CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

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Full Report

Child

- A.A.

Date of Child's Birth

- [redacted] 2021

Date of Fatality

- August 15, 2022

Child Fatality Review Date

- December 7, 2022

Committee Members

- Elizabeth Bokan, JD, Ombuds, Office of the Family and Children's Ombuds
- Myranda Dixon, Quality Practice Specialist, Department of Children, Youth, and Families
- Lori Vanderburg, LMFT, Executive Director, Dawson Place Child Advocacy Center
- Margaret McCurdy, LICSW, Executive Director, Children's Justice Center of King County, KCPAO
- Jordan Tracy, MSN, RN, Public Health Nurse, Tacoma-Pierce County Health Department

Facilitator

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

Finalized Date: May 9, 2023
Approved for distribution by Paul Smith, Critical Incident Supervisor

Executive Summary

On December 7, 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 A.A. and RCW 74.1 family. A.A. will be referenced by RCW 74.1 initials throughout this report.[2]

On August 15, 2022, RCW 74.13.520 called DCYF to report that A.A. had died of cardiac arrest. A.A. had medically complex needs due to a diagnosis of short bowel syndrome[3] and required a central line for nutritional feedings. A.A. had a history of central line infections[4], which can be a life-threatening condition. Initially, DCYF was told that no autopsy would be completed and understood the child died of medical causes.

On September 13, 2022, DCYF was contacted by RCW 74.13.520 who reported concerns that A.A. had experienced non-accidental trauma based on a consultation completed with the medical examiner's office. DCYF contacted the medical examiner who reported that A.A. had 11 fractures of varying ages and a lacerated spleen. At the time of A.A.'s death, the family had an open Child Protective Services (CPS) case.

A 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 A.A. 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 field staff who were involved with the family.

Case Overview

On July 14, 2022, a medical professional contacted DCYF to report concerns that A.A.'s mother was not following A.A.'s care plan to meet RCW 74. medically complex needs. A.A. was diagnosed with short bowel syndrome and required a central line to provide nutrients and antibiotics. The dressing for the central line needed to be changed frequently and within certain timelines to prevent infection. The referrer said that A.A.

[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 CFR should not be construed to be a final or comprehensive review of all circumstances surrounding the death of a child. The CFR Committee's review is generally limited to documents in the possession of, or obtained by DCYF or its contracted service providers.

The Committee has no subpoena power or authority to compel attendance and generally only hears from DCYF employees and service providers. It does not hear the points of view of the child's parents and relatives, or of other individuals associated with the child. A CFR is not intended to be a fact-finding or forensic inquiry to replace or supersede investigations by courts, law enforcement agencies, or other entities with legal responsibility to investigate or review some or all the circumstances of a child's fatal injury or near fatal injury. Nor is it the function or purpose of a CFR to recommend personnel action against DCYF employees or other individuals. "The restrictions [described in this paragraph, and the paragraph immediately above,] do not apply in a licensing or disciplinary proceeding arising from an agency's effort to revoke or suspend the license of any licensed professional based in whole or in part upon allegations of wrongdoing in connection with a minor's death or near-fatality reviewed by a child fatality or near-fatality review team." See RCW 74.13.640(4)(d). See: https://app.leg.wa.gov/RCW/default.aspx?cite=74.13.640.

[2]A.A.'s name is not used in this report because RCW name is subject to privacy laws. See RCW 74.13.500.

[3]For information on short bowel syndrome, see: https://www.seattlechildrens.org/conditions/short-bowel-syndrome/. Last accessed on December 22, 2022.

[4]For information on central line infections, see: https://www.cdc.gov/hai/bsi/clabsi-resources.html. Last accessed on January 10, 2023.

[5]For information on RCW 74.13.520 . Last accessed on December 22, 2022.

had been admitted to the hospital on four occasions due to central line infections. A CPS investigation was assigned.

On July 15, 2022, a supervisory staffing occurred and the case was assigned to a CPS investigator. The caseworker attempted to conduct an initial face-to-face, but the mother declined to allow the caseworker to complete a visit saying the family was sick and may have COVID-19. The mother said this was the reason she had not been able to attend A.A.'s scheduled medical appointments. The caseworker left their contact information for the mother. The caseworker requested an extension for the initial face-to-face visit.

