QUARTERLY CHILD FATALITY REVIEW RCW 74.13.640 OCTOBER–DECEMBER 2019

Washington State Department of
CHILDREN, YOUTH & FAMILIES

Washington State Department of
CHILDREN, YOUTH & FAMILIES

Executive Summary

This is the Quarterly Child Fatality Report for October through December 2019, 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 receiving services described in this chapter or who has been in the care of the department or received services described in this chapter within one year preceding the minor's death.
>
> (b) The department shall consult with the office of the family and children's ombudsman to determine if a child fatality review should be conducted in any case in which it cannot be determined whether the child's death is the result of suspected child abuse or neglect.
>
> (c) The department shall ensure that the fatality review team is made up of individuals who had no previous involvement in the case, including individuals whose professional expertise is pertinent to the dynamics of the case.
>
> (d) Upon conclusion of a child fatality review required pursuant to this section, the department shall within one hundred eighty days following the fatality issue a report on the results of the review, unless an extension has been granted by the governor. A child fatality review report completed pursuant to this section is subject to public disclosure and must be posted on the public web site, except that confidential information may be redacted by the department consistent with the requirements of RCW 13.50.100, 68.50.105, 74.13.500 through 74.13.525, chapter 42.56 RCW, and other applicable state and federal laws.
>
> (2) In the event of a near fatality of a child who is in the care of or receiving services described in this chapter from the department or who has been in the care of or received services described in this chapter from the department within one year preceding the near fatality, the department shall promptly notify the office of the family and children's ombuds. The department may conduct a review of the near fatality at its discretion or at the request of the office of the family and children's ombuds.

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

This report summarizes information from completed reviews of four (4) child fatality and two (2) near-fatalities[1] that occurred in the fourth quarter of 2019. All child fatality review reports can be found on the Child Fatality & Serious Injury Reports page of the DCYF website.

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

DCYF Region	Number of Reports
Region 1	1
Region 2	0
Region 3	2
Region 4	0
Region 5	2
Region 6	1
Total Fatalities and Near Fatalities Reviewed During Fourth Quarter 2019	**6**

This report includes Child Fatality Reviews and Near Fatality Reviews conducted following a child's death or near-fatal injury that was suspicious for abuse and neglect and the child had an open case or received services from the DCYF within the 12 months prior to the child's death or injury. A critical incident review consists of a review of the case file, identification of practice, policy or system issues, recommendations and development of a work plan, if applicable, to address any identified issues. A review team consists of a larger multidisciplinary committee including community members whose professional expertise is relevant to the family history. The review committee members may include legislators and representatives from OFCO.

The following charts provide the number of fatalities and near-fatalities reported to DCYF and the number of reviews completed and those that are pending for calendar year 2019. The number of pending reviews is subject to change if DCYF discovers new information by reviewing the case. For example, DCYF may discover that the fatality or near-fatality was anticipated rather than unexpected, or there is additional DCYF history regarding the family under a different name or spelling.

Child Fatality Reports for Calendar Year 2019			
Year	**Total Fatalities Reported to Date Requiring a Review**	**Completed Fatality Reviews**	**Pending Fatality Reviews**
2019	15	13	2

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

Child Near-Fatality Reports for Calendar Year 2019			
Year	**Total Near-Fatalities Reported to Date Requiring a Review**	**Completed Fatality Reviews**	**Pending Fatality Reviews**
2019	9	8	1

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

This report includes information from an internal fatality review. This review did not meet the statutory requirements for a review and was conducted at the behest of DCYF leadership. This review is not subject to public disclosure and is not included in this report.

Near-fatality reports are not subject to public disclosure and are not posted on the public website.

Notable Fourth Quarter Findings

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

- Five (5) of the six (6) cases referenced in this report were open at the time of the child's death or near fatal injury.
- In three (3) of the six (6) cases, the children were 2 years old or younger at the time of death or near fatal injury.
- There was one (1) infant fatality due to unsafe sleep environment.
- The mother of the infant who died in an unsafe sleep environment was provided information on how to ensure a safe sleep environment for her baby prior to the child's death.
- Three (3) of the child fatalities were ruled homicides by medical examiners.
- One (1) near-fatality case was due to an overdose of opiates. The other near fatality case in this report was a near drowning.
- One (1) near fatality had been closed for eight (8) months prior to the near fatal injury. All other cases referenced in this report were open when the death or near fatal injury occurred.
- Four (4) children referenced in this report were Caucasian, one (1) was African American.
- Substance abuse and physical abuse were identified risk factors in three (3) of the six (6) cases. Domestic violence and mental health issues 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 or near fatal injury of the child. In three (3) of the cases, there were two (2) prior report made regarding the family. In two (2) other cases, there was one (1) intake reports on the family prior to the critical incident. In one (1) fatality case, the department received three (3) prior reports.
- Due to the small sample of cases reviewed, no statistical analysis was conducted to determine relationships between variables.

Child Fatality Reviews

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

Exhibit A contains the following child fatality reviews from the fourth quarter of 2019:

- P.Y. & L..Y. Child Fatality Review
- L.W. Child Fatality Review
- T.C. Child Fatality Review
- H.D. Child Fatality Review

CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

February 2019

Washington State Department of
CHILDREN, YOUTH & FAMILIES

Contents

February 2019

Full Report

Child

- P.Y.
- L.Y.

Date of Child's Birth

- [redacted] 2015
- [redacted] 2016

Date of Fatality

- June 27, 2018 (estimated)

Child Fatality Review Date

- Feb. 6, 2019

Committee Members

- Brad Graham, Senior Investigator/Analyst, Criminal Justice Division Office of the Attorney General (Seattle)
- Jake Fawcett, DV Fatality Review/Public Policy, Washington State Coalition Against Domestic Violence (WSCADV)
- Patrick Dowd, JD, Director, Office of the Family and Children's Ombuds
- Lonna Bowers, Guardian ad Litem (GAL), Kitsap County Juvenile & Family Court Services
- Tarassa Froberg, Child and Family Welfare Services and Family Voluntary Services Program Manager, Department of Children, Youth, and Families

Facilitator

- Bob Palmer, Critical Incident Case Review Specialist, Department of Children, Youth, and Families

Executive Summary

On Feb. 6, 2019, the Department of Children, Youth, and Families (DCYF or Department) convened a Child Fatality Review (CFR)[1] to examine the Department's practice and service delivery to P.Y., L.Y. and their family. This review originated from an apparent familicide.[2] On June 27, 2018, a DCYF Child and Family Welfare Services (CFWS) worker became concerned when she was unable to contact the children's parents about a scheduled home visit. The CFWS worker asked law enforcement authorities to conduct a child welfare check at the family apartment. Law enforcement made repeated efforts to locate the family. When found, law enforcement discovered that all four family members were deceased. The time of death is estimated at one week before discovery of the bodies. With regard to the mother and children, the 74.13.515 County Medical Examiner determined the cause of death was blunt force trauma to the head. The authorities did not initially publically disclose the father's cause and manner of death. The authorities believe the father killed both children, his wife, and himself.[3]

The CFR Committee (Committee) includes a DCYF CFWS program manager, a representative from the Office of Family and Children's Ombuds, a criminal justice investigator/analyst, a domestic violence (DV) expert with experience in DV related fatality reviews and a Guardian ad Litem (GAL) with prior experience in public child welfare social work. None of the Committee members had any previous direct knowledge of or involvement with the family.

At the beginning of the review, each Committee member received un-redacted DCYF documents (e.g., intakes, assessments and case notes) and a chronology summarizing the public child welfare involvement with the family. Committee members also received copies of the following Dependency Court documents: the GAL report to the court and a verbatim court hearing transcript. The hearing transcript is the transcript of the hearing pertaining to the judge's decision to order the return of the children to the care of their parents. This hearing occurred approximately 2 months before the deaths of the children and their parents. Supplemental information sources were also available to the Committee, including the following: mental health assessments and case management information, various community and Department-contracted service provider reports, 74.13.515 County Sheriff's Department records and court documents from 74.13.515 describing prior DV incidents.

