WASHINGTON STATE
Department of
Children, Youth, and Families

QUARTERLY CHILD FATALITY REVIEW
RCW 74.13.640
OCTOBER – DECEMBER 2018

April 2019

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[1] The child fatality reviews referenced in this Quarterly Child Fatality Report **are subject to public disclosure** and posted on the DCYF website: https://www.dcyf.wa.gov/practice/oiaa/reports/child-fatality.
Near-fatality reports **are not subject to public disclosure** and **not** posted on the public website nor are the reports included in this report.

EXECUTIVE SUMMARY

This is the Quarterly Child Fatality Report for October through December 2018, provided by the Department of Children, Youth, and Families (DCYF) to the Washington State Legislature. RCW 74.13.640 requires DCYF to report on each child fatality review conducted by the department and provide a copy to the appropriate committees of the legislature:

Child Fatality Review — Report

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

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

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

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

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

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

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

This report summarizes information from completed reviews of six child fatalities and one near fatality that occurred in the fourth quarter of 2018. All child fatality review reports can be found on the DCYF website: https://www.dcyf.wa.gov/practice/oiaa/reports/child-fatality.

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

Region	Number of Reports
1	2
2	
3	2
4	2
5	
6	1
Total Fatalities Reviewed During Fourth Quarter 2018	**7**

This report includes information from child fatality and near-fatality reviews conducted following a child's death or near-fatal injury that was suspicious for abuse and neglect and the child had an open case or received services from the DCYF within the 12 months prior to their 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 charts below provide the number of fatalities and near-fatalities reported to DCYF, the number of reviews completed, and those that are pending for the calendar year 2018. 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 Reviews for Calendar Year 2018			
Year	**Total Fatalities Reported to Date Requiring a Review**	**Completed Fatality Reviews**	**Pending Fatality Reviews**
2018	18	14	4

Child Near-Fatality Reviews for Calendar Year 2018			
Year	**Total Near-Fatalities Reported to Date Requiring a Review**	**Completed Near-Fatality Reviews**	**Pending Near-Fatality Reviews**
2018	4	2	2

NOTABLE FOURTH QUARTER FINDINGS

Based on the data collected and analyzed from the six fatalities and one near-fatality during the fourth quarter, the following were notable findings:

- Five child fatality cases and one near fatality case referenced in this report were open at the time of the child's death or near fatal injury.
- In five of the seven cases referenced in this report, the children were under the age of 6 months at the time of their deaths.
- Four of the six child fatalities occurred in unsafe sleep environments.
- Safe sleep was discussed with the caregivers prior to the death of the children in their care.
- One child fatality occurred in another state and the child welfare case had been closed for 8 months.
- In two cases, the children died from blunt force trauma inflicted by caregivers and parents.
- In one case, the child died from injuries inflicted by non-biological caregivers. Custody was turned over to the perpetrators by the custodial parent after DCYF's case closure. This family lived in another state when the child died.
- Four children referenced in this report were Caucasian, two were African American and one was Native American.
- Substance abuse was an identified risk factor in six of the seven cases. Domestic violence, mental health concerns, in utero drug exposure and prior termination of parental rights were other significant risk factors identified in several of the cases in this report.
- DCYF received intake reports of abuse or neglect in each of the cases in this report prior to the death of the child. In two of the fatality cases, there was only one prior report made regarding the family. In the other fatality cases, the department received two, four, eight and nine intake reports prior to the children's deaths. In the one near-fatality case, there were three prior reports made regarding the family.
- Due to the small sample of cases reviewed, no statistical analysis was conducted to determine relationships between variables.

EXHIBIT A: CHILD FATALITY REVIEWS

The child fatality reviews referenced in this Quarterly Child Fatality Report are subject to public disclosure and posted on the DCYF website: https://www.dcyf.wa.gov/practice/oiaa/reports/child-fatality.

- **T.K. Child Fatality Review**
- **S.S. Child Fatality Review**
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WASHINGTON STATE
Department of
Children, Youth, and Families

CHILD FATALITY REVIEW

February 2019

www.dcyf.wa.gov

FULL REPORT

CHILD
- T.K.

DATE OF CHILD'S BIRTH
- RCW 74.13.515 2018

DATE OF FATALITY
- July 2018

CHILD FATALITY REVIEW DATE
- November 8, 2018

COMMITTEE MEMBERS
- Mary Moskowitz, JD, Ombuds, Office of the Family and Children's Ombuds
- Amy Boswell, Child Protective Services (CPS) Program Manager, Department of Children, Youth, and Families
- Lindsey Barcklay, MSW, LICSW, CDP, CMHS, Mental Health Program Manager, Domestic Abuse Women's Network
- Kellie Rogers, Director of Advocacy Programs, Domestic Abuse Women's Network
- Anna Tran, MSW, Family Voluntary Services Supervisor, Department of Children, Youth, and Families

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

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

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

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

EXECUTIVE SUMMARY

On November 8, 2018, the Department of Children, Youth, and Families[1] (DCYF) convened a Child Fatality Review (CFR) to assess DCYF's practice and service delivery to T.K. and RCW 7 family.[2] T.K. will be referenced by RCW 74 initials throughout this report.

On July 5, 2018, DCYF received a call stating RCW 74.13. month-old T.K. had passed away. This intake was screened in for a Child Protective Services (CPS) investigation. At the time of RCW 7 death, T.K. lived with RCW 7 mother and maternal grandmother. There was an open Family Voluntary Services (FVS) case with DCYF at the time of RCW 7 death.

The CFR Committee (Committee) included members selected from diverse disciplines within the community with relevant expertise including individuals from the Office of the Family and Children's Ombuds, domestic violence advocacy, substance abuse, and child welfare. The Committee members did not have any involvement or contact with T.K. or RCW 7 family.

The Committee interviewed two DCYF staff. At the time of the CPS investigation immediately after the child's birth, another DCYF employee was providing coverage for the CPS supervisor. That person and the FVS supervisor were interviewed by the Committee. Due to the Committee's responsibility to focus on events prior to the critical incident, the Committee chose not to interview the CPS worker who investigated the fatality. The CPS worker and FVS worker both ended their employment with DCYF prior to this review.

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

FAMILY CASE SUMMARY

On RCW 74.13.515, 2018, DCYF received an intake following T.K.'s birth because the mother told hospital staff that she used RCW 13.50.100 during the pregnancy and she was not currently connected with any treatment programs. Both the mother and T.K. tested RCW 74.13.520 at RCW 74 birth. T.K.'s mother told hospital staff that she uses drugs to RCW 13.50.1. It was also reported that T.K.'s father uses drugs, there is domestic violence between the parents, and a restraining order had been filed by T.K.'s mother against T.K.'s father. This intake was assigned as a CPS Risk Only investigation.[3] This is the first child for both parents.

The assigned CPS worker made contact with the mother and T.K. the following day at the hospital. A Family Team Decision Making (FTDM) meeting was scheduled for two days later on RCW 74.13.515, 2018, and the hospital agreed to delay T.K.'s discharge until after that meeting.[4]

The FTDM occurred as scheduled on RCW 74.13.515, 2018, and the decision was to allow the mother and baby to discharge to the maternal grandmother's home with voluntary services to start. The mother stated she self-referred for an assessment by a substance abuse treatment provider and would be starting intensive outpatient (IOP) treatment four days later on RCW 74.13.515, 2018. The mother is required to attend three classes a week and provide weekly urinalysis, attend Narcotics Anonymous groups, and enroll in parenting classes as part of her IOP. The father reported he had been ordered, by a court not through DCYF, to take anger management and domestic violence classes. The CPS worker agreed to make a public health nurse (PHN) referral within five days of the FTDM. Both parents agreed to complete random urinalyses for DCYF and the maternal grandmother agreed to let DCYF know if the mother presents a danger to T.K., does not provide adequate care for T.K., or relapses.

On March 12, 2018, the CPS worker completed a safety plan with the mother, maternal aunt, and maternal grandmother. That same day, the CPS worker conducted a walkthrough of the maternal grandmother's home. After the safety plan and walkthrough occurred, the CPS worker contacted the hospital to let them know they could discharge T.K. to RCW 7 mother.

Despite deciding at the FTDM to engage the family in voluntary services, the case did not transfer to FVS until April 2018. On April 10, 2018, the FVS worker called the mother and left a voicemail message requesting a return call. The FVS worker did this again on April 11 but did not receive a return call from the mother either time. On April 16, 2018, the FVS reached the mother by telephone. The mother reported she was looking into domestic violence (DV) shelters because her mother's home was too crowded. The mother also reported she needed a DV advocate. The FVS worker told the mother she would bring resources with her to the first home visit. The mother also reported she considered dropping the restraining order against the father so they could co-parent, but she wanted to make sure he was no longer using drugs before taking this step. The mother also reported that she would prefer to do inpatient treatment but was still attending IOP. The FVS worker also spoke with the grandmother who asked for a letter to support the addition of T.K. and RCW 74 mother in the grandmother's home due to RCW 13.50.100 housing restrictions.

On April 19, 2018, the FVS worker conducted her first home visit with T.K., RCW 74 mother, and RCW 74 maternal grandmother. When she arrived, the worker observed T.K. asleep on the mother's mattress. The worker asked if anyone had discussed safe sleep to which the mother responded yes, but the mother also indicated that T.K. would not sleep in RCW 74 bassinet. The FVS worker

[3] https://www.dcyf.wa.gov/practices-and-procedures/2200-intake-process-and-response
[4] https://www.dcyf.wa.gov/1700-case-staffings/1720-family-team-decision-making-meetings

discussed the risk of suffocation and death related to co-sleeping and bed sharing. They also discussed the mother's feelings of RCW 13.50.100 and RCW 13.50.100 The mother reported that she was receiving mental health and substance abuse treatment. The mother also provided the contact information for the child's pediatrician. The FVS worker and the mother discussed how the PHN met with the mother earlier that same day. The FVS worker provided the mother with 20 bus tickets, the letter requested for the maternal grandmother for RCW 13.50.100 housing, DV resources, housing resources, and supportive resources for T.K.'s mother to engage in groups with other new mothers to build healthy relationships.

On April 20, 2018, the FVS worker called the father and left him a message asking him to return the telephone call, but the FVS worker never heard back. On May 3, 2018, the FVS worker received a call from T.K.'s mother stating she and T.K. were in need of emergency shelter because the maternal grandmother was verbally abusive. The FVS worker provided the mother with a resource to call and the worker called the YWCA and discussed shelter options with the program manager. The FVS worker went out to the home that same day to talk with the mother and conducted a health and safety visit. During this visit, the mother reported she obtained a new Pack 'n Play that T.K. enjoyed sleeping in. The worker and the mother again went over safe sleep, and the mother reported she was no longer bed-sharing with her RCW 74.1 and that she was getting more sleep than she had been since the child was born.

The FVS worker was able to make contact with the father on May 4, 2018. He agreed to FVS services at that time. The FVS worker met with T.K.'s father on May 7, 2018. They discussed the no-contact order between the parents, that he wanted to set up visits with his RCW 74.13 his lack of follow through with the requested urinalysis tests, and that the worker recommended he complete a chemical dependency assessment. Six days later, the worker was notified that T.K.'s father had been arrested, which the worker confirmed by reviewing jail roster information online. T.K.'s mother told the FVS worker she was sad about the father's arrest and the worker discussed the mother's mental well-being with her and suggested activities she could do to cheer herself up. The mother also discussed other stressors within her household with the FVS worker pertaining to her sister and niece. The FVS worker provided guidance to the grandmother regarding this issue.

Between May 10 and May 23, 2018, the FVS worker provided the mother with more community resources to support healthy parenting including community events and domestic violence supports. The FVS worker also communicated with the PHN regarding T.K. and RCW 74 mother. The PHN stated she did not have any concerns for the family at that time. The worker also reviewed the inmate roster and learned that T.K.'s father had been released from jail. She then texted the father with information for a chemical dependency assessment and requested the father's contact information and an email address.

On May 24, 2018, the FVS worker conducted another health and safety visit. During this visit, the FVS worker observed T.K. gently shake while RCW 7 was sitting up. The mother stated RCW 74 tremors had ended a month prior but due to increased fussiness and the observed tremors by the FVS worker, the mother reached out to the PHN who stated it may just be RCW 74 age. During the health and safety visit, the mother also said she connected with a DV advocate but had not yet completed her mental health assessment, which contradicted the mother's prior statements to the FVS worker indicating she had completed the assessment. The mother further explained to the FVS worker how she has been avoiding the mental health assessment because she did not like to talk about her trauma history. The worker and mother then completed the FVS case plan. The FVS worker followed up with the mother regarding her mental health assessment on June 4, 2018, at which point the mother stated she still had not completed it yet. The FVS worker contacted the mother's chemical dependency counselor and asked for his help in encouraging the mother to complete the mental health assessment.

