CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

February 2020

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CHILDREN, YOUTH & FAMILIES

Contents

February 2020

Full Report

Child

- E.P.

Date of Child's Birth

- [redacted] 2004

Date of Fatality

- October 10, 2019

Child Fatality Review Date

- February 20, 2020

Committee Members

- Elizabeth Bokan, JD, Ombuds, Office of the Family and Children's Ombuds
- MaShelle Hess, MSW, LICSW-A, CFWS & Guardianship Program Manager, DCYF
- Charity Criswell, MSW, Safety & Health Program Consultant, DCYF
- Kymm Dozal, MSW, Clinical Director, Comprehensive Life Resources
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Observer

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Facilitator

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

Executive Summary

On February 20, 2020, the Department of Children, Youth, and Families (DCYF)[1] convened a Child Fatality Review (CFR)[2] to examine DCYF's practice and service delivery to E.P. and [redacted] family.[3] [redacted] will be referenced by [redacted] initials throughout this report.

On October 6, 2019, DCYF received a call from [redacted] Hospital stating that E.P. had been brought to the hospital four days prior after [redacted] was found unresponsive in [redacted] home. E.P. was diagnosed with a diffuse hypoxic injury, which results from a lack of oxygen to the brain. The family provided no explanation for E.P.'s condition and reportedly delayed calling 911 for 20 to 30 minutes. Additionally, hospital staff reported that the mother may have been under the influence of substances and unable to consent to any additional medical procedures.

On October 10, 2019, the Department received a call from the medical examiner reporting that E.P. passed away following the removal of life support. The initial autopsy reported that E.P.'s death presents as an overdose to an unknown substance, but further toxicology testing would be required. The medical examiner also reported that E.P. did not have a heart condition or underlying medical condition that would have caused cardiopulmonary failure. At the time of the incident, DCYF had an open Child and Family Welfare Services (CFWS)[4] case involving the family. E.P. and [redacted] two younger siblings were [redacted] and residing with their mother under a trial return home[5] that began in August 2018.

The CFR Committee includes members with relevant expertise selected from diverse disciplines within DCYF and the community. The Committee members have not had any involvement or contact with E.P. or [redacted] family. The Committee received relevant case history that includes CPS history, case notes, and ongoing case planning.

On the date of the CFR, the Committee interviewed a prior CFWS caseworker who carried the case from 2016 to 2017, a CFWS supervisor who supervised the case from 2016 to 2018, the CPS investigator from 2018, and the CFWS supervisors and caseworker who carried the case in 2019. The CFWS caseworker

[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)]. " RCW 74. 13. 640(4)(a).

[3]The names of the deceased child's parents are not used in this report because neither parent has been charged with a crime in connection to the fatality incident. The names of the siblings are also not used in this report because they are subject to privacy laws. See RCW 74. 13. 500.

[4]Child and Family Welfare case workers assume responsibility of a child welfare case after the child has been removed from his or her caregivers and a dependency petition has been filed.

[5]Trial Return Home. Follow requirements outlined in the Reasonable Efforts policy prior to requesting a trial return home or when the Court orders the child's immediate return home. Prior to a dependent child returning to the home of a parent a background check must be completed on all adults living in the home. A trial return home must not exceed 6 months in duration, unless ordered by the court. Identify and assess all caregivers of the child for services related to the safety of the child, and: Recommend the caregiver participate in the identified services, notify the court of any service recommendations made to the caregiver during a regular review hearing, and promptly notify the court if a caregiver fails to engage in or follow through with the recommended services. [Source DCYF Practices and Procedures Guide 43051A].

who carried the case from 2017 to 2019 is no longer employed with the Department and was unavailable to participate in this review.

Case Overview

E.P. 's family initially came to the Department's attention in 2012. From 2012 to 2014, the family had six Child Protective Services (CPS) intakes reporting significant mental health concerns for E.P. and for both of [redacted] parents, substance abuse and the failure to meet the medical needs of E.P. 's youngest sibling, [redacted]. Two separate CPS investigations determined the children were safe. Either no services were offered or the parents declined services and the cases were closed. In June 2014, a CPS intake was screened-in for investigation after E.P. drove [redacted] mother and younger siblings to the hospital at [redacted] mother's direction because E.P. 's mother said she was being choked and pinched by an invisible force. The Department [redacted] and the children were removed from their mother's care.

