CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

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CONTENTS

Nondiscrimination Policy

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

- L.E.

Date of Child's Birth

- [redacted] 2021

Date of Fatality

- March 27, 2022

Child Fatality Review Date

- Aug 3. 2022

Committee Members

- Linda Soltero, MSW, Continuing Education Specialist for the Alliance for Child Welfare Excellence
- Patrick Dowd, JD, Director of the Office of the Family and Children's Ombuds
- Melissa Sayer, MSW, Licensing Division Safety Administrator for the Department of Children, Youth, and Families
- Devon Jenkins, MSW, Licensing Safety and Monitoring/CPS Supervisor for the Department of Children, Youth, and Families
- Wendi Andres, Stevens, Ferry and Pend Oreille Counties, Family Court investigator and former CASA/GAL for dependency court

Facilitator

- Cheryl Hotchkiss, Critical Incident Review Specialist for the Department of Children, Youth, and Families

Executive Summary

On Aug. 3, 2022, the Department of Children, Youth, and Families ("agency" or "DCYF") convened a Child Fatality Review (CFR)[1] Committee to assess the agency's service delivery to L.E. and RCW 74. family.[2]

On March 27, 2022, DCYF received a report concerning L.E. DCYF learned that L.E. was allegedly found unresponsive after sleeping in a Dock-A-Tot[3] product in a camper trailer at RCW 74. foster family's property. L.E.'s foster mother said she performed CPR and revived L.E. After contacting 911, L.E. was taken to the hospital and placed on assisted breathing. On March 29, 2022, L.E. died from RCW 74. condition. DCYF later learned that contrary to DCYF foster care licensing training, the foster mother used the Dock-A-Tot as a sleeping tool for L.E. Also, contrary to DCYF guidelines and training, DCYF learned that the foster mother had been swaddling and propping L.E.'s bottle during feeding time. As a result of the circumstances surrounding L.E.'s death, the foster family's authority to provide foster care has been revoked.

The CFR Committee (Committee) includes members with relevant expertise selected from diverse disciplines within the community. Before the fatal incident, Committee members had no involvement or contact with L.E. or RCW 74. family. The Committee received a case chronology and other relevant documents including, but not limited to, intakes, Child and Family Welfare Service (CFWS) and licensing provider case notes, and other DCYF documents maintained in DCYF's electronic computer system.

The Committee interviewed the 2022 Licensing Division (LD) licensor and supervisor, who completed and approved the foster care license re-assessment pertaining to L.E.'s foster parents. The Committee also interviewed a CFWS caseworker and supervisor, a courtesy supervision caseworker and supervisor, and the 2016 initial home study licensing supervisor.

Case Overview

L.E. was born in RCW 74.13.515 2021. L.E. was placed into DCYF's care and custody at birth due to RCW 74. parents' substance use issues. A DCYF Child Protective Services (CPS) investigation was opened at the time of L.E.'s placement. On RCW 74.13.515, 2021, L.E. was discharged from the hospital to an initial foster home placement. The case was transferred to a Child and Family Welfare Service (CFWS) worker. On Jan. 29, 2022, L.E. was moved into a second foster family home because the original foster home could not continue care. Because L.E.'s new foster home was outside the primary CFWS caseworker's jurisdiction, a courtesy supervision[4] caseworker was assigned to complete monthly health and safety visits. Between January 29 and L.E.'s subsequent death on

[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 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 the Agency 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 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 Agency employees or other individuals.

[2] No one is named in this report because no one has been charged with a crime in connection with the fatal injuries. See RCW 74.13.500.

[3] For information about infant safe sleep, see: https://www.consumerreports.org/child-safety/more-infant-sleep-products-linked-to-deaths-a1380476200/; and https://www.fda.gov/consumers/consumer-updates/do-not-use-infant-sleep-positioners-due-risk-suffocation. Last accessed on September 07, 2022.

[4] For information about courtesy supervision, see: https://www.dcyf.wa.gov/4400-concurrent-tanf-benefits/4430-courtesy-supervision. Last accessed on September 07, 2022.

March 2022, the courtesy supervision worker observed L.E.'s sleeping environment at the foster home. The courtesy supervision worker also discussed safe sleep guidelines with the foster mother. In February 2022, the foster home licensing caseworker assigned to complete a foster home re-assessment met with the foster mother at the foster home. The licensing caseworker observed and documented that safe sleep guidelines were being followed.

Licensing timeline: On June 30, 2016, the foster family first applied for a foster home license. The foster family planned to be kinship care providers for two children they knew. The two children are unrelated to L.E. In August 2016, a concern about the family's suitability as foster parents was expressed by a former DCYF caseworker. On Aug. 11, 2016, the foster family voluntarily withdrew their application as the two children were no longer in their care.