On June 16, 2018, the FVS worker contacted the mother again, who at that point indicated she had completed her mental health assessment. They also discussed other case activities. On June 18, the worker completed another health and safety visit at the mother's home, and the FVS worker reported no concerns for the child's safety.

During a conversation between the FVS worker and the mother on June 27, 2018, the mother indicated she was considering moving to Oregon. The mother stated she had a positive and supportive family there. After speaking with the mother, the FVS worker attempted to contact the father and left a voicemail message asking for a return call. The FVS worker also went to the mother's home later that same day to conduct another health and safety visit. When the worker arrived, the mother and T.K. were both asleep. Based on what the FVS worker observed, they had both fallen asleep while the mother was breastfeeding. When the FVS worker discussed this with the mother after she woke up, the mother stated this happens often but generally, the maternal grandmother comes in and will move the child to RCW 7 own bed. The FVS worker expressed that falling asleep with the child while breastfeeding was dangerous and could lead to accidental suffocation of T.K. The mother shared that she had decided to move to Oregon at the beginning of July. The FVS worker addressed how the mother could obtain services in Oregon.

On July 5, 2018, T.K.'s mother texted the FVS worker to notify her that T.K. had passed away. An intake was created regarding the child's death, and it was assigned for a CPS investigation. The mother reported she had been bed sharing with T.K. and when she woke up she found RCW 74.1 with blood and foam coming out of RCW 7 mouth and RCW 7 was not breathing. The mother reported that she then called emergency services. The mother reported that the Medical Examiner said T.K. may have had a seizure while sleeping. The mother further stated she did not roll over on RCW 74. and that she believed RCW 7 death was not her fault. The family preservation services (FPS) worker was there with the family. The FVS worker spoke with the FPS worker and they discussed safety planning regarding the mother and maternal grandmother's mental well-being.

On July 11, 2018, the assigned CPS investigator made contact with the mother and maternal grandmother at their residence. They discussed T.K.'s passing and supports for the mother and grandmother. The mother stated that when she went to bed the night before the child's death, she had brought T.K. to bed with her to breastfeed. She stated this was a regular occurrence. It was also regular practice for the grandmother to come in during the night and remove T.K. from the bed and put RCW 74. in RCW 7 bed. However, this last evening the grandmother did not wake up and move T.K. from the mother's bed after the mother fell asleep.

The mother told the CPS investigator that she knew about safe sleep and that the FVS worker and PHN both discussed it with her. The mother had also been given a Pack 'n Play so that she would have a separate sleep environment for T.K. The grandmother interrupted at one point during the mother's conversation with the CPS investigator stating that she felt the mother was being attacked for her sleep situation. The CPS worker tried to ask the mother about how she was coping with the child's death, but the mother started to withdraw. The CPS investigator subsequently ended the interviews. A founded finding for neglect and/or maltreatment was made against the mother regarding T.K.'s death.

COMMITTEE DISCUSSION

The Committee discussed many aspects of the case. The Committee highlighted the positive relationship between the FVS worker and the mother. The fact that the mother notified the FVS worker of T.K.'s passing showed that she trusted the FVS worker and had a good working relationship with her.

There was a discussion about how people or parties are notified of a critical incident on an open case, specifically how there was no notification provided to the PHN after T.K.'s death. As a result, the PHN unknowingly called the mother to make her next appointment after the child died. The Committee stated their hope was that all people who were working with the family (providers, legal parties, etc.) would receive notice so that there would not be a repeat of what occurred in this case.

The Committee struggled with the founded finding related to T.K.'s death. The Committee discussed that there is no law stating a person cannot bed share or co-sleep with their child. They agreed if other identified risk factors had been known, such as substance use the night before or medications which caused a parent to sleep deeply and not easily wake or sleeping on an air mattress, and that the parent or caregiver had been educated on the topic that then it might be appropriate to make the finding. However, in this case, there were no such documented risk factors. There is no documentation of whether the mother was even asked about the events the evening before the child died or asked whether she had consumed alcohol or used substances before breastfeeding the night before the child was found deceased. This part of the Committee's discussion is further addressed in the recommendation section below.

There was a lengthy discussion surrounding trauma-based training and interventions for the families that DCYF interacts with which are not provided to the Department's own staff. The Committee was very saddened to learn that the FVS worker had left her employment with DCYF related to this fatality and another critical incident, which both occurred within a very short period of time. The issue of turnover within DCYF was discussed and the Committee noted that DCYF should make changes regarding how business is conducted and staff are supported after a critical incident. The hope of the Committee was that when a critical incident occurs, staff are met with more trauma-informed support and that turnover related to critical incidents will decrease. This discussion also included the current option for staff to utilize Peer Support[5] and the Employee Assistance Program.[6]

Based on the CPS investigator's observation of the mother sleeping on an air mattress during the fatality investigation, the Committee discussed the following about this topic. The Committee acknowledged that the majority of CFRs involving an unsafe sleep element include at least one, if not numerous, discussions by the assigned DCYF staff with the parent or caregiver regarding safe sleep and ways to ameliorate identified unsafe sleep environments, yet many families who were provided this information still chose to bed share with their child. The Committee members discussed that offices purchase Pack 'n Plays for many families that DCYF interacts with. However, the Committee noted that they are not aware of DCYF offering to purchase mattresses when/if it is identified that a family uses air mattresses or other sleeping arrangements other than a bed. The Committee discussed that due to the high correlation of child fatalities of newborn/infant children and bed sharing, DCYF should consider making a concerted effort to assist families in obtaining non-inflated mattresses.

The Committee discussed that the FVS policy says if a case is being transferred from CPS to FVS, the case must transfer within three days.[7] In this case, that did not occur because the CPS investigative casework was not yet completed when everyone agreed to voluntary services during the FTDM. The Committee noted that the CPS worker had not completed the required work in order for the case to transfer to the FVS worker, and the Committee discussed how it would be difficult for an FVS worker to receive an incomplete case. But the Committee also discussed its concern for a delay in services to the family since the case was not transferred within three days. Also discussed was the high turnover this office had experienced during the

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[5] http://intranet.dcyf.wa.gov:8090/drupal-8.4.0/personnel/peer-support
[6] https://des.wa.gov/services/hr-finance-lean/employee-assistance-program-eap
[7] https://www.dcyf.wa.gov/practices-and-procedures/3000-family-voluntary-services

time period the case was open for services, and staff in the CPS units were receiving two to three intakes per day. The Committee noted this level of new assignments was not sustainable. The office has been able to stabilize more since that time, but the Committee acknowledged that the turnover and case assignment, prior to the fatality, was an infeasible workload.

FINDINGS

The Committee did not identify any critical errors made by DCYF during the CPS investigation or the FVS case. However, the Committee discussed areas not related to T.K.'s passing in which Department practice could be improved. Those recommendations are addressed below.

While safe sleep discussions occurred between the FVS worker and the mother, CPS did not document discussion of Period of Purple Crying or Safe Sleep.[8]

CPS did not comply with policy regarding the assessment of Domestic Violence.[9]

The Committee believes that there could have been an enhanced assessment of safety for T.K. during the initial CPS investigation, had other collaterals been completed. Those collaterals could have included contact with law enforcement, obtaining law enforcement or court records pertaining to contact and protection or no-contact orders, as well as requesting records from T.K.'s pediatrician and discussions with the pediatrician and/or nurse regarding T.K.'s care and tremors.

The CPS worker stated to her supervisor that she made a referral for Project Safe Care per Policy 1135, however, there was no documentation regarding this. This delayed supportive services to the mother and T.K.

DCYF policy regarding safety planning includes the directive that staff must assess the suitability and reliability of potential safety plan participants to include reviewing the individual's information in FamLink.[10] This did not occur while this case was open to CPS or FVS.

RECOMMENDATIONS

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

The Committee recommends that DCYF staff should receive training on identifying tremors in newborns and infants that were exposed to substances in utero, the next steps after identifying or hearing reports of tremors, and how to discuss this with parents and/or caregivers.

The Committee identified that many families who come into contact with DCYF use marijuana recreationally. The consumer most often attributes use to self-medication related to physical ailments or mental health issues. The Committee recommends that all DCYF staff receive mandatory training regarding the impacts of marijuana exposure to children (in utero and use post-birth by parents); the research-supported benefits of marijuana; effects of marijuana on adults, adolescents, and children; differing ways to use/ingest marijuana; how marijuana use

[8] https://www.dcyf.wa.gov/1100-child-safety/1135-infant-safety-education-and-intervention
[9] https://www.dcyf.wa.gov/1100-child-safety/1170-domestic-violence
[10] https://www.dcyf.wa.gov/1100-child-safety/1130-safety-plan

impacts the body; and assessing child safety when a caregiver is using marijuana. The mother used RCW 13.50.100 prior to T.K.'s birth and the father admitted to using during the case.

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

WASHINGTON STATE
Department of
Children, Youth, and Families

CHILD FATALITY REVIEW

January 2019

www.dcyf.wa.gov

FULL REPORT

CHILD
- S.S.

DATE OF CHILD'S BIRTH
- RCW 74.15.515 2017

DATE OF FATALITY
- June 11, 2018

CHILD FATALITY REVIEW DATE
- October 12, 2018

COMMITTEE MEMBERS
- Patrick Dowd, Director, Office of the Family & Children's Ombuds
- Tiffany Kelly, Clinical Director, Lutheran Community Services Spokane
- Jennifer Cooper, MSW, Area Administrator, Department of Children, Youth, and Families
- Molly Rice, Safety Program Manager, Department of Children, Youth, and Families

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

Nondiscrimination Policy

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EXECUTIVE SUMMARY

On October 12, 2018, the Department of Children, Youth, and Families (DCYF or CA)[1], convened a Child Fatality Review (CFR)[2] to conduct a review of the Department's practice and service delivery to S.S. and RCW 74.1 family.[3] The incident initiating this review occurred on June 11, 2018, when the parents of S.S. took RCW 74.1 to a local hospital. S.S. was unresponsive when RCW 74.15 arrived at the hospital. The father was arrested at the hospital, but was later released. The mother (Skye Metcalf[4]) has been accused of causing S.S.'s death and has been charged with second degree murder.

The CFR Committee (Committee) included members selected from diverse disciplines within the community with relevant expertise including the Office of the Family and Children's Ombuds, a DCYF Area Administrator, Mental Health Professional, and a DCYF safety program manager. Neither DCYF staff nor any other Committee members had previous direct involvement with S.S. or RCW 74.1 family.

Prior to the CFR, each Committee member received a family genogram, a case chronology, a Department summary describing Department involvement with the family and un-redacted Department case documents. Supplemental sources of information and resource materials were available to the Committee at the time of the review. These included mental health records, relevant state laws, and Department policies.

During the course of this CFR, the Committee interviewed the Child Protective Services (CPS) supervisor and the CPS worker assigned to the case. The Committee discussed possible areas for practice improvement after the Committee reviewed the case file documents, completed department interviews, and discussed the department activities and decisions. The Committee made one finding and two recommendations. The finding and recommendations are included at the end of this report.

[1] On July 1, 2018 the Department of Social and Health Services (DSHS) Children Administration division was moved to DCYF. The fatality that is the subject of this CFR occurred before July 1, 2018. For purposes of this CFR and depending on the context, a reference to DCYF may be considered a reference to the Department of Social and Health Services or the Department of Children, Youth and Families.

[2] Given its limited purpose, a CFR should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of the child. The CFR Committee's review is generally limited to documents in the possession of or obtained by DSHS or its contracted service providers. The Committee has no subpoena power or authority to compel attendance and generally only hears from DSHS 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 Department employees or other individuals.

[3] Family members are not named in this report because they have not been charged in an accusatory instrument with committing a crime related to a report maintained by the department in its case and management information system. [Source: 74.13.500(1)(a)]

[3] The full name of Skye Metcalf is used in this report because she was charged with committing a crime related to this report of abuse. *See* RCW 74.13.500(1)(a).

[4] The full name of Skye Metcalf is used in this report because she was charged with committing a crime related to this report of abuse investigated by DSHS. *See* RCW 74.13.500(1)(a).

CASE OVERVIEW

On March 8, 2018, the Department opened an investigation regarding the mother and her RCW 74.15.515 S.S. The mother's mental health counselor (Counselor) reported concerns to the Department about the safety of the child and the mother due to the mother's mental health, her recent statements about harming S.S., her lack of desire to care for S.S., and about harming herself if she (the mother) could not be in a relationship with S.S.'s father, adding to the counselor's concerns for ongoing domestic violence (DV) in combination with the mother's mental health concerns.

The Department opened an investigation on March 9, 2018, and the assigned CPS worker met with the Counselor, the mother, and a medical crisis worker. Based on the mother's statements, the Counselor believed the mother needed to be assessed RCW 74.13.520 . The Counselor also disclosed that based on the father's domestic violence history against the mother, the father would not be a safe placement for S.S. At the time of the March 9 meeting, the mother was living with a friend (mother's roommate) who was assisting with the daily care of S.S. It was reported the father was not living with the mother or providing care to S.S. Department staff made collateral contacts with the mother's and father's friends and family. These contacts also reported concern about the father's ability to care for S.S. These concerns are based on a previous domestic violence incident between the father and the mother, and the father's unemployment status.