The children were placed with their maternal grandmother and her husband, and [redacted]. The court ordered services for both parents. The parents were separated at this time and remained separated throughout the duration of this case. Initially, the court allowed the mother to reside in the maternal grandmother's home with the understanding that she would participate in the court-ordered services. In 2015, the Department moved for the mother's removal from the home due to her continued non-compliance and lack of progress with court-ordered services. The court granted the Department's motion and the mother moved out of the home and began supervised visitation. At the onset of this case, the father engaged in services and visited the children fairly regularly. The children began refusing to see him and he became less involved with the case over time. The Department did not explore a return home to the father due to his minimal engagement and the children's ongoing refusal to see him. In late 2017, the mother made slow progress toward reunification.

Throughout this case, the Department experienced challenges with accessing the children to ensure their health, safety and well-being. Both the maternal grandmother and mother created barriers to the Department's ability to assess the health and safety of the children by asking the children not to talk to the caseworkers. The grandmother did not complete a relative home study[6] as required by policy and the home study referral was closed in April 2016 due to participation failure. The Department moved to remove the children from the maternal grandmother's home, the court supported the children remaining in their grandmother's care.

In 2017, there were two CPS investigations following allegations that E.P. was brought to the hospital intoxicated and suicidal. [redacted] mother was at the hospital and reportedly also appeared to be intoxicated. E.P. had also posted a video online making suicidal threats and indicating that [redacted] had a gun. It was reported that [redacted] mother was in the background of the video. The grandmother denied being home at

[6] "The term 'home study' means an evaluation of a home environment conducted in accordance with applicable requirements of the State in which the home is located, to determine whether a proposed placement of a child would meet the individual needs of the child, including the child's safety, permanency, health, well-being, and mental, emotional and physical development. " [Source: Safe and Timely Interstate Placement of Foster Children Act of 2006 P. L. 109-239]

DCYF Practices and Procedures Guide 5110 was recently issued to clarify that if a home study has not been completed prior to placement, a request must be made within thirty days of placement.

the time of this incident. The Department filed an emergency motion to remove the children from the grandmother's care, which the court denied. The court ordered that the family participate with Intensive Family Preservation Services[7] and receive case management services from 13.50.100 , in addition to allowing the mother only supervised visitation. In 2018, CPS investigated three different intakes due to E.P. 13.50.100 in the home of the grandmother, E.P. being highly intoxicated at school and the mother driving E.P.'s youngest sibling to a medical appointment where she was nodding off and needed to be picked up by the grandmother. Again, the Department filed a motion to have the children removed from the home but the court denied the motion. The grandmother made it clear to the Department that she and her husband were not a permanent resource for the children and she wished them to be returned to their mother's care.

The Department 13.50.100 in 2017, but 13.50.100 the mother began making progress. Due to the length of time the case was open without achieving permanency for the children, the court ordered that the Department refer the family to the Foster Care Assessment Program (FCAP)[8] to complete a comprehensive evaluation. The FCAP was completed in June 2018 with recommendations that the children return to their mother's care immediately so that the Department could best assess the mother's independent capacity to care for the children. This recommendation was based on the mother's slow progress and compliance with services, no other viable permanency options and the length of time the children had been in out-of-home care. It was noted that if the return home failed, alternate relative options should be explored and that if the children entered foster care, placement together was in their best interest. FCAP recommended the following plan to provide support and monitoring of the trial return home: (1) coordination between the mother's therapeutic providers, cognitive behavioral therapy and random urinalysis (UA); (2) E.P. should be evaluated for 74.13.520 74.13.520 and substance abuse, as well as cognitive-behavioral therapy or dialectical behavior therapy; (3) E.P. would benefit from extra-curricular activities; (4) refer for a home-based health program to monitor the 74.13.520 care needs of the youngest child, as well as attend regular appointments with the 74.13.520 clinic. In August 2018, the children were returned to their mother's care with an agreed court order that included these conditions. Initially, it appeared that things were on track for the family and no safety issues were noted. The family obtained independent housing and moved out of the grandmother's home. At the sixth-month marker of the trial return home, the mother requested a parenting plan. As a result, the Department did not recommend dismissal. The mother reported that she felt the father may attempt to abscond with the children if the Department was no longer involved. The Department made efforts to collaborate with the parent's attorney and began the process for family court involvement.

In the late summer of 2019, the family lost its independent housing and moved back to the grandmother's home. The reported cause was a neighborhood youth stealing money from the home,

[7]Intensive Family Preservation Services (IFPS) are short-term, family-based services designed to assist families in crisis by improving parenting and family functioning while keeping children safe. IFPS is generally authorized for 30 days. [DCYF Practices and Procedures Guide 4502].