On Oct. 24, 2016, the foster family submitted a second application for a foster care license to become a general foster care provider. On Dec. 13, 2016, an assigned LD licensor emailed the foster family confirming the new licensing application was received. In December 2016, a second concern about the family's suitability as foster parents were expressed by former DCYF caseworkers. The concerns were about transportation conflicts and a general statement that the foster family was considered "inappropriate." On June 6, 2017, the home study and pending license were completed and sent to the licensing supervisor, who approved the license for the time period June 6, 2017, through June 5, 2020.

Between 2017 and 2020, six children were placed with the foster family. On Feb. 24, 2020, the foster mother emailed the LD licensor expressing her desire to renew or re-instate her foster care license. On May 13, 2020, a Safety and Monitoring (SAM)[5] Licensor was assigned to the foster family's renewal application to reassess the home, complete follow-up interviews, complete new background checks, complete a home inspection, review policies, and complete caregiver interviews.

On June 14, 2021, a SAM licensor called the foster mother to verify the foster home's infant sleeping area. A photo of the crib area was sent. The worker reviewed safe sleep and Period of Purple Crying with the foster mother. On March 4, 2022, the license renewal was completed and approved by a newly assigned SAM licensor and supervisor. The foster family license was approved for the period of June 6, 2020, to June 5, 2023. The SAM licensor observed the room in the foster home designated for infant placements and commented: "…appropriate safe sleep was being used for current placements during the inspection." The foster family applied for a child care license to become dually licensed on 12/07/2021, and as of the date L.E. died, the license was in pending status and had not been approved.

Committee Discussion

The Committee understands that before the fatality, DCYF was involved with L.E. and RCW 74. family for a limited time. The Committee also understands that DCYF was unaware of the foster family's use of a Dock-A-Tot[6] product. Information received by the Committee indicates the courtesy supervision and LD staff did not

[5] For information about safety and monitoring (SAM) licensors, see: https://www.dcyf.wa.gov/services/foster-parenting/licensing-restructure-update. Last accessed on September 07, 2022.

[6] For information about infant sleepers, See: https://healthychildren.org/English/ages-stages/baby/sleep/Pages/Inclined-Sleepers-and-Other-Baby-Registry-Items-to-Avoid.aspx. Last accessed on September 07, 2022.

observe the product in the home. The Committee believes that during the limited intervention, the CFWS and courtesy supervision caseworkers and supervisors worked within the required policies and practices.

The Committee believes there were opportunities for improvement during the limited intervention with the foster family. For example, during the initial foster care license home study[7] and the later visitation and health and safety re-assessment, the assigned licensors and licensing supervisors did not appear to analyze the 2016 CFWS' expressed concerns about the foster mother. Information from CFWS staff between 2016 and 2022 shows licensing staff briefly documented the former CFWS caseworkers' concerns. However, further analysis of the concerns was not documented or saved as being acted upon or analyzed.

With regard to the suitability of the caregivers to provide foster care, the Committee noted that in August and December 2016, there were reported concerns by previous CFWS caseworkers and licensing division staff. The Committee opined that the documented concerns were ambiguous and observed no follow-up to assess the reported concerns. Licensing staff on the Committee told fellow Committee members that there is a requirement to ask child welfare staff about any caregiver concerns. The Committee learned that the information is often gathered, but assigned licensing staff can lack critical thinking and response.

The Committee discussed the benefits of holding an immediate and mandatory staffing that includes LD program managers. The purpose of the staffing would be to collaborate and analyze any DCYF caseworker reported concerns. The Committee believes internal staffing may be advantageous because it may result in action steps to address or respond to concerns and provide an opportunity to document why actions were or were not taken. The Committee believes documentation that describes reported concerns and a description of the response to concerns will reduce future ambiguity about DCYF's response, ensure appropriate intake referrals are made and provide for a more comprehensive home assessment.

The licensing staff who were interviewed and Committee members who work in the licensing division agreed that travel trailer walk-throughs are not a policy requirement or statewide standard practice. The Committee discussed the policy's requirement[8] to complete a physical walk-through during the outbuilding assessment and wondered if travel trailers and/or recreational vehicles should be added to the policy. The Committee believes DCYF should consider adding language to the policy that reads: "assigned DCYF caseworkers and/or courtesy supervision and licensing workers should have and document caregiver conversations about safe sleep planning when the primary sleep environment is not accessible during health and safety visits, the initial foster parent application and home study meeting, and during re-assessment and license renewals.

The Committee understands that given the existing requirements foster parents must satisfy, applicants and DCYF workers may consider the additional policy requirements unnecessary and overly burdensome. The Committee noted a locked outbuilding at the foster home that was not entered by DCYF licensing staff or courtesy supervision caseworkers. The Committee believes this outbuilding should have been inspected. The Committee agreed it is appropriate for licensing, courtesy supervision, CPS, and CFWS caseworkers to have

[7] For information about home studies, see: https://www.dcyf.wa.gov/5100-applying-foster-parent-or-unlicensed-caregiver/5110-completing-home-study; and https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.dcyf.wa gov%2Fsites%2Fdefault%2Ffiles%2Fforms%2F10-183.docx&wdOrigin=BROWSELINK. Last accessed on September 07, 2022.