On March 9, 2018, the mother was willing to agree to a Voluntary Placement Agreement (VPA[5]). The mother's friend (also a roommate) requested placement of S.S, however, the Department advised that Department policy and state law prevented the Department from placing S.S. in the roommate's care[1]. S.S. was then placed in a temporary foster care placement until a further assessment of family could be completed. The mother's roommate advised the Department that she would seek third-party custody[6] of S.S. through family court.

Pursuant to a request from the mother's Counselor, crisis intervention community mental health professionals conducted an assessment. On March 11, 2018, the assessment was completed. The assessment concluded the mother was not a threat to herself or S.S. The mother's Counselor communicated this information to the Department, and on March 12, 2018, the mother asked that S.S. be returned to her care. The mother's roommate advised the CPS worker she filed a third party custody petition seeking the custody of S.S. and future hearings were scheduled.

On March 14, 2018, separate Family Team Decision-Making Meetings (FTDM)[7] were held for each parent.[8] During the mother's FTDM there were notable discrepancies between the

[5] A Voluntary Placement Agreement (VPA) safety supports a time-limited plan for a short-term removal and placement in out-of-home care for a child who cannot safely remain in the parent or legal guardian's home. [Source: CA Practice and Procedures Guide, Section 4307]

[6] Third party custody, or non-parental custody, is a legal mechanism whereby an individual who is not a child's parent may obtain physical and legal custody of a child through a court order. Chapter 26.10 RCW. An individual seeking a custody order must submit, along with his or her motion for custody, an affidavit declaring that the child is not in the physical custody of one of its parents or that neither parent is a suitable custodian and setting forth facts supporting the requested order. The party seeking custody shall give notice, along with a copy of the affidavit, to other parties to the proceedings, who may file opposing affidavits. [Source: RCW 26.10.034 (1)]

[7] An FTDM is a facilitated team process, which can include birth/adoptive parents, guardians, extended family members, youth (as appropriate), community members, service providers, child welfare staff and/or caregivers. These meetings are held to make critical decisions regarding the placement of children following the emergent removal of child(ren) from their home, changes in out-of-home placement, and reunification or placement into a permanent home. There may be instances when a FTDM can be held prior to placement if there is not an immediate safety threat such as a child who is on a hospital hold. Permanency planning starts the moment children are placed out of their homes and is discussed during a Family Team Decision-Making meeting. A FTDM will take place for all placement decisions in order to achieve the least restrictive and safest placement that is in the best interests of the

Counselor's concerns for the mother, versus the responding crisis mental health professional's final assessment.[9] Identified concerns about the mother included: RCW 74.13.520 , and the discrepancy between the community mental health responders and the Counselor's initial assessments. Department staff determined there was insufficient information establishing an active safety threat that would prohibit the return of S.S.to the mother's care. The father supported S.S.'s return to the mother. During the father's FTDM, he admitted to a domestic violence incident in April 2017 with the mother that resulted in a no-contact order between them. The father was reportedly RCW 13.50.100 as a result of the domestic violence incident. The Department did not receive substantial information from family and friends concerning the father's inability to care for the child that would prohibit him from visiting S.S. The majority of the reported concerns surrounded his lack of employment or involvement with S.S.

A court hearing on April 24, 2018, considered the roommate's third party custody petition. The Department was not involved in the hearing. Both parents opposed the motion and provided the court with information about the mother's mental health crisis assessment that determined she did not pose a threat of harm to herself or others at that time. The Court dismissed the third party petition. The court cited, "The court cannot compare the petitioner's home and the parents' homes. Burden of proof for adequate cause has not been met for unfitness or actual detriment."

Shortly after the custody hearing, the mother and S.S. moved out of the roommate's home. On May 1, 2018, the CPS worker contacted S.S.'s pediatrician and was told the child was current on exams and had a subsequent exam scheduled for later that month. No concerns were communicated to the CPS worker regarding the child or the mother. On June 6, 2018, the CPS worker conducted a health and safety[10] visit at the mother's home. The mother told the CPS worker that she was continuing with counseling and was RCW 13.50.100 . She also stated she was receiving support from her maternal and paternal grandparents. The father was not present during the meeting, and as described by the mother, he was not visiting or living at the mother's home. The CPS worker did not identify any obvious hazards in the home or have concerns for the mother's behavior or statements during this visit. Later, after the child's death, the Department learned the father had been in the mother's home within a week prior to S.S.'s death.

On June 11, 2018, the Medical Examiner's (ME) Office called the Department to report the death of RCW 74.15.515-old S.S. The child was declared deceased at 1:25 p.m. The suspected manner of death was homicide. According to the ME's office, on June 11, 2018, the mother and the father arrived at the local hospital at 1:15 p.m. with S.S. who was non-responsive. Medical staff attempted to resuscitate S.S. without success and RCW 74.15 was declared deceased.

At the hospital the mother initially told authorities she accidentally fell while holding S.S. and this was the cause of the child's injuries. However, according to investigators the mother's story "changed many times" and the parents eventually became uncooperative with sheriff's deputies. The father was arrested at the hospital due to the no-contact order between the father and mother. The initial charge of violation of a no-contact order was later amended to second-degree criminal mistreatment.

child. By utilizing this inclusive process, a network of support for the child(ren) and adults who care for them may be ensured. www.dshs.wa.gov/pdf/ca/FTDMPracticeGuide/pdf

[8] Separate FTDMs were necessary because of a no contact order between the parents.

[9] During the FTDM the mother's Counselor disclosed that crisis mental health assessment and response was out of her professional scope and expertise.

[10] According to Department policy investigators must conduct monthly health and safety visits with children and parents if the case is open longer than 60 calendar days.

On June 12, 2018, the mother was arrested and charged with second-degree murder for the death of S.S. After she was arrested, the mother admitted to causing S.S.'s death. She reported that the father had been in the home prior to S.S.'s death but had left due to an argument. The mother explained that after the argument she was frustrated with S.S and threw RCW 74.1 face first into the bottom of RCW 74.1 playpen. The mother admitted that she then struck S.S. multiple times with a closed fist on the back of RCW 74.1 head, which caused the skull fractures described in the autopsy. After the assault the mother noticed a soft spot on the back of S.S.'s head causing her to call the father and request a ride to the hospital.

COMMITTEE DISCUSSION

With regard to domestic violence, the Committee observed that a domestic violence assessment was initiated but does not believe it included a complete assessment of power and control issues. Further, it appeared to the Committee that the domestic violence screening overlooked the impacts of domestic violence on the mother's mental health, and S.S.'s safety and functioning. Instead of examining all domestic violence indicators it appears the CPS staff primarily focused on the April 2017 physical altercation between the mother and father.

With regard to services offered to the family, while the Structured Decision Making Assessment[11] (SDMRA) demonstrated a moderate risk tag which does not mandate the offering of services, the Committee believes such services should have been offered. The Committee notes that the SDMRA was completed just prior to S.S.'s death. The Committee believes the SDMRA should have been completed during the case activities. Despite this concern, the Committee believes this delay is not an area of practice that needs to be addressed in this particular case, and the offered SDMRA services would not have prevented the mother's impulsive behavior that resulted in S.S.'s death. Regardless, the Committee believes domestic violence victim support services and other home-based community infant support services should have been offered.

With regard to the timely collection and analysis of records, the Committee discussed the importance of gathering records to verify and analyze second-hand reports. The Committee believes this would have been especially helpful for purposes of the review and analysis of mental health records; in particular, and the crisis mental health assessment and results. Despite the fact the mental health records were not gathered before S.S.'s death, or that direct contact was not initiated with the crisis mental health staff, the mother's primary Counselor was in direct communication with the crisis team and communicating information to Department staff and FTDM participants. The delay in gathering the records or failure to initiate direct contact with the crisis mental health staff did not directly or indirectly cause S.S.'s death. The Committee believes the best practice is for the Department to timely obtain the necessary information directly from the information's source.

With regard to Department staff training, the Committee has concerns Department staff are sometimes expected to have expertise beyond their actual qualifications or what is described in their job description. For example, expectations related to a staff person's mental health training and/or expertise. The Committee recognizes that if this concern is valid, Department staff may be unable to properly understand mental health records to the extent necessary to gain a clear understanding of the diagnoses and recommendations. The Committee does not have sufficient information to determine whether the Department has the resources to make available, or

[11] The Structured Decision Making Risk Assessment ®(SDM-RA®) is an evidence-based actuarial tool from the Children's Research Center (CRC) that was implemented by Washington State CA in October, 2007. It is one source of information for CPS worker and supervisors to consider when making the decision to provide ongoing services to families.
[Source: DSHS CA Practices and Procedures Guide, Chapter 2541]

retain, expert mental health professional(s) for the purpose of analyzing information received from mental health providers.

The Committee understands that unlike Department staff who are responsible for assessing a situation for impending danger over a period of time, crisis mental health responders are tasked with assessing clients for just a moment in time. To assess child safety, the Committee believes Department staff must apply a global perspective considering all relevant factors including, but not limited to, the crisis team assessment.

FINDINGS

The Committee did not identify any critical errors made by CA that contributed to the death of S.S. However, while not directly or indirectly connected to the circumstances of the child's death, the Committee did identify practice areas that the Department may want to consider for possible improvement.

Although staff made initial domestic violence inquiries involving the parents, the Committee believes the patterns and statements related to domestic violence could have been more thoroughly evaluated and analyzed for a more accurate assessment. Specifically, the Committee believes that a more accurate safety assessment may have been developed if there had been a more in-depth analysis of the lethality indicators, family functioning, child safety, the cycle of violence, and the possible impacts domestic violence had on the mother's mental health issues.

Child welfare staff are often required to have expertise in a variety of professional services or vocations and often beyond their education and training, such as mental health assessment and domestic violence.

RECOMMENDATIONS

The local unit involved in this case might consider refreshing their domestic violence assessment skills with a Department program manager.

In an effort to enhance the workers' assessment and analysis of client mental health issues, Department leadership should make a statewide mental health consultant(s) available to staff. The purpose for the statewide mental health consultant(s) would be similar to the purpose of the statewide medical consultants.

WASHINGTON STATE
Department of
Children, Youth, and Families

CHILD FATALITY REVIEW

December 2018

www.dcyf.wa.gov

FULL REPORT

CHILD

- Y.B., aka Y.G.

DATE OF CHILD'S BIRTH

- RCW 74.15.515 2018

DATE OF FATALITY

- June 2018

CHILD FATALITY REVIEW DATE

- October 11, 2018

COMMITTEE MEMBERS

- Cristina Limpens, MSW, Senior Ombuds, Office of the Family and Children's Ombuds
- Ruth Wolbert-Neff, CDP, Drug and Alcohol Treatment Counselor 1, Tacoma-Pierce County Health DCYF
- Lindsay Finney, MSW, LSWAIC, Social Worker, Mary Bridge Hospital
- Ly Dinh, MSW, Quality Practice Specialist, Department of Children, Youth, and Families

FACILITATOR

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

Nondiscrimination Policy

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

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).

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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).

EXECUTIVE SUMMARY

On October 11, 2018, the Department of Children, Youth, and Families[1] (DCYF) convened a Child Fatality Review (CFR).[2] The purpose of the review was to assess DCYF's practice and service delivery to Y.B. and RCW 74.1 family.[3] Y.B. was also known to DCYF as Y.G. and is referenced so throughout DCYF case records. However, RCW 74.15 will be referenced in this report by the initials of RCW 74.1 legal name, Y.B., as stated on RCW 74.1 birth certificate.

On June 5, 2018, DCYF received a call stating that Y.B. had passed away while in the care of RCW 74.1 mother. Y.B. had been taken to the hospital via ambulance and was declared deceased at the hospital. At the time of RCW 74.1 death, Y.B. was living with RCW 74.1 alleged father, there was an open Family Voluntary Services (FVS) case with the DCYF, and the family had agreed that Y.B.'s mother would not be allowed unsupervised contact with the child. A Child Protective Services (CPS) investigation regarding Y.B.'s death concluded that both the mother and alleged father were negligent, resulting in a founded finding for negligent treatment and/or maltreatment being assessed for each of them.

The CFR Committee (Committee) included members selected from diverse disciplines within the community with relevant expertise including individuals from the Office of the Family and Children's Ombuds, substance abuse treatment, a children's hospital, and child welfare. The Committee members did not have any involvement or contact with this family.

Prior to the CFR, each Committee member received a summary of DCYF's involvement with the family and DCYF case documents with no redaction (e.g., intakes, investigative assessments, and case notes in their entirety). Supplemental sources of information and resource materials were available to the Committee at the time of the CFR. These included relevant state laws and DCYF policies.

