and initial face-to-face. The Committee viewed the CPS case worker's choice to conduct an unannounced home visit as positive and utilizing critical thinking, even though it did not fully adhere to the FAR policy.

The Committee discussed at length the issue relating to families who frequently go between the states that border Washington, Oregon and Idaho. This issue specifically impacted this case because the CPS case worker was not able to go to 74.13.515 to observe the grandmother's home where the mother would often go. In addition, because the death occurred in 74.13.515 DCYF could not make a finding or complete its investigation of L.N.'s death. An AAG provided the Committee with information indicating that, specific to this case, DCYF staff could not physically go into 74.13.515 to conduct social work. There were questions raised by the Committee about the difference between physically going into another state and calling persons in another state or country, but those questions were not resolved. The Committee also struggled with other aspects of this discussion and addressed it in the recommendation section below.

The Committee discussed that the CPS case worker's caseload was too high. At the time of the May 7, 2019 intake, the CPS case worker's caseload was 47 intakes. At the time of the review, the CPS case worker had 40 intakes. While the CPS case worker had a high caseload, the Committee did not believe there was any correlation between the high caseload and L.N.'s death.

Findings

The Committee did not identify any critical errors. This case was open for 17 calendar days, which is a small amount of time considering that a CPS case worker has 60 days to complete an assessment.

The Committee identified that a urinalysis from L.N.'s mother should have been requested as part of the assessment process. This is based on the allegations in the May 7, 2019 intake. The Committee understands that utilizing a urinalysis is only a tool used in assessments completed by DCYF. There was also some discussion that a urinalysis of the father, based on the mother's statements, would have been appropriate.

Recommendation

The Committee recommends that DCYF work with DCYF's legal team and neighboring states (Oregon and Idaho) to discuss how cases that move between state lines can have a more fluid and comprehensive assessment. The Committee believes if there was a reciprocal memorandum of understanding, or something similar, DCYF cases would be more comprehensive, completed in a more timely manner and closure may occur more quickly.

CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

January 2020

Washington State Department of
CHILDREN, YOUTH & FAMILIES

Contents

Full Report

Child

- Z.E.

Date of Child's Birth

- 74.13.515 2003

Date of Fatality

- September 7, 2019

Child Fatality Review Date

- January 30, 2020

Committee Members

- Mary Anderson Moskowitz, Ombuds, Office of Children and Family's Ombuds
- Mariah Fabiani, CFWS Supervisor, DCYF
- Ly Dinh, MSW, Quality Practice Specialist, DCYF
- MaShelle Hess, MSW, LICSW-A, CFWS & Guardianship Program Manager, DCYF
- Julio Serrano Jr, Guardian Ad Litem, Pierce County Juvenile Court
- Kris Sanborn, LICSW, Clinical Director, YMCA

Observer

- DeAnn Bauer, Social Service Specialist III, DCYF

Facilitator

- Leah Mattos, MSW, Critical Incident Review Specialist, DCYF

Executive Summary

On January 30, 2020, the Department of Children, Youth, and Families (DCYF)[1] convened a Child Fatality Review (CFR)[2] to examine DCYF's practice and service delivery to Z.E. and [redacted] family.[3] [redacted] will be referenced by [redacted] initials throughout this report.

During the summer of 2019, Z.E. was periodically running away from [redacted] foster care placements. The Department made efforts to locate Z.E. by working with local law enforcement and the National Center for Missing and Exploited Children. During this same time period, the Department was working to identify an appropriate, long-term placement option. As a part of this effort the Department initiated an updated relative search to determine whether there was an appropriate relative placement. While missing from care in mid-August, law enforcement told the Department Z.E. had been RCW 13.50.100 [redacted] and was then released to [redacted] guardian. Law enforcement gave the Department the guardian's contact information. The CFWS worker contacted the individual and they stated their intent to become a caregiver for Z.E. The CFWS worker immediately took the necessary steps to complete an emergent background check[4] and complete a walk-through of the caregiver's home. The Department determined the placement was a suitable other placement and authorized Z.E.'s placement with the caregiver.[5]

On September 7, 2019, DCYF learned from the Sheriff's Department that Z.E. killed [redacted] self. The 911 call reporting the shooting was made by Z.E.'s caregiver, who Z.E. had been residing with for approximately 3 weeks. Emergency services at the scene pronounced Z.E. dead. The cause of death appears to be accidental and was determined to be due to a perforating handgun wound to the head.

The CFR Committee includes members with relevant expertise selected from diverse disciplines within DCYF and the community. Committee members have not had any involvement or contact with Z.E. or [redacted] family. The Committee received relevant case history that includes CPS history, case notes and on-going case planning.

On the date of the CFR the Committee interviewed two prior CFWS workers[6] and the CFWS supervisor who oversaw the courtesy supervision workers. The on-going CFWS supervisor last supervising the case had moved to another office and did not participate in the review as initially anticipated.

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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 the Department of Early Learning for childcare 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)].

[3]The names of the deceased child's parents are not used in this report because neither parent has been charged with a crime in connection with the fatality incident. The names of the siblings are also not used in this report because they are subject to privacy laws. See RCW 74.13.500.

[4]Under RCW 26.44.240 DCYF is authorized to conduct a federal name-based criminal history record (Purpose Code X) check of each adult residing in a home where a child may be placed during emergent situations. Purpose Code X checks are not conducted for non-emergent placements, planned placements changes, Child Protective Services (CPS) investigations, individuals who live out-of-state, or Child In Need of Services (CHINS) cases. An emergent placement refers to the limited circumstance involving the sudden unavailability of a child's primary caregiver. Under these circumstances the child may be placed in the home of an unlicensed individual under a Voluntary Placement Agreement (VPA), or pursuant to a protective custody determination. The unlicensed individual may be a neighbor, friend, or relative.

[5]A suitable person is defined as someone who has a pre-existing relationship with the child or child's family. See RCW 13.34.130(1)(b)(ii)(B); and DCYF Practice and Procedures Guide Section 45274 (Placements with Unlicensed Relatives or Suitable Persons).

[6]Child and Family Welfare social workers assume respons bility of a child welfare case after the children have been removed from their caregivers and a dependency petition filed.

Case Overview

In 2006, Z.E.'s family first came to the Department's attention. From 2006 to 2015 there were four CPS investigations with concerns related to [redacted] and [redacted]. These concerns led to a 2015 [redacted] of Z.E.'s younger half-sibling. The basis for the [redacted] was the arrest of the mother and there being no parent available to care for the child. When the [redacted], relatives were caring for Z.E. and [redacted] older sibling, so a dependency was not filed for Z.E. In 2016, a CPS intake was made alleging there was no responsible adult available to care for Z.E. due to the arrest of [redacted] mother. Law enforcement placed Z.E. in protective custody and a dependency action was filed. This dependency action pertained to Z.E. [redacted].