On July 21, 2022, the caseworker submitted a referral for the family to be connected with a public health nurse. The caseworker contacted the clinic staff who frequently worked with the family. The clinic staff shared that the mother had been consistent with appointments in the last one to two months. The clinic staff said that it was critical A.A. have the dressing on RCW 74. central line changed every seven days. The clinic confirmed there was a schedule set up for a home care provider to change the dressing every other week with the mother needing to take A.A. to RCW 74.13.520 to have the dressing changed on alternating weeks.

On July 25, 2022, the caseworker completed an initial face-to-face visit with the mother and A.A in their home. No present danger or safety threats were identified during the visit. The mother told the caseworker she planned to move A.A.'s medical care from RCW 74.13 to RCW 74.13.520 The mother told the caseworker she had a new patient appointment at RCW 74.13.520 on July 26, 2022, and an in-home appointment for A.A.'s dressings to be changed on July 27, 2022. The caseworker spoke with the maternal grandmother, who said she was a natural support for the mother and children. No concerns were shared by the grandmother. The caseworker contacted RCW 74.13 to confirm they would transfer A.A.'s medical records to RCW 74.13.520 RCW 74.13. confirmed, but said that it was important the mother take A.A. in for an appointment as soon as possible.

On July 26, 2022, the caseworker contacted the mother to see if she attended the new patient appointment that had been scheduled with RCW 74.13.520 The mother said RCW 74.13.520 staff asked her to bring A.A. for an appointment on July 28, 2022. The caseworker asked for the contact information for RCW 74.13.520 so that the information could be shared with the RCW 74.1 medical team.

On July 27, 2022, the caseworker contacted the provider who oversaw A.A.'s in-home appointments. The caseworker left a message to confirm if A.A.'s appointment had been completed as scheduled.

On July 28, 2022, a monthly supervisor review took place. The DCYF caseworker and supervisor participated in a meeting as requested by RCW 74.13 medical professionals. The hospital expressed concerns about the mother intermittently attending appointments and the pattern of A.A. developing central line infections. RCW 74.13 medical professionals shared with DCYF their efforts to engage the mother, coordinate transportation for appointments, and teach the maternal grandmother how to care for A.A.'s needs. The hospital said they had contacted the maternal grandmother when the mother had not responded. Following the meeting, the caseworker sent the mother a message to provide an update about the meeting between DCYF and RCW 74.13.

On August 1, 2022, the caseworker contacted the mother to help her schedule A.A.'s appointment at [redacted] An appointment was scheduled for the following day and the caseworker offered to attend the appointment with the mother and A.A. The caseworker contacted [redacted] to confirm the appointment.

On August 2, 2022, the caseworker spoke with the mother to confirm she had transportation to the appointment. The mother said her father was providing transportation and they confirmed a meeting location at the hospital. The mother was late to the appointment, so was not able to see the doctor or nutritionist. The caseworker followed up with the [redacted] social worker who confirmed A.A. had no new medical concerns and would not need to be seen again at [redacted] A.A.'s next appointment was scheduled at RCW 74.13.520 [redacted] on August 9, 2022. The [redacted] social worker sent a follow up email to the mother.

On August 10, 2022, the caseworker contacted the mother to follow up on the GI appointment. The mother told the caseworker about the additional follow-up appointments she had scheduled for A.A. at RCW 74.13.520 The mother told the caseworker things were going well and that she was going to baby-proof the house because A.A. had started crawling.

On August 11, 2022, the caseworker received correspondence from the [redacted] social worker. She reported that their clinic received notification that the mother and A.A. did not attend the appointment on August 9, so [redacted] had not discharged the family from their care. The caseworker contacted the mother, who apologized for the miscommunication and believed the clinic had already contacted the caseworker and [redacted] The mother attempted to explain what occurred and the caseworker asked to schedule a phone call to ask clarifying questions about why the appointment was missed. The mother reported that additional two-week follow-up appointments were scheduled at RCW 74.13.520 The caseworker spoke with the [redacted] social worker who reported RCW 74.13.520 did not have additional appointments scheduled.

