CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

Paul Smith
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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

- J.C.

Date of Child's Birth

- [redacted] 2021

Date of Fatality

- December 12, 2022

Child Fatality Review Date

- February 16, 2023

Committee Members

- Patrick Dowd, JD, Director, Office of the Family and Children's Ombuds
- Sandy McCool, MSW, Quality Practice Specialist Region 4, Department of Children, Youth, and Families
- Derek Murphy, M-RAS, SUDP, CSC, Director of Clinical Services, Olalla Recovery Center
- Alissa Copeland, MA, Intake and Early Learning Program Manager, Department of Children, Youth, and Families

Facilitator

- Libby Stewart, Critical Incident Review Specialist, Department of Children, Youth, and Families

Executive Summary

On February 16, 2023, the Department of Children, Youth, and Families (DCYF) convened a Child Fatality Review (CFR)[1] to examine DCYF's practice and service delivery to J.C. and RCW 7 family. J.C. will be referenced by RCW 7 initials throughout this report.[2]

On December 13, 2022, a detective with the sheriff's office informed a DCYF Child Protective Services (CPS) supervisor that J.C. died. The detective said J.C. died the previous day due to fentanyl exposure. J.C. was with RCW 7 mother and a male when he died. The detective also stated the mother was arrested related to her RCW 74.13.5 death. This case was open for a CPS investigation at the time of J.C.'s death. A new CPS investigation was initiated due to the information reported about J.C.'s death.

A diverse 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 J.C. or RCW 7 family. Before the review, the Committee received relevant case history from DCYF.

The Committee met with three of the staff who interacted on this case and the current area administrator. The area administrator who was involved in the decision to close the case in May of 2022 retired prior to the critical incident. The supervisor from the first two intakes left DCYF employment prior to the critical incident.

Case Overview

On February 11, 2022, DCYF received a telephone call regarding a mother and her two-month-old RCW 74.13 J.C. The caller reported concerns that the mother was "nodding off" and the caller was concerned the mother would roll on top of the infant. The caller has stepped in to care for J.C. when she believes the mother is unable due to substance use. The caller reported the mother is RCW 74.13.520 and the mother is living in a shelter. The intake did not meet legal sufficiency for a DCYF intervention and therefore was screened out.

On February 15, 2022, an employee of the shelter where J.C. and RCW 7 mother lived called DCYF. This employee had the mother's roommate describe the concerns. The mother's roommate told the intake caseworker that she observed J.C.'s mother to be "hunched over" in the front seat of the mother's car and appeared to have "nodded off", inferring that the mother was using substances. J.C. was inside the car screaming. It is not documented when this occurred or if there was any intervention. Then on February 14, J.C.'s mother told the roommate she had been in a car accident. She did not seek medical attention and law enforcement was not called. The roommate said the car smelled of feces and vomit. The roommate reported that J.C. cries and

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

[3] RCW 74.13.515, R is a brand name for the medication naloxone or buprenorphine. The medication is used to treat Opioid Use Disorder. For more information see: https://www.samhsa.gov/medications-substance-use-disorders/medications-counseling-related-conditions/buprenorphine

screams a lot and RCW 7 mother does not comfort him. This intake screened in for a CPS/Family Assessment Response (FAR)[4] assessment, "FAR is a CPS alternative response to a screened-in allegation of abuse or neglect."

That same day the assigned CPS caseworker contacted the shelter employee who called in the most recent intake. They discussed some details related to the mother, length of stay at the shelter, services, etc. Then the caseworker called the mother and her roommate and left a voice mail message. The caseworker also texted both women. The caseworker put in a referral for a urinalysis test for the mother. There is no documentation if the caseworker left information in a voice mail or text message to the mother about the urinalysis.

On February 16, 2022, the caseworker left multiple voice mail messages for J.C.'s mother. The caseworker and a coworker went to the mother's residence and checked in with the original referrer at the shelter. J.C. and RCW 7 mother were not in their apartment. The caseworker spoke with the mother's roommate. Later that day the mother met with the caseworker in a room at the shelter. J.C. was reportedly with RCW 7 maternal grandmother. The caseworker told the mother she needed to see J.C. today. The mother said she would consult with an attorney first.

Later that same afternoon the mother, maternal grandmother, and J.C. met the caseworker at a park. The grandmother said she sees her daughter and RCW 74.13.515 almost every day. The mother said she is on a waitlist for another shelter and is involved in First Step, PCAP, and has a mentor. She also shared J.C.'s pediatrician's name.