In May 2017, dependency was established [redacted]. Accordingly, the Department made efforts to contact both parents to offer the required court-ordered services. However, neither parent consistently maintained communication with the Department or participated in the services. Likewise, visitation and on-going contact between Z.E. and [redacted] parents did not occur. Z.E.'s father did contact the Department a few times to request visits but failed to follow through. While Z.E. had contact with [redacted] older sibling, [redacted] had less frequent contact with [redacted] younger half-sibling.

Upon entering the foster care system, Z.E. was assessed under the Child Health and Education Tracking program (CHET).[7] The program identified a need for mental health counseling and challenges within the educational setting to include [redacted] and [redacted]. In early 2017, Z.E. was referred for a psychological evaluation. However, this evaluation never occurred largely due to placement instability and Z.E. being on the run. The Department made attempts to encourage Z.E.'s relative caregiver to enroll [redacted] in mental health services but the relative caregiver was unresponsive. The family was also referred for in-home counseling services, but the family failed to engage and the referral was closed. Future attempts to refer Z.E. for services were declined by the youth as well as [redacted] relative caregiver.

Due to the reported academic and behavioral needs identified within the school setting, Z.E. was referred to the [redacted] Educational Advocacy Program.[8] Throughout this dependency there were significant gaps in Z.E.'s education due to [redacted], which was caused in part by [redacted] placement instability. The Department's CFWS worker reported that despite these gaps, Z.E. was motivated to graduate from high school, as had [redacted] older sibling.

In 2018, a CPS Risk-Only intake was generated for [redacted]) services. The basis for the intake involved an allegation that Z.E. committed the crime of [redacted]. However, because Z.E. was less than twelve years old [redacted] was presumed to have insufficient capacity to commit the crime (see RCW [redacted]). Under chapter [redacted] RCW the case was transferred to Child Protective Services. The CFWS worker met with Z.E. and [redacted] family to discuss available [redacted] services. Because they were

[7] The Child Health and Education Tracking (CHET) program is responsible for identifying each child's long-term needs at initial out-of-home placement. The evaluation's results are used to develop an appropriate case plan and assist with placement decisions. See DCYF Practices and Procedures, No. 43092 (Child Health and Education Tracking).

[8] The Educational Advocacy Program provides direct advocacy, consultation, information, and referral services for youth in care. All youth with educational needs who are in out-of-home care are eligible. Educational Advocacy Coordinators (EACs) are located throughout the state. EACs provide information and referral services designed to help keep foster youth engaged in school, and progress toward graduation.

concerned about the implications associated with accepting [redacted] services, the family and Z.E. declined [redacted] services. Z.E. denied the allegations and the Department was not concerned about the [redacted] allegation, as there had been no other incidents reported to the CFWS worker.

Z.E. had over 25 placement changes that included foster homes, group homes, relative placement, and hotel stays when no placement was available to meet [redacted] needs. Z.E.'s runaway history includes lengthy time periods when [redacted] was missing from [redacted] foster care placement for more than 90 days. During those times the Department made search efforts to locate [redacted] including working with local law enforcement, and the National Center for Missing and Exploited Children. Both [redacted] grandmother and aunt struggled to maintain the placement of Z.E. for a variety of reasons including their inability to maintain safe and stable housing, a lack of follow through with educational, medical, and therapeutic needs; and an inability to manage Z.E.'s behavioral challenges. Also, contrary to department policy, neither family member completed a home study. The Department had on-going concerns about the relative placements and requested placement be changed due to the family's failure to adhere to the DCYF home-study policy. Permanency was not achieved through the foster care system.

Committee Discussion

The Committee had an engaging discussion about the DCYF work associated with Z.E. and the Committee recognizes the efforts made by the CFWS workers. The case workers' efforts were made despite the challenges facing the CFWS workers including high caseloads, supervisor and staff turnover and complexities associated with learning how to navigate through the child welfare system. The Committee believes it is difficult to hold case worker staff accountable without the proper training, clinical supervision and leadership guidance.

One CFWS worker said for the first nine months of employment he did not have a consistent supervisor. This caused the worker to rely on co-workers. Also discussed was the concept of clinical supervision. For purposes of case planning, under the current approach there appears to be a lack of supervision documentation that shows how critical thinking was used. Instead, the current process is more task-oriented in nature.

The Committee discussed the current practice DCYF uses to determine the appropriate services for youth in foster care, the appropriate placement type and the use of appropriate screening tools. The current tool used by the department is the CHET screening, which is completed at the beginning of a case. This tool makes recommendations about a child's medical, mental health and educational needs, as well as placement. It was discussed how important it is that when a case transfers, the new worker is made aware of what was previously recommended and whether the need has been met, or is still outstanding. The Committee also discussed community-based screenings through mental health and private agencies, which may be beneficial in development of youth service and placement plans. This included a discussion about Wraparound with Intensive Services (WISe) screenings[9] through county-based mental health agencies.

[9] WISe/"Wraparound is a team based planning process for youth with complex needs and their families designed to help produce better outcomes for youth so that they can live in their homes and communities and realize their hopes and dreams." Wraparound with Intensive Services (WISe), are Medicaid Elig ble; have a qualifying mental health diagnosis; and have concerning behaviors at home, school, and in the community that meet clinical criteria for the program. See https://www.kingcounty.gov/depts/community-human-services/mental-health-substance-abuse/services/Youth/wraparound.aspx]. DCYF Practice and Procedures Guide Section 4542 (Wraparound Instensive with Intensive Services).

Another component discussed on this case was the use of courtesy supervision case workers in addition to the ongoing CFWS worker. The youth was frequently placed out of county, so the CFWS worker utilized courtesy supervision case workers to assist with completing monthly health and safety visits. The Committee had the opportunity to interview one CFWS supervisor who oversaw courtesy supervision case workers that interacted with Z.E. The Committee highlighted the importance of communication between the on-going case worker and the courtesy supervision case worker. Also, the Committee felt it was important that on-going case workers understand their role and that they are responsible for the ongoing case planning.

Despite the fact that efforts were made to re-engage Z.E. with [redacted] educational plan, the Committee felt this was a missed opportunity. While Z.E. was referred to a [redacted] educational advocate to help navigate [redacted] academic needs, there was limited direct correspondence from the CFWS workers to the schools. A courtesy supervision case worker did have contact with the school and the Committee discussed the importance of the case worker who is assigned as the primary worker taking the lead in this type of correspondence. While one CFWS worker did not agree with Z.E. being moved to the next grade [redacted], the CFWS worker did not know how to advocate for Z.E. within this system.

There was a lengthy discussion about the specific issues facing the adolescent foster care population that not only addresses their service needs, but also their safety needs. The Committee believes adolescents are often viewed as being less vulnerable and able to self-protect, placing too much responsibility on the youth for protecting his or her safety. The Committee also discussed specific training opportunities to better educate the work force about adolescent-related needs, including the need to shift thinking in a direction that is more aligned with how DCYF works with and assesses safety of an older population. In this particular case there were significant challenges associated with Z.E., who demonstrated risky behaviors throughout the life of this case. The Committee does recognize the challenges the Department faced in trying to mitigate those concerns, including Z.E. and [redacted] family's refusal to engage in therapeutic services. Another difficulty with this case identified by both CFWS workers included the lack of placement resources. Despite this difficulty the Committee strongly believes the Department has an obligation to assess the caregiver's safety and suitability to ensure the caregiver can meet the youth's needs.