The CFWS supervisor provided additional information during the Committee's in-person interview process. The assigned CFWS worker was not available for an interview and the previous CFWS worker was on maternity leave. The Committee made findings and recommendations after the case documents

[1] "A child fatality or near fatality review completed pursuant to [RCW 74.13.640] is subject to discovery in a civil or administrative proceeding, but may not be admitted into evidence or otherwise used in a civil or administrative proceeding except pursuant to [RCW 74.13.640(4)]." Given its limited purpose, a child fatality review (CFR) or child near fatality review (CNFR) should not be construed to be a final or comprehensive review of all circumstances surrounding the death or near death of a child. The CFR Committee's review is generally limited to documents in the possession of or obtained by DCYF or its contracted service providers. The Committee has no subpoena power or authority to compel attendance and generally only hears from DCYF employees and service providers. It does not hear the points of view of the child's parents and relatives, or of other individuals associated with the child. A CFR or CNFR is not intended to be a fact-finding or forensic inquiry to replace or supersede investigations by courts, law enforcement agencies, or other entities with legal respons bility to investigate or review some or all the circumstances of a child's fatal injury or near fatality. Nor is it the function or purpose of a CFR or CNFR to recommend personnel action against DCYF employees or other individuals. "The restrictions [described in this paragraph, and the paragraph immediately above,] do not apply in a licensing or disciplinary proceeding arising from an agency's effort to revoke or suspend the license of any licensed professional based in whole or in part upon allegations of wrongdoing in connection with a minor's death or near fatality reviewed by a child fatality or near fatality review team." RCW 74.13.640(4)(d).

[2] **Familicide** is defined as one family member who murders other members of their family, commonly taking the lives of all. It is most often used to describe cases where a parent, usually the father, kills his wife and children and then himself.

[3] There are no known criminal charges filed relating to the incident. Although the names of the family members have been released to the public, none are identified by name in this report. The names of the children are subject to privacy laws. See RCW 74.13.500.

review, consideration of interview responses by the DCYF supervisor and discussion about Department activities and decisions. The Committee findings and recommendations are included at the end of this report.

Case Overview

On Sept. 11, 2017, P.Y., L.Y. and their family were first brought to the Department's attention when a family relative contacted the Department seeking help to care for P.Y. and L.Y. At the time, the children's father was in jail due to criminal charges related to domestic violence and resisting arrest. The mother was in custody for an outstanding 74.13.515 bench warrant. The relative provided second-hand information to the Department indicating the father recently slapped 1-year old L.Y. in the head. Local law enforcement responded to the abuse allegations but did not take any further action. On Sept. 13, 2017, Child Protective Services (CPS) initiated a physical abuse and negligent treatment/maltreatment investigation. CPS issued an unfounded finding after the investigation was completed.[4]

On Sept. 14, 2017, the Department filed dependency petitions on behalf of both children. The petitions alleged the father was unavailable to care for the children because he was in jail and there was a No Contact Order prohibiting him from having contact with the children. The petition also alleged the mother was unavailable because she was extradited to 74.13.515 At the shelter care hearing, the children were placed in relative care.

In early November 2017, the mother returned to Washington State after a 74.13.515 court revoked the bench warrant. Also in early November and with regard to the father, the 74.13.515 County Juvenile Court entered a default order and dependency order. The dependency order required the father to complete a chemical dependency assessment, a domestic violence perpetrator evaluation and a psychological assessment with a parenting assessment component. The father's attorney requested his client be provided a neuropsychological evaluation due to possible previous 74.13.520.[5] On Dec. 12, 2017, the mother agreed that P.Y. and L.Y. were both dependent. Dependency orders involving the mother and children were entered on the same date. The court ordered the mother to participate in a parenting assessment, a parenting program such as Promoting First Relationships[6] and a chemical dependency assessment (pending any positive urine analysis results).

On Feb. 26, 2018, the Department filed a motion to change the children's placement from relative placement to licensed foster care due to disruption with the relative placement. The motion and supporting documents described the Department's concerns about the parents' ongoing parental deficiencies that were preventing, at that time, any consideration of reunification. On March 1, 2018, the court granted the motion to change placement.

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[4] The Department issues a "founded" or "unfounded" finding after the Department completes its abuse or neglect investigation. The preponderance of evidence standard applies to the Department's founded or unfounded determination. *Unfounded* means the "determination following an investigation [by CPS] that available information indicates that, more likely than not, child abuse or neglect did not occur, or that there is insufficient evidence for the Department to determine whether the alleged child abuse did or did not occur." RCW 26.44.020(28). **Founded** means the "determination following an investigation [by CPS] that based on available information, it is more l kely than not that child abuse or neglect did occur." RCW 26.44.020(13).

[5] A neuropsychological evaluation is a testing method through which a neuropsychologist can acquire data about a person's cognitive, motor, behavioral, linguistic, and executive functioning.

[6] *Promoting First Relationships® (PFR)* is a prevention curriculum program dedicated to promoting children's social-emotional development through responsive, nurturing caregiver-child relationships. Professionals who work with caregivers and young children often see the need to support and guide caregivers so the caregivers can build nurturing and responsive relationships with children. As PFR is a positive, strengths-based model, caregivers are open to the intervention and gain competence, and thus investment, in their caregiving.

On April 17, 2018, the father's attorney filed a motion to change placement. The father's motion raised concerns the new foster placement was failing to provide proper care to the children. The father's motion also asked that the parents be allowed to have weekend overnight visitation. On April 18, 2018, the children's GAL filed a declaration in support of the children being returned home. In the alternative, the GAL recommended that unsupervised weekend visitation should begin. The Department filed a declaration opposing any transition to parental care based on the parents' failure to complete their court-ordered services (e.g., DV assessments, parenting programs). On April 19, 2018, the court denied hearing the motion to transition the children to parental care.

A Family Team Decision Making (FTDM) meeting occurred on May 1, 2018. Meeting participants included the parents and their attorneys, the children's GAL, the foster parent and Department staff. At the conclusion of the FTDM meeting, the team made a transition to reunification recommendation.

At the May 3, 2018, Permanency Planning Review Hearing, the Department recommended the court find the mother in compliance and making progress. The Department reported the father's neuropsychological evaluation was complete, subject to completion of an [redacted] that had yet to be arranged due to [redacted]. The Department also reported the father had not been consistent with urine analysis testing requests, did not complete a chemical dependency evaluation and did not complete the court-ordered domestic violence perpetrator evaluation. Because of his partial compliance with court-ordered services, the Department requested the court reserve a finding of progress on the father. After hearing the parties' arguments, the court ordered that on May 5, 2018, the children begin a trial return home.

During the initial month of the trial return home, the Department conducted two Health and Safety Visits. The first visit was at the family residence and the second visit at the children's child care. Observations by the CFWS worker and providers reported the parents and children doing well. The Department continued to monitor services, including the following: parenting, in-home Family Preservation Services (FPS), the father's individual counseling and occasional UA testing. The CFWS worker continued to make efforts to seek referrals for the father for a DV perpetrator assessment and chemical dependency services.

On June 27, 2018, a CFWS worker became concerned when she was unable to contact the mother before a scheduled Health and Safety Visit. The worker shared her concerns with her supervisor and the GAL. The GAL reported she also had a home visit scheduled for June 27. The Department learned from the FPS provider that she saw the family a week prior to June 27 but was unsuccessful in her efforts to meet with the family earlier in the day. Based on all of this information the CFWS worker called law enforcement to request a welfare check. At approximately 5:00 p.m. law enforcement reported they were unable to contact the family at the apartment. A relative went to the family apartment but no one answered. At approximately 9:00 p.m. law enforcement told the CFWS worker that a criminal investigation had been initiated at the family residence. Law enforcement did not provide any other details at that time.

On June 28, 2018, DCYF learned the police found the deceased bodies of all four family members. Law enforcement authorities believe the father killed the children and mother and himself, about one week prior to June 28.

Committee Discussion

The CFR Committee initially looked at the circumstances that led to the dependency matter and the September 2017 decision to place the children in out-of-home placement. Those discussions did not result in any significant insights. The remaining discussions and deliberations focused on the reunification decision. There were three separate components to the Committee's reunification discussions: the reunification process, the compliance with court-ordered services and third, the procedures occurring at the Permanency Planning Hearing Review that led to the court's decision to order reunification.

