QUARTERLY CHILD REVIEW RCW 74.13.640 JULY – SEPTEMBER 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 July through September 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 Gov. Gregoire. The revised child fatality statute (RCW 74.13) became effective Oct. 22, 2011, and requires the department to conduct fatality reviews in cases where a child's death is suspected to be caused by abuse or neglect. This eliminated conducting formal reviews of accidental or natural deaths unrelated to abuse or neglect. The revised statute requires the department to consult with the Office of Family and Children's Ombuds (OFCO) if it is not clear that the fatality was caused by abuse or neglect. The department can conduct reviews of near-fatalities or serious injury cases at the discretion of the department or by recommendation of OFCO. The statutory revision allows the department access to autopsy and post mortem reports for the purpose of conducting child fatality reviews.

Quarter Three Report

This report summarizes information from completed reviews of two child fatalities and four near-fatalities[1] that occurred in the third 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 five of the six regions (DCYF divides Washington State into six regions).

DCYF Region	Number of Reports
Region 1	1
Region 2	1
Region 3	0
Region 4	1
Region 5	1
Region 6	2
Total Fatalities and Near Fatalities Reviewed During Third 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 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.

Child Fatality Reports for Calendar Year 2020			
Year	**Total Fatalities Reported to Date Requiring a Review**	**Completed Fatality Reviews**	**Pending Fatality Reviews**
2020	8	3	5

[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 Near-Fatality Reports for Calendar Year 2020			
Year	**Total Near-Fatalities Reported to Date Requiring a Review**	**Completed Fatality Reviews**	**Pending Fatality Reviews**
2020	18	10	8

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 Third Quarter Findings

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

- Four of the six cases referenced in this report were open at the time of the child's death or near fatal injury.
- One near fatality case involved a 15-year-old who nearly died from diabetic ketoacidosis. The case was reviewed due to the parents' negligence in managing this serious medical condition.
- In five cases referenced in this report, the children were less than 2 years old at the time of death or near fatal injury.
- There were no infant fatalities related to unsafe sleep environments. This has been a prevalent cause of death for infants in prior quarterly reports.
- There were two incidents this quarter involving children overdosing on narcotics and illegal drugs. One of the incidents resulted in the death of the child involved. This child was 15 months old at the time of death. The other overdose involved a 2-year-old. This was a near fatal incident.
- There were three incidents the prior quarter involving children overdosing on narcotics and illegal drugs. Two of the incidents involved children under 12 months of age.
- One near-fatal incident in the third quarter involved a CPS case that closed six months prior to the near fatal injury. A child fatality documented in this report occurred seven months after case closure. All other cases referenced in this report were open when the death or near fatal injury occurred.
- Two children referenced in this report were white, two were Native American, one was African American, and one was Pacific Islander.
- Substance abuse was an identified risk factor in four of the six cases. Pre-natal drug exposure was alleged in two of the cases. Medical neglect was a significant risk factor in two cases. Domestic violence, mental health, and neglect (lack of proper 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 fatality case, there were 15 reports made regarding the family prior to the death of the child. In a near fatality case, there were 11 prior reports on the family. In one near fatality case, there were two prior reports to DCYF intake on the family. In three cases, there was one intake report on the family prior to the critical incident.
- Due to the small sample of cases reviewed, no statistical analysis was conducted to determine relationships between variables.

Exhibit A

Child Fatality Reviews

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

Exhibit A contains the following child fatality reviews from the third quarter of 2020:

- S.R. Child Fatality Review
- A.H. Child Fatality Review

CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

September, 2020

Washington State Department of CHILDREN, YOUTH & FAMILIES

Contents

September, 2020

Full Report

Child

- S.R.