The Committee interviewed the CPS worker, the FVS supervisor, and the area administrator. The CPS supervisor and FVS worker were not interviewed because both had terminated their employment with DCYF prior to the CFR. The Committee chose not to interview the CPS worker and supervisor of the fatality investigation.

[1] 1 Effective July 1, 2018, the DCYF of Children, Youth, and Families (DCYF) replaced the DCYF of Social and Health Services (DSHS) Children's Administration (CA), the state agency responsible for child welfare, and the DCYF of Early Learning. The fatality happened prior to July 1, 2018, therefore CA or DSHS may be referenced in the report.

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

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

FAMILY CASE SUMMARY

On RCW 74.15.515, 2018, DCYF received a call stating that the mother gave birth to Y.B. but had RCW 13.50.100, admitted to ongoing RCW 13.50.100, and was interested in getting into RCW 13.50.100. Y.B. RCW 74.13.520 at RCW 74.1 birth. This intake was assigned for a CPS Risk Only[4] investigation.

The CPS worker made contact with the mother and Y.B. the following day. Y.B. was RCW 74.13.520, but the hospital did not have concerns regarding the child's mother and the care she was giving to her RCW 74.15.515 while in the hospital. The CPS worker was able to discuss the mother's history of RCW 13.50.100 with her and obtained information from the mother regarding her supports as well as the name of the child's alleged father and his contact information. The mother stated that she and the alleged father were no longer a couple and she has not yet signed the birth certificate.

The CPS worker made many diligent efforts to contact relatives and other collateral support persons for the mother. She also contacted the alleged father. As part of that contact, the alleged father provided his parole officer's name and contact information.

On RCW 74.15.515, 2018, DCYF held a Family Team Decision Meeting (FTDM). The child had not yet been released from the hospital but was expected to be discharged soon. Y.B. remained hospitalized due to RCW 74.13.520. Because of the mother's recent RCW 13.50.100, DCYF determined Y.B. would not be safe if placed with RCW 74.1 mother without another person living in the home and supervising contact. Different placement options were discussed during the FTDM, and the first priority was placement of Y.B. with RCW 74.1 mother if an in-home safety plan could be completed where the mother was never unsupervised with the child. If the mother did not have sufficient supports available to supervise her contact with the child in the home at all times, then a second option was placement with the child's alleged father. If neither option was available, then DCYF would request the mother and alleged father voluntarily place the child in out-of-home care under a voluntary placement agreement. The FTDM also included the mother's agreement to provide RCW 13.50.100. DCYF referred the mother for RCW 13.50.100 between April 26 and May 25, but as of May 4, the mother had RCW 13.50.100.

When the CPS worker contacted the people the mother identified as supports, they were not willing to participate. Since DCYF did not identify any safety threats regarding the child's alleged father and he agreed to care full-time for his RCW 74.15.515 the mother and alleged father agreed for the child to be placed with him and that the mother would not be allowed to have unsupervised contact with the child. The mother and alleged father also signed a family action plan stating this.

At the time of the agreement to place the child with the alleged father, he lived with his sister. The CPS worker made contact with the alleged father's sister, but she asked that the CPS worker call her back another time. Before the CPS worker could call back, the alleged father asked the CPS worker to not contact his sister again, stating he would lose his housing but would not provide any further explanation. However, he denied that statement during a later discussion. The CPS worker consulted with her supervisor who directed her to assess the alleged paternal aunt through a search in Famlink, which is the DCYF's case management system. The search showed that RCW 13.50.100

[4] https://www.dcyf.wa.gov/practices-and-procedures/2200-intake-process-and-response

On May 11, 2018, the CPS worker conducted a walk-through of the home where the alleged father lived. The CPS worker discussed the Period of Purple Crying and safe sleep with him.[5] The worker discussed in detail how to handle situations that may arise if Y.B. became inconsolable and walked through what safe sleep should look like in his home. The CPS worker also discussed community resources, housing, and childcare resources. The alleged father identified family friends that would care for Y.B. while he was at work. The CPS worker again reiterated that the mother could not have unsupervised contact with Y.B. as agreed to in the family action plan. The CPS worker also left a background check form for the alleged paternal aunt to fill out and return since the alleged father said she also lived in this house. After leaving the alleged father's house and prior to driving out of the driveway, the CPS worker called the mother and gave her an update. She also reiterated that she could not have unsupervised contact with Y.B., to which the mother agreed.

On May 16, 2018, the CPS worker received a message from the mother stating that the alleged father was requesting a paternity test. The CPS worker called the mother back, the mother reported that she was receiving supervised visitation and attending Y.B.'s pediatrician appointments with the alleged father. The mother also provided the pediatrician's name and location to the CPS worker. The mother further stated she was receiving RCW 13.50.100 . The mother also indicated she has been providing RCW 13.50.100 . The mother refused the offer of voluntary services to assist with parenting. The CPS worker then called the alleged father. He agreed to voluntary services to include an in-home provider, Project Safe Care, to address housing and parenting and to see if he qualified for a childcare subsidy through the state.

On May 16, 2018, the CPS worker completed the Structured Decision Making Risk Assessment (SDM) tool which indicated a moderate level for future risk.[6] This same day, the case was staffed with the FVS supervisor and FVS workers. The case transferred to FVS on May 22, 2018.

On May 22, 2018, the FVS worker spoke with the alleged father. He was offered paid childcare through DCYF because he indicated that he was struggling to cover the cost himself. However, he chose to have Y.B. receive care from a friend instead.

On May 23, 2018, the FVS worker conducted an in-person health and safety visit.[7] The FVS worker assessed for observable safety threats, discussed safe sleep, and provided the alleged father with safe sleep and Period of Purple Crying documents. The alleged father denied co-sleeping with the child and stated that he had watched the Period of Purple Crying video previously. The FVS worker observed a diaper change and discussed the child's RCW 13.50.100 with the alleged father, though there were no concerns about RCW 13.50.100 at that time. The FVS worker also provided the alleged father with diapers and formula. The alleged father stated that Y.B. was not consistently sleeping, was constipated and eating well but was consistently RCW 74.13.520. He stated he was unfamiliar with the needs of RCW 74.13.520 children prior to his experience with Y.B. The FVS worker stated she would follow-up with a nurse to provide additional assistance for the alleged father. The worker also stated that he could access the nurse's line through the pediatrician's office. Coinciding with the alleged father's statements, the FVS worker observed the child having RCW 74.13.520 during the 30-minute visit.

Also during this visit, the alleged father signed releases of information for Project Safe Care, the pediatrician's office, his parole officer, and a public health nurse. While still agreeing to the

[5] https://www.dcyf.wa.gov/1100-child-safety/1135-infant-safety-education-and-intervention

[6] https://www.dcyf.wa.gov/practices-and-procedures/2541-structured-decision-making-risk-assessmentrsdmra

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

services, the alleged father expressed concern about his ability to schedule all of the necessary appointments around his work schedule. He also stated that he was planning on seeking a paternity test but regardless of the outcome was attached to the child and may seek third party custody if he is in fact not RCW 74.1 biological father. The FVS worker also discussed the supervised contact by the mother. The alleged father indicated she usually visits at the daycare providers' home and that he and the mother do not get along well. The alleged father provided the FVS worker with his day care providers' names and stated he would share the family action plan with them. The alleged father also discussed the conditions of his parole.

On May 25, 2018, the FVS worker called and spoke with a pediatric nurse regarding Y.B.'s observed RCW 74.13.520 The nurse recommended that the child be seen by a medical provider. The FVS worker texted that information to the alleged father and recommended that he take the child into urgent care.

On June 4, 2018, the FVS worker faxed a referral for the public health nurse to work with the alleged father and Y.B. The following day, DCYF received a call stating Y.B. had passed away while in RCW 74.1 mother's care. The alleged father admitted to hospital staff that he had left Y.B.in the care of RCW 74.1 mother for the "last couple of days" because he could not find anyone else to watch RCW 74.15. The alleged father told the hospital staff that the mother told him she had placed their child face down on a "pile of blankets." Law enforcement was notified but did not pursue a criminal investigation. At the conclusion of the CPS investigation, both parents received founded findings for negligent treatment and/or maltreatment related to Y.B.'s death.

COMMITTEE DISCUSSION

The Committee discussed their experience with hospital staff upon discharge of RCW 74.13.520 newborns and a lack of hospital training to fathers regarding what they may experience and expect while caring for their child. This discussion included how the focus usually includes the mother only regarding instructions and cautions but that including both of the children's parents would seem appropriate.

Another point of discussion included the documentation throughout the case. The Committee discussed that the Investigative Assessment (IA) indicated that Y.B was safe under the mother's care and that the SDM was showing moderate for future risk.[8] The intent of the CPS worker was to show that DCYF did not believe that Y.B. was safe in RCW 74.1 mother's care but it was not documented correctly. The Committee discussed how the case documentation read, that it did not fit the policy requirements for transferring a case to FVS (this is further discussed in the findings section below). The documentation regarding the FTDM was also not clear to the Committee. The documentation indicates that the placement decision was for Y.B. to remain in the hospital until medically ready for discharge, and upon discharge Y.B. would then be placed in out-of-home care on a voluntary basis and the placement recommendation was a medical facility.

In contrast, based on the staff interviews, the Committee understood the plan had actually been that upon discharge, Y.B. would be placed with RCW 74.1 mother if a suitable supervision plan could be created and, if not, placed with the alleged father. If placement with the alleged father was not possible, only then would the parents have been asked to sign a voluntary placement agreement which would result in Y.B. being placed in out-of-home care.

The Committee discussed that the assessment of the alleged father, including his suitability and desire to parent Y.B., was not adequately documented. The Committee believed that further discussion with the alleged father regarding his ability, desire, and support in caring for Y.B. would have been appropriate. The Committee also discussed how DCYF tries to avoid informal placements, yet one occurred in this case since the alleged father was not the child's legal parent. During the CPS investigation, the CPS worker recalled that the mother told her that she had put the father's name on the birth certificate, but this was not corroborated. The alleged father questioning paternity later on was another concern to the Committee regarding his commitment to providing safe and stable care to Y.B. After the CFR was completed, this writer requested the area administrator to review the birth certificate. This is where the legal last name was found to be different than documented in DCYF's records and that there is no father listed for Y.B.

Part of assessing for suitability of placement also includes assessing all persons who live in that home, and the Committee discussed that the assessment of the alleged father's sister could have been more comprehensive. The Committee would have liked to have seen a more aggressive approach to understanding the alleged aunt's thoughts and willingness to have Y.B. placed in her home. She would also have been a good collateral contact in assessing the suitability of the alleged father.

The Committee discussed the use of the family action plan in this case. The Committee discussed that the family action plan included parental promises and that the document is no longer available in Famlink. The Committee discussed that DCYF likely discontinued use of the document but the timeframe was unknown. It was shared that some offices have printed copies of the document and complete it in a handwritten form, and therefore are possibly not aware

[8] https://www.dcyf.wa.gov/practices-and-procedures/2540-investigative-assessment

that it is no longer available in Famlink. After the CFR concluded, this writer reached out to the CPS program manager who indicated that the family action plan had been discontinued, but there may have been confusion regarding how this was messaged out to the field. The CPS program manager shared this information again with the CPS/Intake Leads on November 7, 2018.

During the staff interviews, the area administrator identified a missed opportunity to include Y.B.'s childcare providers in the case plan and as a collaborative partner in this case. The area administrator stated after Y.B. passed away, she requested training for all of her staff on how to create safety plans.

FINDINGS

The Committee reached full consensus that there were no critical errors made by DCYF that would have affected the outcome of this case. However, the Committee discussed areas, not directly correlated to Y.B.'s passing, where DCYF practice could be improved. Those findings are addressed below.

The transfer of the case from CPS to FVS needed some clarification. The FVS policy indicates that a CPS case can transfer to FVS if the case meets four different requirements.[9] This case did not meet those requirements based on the information in the completed CPS investigation, but the Committee did not disagree with the case moving to FVS based on the Committee's understanding of the case as presented by the staff during their interviews. Nonetheless, the Committee discussed how the SDM should have been overridden to show a moderately high risk based on the circumstances of the case and the child should have been shown as unsafe in the mother's home, which could then have been mitigated by a safety plan and placement with the alleged father had paternity been established. However, placing the child with an individual who was not the child's legal parent was therefore an informal placement that the Committee determined should not have occurred.