For purposes of the first component, the Committee reviewed the case evolution from the first review hearing in January 2018 in which reunification was clearly not a consideration, to the Department eventually supporting reunification during the May 1, 2018 FTDM meeting. The Committee understands why case decisions change over time. With this in mind, however, the Committee struggled to understand the basis for which the CFWS worker supported reunification at the May 1, 2018 FTDM meeting. Twelve days earlier on April 19, 2018, at the change of placement hearing, the department opposed the parents' request to allow the children to transition to parental care based on the parents' failure to complete their court-ordered services. One plausible explanation for DCYF's May 1 recommendation may be that based on the facts presented at the May 3, 2018 permanency planning hearing, the mother was in compliance and making progress; and the father was in partial compliance. Another possible explanation may be that based on interview responses from the CFWS supervisor during the CFR, the Committee explored whether a confluence of system and individual biases may have contributed to a premature agreement to support transition and reunification efforts. Described another way, a function of "Groupthink".[7]

For instance, there was formidable pressure from the parents' attorneys who argued that due to incidents in disruption in out-of-home placements, the children would be better off in their parents' care. Similarly, based on GAL correspondence with the CFWS worker and a filed court declaration, the GAL strongly argued that frequent placement changes are severely traumatic to children and needed to be immediately addressed. There also appeared to be a worker bias in favor of early reunification, versus risking the parents' possible loss of housing resources if the children continued to remain in out-of-home placement. The Committee also considered the possibility that some DCYF workers believe Department legal representatives in [redacted] County Dependency Court tend to lean toward arguing for an agreement rather than risk an adverse court decision. This may result in worker staff capitulation. The Committee considered whether this impacted the decision to return home at the May 3 court hearing and discussed this with the assigned social worker and supervisor. The social worker and supervisor informed the Committee that this was not a factor in the decision to propose a trial return home.

[7] Groupthink is the psychological phenomenon that occurs within a group of people in which the desire for harmony or conformity in the group results in an irrational or dysfunctional decision-making outcome. Group members try to minimize conflict and reach a consensus decision without critical evaluation of alternative viewpoints by actively suppressing dissenting viewpoints, and by isolating themselves from outside influences

However, they agreed with the Committee's supposition that the appeal for compromise has been an issue in other dependency cases.

For purposes of the second component, the Committee discussion focused on compliance with the court-ordered services listed in the dependency orders, most notably, the case services ordered for the father in November 2017 and the case services ordered for the mother in December 2017. From January through March 2018, the parents demonstrated some efforts to engage in court-ordered services. However, such efforts were insufficient to remedy the parents' significant parental deficiencies or meet full compliance with the court-ordered services. For example, the father completed an initial mental health diagnostic evaluation that included the following diagnoses: 74.13.520 – 74.13.520 During the January 2018 to March 2018 timeframe, the father was only in the initial stages of the mental health management services. During the May 3, 2018 Permanency Planning Hearing the CFWS worker clearly described concerns about the father's failure to consistently submit to 74.13.520 urine analysis testing, complete a chemical dependency evaluation and complete a domestic violence perpetrator assessment. The CFWS worker also reported the father's neuropsychological evaluation was incomplete because he failed to submit to an 74.13.520 At the time of the Permanency Planning Hearing, there was uncertainty about the father's mental health status and his current mental health medications.

The Committee also discussed the Department's May 3, 2018 permanency planning recommendations. At that time, the Department told the court the mother complied with the court's order and was making progress. The mother appeared to have completed a CD evaluation, participated in counseling, was engaged in a variety of parenting education and skills classes and was submitting to urine analysis testing. However, the documents also show the mother frequently failed to appear for such testing. Documents also indicated some minor concerns about the mother's possible minimalizing behavior toward her DV relationship with her husband. The Department's permanency planning hearing documents also suggest the mother could benefit from strengthening her general child safety skills. With regard to the father, the Department recommended that he be found in compliance with court services but reserved judgment on his progress with services. However, the court reserved judgment on the father's progress. The court adopted the recommendation for trial return home. The Committee is concerned the reunification recommendation was based on an uncertain favorable assessment that concluded the parents were in compliance with court-ordered services.

For purposes of the third component, the Committee's discussion focused on the May 3, 2018 Permanency Planning Hearing. The Committee considered the arguments and positions offered at the hearing by reviewing the original transcript (Verbatim Report of Proceedings). This included arguments by the parents' attorneys, the GAL's testimony and the recommendations of the CFWS worker and supervisor. All parties gave testimony that the parents had made significant improvements and were ready to begin transition and reunification. Following all hearing arguments, the presiding judge ordered the return of the children to their parents effective May 5, 2018.

Findings

The Committee did not reach consensus as to any definitive catastrophic errors or substantive policy violations by DCYF that directly contributed to the children's deaths. Similarly, the Committee did not

reach consensus as to definitive system improvements that would prevent a significant likelihood of a similar future incident (i.e., root cause analysis). For purposes of this CFR, a part of the challenge involved the lack of any information about the specific circumstances leading to the deaths. This lack of information caused Committee members to speculate what the assumed facts are and what did or did not happen. It is unknown if a major mental illness episode, a direct DV incident or some other situation triggered the event. For those reasons, it is difficult to know with certainty whether the events that caused the children's deaths were predictable.

The Committee did agree that the following aspects of the case raised practice-related concerns.

- The Committee believes the CFWS staff assigned to the dependency matter did not adequately understand the history, nature, frequency and extent of the parents' DV (intimate partner violence) issues. The Committee found workers did not have a reasonably sufficient working knowledge of DV policy and practice guidelines. Instead, the workers appeared to have only a peripheral understanding of DV dynamics. Although the intimate partner violence history may not have been extreme in terms of a history of physical violence or weapons, there was no effort to assess lethality as recommended by the Department's DV policy and published practice guidelines.
- With regard to the May 3, 2019 Permanency Planning Review Hearing, the Committee believes there were significant reasons why the Department should have argued that the father failed to adequately complete court-ordered services sufficient for the Department to support reunification. The Committee found multiple uncertainties related to incomplete efforts to improve mental health issues, the status of [redacted] use, the lack of a thorough chemical dependency evaluation and the lack of a substantive domestic violence assessment. While the Committee agrees the mother did appear to be making progress and complied with the court's orders, the Committee believes the Department's support for both parents to resume caring for their children was questionable. However, under the circumstances, the Committee understands the court would have likely ordered the children returned home even if the Department had disagreed with the reunification recommendation.
- For almost two months after the children's placement with their parents, there were no reports of serious issues or safety risks. However, there were reports the father had become less engaged and somewhat more remote. In hindsight, these reports may have been a red flag but not necessarily a clear indication of imminent danger issues.

Recommendations

The Department should explore the feasibility of requiring mandatory DV training every 1 or 2 years for all child welfare workers. This could be in-service training or on-going electronic training. The training should include subject matter pertaining to lethality assessments as a part of child safety assessments.

DCYF should consider using this case for a statewide Child Fatality Lessons Learned training. This is not due to any definite critical errors but instead due to the number of issues the case would facilitate for case discussions.

The Committee suggests DCYF explore ways to develop a more formal integrated team case approach. This should encourage information sharing with professionals who are working with family members (e.g., medical providers, educators, mental health providers and those providing assessments). The information-sharing should reduce the likelihood the worker accumulates information without the benefit of multiple professional perspectives having the opportunity to discuss the family's issues.

CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

January 2020

Washington State Department of
CHILDREN, YOUTH & FAMILIES

Contents

Nondiscrimination Policy

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

Full Report

Child

- L.W.

Date of Child's Birth

- [redacted] 2019

Date of Fatality

- July 2019

Child Fatality Review Date

- November 7, 2019

Committee Members

- Patrick Dowd, JD, Director, Office of the Family and Children's Ombuds
- Molly Rice, DCYF, Quality Practice Specialist, Region 2
- Stephanie Widhalm, MSW, LICSW, MHP, CMHS, Partners with Families and Children, Children's Advocacy Center Director and Forensic Interviewer
- Jamie Huguenin, Department of Corrections, Community Corrections Supervisor

Facilitator

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

Executive Summary

On November 7, 2019, the Department of Children, Youth, and Families (DCYF)[1] convened a Child Fatality Review (CFR)[2] to assess DCYF's service delivery to L.W. and [redacted] family.[3] [redacted] will be referenced by [redacted] initials throughout this report.

On July 22, 2019, DCYF received a call reporting [redacted] month old L.W. died when [redacted] father accidentally drove the family truck over L.W. This occurred in a remote area while the family was picking berries and chopping wood. Both parents were present during the accident. L.W. was in [redacted] stroller when the mother moved [redacted] behind the back wheel of the truck. At the time, the parents were also operating the truck's winch to remove a stump. Unaware the mother placed L.W. behind the rear truck wheel, the father entered the truck to move it and unknowingly ran over his [redacted] causing [redacted] death. The mother reported she dropped the remote to the winch and ran to her [redacted] She started screaming and a woman nearby heard her and came to help. The woman drove L.W. and [redacted] mother down the hill to an area with cellular phone service. L.W.'s father followed in the truck. While driving, the father drank a bottle of alcohol. The mother reported the father consumed a small amount of the bottle while they were working. The father reported he was so upset that he drank a significant amount while driving down the mountain. This intake was assigned for a Child Protective Services (CPS) investigation. Earlier that same day, DCYF closed out a Family Voluntary Services (FVS) case that pertained to this family.