[8]The Foster Care Assessment Program (FCAP) is a multi-disciplinary contract between Children's Administration (CA) and Harborview Center for Sexual Assault and Traumatic Stress and its subcontractors to assess the needs of children who have been in out-of-home care for more than 90 days. Assessment services include a six-month follow-up period to assist the DCFS case worker in implementing a placement plan and to help meet the needs of the child and family. The program has two goals: Ensure that the physical and emotional health, developmental status, and educational adjustment of children in the care of the state have been assessed and any significant needs addressed; and, Identify and help resolve obstacles to reunification, adoption, guardianship, or other permanent plan. [Source: DCYF Practice and Procedure Guide 4543].

leaving the mother without a way to pay rent. She indicated that she had called 911 and filed a police report. On September 19, 2019, the Department was notified of concerns related to the youngest child's 74.13.520 care needs and that she had been hospitalized. It was reported by hospital staff that the mother had never done well at monitoring and maintaining the child's 74.13.520 care needs, but that the child had not been hospitalized in some time. The Department reached out to the child's school and the school nurse to follow up about her 74.13.520 care routines and it was reported that the mother was not bringing the appropriate supplies to school and that the child had missed a significant amount of school this school year.

On September 30, 2019, a caseworker attempted a health and safety visit[9] with E.P. in [redacted] school setting but [redacted] was not in attendance. The Department did not see E.P. in the month of September due to this missed visit. On October 6, 2019, 74.13.515 Hospital contacted the Department to report that E.P. had been admitted to the hospital on October 2 while unconscious. The hospital indicated that [redacted] had not regained consciousness and had no brain activity. It was also noted that the mother appeared to be impaired by substances and the staff was concerned she would not be able to make an informed decision should an invasive medical procedure be required. This incident generated a CPS investigation surrounding the concerns identified by the hospital. There was also ongoing collaboration between the CFWS caseworker and hospital personnel regarding E.P. 's medical condition. On October 10, 2019, [redacted] E.P. passed away 74.13.520 .

Committee Discussion

The Committee had the opportunity to review the case history as well as interview CFWS caseworkers, CFWS supervisors, and a CPS caseworker, which fostered the below discussion. Although the Committee addressed a number of areas where it believes practice could have been improved, it recognizes the significant workload challenges faced by this particular office and social work staff. The discussion centered around the following areas: systemic barriers, family engagement, and permanency.

The intent of highlighting the struggles with staffing shortages and high caseloads is not to detract from the responsibilities of the Department caseworkers and supervisors, but rather to approach this review in a multi-faceted manner to encompass all areas that may have impacted practice. The Committee was provided with information regarding the caseworkers' caseloads, all of which were higher than the recommended caseload of 12 to 15 cases per month for CFWS workers and 12 cases per month for CPS workers as outlined by the Child Welfare League of America. One caseworker reported that she had a caseload of 47 child assignments. A CFWS supervisor shared that at one point she was the only CFWS supervisor for the office, tasked with supervising 21 caseworkers. She also reported that while supervising, she carried a caseload of approximately 44 child assignments due to staff shortages. Another caseworker shared that upon beginning employment with DCYF, she was removed from Alliance for Child Welfare Excellence Regional Core Training[10] after only four days due to staffing

[9] Health and Safety Visits. DCYF case workers are required to visit with all children in person on a monthly basis if the case is open for services. The goal of these visits is to ensure the child is safe and that the child's basic well-being needs are being met. [Source – DCFY Practice and Policy Guide 4420].

[10]The Alliance for Child Welfare Excellence is a program through the University of Washington, in partnership with DCYF, that provides regular training to DCYF staff. The Alliance provides the Regional Core Training (RCT) that all new DCYF case carrying employees must complete before they can be assigned cases. See https://allianceforchildwelfare. org/.

shortage and was assigned a full caseload. Because of staffing limitations, this case transitioned to multiple CFWS workers, including approximately 10 different caseworkers and 10 different supervisors providing oversight from 2014 to 2019.

In addition to high caseloads and staff shortages at this office, the office has also struggled with children who have disrupted placement. On multiple occasions, children who were in out-of-home care required field social work staff to provide transportation to and from school, as well as medical and therapeutic appointments, general supervision at the office, and placement coordination. It was reported that at one point 14 to 15 children required support from caseworkers while awaiting placement. The caseworkers also stated there is sometimes a lack of relief from the After Hours team, which requires that the caseworkers supervise children late into the evening. The Committee acknowledged the impact this has on caseworkers' ability to complete their day to day tasks, such as referring parents for services and completing collateral contacts. The Committee speculated this may also contribute to staff retention as staff who do not have the minimum support and training necessary to do their job may not remain in their job. The Committee discussed what support is available to offices, such as roving units designed to fill in when there are staff shortages, but that was not available to this particular office. The Committee also noted that the focus of roving units is often on CPS work and not CFWS work.