A plan of safe care was not completed on this case but should have been completed per DCYF policy.[10]

The Committee believed that there needed to be two medical collaterals completed. The first was after Y.B. was discharged from the hospital since the mother reported the child had pediatric appointments. The Committee believed that the worker should have corroborated the mother's assertions. Second, the Committee believed that the FVS worker should have followed up and corroborated with medical staff that Y.B. was seen regarding RCW 74.1 RCW 74.13.520

[9] https://www.dcyf.wa.gov/practices-and-procedures/3000-family-voluntary-services

[10] https://www.dcyf.wa.gov/1100-child-safety/1135-infant-safety-education-and-intervention

RECOMMENDATIONS

The Committee reached full consensus that there were no critical errors made by DCYF and that DCYF staff should receive training on identifying RCW 74.13.520 in newborns and infants that were RCW 74.13.520, including the next steps after identifying or hearing reports of RCW 74.13.520 and how to discuss this with parents and/or caregivers.

WASHINGTON STATE
Department of
Children, Youth, and Families

CHILD FATALITY REVIEW REPORT

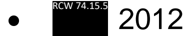
December 2018

www.dcyf.wa.gov

FAMILY MEMBERS

- J.B.

DATE OF CHILD'S BIRTH

-  2012

DATE OF FATALITY

- April 09, 2018

DATE OF FATALITY REVIEW

- August 14, 2018

COMMITTEE MEMBERS

- Patrick Dowd, Director, Office of the Family & Children's Ombuds
- Stephanie Widhalm, MSW, LICSW, MHP, CMHS, Supervisor, Partners for Families and Children Spokane
- Jenna Kiser, MSW, Deputy Regional Administrator, Department of Children, Youth, and Families
- Ben Buriak, Sergeant, Adams County Sheriff's Office
- Patricia Erdman, MSW, Regional Administrator, Alliance for Child Welfare Excellence, University of Washington

FACILITATOR

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

OBSERVER

- Wendy Pratt, MSW, Supervisor, Department of Children, Youth and Families

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).

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Nondiscrimination Policy

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

EXECUTIVE SUMMARY

On August 14, 2018, the Department of Children, Youth, and Families (DCYF)[1], convened a Child Fatality Review (CFR)[2] to assess DCYF's practice and service delivery to J.B. and RCW 74. family[3]. All of the information surrounding the circumstances of J.B.'s death was obtained by DCYF staff via publicly available television and online news sources. According to online newspaper articles located by this writer, the incident initiating this review occurred on April 09, 2018, when J.B. was brought to an out-of-state hospital unresponsive. Efforts to revive J.B. were unsuccessful and RCW 74 was declared dead by hospital staff. The hospital contacted law enforcement concerning J.B.'s death because of the suspicious circumstances under which RCW 74 died. According to a news article, "The detective found aspects of the RCW 74.15.515 appearance disturbing, including marks that covered the RCW 74.15 from head to toe, including sores, cuts and scratches. The child's hair was patchy, and it appeared parts had been pulled out or were just not growing. The detective also noticed a mark on the RCW 74.15.515 upper body that was 2 to 3 inches wide and appeared consistent with a strap or some kind of restraint. The RCW 74.15.515 face was scabbed over and scarred with multiple injuries that were in various stages of healing…." At the time of RCW 74. death, J.B. and RCW 74. twin sibling were in the care of a family friend, Bobbie Bishop[4], and her paramour, Walter Wynhoff[5]. J.B.'s legal custodian, RCW 74. maternal grandmother, sent the twin siblings to live with Bishop in August 2017 and ultimately gave Bishop temporary custody. Bishop and Wynhoff were arrested and charged with second degree murder without intent, first-degree manslaughter, two counts of second-degree manslaughter, and malicious punishment of a child resulting in great bodily harm in connection with J.B.'s death. DCYF has limited information as to this matter as the child's death occurred and is being investigated out-of-state.

The CFR Committee (Committee) included members selected from diverse disciplines within the community with relevant expertise including the Office of the Family and Children's Ombuds, a DCYF Deputy Regional Administrator, law enforcement, a supervisor from a local child advocacy center, and a Regional Administrator from the Alliance for Child Welfare.

Excellence[6]. A DCYF Child Protective Services (CPS) supervisor was invited but was not able to attend the CFR. The Confederated RCW 74.15.515 and RCW 74.15.515 Tribes received notification of the CFR and a representative was invited to participate, however the representative was not present for the review. Additionally, a DCYF supervisor observed a portion of the review. Neither CA staff nor any other Committee members had previous direct involvement with this family. One Committee member had professional involvement with Wynhoff over a decade prior, but that Committee member did not have involvement or contact with this family or children in question. Additionally, the facilitator and writer of this report once staffed the case involving

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[1] As of July 1, 2018, the work of the Department of Social and Health Services (DSHS) Children's Administration (CA) transferred to DCYF. However, because case events occurred before July 1, 2018, CA is referenced throughout this report.

[2] Given its limited purpose, a CFR should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of the child. The CFR Committee's review is generally limited to documents in the possession of or obtained by DSHS or its contracted service providers. The Committee has no subpoena power or authority to compel attendance and generally only hears from DSHS 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 Department employees or other individuals.

[3] Family members are not named in this report because they have not been charged in an accusatory instrument with committing a crime related to a report maintained by the department in its case and management information system. [Source: 74.13.500(1)(a)]

[4] The family friend/caregiver is named in the report because she was charged with committing a crime related to this report of child abuse or neglect investigated by Children's Administration. RCW 74.13.500(1)(a). The names of the children are subject to privacy laws.

[5] The family friend/caregiver is named in the report because he was charged with committing a crime related to this report of child abuse or neglect investigated by Children's Administration. RCW 74.13.500(1)(a). The names of the children are subject to privacy laws.

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

J.B.'s biological mother in 2012 while in a supervisory role to assist a neighboring county investigating the biological mother's case, but neither the facilitator nor the writer of this report had direct contact with the involved children, family, or caregivers.

Prior to the CFR, each Committee member received a family genogram, a case chronology, a summary of Department involvement with the family and un-redacted Department case documents (*e.g.*, intakes[7], investigative assessments and case notes). Supplemental sources of information and resource materials were available to the Committee at the time of the review. These included medical reports, relevant state laws and Department policies.

During the course of this CFR, the Committee interviewed the Child and Family Welfare Service (CFWS) supervisor and worker assigned to the biological mother's case from 2013-2014 and to the maternal grandmother's case in 2015. The Committee additionally interviewed the supervisor (a newly transitioning and in-training supervisor) and the Family Assessment Response[8] (FAR) worker who were assigned to the maternal grandmother's case in 2016-17. Following the review of the case file documents, completion of interviews and discussion regarding department activities and decisions, the Committee discussed possible areas for practice improvement. The Committee made findings and recommendations related to the Department's response and systems that can be located at the end of this report.

[7] An "intake" is a report received by the Department in which a person or persons have reasonable cause to believe or suspect that a child has been abused or neglected. A decision to screen out an intake is based on the absence of allegations of child abuse or neglect as defined by Washington Administrative Code (WAC) 110-30-0030.

[8] FAR is a CPS alternative response to an investigation of a screened-in allegation of child abuse or neglect. FAR focuses on child safety along with the integrity and preservation of the family when lower risk allegations of child maltreatment have been reported. [Source: CA Practices and Procedures Guild 2332. Family Assessment Response]

FULL REPORT

SUMMARY OF FAMILY HISTORY

J.B.'s biological mother has a history with CPS dating back to 1999 including reported concerns for RCW 13.50.100, RCW 13.50.100, and RCW 13.50.100. In 2012, the biological mother left J.B. and [redacted] twin, who were two months old, with Bishop and Wynhoff. At the time, CA determined that Bishop and Wynhoff were inappropriate and unsafe caregivers due to reported substance abuse, mental health issues, unsanitary condition of their living environment, and lack of appropriate supervision of J.B. and RCW 74. twin sibling. A dependency petition and motion to take the twins into protective custody were filed on May 25, 2012. The twins were placed in foster care until May 31, 2012, when they were moved to the care of a maternal relative. The twin's maternal grandmother, who at the time was residing in RCW 74.15.515, worked with her enrolled tribe to obtain custody of the twins. The Indian Child Welfare Act[9] (ICWA) applied to the dependency case, but the children's tribe did not request transferring the case to tribal jurisdiction. CA staff assigned to the case had been in communication with Tribal Social Services as well as RCW 74.15.515 State CPS in an effort to gain information on the maternal grandmother and address jurisdictional issues. The Tribe reportedly did not want to seek jurisdiction of the case as the children were not enrolled. However, the Tribe provided legal support to the grandmother who was enrolled and intervened, assisting her in court proceedings to obtain third party custody. Limited information was provided to CA by RCW 74.15.515 Tribal Social Services or RCW 74.15.515 State CPS regarding the maternal grandmother's caregiving capabilities or her home. The twins were transferred to their maternal grandmother's care and custody in RCW 74.15.515 after CA agreed to and entered into an order dismissing the dependencies in Washington state court on April 16, 2014. The CA's case as to J.B.'s biological mother was later closed.

On December 07, 2014, a relative contacted law enforcement regarding the twins after the maternal grandmother had left the twins in her care. The relative was concerned that the children had been neglected, possibly physically abused RCW 13.50.100. The relative RCW 13.50.100 reported unexplained bruising on both children. Law enforcement contacted CA, and the intake report was assigned to a CPS investigator. On December 08, 2014, law enforcement placed the twins into protective custody[10]. The assigned CPS worker completed a safety assessment,[11] determined the maternal grandmother was unsafe to care for the twins, and CA filed a dependency petition as to both children on December 10, 2014. The dependency petition outlined a number of safety threats[12] including that the maternal grandmother lacked parenting knowledge, skills, or motivation necessary to assure the children's safety. Further, the maternal

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[9] The federal Indian Child Welfare Act (ICWA) of 1978 (USC 1901 et. Seq.) was the first federal legislation enacted to protect Indian children and families. This landmark law defines the rights of Tribes to assume jurisdiction over children who are members or eligible to be members in a Tribe. The Indian Child Welfare Act (ICWA), 25 U.S.C. 1901, et. seq., authorizes the state of Washington to enter into agreements concerning the care and custody of Indian children and jurisdiction over child custody proceedings involving Indian children. [Source: Children's Administration Indian Child Welfare manual.].

[10] RCW 26.44.050: "A law enforcement officer may take, or cause to be taken, a child into custody without a court order if there is probable cause to believe that the child is abused or neglected and that the child would be injured or could not be taken into custody if it were necessary to first obtain a court order pursuant to RCW 13.34.050."

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

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

grandmother could not explain the children's injuries or explain why she had given the children to another relative rather than caring for the children herself. On December 11, 2014, a contested Shelter Care hearing was held, and the court ruled that the children were at serious threat of substantial harm in the maternal grandmother's care and were to remain in foster care. The court listed seven findings at the shelter care related to the maternal grandmother's neglect of the children. On December 12, 2014, the children were seen by a local child advocacy center (CAC) and had a thorough medical evaluation. While it could not be determined whether the children had been RCW 13.50.100, the medical evaluation concluded that the twins were severely neglected and recommended they receive specialized placement and care to address their developmental and medical needs.

CA's investigation of the negligent treatment allegations resulted in a founded finding[13] as to the maternal grandmother. The dependency case was transferred to the CFWS unit on December 12, 2014. The CFWS worker completed home visitations, assisted in getting the children set up with medical and developmental services as well as monitored visitation outcomes between the children and maternal grandmother.

On January 28, 2015, a Family Team Decision-Making Meeting (FTDM)[14] was held, and the decision was made to return J.B. and RCW 74. sibling to the maternal grandmother's care. While there were concerns within CA about returning the children to the maternal grandmother, CA ultimately determined that doing so was in the children's best interests. After consultation with the Area Administrator and internal consultants, the assigned staff and supervisors concluded there was not sufficient evidence or safety threats to prevent the children from returning to the grandmother's care. The children were transported to their maternal grandmother in RCW 74.15.515, and Washington dismissed the dependencies in April 2015.

The grandmother and the children later moved back to the RCW 74.15.515 area from RCW 74.15.515. On December 13, 2016, CA received an intake that initially screened out. The reviewing supervisor then staffed the report with five additional intake supervisors who deliberated and determined that the report should screen in[15] for a FAR response. The intake alleged the maternal grandmother allowed the biological mother to remain in the home RCW 13.50.100 . There were also concerns because the maternal grandmother knew that the biological mother was an inappropriate and unsafe person to have around the children, and there were other recent reports that the children had been outside of the home unsupervised. The intake report further documented allegations of the biological mother being verbally abusive towards the twins. The report included an historical summary of CA involvement with the family including case history involving Bobbie Bishop.

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[13] CA findings are based on a preponderance of the evidence. "Child abuse or neglect" is defined in Chapter 26.44 RCW, WAC 110-30-0030and WAC 110-30-0040. Findings are determined when the investigation is complete. Founded means the determination, following an investigation by CPS and based on available information, that it is more likely than not child abuse or neglect did occur. Unfounded means the determination, following an investigation by CPS and based on available information that it is more likely than not child abuse or neglect did not occur, or there is insufficient evidence for DSHS to determine whether the alleged child abuse did or did not occur.