Findings

In this case the Committee believes DCYF did not make any critical errors. The Committee does find that the Department did not complete, as required by policy, a Family Team Decision Meeting[10] after Z.E.'s placement was changed to an "other suitable person." Neither a Family Team Decision meeting, nor a shared planning meeting was held or scheduled. This would have been an opportunity to share information about Z.E.'s ongoing emotional and behavioral needs, and [redacted] academic support needs. It would have also been an opportunity to ensure continuity of care in the new placement setting.

The Committee also believes the Department did not assess the safety and suitability of the suitable person caregiver to ensure the caregiver could provide a safe, appropriate home that would meet Z.E.'s

[10] 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 about the removal of child(ren) from their home, placement stabilization and prevention, and reunification or placement into a permanent home. See DCYF Practices and Procedures Policy No. 1720, Family Team Decision Making Meetings.

long-term needs. The Department did complete an emergent background check, which conditionally cleared the caregiver but did not complete the next steps for the background check process. Before authorizing the placement of Z.E. in the caregiver's home, the CFWS worker did review the caregiver's CPS history and consulted with her supervisor. The Committee believes the Department was focused on the fact that the caregiver's CPS history did not include any founded findings.[11] The Committee believes the Department should pay closer attention to reviewing the content and concerns identified within the CPS history. A home study referral was not submitted, which would have further explored the suitability and sustainability of this placement.

Recommendations

The Committee recommends that for DCYF programs experiencing significant turnover, the area administrator should develop a plan with the unit supervisor to address the turnover and a plan to improve retention. For the staff to do their jobs effectively these plans should ensure the staff have the necessary training and support from their area administrator, immediate supervisor and DCYF management. This plan should include utilizing the training and coaching supports that are available through the UW Alliance, Regional Quality Practice Specialists and Program Managers.

The Committee recognizes that because of time limitations the staff may not always know about relevant training opportunities. This is the case, despite the fact the Department has access to a wide variety of UW Alliance classroom and online trainings. With this in mind the Committee recommends the local office leadership, including the area administrator and supervisors, disseminate upcoming training opportunities to staff at All-Staff Meetings and Unit Meetings.

To establish a strong continuity of care when a CFWS case is transferred from one worker to another, the Committee recommends the receiving CFWS worker incorporate into his or her practice a review of any previous CHET Screening reviews. If the new CFWS worker conducts this review, the new case CFWS worker should have a better understanding of prior recommendations designed to address the child's health needs, mental health needs and education needs. For referrals previously recommended by the CHET Screening that have not been made, the new CFWS worker should be able to make such referrals after assuming responsibility for the case. This recommendation was developed specifically for this office due to frequent case transfers within CFWS, but should be considered a statewide best practice.

Department CFWS workers assigned as the primary caseworker, in addition to having a courtesy supervision caseworker for monthly health and safety visits, should adhere to the expectations in the courtesy supervision policy. The primary assignment CFWS worker has responsibility for service referrals, decision making and payment authorization.

The Wraparound Intensive Services (WISe) screenings should be implemented in cases involving a child or youth who is experiencing placement instability, or emotional, behavioral or academic challenges. WISe access is based on Medicaid eligibility for mental health services and can provide intensive

[11] "'Founded' means the determination following an investigation by CPS that based on available information it is more likely than not that child abuse or neglect did occur." WAC 388-15-005.

supports to children and youth statewide. The Committee understands that youth have the right to refuse services that are based on WISe screenings.

CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

February 2020

Washington State Department of
CHILDREN, YOUTH & FAMILIES

Contents

February 2020

Full Report

Child

- E.P.

Date of Child's Birth

- [redacted] 2004

Date of Fatality

- October 10, 2019

Child Fatality Review Date

- February 20, 2020

Committee Members

- Elizabeth Bokan, JD, Ombuds, Office of the Family and Children's Ombuds
- MaShelle Hess, MSW, LICSW-A, CFWS & Guardianship Program Manager, DCYF
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- Kymm Dozal, MSW, Clinical Director, Comprehensive Life Resources
- Lindsey Barcklay, MSW, LICSW, CMHS, CDP, CCTP, Program Manager, Domestic Abuse Women's Network

Observer

- DeAnn Bauer, Social Service Specialist III, DCYF

Facilitator

- Leah Mattos, MSW, Critical Incident Review Specialist, DCYF

Executive Summary

On February 20, 2020, the Department of Children, Youth, and Families (DCYF)[1] convened a Child Fatality Review (CFR)[2] to examine DCYF's practice and service delivery to E.P. and [redacted] family.[3] [redacted] will be referenced by [redacted] initials throughout this report.

On October 6, 2019, DCYF received a call from [redacted] Hospital stating that E.P. had been brought to the hospital four days prior after [redacted] was found unresponsive in [redacted] home. E.P. was diagnosed with a diffuse hypoxic injury, which results from a lack of oxygen to the brain. The family provided no explanation for E.P.'s condition and reportedly delayed calling 911 for 20 to 30 minutes. Additionally, hospital staff reported that the mother may have been under the influence of substances and unable to consent to any additional medical procedures.

On October 10, 2019, the Department received a call from the medical examiner reporting that E.P. passed away following the removal of life support. The initial autopsy reported that E.P.'s death presents as an overdose to an unknown substance, but further toxicology testing would be required. The medical examiner also reported that E.P. did not have a heart condition or underlying medical condition that would have caused cardiopulmonary failure. At the time of the incident, DCYF had an open Child and Family Welfare Services (CFWS)[4] case involving the family. E.P. and [redacted] two younger siblings were [redacted] and residing with their mother under a trial return home[5] that began in August 2018.

The CFR Committee includes members with relevant expertise selected from diverse disciplines within DCYF and the community. The Committee members have not had any involvement or contact with E.P. or [redacted] family. The Committee received relevant case history that includes CPS history, case notes, and ongoing case planning.

On the date of the CFR, the Committee interviewed a prior CFWS caseworker who carried the case from 2016 to 2017, a CFWS supervisor who supervised the case from 2016 to 2018, the CPS investigator from 2018, and the CFWS supervisors and caseworker who carried the case in 2019. The CFWS caseworker

[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 respons ble for child welfare and the Department of Early Learning for childcare 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)]. " RCW 74. 13. 640(4)(a).

[3]The names of the deceased child's parents are not used in this report because neither parent has been charged with a crime in connection to the fatality incident. The names of the siblings are also not used in this report because they are subject to privacy laws. See RCW 74. 13. 500.

[4]Child and Family Welfare case workers assume responsibility of a child welfare case after the child has been removed from his or her caregivers and a dependency petition has been filed.