Date of Child's Birth

- RCW 74.13.515, 2018

Date of Fatality

- March, 29 ,2020

Child Fatality Review Date

- July 15, 2020

Committee Members

- Elizabeth Bokan, J.D., Office of the Governor Children's Ombuds
- Cassey Aranda, Case Manager Supervisor, Yakama Nation Nak Nu We Sha Program
- Cassie Anderson, Aftercare Program Manager, The Healing Lodge of the Seven Nations
- Linda Adkinson, Tribal Liaison and Social and Health Program Consultant, Department of Children, Youth, and Families Headquarters
- Nicole Labelle, Region 1 Programs Administrator, Department of Children, Youth, and Families

Facilitator

- Cheryl Hotchkiss, Critical Incident Review Specialist, Department of Children, Youth, and Families

Executive Summary

On May 10, 2020, the Department of Children, Youth, and Families (DCYF) convened a Child-Fatality Review (CFR) [1] to assess DCYF's service delivery to S.R.[2] and RCW 7 family. The child's initials are used throughout this report to maintain confidentiality. The mother Samantha Tainewasher, other adults in the home and Calvin Hunt are identified by name because they have been charged with committing a crime associated with the death of S.R.[3]

On March 29, 2020, hospital personnel called Child Protective Services (CPS) to report the death of 15-month-old S.R., who was brought to the hospital by ambulance. At the time of RCW 7 arrival RCW was not breathing. While at the family residence and before being transported by ambulance to the hospital, law enforcement administered CPR to S.R. Soon after RCW 7 arrival to the hospital, S.R. was pronounced dead. At the time of death, the cause of death was undetermined. The mother reported to officials that S.R. had been sick for the last few days and that RCW was last observed awake and alert about one hour before RCW was found unresponsive. The mother and other adults in S.R.'s home reported to officials that they immediately called 911 after they discovered S.R. was unresponsive. Based on toxicology reports obtained by the coroner in April, 2020, the coroner concluded the cause of death was due to a fentanyl overdose. Both the mother and her friend who was residing in the home are being considered for homicide-related charges.

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 S.R. or RCW 74 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 DCYF area administrator, the CPS social worker, the Family Voluntary Service (FVS) worker, and the FVS supervisor. The CPS supervisor was out of the office on the date of the CFR.

Case Overview

Prior to the birth of S.R., the mother had RCW 13.50.100 involving two different partners and six older children, one of whom is now an adult. Not including the child who is now an adult, three of the children RCW 13.50.100 and the two oldest children RCW 13.50.100. The children RCW 13.50.100 before S.R.'s death. The documented historical concerns relate to the following: RCW 13 50.100

[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 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 to replace or supersede investigations by courts, law enforcement agencies or other entities with legal responsibility to investigate or review some or all the circumstances of a child's fatal injury or near-fatal injury. Nor is it the function or purpose of a CFR to recommend personnel action against DCYF employees or other individuals. "The restrictions [described in this paragraph, and the paragraph immediately above,] do not apply in a licensing or disciplinary proceeding arising from an agency's effort to revoke or suspend the license of any licensed professional based in whole or in part upon allegations of wrongdoing in connection with a minor's death or near-fatality reviewed by a child fatality or near-fatality review team." RCW 74.13.640(4)(d).

[2] The names of the children are subject to privacy laws. See **RCW 74.13.500**.

[3] S.R.'s parents and caregivers are named in this report because they have been charged with a crime involving the circumstances described in the report maintained in DCYF's case and management information system. See **RCW 74.13.500**.

RCW 13.50.100 ,RCW 13.50.100, RCW 13.50.100 ,RCW 13.50.100, RCW 13.50.100, RCW 13.50.100 .

S.R. was born in RCW 74.13.515 2018. On RCW 74.13 515, 2018, the local hospital called DCYF to report that the mother tested positive for RCW 74.13.520. Despite this positive test in RCW 74.13.515, the mother's urine sample tested negative for illegal substances in RCW 74.13.515, upon S.R.'s birth. However, the attending pediatrician was concerned the mother's urine specimen may have been altered because it was not at body temperature and the color was clear. An umbilical cord tissue drug test was ordered by the hospital. DCYF assigned the case for CPS intervention and the intake report was sent to the Tribal Prosecutor's office for the tribe with whom the family is affiliated. Tribal social and health services was not contacted. The mother agreed to services with DCYF and the case was transferred to Family Voluntary Services (FVS).[4]