The Committee acknowledged that the scope of its review was related to the work provided by DCYF, but discussed areas of concern outside of the Department's control that may have impacted this case. The Committee questioned the court's continued decision to allow the children to remain in a relative caregiver's home when a home study had not been completed, the family was unwilling to be a permanent resource for the children, the family presented barriers to health and safety visits with the children, and multiple CPS investigations led to founded findings with the relative caregiver as a subject. The Committee recognized that a caseworker may be reluctant to continue filing motions for removal after a history -of prior denials, but felt that there may have been other points worthy of the court's consideration. One such point was when the mother lost her independent housing and returned to the grandmother's home, despite a prior court order requiring the mother to obtain independent housing. Based on the court's response, which was reported by the caseworkers and supervisors as common practice, the Committee speculates about the Department's relationship with the court system and wonders what mechanism is in place to have dialogue between DCYF and the court. The Committee also identified a concern related to the limited reporting by medical and school professionals pertaining to the children's health and well-being needs, specifically for the youngest child's 74.13.520 care. Although the Department is responsible for making collateral contacts and gathering information, it is also typical for schools and medical professionals to report concerns of significant nature to the Department either directly through the assigned caseworker or through the intake line. The Committee felt there were fewer contacts from community members and other professionals to the Department in this case.

The Committee discussed the Department's efforts to engage with the family throughout the life of this case and concluded there were missed opportunities for engagement. The Committee did not overlook the difficulties the Department reported in working with the family and that at times the workers did not feel safe in their interactions with the family. As mentioned above, the case transferred to multiple workers and supervisors, leading to frustration on the part of the family, which was captured in case notes. In 2019 alone, there were five caseworkers completing health and safety visits with the family in

a 10-month period. The Committee speculated that this could have led to the loss of continuity. The Committee noted that it would have liked to have seen more consistent engagement efforts with the father over the life of the case. There also appeared to be a lack of historical knowledge from the most recent worker about the father's previous involvement with the case and completion of court-ordered services.

A significant challenge identified through the caseworker interviews was the mother and grandmother's refusal to participate and engage in services that were offered to them in the home. The Department relied upon the relative caregiver and the mother to ensure that the children's therapeutic and medical needs were met and accepted their verbal reports about medical appointments and school. The Department made limited collateral contacts to verify the information the family reported. For example, school notification letters were not sent to the schools, even though E.P. changed schools in 2019. The Department reported that the schools did not report concerning information about the 74.13.520 care management of the youngest child or attendance issues for E.P. The school personnel stated they were not aware the Department was still involved with the family. This could have been mitigated if a school notification letter had been sent providing contact information for the Department caseworker and may have opened up the lines of communication. The Committee felt this family would have benefited from wrap-around services[11] through community mental health or with Coordinated Care to better assist the family in managing and navigating the children's needs for therapeutic care, including 74.13.520 care.

Following the 2018 CPS investigations in the grandmother's home, a safety plan was drafted during a shared planning meeting where the grandmother was not in attendance. The plan that was developed listed the grandmother as an individual to monitor and enforce the safety plan along with the mother, although it was unclear whether the grandmother ever read or signed the plan. Also, the grandmother was the subject of the CPS investigation; and she should not have been named as a safety plan monitor. The Committee felt an in-home provider, wrap-around provider, or coordinated care manager should have been referred and been incorporated as a safety plan monitor at that time, but accepted that the family may have refused to participate with the provider.

Permanency was not established for the children in this lengthy case. The preferred goal of a permanency outcome for children in out-of-home care should be achieved prior to month 15.[12] Neither parent made progress toward reunification, and the grandmother was unwilling to enter into a permanent plan with the children. Third-party custody was explored with the grandmother in 2017, but she declined and the Department could not support that plan because a home study had not been completed. A 13.50.100 in 2017, but the Department did not move forward 13.50.100 because the mother began making progress toward reunification. The Committee felt the Department could have focused on concurrent planning earlier on and utilized recruitment strategies to identify an appropriate, long-term resource that could have met the children's needs.