[5]Trial Return Home. Follow requirements outlined in the Reasonable Efforts policy prior to requesting a trial return home or when the Court orders the child's immediate return home. Prior to a dependent child returning to the home of a parent a background check must be completed on all adults living in the home. A trial return home must not exceed 6 months in duration, unless ordered by the court. Identify and assess all caregivers of the child for services related to the safety of the child, and: Recommend the caregiver participate in the identified services, notify the court of any service recommendations made to the caregiver during a regular review hearing, and promptly notify the court if a caregiver fails to engage in or follow through with the recommended services. [Source DCYF Practices and Procedures Guide 43051A].

who carried the case from 2017 to 2019 is no longer employed with the Department and was unavailable to participate in this review.

Case Overview

E.P. 's family initially came to the Department's attention in 2012. From 2012 to 2014, the family had six Child Protective Services (CPS) intakes reporting significant mental health concerns for E.P. and for both of [redacted] parents, substance abuse and the failure to meet the medical needs of E.P. 's youngest sibling, [redacted]. Two separate CPS investigations determined the children were safe. Either no services were offered or the parents declined services and the cases were closed. In June 2014, a CPS intake was screened-in for investigation after E.P. drove [redacted] mother and younger siblings to the hospital at [redacted] mother's direction because E.P. 's mother said she was being choked and pinched by an invisible force. The Department [redacted] and the children were removed from their mother's care.

The children were placed with their maternal grandmother and her husband, and [redacted]. The court ordered services for both parents. The parents were separated at this time and remained separated throughout the duration of this case. Initially, the court allowed the mother to reside in the maternal grandmother's home with the understanding that she would participate in the court-ordered services. In 2015, the Department moved for the mother's removal from the home due to her continued non-compliance and lack of progress with court-ordered services. The court granted the Department's motion and the mother moved out of the home and began supervised visitation. At the onset of this case, the father engaged in services and visited the children fairly regularly. The children began refusing to see him and he became less involved with the case over time. The Department did not explore a return home to the father due to his minimal engagement and the children's ongoing refusal to see him. In late 2017, the mother made slow progress toward reunification.

Throughout this case, the Department experienced challenges with accessing the children to ensure their health, safety and well-being. Both the maternal grandmother and mother created barriers to the Department's ability to assess the health and safety of the children by asking the children not to talk to the caseworkers. The grandmother did not complete a relative home study[6] as required by policy and the home study referral was closed in April 2016 due to participation failure. The Department moved to remove the children from the maternal grandmother's home, the court supported the children remaining in their grandmother's care.

In 2017, there were two CPS investigations following allegations that E.P. was brought to the hospital intoxicated and suicidal. [redacted] mother was at the hospital and reportedly also appeared to be intoxicated. E.P. had also posted a video online making suicidal threats and indicating that [redacted] had a gun. It was reported that [redacted] mother was in the background of the video. The grandmother denied being home at

[6] "The term 'home study' means an evaluation of a home environment conducted in accordance with applicable requirements of the State in which the home is located, to determine whether a proposed placement of a child would meet the individual needs of the child, including the child's safety, permanency, health, well-being, and mental, emotional and physical development. " [Source: Safe and Timely Interstate Placement of Foster Children Act of 2006 P. L. 109-239]

DCYF Practices and Procedures Guide 5110 was recently issued to clarify that if a home study has not been completed prior to placement, a request must be made within thirty days of placement.

the time of this incident. The Department filed an emergency motion to remove the children from the grandmother's care, which the court denied. The court ordered that the family participate with Intensive Family Preservation Services[7] and receive case management services from 13.50.100 , in addition to allowing the mother only supervised visitation. In 2018, CPS investigated three different intakes due to E.P. 13.50.100 in the home of the grandmother, E.P. being highly intoxicated at school and the mother driving E.P.'s youngest sibling to a medical appointment where she was nodding off and needed to be picked up by the grandmother. Again, the Department filed a motion to have the children removed from the home but the court denied the motion. The grandmother made it clear to the Department that she and her husband were not a permanent resource for the children and she wished them to be returned to their mother's care.

The Department 13.50.100 in 2017, but 13.50.100 the mother began making progress. Due to the length of time the case was open without achieving permanency for the children, the court ordered that the Department refer the family to the Foster Care Assessment Program (FCAP)[8] to complete a comprehensive evaluation. The FCAP was completed in June 2018 with recommendations that the children return to their mother's care immediately so that the Department could best assess the mother's independent capacity to care for the children. This recommendation was based on the mother's slow progress and compliance with services, no other viable permanency options and the length of time the children had been in out-of-home care. It was noted that if the return home failed, alternate relative options should be explored and that if the children entered foster care, placement together was in their best interest. FCAP recommended the following plan to provide support and monitoring of the trial return home: (1) coordination between the mother's therapeutic providers, cognitive behavioral therapy and random urinalysis (UA); (2) E.P. should be evaluated for 74.13.520 74.13.520 and substance abuse, as well as cognitive-behavioral therapy or dialectical behavior therapy; (3) E.P. would benefit from extra-curricular activities; (4) refer for a home-based health program to monitor the 74.13.520 care needs of the youngest child, as well as attend regular appointments with the 74.13.520 clinic. In August 2018, the children were returned to their mother's care with an agreed court order that included these conditions. Initially, it appeared that things were on track for the family and no safety issues were noted. The family obtained independent housing and moved out of the grandmother's home. At the sixth-month marker of the trial return home, the mother requested a parenting plan. As a result, the Department did not recommend dismissal. The mother reported that she felt the father may attempt to abscond with the children if the Department was no longer involved. The Department made efforts to collaborate with the parent's attorney and began the process for family court involvement.

In the late summer of 2019, the family lost its independent housing and moved back to the grandmother's home. The reported cause was a neighborhood youth stealing money from the home,

[7]Intensive Family Preservation Services (IFPS) are short-term, family-based services designed to assist families in crisis by improving parenting and family functioning while keeping children safe. IFPS is generally authorized for 30 days. [DCYF Practices and Procedures Guide 4502].

[8]The Foster Care Assessment Program (FCAP) is a multi-disciplinary contract between Children's Administration (CA) and Harborview Center for Sexual Assault and Traumatic Stress and its subcontractors to assess the needs of children who have been in out-of-home care for more than 90 days. Assessment services include a six-month follow-up period to assist the DCFS case worker in implementing a placement plan and to help meet the needs of the child and family. The program has two goals: Ensure that the physical and emotional health, developmental status, and educational adjustment of children in the care of the state have been assessed and any significant needs addressed; and, Identify and help resolve obstacles to reunification, adoption, guardianship, or other permanent plan. [Source: DCYF Practice and Procedure Guide 4543].

leaving the mother without a way to pay rent. She indicated that she had called 911 and filed a police report. On September 19, 2019, the Department was notified of concerns related to the youngest child's 74.13.520 care needs and that she had been hospitalized. It was reported by hospital staff that the mother had never done well at monitoring and maintaining the child's 74.13.520 care needs, but that the child had not been hospitalized in some time. The Department reached out to the child's school and the school nurse to follow up about her 74.13.520 care routines and it was reported that the mother was not bringing the appropriate supplies to school and that the child had missed a significant amount of school this school year.