On February 25, 2022, the caseworker went to the mother's home. The caseworker case noted multiple topics they discussed but also that the mother was sweating and shaking during their conversation. The mother provided information about the father, that he was incarcerated and where he was incarcerated. The mother also provided the paternal grandmother's name and telephone number. The mother said she may be willing to provide a urinalysis but did not clearly indicate that she would. The caseworker referred the mother for a urinalysis.

The caseworker contacted the paternal grandmother. The grandmother stated that her RCW 74.1 has four children from a previous relationship. The grandmother stated she sees J.C. and RCW 74 mother a couple times a week and she did not have any concerns about the mother or J.C.'s care or safety.

On March 2 and 7 the caseworker called the mother to discuss delivery of a Pack-n-Play, stroller and formula but the caseworker was unable to reach the mother or leave a voice mail. On March 11 the caseworker, along with a coworker, went to the mother's home to deliver the items. The caseworker documented in a case note that she asked about J.C.'s doctor appointment, observed J.C. to be calm and quiet, and that the mother appeared calmer than their previous contact.

On March 16, 2022, a local therapist called DCYF and reported that she has known J.C.'s mother for years and has known that the mother experiences substance use. She also reported that earlier in the day she said the mother and child. The mother appeared to be under the influence of a substance, had "twitchy fast

[4] For more information about FAR see: https://www.dcyf.wa.gov/policies-and-procedures/2332-child-protective-services-family-assessment-response

movements" and J.C.'s head was dangling with no support. The mother had trouble balancing and her gait appeared to be abnormal according to the therapist. This intake screened in for a CPS/FAR assessment.

The case was assigned to the caseworker who already had the case open. The caseworker called the reporter and left voice mail messages. The caseworker also tried to call the mother on March 17 and 18, went to the home and texted the mother. The mother's roommate was home during one attempt but the mother and J.C. were not present. The caseworker did see the mother walking J.C. in a stroller when she was driving, went back to the home but the mother and J.C. did not return. The caseworker spoke with the roommate again. The roommate said the mother often smells like cannabis, that J.C. cries all the time and sometimes the mother and J.C. will be gone for days at a time.

The caseworker was unavailable to continue following up so another coworker attempted to find the mother and J.C. On March 21, 2022, the second caseworker called the referrer from the most recent intake but no one answered. She went to the address listed on the intake and no one answered. She also tried calling the mother but no one answered the call. On March 22 the caseworker called the housing complex and was informed that the mother had moved to a different unit. She went to that unit but learned from the housing representative that the mother had left and it would be a few hours before she returned. The caseworker called the housing representative and explained the importance of seeing them that same day and that if she was unable to make that happen she would need to have law enforcement conduct a welfare check.

That afternoon the mother called the caseworker and set a time to meet at a local park. The caseworker case noted the mother appeared nervous and was a bit shaky but there were no concerns about her gait or balance. They discussed the newest intake. The mother discussed the services she is involved in they discussed Period of Purple Crying[5] and Safe Sleep[6]. The caseworker noted that J.C. was dressed appropriate and he was happy and alert. The caseworker observed a diaper change and did not observe any concerns for [RCW 7] physical well-being.

On March 30 and April 4, the regularly assigned caseworker called and texted the mother but the mother did not respond. On April 5, 2022, the mother responded to another text and the caseworker asked the mother to sign consent forms so that the caseworker can verify that the mother is working with the multiple agencies she said she was as well as provide a urinalysis. The mother refused both requests. The caseworker did get the mother to agree to meet the following day, in person.

On April 6, 2022, the caseworker saw J.C. and [RCW 7] mother at their apartment. The maternal grandmother was also present. The caseworker again asked about the consent forms and urinalysis and the mother again denied the requests. The caseworker documented positive observations of J.C. They discussed multiple topics and those were documented in the case note. The caseworker discussed scheduling a Family Team Decision Meeting (FTDM)[7] with the mother and grandmother and they discussed the meeting details.

[5] "Period of Purple Crying is the phrase used to describe the time a baby's life when they cry more than any other time." For more information see: http://purplecrying.info/ . Last accessed on April 21, 2023.

[6] For more information about Safe Sleep see: https://safetosleep.nichd.nih.gov/. Last accessed on April 21, 2023.

[7] For more information about the family team decision amking meetings process, see: https://www.dcyf.wa.gov/1700-case-staffings/1720-family-team-decision-making-meetings

The FTDM was originally scheduled for April 22 but had to be moved to April 27. The mother and caseworker discussed the purpose and process on April 22. During the FTDM multiple community partners supported the mother and her care of J.C. and the decision was while DCYF had ongoing concerns that DCYF would not file a dependency petition to ask for J.C. to be removed from [redacted] mother's care.