On December 17, 2018, a referral to **SafeCare®** [5] was made. The provider met with the mother on a few occasions. Most of these meetings occurred outside of the mother's home. The mother failed to fully participate in services and the assigned FVS worker and supervisor became concerned she was using illicit substances. This raised additional concerns for the safety of S.R. DCYF scheduled a Local Indian Child Welfare Advisory Committee (LICWAC[6]) meeting and made contact with the tribe seeking the tribe's participation. At the meeting the mother again agreed to services, including inpatient treatment in RCW 74.13.515. DCYF verbally verified that the mother arrived at the treatment facility, was completing treatment objectives and was sober. It was documented in the treatment provider notes that RCW 74 . While the mother was in the RCW 74.13.515 inpatient facility, the assigned worker did not complete health and safety visitations[7] or make a courtesy supervision[8] referral. In June, 2019, a Native American Inquiry Referral (NAIR)[9] request was made, and in July 2019, the case was closed. DCYF received no other reports until S.R.'s Death in March 2020.

Committee Discussion

The Committee spent considerable time discussing Safecare. The Committee agreed the home-based service model should have occurred primarily in the home. The Committee also agreed that model fidelity was not occurring. The Committee discussed Family Impact Network (FIN).[10] FIN is currently responsible for the DCYF service contracts. FIN began maintaining service contracts for the local office in May 2020. The Committee wondered who holds the providers accountable to the model standards. In the past DCYF, employed program managers who monitored such contracts. However, these positions are no longer in place in many DCYF regions. The Committee discussed that unless a worker or manager

[4] "Family Voluntary Services (FVS) allows parents to voluntarily engage in services to increase their protective capacities and meet the child's safety, health and well-being needs." See **https://www.dcyf.wa.gov/practices-and-procedures/3000-family-voluntary-services-fvs**.

[5] **SafeCare® "**is an evidenced-based home visitation program aimed at reducing child maltreatment among families with a history of maltreatment or risk-factors for maltreatment. SafeCare is a weekly home based service lasting 18-20 sessions for families with a child from age birth to 5 years. The expected outcome is to increase parents' understanding and management of child illness and injuries; increase home safety; and improve and enhance safe parenting skills. The provider reviews the safety plan each week." **https://www.dcyf.wa.gov/services/child-welfare-providers/evidence-based-practices**

[6] LICWAC stands for *Local Indian Child Welfare Advisory Committee*. "The Local Indian Child Welfare Advisory Committees (LICWAC) serve in an advisory capacity to Division of Children and Family Services (DCFS) caseworkers and supervisors by recommending culturally appropriate case plans and services for Indian families. LICWACs offer assistance in the case management of these cases with respect to the needs and rights of Indian children and their families. LICWAC recommendations are included in the court report. LICWAC members are considered volunteers, and are subject to the same confidentiality requirements as Children's Administration (CA) staff." **https://www.dcyf.wa.gov/indian-child-welfare-policies-and-procedures/10-local-indian-child-welfare-advisory-committees**

[7] See **https://www.dcyf.wa.gov/4400-concurrent-tanf-benefits/4420-health-and-safety-visits-children-and-youth-and-monthly-visits**

[8] See **https://www.dcyf.wa.gov/4400-concurrent-tanf-benefits/4430-courtesy-supervision.**

[9] See **https://www.dcyf.wa.gov/indian-child-welfare-policies-and-procedures/3-inquiry-and-verification-childs-indian-status.**

[10] See **http://familyimpactnetwork.org/.**

is aware of the contract requirements and makes a complaint, model fidelity may not be occurring due to lack of monitoring.

The Committee noted missed opportunities to gather additional clarifying information from law enforcement, schools, treatment providers, S.R.'s six older siblings and from other sources within the family's community, including tribal members and neighbors. The Committee discussed the importance of teaming with tribal social and health services to gather information from the tribal community, noting cultural intricacies of which DCYF may not be aware or understand. The Committee believes DCYF should have contacted tribal social and health services earlier, and arranged a LICWAC, and made a NAIR request. The Committee believes it may have improved engagement with the mother, and her engagement into services. This is an important reminder for practice improvement.

The Committee finds that while the mother was in treatment, the local office failed to make a courtesy supervision referral to the RCW 74.13.515 office and did not complete health and safety checks. The Committee views these issues as missed opportunities to provide the family with the level of oversight and support that may have provided an elevated level of intervention. The Committee believes this was a high risk case due to the mother's historical issues, and, to complete a global assessment, an in-person assessment is essential. The Committee believes the CPS and FVS assessments met the minimum requirements for assessing safety. However, the assessment could have been more comprehensive.