On September 30, 2019, a caseworker attempted a health and safety visit[9] with E.P. in [redacted] school setting but [redacted] was not in attendance. The Department did not see E.P. in the month of September due to this missed visit. On October 6, 2019, 74.13.515 Hospital contacted the Department to report that E.P. had been admitted to the hospital on October 2 while unconscious. The hospital indicated that [redacted] had not regained consciousness and had no brain activity. It was also noted that the mother appeared to be impaired by substances and the staff was concerned she would not be able to make an informed decision should an invasive medical procedure be required. This incident generated a CPS investigation surrounding the concerns identified by the hospital. There was also ongoing collaboration between the CFWS caseworker and hospital personnel regarding E.P. 's medical condition. On October 10, 2019, [redacted] E.P. passed away 74.13.520 .

Committee Discussion

The Committee had the opportunity to review the case history as well as interview CFWS caseworkers, CFWS supervisors, and a CPS caseworker, which fostered the below discussion. Although the Committee addressed a number of areas where it believes practice could have been improved, it recognizes the significant workload challenges faced by this particular office and social work staff. The discussion centered around the following areas: systemic barriers, family engagement, and permanency.

The intent of highlighting the struggles with staffing shortages and high caseloads is not to detract from the responsibilities of the Department caseworkers and supervisors, but rather to approach this review in a multi-faceted manner to encompass all areas that may have impacted practice. The Committee was provided with information regarding the caseworkers' caseloads, all of which were higher than the recommended caseload of 12 to 15 cases per month for CFWS workers and 12 cases per month for CPS workers as outlined by the Child Welfare League of America. One caseworker reported that she had a caseload of 47 child assignments. A CFWS supervisor shared that at one point she was the only CFWS supervisor for the office, tasked with supervising 21 caseworkers. She also reported that while supervising, she carried a caseload of approximately 44 child assignments due to staff shortages. Another caseworker shared that upon beginning employment with DCYF, she was removed from Alliance for Child Welfare Excellence Regional Core Training[10] after only four days due to staffing

[9] Health and Safety Visits. DCYF case workers are required to visit with all children in person on a monthly basis if the case is open for services. The goal of these visits is to ensure the child is safe and that the child's basic well-being needs are being met. [Source – DCFY Practice and Policy Guide 4420].

[10]The Alliance for Child Welfare Excellence is a program through the University of Washington, in partnership with DCYF, that provides regular training to DCYF staff. The Alliance provides the Regional Core Training (RCT) that all new DCYF case carrying employees must complete before they can be assigned cases. See https://allianceforchildwelfare. org/.

shortage and was assigned a full caseload. Because of staffing limitations, this case transitioned to multiple CFWS workers, including approximately 10 different caseworkers and 10 different supervisors providing oversight from 2014 to 2019.

In addition to high caseloads and staff shortages at this office, the office has also struggled with children who have disrupted placement. On multiple occasions, children who were in out-of-home care required field social work staff to provide transportation to and from school, as well as medical and therapeutic appointments, general supervision at the office, and placement coordination. It was reported that at one point 14 to 15 children required support from caseworkers while awaiting placement. The caseworkers also stated there is sometimes a lack of relief from the After Hours team, which requires that the caseworkers supervise children late into the evening. The Committee acknowledged the impact this has on caseworkers' ability to complete their day to day tasks, such as referring parents for services and completing collateral contacts. The Committee speculated this may also contribute to staff retention as staff who do not have the minimum support and training necessary to do their job may not remain in their job. The Committee discussed what support is available to offices, such as roving units designed to fill in when there are staff shortages, but that was not available to this particular office. The Committee also noted that the focus of roving units is often on CPS work and not CFWS work.

The Committee acknowledged that the scope of its review was related to the work provided by DCYF, but discussed areas of concern outside of the Department's control that may have impacted this case. The Committee questioned the court's continued decision to allow the children to remain in a relative caregiver's home when a home study had not been completed, the family was unwilling to be a permanent resource for the children, the family presented barriers to health and safety visits with the children, and multiple CPS investigations led to founded findings with the relative caregiver as a subject. The Committee recognized that a caseworker may be reluctant to continue filing motions for removal after a history -of prior denials, but felt that there may have been other points worthy of the court's consideration. One such point was when the mother lost her independent housing and returned to the grandmother's home, despite a prior court order requiring the mother to obtain independent housing. Based on the court's response, which was reported by the caseworkers and supervisors as common practice, the Committee speculates about the Department's relationship with the court system and wonders what mechanism is in place to have dialogue between DCYF and the court. The Committee also identified a concern related to the limited reporting by medical and school professionals pertaining to the children's health and well-being needs, specifically for the youngest child's 74.13.520 care. Although the Department is responsible for making collateral contacts and gathering information, it is also typical for schools and medical professionals to report concerns of significant nature to the Department either directly through the assigned caseworker or through the intake line. The Committee felt there were fewer contacts from community members and other professionals to the Department in this case.

The Committee discussed the Department's efforts to engage with the family throughout the life of this case and concluded there were missed opportunities for engagement. The Committee did not overlook the difficulties the Department reported in working with the family and that at times the workers did not feel safe in their interactions with the family. As mentioned above, the case transferred to multiple workers and supervisors, leading to frustration on the part of the family, which was captured in case notes. In 2019 alone, there were five caseworkers completing health and safety visits with the family in

a 10-month period. The Committee speculated that this could have led to the loss of continuity. The Committee noted that it would have liked to have seen more consistent engagement efforts with the father over the life of the case. There also appeared to be a lack of historical knowledge from the most recent worker about the father's previous involvement with the case and completion of court-ordered services.

A significant challenge identified through the caseworker interviews was the mother and grandmother's refusal to participate and engage in services that were offered to them in the home. The Department relied upon the relative caregiver and the mother to ensure that the children's therapeutic and medical needs were met and accepted their verbal reports about medical appointments and school. The Department made limited collateral contacts to verify the information the family reported. For example, school notification letters were not sent to the schools, even though E.P. changed schools in 2019. The Department reported that the schools did not report concerning information about the 74.13.520 care management of the youngest child or attendance issues for E.P. The school personnel stated they were not aware the Department was still involved with the family. This could have been mitigated if a school notification letter had been sent providing contact information for the Department caseworker and may have opened up the lines of communication. The Committee felt this family would have benefited from wrap-around services[11] through community mental health or with Coordinated Care to better assist the family in managing and navigating the children's needs for therapeutic care, including 74.13.520 care.

Following the 2018 CPS investigations in the grandmother's home, a safety plan was drafted during a shared planning meeting where the grandmother was not in attendance. The plan that was developed listed the grandmother as an individual to monitor and enforce the safety plan along with the mother, although it was unclear whether the grandmother ever read or signed the plan. Also, the grandmother was the subject of the CPS investigation; and she should not have been named as a safety plan monitor. The Committee felt an in-home provider, wrap-around provider, or coordinated care manager should have been referred and been incorporated as a safety plan monitor at that time, but accepted that the family may have refused to participate with the provider.

