CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

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Nondiscrimination Policy

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

Full Report

Child

- A.H.

Date of Child's Birth

- 74.13.515 2019

Date of Fatality

- January 2020

Child Fatality Review Date

- March 26, 2020

Committee Members

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

Facilitator

- Libby Stewart, DCYF, Critical Incident Review Specialist

Executive Summary

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

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

The CFR Committee (Committee) includes members with relevant expertise selected from diverse disciplines within the community. A representative from the substance use disorder community was unable to attend the review. Committee members have not had any involvement or contact with A.H. or 74.13.51 family. The Committee received relevant documents including intakes, case notes and other DCYF documents maintained in DCYF's electronic computer system.

The Committee interviewed the CPS case worker who assessed the 74.13.515 2019 intake, the case worker's supervisor, the FVS case worker and the FVS worker's supervisor.

Case Overview

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

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

[2] "A child fatality or near-fatality review completed pursuant to [RCW 74.13.640] is subject to discovery in a civil or administrative proceeding, but may not be admitted into evidence or otherwise used in a civil or administrative proceeding except pursuant to [RCW 74.13.640(4)]." Given its limited purpose, a child fatality review (CFR) should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. The CFR committee's review is generally limited to documents in the possession of or obtained by DCYF or its contracted service providers.
The committee has no subpoena power or authority to compel attendance and generally only hears from DCYF employees and service providers. It does not hear the points of view of the child's parents and relatives, or of other individuals associated with the child. A CFR is not intended to be a fact-finding or forensic inquiry or to replace or supersede investigations by courts, law enforcement agencies, or other entities with legal responsibility to investigate or review some or all of the circumstances of a child's fatal injury. Nor is it the function or purpose of a CFR to recommend personnel action against DCYF employees or other individuals.

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

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

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

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

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

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

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

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[4] 74.13.520 .

[5] See: http://depts.washington.edu/pcapuw/

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

[7] See https://www.cdc.gov/vitalsigns/safesleep/index.html.

[8] See: http://www.purplecrying.info/.

[9] Plan of safe care, see: https://www.dcyf.wa.gov/1100-child-safety/1135-infant-safety-education-and-intervention.

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

On November 6, 2019, A.H. was discharged home to 74.13.51 mother. All safety plan participants agreed to, and signed the in-home safety plan, which was provided to the hospital. The CPS case worker referred the mother to an in-home service provider (Promoting First Relationships) to support her during the voluntary services portion of her involvement with DCYF.

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

On January 21, 2020, the FVS case worker arrived at Ms. Hammonds' home for the scheduled health and safety visit. The PFR provider was also present. They discussed Ms. Hammonds' substance use outpatient treatment and how the current service provider was not allowing her to bring 74.13.515 to the sessions. Without child care, Ms. Hammonds could not attend her treatment sessions. There was discussion about contacting one of the prior providers to see if she could change her treatment to allow her to bring A.H. with her to sessions with the other provider. The mother agreed to contact the previous provider and change back to substance use treatment with that previous provider. The FVS worker did not observe any concerns. Ms. Hammonds discussed how she practiced safe sleep with 74.13.51 and the sleep environment was observed.

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

Committee Discussion

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

Some Committee members discussed their preference to have the DCYF staff look into whether it would have been possible for Ms. Hammonds and 74.13.515 to live with another relative or sober support person. However, it was also discussed that Ms. Hammonds had successfully completed inpatient treatment and this was not identified as a need by her service providers. Based on the conversation the

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

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

The Committee identified positive aspects of this case as well. While understanding that Ms. Hammonds has a significant history of substance abuse the Committee believes the decision to allow the case to move forward with FVS was acceptable given the demonstrated positive improvement made by Ms. Hammonds. The Committee also appreciated the statements made by the CPS supervisor. The CPS supervisor stated she went into the FTDM believing that based on the historical information, DCYF should file a dependency petition requesting the removal of A.H. from [74.13.51] mother. However, after attending the FTDM and listening to the community professionals and Ms. Hammonds regarding the positive changes and progress she made, she agreed with the decision to move forward with FVS. This was also supported by statements made by the FVS supervisor. The Committee appreciated the FVS supervisor's presentation about the office standards of practice regarding case transfers from CPS to FVS, the FVS supervisor's ability to question whether a transfer is appropriate and the FVS supervisor's ability to intervene if he believes the transfer is not appropriate.

Findings

The Committee made a finding that due to A.H.'s age and pursuant to DCYF Practices and Procedures Policy No. 4420, two health and safety visits per calendar month were required. The policy says one of the two visits may be conducted by a contracted provider, such as the PFR provider. While it was understood that a contracted service provider was in regular contact and making home visits with A.H. and [74.13.51] mother, this was not documented in the case notes.

Recommendations

The Committee did not make any recommendations.