CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

October 2019

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CHILDREN, YOUTH & FAMILIES

Contents

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The Department of Children, Youth, and Families (DCYF) does not discriminate and does provide 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

- S.M.

Date of Child's Birth

- [redacted] 2019

Date of Fatality

- August 2019

Child Fatality Review Date

- October 24, 2019

Committee Members

- Cristina Limpens, M.S.W., Senior Ombuds, Office of the Family and Children's Ombuds
- Pilar Lopez, CDP, DCYF, Child Protective Services Supervisor
- Lindsey Barclay, CDP, LICSW, CMHS, MSW, CCTP, DAWN Services, Clinical Director
- Jason Escobar, King County Sheriff's Office, Sexual Assault Unit Sergeant

Observer

- Michael Parker, DCYF, Quality Practice Specialist Region 4

Facilitator

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

Executive Summary

On October 24, 2019, the Department of Children, Youth, and Families (DCYF)[1] convened a Child Fatality Review (CFR)[2] to assess DCYF's service delivery to S.M. and [redacted] family,[3] [redacted] will be referenced by [redacted] initials throughout the report.

On August 10, 2019, DCYF received a telephone call reporting [redacted]-old S.M. was pronounced dead at a local hospital. DCYF learned that the parents provided multiple versions of the events leading up to S.M. being transported to the hospital. Law enforcement and the medical examiner's office are both involved in the death investigation. This intake was screened in for a Child Protective Services (CPS) investigation. The family already had an open CPS/Family Assessment Response (FAR) case with DCYF at the time of S.M.'s death.

The CFR Committee (Committee) includes members with relevant expertise selected from diverse disciplines within the community. Committee members have not had any involvement or contact with S.M. or [redacted] family. The Committee received relevant documents including intakes, case notes and other DCYF documents maintained in DCYF's electronic computer system.

The Committee interviewed the area administrator and CPS supervisor. The CPS worker was out of the country at the time of the CFR. However, prior to the CPS worker's departure, the Committee had the opportunity to submit questions. Her answers were provided to the Committee prior to the day of the CFR.

Case Overview

On July 13, 2019, DCYF received a telephone call that reported allegations involving S.M.'s family. This report resulted in a CPS/FAR assessment.[4] The allegations reported to DCYF included information obtained during a law enforcement investigation of domestic violence (DV). The officer reported S.M. was present during the DV incident and was at risk of being injured. S.M.'s mother reported to law enforcement that S.M.'s father was upset as a result of S.M. crying while under his care. The parents began to argue and at some point the father broke the mother's phone, pushed her, ripped her shirt, and would not allow her to leave the room. Due to the noise, a neighbor called law enforcement. S.M.'s mother [redacted]. The mother did not cooperate with law enforcement when asked questions about the DV incident or S.M. The officer observed broken glass

[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 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)]." 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 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] S.M.'s parents have not been named in this report because they have not been charged with a crime involving the circumstances described in the report maintained in DCYF's case and management information system.

[4] Family Assessment Response (FAR) is a Child Protective Services (CPS) alternative response to an investigation of a screened-in allegation of child abuse or neglect. FAR focuses on child safety along with the integrity and preservation of the family when lower risk allegations of child maltreatment have been screened in for intervention.

on the floor two feet away from S.M.'s crib. The mother said the glass was from a fight that occurred the night before.

Because of a diaper rash, on July 15, 2019, S.M.'s mother took S.M. to a hospital's emergency department. S.M. received antibiotics and was discharged on the same day. On July 16, 2019, S.M. developed a fever and increasing symptoms which prompted [redacted] mother to take [redacted] back to the emergency department. S.M. was admitted to the hospital for an infection and cellulitis. Also on July 16, 2019, the assigned CPS worker attempted contact at the family's residence. On the following day, she went back to the home again but no one answered. The inability to contact the mother caused the CPS worker to leave a letter at the residence asking the mother to contact the CPS worker. On July 17, 2019, the CPS worker received a call from a hospital social worker. The hospital social worker called the CPS worker after S.M.'s mother told her about the letter. The hospital social worker said S.M. was admitted to the hospital on July 16, 2019, and S.M. and [redacted] mother remained at the hospital since that date.

The hospital social worker reported the mother has been appropriate and was currently out of the hospital attempting to schedule a mental health appointment. The hospital planned on keeping S.M. through the weekend. The hospital social worker also shared that S.M.'s father was incarcerated. The hospital social worker shared that S.M's mother stated they may be evicted from their residence due to non-payment. A plan was made for the CPS worker to meet with the mother and S.M.

On July 19, 2019, the CPS worker met with S.M. and [redacted] mother at the hospital. During this interview, the mother was not willing to answer questions with the detail the CPS worker was seeking. The mother was at times evasive and minimized the DV. The mother told the CPS worker that S.M.'s father had helped her[redacted], they had been together for a year and S.M. was a planned pregnancy. The mother also shared that she has a [redacted]. During this contact, the CPS worker discussed with the mother safe sleep and Period of Purple Crying.

On July 31, 2019, the CPS worker met S.M. and [redacted] mother at their home. The Women, Infants, and Children (WIC) worker was also present. The CPS worker provided the mother with bus tickets. The mother said she did not want to be involved in the DV criminal charges involving S.M.'s father. S.M.'s mother also reported that she had not yet engaged in any therapy. The mother disclosed that in order to facilitate visitation and pursuant to a no-contact order, she is allowed to have contact with S.M.'s father. The mother denied knowing where the father was staying or how to reach him.

