CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

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CONTENTS

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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

- C.M.

Date of Child's Birth

- [redacted] 2021

Date of Fatality

- Oct. 18, 2021

Child Fatality Review Date

- Jan. 6, 2022

Committee Members

- Patrick Dowd, JD, Director, Office of Family and Children's Ombuds
- Jasmine Hodges, MA, Quality Practice Specialist, DCYF
- Kari Matheny, CPS Supervisor, DCYF
- Judy Ziels, MPH, RN, Public Health Nurse Supervisor, Whatcom County Public Health
- Nanette Noma, MA, SUDP, AAC, ICADC, Substance Use Disorder Professional, Sunrise Recovery Services

Observer

- Tiffany Lindsey, EdD, LPC-MHSP, Assistant Professor, University of Kentucky

Facilitator

- Leah Mattos, MSW, Critical Incident Review Specialist, DCYF

Executive Summary

On Jan. 6, 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 C.M. and RCW 74 family. C.M. will be referenced by RCW 7 initials throughout this report.[2]

On Oct. 18, 2021, C.M. died. Law enforcement contacted DCYF to report they responded to a 911 call where C.M. was discovered face-down in RCW 7 parents' bed and not breathing. The father told law enforcement that C.M. awakened during the night and was crying. While the mother was in bed, the father took C.M. to her for feeding. The father went back to sleep in another area of the home. The father returned to find the mother asleep with C.M. face down and covered in blankets. C.M. was blue and not breathing. The mother began CPR while the father called 911.

Law enforcement reported there was drug use evidence throughout the home. This included a small bag of a suspected controlled substance and several burnt foils in the bedroom and kitchen floor. The parents reportedly admitted to drug use but denied using drugs in the children's presence. At the time of C.M.'s death, there was an open Family Voluntary Services (FVS) and Child Protective Services (CPS) case involving the family.

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 C.M. or RCW 7 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 the area administrator who was involved with the family.

Case Overview

C.M.'s immediate family included RCW 7 mother, father, and older sibling RCW 74.13.515). RCW 74.13.5's father is unknown to DCYF. Prior to the birth of C.M., there was a 2019 intake involving C.M.'s family. The 2019 intake alleges the possible abuse of RCW 74.13.5 by her babysitter. The information was referred to law enforcement and did not require a CPS investigation because there was no parental abuse or neglect allegation.

On RCW 74.13.515, 2021, DCYF was contacted by a medical professional reporting the birth of C.M. The mother and C.M. both tested positive for RCW 74.13.520. The mother denied substance use and said she consumed the RCW 74.13.520 by kissing someone. C.M. was born RCW 74.13.520 and was experiencing complications associated with

[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 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 CFR 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 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.

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

maintaining a normal oxygen level. The mother did not receive prenatal care. A CPS risk-only[3] investigation was assigned.

While at the hospital on RCW 74.13.515, 2021, a CPS caseworker conducted an initial face-to-face visit with C.M. The nursing staff reported that C.M. was beginning to demonstrate signs of withdrawal, evidenced by high pitch cries and feeding challenges. The hospital staff told the caseworker the mother initially said that C.M. would be raised by her sister upon discharge. The mother then said RCW 7 maternal grandmother would raise RCW 74.1.

The caseworker attempted to meet with the mother, who initially refused to engage and declined CPS services. After the mother's refusal and without the father present, the caseworker explained CPS' role. Later, the caseworker made a second attempt to meet with the mother on the same day. The mother was encouraged to attend the family team decision meeting (FTDM)[4] the following day. The mother continued to refuse to share information with the caseworker and threatened to file a restraining order against the caseworker.