On May 16 the caseworker, her supervisor, and the area administrator staffed the case. The determination was there was insufficient evidence to file a dependency petition and the case would close. They remained concerned about the mother's sobriety and the fact that she would not consent to information sharing with other agencies to verify her statements.

On November 23, 2022, a third intake was received regarding J.C. A deputy called DCYF and reported a welfare check had been requested regarding J.C. due to fentanyl exposure. The sheriff's office went to the residence on November 22 and observed needles and tinfoil on the floor. The mother and J.C. were not present during that encounter but had been present earlier in the day when the mother requested removal of another person from the home. The deputy was told by a couple different people that the mother is smoking fentanyl with her [redacted] present. This intake screened in for a CPS investigation.

That same day the assigned CPS caseworker and [redacted] supervisor contacted the deputy who called in the report. The deputy informed them that law enforcement did find J.C. and he was with [redacted] maternal grandmother. The deputy provided the maternal grandmother's address and the CPS caseworker went there immediately. No one answered at the residence. The supervisor then called the two telephone numbers listed on the intake. The first went straight to voice mail and was full therefore no more messages could be left. A woman answered the second number and identified herself as J.C.'s mother. She said she and her [redacted] were with the maternal grandmother and staying at a differing address but were not there physically at the time of the telephone call. The mother was not cooperative with the supervisor who was trying to arrange a way for the CPS caseworker to meet up with them. The supervisor provided the caseworker with the details provided by the mother and the caseworker immediately left to go to their current location at a gas station.

The supervisor then called a deputy regarding the situation. This deputy told the supervisor that J.C. was not placed in protective custody because the grandmother met with yet a different deputy and that deputy decided J.C. could leave with the grandmother because J.C. was going to stay at a different address then the one with drug paraphernalia.

After that telephone call ended the supervisor called the caseworker. The caseworker was able to see J.C., [redacted] mother, and maternal grandmother. J.C. appeared alert and not in distress. According to the case note both the mother and grandmother were calm and cooperated. The mother denied the allegations of substance use. The caseworker told the mother he would follow up with her on Monday (November 22 was a Tuesday of the Thanksgiving week).

On November 28, 2022, the CPS caseworker went to the mother' home. The mother spoke with the caseworker on the porch while holding J.C. The caseworker documented the J.C. appeared to be dressed appropriately and was clean. The mother again denied the allegations but agreed to provide a urinalysis. The caseworker told the mother he would arrange for a meeting with the mother and the caseworker's supervisor to discuss the incident on November 23.

On November 30 the caseworker again referred the mother for a urinalysis. On December 5, 2022, the caseworker tried to reach the mother four different times and each time the call went straight to voicemail. The next case note states an FTDM was scheduled but the mother did not cooperate.

On December 13, 2022, DCYF was notified of J.C.'s death.

Committee Discussion

When discussing why a dependency petition was not considered at multiple junctures of this case, the staff discussed that their court system in Clallam County was already using the standards for dependency court cases for the House Bill 1227.[8] This law has an effective date in the future, July 2023, but the staff stated the higher burden for removal of a child from parental care was already effectuated by their court and therefore it has negatively impacted their ability to successfully pursue out of home care for children they assess at imminent danger. The area administrator discussed that there is a new judicial officer and he plans on meeting with this judicial officer to discuss this issue.

The staff who met with the Committee discussed very challenging relationships with their community partners. These relationships were described as hostile and uncooperative at times. The county that this case is in has very limited resources for supportive services. It was also discussed that these issues have been raised in other reviews that are also small communities and it is not just this one county. This issue is addressed in the Recommendations section below. They also discussed concerns regarding inappropriate relationships between professional community partners and parents. This information was discussed with the regional administrator and area administrator after the review concluded.

The Committee was concerned about the lack of FTDM facilitators to provide timely meetings. This case highlighted this issue because the first FTDM did not occur in a timely manner. The staff shared there was only one facilitator at the time of this case. However, the region has remedied this since the critical incident. There are now three trained back-up FTDM facilitators to assist the designated FTDM facilitator for the two counties.

While the Committee discussed there were improvement opportunities throughout the case, they also appreciated that the significant turnover and vacancy issues faced by the office may have hampered the ability of the staff to conduct their work. The Committee also learned that the first CPS caseworker assigned to this case was one of three CPS caseworkers in the office. There were three vacancies in the unit. The caseworker was brand new to child welfare and did not receive adequate support or guidance from her then supervisor (that supervisor left DCYF employment prior to the review process). The CPS caseworker did share that she received good support from her coach through the Alliance. The Alliance is the contracted training partner, through the University of Washington for DCYF. The Committee was impressed with the caseworker's honesty, vulnerability during the review, and how open she was to learning from this process.