On August 10, 2019, DCYF received a telephone call reporting the death of [redacted]-old S.M. This intake was screened in for a CPS investigation.

Committee Discussion

The Committee discussed at length that while there were some areas within the DCYF practice that could have been improved, DCYF's work was appropriate in light of the following factors: (1) the agency's workload and caseload, (2) the agency's office changes within the CPS section responsible for the S.M. case, (3) the CPS worker's recent hire into her job position and (4) the length of time the case was open.

During the Committee's meeting with the CPS supervisor and area administrator, the Committee learned about system barriers that prevented a higher level of case practice for S.M. and [redacted] family.

The CPS supervisor also reported that at the time of S.M.'s death the CPS worker had only been on the job for approximately eight months, this particular CPS office had experienced significant turnover and the area administrator had been promoted from within the office. The Committee believes these factors contributed to coverage and staffing shortages. At the same time as the S.M. case, the CPS worker was also working on two other cases involving the removal of children from their parents. The other two cases required court involvement, transportation and supervised visits issues, and a child who was in the office on a daily basis needing full supervision due to a lack of placement options. In addition, at the time of S.M.'s death, the CPS worker had 43 open CPS cases. DCYF has a desired goal of 8 new intakes assigned to a CPS worker each month. The Child Welfare League of America recommends no more than 12 active cases for a CPS worker. Per DCYF policy, a CPS investigator has 60 days to complete an investigation and a CPS/FAR worker has 45 days to close their assessment. Some cases take longer to assess or investigate and therefore a specific caseload number has not been created. The Committee has concerns with regard to the impact these factors may have on the staff in general, the assigned CPS worker in particular and how these identified issues may impact future child safety assessments.

During the staff challenges discussion, the Committee also considered the fact that the original CPS worker was also assigned to the CPS investigation regarding S.M.'s death. The Committee expressed concerns that while this may be workers' preference to have these critical incidents assigned to them, it may not be healthy for the assigned worker and may cause a possible bias of that investigation. The Committee believes DCYF should create a policy and protocol for how critical incidents are handled. This is further discussed in the Recommendation section below.

The Committee believes DV was a presenting issue within the family. The CPS worker's documentation did not clearly identify a DV assessment or clear attempt to conduct the assessment in a manner consistent with DCYF policy. However, this concern must be viewed in light of the short length of time the CPS worker had been on the job, staff turnover, coverage and workload issues and that the worker had not yet the ability to attend a mandatory 3-day DV training. The Committee was also told that the CPS supervisor had been in her position for a year and a half, and at the time of the review, she had never been in the role of a CPS investigator or CPS/FAR worker. The supervisor told the Committee her regular practice is to meet with her staff to discuss what questions and areas they needed to follow up on, specifically with regard to DV.

At the time of S.M.'s death, the case had been open for slightly less than one month. During this time the CPS worker was attempting to build a rapport with the mother so that a full assessment could be completed. The significant challenges to building a rapport with S.M.'s mother (who was evasive), the workload and caseload challenges and time on the job are all mitigating factors considered by the Committee as it relates to the work not completed before S.M.'s death.

Another subject area discussed by the Committee was the Safety Assessment completion and approval process. The approval was issued the same day as the CPS worker's initial face-to-face contact with the mother and child. The Committee believes more collateral contacts and a subject interview with the father may have been appropriate. The Committee noted that DCYF could have taken more steps to learn about S.M. and [redacted] family including, but not limited to, gathering S.M.'s birth records, initiating contact with [redacted] child welfare agency and initiating contact with law enforcement. This is further addressed in the findings section below.

Based on the mother's claim the father used 13.50.100 the Committee appreciates the fact the CPS supervisor directed the worker to further assess the parents' possible substance use issues. The Committee discussed that if one parent is using drugs, and given the circumstances involving this particular family, there was a higher likelihood the mother may have also been using drugs. This was discussed as something that is often learned with experience, as compared to the CPS worker's shorter job experience.

Findings

The Committee agreed there were no critical errors made in this case. However, the Committee identified some areas where practice could have been improved. However, the Committee did conclude it would be incredibly challenging, if not impossible, to conduct best case practice protocols when faced with the system challenges that have been described in this CFR.

The Committee believes the CPS worker may have gained a better understanding of the safety risks confronting S.M., had the CPS worker had the opportunity to contact the officer who called in the July 13, 2019 intake (e.g., gathering more information about the father's criminal history and an opportunity to discuss the intake information). Records from 74.13.515 child welfare agency may have also assisted with the safety assessment. In particular, records related to the mother's 13.50.100 . The police officer in the first intake identified the neighbor by first name and provided a phone number. Contacting that neighbor would have been appropriate. Finally, the father was incarcerated during the beginning of the first intake. Because his whereabouts were known and he was accessible, it would have been an appropriate time for the CPS worker to meet with him. However, for the reasons previously discussed in this CFR, the Committee believes establishing contact with the father and initiating the other collateral contacts would have been nearly impossible.

Recommendations

The Committee recommends that Region 4 assess how to gain access to electronic court records. This case highlights the fact that the office did not have access to such information which could have been beneficial.

Recognizing the emotional toll on DCYF staff when a child fatality or near-fatality occurs, the Committee recommends that DCYF submit a request to the legislature to fund a critical incident protocol. The Committee believes a protocol similar to those used by many law enforcement agencies would be appropriate. Key components of a DCYF critical incident protocol should include directives that relieve the involved staff from new responsibilities and a triage team to provide protected time for the worker(s) and supervisor(s) to address their secondary trauma needs. The critical incident protocol would be in addition to any Peer Support or other emotional support programs available to DCYF staff.