Law enforcement arrested the father and he was criminally charged for the death of his [redacted] However, the charges were eventually dismissed. After the CPS investigation was completed, DCYF entered a founded finding for negligent treatment against L.W.'s father.

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

The Committee interviewed the area administrator, CPS supervisor and CPS worker. The CPS worker was also the FVS worker for the family.

Case Overview

On [redacted] 2019, DCYF received a call stating L.W. was born the day before. During the pregnancy, the mother had consistent prenatal care. The mother reported she [redacted] in November but had been clean since that time, [redacted]. The caller reported there were no other concerns and the baby appeared to be healthy. Due to the mother having previously given

[1]Effective July 1, 2018 the Department of Children, Youth, and Families (DCYF) replaced the Department of Social and Health Services (DSHS) Children's Administration (CA) as the state agency respons ble for child welfare; and the Department of Early Learning for childcare and early learning programs.

[2]"A child fatality or near-fatality review completed pursuant to [RCW 74.13.640] is subject to discovery in a civil or administrative proceeding, but may not be admitted into evidence or otherwise used in a civil or administrative proceeding except pursuant to [RCW 74.13.640(4)]." Given its limited purpose, a child fatality review (CFR) should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. The CFR committee's review is generally limited to documents in the possession of or obtained by DCYF or its contracted service providers.

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

[3]There are no current criminal charges regarding the death of L.W., therefore no parent is identified by name in this report.

birth to another child RCW 13.50.100 and the history of both parents with DCYF, this case was opened for a CPS Risk Only assessment.[4]

Before making contact with the parents, the CPS worker staffed the case with her supervisor and area administrator. Based on the information contained in the current intake, the family's history and the CPS worker's prior knowledge of the parents, a decision was made allowing L.W. to stay with 74.13.5 parents if they were willing to engage in a safety plan and voluntary services.

The CPS worker went to the hospital and met with the parents and L.W. They discussed a safety plan for discharging L.W. home with 74.13.5 parents and the13.50.100 . The mother disclosed that she believed she13.50.100 . The mother also said she 13.50.100 . She also told the CPS worker that during that period of her life she was RCW 13.50.100 . The mother shared that she has changed, RCW 13.50.100 and was healthy at this time.

L.W.'s mother also shared that74.13.520 . The mother also reported 74.13.520 . She did not plan on having any other children and appeared motivated to keep L.W.

During this contact, the mother was forthcoming regarding her other children, her struggles RCW 13.50.100 . She agreed to voluntary services. The maternal grandmother agreed to be a part of a safety plan that would allow the parents and baby to move in with her while they engaged in voluntary services. The plan included random urinalysis testing for both parents. L.W.'s father asked that his parents be included in the plan RCW 13.50.100 . He stated his parents are very strict and they make him provide a clean urinalysis before they allow contact with the children.

The parents engaged in Project Safe Care[5] and provided random urinalysis testing. There was ongoing contact by the service providers as well as the CPS/FVS worker. On July 22, 2019, the case was submitted for closure. Later that same day DCYF received the intake regarding L.W.'s death.

Committee Discussion

This case has emotionally impacted the Committee members which caused them to have sincere concerns for the well-being of the staff that worked with L.W. and 74.13.5 family. The emotional impact from critical incidents on DCYF staff consumed a large portion of the Committee's discussion. The absence of a policy and procedure regarding how these types of cases are handled, in a way that shows the

[4] Screened in CPS Risk Only reports involve cases in which a child is at imminent risk of serious harm and there are no CA/N allegations.

[5] "Safe Care is an evidenced-based home visitation program aimed at reducing child maltreatment among families with a history of maltreatment or risk factors for maltreatment. Safe Care is a weekly home-based service lasting 18-20 sessions for families with a child from age birth to 5 years. The expected outcome is to increase parents' understanding and management of child illness and injuries, increase home safety, and improve and enhance safe parenting skills. The provider reviews the safety plan each week. There is no afterhours support for the family." See DCYF Evidence Based Practices-Description and Directory https://www.dcyf.wa.gov/services/child-welfare-providers/evidence-based-practices.

importance of trauma informed practice, led to the recommendation described in the Recommendations section below.

This concern was also highlighted when discussing the child fatality review requirements. The Committee did not view L.W.'s death as neglectful or abusive. The Committee believes the death was an accident. This was discussed because the founded finding for neglect necessitated this CFR and the fact that being involved in a CFR often adds stress to the participating staff. The Committee discussed whether this may have been unnecessary stress to the staff that was involved in this case from the beginning.

Another aspect that was discussed was the fact that the CPS worker assigned to this case at the birth of L.W., was one of two CPS workers in the office. This CPS worker has extensive knowledge and experience in this role and is often given more difficult cases. The cumulative effect of higher risk cases on an ongoing basis is a concern for the Committee. The Committee appreciates the fact that in this case the CPS worker was not assigned to the investigation regarding L.W.'s death. This often occurs for a number of reasons but they were thankful it did not happen in this case. The Committee believed that this would have added to the emotional toll this case already had on this worker.

The Committee discussed the positive relationship the CPS/FVS worker has with L.W.'s mother. This is illustrated by the relationship built and documented in the case file. This is also supported by the fact that after her [redacted] death, L.W.'s mother reached out to the CPS worker for support and continues to do so. The Committee recognizes and appreciates the CPS worker's efforts to establish a positive rapport with the mother.

The Committee would have liked to have seen more documentation regarding the assessment of the father, specifically regarding his trauma history, parenting capabilities and functioning/coping. With regard to the mother, there was good documentation about these areas.

The Committee also discussed whether the CPS worker should have made substance use referrals. This was countered with the fact that the CPS worker has maintained her qualifications and certification as a substance use professional (also known as a chemical dependency professional) and this specialty gives her additional tools to rely on when assessing the need for such a referral. Many CPS workers who do not have this qualification will utilize urinalysis testing as the first step before referring parents or caregivers for full assessments. For example, it is common practice within DCYF that a parent will be referred for a full substance use assessment if the parent has been referred for random urinalysis testing and he or she either fails to provide the urinalysis or if the test results are positive for drugs or alcohol.

Findings

The Committee finds that in this case, DCYF made no critical errors.

There was a finding that a domestic violence assessment was not conducted pursuant to DCYF practices and procedures policy 1170. The Committee was very clear that this finding in no way had any impact on the critical incident. However, it was something that was discussed because of the parents' trauma history [redacted].

Recommendations

Recognizing the emotional toll on DCYF staff when a child fatality or near-fatality occurs, the Committee recommends that DCYF submit a request to the legislature to fund a critical incident protocol. The Committee believes a funded protocol similar to those used by many law enforcement agencies would be appropriate. Key components of a DCYF critical incident protocol should include directives that relieve the involved staff from new responsibilities and a triage team to provide protected time for the worker(s) and supervisor(s) to address their secondary trauma needs. The critical incident protocol would be in addition to any Peer Support or other emotional support programs available to DCYF staff.

CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

August 2019

Washington State Department of
CHILDREN, YOUTH & FAMILIES

Contents

Nondiscrimination Policy

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

Full Report

Child

- T.C.

Date of Child's Birth

- [redacted] 2005

Date of Fatality

- January 19, 2019

Child Fatality Review Date

- May 2, 2019

Committee Members

- Mary Moskowitz, JD, Ombuds, Office of the Family and Children's Ombuds
- Pam Hubbard, LMHC, CDP, Co-Occurring therapist and Outpatient Counselor Supervisor, Evergreen Recovery Centers
- Ida Keeley, Court Appointed Special Advocate Program Manager, Snohomish County
- Wendy Burchill, Child Death Review Coordinator and Injury Prevention Specialist, Snohomish Health District
- Kelly Boyle, Child Protective Services Program Manager, Department of Children, Youth, and Families
- Jennifer McCarthy, Quality Practice Specialist, Department of Children, Youth, and Families

Observer

- David Underwood, Child Protective Services worker, Department of Children, Youth, and Families

Facilitator

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

Executive Summary

On May 2, 2019, the Department of Children, Youth, and Families (DCYF)[1] convened a Child Fatality Review (CFR)[2] to assess the service delivery to T.C. and [74.13.5] family.[3] [74.13.5] will be referenced by [74.13.5] initials throughout this report.