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

[15] Intake social workers determine program response type and response times (emergent or non-emergent) for an investigation.CA intakes fall into three categories: CPS – Involves a child who is allegedly abused, neglected, or abandoned and includes child abuse allegations. CPS Risk Only – Involves a child whose circumstances places him or her at imminent risk of serious harm but does not include child abuse allegations. Non-CPS – Involves a request for services for a family or child.

The assigned FAR worker made contact with the maternal grandmother, biological mother and the twins on December 20, 2016. The FAR worker noted that the maternal grandmother lacked parenting skills and needed help managing the twins. The grandmother RCW 13.50.100 . The biological mother denied RCW 13.50.100 or using foul language in the home; however, the biological mother confirmed yelling in the home. The assigned FAR worker did not observe marks on the twins but noted that they were dressed without documenting observing their skin under the clothing. The FAR worker also identified a non-relative roommate that was living in the home. The FAR worker documented assessing the roommate and having conversations with the maternal grandmother regarding the roommates contact with the children. It was reported and documented that the roommate had no caregiving responsibilities. This roommate reportedly moved out in February 2017. Minimal case activity occurred between February and August 2017.

On August 02, 2017, the FAR worker completed a health and safety[16] visitation with the children and maternal grandmother. The maternal grandmother informed the FAR worker that she cannot care for the twins any longer and was sending them to live with her friend, Bobbie Bishop, who resided in another state. The maternal grandmother said she was then planning on returning to RCW 74.15.515. The FAR worker was also informed that Bishop was planning to obtain legal custody of the twins. The FAR worker was able to make telephonic contact with Bishop on August 11, 2017, and received verbal confirmation that the twins were with her and that Bishop planned on having the temporary custody paperwork filed on August 14, 2017. Bishop stated that the twins were doing great and that she looked forward to raising them. Bishop reported that the maternal grandmother was somewhere in RCW 74.15.515 and that she was not sure of the maternal grandmother's future plans regarding where she would be living or when she planned on caring for the twins again. The Department subsequently contacted RCW 74.15 515 CPS. The supervisors who approved the FAR worker's assessments and entered documentation on the case had historical background knowledge of Bishop and the family but did not contact CPS in the state where Bishop was residing. This case was closed by the supervisor and FAR worker in August 2017 after they documented no safety threats. In April 2018, CA staff became aware of J.B.'s death via various news reports, which resulted in the CFR.

DISCUSSION

The Committee first discussed the CFWS case that closed in April 2014. The Committee questioned why CA agreed to dismiss the dependency petition without requesting a home study or submitting an Interstate Compact Placement of Children (ICPC) request to RCW 74.15.515[17]. The Committee heard from the supervisor and assigned CFWS worker that the tribe intervened in the dependency when the maternal grandmother, who was an enrolled tribal member, requested custody of J.B. and RCW 74. sibling, resulting in the tribe assigning an attorney to assist the grandmother. However, the tribe did not assume legal jurisdiction but instead intervened and pursued a third party custody agreement on behalf of the maternal grandmother. CA staff reported that the children may have been considered domiciled on the reservation since they were in the custody of the grandmother who resided there and was enrolled. The third party custody was reported by staff to have been entered in RCW 74.15.515 County; however, a copy was not found by the facilitator or previously assigned staff in the case file. The court entered the agreement for dismissal with the support of all parties. Reflecting back, the supervisor stated that they possibly should have consulted further with management or requested a home study in

[16] Investigators must conduct monthly health and safety visits with children and parents if the case is open longer than 60 calendar days according to Department policy.
[17] ICPC is a uniform reciprocal compact enacted in every state that governs the interstate placement of foster children. The Compact prohibits states from sending a dependent child to live with an out-of-state caregiver without first obtaining approval from the receiving state's child welfare agency following a home study and other assessments of the caregiver. Chapter 26.34 RCW.

RCW 74.15 515 on the grandmothers' home prior to agreeing to the dismissal of the case. The supervisor noted that her understanding of court procedures in such situations was very limited as she was new to her supervisory position. The Committee appreciated the CFWS supervisor's presentation of case information as she was clear, concise, and candid but wondered about the levels of guidance from her superiors and consultants during that time. Some members of the Committee also questioned the authority of the tribe in such circumstances where ICWA applied but the tribe did not take jurisdiction and if CA staff were uncomfortable challenging tribal preferences and case planning. After hearing from the CFWS supervisor and DCYF Deputy Regional Administrator Committee member, the Committee better understood Indian Child Welfare processes and laws and what occurred during this time on the case.

The Committee briefly discussed law enforcement involvement in neglect and FAR responses generally across the state. Some Committee members wondered why law enforcement was not involved more often during the home visitation and specifically during the FAR responses in 2016-17 and speculated about whether law enforcement involvement would have impacted the case. The Committee discussed differences between counties and jurisdictions as well as varied community protocols for response.

The Committee noted the importance of CA staff and supervisors addressing each concern with caregivers and verifying information that is gathered or supplied for accuracy of the Department's risk and safety assessments. After hearing from the assigned CA staff regarding the decision to return the children to the maternal grandmother, the Committee discussed that it was unclear how CA came to determine the maternal grandmother was a safe caregiver in 2014 and 2015, in particular after the maternal grandmother's founded finding for neglect in 2015. The Committee did not locate a documented safety assessment in FAMLINK[18] related to the 2015 CFWS case but did receive a verbal report from the assigned worker that CA determined there was not an active safety threat preventing the children from being returned to their grandmother. The worker's recollection and reasoning behind the safety assessment determination was limited and did not provide the Committee with a clear understanding as to how staff arrived at the determination it was safe to place the children with the grandmother. The Committee wondered if bias might have swayed the assessment of the assigned worker in the 2014 and 2015 decisions in returning the children to their grandmother. The Committee based this speculation on a brief admission by the worker that she was Native American and had a personal desire to place with the maternal grandmother to maintain the children's connection to their Native heritage even though the court had strong findings about the maternal grandmother's inability to care for the children at the shelter care hearings. The Committee discussed the findings made by the court at the 2015 shelter care hearing and believed it should have been given greater weight in the assessment of safety.

Regarding the 2017 FAR response, the Committee agreed with the intake supervisor's decision in 2017 to overrule the intake SW's initial decision to screen out the intake. The Committee found that this was an appropriate screening decision. The Committee determined that there was readily available information regarding Bishop that the assigned staff or supervisor should have responded to either immediately with a request for a VPA, law enforcement involvement or with a call to the CPS jurisdiction where Bishop was residing once the Department learned that the children were no longer in Washington State. The Committee was pleased to see that the intake supervisors who screened this in documented that they had assessed the biological mother as a risk to the children. The Committee felt that Bishop's history with CA and the grandmother's notable and consistent inability to provide care for the twins should have been acted on more aggressively by the assigned staff. Further, the Committee wondered why the biological mother's presence in the home was minimized during this intervention. The assigned

[18] FamLink is the case management information system that CA implemented on February 1, 2009, and it replaced CAMIS, which was the case management system used by the agency since the 1990's.

worker informed the Committee that they had unintentionally failed to review the historical record for either Bishop or the biological mother. The Committee believed this led to an inaccurate safety assessment.

The Committee heard from the assigned workers and supervisors of the historical workload issues and vacancies in their unit between 2012 and 2017 that significantly impacted their ability to do thorough assessments and supervision. The Committee heard that often a supervisor was left to oversee multiple units as well as having case carrying responsibilities or that workers would have to assume multiple caseloads. While recognizing workload constraints, systemic issues surrounding turnover, and insufficient staffing levels related to the workload, the Committee noted that the 2017 FAR response had not been completed in the required timeframes. The Committee questioned whether global assessments of child safety and family functioning were adequate in this case given the difficulties mentioned above.

The Committee discussed both the CFWS worker and FAR workers' verbal reports regarding the maternal grandmother and the children. The Committee felt there was a discrepancy in the workers' verbal report during the review in comparison to what was documented regarding the maternal grandmother's abilities to care for J.B. and RCW 74. sibling at the time of the Department's prior involvement with the family. The Committee discussed the evidence pointing to the maternal grandmother's inability to care for the children in 2015. Specifically, there was a recommendation in 2015 by the local CAC that the children should be in a medical placement to address their developmental needs. The Committee discussed how the workers may have had sympathy for the maternal grandmother an elderly woman caring for her active grandchildren and did not fully acknowledge the risk of leaving the children in her care. In addition, it seemed to the Committee that the assigned workers may have not understood how to fully identify and assess information relevant to children who have experienced chronic trauma and child safety. The Committee felt that the assigned workers had minimized the children's behavioral and medical needs as well as the grandmother's inability to care for the children.

FINDINGS

Based on a review of the case documents and interviews with staff, the Committee found one critical error made by Department staff. The Committee found that the Department did not utilize or respond sufficiently to readily available information on Bishop during the 2017 FAR intervention.

ADDITIONAL FINDINGS

Understanding that workload, medical leave, and staff turnover impact a worker's ability to carry out their job responsibilities fully and completely, the Committee found that readily available information was not utilized to assess the maternal grandmother's suitability and capability to provide care to J.B. and RCW 74. sibling and such information was not utilized accurately in the safety assessments during CA's 2015 and 2017 involvement with J.B. Further, the Committee believed that there may have been an active safety threat when the children were returned to their grandmother in 2015 as well as present danger during the FAR intervention in 2017.

RECOMMENDATIONS

DCYF management should develop alternatives to current practices to address high workload and staffing vacancies in an effort to reduce overloading employees and improve safety assessment and case planning. The Committee provided one suggestion, which is for the Department to consider using program managers with supervisory and field experience to fill in across the state where staffing levels are low and caseloads are over the recommended levels.

DCYF should consider clarifying CPS safety assessment policy so workers better understand how to utilize all available information about all individuals who have frequent contact with a child(ren) or are who are seeking custody of a child(ren).

WASHINGTON STATE Department of Children, Youth, and Families

Child Fatality Review

J.T.

RCW 74.15.515 **2017**
Date of Child's Birth

April 2018
Date of Fatality

July 10, 2018
Child Fatality Review Date

Committee Members
Elizabeth Bokan, Ombuds, Office of the Family and Children's Ombuds
Ashley Robillard, Sexual Assault Unit Detective, Tacoma Police Department
Stuart King AA/CDP, Chemical Dependency Provider, MultiCare Health System
Brandy Otto, Office Chief, Department of Children, Youth, and Families
Chad Baker, Child Protective Services Supervisor, Department of Children, Youth, and Families

Observer
Amanda Sutherland, Child Protective Services worker, Department of Children, Youth, and Families

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

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Executive Summary

On July 10, 2018, the Department of Children, Youth, and Families[1] (DCYF or Department) convened a Child Fatality Review (CFR)[2] to assess the Department's practice and service delivery to J.T. and RCW 74. family.[3] The child will be referenced by RCW 74. initials in this report.

On April 30, 2018, Children's Administration (now DCYF) received an intake stating that J.T.'s mother had called 911 saying, "I think my baby is dead." Paramedics arrived and performed cardiopulmonary resuscitation on J.T. and transported RCW 74.15. to a hospital where RCW 74 was declared deceased. J.T.'s mother told the caller that she had fed RCW 74.15.5 laid down for a nap at 10:00 a.m. with J.T. in the same bed and woke four hours later. When she woke up, she realized that she had rolled over on top of J.T. At the time of RCW 74. death, the Department had an open Children Protective Services (CPS) investigation alleging concerns for substance abuse by J.T.'s mother and neglect of J.T.

The CFR Committee (Committee) included members selected from diverse disciplines within the community with relevant expertise including individuals from the Office of the Family and Children's Ombuds, law enforcement, substance abuse treatment and child welfare. There was an observer from DCYF as well. The Committee members and observer did not have any involvement or contact with this family.

Prior to the CFR, each Committee member received a summary of the Department's involvement with the family and unredacted Department case documents (e.g., intakes, investigative assessments and case notes). Supplemental sources of information and resource materials were available to the Committee at the time of the CFR. These included relevant state laws and Department policies.

The Committee was unable to interview the CPS worker and supervisor as both staff members left employment with the Department prior to this review. The CPS worker left the Department while the CPS case was open and prior to the fatality. The CPS supervisor left the agency after the fatality but prior to the fatality review.

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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. The fatality here happened prior to July 1, 2018, and therefore CA or DSHS may be referenced in this report.

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

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

Family Case Summary

The mother first came to the attention of the Department on March 7, 2014. At that time the mother was RCW 13.50.100 on RCW 13.50.100 and the intake caller reported a history and current use of RCW 13.50.100 Another intake was received on March 31, 2014, indicating that the mother RCW 13.50.100. On May 20, 2014, the mother called to report that she was RCW 13 and had RCW 13.50.100. She also reported that she was attending RCW 13.50.100. All three 2014 intakes were screened out because the RCW 13.50.100.