Permanency was not established for the children in this lengthy case. The preferred goal of a permanency outcome for children in out-of-home care should be achieved prior to month 15.[12] Neither parent made progress toward reunification, and the grandmother was unwilling to enter into a permanent plan with the children. Third-party custody was explored with the grandmother in 2017, but she declined and the Department could not support that plan because a home study had not been completed. A 13.50.100 in 2017, but the Department did not move forward 13.50.100 because the mother began making progress toward reunification. The Committee felt the Department could have focused on concurrent planning earlier on and utilized recruitment strategies to identify an appropriate, long-term resource that could have met the children's needs.

[11] WISe/Wraparound is a team-based planning process for youth with complex needs and their families designed to help produce better outcomes for youth so that they can live in their homes and communities and realize their hopes and dreams. Wraparound with Intensive Services (WISe), are Medicaid Elig ble; have a qualifying mental health diagnosis; and have concerning behaviors at home, school and in the community that meet clinical criteria for the program. [Source - https://www. kingcounty. gov/depts/community-human-services/mental-health-substance-abuse/services/Youth/wraparound. aspx]

[12] See RCW 13. 34. 145 https://app. leg. wa. gov/RCW/default. aspx?cite=13. 34. 145

The Committee speculated that at the point of the trial return home, the mother may have reasoned that there were no repercussions for failing to follow court-ordered expectations. As a result, the home became increasingly unstable without immediate recognition by the Department. Additionally, once the children were returned home, the Department did not move forward with recommending dismissal during the sixth month of the trial return home. A parenting plan had been requested by the mother due to her fear that the father would abscond with the children when the Department ended its involvement with the family. This significantly delayed case closure. The Department does not have control over the processes involved with family court in establishing a parenting plan, and the Department made efforts to aid in the completion of this process. A CFWS supervisor shared that the office is now staffing cases on a weekly basis that have been on trial return home for approximately 180 days to address barriers, such as existed in this particular case.

Findings

The Committee believes DCYF did not make any critical errors in this case. The Committee agrees on the following findings.

The case did not achieve permanency within the federally recognized timelines. Permanency planning meetings were held but could have been utilized more frequently to discuss movement toward permanency and the development of a concurrent plan.

In 2019, the Department missed two monthly health and safety visits with E.P. with the last missed visit the month prior to [redacted] untimely passing. In addition to the missed visits, it was noted that throughout the course of this case, documentation of the health and safety visits was inconsistent and did not always provide a clear picture of how safety was assessed, how service needs were identified and met, and whether the children met with the caseworkers individually.

To the caseworker's recollection, school notification letters were not utilized in this case. E.P. changed schools in September 2019 and a notification letter was not sent to inform school personnel of the Department's contact information.

Self-reporting was relied on by both the grandmother and mother for the children's medical, academic and therapeutic care rather than utilizing collateral contacts to verify the information.

Following the 2018 CPS investigations in the relative caregiver's home, a safety plan was developed after the court denied the children's removal. This plan was developed at a shared planning meeting. The mother was present but the grandmother was not in attendance. It was unclear whether the grandmother ever reviewed or agreed to this plan. She and the mother were both named as safety plan participants, although the grandmother was the subject of the investigation. No other individuals or providers were named to assist with enforcement of the plan. Safety plan participants should not be those individuals who are the subject of the CPS investigation.

Recommendations

The Committee recommends court improvement and teamwork with the juvenile court system in this county. The Committee specifically recommends that DCYF regional leadership, including area administrators, take steps to develop an ongoing dialogue to address systemic challenges between the court, DCYF and other legal parties.

The Committee believes it is critical that DCYF address staff retention and develop a plan that requires staff training through RCT and other required in-service training within staff's first year of service and that prohibits the assignment of cases before staff is ready. The following recommendations should be overseen by local office leadership, such as an area administrator, through ongoing supervision and consultation. The Department should utilize the onboarding plan that is recommended for new employees through the UW Alliance RCT training model, which supports the gradual assignment of cases after a worker has completed various training activities. The Committee further recommends that leadership ensure a plan for a daytime staff transition to after-hours so that staff is relieved when there are unresolved matters from the daytime. Leadership also needs to address the matter of staff safety, so that if a worker feels unsafe when meeting with a family individually, a plan is developed to support them in performing their work safely. The Committee also identified the importance of additional support for offices struggling with turnover and retention, such as utilizing resources offered through Quality Practice Specialists (QPS) and UW Alliance for training.

It was reported by this office that they have developed a schedule to support and supervise the children who are spending time at the office awaiting a new placement. The Committee requested the office expand this plan to address whether the children's medical, dental, academic and therapeutic needs are being met when the children do not have an identified placement that is assisting in the oversight of these well-being needs. The Committee requests a safety planning training for both CPS and CFWS sections to be hosted by the QPS team for this specific office. The focus should ensure that the staff understands when a safety plan is required and the elements that should be addressed to ensure appropriate monitoring by individuals who can safely monitor and reliably report back to the caseworker.

The Committee also recommends the promotion of statewide education for caseworkers and DCYF staff regarding Narcan.[13] This should include training that is offered by county health departments or through online health department resources so that caseworkers can be better informed when speaking with families about the risk of overdose. This would also enhance workers' ability to direct families to community-based resources for education, supports and supplies as needed.

[13] Opioid Overdose Prevention. See https://www. kingcounty. gov/depts/community-human-services/mental-health-substance-abuse/task-forces/heroin-opiates-task-force/opioid-overdose-prevention. aspx

CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

June 2019

Washington State Department of
CHILDREN, YOUTH & FAMILIES

Contents

Full Report

Child

- R.M.

Date of Child's Birth

- 74.13.515 2018

Date of Fatality

- November 23, 2019

Child Fatality Review Date

- April 1, 2020

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- Tarassa Froberg, Child Protective Services and Family Voluntary Services Program Manager, DCYF
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Executive Summary

On April 1, 2020, the Department of Children, Youth, and Families (DCYF)[1] convened a Child Fatality Review (CFR)[2] to examine DCYF's practice and service delivery to R.M. and [redacted] family. [redacted] will be referenced by [redacted] initials throughout this report.[3]

On November 22, 2019, a Child Protective Services (CPS) intake screened in for the family assessment response (FAR)[4] program, requiring a response within 72 hours. The intake alleged that the oldest child in the home had an altercation with his stepfather and was punched under the eye. No mark or swelling was observed by the referent. The blended family also included three other children, with R.M. being the youngest.

On November 25, 2019, the assigned FAR case worker went to the school to interview [redacted], the child who was punched by his stepfather. School personnel reported that he was not in attendance due to [redacted].'s infant [redacted] passing away over the weekend. The FAR case worker contacted law enforcement to confirm a 911 call was made from the home and request a copy of the police report. The FAR case worker called in an intake reporting the allegation that R.M. died.