On January 12, 2019, DCYF received a telephone call reporting that 13-year-old T.C. died by suicide. T.C. shot [74.13.515] self with a shotgun that was hanging on the wall at [74.13.5] home. Ammunition for the gun was stored in a different part of the house. At the time of the shooting T.C.'s parents were not home. However, T.C.'s paternal grandmother and [74.13.5] sister were in their respective bedrooms. Neither the grandmother nor T.C.'s sister, heard the gunshot. After returning home T.C.'s parents discovered their deceased [74.13.515] Earlier, on the same day as the shooting, T.C.'s parents told T.C. [74.13.5] must do extra chores because of [74.13.5] declining grades. This intake resulted in a Child Protective Services (CPS) Risk Only intake. However, on January 22, 2019, a subsequent intake was received providing more details about the family situation. That intake initially screened in for a CPS Family Assessment Response (FAR) assessment but was overridden by a CPS supervisor and assigned for a CPS investigation. With regard to T.C.'s death, DCYF issued a founded finding for negligent treatment or maltreatment against both of T.C.'s parents.

At the time of [74.13.5] death, T.C. lived with [74.13.5] mother, father, paternal grandmother and one of [74.13.5] two sisters. [74.13.515] 18-year-old sister did not live in the family home. During the death investigation, DCYF[13.50.100] as to T.C.'s sister, who remained in the family home. T.C.'s sister[13.50.100].

The CFR Committee (Committee) includes members with relevant expertise selected from diverse disciplines within the community. Committee members have not had any involvement or contact with T.C. or [74.13.5] family. The Committee received relevant documents pertaining to this family including intakes, case notes, other DCYF documents maintained in DCYF's electronic computer system and a draft medical examiner's report. The Committee interviewed the original CPS worker for the January 2018 intake and the current CPS supervisor for the office that conducted the January 2019 investigation. The worker who completed the January 2018 intake no longer works for DCYF.

Case Overview

On January 31, 2018, DCYF received an intake reporting that T.C.'s parents have alcohol and drug problems. It was reported that the mother sells [13.50.100] and [13.50.100] and many people are in and out of the home. It was also reported the parents verbally abuse [74.13.515], [74.13.515] attempted suicide in October of 2017 and the parents will not buy any food that their 17-year-old daughter needs related to her[74.13.520] needs. The intake also reported that broken furniture is in the home due to the father and friend drinking and getting

[1] Effective July 1, 2018, the Department of Children, Youth and Families (DCYF) replaced the Department of Social and Health Services (DSHS) Children's Administration (CA) as the state agency responsible for child welfare, and the Department of Early Learning for child care and early learning programs.

[2] "A child fatality or near-fatality review completed pursuant to [RCW 74.13.640] is subject to discovery in a civil or administrative proceeding, but may not be admitted into evidence or otherwise used in a civil or administrative proceeding except pursuant to [RCW 74.13.640(4)]." Given its limited purpose, a child fatality review (CFR) or child near-fatality review (CNFR) should not be construed to be a final or comprehensive review of all 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 the Department of Children, Youth, and Families (DCYF) or its contracted service providers.

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[3] T.C.'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. See RCW 74.13.500(1)(a).

into a fight. In addition, it was reported that a year ago the father punched 74.13.515 in the face and 74.13.515 went to school with a black eye. In October 2017, 74.13.515 stopped taking her 74.13.520 medication. However, on her own she recently went back to her physician to obtain the needed prescription. This intake was screened in for a CPS/FAR assessment.

On February 2, 2018, the assigned CPS/FAR worker contacted T.C.'s oldest sister at her school. The sister disclosed during the CPS worker's interview that on a daily basis the mother drinks two-fifths of alcohol and is addicted to 74.13.520 and 74.13.520 The sister denied the mother uses 13.50.100 or sells drugs. The child said she believes her mother is clinically depressed. In October 2017, after returning home from babysitting, T.C. and a cousin told T.C.'s sister that 74.13.515 had put a gun to 74.13.515 mouth and pulled the trigger. However, the gun did not go off. T.C.'s sister also said that in the summer of 2016 she saw their dad try to kill their mother by strangling her. T.C.'s sister tried to wake her paternal grandmother who lived in the home but the grandmother was passed out and could not be awakened. The sister said she began to scream for help because her dad was going to kill her mom. Neighbors called the police. T.C.'s sister said their mother lied to police and made the children lie at court to say nothing happened. According to the sister, the legal case did not go forward.

T.C.'s sister described other substance abuse incidents involving her parents. She also disclosed that their dad punched 74.13.51 in the face after their dad tried to attack T.C. 74.13.515 had a black eye and did not go to school for two weeks. The sister provided other allegations involving abuse and neglect against the children by their parents. T.C.'s sister said she is worried that if the children are removed from the home, their dad would kill their mother. She also said T.C. is the victim of most of the abuse inflicted by the parents. She said that because of the abuse inflicted on T.C., 74.13.5 has behavior issues. For example, last year T.C. 13.50.100 . Their other sister 13.50.100 .

T.C.'s sister said an aunt has tried to get their mother help. T.C.'s sister has told her doctor and youth pastor about what happens at home but nothing has helped. T.C.'s sister was asked if she had ever gone to counseling. T.C.'s sister said their dad said counseling is for "pussies."

On Friday, February 2, 2018, the CPS worker requested law enforcement go with her to the family home. When they arrived the parents and all three children were home. The parents denied all of the allegations. The dad admitted they occasionally "get their drink on" but denied the alcohol abuse allegations. The dad repeatedly said he works for a large private company in the area and makes $100,000 a year. The CPS worker observed that the home was cluttered with mattresses, furniture, boxes and other items strewn about the home. However, the worker did not identify any safety hazard to teenage children. The parents agreed to provide urine samples on Monday, February 4, 2019.

While still at the family home, the CPS worker spoke with T.C. and 74.13.5 youngest sister. The children did not disclose anything and were told there would be follow up conversations at school.

After this contact with the family, the originally assigned CPS worker was promoted to a CPS supervisor position. On March 15, 2018, the newly assigned CPS worker contacted T.C.'s oldest sister. T.C.'s sister expressed concerns about her parents drinking, cleanliness of the house and lack of appropriate food. The CPS worker informed the child that she and her siblings were old enough to clean the home and prepare their own meals. The CPS worker also

told the child that unless the parents' drinking caused harm to someone in the home, there was no safety threat or hazard.

The document recording the parents' results of the observed urine samples provides an incorrect date of birth for T.C.'s father. It also indicates that both parents observed urine samples were collected at 12:00 a.m. This is not possible because the provider is normally not open at that time. The document for T.C.'s father indicates the urine was collected on February 5, the Monday following the CPS worker's contact. The father's 13.50.100 was considered in the normal range but very close to the cutoff. An identified 13.50.100 is often associated with a diluted result. The mother's urinalysis was collected on February 8, not the date requested by the CPS worker. Both parent's urine samples were negative for the tested substances. However, neither parent was tested for Ethyl glucuronide (ETG).[4] The ETG test is a test that detects recent alcohol consumption.

On April 12, 2018, the CPS worker conducted a health and safety visit with T.C. and the sister who was not interviewed on March 15, 2018. Both children talked about their parents' drinking habits. They both said their mother drinks more than their father and described the mother's drunken behaviors. T.C. said 74.13.5 did not have anything 74.13.5 liked about 74.13.5 mom because 74.13.5 doesn't really know her. 74.13.5 likes the fact that 74.13.5 father will play video games with 74.13.515 Both children said they go to friends' houses over the weekend to get away from their parents' drinking and yelling. Both children said they felt safe in their home and had adults they could go to for help if they needed it. On April 19, 2018, the case was closed with no further intervention or referrals for services.

On January 12, 2019, DCYF received a telephone call reporting that 13-year-old T.C. died by suicide. T.C. shot 74.13.515 self with a shotgun that was hanging on the wall at 74.13.5 home. Ammunition for the gun was stored in a different part of the house. At the time of the shooting T.C.'s parents were not home. However, T.C.'s paternal grandmother and 74.13.5 sister were in their respective bedrooms. Neither the grandmother, nor T.C.'s sister, heard the gunshot. After returning home T.C.'s parents discovered their deceased 74.13.515 Earlier, on the same day as the shooting, T.C.'s parents told T.C. 74.13.5 must do extra chores because of 74.13.5 declining grades. This intake resulted in a Child Protective Services (CPS) Risk Only intake. However, a subsequent intake received on January 22, 2019 provided more details about the family situation. That intake initially screened-in for a CPS Family Assessment Response (FAR) assessment but was overridden by a CPS supervisor and assigned for a CPS investigation. With regard to T.C.'s death, DCYF issued a founded finding for negligent treatment or maltreatment against both of T.C.'s parents.

