WASHINGTON STATE
Department of
Children, Youth, and Families

CHILD FATALITY REVIEW

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FULL REPORT

CHILD

- E-R.J.

DATE OF FATALITY

- May 2018

CHILD FATALITY REVIEW DATE

- April 23, 2018

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EXECUTIVE SUMMARY

On August 23, 2018, the Department of Children, Youth and Families1 (DCYF or Department) convened a Child Fatality Review (CFR)2 to assess the Department's practice and service delivery to E-R.J. and [redacted] family.3 The child will be referenced by [redacted] initials in this report.

On May 3, 2018, Children's Administration (which is now DCYF) received an intake stating that E-R.J.'s father called 911 and reported that E-R.J. was cold and unresponsive. Emergency services personnel provided CPR and transported [redacted] to the hospital where [redacted] was declared deceased. The father reported the parents had been bed-sharing with their [redacted] and they awoke to find [redacted] unresponsive. The referrer stated the parents appeared to be under the influence and was concerned as to why it took them an hour to get to the hospital. At the time of the death, the family had an open Family Voluntary Services (FVS) case with the Department.

The CFR Committee (Committee) included members selected from diverse disciplines within the community with relevant expertise including individuals from the Office of the Family and Children's Ombuds, substance abuse treatment, public health and child welfare. There was a consultant from DCYF to discuss any specific questions related to DCYF intakes. The Committee members and consultant did not have any involvement or contact with this family.

Prior to the CFR, each Committee member received a summary of Department involvement with the family and unredacted Department case documents (e.g., intakes, investigative assessments and case notes). Supplemental sources of information and resource materials were available to the Committee at the time of the CFR. These included relevant state laws and Department policies.

The Committee interviewed the Child Protective Services (CPS) worker and her supervisor, the FVS worker and her supervisor, as well as the area administrator. The CPS investigator regarding the fatality investigation no longer was employed with DCYF.

[1] 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 early learning programs). The fatality happened prior to July 1, 2018, therefore CA or department may be used in the report.

[2] Given its limited purpose, a 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] E-R.J.'s parents are not named in this report because they have not been charged in an accusatory instrument with committing a crime related to a report maintained by the Department in its case and management information system. [Source-Revised Code of Washington 74.13.500(1)(a)]

CASE OVERVIEW

E-R.J.'s father first came to the attention of the Department in RCW 13.50.100 of 2004. There were allegations of RCW 13.50.100 of his infant RCW 13.50.100 He and the mother of the child were living together at the time. There were concerns regarding RCW 13.50.100, RCW 13.50.100, and RCW 13.50.100. This child became RCW 13.50.100 in September of 2010.

E-R.J.'s mother first came to the attention of the Department when her first child was an infant. An intake was received on RCW 13.50.100, 2010, alleging concerns for RCW 13.50.100 There were concerns for RCW 13.50.100 for the infant and the mother was not cooperating with supportive services. The intake worker searched through the Department's computer system and learned that the mother's husband was a RCW 13.50.100. This intake was screened in for a CPS investigation. This intake was unfounded.

Another intake was received on May 9, 2010, alleging that the mother had RCW 13.50.100 and was RCW 13.50.100. The caller reported changes to the mother's RCW 13.50.100 and suspected RCW 13.50.100. The caller alleged RCW 13.50.100 as well. This intake was also screened in for a CPS investigation. This intake was founded. A RCW 13.50.100 was filed. The court RCW 13.50.100.

A third intake was received on July 6, 2010, stating that the RCW 13-month old infant was being RCW 13.50.100 by her father. The father allegedly RCW 13.50.100. This intake was unfounded, however the RCW 13.50.100 process continued and the child RCW 13.50.100 the next year. She was ultimately RCW 13.50.100. The mother and father dissolved their marriage.

The next intake was received on RCW 74.15.515, 2018, reporting that E-R.J. was born. The caller reported that the mother was not compliant with RCW 13.50.100 and her RCW 13.50.100. Prenatal records indicated the mother had previously RCW 13.50.100. The mother and her new husband, E-R.J.'s father, reported RCW 13.50.100 as recently as 13 days prior to their RCW 74.15.515 birth. The caller also reported that the father had an older child who was RCW 13.50.100 and that both parents reported RCW 13.50.100. The father also reported a history of RCW 13.50.100. This intake was assigned for a CPS Risk Only assessment.[4]

Contact was made the same day with the parents and E-R.J. The CPS worker learned that the mother had been RCW 13.50.100 through the Department and had Native American heritage through her biological family. The mother also shared that she was RCW 13.50.100 as a teenager because she was "RCW 13.50.100." The mother stated she wanted to become clean and sober and parent her newborn.

Concerns were noted by hospital staff regarding the mother's care of E-R.J. and that the father had been escorted off the property and was not allowed to return. The father was allegedly following people to their cars and going through other people's belongings. A family team decision meeting (FTDM) was held at the hospital and a plan was put into place for E-R.J. to be placed through a voluntary placement agreement (VPA) with the maternal grandparents. The mother would be allowed to live in the home and parent her RCW 74.15 515 with full supervision by at least one of the grandparents while the parents addressed their identified mental health and substance abuse issues. The father reported he RCW 13.50.100.