The Department received a November 23, 2019, law enforcement report that verified the death of R.M. According to the report, the father called 911 after discovering the infant was not breathing and was cold to the touch. Law enforcement completed an initial death investigation and a new CPS investigation was generated to further assess the safety of the other children in the household. On December 11, 2019, the medical examiner called the Department with information that R.M.'s toxicology came back positive for methadone. It was noted by the medical examiner that this may have contributed to the death, but further investigation was necessary.

The CFR Committee includes members with relevant expertise selected from diverse disciplines within DCYF and the community. Committee members have not had any involvement or contact with R.M. or [redacted] family. The Committee received relevant case history to include CPS intakes and case notes. On the date of the CFR, the Committee interviewed the FAR case worker and supervisor who were assigned the case in May 2019. The FAR case worker assigned to the November 2019 intake is no longer employed by DCYF and was not interviewed. The DCYF CPS/FAR case worker and supervisor who were involved with the family in 2016 are no longer employed by DCYF.

[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 the Department of Early Learning for childcare 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)]. RCW 74.13.640(4)(a).

[3]The names of the deceased child's parents are not used in this report because neither parent has been charged with a crime in connection with the fatality incident. The names of the deceased child and her siblings are also not used in this report because they are subject to privacy laws. See RCW 74.13.500.

[4]Family Assessment Response (FAR) is a Child Protective Services 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 have been reported.

Case Overview

R.M.'s family first came to the Department's attention in 2016 when three intakes were received by the Department, and were screened out due to standard criteria for screening. Allegations included supervision issues in the home, frequent late attendance at school and according to the oldest child, [redacted]., he was being hit on the bottom. The family at that time included the mother, stepfather and two children ([redacted]. and [redacted]).

On November 17, 2016, an intake screened in for family assessment response requiring face-to-face contact with the alleged victims within 72 hours. The allegation reported that the two children had been locked out of the home without an immediate response by either parent. The referent also said they often heard the stepfather and sometimes the mother yelling. Both children reportedly appeared fearful.

The FAR case worker made multiple unsuccessful attempts to contact the mother at the family home by initiating telephone contact, mailing letters to request contact and drop-ins at the home. The documentation indicates that no attempts were made to contact the biological father or stepfather. Both children were interviewed in their school setting. They reported that they had lost three different house keys, which led to them being locked out of the home. [redacted]. told the FAR case worker that he was crying and worried that his mother may be dead because they never had to wait for more than a few minutes for her to arrive home. The younger brother expressed surprise to the FAR case worker about his brother crying and said it was not because [redacted]. was afraid, but because [redacted]. was eager to play his video game. The FAR case worker did not identify any bruises or marks on either child and both children indicated they felt safe at home. The FAR case worker also spoke with the school counselor who did not report any concerns for either of the children. No safety concerns were identified and the risk was assessed as low. Due to a lack of parental response, the case was submitted for closure as incomplete in January 2017.

On May 31, 2019, an intake screened in for a family assessment response with a 72-hour response time. On this date the family also included two younger children, [redacted]. and R.M. These children were born subsequent to the Department's 2016 involvement with the family. The allegation reported that for a few weeks the oldest child, [redacted]., had been taking food out of the garbage at school. His response to school personnel was that he was trying to help his family by bringing home food because they have a lot of bills. School personnel also learned the custodian had been giving him snacks. Because the custodian was currently on leave, the school sent additional food home with [redacted]. The younger brother's school counselor also called reporting that [redacted] was coming to school hungry. In addition, [redacted] appeared stressed and was frequently crying at school following a visit to his biological father's home earlier in the year. He made a statement about wanting to 13.50.100.

On May 31, 2019, the FAR case worker unsuccessfully attempted to see the family at their home. The FAR case worker also left a telephone message for the mother to call, but the mother did not immediately return the call. On June 3, 2019 the FAR case worker conducted initial face-to-face visits with [redacted]. and [redacted]. at their respective schools. In addition to meeting with the children, the FAR case worker also met with school counselors at the middle and elementary schools. [redacted]. said he was getting enough food at home, but that he is a picky eater and sometimes "binge" eats junk food. He also said that he feels safe at home. The school counselor's only identified concern for [redacted]. was that [redacted]. had been eating out of the trash. It was noted that he 13.50.100 [redacted]

[redacted]). During his interview, [redacted] reported that there is food in the home, but sometimes his parents do not cook. He also shared that his older brother eats all the good things for their lunches, so he does not take a lunch to school. When asked if he is hungry during the day he stated he eats two sandwiches for breakfast. During the interview [redacted]. did express concerns about losing privileges at home and that he may have lied, but appeared to be confused about what he may have lied about.

The FAR case worker spoke with the stepfather who acknowledged he was aware of the concerns and they had been speaking with [redacted] about the concerns. The following day, the FAR case worker met with the entire family at their home. Initially, the stepfather refused to allow the FAR case worker in the home to complete a walkthrough to assess the safety of the home environment. He stated that he knows his rights and did not have to allow the worker inside the home. Eventually, the family did allow the FAR case worker in the kitchen to verify there was adequate food in the home. The family was able to show how the food was stored and that snack items were locked up so that [redacted] would not be able to eat them at one time. The parents said this behavior was an ongoing issue. [redacted] was reported as having a diagnosis of [redacted] and [redacted] He was taking medications for these diagnoses. The mother reported [redacted] was scheduled to see his doctor next week and she would address these concerns with the doctor as well.

In addition to addressing the older children's issues, the FAR case worker assessed the younger children as well. The FAR case worker did not observe marks, bruises or anything of concern involving the younger children. The FAR case worker reviewed both Safe Sleep[5] and the Period of Purple Crying[6] with the parents. The mother and father said that they were co-sleeping with the youngest infant, R.M., and adamant they would continue to do so. The FAR case worker reiterated the Safe Sleep practice and offered to purchase a co-sleeper. The mother agreed, but later the FAR case worker realized this item could not be purchased by the Department and offered a portable crib as an alternate resource. The mother declined and said they already had a crib.

In July 2019, the Department recommended case closure after the completion of the safety and risk assessment. The risk was calculated as moderately high, but services were not offered because the family had already arranged counseling services for the oldest child to address his emotional and behavioral needs.

[5]Safe Sleep is a nationwide campaign to promote safe sleeping habits for children. Safe sleep practice can reduce the risk of SIDS. According to the National Institute of Child Health and Human Development, the top 10 safe sleep guidelines are: 1) Always place your baby on his or her back to sleep, for naps and at night. 2) Place your baby on a firm sleep surface, such as on a safety-approved crib mattress, covered by a fitted sheet. 3) Keep soft objects, toys, and loose bedding out of your baby's sleep area. 4) Do not allow smoking around your baby. 5) Keep your baby's sleep area close to, but separate from, where you and others sleep. 6) Think about using a clean, dry pacifier when placing the infant down to sleep. 7) Do not let your baby overheat during sleep. 8) Avoid products that claim to reduce the risk of SIDS because most have not been tested for effectiveness or safety. 9) Do not use home monitors to reduce the risk of SIDS. 10) Reduce the chance that flat spots will develop on your baby's head: provide "Tummy Time" when your baby is awake and someone is watching; change the direction that your baby lies in the crib from one week to the next; and avoid too much time in car seats, carriers, and bouncers. [Source: A Parent's Guide to Safe Sleep] https://www.healthychildren.org/english/ages-stages/baby/sleep/pages/a-parents-guide-to-safe-sleep.aspx

[6]The Period of Purple Crying is a method to help parents understand the time in their baby's life where there may be significant periods of crying. During this phase of a baby's life they can cry for hours and still be healthy and normal. The Period of Purple Crying begins at about 2 weeks of age and continues until about 3-4 months of age. See http://www.purplecrying.info/what-is-the-period-of-purple-crying.php.