Committee Discussion

The Committee discussed many aspects of this case and the general practice within DCYF. The Committee spent significant time discussing the need for training and guidance for all field staff, versus challenges related to high staff turnover and high caseloads. High caseloads often prohibit staff from attending trainings, the mentoring of new staff and many other areas that support strong social work practice. The Committee discussed that the current infrastructure does not fully support best practice.

The Committee believes DCYF could bolster suicide and weapons training. The Committee discussed the rising numbers of death by suicide, the decreasing age of children attempting

[4] See http://cordantsolutions.com/wp-content/uploads/2015/09/etG.pdf.

suicide and dying by suicide and the immediate need to address this issue. The Committee is mindful of the fact that this case included the use of a gun in a suicide attempt by 74.13.515 and T.C. died by suicide with an unsecured gun in the home. This topic is addressed in the recommendation section below.

The Committee also discussed DCYF's initial contact with T.C.'s oldest sister. The interview was thorough and well documented. However, that same level of questioning and detail did not continue during other contacts with the parents, T.C., 74.13.5 sister and the paternal grandmother. The Committee also discussed that DCYF historically holds a higher legal intervention threshold. The Committee discussed that it is important for DCYF to only become legally involved when it is absolutely necessary. However, when a case involves a teenager there may be too much emphasis placed on the teen's ability to protect him or herself.

For purposes of assessing substance use and dependency allegations, the Committee also discussed whether there was an over-reliance on urinalyses results. The children made clear and consistent statements about their parents' alcohol abuse. Despite these statements there appeared to be an over-reliance on the "negative" urinalyses provided by each parent. In addition, the Committee discussed the issue with regard to when the tests were completed, versus when they were requested to be completed; and concerns related to how close the 13.50.100 were to a finding consistent with dilution findings. The Committee considered whether these factors support a finding of possible substance abuse. If so, consideration should have been directed towards appropriate next steps, including asking both parents to provide an assessment completed by a substance use disorder specialist.

The Committee also discussed the fact that the particular office that handled this case consistently struggles with significant staff turnover, from the area administrator down to all staff positions. The Committee discussed the need for this particular office to receive stronger support and stabilization from DCYF. The Committee was told this office consistently receives approximately 20 intakes per CPS worker per month. This number is significantly above the identified goal of 8 intakes per month.

To reduce staff turnover the Committee discussed concerns about necessary staff support during challenging cases, critical incidents, struggles with completing daily tasks and staff feeling unsafe to be vulnerable. The Committee received information about DCYF's Peer Support team. The Committee believes the Peer Support team is not designed to provide the type of support necessary to address the trauma and secondary trauma experienced firsthand by field offices and all levels of the staff within those offices. The Committee believes there is a high likelihood of continued turnover when there is such a significant gap in staff support. The Committee believes staff may feel more valued and secure if they are given the opportunity to have a support/triage team, as well as mentoring and robust onboarding for new and promoted staff. Hopefully, this would lead to stabilization within the workforce. The Committee believes that within the field offices, at the supervisor level and above, DCYF lacks consistent onboarding and continuing staff support. There was also a discussion about area administrator training and supervisor core training. The ongoing mentoring and support for day-to-day tasks were identified as an unmet need.

The Committee also talked about the fact that the community surrounding this specific office has strong supports from local tribes and other organizations. The discussion included recognition of the fact that local tribes have previously offered healing circles. The Committee also understands that therapy dogs have been brought into offices and other therapeutic supports have been made accessible to staff from within the local community. The Committee discussed

it would be helpful to the office if local connections with the various organizations were strengthened so that there is support for each other when a crisis (such as the suicide death of a child) occurs.

Findings

The Committee did not reach a full agreement as to whether there was a critical error. However, the Committee identified missed opportunities to improve practice areas.

The Committee noted that DCYF did not comply with the DCYF policy regarding domestic violence (DV).[5] The policy includes a directive to conduct universal DV screening through individual and separate interviews with all parents, caregivers, adults and children in the home.

The Committee also talked about whether DCYF missed an opportunity to assess the risk of weapons in the home. In particular, firearms. There was a documented gun-related suicide attempt by 74.13.515. When conducting their assessments and contact in the home, it would have been appropriate for the CPS workers to ask specific questions about firearms, including the storage of the weapon and ammunition.

The Committee believes DCYF did not fully assess the allegations during the two younger children's interviews. The interview of the oldest child was thorough, but contact with T.C. and the other sister did not include an adequate assessment.

Recommendations

The Committee recommends DCYF provide to all field staff mandatory suicide awareness training. This training should include what questions to ask, provide information on risk factors, provide suicide resources within the family's community including prevention, intervention, support and provide instruction about what next steps should be if suicidal ideation or attempts are identified. The Committee understands it is difficult to schedule trainings due to the high turnover experienced by DCYF. With that in mind, the intent for this recommendation is for an approximately 90-minute training for groups no larger than 30 individuals. This training should occur within the next 12 months for all current DCYF staff and be required ongoing training for all new staff.

The Committee believes that immediately after the implementation of the training recommendation described above, DCYF should add a question to the gathering questions[6], specifically identifying suicide as a topic. The question should be asked of children 10 years of age or older and ask the following: has the child considered and/or attempted suicide, or considered and/or attempted to kill himself or herself. If a child answers "Yes", then there should be documented follow-up regarding what next steps the worker took to address the issue. Next steps may include, but not be limited to, provide a crisis help number, contact a crisis mental

[5] See https://www.dcyf.wa.gov/1100-child-safety/1170-domestic-violence.
[6] Gathering questions are six questions required to be completed by DCYF staff during a CPS assessment or investigation.

health professional, discussion of weapons or access to other means related to their suicidal ideation or plan and engaging the child's parent or caregiver.

The Committee believes DCYF should submit a request to the legislature to fund a critical incident protocol. The Committee recognizes the emotional toll that it takes on DCYF staff when a critical incident occurs. This is especially the case if the Department does not have a staff support protocol. The Committee discussed that a protocol similar to the law enforcement protocols would be appropriate. The Committee believes a funded protocol should be created that supports a triage response from a group specifically trained to respond. The protocol should include directives that relieve the assigned staff from new responsibilities. This triage team would provide protected time for the worker and supervisor to address their secondary trauma needs. This would not take the place of any Peer Support or other emotional support programs.

The Committee recommends DCYF work with substance use disorder and mental health agencies to co-locate staff within each DCYF office. Ideally, a co-occurring provider could provide for both identified areas of need.

CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

June 2019

Washington State Department of
CHILDREN, YOUTH & FAMILIES

Contents

Nondiscrimination Policy

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Full Report

Child

- H.D.

Date of Child's Birth

- 74.13.515 2018

Date of Near-Fatality

- November 24, 2018

Child Near-Fatality Review Date

- May 8, 2019

Committee Members

- Erin Summa, MPH, Health Promotion Coordinator, Mary Bridge Children's Hospital and Health Network
- Cristina Limpens, MSW, Office of Family and Children's Ombuds
- Nicole Muller, Region 6 Quality Assurance and Programs Administrator, Department of Children, Youth, and Families
- Amy Scanlon, Coordinator, Child Advocacy Center of Pierce County

Facilitator

- Bob Palmer, Critical Incident Review Specialist, DCYF

Executive Summary

On May 8, 2019, the Department of Children, Youth, and Families (DCYF or Department) convened a Child Fatality Review (CFR)[1] to examine the Department's practice and service delivery to H.D. and [redacted] family. This review originated from an incident occurring on November 24, 2018, on an open Child Protective Services (CPS) case. On that date, paramedics and police responded to a 911 call of an unresponsive infant subsequently pronounced dead at the scene. The incident initially appeared to be an infant sleep-related death. Subsequently police became skeptical about the mother's explanation of events and arrested Amelia Day four months later, charging her with suspicion of second-degree murder.[2] Reportedly, the autopsy determined the cause of death to be "undetermined suffocation."

The CFR Committee (Committee) included a DCYF quality assurance administrator, a representative from the Office of Family and Children's Ombuds, a child safety educator with expertise in infant safe sleep and the coordinator of a local Child Advocacy Center. A detective originally scheduled to participate on the Committee was unexpectedly unable to attend the CFR. None of the Committee members had any previous direct knowledge of or involvement with H.D. or [redacted] family.