The Committee agrees that during the investigation the CPS worker did not accurately complete the Structured Decision Making assessment (SDM).[11] Despite this, the Committee agrees the CPS worker's referral for services was the proper course of action. The FVS supervisor and FVS workers reported they believed the case needed to close within a six-month time frame and relied solely on the LICWAC plan as the official case plan. The official case plan was not included in the Comprehensive Family Evaluation (CFE).[12] The Committee believes there is a lack of understanding of related policies and timeframes. The Committee noted that if warranted, and with administrator approval, FVS cases are authorized to remain open for a longer period of time than typically authorized.

Some Committee members discussed secondary trauma and the challenges DCYF staff face when responding to child fatalities or near-fatalities. Some Committee members also felt it pertinent to document and recognize the daily work-related emotional and mental hardships DCYF staff experience. The Committee discussed how traumatizing situations and incidents can result in grief and other forms of trauma for DCYF staff. For purposes of assisting DCYF staff, DCYF should consider a response to critical incidents that mirrors law enforcement practices. This possible response however, is not an official recommendation.

Findings

The Committee did not identify any critical errors. DCYF's actions and inactions with S.R. and RCW 7 family were not a contributing cause to S.R.'s death.

The Committee found that model fidelity was lacking with a contracted in-home service provider. There is questionable oversight and accountability to ensure providers maintain model fidelity.

[11] "…By completing the SDMRA following the Safety Assessment, the worker obtains an objective appraisal of the risk to a child. The SDMRA informs when services may or must be offered." See **https://www.dcyf.wa.gov/practices-and-procedures/2541-structured-decision-making-risk-assessmentrsdmra.**

[12] See **https://www.dcyf.wa.gov/practices-and-procedures/3000-family-voluntary-services-fvs.**

The Committee found that the staff and supervisors were unsure about policies related to initial contact and engagement with the tribe, courtesy supervision, health and safety and FVS policies.

Recommendations

For purposes of program fidelity, DCYF should assess contract oversight processes and consider program fidelity audit solutions. DCYF should consider providing DCYF staff with a tip sheet or training that provides staff with an awareness of in-home contracted provider requirements, and a process for staff to submit concerns to address model fidelity issues.

The local office should work with the regional program managers to review policies that pertain to initial contact and engagement with the tribe, courtesy supervision, health and safety and FVS time frames.

CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

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Nondiscrimination Policy

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

Full Report

Child

- A.H.

Date of Child's Birth

- [redacted] 2019

Date of Fatality

- January 2020

Child Fatality Review Date

- March 26, 2020

Committee Members

- Patrick Dowd, JD, Office of the Family and Children's Ombuds, Director
- Yaquelin Rosas, DCYF, Quality Practice Specialist Region 2
- Cori Schumacher, Olympia Police Department, Detective
- Jennifer Gorder, DCYF, Quality Practice Specialist Region 6

Facilitator

- Libby Stewart, DCYF, Critical Incident Review Specialist

Executive Summary

On March 26, 2020, the Department of Children, Youth, and Families (DCYF)[1] convened a Child Fatality Review (CFR)[2] to assess DCYF's service delivery to A.H. and 74.13.51 mother, Erin Hammonds.[3] A.H. will be referenced by 74.13.51 initials throughout this report.

On January 29, 2020, the assigned DCYF Family Voluntary Services (FVS) worker received a telephone call from a DCYF Promoting First Relationships (PFR) contracted services provider. The provider called to report that A.H. had died. 13.50.100 called in an intake to DCYF and the intake was screened out due to no known or suspected abuse related to A.H.'s death. However, on February 5, 2020, information was reported to intake that during A.H.'s autopsy the medical examiner (ME) found three skull fractures. Based on the new information this intake was screened in for a Child Protective Services (CPS) investigation. The investigation is currently waiting for the completed ME report and law enforcement report. Erin Hammonds has been charged with second degree assault of a child, second degree murder, first degree assault of a child domestic violence, and fourth degree assault domestic violence.

The CFR Committee (Committee) includes members with relevant expertise selected from diverse disciplines within the community. A representative from the substance use disorder community was unable to attend the review. Committee members have not had any involvement or contact with A.H. or 74.13.51 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 74.13.515 2019 intake, the case worker's supervisor, the FVS case worker and the FVS worker's supervisor.