On September 17, 2019, the Department received a report that 74.13.515 told school staff that he and his brother were home alone and used a gun from the safe to scare away an intruder. The school officer spoke to 74.13.515 who reported he is not aware of a gun, but that food is locked up because of his older brother. The mother reported to the school officer there is not a gun in the safe. This information did not require a response from the Department. On October 2, 2019, a report was made to the Department indicating 74.13.515 was still taking and eating food out of the garbage. The referent stated there is something "off" about the child and that he is not in counseling. The referent was also concerned the child 13.50.100 . This information was screened out as there was no reported child abuse or neglect and the Department did not investigate.

On November 22, 2019, the Department received a report that 74.13.515 . said he had a fight with his stepfather about his cell phone and he was punched in the face under his right eye. The referent did not observe a mark, redness or bruising. However, 74.13.515 . reported soreness. This intake screened in for a family assessment response intervention, requiring face-to-face contact with the alleged victim within 72 hours. On November 25, 2019, the Department case worker went to 74.13.515 school to complete an in-person visit and it was reported that he was not at school due to the death of his younger sibling. The mother contacted the school to report their youngest child died from Sudden Unexpected Infant Death (SUID).[7] The school's behavioral specialist met with the FAR case worker and shared that 74.13.515 reported concerns about the stepfather using drugs and that his mother had temporarily made the stepfather leave. The behavior specialist indicated that 74.13.515 said he would now have to take on more responsibility since his stepfather was out of the home.

The Department case worker contacted law enforcement to request a copy of the police report and received confirmation regarding the 911 call that reported the death of R.M. An intake was called in regarding the infant's death. On December 11, 2019 the Department was contacted by the medical examiner's office with a report that R.M.'s toxicology came back positive for methadone and that this may have contributed to the infant's death.

Committee Discussion

In addition to interviewing the FAR case worker and supervisor who were assigned to the case in May 2019, the Committee also reviewed the Department's case file including relevant CPS intakes, case notes and family assessments.

The Committee strongly believes the Department could have not been aware that an incident of this nature would occur based on the Department's prior involvement with the family. Previous intakes received by the Department referenced challenges associated with the oldest child's mild behavioral challenges and parental supervision.

The FAR case worker reported that during her interview with the step-father he disclosed a history of substance abuse and served jail time for prior offenses approximately a decade ago. Despite this history,

[7] Sudden unexpected infant death (SUID) is a term used to describe the sudden and unexpected death of a baby less than one-year-old in which the cause was not obvious before investigation. These deaths often happen during sleep or in the baby's sleep area. See https://www.cdc.gov/sids/about/index.htm.

the FAR case worker did not identify any concerns related to substance use, nor was it identified as a concern in the then-current intake. The Committee discussed the Department's use of urinalysis testing for clients. From the perspective of a substance use treatment provider it would have made sense to complete a urinalysis to establish a baseline for the individual based on their past reported substance use. The Department's use of urinalysis testing is a single tool that can be used to obtain information that may be considered later for purposes of safety and case planning. Substance use on its own would need to be directly tied to child abuse or neglect to warrant the Department further intervening, which in this case it was not. The Committee did not identify missed indicators of possible problematic substance use based on the information gathered from the parents. The FAR case worker and supervisor were able to explain their rationale for not requesting urinalysis testing because it was not a concern identified in the intake, and it was not an issue that presented itself with the other information gathered from interviews with the parents, children and school personnel. Also, given this was a voluntary intervention to which the family agreed, it was unlikely they would have consented to submit urinalysis testing.

The Committee believes there were strong efforts made by the FAR case worker to engage the family. Based on the information reviewed and gathered during the interview with the FAR case worker, the Committee believes critical thinking was utilized and applied appropriately, and the Department was culturally responsive to the family. The FAR case worker was respectful of the family's beliefs, while still addressing the allegations and safety of all children in the household. This is evidenced by the FAR case worker obtaining access to the family's home despite the initial refusal by the stepfather to allow the worker to complete a walkthrough. The FAR case worker patiently worked with the family to explain everyone's role, the purpose of the intervention and the need for a safety assessment. The FAR case worker was then allowed to complete a walkthrough of the kitchen, which allowed for an assessment of the identified concerns reported in the intake.

Another strength identified by the Committee was the FAR case worker's use of databases to gather information to complete foundational work about the family and case. The FAR case worker also did a nice job documenting all databases searched and the results in one cohesive case note. The Committee discussed how important it is for Department case workers to have access to a variety of databases to be able to gather information to fully assess a family.

The Committee also highlighted the strong documentation associated with the 2016 case, as well as the case in May 2019. The documentation was detailed and provided a comprehensive picture of the concerns and how they were addressed. The FAR case worker was able to share additional information about recommendations to the family about community-based services. Although that information was not documented, the Committee recognizes there is typically more work completed on a case than is actually documented.

Safe Sleep became a concerning intervention issue for the Department and Committee. With this in mind, more information about how this was addressed was gathered from the FAR case worker and supervisor. There was clear messaging provided by the Department that included multiple telephone and in-person conversations with the family. Safe Sleep literature was also provided. The Department offered the family a co-sleeper but when the worker later learned it was not an item the Department can purchase, the Department offered an alternative resource that would have provided a Safe Sleep environment.

With both the 2016 and May 2019 case, the Committee felt there was a missed opportunity due to the lack of contact between the Department and the older children's biological father. There were no documented efforts to contact the biological father in 2016. In May 2019, the FAR case worker was aware the biological father resided out of state, but did not recall having contact with him. The Committee speculated that contact with him could have provided a more well-rounded assessment not only of the children, but also the larger family dynamic.

During the May 2019 intervention, the mother reported that in addition to the supports the oldest child had in place through his school setting, he was also taking medications and seeing a counselor. The Committee would have liked to see the case worker make contact with the counselor to verify the child was in services. The Committee also felt that contact may have been an opportunity to gather information that could have impacted service planning for the child and family.

Findings

The Committee concludes the Department should have made contact with the oldest children's biological father for purposes of both the 2016 and 2019 interventions. This may have provided additional information about the children, their needs and the family dynamic. This also would have been consistent with the Department's efforts for fatherhood engagement. The Committee also finds the Department should have made contact with the counselor the mother said the oldest child was seeing for mental health services.

Recommendations

The Committee did not make any recommendations.