Prior to the review, each Committee member received a chronology summarizing the CPS involvement with the family, un-redacted DCYF documents (e.g., intakes, assessments and case notes), initial law enforcement response reports and a brief news article regarding Amelia Day's arrest in March 2019. At the time of the review, supplemental sources of information and other reference materials were available to the Committee, including H.D.'s medical records, materials regarding infant safe sleep and the legal definition of Murder in the second degree (RCW 9A32.050).

The primary assigned CPS worker provided additional information during the Committee's in-person interview process. The CPS supervisor and a co-assigned CPS worker were unavailable for Committee interview. However, Committee members were briefed with regard to responses to questions posed during an earlier interview conducted by the CFR facilitator with those workers. This included written responses from the co-assigned worker regarding recollections from the initial (pre-critical incident) home visit. After the review of case documents, consideration of interview responses by DCYF staff and discussion regarding Department activities and decisions, the Committee made findings and recommendations that are included at the end of this report.

[1] "A child fatality or near fatality review completed pursuant to [RCW 74.13.640] is subject to discovery in a civil or administrative proceeding, but may not be admitted into evidence or otherwise used in a civil or administrative proceeding except pursuant to [RCW 74.13.640(4)]." Given its limited purpose, a child fatality review (CFR) or child near fatality review (CNFR) should not be construed to be a final or comprehensive review of all circumstances surrounding the death or near death of a child. The CFR Committee's review is generally limited to documents in the possession of or obtained by DCYF or its contracted service providers. The Committee has no subpoena power or authority to compel attendance and generally only hears from DCYF employees and service providers. It does not hear the points of view of the child's parents and relatives, or of other individuals associated with the child. A CFR or CNFR is not intended to be a fact-finding or forensic inquiry to replace or supersede investigations by courts, law enforcement agencies, or other entities with legal respons bility to investigate or review some or all the circumstances of a child's fatal injury or near fatality. Nor is it the function or purpose of a CFR or CNFR to recommend personnel action against DCYF employees or other individuals. "The restrictions [described in this paragraph, and the paragraph immediately above,] do not apply in a licensing or disciplinary proceeding arising from an agency's effort to revoke or suspend the license of any licensed professional based in whole or in part upon allegations of wrongdoing in connection with a minor's death or near fatality reviewed by a child fatality or near fatality review team." RCW 74.13.640(4)(d).

[2] As a criminal charge was filed relating to the incident, the mother is identified by name in this report. The name of the child is subject to privacy laws. See RCW 74.13.500.

Case Overview

Initial DCYF involvement with the family occurred on Thursday, November 15, 2018, in response to a report from law enforcement regarding a child welfare check conducted the day before. According to 74.13.515 Police, an officer responded to a 911 call from Amelia Day's roommate regarding a possible RCW 13.50.100 of 74.13.515 old H.D. The roommate and her boyfriend had the infant with them in a parking lot. The officer saw the child and then went to the apartment to contact the mother, Amelia Day. While denying any RCW 13.50.100 Ms. Day admitted being overwhelmed with her baby whom she described as having purple crying.[3] The roommate returned the child to the mother in the presence of the officer and a more detailed examination of the child ensued. There were no observed marks or bruising, 74.13.520 . The officer found sufficient baby formula, diapers and other infant necessities at the residence. After informing the mother that he would be notifying CPS, the office cleared the field contact without taking the child into protective custody.[4]

In response to the police report sent to CPS, two DCYF staff conducted an unannounced home visit within hours of the CPS Risk Only intake.[5] Present at the residence was Amelia Day and H.D who was asleep in an infant swing. Neither the roommate nor the roommate's boyfriend were home at the time of the CPS contact. When asked about the recent police response to her residence, Amelia Day indicated that H.D. was crying so often that night that she got exhausted and overwhelmed. Her roommate offered to take the baby for a while. She denied RCW 13 50.100 or otherwise RCW 13.50.100 H.D.

A brief walk through of the residence by the CPS workers did not reveal any obvious safety concerns, with the exception of the sleep environments for mother and child. Mother slept on a pullout sofa bed in the living room area of the apartment and admitted bed-sharing[6] to help H.D. calm down at night. The CPS workers reviewed infant safe sleep issues with the mother, including safer options than relying on use of the infant swing during the day and bed-sharing at night.

During the home visit, the workers observed the mother's interactions with H.D. Although appearing relatively appropriate when holding, feeding, burping and diapering the baby, the mother's non-verbal behavior presented as awkward, being flustered, indecisive, overwhelmed and inexperience in caring for an infant. She admitted the pregnancy had been unexpected, that the alleged father indicated no desire to be involved with the baby and her "toxic" family of origin resided in 74.13.515 . Some brief discussion occurred with the mother about the stress of being a young, single, first-time mother, dealing with a fussy baby with limited support and possibly experiencing 74.13.520 .[7]

The workers saw no marks or signs of abuse on H.D. 74.13.520 74.13.520 [8] Amelia Day provided some information

[3] Purple Crying refers to a time in a baby's life where there may be significant periods of crying. The Period of Purple Crying begins at about 2-weeks of age and continues until about 3-4 months of age. [Source: What is the Period of Purple Crying?]
[4] RCW 26.44.0450: "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."
[5] DCYF will screen in a CPS Risk Only intake when information collected lacks specific allegations of child maltreatment, but provides reasonable cause to believe that risk or safety factors exist that place the child at imminent risk of serious harm.
[6] **Bed-Sharing**: A sleep arrangement in which an infant sleeps on the same surface with another person (e.g., bed, couch or chair). Sleeping with a baby in an adult bed increases the risk of suffocation and other sleep-related causes of infant death.
[7] For more information about sign and symptoms 74.13.520 , see: 74.13.520
[8] 74.13.520

regarding H.D.'s daily routine (sleep, feeding, crying) and medical/health history. This included her admission of frequently changing H.D.'s formula without consulting the Primary Care Physician (PCP).

Potential resources and services were discussed during the home visit, including the Department providing a Rock 'n Play Sleeper[9] and other baby items, referring the family to SafeCare[10] or for Public Health Nurse (PHN) services. The workers also suggested the mother schedule an appointment for a consult with the PCP in 74.13.515 and seek a local medical provider for H.D. if her plan was to permanently reside in 74.13.515 County.

After departing from the home visit, the two workers discussed their observations, identified risk factors and areas where safety threats could eventually emerge (e.g., safe sleep). They discussed next steps in the case, including the need to conduct another home visit soon, to contact collateral sources of information and to put intervention services and support resources into motion. Following the home visit, the primary assigned worker inquired with a local WIC office as to the availability of soy formula.[11] The co-assigned worker briefed the supervisor on the home visit observations.

The following day (Friday), the primary worker contacted the County Public Health District regarding a PHN referral and requested H.D.'s PCP medical records. After further discussion between the two co-assigned CPS workers, the decision was made to conduct another home visit that day, before the weekend. That evening, the primary worker conducted a second home visit. The worker again discussed the baby's routine for feeding, sleeping and bowel movement and urination. The worker delivered numerous baby items (pacifiers, diaper rash cream, diapers, sleeper outfits and a Fisher-Price Rock 'n Play sleeper). Materials regarding Infant Safe Sleep[12] and the Period of Purple Crying[13] were provided to Amelia Day, as well as information regarding Use of Force on Children (RCW 9A.16.100), a list of county medical providers and information about contacting WIC. During the home visit, the CPS worker overheard a heated discussion between Amelia Day and the PCP's Clinic in 74.13.515 that resulted in an appointment scheduled two weeks out. The CPS worker strongly encouraged Amelia Day to have H.D. seen at an Urgent Care for the possible 74.13.520 situation.

On November 19, 2018, the worker text-messaged Amelia Day to follow up on the 74.13.520 situation and viewing of the Period of Purple Crying video. The following day, the worker got confirmation of a PHN to work with the mother and infant.

On November 21. 2018, the eve of the 4-day Thanksgiving Holiday weekend, afterhours intake received information from H.D.'s PCP in 74.13.515 County. H.D. had been seen for a well-child check on October 31, 2018, but efforts to get Amelia Day to bring H.D. in for routine follow up had been unsuccessful.

74.13.520

[9] *The U.S. Consumer Product Safety Commission (CPSC) and Fisher-Price took the advice of the American Academy of Pediatrics and issued a recall of the Rock 'n Play Sleeper in April 2019 due to concerns for infant safety for those infants able to rollover (typically 3 months of age).*

[10] SafeCare is an in-home parent training for at-risk families to improve parenting skills and address health and safety issues.