Case Overview

Erin Hammonds first came to the attention of the Department of Social and Health Services (DSHS) Children's Administration (now known as DCYF), on 74.13.515 2009. According to the intake Ms. Hammonds RCW 13.50.100 . The 13.50.100 . Ms. Hammonds was engaged in 13.50.100 . In addition to A.H. and child who was born in 74.13.515 2009, Ms. Hammonds is the mother of two other children. Between June 6, 2009 and May 27, 2014 DSHS received five intakes involving Ms. Hammonds and her children. The allegations included neglect and substance abuse. There was a 13.50.100

[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)]." 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.

[3] A.H.'s mother, Erin Hammonds, has been criminally charged with crimes related to 74.13.515 death and is therefor named in this report.

13.50.100 . The rest of the allegations were made against Ms. Hammonds. There was a 13.50.100

The next intake received by DCYF was on August 16, 2019. The intake alleged that Ms. Hammond 13.50.100 . After 13.50.100 . She 13.50.100 . Ms. Hammonds was 13.50.100 . The referent also reported that Ms. Hammonds not only struggled with substance use but also with an untreated mental health diagnosis. This intake 13.50.100 .

On 74.13.515, 2019, an intake was received alleging Ms. Hammonds had given birth to 74.13.515, A.H.. A.H. was born 74.13.520 .[4] Ms. Hammonds had a 74.13.520 due to her current treatment for substance misuse. Ms. Hammonds also reportedly had a lengthy substance misuse history. The referent later reported that Ms. Hammonds' three other children were in the care and custody of relatives. In addition, she had multiple mental health diagnoses. Ms. Hammonds completed a three-month treatment program and a 30 day inpatient treatment program through 74.13.520 for pregnant mothers. Ms. Hammonds also completed an intake with 74.13.520 for her mental health treatment, secured housing and had a Parent-Child Assistance Program (PCAP) worker.[5] This intake was assigned for a CPS Risk Only assessment.[6]

The CPS case worker made contact with Ms. Hammonds and A.H. at the hospital. While at the hospital the alleged father arrived. The CPS case worker spoke with both parents and notified them that a Family Team Decision Meeting (FTDM) would be scheduled the following week to discuss the safety of the baby and whether 74.13.51 can safely remain with the mother.

On October 19, 2019, an FTDM was held. The mother, relatives and community support professionals participated in the meeting. Based on the information shared at the meeting it was decided that A.H. could safely live with 74.13.51 mother after being discharged from the hospital. At the meeting Ms. Hammonds agreed to engage in FVS, including providing voluntary random urinalyses. Ms. Hammonds engaged in all requested services and provided clean urinalyses. Ms. Hammond remained in consistent communication with her DCYF case workers.

On October 29, 2019, the CPS case worker walked through Ms. Hammonds' residence to make sure it was suitable for A.H.. The CPS case worker did not observe any hazards. The case worker discussed Safe Sleep[7], Period of Purple Crying[8], shaken baby syndrome and abusive head trauma. The CPS case worker also conducted a safe sleep assessment, created an in-home safety plan and Plan of Safe Care.[9]

[4] 74.13.520 .
[5] See: http://depts.washington.edu/pcapuw/
[6] "Screen in CPS Risk Only reports when a child is at imminent risk of serious harm and there are no CA/N allegations." See: https://www.dcyf.wa.gov/practices-and-procedures/2200-intake-process-and-response.
[7] See https://www.cdc.gov/vitalsigns/safesleep/index.html.
[8] See: http://www.purplecrying.info/.
[9] Plan of safe care, see: https://www.dcyf.wa.gov/1100-child-safety/1135-infant-safety-education-and-intervention.

On November 5, 2019, the CPS case worker spoke with a physician who was familiar with the mother and her substance abuse treatment and was going to be the primary care physician for A.H. The doctor shared details about the treatment provided to the mother before A.H. was born, and did not express any concerns about A.H. being discharged to Ms. Hammonds' care.

On November 6, 2019, A.H. was discharged home to [redacted] mother. All safety plan participants agreed to, and signed the in-home safety plan, which was provided to the hospital. The CPS case worker referred the mother to an in-home service provider (Promoting First Relationships) to support her during the voluntary services portion of her involvement with DCYF.

