CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

September, 2020

Washington State Department of CHILDREN, YOUTH & FAMILIES

Contents

September, 2020

Full Report

Child

- S.R.

Date of Child's Birth

- RCW 74.13.515, 2018

Date of Fatality

- March, 29 ,2020

Child Fatality Review Date

- July 15, 2020

Committee Members

- Elizabeth Bokan, J.D., Office of the Governor Children's Ombuds
- Cassey Aranda, Case Manager Supervisor, Yakama Nation Nak Nu We Sha Program
- Cassie Anderson, Aftercare Program Manager, The Healing Lodge of the Seven Nations
- Linda Adkinson, Tribal Liaison and Social and Health Program Consultant, Department of Children, Youth, and Families Headquarters
- Nicole Labelle, Region 1 Programs Administrator, Department of Children, Youth, and Families

Facilitator

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

Executive Summary

On May 10, 2020, the Department of Children, Youth, and Families (DCYF) convened a Child-Fatality Review (CFR) [1] to assess DCYF's service delivery to S.R.[2] and RCW 7 family. The child's initials are used throughout this report to maintain confidentiality. The mother Samantha Tainewasher, other adults in the home and Calvin Hunt are identified by name because they have been charged with committing a crime associated with the death of S.R.[3]

On March 29, 2020, hospital personnel called Child Protective Services (CPS) to report the death of 15-month-old S.R., who was brought to the hospital by ambulance. At the time of RCW 7 arrival RCW was not breathing. While at the family residence and before being transported by ambulance to the hospital, law enforcement administered CPR to S.R. Soon after RCW 7 arrival to the hospital, S.R. was pronounced dead. At the time of death, the cause of death was undetermined. The mother reported to officials that S.R. had been sick for the last few days and that RCW was last observed awake and alert about one hour before RCW was found unresponsive. The mother and other adults in S.R.'s home reported to officials that they immediately called 911 after they discovered S.R. was unresponsive. Based on toxicology reports obtained by the coroner in April, 2020, the coroner concluded the cause of death was due to a fentanyl overdose. Both the mother and her friend who was residing in the home are being considered for homicide-related charges.

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.R. or RCW 74 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 DCYF area administrator, the CPS social worker, the Family Voluntary Service (FVS) worker, and the FVS supervisor. The CPS supervisor was out of the office on the date of the CFR.

Case Overview

Prior to the birth of S.R., the mother had RCW 13.50.100 involving two different partners and six older children, one of whom is now an adult. Not including the child who is now an adult, three of the children RCW 13.50.100 and the two oldest children RCW 13.50.100. The children RCW 13.50.100 before S.R.'s death. The documented historical concerns relate to the following: RCW 13 50.100

[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)]. Given its limited purpose, a child fatality review (CFR) should not be construed to be a final or comprehensive review of all 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 to replace or supersede investigations by courts, law enforcement agencies or other entities with legal responsibility to investigate or review some or all the circumstances of a child's fatal injury or near-fatal injury. Nor is it the function or purpose of a CFR to recommend personnel action against DCYF employees or other individuals. "The restrictions [described in this paragraph, and the paragraph immediately above,] do not apply in a licensing or disciplinary proceeding arising from an agency's effort to revoke or suspend the license of any licensed professional based in whole or in part upon allegations of wrongdoing in connection with a minor's death or near-fatality reviewed by a child fatality or near-fatality review team." RCW 74.13.640(4)(d).

[2] The names of the children are subject to privacy laws. See **RCW 74.13.500**.

[3] S.R.'s parents and caregivers are named in this report because they have been charged with a crime involving the circumstances described in the report maintained in DCYF's case and management information system. See **RCW 74.13.500**.

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S.R. was born in RCW 74.13.515 2018. On RCW 74.13 515, 2018, the local hospital called DCYF to report that the mother tested positive for RCW 74.13.520. Despite this positive test in RCW 74.13.515, the mother's urine sample tested negative for illegal substances in RCW 74.13.515, upon S.R.'s birth. However, the attending pediatrician was concerned the mother's urine specimen may have been altered because it was not at body temperature and the color was clear. An umbilical cord tissue drug test was ordered by the hospital. DCYF assigned the case for CPS intervention and the intake report was sent to the Tribal Prosecutor's office for the tribe with whom the family is affiliated. Tribal social and health services was not contacted. The mother agreed to services with DCYF and the case was transferred to Family Voluntary Services (FVS).[4]

On December 17, 2018, a referral to **SafeCare®** [5] was made. The provider met with the mother on a few occasions. Most of these meetings occurred outside of the mother's home. The mother failed to fully participate in services and the assigned FVS worker and supervisor became concerned she was using illicit substances. This raised additional concerns for the safety of S.R. DCYF scheduled a Local Indian Child Welfare Advisory Committee (LICWAC[6]) meeting and made contact with the tribe seeking the tribe's participation. At the meeting the mother again agreed to services, including inpatient treatment in RCW 74.13.515. DCYF verbally verified that the mother arrived at the treatment facility, was completing treatment objectives and was sober. It was documented in the treatment provider notes that RCW 74 . While the mother was in the RCW 74.13.515 inpatient facility, the assigned worker did not complete health and safety visitations[7] or make a courtesy supervision[8] referral. In June, 2019, a Native American Inquiry Referral (NAIR)[9] request was made, and in July 2019, the case was closed. DCYF received no other reports until S.R.'s Death in March 2020.