On April 13, 2021, an FTDM was held. Both parents, as well as their relatives, were in attendance. The agreed plan was for C.M. to reside with RCW 7 parents in the paternal grandmother's home. This agreed plan included a safety plan and services for the parents. The alternate plan was for out-of-home relative care with the maternal grandfather. Both parents agreed to participate in services and said they would do what was necessary to keep C.M. in their care. At the hospital, the caseworker followed up with the mother and completed a Plan of Safe Care.[5]

On April 14, 2021, both parents were interviewed. During the interviews, the caseworker learned about a no-contact order (NCO) protecting the father from the mother. The mother said she was working on getting the NCO quashed. The parents confirmed their desire to care for C.M. The mother said it was not true that her plan was for C.M. to be raised by relatives. The caseworker discussed and provided literature about Safe Sleep[6] and Period of Purple Crying[7] to both parents. The parents agreed to the safety plan and provided relative contacts who could be safety plan participants.

On April 15, 2021, the caseworker conducted a face-to-face visit with RCW 74.13. At the time of the visit, RCW 74.13. was being cared for by RCW 74.13.'s maternal relatives. No concerns were noted. The caseworker received a message from the hospital reporting toxicology results taken from C.M.'s umbilical cord tissue. C.M. tested positive for RCW 74.13.520, RCW 74.13.520, and RCW 74.13.520. A monthly supervisor review was completed that concluded the safety plan should be revised.

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

[4]For information about Family Team Decision Making Meetings (FTDM), see: https://www.dcyf.wa gov/1700-case-staffings/1720-family-team-decision-making-meetings.

[5]For information about a Plan of Safe Care, see: https://www.dcyf.wa.gov/1100-child-safety/1135-infant-safety-education-and-intervention.

[6]For information about Safe Sleep, see: https://safetosleep.nichd.nih.gov/safesleepbasics/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.

[7] For information about Period of Purple Crying, see: http://www.purplecrying.info/what-is-the-period-of-purple-crying.php.

On April 20, 2021, separate FTDMs were held for each parent to revise the plan. The primary plan developed by the family was for a safety plan to be in place for C.M. and C.M. and [redacted] mother to stay at the maternal aunt's home. The safety plan required the maternal aunt to supervise the mother and C.M. If the plan was not followed, the secondary plan required court intervention. Both parents agreed to the plan for the time period that the NCO remained in effect. A walk-through of the relative's home was conducted, and the relative signed the safety plan.

On April 21, 2021, the mother was referred for a substance use disorder (SUD) evaluation. On April 22, 2021, the father was referred for urinalysis testing. He also agreed to participate in a SUD evaluation and reported that he was seeking options for a detox bed due to withdrawal symptoms.

On April 28, 2021, the father completed a SUD evaluation. The evaluation recommended [redacted]. The mother began participation in an evidence-based parenting program known as Promoting First Relationships (PFR)[8].

On April 30, 2021, the caseworker contacted all the safety plan participants to extend the safety plan to May 7. The caseworker learned the relative caregiver left the mother and C.M. unsupervised. The caseworker repeated the expectation that supervision must include direct, line-of-sight supervision of the mother and C.M. The relative agreed to provide the expected level of supervision.

On May 4, 2021, the mother completed the SUD evaluation. The recommendation included [redacted]. The CPS investigative assessment was completed. The CPS assessment recommended a case transfer to Family Voluntary Services (FVS) for the purpose of continued safety plan monitoring and completion of services.

On May 5, 2021, there was a monthly supervisor review, and the case was transferred from CPS to FVS. The monthly supervisory review case note documented that the mother would begin SUD outpatient services on May 10 and participate in the PFR program. Next steps included completing a health and safety visit within seven days, verifying the mother's participation in treatment, and confirming whether the father had located an inpatient treatment bed.

From May 17 to May 20, 2021, the FVS caseworker attempted to contact the mother to schedule a health and safety visit. Because the mother did not respond, the caseworker contacted the mother's relatives. An appointment was scheduled for May 20, but the mother contacted the caseworker on the day of the appointment to reschedule. The mother said [redacted] was sick.

