CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

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

Full Report

Child

- M.M.

Date of Child's Birth

- [redacted] 2021

Date of Fatality

- May 16, 2022

Child Fatality Review Date

- July 12, 2022

Committee Members

- Elizabeth Bokan, JD, Ombuds, Office of the Family and Children's Ombuds
- Tarassa Froberg, Statewide CPS-FVS Program Manager, Department of Children, Youth, and Families
- Jennifer Gorder, Quality Practice Specialist, Department of Children, Youth, and Families
- Nanette Noma, MA, SUDP, AAC, ICADC, Clinical Supervisor, Sunrise Recovery Services
- Whitney Miller, MSW, Neonatal Intensive Care Unit Social Worker, Mary Bridge Children's Hospital

Facilitator

- Leah Mattos, MSW, Critical Incident Review Specialist, Department of Children, Youth, and Families

Executive Summary

On July 12, 2022, the Department of Children, Youth, and Families (DCYF) convened a Child Fatality Review (CFR)[1] to examine DCYF's practice and service delivery to M.M. and RCW 74. family. M.M. will be referenced by RCW 74. initials throughout this report.[2]

On April 18, 2022, DCYF was notified by law enforcement that M.M. had been placed in protective custody and admitted to the critical care unit at RCW 74.13.520. Emergency medical services responded to M.M.'s home after RCW 74. mother found M.M. unresponsive. The mother admitted to smoking fentanyl, and the officer said they found fentanyl and methamphetamine in M.M.'s play area. M.M. had a cardiac arrest and was diagnosed with a brain injury secondary to probable Fentanyl ingestion. On May 16, 2022, M.M. was taken off life support and passed away.

At the time of M.M.'s death, RCW 74. family was involved in an open DCYF Child Protective Services Family Assessment Response (CPS-FAR)[3] case. A CPS investigation was assigned to investigate the circumstances surrounding M.M.'s death.

A diverse CFR Committee (Committee) was assembled to review DCYF's involvement and service provision to the family. The Committee included members with relevant expertise selected from diverse disciplines within DCYF and community partnerships. Committee members had no prior direct involvement with M.M. or RCW 74. family. Before the review, the Committee received relevant case history from DCYF. On the day of the review, the Committee had the opportunity to speak with DCYF caseworkers, supervisors, and area administrators who were all involved with the family.

Case Overview

M.M. was born in RCW 74.13.515 2021. In April 2021, M.M. and RCW 74. family came to the attention of DCYF. A medical professional notified DCYF that due to prenatal exposure to harmful substances, M.M. was receiving care from the neonatal intensive care unit. The mother disclosed that during her pregnancy, she ingested heroin on a daily basis and periodically used methamphetamines. The mother received limited prenatal care during the pregnancy. The father also disclosed methamphetamine use. Based on this report, a CPS risk-only[4] investigation was assigned.

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

The Committee has no subpoena power or authority to compel attendance and generally hears only from Agency 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 the circumstances of a child's fatal injury. Nor is it the function or purpose of a CFR to recommend personnel action against DCYF employees or other individuals.

[2] The names of M.M.'s parents' are not used in this report because neither parent has been charged with a crime in connection with the fatality. M.M.'s name is also not used in this report because RCW name is subject to privacy laws. See RCW 74.13.500.

[3] For information about CPS-Family Assessment Response (CPS-FAR), see: https://www.dcyf.wa.gov/policies-and-procedures/2332-child-protective-services-family-assessment-response.

[4] A CPS Risk Only investigation should be screened in when there are "reports [that] a child is at imminent risk of serious harm and there are no child abuse or neglect allegations". For more information about CPS Risk Only investigations, see: https://www.dcyf.wa.gov/practices-and-procedures/2200-intake-process-and-response.

During the investigation, the CPS caseworker contacted the mother, the father, M.M., a relative, and the medical professional, who alerted DCYF about M.M.'s condition. The mother told the caseworker she was motivated to continue with her substance use disorder (SUD) treatment. She also said she was receiving ongoing services from RCW 74.13.520.[5]

A family team decision making meeting[6] was held to discuss concerns and strengths and to develop a plan to support M.M. and the mother. In attendance were the mother's relative supports, professional supports, and a nurse from the hospital where M.M. was treated. The meeting also included a DCYF Family Voluntary Services (FVS)[7] caseworker to discuss the FVS program and additional available family support services. A safety plan was developed that was designed to support the mother while she resided with M.M. in a relative's home.

To explore the possibility of offering FVS to the mother, the CPS caseworker and supervisor worked with the DCYF office in the catchment area where the relative's home was located. A courtesy FVS caseworker was assigned to complete a walk-through of the relative's home and conduct health and safety visits for the mother and M.M.