During an unannounced home visit on December 2, 2019, the CPS case worker notified the mother that her case would be transferred to FVS. The CPS case worker did not observe any concerns during this unannounced home visit. On December 17, 2019, the FVS worker arrived at Ms. Hammonds' home for their scheduled meeting. They discussed Ms. Hammonds' services and support system. No concerns were identified by the FVS case worker.

On January 21, 2020, the FVS case worker arrived at Ms. Hammonds' home for the scheduled health and safety visit. The PFR provider was also present. They discussed Ms. Hammonds' substance use outpatient treatment and how the current service provider was not allowing her to bring [redacted] to the sessions. Without child care, Ms. Hammonds could not attend her treatment sessions. There was discussion about contacting one of the prior providers to see if she could change her treatment to allow her to bring A.H. with her to sessions with the other provider. The mother agreed to contact the previous provider and change back to substance use treatment with that previous provider. The FVS worker did not observe any concerns. Ms. Hammonds discussed how she practiced safe sleep with [redacted] and the sleep environment was observed.

On January 29, 2020, DCYF was notified of A.H.'s death. The intake was screened out due to no indication of child abuse or neglect. However, subsequent information received after the autopsy required a new intake to be generated and a CPS investigation to be initiated.

Committee Discussion

The Committee discussed that Ms. Hammonds' sobriety was fairly new and she has a lengthy substance use history. Despite this history however, she was following a treatment plan. The Committee discussed that DCYF is required to provide reasonable efforts prior to requesting that a child be removed from a parent, unless the child is in imminent danger. The Committee agreed it is a significant challenge for DCYF workers to balance all aspects of a case (e.g. history, current actions by the parent, bonding between child and mother, etc.) to determine whether a child should remain in a parent's care and custody, or if DCYF should request the child be removed. This is especially challenging to DCYF workers when the decision is made to not request removal and a child death occurs. The Committee members discussed these aspects while trying to avoid the challenge of hindsight bias.

Some Committee members discussed their preference to have the DCYF staff look into whether it would have been possible for Ms. Hammonds and [redacted] to live with another relative or sober support person. However, it was also discussed that Ms. Hammonds had successfully completed inpatient treatment and this was not identified as a need by her service providers. Based on the conversation the

FVS worker heard during the last health and safety visit, the Committee discussed whether there were concerns regarding the consistency of her outpatient treatment and support for her sobriety.

The Committee also discussed that after the Family Team Decision Meeting (FTDM) occurred it would have been appropriate for the DCYF staff to request the mental health evaluation completed by Ms. Hammonds, as well as further progress verification directly from the treatment providers. Another contact that could have been supportive to the ongoing assessment of safety would have been contact with the relatives who were safety plan participants. The DCYF staff did have contact with the PFR, maternity support services worker and Parent-Child-Assistance-Program worker.

The Committee identified positive aspects of this case as well. While understanding that Ms. Hammonds has a significant history of substance abuse the Committee believes the decision to allow the case to move forward with FVS was acceptable given the demonstrated positive improvement made by Ms. Hammonds. The Committee also appreciated the statements made by the CPS supervisor. The CPS supervisor stated she went into the FTDM believing that based on the historical information, DCYF should file a dependency petition requesting the removal of A.H. from [redacted] mother. However, after attending the FTDM and listening to the community professionals and Ms. Hammonds regarding the positive changes and progress she made, she agreed with the decision to move forward with FVS. This was also supported by statements made by the FVS supervisor. The Committee appreciated the FVS supervisor's presentation about the office standards of practice regarding case transfers from CPS to FVS, the FVS supervisor's ability to question whether a transfer is appropriate and the FVS supervisor's ability to intervene if he believes the transfer is not appropriate.

Findings

The Committee made a finding that due to A.H.'s age and pursuant to DCYF Practices and Procedures Policy No. 4420, two health and safety visits per calendar month were required. The policy says one of the two visits may be conducted by a contracted provider, such as the PFR provider. While it was understood that a contracted service provider was in regular contact and making home visits with A.H. and [redacted] mother, this was not documented in the case notes.

Recommendations

The Committee did not make any recommendations.