On May 21, 2021, the caseworker completed a health and safety visit with [redacted] and the maternal relatives. No safety concerns were noted. The caseworker also completed a health and safety visit with C.M. and the mother in the paternal relative's home. The mother reported the father was in a detox bed in another county but did not provide information about the facility. The mother confirmed the continuation of SUD outpatient treatment and her work with the PFR provider. The caseworker observed C.M.'s sleep environment. The

[8]Promoting First Relationships (PFR) is an evidence-based parenting program. For information about the PFR program, see: https://pfrprogram.org/.

mother confirmed she did not co-sleep with C.M. and followed Safe Sleep guidelines. The paternal relative also confirmed the mother followed Safe Sleep practices.

On May 26, 2021, the caseworker unsuccessfully attempted to contact the mother to confirm a scheduled health and safety visit. The caseworker contacted a relative who said the mother was arrested RCW 13.50.100 . The caseworker located the children at the paternal relative's home and completed a health and safety visit. The paternal relative said she did not tell the caseworker the mother was in jail because she wanted the mother to tell the caseworker directly. The relative reported that she did not have any concerns about the mother using illegal substances. With regard to the care of the children, no safety concerns were noted.

On May 28, 2021, the caseworker contacted the mother requesting she complete urinalysis testing. The mother said she could not because she was leaving town to go camping and taking the children with her. A urinalysis referral was not submitted.

On May 31, 2021, the initial comprehensive family evaluation was completed. The evaluation documented that both C.M. and RCW 74.13.5 were doing well, their medical appointments were up-to-date, and the mother was following Safe Sleep guidance. The evaluation recommended the case remain open for continued monitoring and service completion.

On June 3, 2021, the caseworker spoke with a maternal relative. The relative reported the mother was doing well and was clean and sober. The caseworker attempted to contact the mother. The mother responded by leaving a message saying she and the children were doing well. On June 9, 2021, the caseworker contacted the mother again to verify where she and the children were staying. The caseworker also asked if she was having contact with the father.

On June 18, 2021, the case was transferred to a different FVS caseworker. On June 24, 2021, the caseworker was unable to contact the mother because the phone number was disconnected. The case note indicated the caseworker would attempt an unannounced visit the following day.

On July 8, 2021, the caseworker was unable to locate the mother. The caseworker's efforts to locate the mother included contacting multiple family members. The mother previously told the caseworker they were unavailable because they were camping in an area with no cell phone service. The caseworker asked the relatives to relay the message to the mother that it was urgent for the caseworker to speak with her.

On July 12, 2021, the caseworker contacted the mother's SUD treatment provider and left a message. The caseworker met with the mother and children at a paternal relative's home. The mother said she had been staying primarily at her father's home but was moving her things to the paternal relative's home. The mother said she felt supported by the PFR provider and continued participating in SUD outpatient treatment. The mother signed an information release form. No safety concerns were identified. The caseworker contacted the PFR provider, who reported she had met with the mother at the paternal relative's home multiple times and believed the mother lived at this residence.

On July 13, 2021, the mother completed urinalysis testing. On July 19, 2021, the toxicology results showed the mother tested positive for RCW 74.13.520.

On July 30, 2021, the caseworker received an update from the PFR provider. The mother was engaged in services, willing to be present and try new things. The provider reported the mother denied seeing the father but suspected she did see him. The provider did not report drug-related concerns or child safety concerns.

On August 13, 2021, the caseworker conducted a health and safety visit. The mother denied seeing the father but said she did allow him to see the children. The caseworker asked to confirm the father's contact information because the caseworker needed to speak with him. The caseworker also asked the mother to tell the father she needed to speak with him. No safety concerns were identified.

On August 31, 2021, the caseworker conducted a health and safety visit with the mother and children at the paternal relative's home. The mother said she was continuing with her SUD outpatient services. The caseworker discussed daycare benefits and other community-based services available to the mother and RCW 74.13. The mother agreed to complete a urinalysis. The caseworker asked to speak with the father, and the relative said he was not willing to speak with CPS. An updated safety assessment was completed indicating the children were safe.