On August 12, 2022, the caseworker spoke with the mother again regarding the needed GI follow-up appointment. The caseworker offered to schedule the appointment for the mother and offered to help her set up transportation. The caseworker discussed the Family Voluntary Services[6] program and HOMEBUILDERS® Intensive Family Preservation[7] with the mother. The caseworker emailed a program description for HOMEBUILDERS® to the mother. The mother said she would think about it over the weekend. The caseworker notified the [redacted] social worker that the mother wanted to schedule the GI appointment for the week of August 15, 2022.

On August 15, 2022, DCYF was notified that A.A. passed away. An additional CPS investigation was initially assigned. The field office determined the case would be screened out because no autopsy would be conducted and DCYF believed A.A. died due to [redacted] medical condition. On September 13, 2022, DCYF was notified by [redacted] that an autopsy had been completed and A.A. was found to have 11 fractures of varying ages and a lacerated spleen. [redacted] stated that these injuries were likely due to non-accidental trauma. A CPS

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

[7]For information on HOMEBUILDERS® Intensive Family Preservation Services, see: https://www.dcyf.wa.gov/services/child-welfare-providers/evidence-based-practices.

investigation was assigned and led to A.A.'s sibling being placed in out-of-home care due to the unexplained injuries of A.A. There is an on-going law enforcement investigation at the time of this report.

Committee Discussion

The Committee discussion focused on the training, support, and resourcing of field staff. The Committee learned about this particular office's challenges related to hiring staff, high vacancy rates, and a workforce of many new field staff and supervisors. In this particular case, the CPS caseworker said they were employed less than six months prior to receiving this case assignment and there was a supervisory change during the initial case assignment. The second supervisor had recently transitioned to supervision of this unit approximately two weeks before A.A.'s death and said they were carrying 15 cases. The Committee learned about some of the supports offered in this region to assist the office, but expressed the importance of the agency exploring creative strategies to aid in hiring, such as incentivizing employment and increasing pay for direct line caseworkers. The Committee understands that consideration for such ideas needs to be addressed at a legislative level and expressed the importance of the agency pursuing additional support for field staff. The Committee discussed areas for improvement with thoughtfulness due to the complexities of the case and challenges the office was experiencing.

The Committee discussed the importance of critical thinking and curiosity in this work. While the Committee recognized that the caseworker was new to this work, they discussed the areas where they felt critical thinking and curiosity may have been utilized to complete a more comprehensive investigation. The Committee heard from the caseworker that she was provided guidance by the initial supervisor to mediate the relationship between the mother and [RCW 74.13.3] The Committee felt this may have detracted from the caseworker's focus of assessing child safety. There was a delay in the initial face-to-face contact with A.A. due to the mother reporting the family may have COVID-19. The supervisor authorized an extension and did not provide the caseworker with additional guidance on next steps or suggest the family seek urgent medical care. The caseworker said she maintained phone contact with the mother, which the Committee appreciated, but would have liked to see it in the case documentation. The DCYF Committee member did not believe this office's use of a 10-day extension was common practice at other offices throughout the pandemic. The Committee felt A.A. needed DCYF to respond with a sense of urgency to the allegations that [RCW 74.13] medical needs were being neglected and to verify the information the mother reported to ensure that [RCW 74.] care needs were being followed up on.

Other aspects discussed related to critical thinking were the agency's knowledge and understanding of the facts related to A.A.'s medical condition. The agency requested medical records, but neither the caseworker or supervisor read the records, and relied on the medical professionals to educate them about A.A.'s care needs. The caseworker relied on the mother's self-reports about the transition to a new medical provider and did not speak with the new provider. The caseworker did attempt to request clarification from the mother when it was not clear why a medical appointment was missed, which the Committee appreciated, but still did not believe there was clarity around the situation.

The Committee also wondered about the details of this family's daily functioning, supports, and resources. For example, the mother would not share information about either of her children's fathers. A.A.'s father was reportedly not involved, but there were references to [RCW 74.] sibling's father being involved, although the details

were not gathered. The Committee learned from the caseworker that the mother presented as being secretive about the fathers of her children. The Committee wondered if the mother's reluctance to share information may be a result of systemic racism that the mother had experienced within systems.