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

The parents were referred for chemical dependency assessments and random urinalysis. The father had a RCW 13.50.100 on February 23, 2018. On March 5, 2018, the father's urinalysis was RCW 13.50.100 and had a RCW 13.50.100 and the mother's urinalysis was RCW 13.50.100 .

On March 8, 2018, the maternal grandmother was notified that the Department was going to vacate the VPA and E-R.J. would be placed with RCW 74.1 parents. The maternal grandparents were in support of this decision. A safety plan was created and intensive family preservation services (IFPS) was referred for the family. On March 21, 2018, another FTDM was held. Both parents as well as paternal grandfather and maternal grandmother participated. The maternal grandparents were leaving the state until June 2018. The safety plan included the paternal grandfather and the mother's friend. The mother's friend agreed to the safety plan and her role and responsibilities as a safety plan participant.

On March 29, 2018, the Department received the father's chemical dependency assessment. It included information stating that the father may be RCW 13.50.100 . The father's assessment indicated a need for a RCW 13.50.100 .[5] The following day, the mother's assessment was received. The assessments of both parents recommended RCW 13.50.100 . On March 31, the father failed to show for his random urinalysis. On April 2, the mother's urinalysis was RCW 13.50.100 On April 2, 6, and 8, the father's random urinalyses were RCW 13.50.100 . On April 4 and 5, the mother's urinalysis was RCW 13.50.100 On April 10, 2018, the case transferred from CPS to FVS. The parents had completed Homebuilders services.[6] The Homebuilders closing summary indicated that, at the conclusion of the services, the home the family was living in became more cluttered, that safe sleep had been reviewed because the mother acknowledged she was sometimes falling asleep with E-R.J. on the bed and there were recommendations for following through with substance abuse recovery services, random urinalysis, supportive community services, and that the parents move to a new location. On April 12, the mother's urinalysis was RCW 13.50.100 On April 16, the mother's urinalysis was RCW 13.50.100 and the father's was RCW 13.50.100 .

On April 18, 2018, the assigned FVS worker met with the parents at their home. Three days later the mother's urinalysis was RCW 13.50.100 and the father's was RCW 13.50.100 . On April 23, 2018, the FVS worker communicated with the family preservation services (FPS) provider who stated a home visit occurred. The FPS provider stated she did not have serious concerns about the family but was concerned the father may be using drugs.

On April 30, 2018, an intake was received by a mandatory reporter indicating the parents and E-R.J. attended an appointment. The caller stated that both parents appeared "out of it" stating they fell asleep while their RCW 74.15.515 was in RCW 74.1 car seat, [both] looked ill, the mother vomited in the trash can, the mother was somewhat rough when handling E-R.J., that the father introduced himself three times, to the same staff member, within five minutes. When E-R.J. started to cry, the staff member suggested feeding RCW 74.1 but the mother stated, " RCW 74.15 is fine and RCW 74.1 just ate." The staff stated they would not have allowed the parents to drive with the child but verified that the paternal grandfather drove them to the appointment and picked them up. This intake was screened out. The next day, May 1, 2018, the parents both failed to appear for their random urinalyses.

On May 3, 2018, the Department received an intake stating that E-R.J. had been brought, via ambulance, to the hospital. RCW 74.15 was cold and unresponsive. RCW 74.15 was declared deceased at the hospital. The father stated that the parents had been sleeping in bed with E-R.J. When they woke up they found RCW 74.1 to be unresponsive. Both parents arrived an hour after their RCW 74.15 515

[5] A co-occurring disorder is the presence of substance abuse along with a mental health disorder.
[6] http://insideca.dshs.wa.gov/Intranet/policy/ebp.html

did, their eyes were dilated and staff were concerned they were under the influence of substances. This intake was assigned for a CPS investigation and ultimately a founded finding for neglect and/or negligent maltreatment was made against both parents. Throughout the open CPS and FVS case in 2018, the parents were offered ongoing assistance with transportation and referrals for supportive services.

COMMITTEE DISCUSSION

The Committee discussed many differing aspects of this case. There was discussion surrounding whether or not the risk of the parents' prior substance abuse history and lack of engagement in services to ameliorate identified parental deficiencies in prior RCW 13.50.100 cases, coupled with the parents' drug use at the birth of E-R.J. rose to a level that needed legal intervention as opposed to allowing for a voluntary placement agreement (VPA). This ultimately led to a reunification with the parents with very little to no change in circumstances. The parents presented with substance abuse as well as mental health issues that were not assessed prior to reunification.

The issue of marijuana being legal, but the need for the Department to assess child safety when a parent uses or abuses marijuana, was also discussed. There have been repeated reviews that discuss this issue of legalized marijuana as it pertains to child safety. The Committee noted that abuse or overuse of any substance, prescribed, legal or otherwise, needs to be assessed by the Department as part of a comprehensive assessment of child safety. It was also discussed that often there are predictable side effects for prescribed medications but marijuana and the method of use or ingestion is not as predictable. There are parents with whom the Department comes into contact who state they use marijuana because they have less side effects than prescribed medications. The Committee noted that if this is the statement the parent makes, the Department should make efforts through collateral contacts, such as the client's physician, to vet these statements for accuracy.