In May 2021, a urinalysis test showed that the mother tested negative for harmful substances. Also, in May, the FVS caseworker completed a health and safety visit at the relative's home. The FVS caseworker spoke with the mother about Safe Sleep[8] and Period of Purple Crying.[9] The FVS caseworker offered advice to the mother about M.M.'s sleep environment and asked that the crib bumpers be removed. The mother agreed.

A monthly supervisor review was conducted by the CPS supervisor and caseworker that included the consideration of appropriate next steps. The caseworker contacted the mother, who agreed to continue participating with services. The mother also confirmed M.M.'s involvement with appropriate services.

In June 2021, the FVS caseworker completed a health and safety visit with the mother and M.M. at the relative's home. It was observed that the mother had removed the crib bumpers from M.M.'s sleep environment. No additional safety concerns were noted.

The CPS caseworker and supervisor determined that because of family and community-based support, FVS was not necessary. The mother reported she was continuing to participate in services, including the following: medically-assisted treatment, four group meetings per month, random urinalysis testing, intensive SUD

[5]For information about RCW 74.13.520, see: https://RCW 74.13 520.org/. Last accessed on July 29, 2022.

[6] For information about the family team decision making meetings process, see https://www.dcyf.wa.gov/1700-case-staffings/1720-family-team-decision-making-meetings.

[7]For information about DCYF Family Voluntary Services (FVS), see: https://www.dcyf.wa.gov/policies-and-procedures/3000-family-voluntary-services-fvs.

[8]For information about Safe Sleep, see: https://safetosleep.nichd.nih.gov/safesleepba sics/about; https://www.nichd.nih.gov/sites/default/files/2019-04/Safe_to_Sleep_brochure.pdf; and https://www.dcyf.wa.gov/safety/safe-sleep. Last accessed on July 29, 2022.

[9]For information about Period of Purple Crying, see: http://www.purplecrying.info/what-is-the-period-of-purple-crying.php. Last accessed on July 29, 2022.

outpatient services, the Parent Child Assistance Program[10], and continued involvement with RCW 74.13.520. In mid-June, DCYF submitted the case for closure.

In October 2021, DCYF received two calls reporting concerns about the mother leaving the relative's home, sometimes for weeks at a time. The caller said they were not sure if the mother was continuing to participate in her SUD treatment. The initial call did not report any child abuse or neglect concerns. This report did not screen in for investigation or services. The second call expressed concern about the mother having drug paraphernalia in her possession. This intake screened in and was assigned to a CPS-FAR worker.

A CPS-FAR caseworker made initial contact with the person who reported the concerns. This person did not express any concerns about the possible abuse or neglect of M.M. The case was transferred to the DCYF office responsible for the area where the relative's home was located. The receiving CPS supervisor staffed the case with the area administrator. A determination was made to screen out the intake because there was no report of abuse or neglect. The case was closed without any further intervention.

On Feb. 9, 2022, DCYF received a call reporting concerns about the mother relapsing and discontinuing her treatment program. The caller expressed concerns that with M.M. present, the mother was using (smoking) drugs in the bedroom. A CPS-FAR case was opened.

The CPS-FAR caseworker contacted the person who reported the concerns and made attempts to contact and locate the parents. Multiple unsuccessful attempts to locate the family were made. On Feb. 15, 2022, the assigned caseworker located the mother and completed an initial face-to-face visit with M.M. and also visited her mother. The father was not present.

The CPS caseworker and supervisor determined a case transfer was appropriate based on the parents residing in a location in the catchment area of a different local DCYF office. On Feb. 16, 2022, M.M.'s case was transferred.

On March 31, 2022, a monthly supervisor review occurred. Next steps were documented to include the following: contact the family and visit the home to discuss the family's needs and possible services, contact the mother's SUD treatment provider to confirm treatment status, interview the father, offer urinalysis testing to both parents, and initiate contact with known collateral contacts.

On April 18, 2022, DCYF was notified that M.M. had been admitted to RCW 74.13.520 in critical condition. On May 16, 2022, M.M. was taken off life support and passed away. The CPS investigation was completed, and DCYF issued negligent treatment or maltreatment founded findings[11] against both parents.

[10]For information about the Parent Child Assistance Program, see: https://pcap.psychiatry.uw.edu/. Last accessed on July 29, 2022.

[11]RCW 26.44.020(14) defines "founded" as follows: "the determination following an investigation by the department that, based on available information, it is more likely than not that child abuse or neglect did occur." RCW 26.44.020(29) defines "unfounded" as follows: "the determination following an investigation by the department that available information indicates that, more likely than not, child abuse or neglect did not occur, or that there is insufficient evidence for the department to determine whether the alleged child abuse did or did not occur."