On September 1, 2021, the mother completed urinalysis testing. On September 7, 2021, a comprehensive family evaluation was completed. The evaluation noted the mother completed PFR services and continues to work with SUD outpatient services. The assessment recommended case closure. On September 8, 2021, the mother's urinalysis testing showed that she tested positive for RCW 74.13.520.

On September 22, 2021, and before closing the case, the caseworker attempted to contact the mother to schedule a final health and safety visit. A message was left for the mother. Because the mother did not respond, the case remained open.

On September 25, 2021, a request for after-hours staff was submitted to complete a health and safety visit. The after-hours worker went to the last known address, but the relative reported the mother was not residing in the relative's home. The relative did not have the address for the location she believed the mother was staying but provided verbal directions to the home and said the driveway is steep and was previously washed out. The relative said the driveway should only be attempted with a four-wheel drive. The after-hours caseworker discussed this with the supervisor. Because the state vehicle was not a four-wheel drive, the decision was made not to attempt the driveway.

On September 27, 2021, DCYF received a call from an acquaintance of the mother who reported the mother said she was going to kill herself. The mother asked the acquaintance to contact her boyfriend to pick up the baby because she was bleeding out. The acquaintance said the mother uses drugs, including Fentanyl. The acquaintance did not have contact information for the boyfriend but did call 911. The DCYF central intake worker contacted law enforcement, who responded to the home. A CPS investigation was assigned.

An after-hours caseworker attempted to complete a health and safety visit at the mother's last known address. The relative at the address said the mother and C.M. were not there but possibly staying with C.M.'s grandfather. The after-hours caseworker contacted law enforcement for assistance. The officer reported receiving a picture of the mother's injury, which did not appear to be life-threatening. The officer went to the

home, and the mother was located. However, she refused to come to the door. The friend confirmed the children were at the home, safe and that the mother's injuries were not life-threatening.

On September 28, 2021, the assigned CPS caseworker began making attempts to locate the mother and children. The caseworker made six unsuccessful in-person attempts to contact the mother at various relatives' homes, including an attempt by an after-hours caseworker. Multiple telephone calls were made to relatives without a response. The caseworker also reached out to the mother via Facebook.

On October 1, 2021, an initial face-to-face visit with C.M. was completed. RCW 7 was located at RCW 7 paternal relative's home. The relative said C.M.'s mother was sick, and that was why the relative was caring for C.M. She reported that RCW 74.13 . was with the maternal relatives. C.M. was observed to be happy and healthy, with no identified safety threats. The caseworker observed RCW 7 bassinet and reviewed Safe Sleep and Period of Purple Crying with the relative.

The caseworker completed an initial face-to-face with RCW 74.13 . and her grandfather. RCW 74.13.5 did not engage in conversation with the caseworker. The grandfather said that C.M.'s mother was sick and planned to contact the caseworker on the following Monday (in 2 days). The caseworker did not observe any safety threats.

On October 18, 2021, DCYF was notified that C.M. died. CPS investigated C.M.'s death. At the conclusion of the investigation, DCYF issued a founded finding[9] against the mother for the negligent treatment of C.M. and RCW 74.13 .

Committee Discussion

The Committee discussion identified areas of positive practice. The caseworkers were commended for a strong assessment of present danger during each interaction with the children and family. It was noted the initial CPS caseworker worked hard to engage and build a trusting relationship with both parents. The caseworkers also made diligent efforts to connect and engage with numerous extended family members. A plan of safe care was quickly and thoroughly developed. Finally, it was noted the family was quickly referred to and connected with an evidence-based service provider.

The Committee discussed the casework and many aspects of this case. One area that was continually discussed was when the parents' compliance decreased, DCYF did not hold another FTDM or shared planning meeting. The April 2021 FTDM indicated the primary plan for C.M. was to remain in the mother's care with a safety plan in place. Court action was the alternate plan. The Committee believes bringing the parents, extended family, and providers together may have led to a transparent conversation about the case. DCYF could have addressed the information discrepancies the safety plan participants and parents reported. When necessary, this may have encouraged the development of a new plan.