As part of the discussion surrounding marijuana, the Committee discussed the confusion surrounding urinalysis tests. When marijuana was legalized it was removed from the standard urinalysis testing list for the Department. Though the conversation of removing it from the standard list had begun prior to the legalization of marijuana, Department staff are able to add it to the list of substances that are tested. But, it appears that not all staff were aware of this change. The Committee discussed that it might be beneficial to share that information again with the field.

There was discussion surrounding the RCW 13.50.100 history reported by the father as well as statements the mother made surrounding RCW 13.50.100 exhibited by the father. The Committee discussed that the case records as well as interviews with staff indicated that there should have been further, separate conversations with the mother surrounding RCW 13 50.100 and safety. It appeared to the Committee that the RCW 13.50.100 was not considered impactful by the Department because it did not include RCW 13.50.100.

The Committee also discussed the reported pressure to close out cases by the FVS worker. The Committee discussed that the FVS worker did not show a sense of urgency regarding the information of the missed UAs and the screened-out intake and how that could impact E-R.J.'s safety.

Some other discussions the Committee had surrounded the inconsistent information shared between staff regarding discussions of the screened out intake in April as well as the direction the FVS worker states she was given regarding prioritizing case closure over responding to

information received on assigned cases. The Committee concluded that they would not be able to determine what exactly happened but that they found the inconsistencies to be concerning. They also discussed that when administrative tasks are emphasized, often client care is decreased as a result.

There was also a discussion regarding systemic barriers. At the time of the intake in RCW 74.15.515 of 2018, the CPS supervisor had a large span of supervision due to supervisory vacancies. The FVS supervisor was new to supervision, having only two months of experience at the time of the fatality. These issues were discussed because the Committee noted that when there is a large span of supervision, combined with other stressors that occur with higher than usual caseloads, often it is difficult to provide consistent clinical supervision.

FINDINGS

The Committee did not identify any critical errors made by DCYF during this investigation. There were areas identified by the Committee where practice could improve. Those areas are discussed in this section.

The Committee believed that there should have been more collateral contacts made throughout the life of this case. Specifically, connecting with the chemical dependency providers prior to the FTDM as well as post reunification, connecting with mental health professionals and safety plan participants, and obtaining the parents' social security records or discussing with that administration the parents' identified mental health issues or deficits related to the traumatic brain injury.

The Committee noted that between the beginning of the case and the time that E-R.J. was returned to RCW 74.1 parents' care unsupervised, there had not been a significant change of circumstances to show that RCW 74.1 parents had made progress toward ameliorating their identified substance abuse and mental health issues. The Committee did not agree with the decision to place E-R.J. back with RCW 74.1 parents with an in-home safety plan.

The Committee believes that the April 30, 2018, intake met sufficiency standards and should have screened in, necessitating a response by the field.

The Committee also noted that the combination of the missed urinalysis test for both parents coupled with the screened out intake from April 30, 2018, should have warranted a response from the Department. The Committee believed that the behaviors identified by the caller, along with the parents missing their random urinalysis tests, raised the risk to E-R.J. enough to require a face-to-face assessment.

The Committee also found that there was a lack of documented clinical supervision provided to the CPS investigator. The discussion surrounding this included concerns that without documentation of clinical supervision, the use of critical and comprehensive thinking is not as apparent.

E-R.J.'s mother has Native American heritage. Even though her first child did not meet the standards for enrollment, the Committee noted that each time the department has contact with the family, the identified tribe should be contacted to determine eligibility for enrollment.[7]

[7] CA caseworkers must complete the Indian Identity Request DSHS 09-761 at the initial visit with the parent(s)/Indian custodian on **all** screened in cases for each child, including those who have not been identified as victims. https://www.dshs.wa.gov/ca/indian-child-welfare-policies-and-procedures/3-inquiry-and-verification-childs-indian-status

The Committee did note that the CPS case notes were inputted in a timely manner and that the CPS worker worked hard to create a positive and supportive relationship with the parents. The inputting of case notes in a timely manner was also discussed in conjunction with the identification of staffing shortages, which made the timeliness stand out.

RECOMMENDATIONS

The Department should provide training to help staff understand how parental poly substance abuse, as well as marijuana abuse, can impact the risk to children and provide education surrounding co-occurring disorders and how that can escalate risk to children.

The Department should have chemical dependency professionals (CDP) co-housed in field offices. This affords Department field staff the opportunity to receive education regarding substance use and abuse much easier than if they were not co-housed, it can create a smoother and less time consuming process of getting an evaluation for parents, and CDPs could be available to respond together with Department staff in the field.

The Department should address the inconsistent use of founded findings regarding unsafe sleep related deaths. The Committee acknowledged that each case is unique with differing circumstances. However, the Committee noted that not all unsafe sleep deaths, with prior Department involvement including education to the care providers regarding safe sleep, result in a founded finding for abuse or neglect.