While taking into consideration the challenges faced by the CPS caseworker due to the vacancies and lacking support from her supervisor, the Committee identified that J.C. would have benefited from a more comprehensive review of RCW 7 [redacted] birth records and collateral contacts, such as J.C.'s pediatrician, regarding RCW 7 [redacted] medical care. J.C. was faced with multiple challenges at birth that would need follow up as a newborn, infant,

[8] https://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bill%20Reports/House/1227-S2.E%20HBR%20FBR%2021.pdf?q=20230419094712

and possible toddler. The CPS caseworker tried to do her best with the time she had addressing her entire caseload, which included multiple placements of children out of their home and dependency petitions on other cases, and identifies that this feedback will help her with future cases.

The Committee also identified that the family may have benefited from a more comprehensive gathering of assessment collaterals such as J.C.'s father, documentation of the history related to J.C.'s mother as a child and J.C.'s grandparents involved with DCYF, providers referenced as engaging with J.C.'s mother, and J.C.'s primary care physician.

The Committee believes that law enforcement's decision making regarding the December 2022 case negatively influenced DCYF's decision regarding J.C.'s safety. Law enforcement initially told DCYF that they would place J.C. in protective custody due to the concerns of substance use in RCW 7 presence. However, they changed their minds when he was found with RCW 7 mother and maternal grandmother even though there is history regarding the maternal grandmother and substance use. The Committee believes it would have been appropriate to consider filing a dependency petition especially after the mother failed to comply with a FTDM. The relationship between DCYF and the local sheriff's office is reportedly very challenging and they often will not go with DCYF staff on cases. The Area Administrator is aware of this and is working to ameliorate this issue with the newly appointed sheriff. The staff did share that they have positive working relationships with two of the police departments in their county.

Recommendations

1. Clallam County will soon begin Early Childhood Courts within their Superior Court system. Included in this recommendation are differing aspects the Committee identified as supports necessary to have a successful Early Childhood Court as well as enhance and support best practice child welfare standards.
    a. The Intake and Early Learning Program Manager will meet with the Area Administrator to discuss the Plan of Safe Care, and make a connection between the Area Administrator and DCYF Strengthening Families Locally (SFL) team to discuss the SFL work in this area. These prevention efforts will help to integrate the work conducted by child welfare staff and hopefully also aid in building quality, professional relationships with community providers.
    b. The Intake and Early Learning Program Manager will also discuss Infant and Early Childhood Mental Health and the Parent Child Interaction (PCI) training available to staff. The Committee believes that having one or more PCI trained staff members will help enhance child safety assessments for DCYF staff.
    c. The Intake and Early Learning Program Manager will also assess, through conversations with the Area Administrator and/or staff, if outreach to mandatory reporters in the county is necessary. The Committee discussed a missed opportunity for intervention at J.C.'s birth. Neither the birthing hospital, and the hospital he was transferred to for his post-birth medical needs, called DCYF. The Committee believes medical records obtained by the initial CPS caseworker supported a report to DCYF at J.C.'s birth.

2. This review will be discussed with the Service Array Program Manager. The purpose of the discussion is to share the Committee's concern regarding a lack of contracted providers to support the work of the child welfare staff.

3. Region 6 management will have a Quality Practice Specialist (QPS) pull a small sampling of CPS cases and review them to see how they adhere to the Child Safety Framework (the process of assessing child safety) utilized by DCYF. This case should be included in that sample. The Committee recommends the QPS staff assess for training needs specific to the Clallam and Jefferson County offices regarding all aspects of the Safety Framework but also regarding utilization of FTDMs, triage staffings, and prefiling or Assistant Attorney General consultations. Triage staffings are internal staffings within a region that consist of multiple disciplines from multiple offices. These staffings are used to discuss difficult situations and they result in recommendations for next steps to be taken by the assigned caseworker and supervisor. Prefiling staffings are also internal staffings to discuss cases for legal sufficiency to file a dependency petition.

4. Region 6 management should consider requiring staff from the Clallam and Jefferson Counties to attend the Advanced Guidelines for Difficult Conversations training offered by the Alliance.

5. The Area Administrator for Clallam and Jefferson counties will discuss the community relationships and the challenges currently faced by the staff in those offices with his regional management. They will create a plan to build cooperative relationships with the community providers and discuss the challenges currently faced by the local child welfare staff. This would include the community partners involved in this specific case.