The Committee also discussed why DCYF did not initiate court action. The Committee understands it can be difficult to initiate court involvement when time has passed from the initial intake to when the parent has

[9] 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."

agreed to and participated in voluntary services. However, the Committee does wonder if external control by a court may have led to improved compliance and progress on the part of the parents.

DCYF staff shared the challenges they face with the dependency court system in this particular county. For example, the office reported the local courts might deny requests for court involvement or out-of-home placement. However, the office clearly articulated that they will file a dependency action when a child is unsafe. If it is safe to do so, the local office makes exhaustive efforts to identify the least restrictive options before initiating court action. The Committee wondered how these reported challenges may have impacted the caseworkers.

The Committee discussed whether the caseworkers experienced bias in this case because of the parents' initial willingness to participate and comply in order to keep C.M. in their care. The Committee also discussed whether this may have led to the caseworkers accepting the parents' reports of service compliance, relationship status, and domestic violence history. For purposes of corroborating the information provided by the parents, the Committee believes it would have been beneficial for DCYF to confirm such information with providers and law enforcement.

The Committee also believes it would have been beneficial if DCYF had been able to learn more about the parents' relationship. For example, it was unclear if the parents intended to be together and what steps they took to resolve the NCO. The Committee believes it may have been helpful to address the parents' relationship goals and plans for those goals. However, the Committee understands that the father avoided CPS after the initial CPS case. The father's avoidance behavior created a limit to the information received by CPS.

The Committee learned from the CPS caseworker that domestic violence was not explored during the initial contact with the mother. Later, the caseworker learned from the mother that the parents had an NCO in place due to a domestic violence incident. For purposes of this incident, the mother was named as the perpetrator. The Committee appreciates that once DCYF had this knowledge, the previously developed plans were adapted through separate FTDMs for each parent. The Committee believes a specialized DV assessment was appropriate and may have led to a deeper understanding of the parents' relationship.

The Committee evaluated the safety plan and identified this as an area for improvement. The safety plan was written with a focus on service compliance. The plan relied on the safety plan participants to identify SUD concerns and reliably report such concerns to DCYF. The Committee discussed whether the safety plan participants knew the parents' SUD triggers and drug use indicators. The Committee discussed the importance of developing safety plans focused on the parents' progress and the importance of behaviorally detailed expectations being clearly described for the parents and safety plan participants. The Committee suggested the local office may benefit from a safety plan training or safety plan consultation provided by their quality practice specialist team.

Findings

The Committee believes the family's identified needs may have been better met if there had been follow-through for the following items:

- An additional FTDM or shared planning meeting when it was determined the family and safety plan participants were not following the previously established plan. This could have addressed a possible need for court involvement or an out-of-home placement through a voluntary placement agreement.
- Additional safety plan discussions with the plan participants to identify how or if they knew the parents were using substances and discussions about behaviorally specific expectations related to how the plan participants would respond.
- Utilization of relevant collateral contacts to verify the parent and safety plan participant reports.
- Additional efforts to engage the father and further assess his needs for service provision related to substance use and building parenting skills.
- The mother may have benefited from additional engagement and encouragement to participate in SUD services and explore options, such as inpatient treatment that allowed her children to be with her.

The Committee believes the family may have benefited if DCYF had learned more about the parents' relationship status and domestic violence history. This may have led to the development of a plan that addressed the parents' relationship goals while still addressing safety concerns. This may have included the following:

- Universal screening for domestic violence during the first contact with the mother
- Separate interviews with the mother and father during follow-up contacts with the parents
- A law enforcement records request for each parent
- Further inquiry into the NCO and details regarding the parents' next steps to resolve the NCO

Recommendations

The Committee did not develop any recommendations.