Committee Discussion

The Committee had the opportunity to speak with the DCYF field staff from the three DCYF offices involved with this family. The Committee discussed the case details, systemic barriers, and family needs. The Committee's discussion focused on the themes of collaboration and communication.

The Committee learned about high staff vacancies and turnover rates in two of the three involved offices and challenges involving employee hiring and onboarding. The Committee was told that caseloads were extremely high and that supervisors were re-assigned to carry full caseloads. The impact of supervisors being assigned caseloads was that it gave the supervisors less time to provide clinical supervision. It was also reported that it had been very challenging to hire new staff.

The Committee recognizes that what was described by the field staff are not ideal working conditions. The Committee wondered how this might be impacting the field staff's well-being and ability to effectively perform their job. The Committee wondered about the DCYF leadership response to the staffing shortages and stressed that DCYF should consider a statewide system response to address the current statewide staffing needs. For example, the Committee suggested field staff may benefit from DCYF developing a triage response team to support field offices that are experiencing a high workload volume and vacancy rates. This may include guidance focused on work prioritization and providing additional supports to field staff to address their needs.

The Committee identified what they believe would have been beneficial for the mother, father, and M.M. The Committee discussed aspects of the case that may have presented work improvement opportunities. The interventions offered to the father involved limited contact with DCYF. The Committee believes more effort should have been made to engage the father and assess his needs. The Committee had questions about many aspects of the father's history and recent involvement with the mother and M.M. The Committee felt that gathering information from the father may have provided a more comprehensive picture of the family and their needs.

The Committee pointed out that it was a positive aspect of this case that the mother was well connected with services following the birth of M.M. However, the Committee believes DCYF may have relied too heavily on these support services to ensure that all of the mother's needs were being met. The Committee believes additional collaboration and communication with the service providers may have benefited the mother. This collaboration may have allowed the caseworker to verify the mother's self-reports of her participation, gather information about her progress, and identify any of the mother's unmet needs.

The Committee discussed the October 2021 intakes received by DCYF. The first intake screened out, while the second intake initially screened in for investigation. The intake that screened in was transferred to another office and subsequently screened out due to no report of abuse or neglect. This occurred after the initial point of contact was made with the individual who made the report. The Committee pointed out that communication between the two offices may have been beneficial in establishing their roles and future plans for how to proceed. Although the Committee understands that no abuse or neglect was reported, leaving DCYF with no legal authority to respond, they also discussed that this may have been a critical time to re-assess the mother's progress, current needs, and whether the previous safety plan was still being followed.

The Committee believes the focus of the various interventions was on the mother and her service plan. This may have led to overlooking M.M.'s individual needs. The Committee's subject matter expert, who is a licensed social worker, pointed out that the first year of life is a critical time for infants who are born premature and who are affected by harmful substances. During the February 2022 CPS investigation, the caseworker told the Committee the mother expressed interest in early learning programs and child care. The caseworker said that because the case was transferred to another office, she did not complete the referrals. The Committee learned it would not be typical for a caseworker to complete referrals knowing the case was transferring. While the Committee understands this practice, they identified this as a missed opportunity to provide additional oversight and support to M.M.

The Committee discussed the use of courtesy supervision and case transfers in the case, which they felt may have contributed to a lack of follow-through and oversight. The Committee's perception is that DCYF has a culture that focuses on identifying which office should be assigned a particular case and that this may detract from focusing on service provision and assessing safety. While the Committee understands there are complicated logistics related to case assignments, the Committee believes communication between the sending, receiving, and courtesy supervision offices could have been increased to provide better continuity of care throughout the various interventions. The Committee strongly emphasized that regardless of the case assignment, the child safety assessment is the responsibility of all DCYF caseworkers.

Findings

The Committee did not identify any findings.

Recommendations

DCYF should consider hiring a licensed therapist that can provide therapeutic support to DCYF staff who may be experiencing secondary trauma.

The Committee made the following suggestions that are related to hiring and staff vacancy rates:

- DCYF's human resources department (HR) should evaluate the minimum qualifications for hiring social service specialists and determine whether any modifications should be made that may expand and diversify DCYF's current hiring practices.
- Because of high employee vacancy rates, a DCYF statewide response system should be considered to address the current staffing crisis for the Region 4 King County offices. The Committee also understands that other offices may also need assistance.
- The Committee suggested DCYF take advantage of support from other neighboring DCYF offices to assist with the current staffing shortages.