[11] WISe/Wraparound is a team-based planning process for youth with complex needs and their families designed to help produce better outcomes for youth so that they can live in their homes and communities and realize their hopes and dreams. Wraparound with Intensive Services (WISe), are Medicaid Elig ble; have a qualifying mental health diagnosis; and have concerning behaviors at home, school and in the community that meet clinical criteria for the program. [Source - https://www. kingcounty. gov/depts/community-human-services/mental-health-substance-abuse/services/Youth/wraparound. aspx]

[12] See RCW 13. 34. 145 https://app. leg. wa. gov/RCW/default. aspx?cite=13. 34. 145

The Committee speculated that at the point of the trial return home, the mother may have reasoned that there were no repercussions for failing to follow court-ordered expectations. As a result, the home became increasingly unstable without immediate recognition by the Department. Additionally, once the children were returned home, the Department did not move forward with recommending dismissal during the sixth month of the trial return home. A parenting plan had been requested by the mother due to her fear that the father would abscond with the children when the Department ended its involvement with the family. This significantly delayed case closure. The Department does not have control over the processes involved with family court in establishing a parenting plan, and the Department made efforts to aid in the completion of this process. A CFWS supervisor shared that the office is now staffing cases on a weekly basis that have been on trial return home for approximately 180 days to address barriers, such as existed in this particular case.

Findings

The Committee believes DCYF did not make any critical errors in this case. The Committee agrees on the following findings.

The case did not achieve permanency within the federally recognized timelines. Permanency planning meetings were held but could have been utilized more frequently to discuss movement toward permanency and the development of a concurrent plan.

In 2019, the Department missed two monthly health and safety visits with E.P. with the last missed visit the month prior to [redacted] untimely passing. In addition to the missed visits, it was noted that throughout the course of this case, documentation of the health and safety visits was inconsistent and did not always provide a clear picture of how safety was assessed, how service needs were identified and met, and whether the children met with the caseworkers individually.

To the caseworker's recollection, school notification letters were not utilized in this case. E.P. changed schools in September 2019 and a notification letter was not sent to inform school personnel of the Department's contact information.

Self-reporting was relied on by both the grandmother and mother for the children's medical, academic and therapeutic care rather than utilizing collateral contacts to verify the information.

Following the 2018 CPS investigations in the relative caregiver's home, a safety plan was developed after the court denied the children's removal. This plan was developed at a shared planning meeting. The mother was present but the grandmother was not in attendance. It was unclear whether the grandmother ever reviewed or agreed to this plan. She and the mother were both named as safety plan participants, although the grandmother was the subject of the investigation. No other individuals or providers were named to assist with enforcement of the plan. Safety plan participants should not be those individuals who are the subject of the CPS investigation.

Recommendations

The Committee recommends court improvement and teamwork with the juvenile court system in this county. The Committee specifically recommends that DCYF regional leadership, including area administrators, take steps to develop an ongoing dialogue to address systemic challenges between the court, DCYF and other legal parties.

The Committee believes it is critical that DCYF address staff retention and develop a plan that requires staff training through RCT and other required in-service training within staff's first year of service and that prohibits the assignment of cases before staff is ready. The following recommendations should be overseen by local office leadership, such as an area administrator, through ongoing supervision and consultation. The Department should utilize the onboarding plan that is recommended for new employees through the UW Alliance RCT training model, which supports the gradual assignment of cases after a worker has completed various training activities. The Committee further recommends that leadership ensure a plan for a daytime staff transition to after-hours so that staff is relieved when there are unresolved matters from the daytime. Leadership also needs to address the matter of staff safety, so that if a worker feels unsafe when meeting with a family individually, a plan is developed to support them in performing their work safely. The Committee also identified the importance of additional support for offices struggling with turnover and retention, such as utilizing resources offered through Quality Practice Specialists (QPS) and UW Alliance for training.

It was reported by this office that they have developed a schedule to support and supervise the children who are spending time at the office awaiting a new placement. The Committee requested the office expand this plan to address whether the children's medical, dental, academic and therapeutic needs are being met when the children do not have an identified placement that is assisting in the oversight of these well-being needs. The Committee requests a safety planning training for both CPS and CFWS sections to be hosted by the QPS team for this specific office. The focus should ensure that the staff understands when a safety plan is required and the elements that should be addressed to ensure appropriate monitoring by individuals who can safely monitor and reliably report back to the caseworker.

The Committee also recommends the promotion of statewide education for caseworkers and DCYF staff regarding Narcan.[13] This should include training that is offered by county health departments or through online health department resources so that caseworkers can be better informed when speaking with families about the risk of overdose. This would also enhance workers' ability to direct families to community-based resources for education, supports and supplies as needed.

[13] Opioid Overdose Prevention. See https://www. kingcounty. gov/depts/community-human-services/mental-health-substance-abuse/task-forces/heroin-opiates-task-force/opioid-overdose-prevention. aspx