[11] The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) provides federal grants to states for supplemental foods, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and non-breastfeeding postpartum women, and to infants and children up to age five who are found to be at nutritional risk. https://www.fns.usda.gov/wic

[12] NIH Pub No 17-HD-7040

[13] *The Period of Purple Crying is a method of helping parents understand the time in their baby's life where there may be significant periods of crying. During this phase of a baby's life they can cry for hours and still be healthy and normal. The Period of Purple Crying begins at about 2 weeks of age and continues until about 3-4 months of age.

According to the PCP, Amelia Day had recently contacted her to request [redacted] medication for the baby and became verbally abusive to clinic staff when the request was denied due to not having examined the infant. It was at that time the PCP apparently became aware that the mother and child had moved to [redacted] County. While not having any current information regarding the family's specific living situation, the PCP had concerns about Amelia Day's ability to meet the needs of the baby, largely due to the mother's history [redacted]. The intake was accepted for CPS investigation of neglect, with a designated 72-hour response time.

Early Saturday morning of November 24, 2018, a CPS worker attempted a home visit in response to this new intake. The worker knocked several times. Getting no response and hearing no noises coming from the apartment, the worker attempted to peek through a window but shades were drawn. The worker later attempted to contact the mother by phone, leaving a voice message.

The following Monday the primary assigned worker got in phone contact with Amelia Day, at which time it was revealed that H.D. had died. Amelia Day initially told the CPS worker that around 8:30 Saturday morning she put H.D. down in the Rock 'n Play sleeper after a feeding. Around 10 a.m. she went to pick [redacted] up - [redacted] was still warm. She laid [redacted] on the bed and noticed [redacted] heart was not beating. She started performing CPR on [redacted] and called 911 at about 10:05. Within about 10 minutes EMT's arrived and took H.D. out to the ambulance where [redacted] was pronounced deceased. Law enforcement and the County Coroner's Office arrived later to initiate a death scene investigation.

Detectives pursued an investigation of the death. While the initial physical findings were not suggestive of foul play, the mother's statements to detectives were inconsistent. Subsequently, Amelia Day admitted to having lied as to the circumstances surrounding the death of her infant [redacted] She indicated that she was alone with the baby the day [redacted] died, having to deal with the baby's crying by herself, as her roommate was gone that day. She became frustrated, angry and exhausted dealing with the crying and [redacted] lack of feeding and held H.D. against her chest until [redacted] stopping crying and moving. Believing [redacted] had fallen asleep, she put [redacted] down on the bed. She then went to sleep and found [redacted] unresponsive when she woke.

The CPS investigation of the death resulted in a founded neglect finding.[14] At the time of the CPS finding, the cause and manner of death was not yet determined. The County Coroner eventually identified the death as an "undetermined suffocation". On March 26, 2019, Amelia Day was arrested and booked into [redacted] County jail, charged with suspicion of second-degree murder of her [redacted] old [redacted]

Committee Discussion

A major area of discussion focused on the fact that the case had been open only 10 calendar days before the fatality incident. This included 5 working week days, 3 weekend days, and a 2-day holiday. The Committee discussed the actions and decisions made by Department staff during the brief interval preceding H.D.'s death. This included the following documented activities:

1. Conducting two home visits.
2. Making face-to-face contact with the child the same day as the intake was received.
3. Conducting an initial interview with the primary caretaker (the mother).

[14] See https://app.leg.wa.gov/RCW/default.aspx?cite=26.44.020

4. Making a Public Health Nurse referral.
5. Requesting medical records from the PCP.
6. Contacting WIC to inquire about obtaining soy formula.
7. Follow up text messaging with mother.

The Committee considered state policy and practice for CPS Risk Only interventions, discussing reasonable activities expected from DCYF staff in the initial stages of CPS, contrasted with the more expansive activities expected during a fully allotted timeframe for completing an investigation. The Committee recognized the likelihood of more detailed information being gathered by the workers during a full course of investigation, assessment and client engagement. In addition, the Committee identified and discussed specific areas of inquiry and corroboration that would have been important to eventual completion of the CPS investigative pathway but not reasonably expected to be completed during the first days of a case being opened. This included extensive collateral contacts, consulting with local child abuse medical professionals (e.g., CAID[15]) and running criminal background checks on the mother, the mother's roommate and the roommate's boyfriend.

The Committee looked closely at the information initially gathered, particularly surrounding risk factors identified by the two CPS workers as "concerning" in terms of assessing for both present (imminent) and possible impending (future) danger.[16] This included evaluating the potential impact of a young, single, first time parent, isolated with very limited support, overwhelmed and stressed, exhibiting subtle indications of parental ambivalence,[17] somewhat resistant to guidance, with a history 13.50.100 [redacted]. Given the number and types of risk factors involved, coupled with the allegation that the mother may have RCW 13.50.100, the Committee debated possible alternatives available to DCYF to prioritize and plan around the immediate care and safety of the baby. This included consideration to seek a temporary Voluntary Placement, filing for dependency, developing an emergency safety support network to ameliorate any possible crisis point or requesting local law enforcement conduct a child welfare check over the long weekend. The Committee did not reach consensus for these options.

The Committee discussed whether the workers had fully understood and followed the DCYF Infant Education and Intervention policy.[18] A major issue was the questionable providing of the Fisher-Price Rock 'n Play as an assumed safe sleep product. The Committee heard the worker's explanation that the Rock 'n Play was deemed to be an available and safer option than the mother's bed-sharing with her infant. It was noted that the Department had been messaging concerns since November 2017 about child welfare services offices providing co-sleepers, sleeper boxes and other infant sleep products not fully approved by the Consumer Product Safety Commission. It was further noted that by late 2018 efforts were being made to remove Rock 'n Play swings from DCYF concrete good supplies in all offices although the actual national recall of the product did not occur until April 2019. The Committee did not

[15] The **Child Abuse Intervention Department** at Mary Bridge offers medical treatment, psychosocial support, legal advocacy and crisis intervention services for victims of child abuse and their families. CAID also provides strategies for Pierce County parents and the community to prevent child abuse through these free programs.

[16] "Present danger is defined as immediate, significant, and clearly observable severe harm or threat of severe harm occurring in the present requiring immediate protective response. Present danger may be a basis to determine that 'Imminent Harm' under RCW 13.34.050(1) exists and therefore may be a basis to seek immediate removal if other less intrusive options for immediate protective actions will not assure child safety." See https://www.dcyf.wa.gov/sites/default/files/pdf/SafetyThresholdHandout.pdf

[17] Parental ambivalence relates to the nurturing and affectionate aspects of a parent-child relationship. It is often identifiable by behavioral or verbal indicators that suggest contradictory attitudes toward the relationship, incompatible expectations and mixed emotions, and self-doubt regarding being able to handle a parent/caretaker role.

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

reach consensus as to whether the Rock 'n Play provided for the child actually contributed to the infant death, but a majority of Committee members called to question that decision.

Given the primary task of the Committee is to review and evaluate recent DCYF service delivery occurring prior to a suspicious child death, there was only limited Committee discussion about the CPS investigation of the fatality incident. This included looking at the information gathered largely by law enforcement over several months of criminal investigative interviews following the child's death. While such information certainly supported the initial concerns of DCYF staff, the Committee was unable to say, with any degree of certainty, that having this information prior to the death would have led the Department to preemptively legally intervene and remove the child.

Findings

The Committee reached full consensus as to the absence of any identified catastrophic errors or significant policy violations by DCYF. The Committee recognizes that when the fatality incident occurred, the case had only been open for 10 calendar days (five working week days) and was in the very early stages of the investigative and assessment process. It is the Committee's opinion, based on the information gathered by the Department in the limited time the case was open (pre-critical incident) that the subsequent fatality outcome was not clearly predictable or reasonably preventable short of removing the infant at first contact. The Committee believes there was insufficient reason to seek legal intervention (removal) at the time.

Recommendations

- DCYF should consider reinstituting specific training for child welfare workers on recognizing indicators of parental ambivalence for risk and safety assessment.
- DCYF should continue messaging the importance of assessing infant safe sleep and provide updates regarding Consumer Product Safety Commission, American Academy of Pediatrics and Centers for Disease Control and Prevention guidelines and infant care products. Consideration should be given to requiring a brief annual refresher training on infant safe sleep (on line or classroom), especially for child welfare workers who have infants on their caseloads.