On September 23, 2014, the Department received an intake stating that the mother was RCW 13.50.100 and RCW 13.50.100). That investigation was RCW 13.50.100. A RCW 13.50.100 and the RCW 13.50.100. The mother's RCW 13.50.100.

On February 9, 2016, the Department received a report from law enforcement detailing an interaction with the mother. The mother reported she was RCW 13.50.100. During this contact the mother stated she was RCW 13.50.100 and wanted to get into a RCW 13.50.100. This intake was screened out because the RCW 13.50.100. On March 7, 2016, the mother's RCW 13.50.100.

On May 26, 2016, an RCW 13.50.100 worker for the Department received an email stating that the mother RCW 13.50.100. This case was screened in for an CPS Risk Only assessment.[4] A RCW 13.50.100 as to RCW 13.50.100 and RCW 13.50.100.

During the RCW 13.50.100, she failed to RCW 13.50.100 s ordered. At the time the mother RCW 13.50.100, she claimed she was RCW 13.50.100 and that the Department RCW 13.50.100. A Family Team Decision Meeting (FTDM) had been scheduled for December 1, 2017, to discuss the mother's RCW 13.50.100. Prior to the scheduled FTDM, the maternal grandmother stated that the mother was RCW 13.50.100 and was RCW 13.50.100. After the mother RCW 13.50.100 the FTDM regarding her RCW 13.50.100 was canceled.

On January 19, 2018, an intake was received from a "friend of a friend" stating that the mother was using RCW 13.50.100 and RCW 13.50.100 in the presence of her child, J.T., and that she would leave RCW 74.15. in a car seat for long periods of time. This intake was assigned for a CPS investigation.

[4] Risk Only reports are when a child is at imminent risk of serious harm and there are no allegations of abuse or neglect https://www.dshs.wa.gov/ca/practices-and-procedures-guide/2200-intake-process-and-response

Another intake was received on January 22, 2018, alleging similar allegations. This intake was screened out because the first intake had already been assigned for investigation.

On January 22, 2018, the assigned CPS worker made contact with the mother, J.T. and the paternal grandfather. The mother, father and J.T. lived with the paternal grandfather. There were no concerns noted during this home visit. The CPS worker discussed Period of Purple Crying and safe sleep with the mother while the grandfather was present. J.T. appeared to be doing well and no injuries were noted during a diaper change. The mother called the father during this contact and the CPS worker spoke with the father by phone. The father stated he would meet with the CPS worker another day as he was working in Seattle that day.

The mother denied the allegations contained in the intake and said she has been clean for well over a year. She said she has contact with her mother regularly, and she agreed to provide a urinalysis. The mother also provided J.T.'s pediatrician information to the CPS worker. The CPS worker spoke with the paternal grandfather who stated he had never seen the mother use drugs in the home. He stated he helped with rocking J.T. to sleep and that he had no concerns regarding J.T.'s care.

The mother failed to provide the urinalysis on the following day, stating she did not have transportation. The CPS worker requested law enforcement reports for the parents for the previous six months at their current residence. On January 24, 2018, the CPS worker received an email from an attorney stating he was representing the parents. The CPS worker left a voice mail message for the attorney requesting a return call on February 22, 2018.

Between February 22nd and February 26, 2018, the CPS worker called the father and maternal grandmother requesting a call back. The CPS worker verified that J.T. was seeing a pediatrician and that the pediatrician had no concerns. The CPS worker also checked the parents' histories through multiple databases covering both Department and criminal histories. The CPS worker learned that the mother and father had criminal history from multiple years, most recently 2016 for the father and 2017 for the mother. There was CPS history for the mother regarding RCW 13.50.100 but no CPS history for the father. There was no history in any of the Department or criminal databases regarding the paternal grandfather.

On February 27, 2018, the CPS worker spoke with J.T.'s father. He denied the allegations about the mother's substance abuse and her leaving the child in a car seat for long periods of time and said he did not have any concerns for J.T. During this conversation, the CPS worker learned that the father had attended RCW 13.50.100 when he was nineteen years old, but the father denied any criminal history after 2012. Unrelated to this case, the CPS worker chose to end his employment with the Department around this time. The CPS supervisor then assigned the case to herself and resumed case activity.

The CPS supervisor made telephone contact with the mother. During their conversation on March 12, 2018, the supervisor discussed the current situation and case closure. The mother

stated her attorney told her to not provide a urinalysis. The CPS supervisor explained that based on the mother's history, she was not comfortable closing the case out without a clean urinalysis and that she was going to staff the case at a Child Protection Team (CPT) meeting. The supervisor called the father, at the request of the mother, to discuss the case. The supervisor then called and texted the parents five different times before finally reaching the father on April 23, 2018. The father stated they believed the case was closed and the supervisor reiterated the concerns and the upcoming staffing at the CPT. The CPS supervisor then requested J.T.'s birth records from the hospital.

On April 26, 2018, the CPS supervisor texted the mother, who did not respond. The following day the CPS supervisor went to the home but no one answered the door. On April 30, 2018, the CPS supervisor mailed letters to the mother and father inviting them to attend the CPT scheduled for May 8, 2018.

Later that same day, the Department received an intake regarding J.T.'s death. This intake was screened in for a CPS investigation. Three subsequent intakes were received regarding the death and were screened out because there was already an open investigation.

During the CPS investigation regarding J.T.'s death, the Department learned that the mother had a felony warrant with Department of Corrections (DOC) and the father had multiple warrants as well. Law enforcement stated that the home had holes in the bedroom and bathroom and that the maternal grandmother told them that there was RCW 13.50.100 between the parents. The parents refused to cooperate with the CPS investigation regarding J.T.'s death. The Medical Examiner's report has not been completed prior to the completion of this report and the CPS investigation remains pending.

Committee Discussion

The author of this report spoke with the area administrator, CPS supervisor who handled the case until J.T.'s death and the CFWS supervisor for the mother's RCW 13.50.100 prior to this review. Information from those discussions were shared with the Committee members.

The Committee discussed the challenges posed with Risk Only intakes. Specifically regarding this case, the Committee discussed that the mother's history of substance abuse was significant, yet when the CPS worker observed the home, child and mother in January of 2018, there did not appear to be any current, obvious threats to the child's safety. The mother's failure to comply with the request for a urinalysis, coupled with her long history of substance abuse, concerned the Committee. The Committee believed that the request for a CPT was appropriate.

As part of the discussion regarding Risk Only cases, the Committee discussed that the FTDM scheduled in December of 2017 before J.T. was born should have taken place since building relationships with relatives and parents is very important to the work of the Department. However, the Committee discussed how it is vital that statements made by relatives and

parents are verified through corroboration and collaterals because the safety of children is paramount. The CPS worker reached out to the maternal grandmother but she did not return that call. Contact with the maternal great grandmother as well as the paternal relatives, after the initial contact with the paternal grandfather, would also have been appropriate. Another avenue that could have been pursued as a collateral would have been the use of National Crime Information Center (NCIC). The Committee speculated that this may have alerted the CPS worker and supervisor to the fact that parents had recent criminal activity and may have led them to contact with the mother's DOC officer.

There was discussion that many times clients present barriers to providing urinalysis or making appointments that are requested by the Department. In this case, the mother stated she did not have transportation to provide the requested urinalysis. The Committee noted that further discussion with the mother regarding how to ameliorate that barrier would have been appropriate. The mother clearly made the well-child checks as documented by the pediatrician's office. The mother also stated her mother visited her often and the paternal grandfather, with whom the parents and J.T. lived, also had transportation.

The issue of staff longevity and turnover was also discussed. With longevity and experience, a person is able to build their confidence in how to discuss difficult topics. It is the hope that experienced staff more readily take into consideration recent history with the Department and how that plays into risk as opposed to relying on identified safety threats alone. This was also discussed regarding the mother's RCW 13.50.100 and the choice to cancel the FTDM RCW 13.50.100. The mother made it clear that she did not want the Department involved in her RCW 13.50.100 child's life and the maternal relatives said they believed the mother was clean and doing well, but the Committee noted that there was no current unbiased documentation of the mother's change because she refused to participate in services, complete a urinalysis, or maintain contact with the Department. The Committee discussed how having difficult discussions with parents regarding the RCW 13.50.100 while another child's birth is pending is not easy, and the ability for a worker to have difficult conversations usually comes with experience and education. The Committee discussed that additional training on difficult discussions is an area which the Department could improve upon.

Findings

The Committee did not identify any critical errors made by the Department during this investigation. There were areas identified by the Committee where practice could improve. Those areas are discussed in this section.

The first intake regarding J.T. was received on January 19, 2018. The CPS worker made face-to-face contact with the mother and J.T. on January 22, 2018. There were multiple attempts made to contact the parents via phone and even email but no other in person attempts were made

until April 27, 2018. A health and safety visit should have been attempted in March and April prior to April 27.[5]

The Committee noted the directive provided by the area administrator to the CFWS supervisor regarding an FTDM prior to the closure of the previous RCW 13.50.100 case was appropriate and should have been followed. The Committee discussed that while this is not a policy that this is a good standard of practice.

The Committee noted that there did not appear to be a sense of urgency regarding the risk to J.T. While the mother and her family stated she was not using or abusing substances, there was no corroboration of those claims. There was, however, a lengthy history of proven RCW 13.50.100 use and failure to comply with court ordered services in the previous RCW 13.50.100 leading to the RCW 13.50.100. The Committee also stated that it would have been appropriate to staff the case with an Assistant Attorney General at the time the parents discontinued contact with the Department and when the mother refused to provide a urinalysis.

Recommendations

The Committee did not make any recommendations regarding this review.

Nondiscrimination Policy

The Department of Social and Health Services does not discriminate and provides equal access to its programs and services for all persons without regard to race, color, gender, religion, creed, marital status, national origin, sexual orientation.

[5] Children in CA custody, or with a Child Protective Services (CPS) or Family Reconciliation Services (FRS) case open beyond 60 days or receiving family voluntary services (FVS) must receive private, individual face-to-face health and safety visits every calendar month. https://www.dshs.wa.gov/ca/4400-concurrent-tanf-benefits/4420health-and-safety-visits-children-and-monthly-visits-caregivers-and-parents

WASHINGTON STATE
Department of
Children, Youth, and Families

CHILD FATALITY REVIEW

January 2019

www.dcyf.wa.gov

FULL REPORT

CHILD

- E-R.J.

DATE OF FATALITY

- May 2018

CHILD FATALITY REVIEW DATE

- April 23, 2018

COMMITTEE MEMBERS

- Patrick Dowd, JD, Director, Office of the Family and Children's Ombuds
- Pam Hubbard, LMHC, CDP, Co-occurring therapist, Evergreen Recovery Centers
- Amy Boswell, Child Protective Services/Family Assessment Response Program Manager, Department of children, Youth, and Families
- Michelle Hedges, Supervisor, Department of children, Youth, and Families
- Judy Ziels, MPH, CPH, RN, Public Health Nurse Supervisor, Whatcom County Health Department

FACILITATOR

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

CONSULTANT

- Janet Pederson, Central Intake Supervisor, Department of Children, Youth, and Families

Nondiscrimination Policy

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

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).

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EXECUTIVE SUMMARY

On August 23, 2018, the Department of Children, Youth and Families1 (DCYF or Department) convened a Child Fatality Review (CFR)2 to assess the Department's practice and service delivery to E-R.J. and RCW 74.1 family.3 The child will be referenced by RCW 74.1 initials in this report.

On May 3, 2018, Children's Administration (which is now DCYF) received an intake stating that E-R.J.'s father called 911 and reported that E-R.J. was cold and unresponsive. Emergency services personnel provided CPR and transported RCW 74.1 to the hospital where RCW 74.15 was declared deceased. The father reported the parents had been bed-sharing with their RCW 74.15.515 and they awoke to find RCW 74.1 unresponsive. The referrer stated the parents appeared to be under the influence and was concerned as to why it took them an hour to get to the hospital. At the time of the death, the family had an open Family Voluntary Services (FVS) case with the Department.

The CFR Committee (Committee) included members selected from diverse disciplines within the community with relevant expertise including individuals from the Office of the Family and Children's Ombuds, substance abuse treatment, public health and child welfare. There was a consultant from DCYF to discuss any specific questions related to DCYF intakes. The Committee members and consultant did not have any involvement or contact with this family.

Prior to the CFR, each Committee member received a summary of Department involvement with the family and unredacted Department case documents (e.g., intakes, investigative assessments and case notes). Supplemental sources of information and resource materials were available to the Committee at the time of the CFR. These included relevant state laws and Department policies.

The Committee interviewed the Child Protective Services (CPS) worker and her supervisor, the FVS worker and her supervisor, as well as the area administrator. The CPS investigator regarding the fatality investigation no longer was employed with DCYF.

[1] 1 Effective July 1, 2018, the Department of Children, Youth, and Families (DCYF) replaced the Department of Social and Health Services (DSHS) Children's Administration (CA) as the state agency responsible for child welfare (and early learning programs). The fatality happened prior to July 1, 2018, therefore CA or department may be used in the report.