[8] For information about requirements related to the licensee's home, see: WAC https://app.leg.wa.gov/wac/default.aspx?cite=110-148-1440. Last accessed on September 07, 2022.

conversations with foster parents and caregivers about the use of travel trailers. The Committee believes the conversation should include a discussion about a sleeping arrangement plan when the foster child is away from or unable to use the regular sleeping area. A Committee member discussed the belief that the use of travel trailers and alternative sleeping arrangements could fall under the prudent parenting guidelines,[9] similar to circumstances such as when foster parents are traveling and staying in hotels.

The Committee believes that from 2016 through 2022, there was minimal assessment and interaction with the foster father. Due to the lack of interaction with the foster father, the Committee believes DCYF missed the opportunity to understand and explore the daily functioning within the foster home, the caregivers' relationships with each other, and the foster father's role in the home and the care of L.E. The Committee believes conversations with the foster father may have provided additional insight and understanding about the foster mother's caretaking abilities and overall mental health. The Committee learned from case file information that the foster mother self-reported prior mental health struggles. From the DCYF documentation, the nature of the foster mother's mental health issues was unclear. The Committee discussed a statewide pattern that in all program areas, there is a lack of assessments pertaining to secondary caregivers and parents. The Committee believes the best practice would be for licensing staff and all child welfare caseworkers and supervisors to include all caregivers and parents in their assessments and health and safety contacts.

The Committee discussed that for parents who provide infant care, training related to Safe Sleep[10] and Period of Purple Crying[11] is mandatory. The Committee learned that this particular caregiver received all required infant training including, but not limited to, sleeping practices, feeding, and developmental stages. The Committee learned that no DCYF staff who went to the foster home was aware of or observed a Dock-A-Tot. The Committee discussed available infant care training[12] that is provided to foster and kinship care providers. The Committee also discussed updated sleeping practice information, including product recalls and information about critical incidents, infant safe sleep, and infant care.

The Committee recognizes the amount of safe sleep training L.E.'s foster family received and, pursuant to policy and procedure guidelines, the licensing staff, and caseworkers' conversations with the foster family. One Committee member believes that many parents unintentionally fail to review online warnings and recalls even with all the available warnings and education about new infant products. The Committee understands that despite efforts to provide infant care education and frequent reminders about DCYF's infant care expectations, parents and caregivers may not always choose to use safe sleep environments or comply with recommended feedings and care standards. The Committee also understands no new documented concerns about the foster home during the Feb. 2, 2022, re-assessment period.

[9] For information about Prudent Parenting, see: https://www.dcyf.wa.gov/publications-library/CWP_0078. Last accessed on September 07, 2022.

[10] 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. Last accessed on September 07, 2022.

[11] For information about Period of Purple Crying, see: http://www.purplecrying.info/what-is-the-period-of-purple-crying.php. Last accessed on July 29, 2022. For information about infant safety education, see: https://www.dcyf.wa.gov/1100-child-safety/1135-infant-safety-education-and-intervention. Last accessed on September 07, 2022.

[12] For information about caregiver applicant requirements, see: https://www.dcyf.wa.gov/5000-case-support/5100-applying-foster-parent-or-unlicensed-caregiver. Last accessed on September 07, 2022.

The Committee discussed the potential benefit of a bi-annual newsletter sent to foster and kinship listservs that provides reminders about proper infant feeding, care guidelines and standards, and infant product information warnings and precautionary measures. Some Committee members believe information about critical incidents involving infants in foster care could be included in the bi-annual information sent to caregivers.

Recommendations

For purposes of practice and assessment improvement, the Committee believes DCYF should consider adding the following to DCYF's existing policies:

- During the assessment of outdoor areas, require Licensing staff, CPS caseworkers, CFWS caseworkers, and courtesy supervision caseworkers to assess travel trailers and recreational vehicles.
- Require workers in all programs to discuss with caregivers the planned sleeping arrangements for areas outside the primary sleep environment and document the caregiver's plan for safe sleep while traveling or napping outside the primary residence.
- Require an immediate internal staffing with assigned licensing staff, supervisors, and regional and headquarters program staff if a licensor or SAM worker receives information concerning the caregiver's suitability during the initial or ongoing assessments. The Committee believes this staffing will allow DCYF to better analyze, collaborate, and document DCYF's actions and assess health or safety concerns.

DCYF should consider sending foster and kinship caregivers bi-annual information and updates for infant care and sleeping practices. The information should include product recalls, product warnings, and for educational purposes, information about cases involving fatalities and near fatalities.