During the intervention, the caseworker did not see A.A.'s younger sibling. The caseworker said he was never present at the home and the mother told her he was not part of the case. Throughout the investigation, it appeared that the mother kept her family and supports, A.A.'s medical team, and DCYF siloed. The mother may have benefited from a collaborative approach and open communication between all of the individuals involved in supporting her and A.A., which DCYF could have offered through a shared planning meeting. The mother struggled to utilize the medical resources and transportation available to her, but was not receptive to the caseworker's offer to assist.

Although outside the scope of the review, the Committee asked to learn more about the office's decision to close out the investigation related to A.A.'s death. The Committee appreciated learning about the elements that went in to the decision making, which included information from law enforcement and medical professionals. The Committee also learned more about the investigation related to the physical abuse allegations received on September 13, 2022. The Committee understood the focus was on A.A.'s sibling and meeting his immediate safety needs, but felt the investigation of A.A.'s death was overlooked.

The Committee had a lengthy discussion about ideas and suggestions on how to reduce barriers for caseworkers and supervisors to be well-resourced to complete thorough assessments. Although the Committee understood the limitations related to CPS field staff availability at this office they wondered if case assignments for such complex cases could be triaged and not assigned to caseworkers newly out of regional core training.

The Committee recognizes that DCYF field staff are not medically trained social workers, nor could they be expected to be subject matter experts in this discipline. The Committee discussed the internal resources available to field staff through Regional Medical Consultation, which offers consultation with a network of medical professionals. The Committee did wonder about the messaging and training available to new staff to learn about these resources and felt it may be beneficial to have additional support to provide guidance and consultation on complex medical cases. A Committee member pointed out the challenges with locating and accessing resources of DCYF's intranet and suggested that DCYF consider a redesign to make resources more easily accessible. The Committee suggested that field staff may benefit from DCYF employing nurses who could accompany them in to the field to assess medical needs for cases involving complex medical diagnosis or allegations of medical neglect.

The Committee also discussed DCYF's relationship with RCW 74.13 and the importance of the collaboration between the two agencies. The Committee sensed that the working relationship on this particular case was challenging and emphasized the importance of DCYF building a strong working relationship with RCW 74.13 and other medical providers in the community.

Throughout the Committee's conversation they expressed the importance of DCYF field staff feeling supported in their work and having outlets to address the secondary trauma they may experience in this work. The Committee discussed DCYF's Peer Support program. The Committee appreciates the availability of peer

support, but also emphasized that more resourcing may be needed to provide field staff with access to licensed counselors, which is currently being explored by the agency. A Committee member pointed out that therapists may not be able to address the underlying cause of staff burnout and suggested DCYF prioritize the wellbeing of field staff by addressing workload related challenges.

Recommendations

The Committee recommendations come from a comprehensive review and discussion of the many aspects of the case. The recommendation is unrelated to the death of A.A. The intent of the recommendation is to help DCYF resource field staff to complete comprehensive assessments and improve practice.

The Committee respectfully recommends that DCYF create a Health Lead position, with designation of one lead per region to provide consultation and guidance to field staff regarding access to medical care for children and families. This may include, but would not be limited to:

- Receive notification of incoming cases with allegations of medical neglect or children with medically complex care needs. This notification could be provided by local field staff assigning CPS intakes, but ideally would be notified automatically through Famlink.
- Provide education and consultation to field staff about the Managed Care Organizations, the Washington State Health Care Authority, and Fostering Well-Being.
- Assist field staff in collaborating with the Managed Care Organizations, Washington State Health Care Authority, and Fostering Well-Being to address medical and well-being needs for children served by DCYF, such as requesting nursing services.
- Creating access to DCYF resources such as Regional Medical Consultation and Fostering Well-Being through education and hands-on support of field staff.
- Act as a liaison between DCYF and local hospitals and medical professionals.
- Update relevant health care resources on DCYF's intranet and sharing with field staff.

The Committee respectfully recommends DCYF continue to expand the array of services and supports offered to field staff through the Peer Support program. This may include, but would not be limited to:

- A DCYF staff psychologist.
- Contracted, licensed mental health professionals to provide therapeutic services to DCYF staff.