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

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

CASE OVERVIEW

E-R.J.'s father first came to the attention of the Department in RCW 13.50.100 of 2004. There were allegations of RCW 13.50.100 of his infant RCW 13.50.100 He and the mother of the child were living together at the time. There were concerns regarding RCW 13.50.100, RCW 13.50.100, and RCW 13.50.100. This child became RCW 13.50.100 in September of 2010.

E-R.J.'s mother first came to the attention of the Department when her first child was an infant. An intake was received on RCW 13.50.100, 2010, alleging concerns for RCW 13.50.100 There were concerns for RCW 13.50.100 for the infant and the mother was not cooperating with supportive services. The intake worker searched through the Department's computer system and learned that the mother's husband was a RCW 13.50.100. This intake was screened in for a CPS investigation. This intake was unfounded.

Another intake was received on May 9, 2010, alleging that the mother had RCW 13.50.100 and was RCW 13.50.100. The caller reported changes to the mother's RCW 13.50.100 and suspected RCW 13.50.100. The caller alleged RCW 13.50.100 as well. This intake was also screened in for a CPS investigation. This intake was founded. A RCW 13.50.100 was filed. The court RCW 13.50.100.

A third intake was received on July 6, 2010, stating that the RCW 13.-month old infant was being RCW 13.50.100 by her father. The father allegedly RCW 13.50.100. This intake was unfounded, however the RCW 13.50.100 process continued and the child RCW 13.50.100 the next year. She was ultimately RCW 13.50.100. The mother and father dissolved their marriage.

The next intake was received on RCW 74.15.515, 2018, reporting that E-R.J. was born. The caller reported that the mother was not compliant with RCW 13.50.100 and her RCW 13.50.100. Prenatal records indicated the mother had previously RCW 13.50.100. The mother and her new husband, E-R.J.'s father, reported RCW 13.50.100 as recently as 13 days prior to their RCW 74.15.515 birth. The caller also reported that the father had an older child who was RCW 13.50.100 and that both parents reported RCW 13.50.100. The father also reported a history of RCW 13.50.100. This intake was assigned for a CPS Risk Only assessment.[4]

Contact was made the same day with the parents and E-R.J. The CPS worker learned that the mother had been RCW 13.50.100 through the Department and had Native American heritage through her biological family. The mother also shared that she was RCW 13.50.100 as a teenager because she was "RCW 13.50.100." The mother stated she wanted to become clean and sober and parent her newborn.

Concerns were noted by hospital staff regarding the mother's care of E-R.J. and that the father had been escorted off the property and was not allowed to return. The father was allegedly following people to their cars and going through other people's belongings. A family team decision meeting (FTDM) was held at the hospital and a plan was put into place for E-R.J. to be placed through a voluntary placement agreement (VPA) with the maternal grandparents. The mother would be allowed to live in the home and parent her RCW 74.15 515 with full supervision by at least one of the grandparents while the parents addressed their identified mental health and substance abuse issues. The father reported he RCW 13.50.100.

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

The parents were referred for chemical dependency assessments and random urinalysis. The father had a RCW 13.50.100 on February 23, 2018. On March 5, 2018, the father's urinalysis was RCW 13.50.100 and had a RCW 13.50.100 and the mother's urinalysis was RCW 13.50.100 .

On March 8, 2018, the maternal grandmother was notified that the Department was going to vacate the VPA and E-R.J. would be placed with RCW 74.1 parents. The maternal grandparents were in support of this decision. A safety plan was created and intensive family preservation services (IFPS) was referred for the family. On March 21, 2018, another FTDM was held. Both parents as well as paternal grandfather and maternal grandmother participated. The maternal grandparents were leaving the state until June 2018. The safety plan included the paternal grandfather and the mother's friend. The mother's friend agreed to the safety plan and her role and responsibilities as a safety plan participant.

On March 29, 2018, the Department received the father's chemical dependency assessment. It included information stating that the father may be RCW 13.50.100 . The father's assessment indicated a need for a RCW 13.50.100 .[5] The following day, the mother's assessment was received. The assessments of both parents recommended RCW 13.50.100 . On March 31, the father failed to show for his random urinalysis. On April 2, the mother's urinalysis was RCW 13.50.100 On April 2, 6, and 8, the father's random urinalyses were RCW 13.50.100 . On April 4 and 5, the mother's urinalysis was RCW 13.50.100 On April 10, 2018, the case transferred from CPS to FVS. The parents had completed Homebuilders services.[6] The Homebuilders closing summary indicated that, at the conclusion of the services, the home the family was living in became more cluttered, that safe sleep had been reviewed because the mother acknowledged she was sometimes falling asleep with E-R.J. on the bed and there were recommendations for following through with substance abuse recovery services, random urinalysis, supportive community services, and that the parents move to a new location. On April 12, the mother's urinalysis was RCW 13.50.100 On April 16, the mother's urinalysis was RCW 13.50.100 and the father's was RCW 13.50.100 .

On April 18, 2018, the assigned FVS worker met with the parents at their home. Three days later the mother's urinalysis was RCW 13.50.100 and the father's was RCW 13.50.100 . On April 23, 2018, the FVS worker communicated with the family preservation services (FPS) provider who stated a home visit occurred. The FPS provider stated she did not have serious concerns about the family but was concerned the father may be using drugs.

On April 30, 2018, an intake was received by a mandatory reporter indicating the parents and E-R.J. attended an appointment. The caller stated that both parents appeared "out of it" stating they fell asleep while their RCW 74.15.515 was in RCW 74.1 car seat, [both] looked ill, the mother vomited in the trash can, the mother was somewhat rough when handling E-R.J., that the father introduced himself three times, to the same staff member, within five minutes. When E-R.J. started to cry, the staff member suggested feeding RCW 74.1 but the mother stated, "RCW 74.15 is fine and RCW 74.15 just ate." The staff stated they would not have allowed the parents to drive with the child but verified that the paternal grandfather drove them to the appointment and picked them up. This intake was screened out. The next day, May 1, 2018, the parents both failed to appear for their random urinalyses.

On May 3, 2018, the Department received an intake stating that E-R.J. had been brought, via ambulance, to the hospital. RCW 74.15 was cold and unresponsive. RCW 74.15 was declared deceased at the hospital. The father stated that the parents had been sleeping in bed with E-R.J. When they woke up they found RCW 74.1 to be unresponsive. Both parents arrived an hour after their RCW 74.15 515

[5] A co-occurring disorder is the presence of substance abuse along with a mental health disorder.
[6] http://insideca.dshs.wa.gov/Intranet/policy/ebp.html

did, their eyes were dilated and staff were concerned they were under the influence of substances. This intake was assigned for a CPS investigation and ultimately a founded finding for neglect and/or negligent maltreatment was made against both parents. Throughout the open CPS and FVS case in 2018, the parents were offered ongoing assistance with transportation and referrals for supportive services.

COMMITTEE DISCUSSION

The Committee discussed many differing aspects of this case. There was discussion surrounding whether or not the risk of the parents' prior substance abuse history and lack of engagement in services to ameliorate identified parental deficiencies in prior RCW 13.50.100 cases, coupled with the parents' drug use at the birth of E-R.J. rose to a level that needed legal intervention as opposed to allowing for a voluntary placement agreement (VPA). This ultimately led to a reunification with the parents with very little to no change in circumstances. The parents presented with substance abuse as well as mental health issues that were not assessed prior to reunification.

The issue of marijuana being legal, but the need for the Department to assess child safety when a parent uses or abuses marijuana, was also discussed. There have been repeated reviews that discuss this issue of legalized marijuana as it pertains to child safety. The Committee noted that abuse or overuse of any substance, prescribed, legal or otherwise, needs to be assessed by the Department as part of a comprehensive assessment of child safety. It was also discussed that often there are predictable side effects for prescribed medications but marijuana and the method of use or ingestion is not as predictable. There are parents with whom the Department comes into contact who state they use marijuana because they have less side effects than prescribed medications. The Committee noted that if this is the statement the parent makes, the Department should make efforts through collateral contacts, such as the client's physician, to vet these statements for accuracy.

As part of the discussion surrounding marijuana, the Committee discussed the confusion surrounding urinalysis tests. When marijuana was legalized it was removed from the standard urinalysis testing list for the Department. Though the conversation of removing it from the standard list had begun prior to the legalization of marijuana, Department staff are able to add it to the list of substances that are tested. But, it appears that not all staff were aware of this change. The Committee discussed that it might be beneficial to share that information again with the field.

There was discussion surrounding the RCW 13.50.100 history reported by the father as well as statements the mother made surrounding RCW 13.50.100 exhibited by the father. The Committee discussed that the case records as well as interviews with staff indicated that there should have been further, separate conversations with the mother surrounding RCW 13 50.100 and safety. It appeared to the Committee that the RCW 13.50.100 was not considered impactful by the Department because it did not include RCW 13.50.100.

The Committee also discussed the reported pressure to close out cases by the FVS worker. The Committee discussed that the FVS worker did not show a sense of urgency regarding the information of the missed UAs and the screened-out intake and how that could impact E-R.J.'s safety.

Some other discussions the Committee had surrounded the inconsistent information shared between staff regarding discussions of the screened out intake in April as well as the direction the FVS worker states she was given regarding prioritizing case closure over responding to

information received on assigned cases. The Committee concluded that they would not be able to determine what exactly happened but that they found the inconsistencies to be concerning. They also discussed that when administrative tasks are emphasized, often client care is decreased as a result.

There was also a discussion regarding systemic barriers. At the time of the intake in RCW 74.15.515 of 2018, the CPS supervisor had a large span of supervision due to supervisory vacancies. The FVS supervisor was new to supervision, having only two months of experience at the time of the fatality. These issues were discussed because the Committee noted that when there is a large span of supervision, combined with other stressors that occur with higher than usual caseloads, often it is difficult to provide consistent clinical supervision.

FINDINGS

The Committee did not identify any critical errors made by DCYF during this investigation. There were areas identified by the Committee where practice could improve. Those areas are discussed in this section.

The Committee believed that there should have been more collateral contacts made throughout the life of this case. Specifically, connecting with the chemical dependency providers prior to the FTDM as well as post reunification, connecting with mental health professionals and safety plan participants, and obtaining the parents' social security records or discussing with that administration the parents' identified mental health issues or deficits related to the traumatic brain injury.

The Committee noted that between the beginning of the case and the time that E-R.J. was returned to RCW 74.1 parents' care unsupervised, there had not been a significant change of circumstances to show that RCW 74.1 parents had made progress toward ameliorating their identified substance abuse and mental health issues. The Committee did not agree with the decision to place E-R.J. back with RCW 74.1 parents with an in-home safety plan.

The Committee believes that the April 30, 2018, intake met sufficiency standards and should have screened in, necessitating a response by the field.

The Committee also noted that the combination of the missed urinalysis test for both parents coupled with the screened out intake from April 30, 2018, should have warranted a response from the Department. The Committee believed that the behaviors identified by the caller, along with the parents missing their random urinalysis tests, raised the risk to E-R.J. enough to require a face-to-face assessment.

The Committee also found that there was a lack of documented clinical supervision provided to the CPS investigator. The discussion surrounding this included concerns that without documentation of clinical supervision, the use of critical and comprehensive thinking is not as apparent.

E-R.J.'s mother has Native American heritage. Even though her first child did not meet the standards for enrollment, the Committee noted that each time the department has contact with the family, the identified tribe should be contacted to determine eligibility for enrollment.[7]

[7] CA caseworkers must complete the Indian Identity Request DSHS 09-761 at the initial visit with the parent(s)/Indian custodian on **all** screened in cases for each child, including those who have not been identified as victims. https://www.dshs.wa.gov/ca/indian-child-welfare-policies-and-procedures/3-inquiry-and-verification-childs-indian-status

The Committee did note that the CPS case notes were inputted in a timely manner and that the CPS worker worked hard to create a positive and supportive relationship with the parents. The inputting of case notes in a timely manner was also discussed in conjunction with the identification of staffing shortages, which made the timeliness stand out.

RECOMMENDATIONS

The Department should provide training to help staff understand how parental poly substance abuse, as well as marijuana abuse, can impact the risk to children and provide education surrounding co-occurring disorders and how that can escalate risk to children.

The Department should have chemical dependency professionals (CDP) co-housed in field offices. This affords Department field staff the opportunity to receive education regarding substance use and abuse much easier than if they were not co-housed, it can create a smoother and less time consuming process of getting an evaluation for parents, and CDPs could be available to respond together with Department staff in the field.

The Department should address the inconsistent use of founded findings regarding unsafe sleep related deaths. The Committee acknowledged that each case is unique with differing circumstances. However, the Committee noted that not all unsafe sleep deaths, with prior Department involvement including education to the care providers regarding safe sleep, result in a founded finding for abuse or neglect.