CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

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CONTENTS

Full Report

Child

- R.C.

Date of Child's Birth

- RCW 74.13.515 2023

Date of Fatality

- October 20, 2023

Child Fatality Review Date

- January 18, 2024

Committee Members

- Elizabeth Bokan, JD, Deputy Director, Office of the Family and Children's Ombuds
- Vanessa Adams, MSW, LICSW, Program Coordinator for Kids Mental Health Pierce County, Pediatric Care Continuum Mary Bridge Children's Hospital
- Julie Stachowiak, RN, MN, Personal Health Services Supervisor, Renton Public Health Center
- Ursula Petters, MSW, Senior Administrator for Support, Integration, and Quality Improvement, Department of Children, Youth, and Families

Facilitator

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

Executive Summary

On January 18, 2024, the Department of Children, Youth, and Families (DCYF) convened a Child Fatality Review (CFR)[1] to examine DCYF's practice and service delivery to R.C. and RCW 74 family. R.C. will be referenced by RCW 74 initials throughout this report.[2]

On October 26, 2023, DCYF was notified that R.C. had passed away six days prior. RCW 74.13.520 RCW 74.13.520 At 11 a.m. on Oct. 20, 2024, his mother called emergency services telling the operator that her RCW 74.1 was cold to the touch. When medics arrived at the home, they declared R.C. deceased. Law enforcement found multiple diapers saturated with blood. The autopsy results identified almost total blood loss. This information met the threshold for a Child Protective Services (CPS) investigation.

There was an open CPS Risk Only investigation at the time of R.C.'s death. A Risk Only investigation is one that does not identify an allegation of abuse or neglect but alleges imminent risk of serious harm. The case was open for 20 calendar days before DCYF was notified of R.C.'s death.

A CFR Committee (Committee) was assembled to review DCYF's involvement and service provision to the family. The Committee included members with relevant expertise selected from diverse disciplines within DCYF and community partnerships. Committee members had no prior direct involvement with R.C. or RCW 7 family. Before the review, the Committee received relevant case history from DCYF. On the day of the review, the Committee had the opportunity to speak with the area administrator for the office in which the case was assigned.

Case Overview

On October 6, 2023, DCYF received allegations of concern for R.C. RCW 74 mother obtained late prenatal care around seven months into her pregnancy. The mother told hospital staff that she had three other children RCW 13.50.100 The caller reported the mother tested positive for cannabis and fentanyl, but the mother only admitted to cannabis use. However, later the caller reported the hospital tested the mother after medical staff administered fentanyl during her delivery.

The caller also alleged that R.C.'s mother was diagnosed with RCW 70.02.020 but was not receiving treatment. However, she was prescribed medications for mental health purposes. RCW 70.02.020

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

On October 6, the same day as the intake, the assigned caseworker and a coworker went to the hospital. The caseworkers met with hospital staff. The caseworkers were unable to obtain an understanding or examples of the mother's "erratic" behaviors observed and reported by some of the nurses. The caseworkers were told that psychiatric services met with R.C.'s mother and cleared her for discharge, yet the nurses were not allowing R.C. to be unsupervised with RCW 7 mother in her hospital room. The hospital staff reported the mother was doing well caring for R.C. The hospital staff reported they made a referral to community support services for the mother.

R.C.'s mother was confused and upset with the presence of the caseworkers. The mother denied the RCW 70.02.020 diagnosis and taking medications. She stated she does not plan on having R.C.'s father involved in RCW 7 care and stated she is in a new relationship with a different man. RCW 13.50.100

The caseworkers spoke with R.C.'s pediatrician and the mother's physician. Neither doctor expressed concerns regarding the mother's ability to care for RCW 74.13.515 The mother and R.C. were going to be discharged the following day, a Saturday. The caseworker arranged for an after-hours caseworker to provide them a ride home from the hospital.

On October 7, an after hours caseworker arrived at the hospital to take the mother and R.C. home. R.C.'s father and another of the father's relatives were in the hospital room with R.C. and RCW 7 mother. R.C.'s father was aggressive and hostile towards the caseworker. The father was asked to leave the room and he eventually left the hospital. The after-hours caseworker drove the mother and R.C. home. The caseworker discussed safe sleep and Period of Purple Crying with the mother, and conducted an inspection of the home.[3] The mother's boyfriend was present but sleeping. The caseworker saw the crib the mother had but observed there was no mattress. The mother stated that R.C. would sleep in a portable play pen until DCYF provided her with a mattress.

On October 10, a staff member from the DCYF office provided the mother with food and clothing vouchers. When the worker dropped off the voucher, they observed R.C. and did not observe any concerns.

On October 26, DCYF was notified that R.C. had died on October 19. The death was being investigated by law enforcement. An intake was assigned for a CPS investigation for concerns of possible medical neglect leading to R.C.'s death.

Committee Discussion

The Committee discussed issues presented by the area administrator regarding ongoing bias concerns with some staff at the local hospital. The area administrator was able to share examples of the bias, how her staff were combating those issues, and how she was addressing the concerns with hospital administrators. This also included a discussion about the concerns nationwide for how people of color are treated, especially pregnant women, in medical settings.

[3] Period of Purple Crying and safe sleep are required topics for caseworkers to discuss with families who have a child that is twelve moths or young. For more information about this policy requirement, see: https://www.dcyf.wa.gov/1100-child-safety/1135-infant-safety-education-and-intervention

The area administrator shared what the caseworker's intended next steps were for the case prior to the notification that R.C. died. The Committee appreciated hearing that those steps were in line with what they had hoped would have occurred and what they understood was to be expected per DCYF policies.

The Committee discussed with the area administrator that the case notes did not contain the same detail as provided during the review process. The area administrator acknowledged this and shared that she has worked with her staff on incorporating that feedback for future case notes. She also shared the other challenges faced by her staff that may have impacted documentation in this case, including large case load size and cases that had more emergent demands.

The area administrator also shared the steps she has taken to help support the office. The staff experienced a high number of critical incidents in the last one-to-two years as well as staffing stabilization challenges. The Committee appreciated that the work put in by the area administrator was done in a comprehensive and thoughtful manner to create a safe and stable working environment, and that those measures take time to develop.

Recommendations

The Committee did not make any recommendations.