Committee Discussion

The Committee spent considerable time discussing Safecare. The Committee agreed the home-based service model should have occurred primarily in the home. The Committee also agreed that model fidelity was not occurring. The Committee discussed Family Impact Network (FIN).[10] FIN is currently responsible for the DCYF service contracts. FIN began maintaining service contracts for the local office in May 2020. The Committee wondered who holds the providers accountable to the model standards. In the past DCYF, employed program managers who monitored such contracts. However, these positions are no longer in place in many DCYF regions. The Committee discussed that unless a worker or manager

[4] "Family Voluntary Services (FVS) allows parents to voluntarily engage in services to increase their protective capacities and meet the child's safety, health and well-being needs." See **https://www.dcyf.wa.gov/practices-and-procedures/3000-family-voluntary-services-fvs**.

[5] **SafeCare® "**is an evidenced-based home visitation program aimed at reducing child maltreatment among families with a history of maltreatment or risk-factors for maltreatment. SafeCare is a weekly home based service lasting 18-20 sessions for families with a child from age birth to 5 years. The expected outcome is to increase parents' understanding and management of child illness and injuries; increase home safety; and improve and enhance safe parenting skills. The provider reviews the safety plan each week." **https://www.dcyf.wa.gov/services/child-welfare-providers/evidence-based-practices**

[6] LICWAC stands for *Local Indian Child Welfare Advisory Committee*. "The Local Indian Child Welfare Advisory Committees (LICWAC) serve in an advisory capacity to Division of Children and Family Services (DCFS) caseworkers and supervisors by recommending culturally appropriate case plans and services for Indian families. LICWACs offer assistance in the case management of these cases with respect to the needs and rights of Indian children and their families. LICWAC recommendations are included in the court report. LICWAC members are considered volunteers, and are subject to the same confidentiality requirements as Children's Administration (CA) staff." **https://www.dcyf.wa.gov/indian-child-welfare-policies-and-procedures/10-local-indian-child-welfare-advisory-committees**

[7] See **https://www.dcyf.wa.gov/4400-concurrent-tanf-benefits/4420-health-and-safety-visits-children-and-youth-and-monthly-visits**

[8] See **https://www.dcyf.wa.gov/4400-concurrent-tanf-benefits/4430-courtesy-supervision.**

[9] See **https://www.dcyf.wa.gov/indian-child-welfare-policies-and-procedures/3-inquiry-and-verification-childs-indian-status.**

[10] See **http://familyimpactnetwork.org/.**

is aware of the contract requirements and makes a complaint, model fidelity may not be occurring due to lack of monitoring.

The Committee noted missed opportunities to gather additional clarifying information from law enforcement, schools, treatment providers, S.R.'s six older siblings and from other sources within the family's community, including tribal members and neighbors. The Committee discussed the importance of teaming with tribal social and health services to gather information from the tribal community, noting cultural intricacies of which DCYF may not be aware or understand. The Committee believes DCYF should have contacted tribal social and health services earlier, and arranged a LICWAC, and made a NAIR request. The Committee believes it may have improved engagement with the mother, and her engagement into services. This is an important reminder for practice improvement.

The Committee finds that while the mother was in treatment, the local office failed to make a courtesy supervision referral to the RCW 74.13.515 office and did not complete health and safety checks. The Committee views these issues as missed opportunities to provide the family with the level of oversight and support that may have provided an elevated level of intervention. The Committee believes this was a high risk case due to the mother's historical issues, and, to complete a global assessment, an in-person assessment is essential. The Committee believes the CPS and FVS assessments met the minimum requirements for assessing safety. However, the assessment could have been more comprehensive.

The Committee agrees that during the investigation the CPS worker did not accurately complete the Structured Decision Making assessment (SDM).[11] Despite this, the Committee agrees the CPS worker's referral for services was the proper course of action. The FVS supervisor and FVS workers reported they believed the case needed to close within a six-month time frame and relied solely on the LICWAC plan as the official case plan. The official case plan was not included in the Comprehensive Family Evaluation (CFE).[12] The Committee believes there is a lack of understanding of related policies and timeframes. The Committee noted that if warranted, and with administrator approval, FVS cases are authorized to remain open for a longer period of time than typically authorized.

Some Committee members discussed secondary trauma and the challenges DCYF staff face when responding to child fatalities or near-fatalities. Some Committee members also felt it pertinent to document and recognize the daily work-related emotional and mental hardships DCYF staff experience. The Committee discussed how traumatizing situations and incidents can result in grief and other forms of trauma for DCYF staff. For purposes of assisting DCYF staff, DCYF should consider a response to critical incidents that mirrors law enforcement practices. This possible response however, is not an official recommendation.

Findings

The Committee did not identify any critical errors. DCYF's actions and inactions with S.R. and RCW 7 family were not a contributing cause to S.R.'s death.

The Committee found that model fidelity was lacking with a contracted in-home service provider. There is questionable oversight and accountability to ensure providers maintain model fidelity.

[11] "…By completing the SDMRA following the Safety Assessment, the worker obtains an objective appraisal of the risk to a child. The SDMRA informs when services may or must be offered." See **https://www.dcyf.wa.gov/practices-and-procedures/2541-structured-decision-making-risk-assessmentrsdmra.**

[12] See **https://www.dcyf.wa.gov/practices-and-procedures/3000-family-voluntary-services-fvs.**

The Committee found that the staff and supervisors were unsure about policies related to initial contact and engagement with the tribe, courtesy supervision, health and safety and FVS policies.

Recommendations

For purposes of program fidelity, DCYF should assess contract oversight processes and consider program fidelity audit solutions. DCYF should consider providing DCYF staff with a tip sheet or training that provides staff with an awareness of in-home contracted provider requirements, and a process for staff to submit concerns to address model fidelity issues.

The local office should work with the regional program managers to review policies that pertain to initial contact and engagement with the tribe, courtesy supervision, health and safety and FVS time frames.