CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

May 2021

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CONTENTS

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May 2021

Full Report

Child

- T.B.G.

Date of Child's Birth

- RCW 74.13.515 2019

Date of Fatality

- May 9, 2020

Child Fatality Review Date

- August 11, 2020

Committee Members

- Mary Anderson Moskowitz, J.D., Ombuds, Office of the Family and Children's Ombuds
- Tarassa Froberg, Statewide FAR and CPS Program Manager, DCYF
- Sheila Green, MSW, LSWAIC, Region 3 Safety & Health Program Consultant, DCYF
- Kris Freeman, Guardian ad Litem/Advocate Supervisor, Pierce County Juvenile Court
- Trina Hopkins, RN BSN, Public Health Nurse, Public Health Seattle & King County

Observer

- Karen Christensen, M.Ed., QA/CQI Program Manager, DCYF

Facilitator

- Leah Mattos, MSW, Critical Incident Review Specialist, DCYF

Executive Summary

On Aug. 11, 2020, the Washington State Department of Children, Youth, and Families (DCYF)[1] convened a Child Fatality Review (CFR)[2] to examine DCYF's practice and service delivery to T.B.G. and [redacted] family. [redacted] will be referenced by [redacted] initials throughout this report.[3]

On May 9, 2020, the agency was notified by law enforcement that T.B.G. had passed away. Law enforcement responded to T.B.G.'s home after a 911 call was made requesting emergency services for T.B.G. The mother reported she was sleeping on her bed, and T.B.G. was in [redacted] infant seat on top of the bed watching cartoons. She woke up to find [redacted] lying face down on the floor on a pile of clothing and a plastic bag. Blood was coming out of [redacted] mouth. She and her roommate were directed to provide CPR and did so until emergency responders arrived.

Emergency responders took over CPR, and T.B.G. was transported to RCW 74.13.515 Hospital. [redacted] was pronounced dead shortly after [redacted] arrival at the hospital. The medical examiner concluded the death was accidental, caused by positional asphyxia. At the time of this fatality, the family was involved in an open DCYF Child Protective Services (CPS) case.

A diverse Committee was assembled to review the agency's involvement and service provision to the family. The Committee included members with relevant expertise selected from diverse disciplines within DCYF and the community. Committee members had no prior involvement or contact with T.B.G. or [redacted] family. The Committee received relevant case history to include CPS history, case notes, and provider records. On the date of the CFR, the Committee had the opportunity to interview the previously assigned CPS caseworker and supervisor who were involved with this case.

Case Overview

On April 28, 2020, T.B.G. and [redacted] parents first came to the agency's attention after a telephone call from a medical professional reported concerns about T.B.G.'s medical needs not being met by the parents. The medical professional reported that T.B.G. had RCW 74.13.520 [redacted]. T.B.G. also had a medical condition that required RCW 74.13.520. The [redacted] [redacted]. The [redacted] requires ongoing care and routine checks. Despite medical advice, it was reported that the parents stopped using the [redacted]. In addition, T.B.G. had not been seen by [redacted] primary care provider since January 2020 and had limited contact with [redacted] expanded medical support team, including limited contact with [redacted] public health nurse (PHN) and occupational therapist (OT). It was also unclear when T.B.G. was last seen and examined by [redacted] RCW 74.13.520 specialist. It was reported [redacted] was last seen by the OT in mid-March 2020 and by the PHN in March 2020. In March, the mother told the PHN she was no longer using the RCW 74.13.520. On four different occasions, the primary care office

[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)]." 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. 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]The names of T.B.G.'s parents are not used in this report because neither parent has been charged with a crime in connection with the fatality incident. T.B.G.'s name is also not used in this report because of privacy laws. See RCW 74.13.500.

attempted to call the family to check in and schedule an appointment. The mother and father did not respond. The medical office then requested a courtesy law enforcement welfare check for T.B.G. at RCW 7 home, and on April 24, 2020, law enforcement conducted a welfare check. During the welfare check, law enforcement made contact with the father and asked him to follow up with T.B.G.'s doctor.

On April 29, 2020, a CPS caseworker was assigned to investigate these concerns. The CPS caseworker contacted the referent who shared an additional concern that the family may be co-sleeping with T.B.G. and not using Safe Sleep[4] practice. At the request of T.B.G.'s primary care doctor, the CPS caseworker scheduled a medical appointment for T.B.G. Later on the same day the CPS caseworker conducted an unannounced visit with the parents and T.B.G. in their home. The intake allegations were reviewed, and the parents could only recall missing one medical appointment. They believed they had been attending all other necessary appointments. They agreed to attend the doctor appointment that was scheduled by the CPS caseworker. The mother shared information about T.B.G.'s birth and medical history with the CPS caseworker. She also reported they were no longer using RCW 74.13.520 because she believed T.B.G. did not need it. The CPS caseworker observed that the mother appeared to have a good understanding of T.B.G.'s reported medical needs. The CPS caseworker did not notice any infection or signs of concern regarding T.B.G.'s RCW 74.13.520. T.B.G. appeared to be very bonded with RCW 7 mother.

The parents confirmed they had been co-sleeping with the baby because RCW 7 outgrew RCW 7 bassinet. During the visit, Safe Sleep and the Period of Purple Crying[5] were reviewed with the parents. The CPS caseworker offered to purchase a crib and mattress for T.B.G. and the parents agreed. During the interview, the mother denied any mental health needs, criminal history, or substance use. The father RCW 74.13.520 . He denied criminal history and confirmed marijuana use but no other substance use. He reported RCW 74.13.520 . The home did smell of marijuana. The CPS caseworker's safety plan addressed the use of marijuana inside the family home. The father said he tries to smoke outside or in the bathroom.

The parents' roommate was also interviewed during the April 29, 2020, home visit. Despite the fact that the roommate had the opportunity to speak with the CPS caseworker, the roommate was reluctant to share information about T.B.G.'s parents. The CPS caseworker also discussed safe storage for marijuana with the roommate and offered to purchase him a lockbox. The roommate declined the offer and said he stores his marijuana in a location not accessible to his child, who visits the home. The roommate agreed to complete a background check, and this form was provided to him.

Following the home visit, the CPS caseworker ordered the crib and mattress along with a few other household supplies. The CPS caseworker contacted the primary care doctor to discuss the worker's visit with the parents and concerns she discussed with the family. In an effort to gather more information, additional contacts were made with other medical professionals, including the PHN and OT. The CPS caseworker also contacted both

[4]The Safe to Sleep® campaign, formerly known as the Back to Sleep campaign, focuses on actions that can be taken to promote baby safe sleep and to reduce the risk of Sudden Infant Death Syndrome (SIDS) and other sleep-related causes of infant death. See: https://safetosleep.nichd.nih.gov/safesleepba sics/about. To reduce the risk of SIDS and other sleep-related causes of infant death: always place the baby on his or her back to sleep, for naps, and at night; share an adult's room with the baby and keep the baby close to the adult's bed on a separate surface designed for infants; and use a firm and flat sleep surface, such as a mattress in a safety-approved crib*, covered by a fitted sheet with no other bedding or soft items in the sleep area. See: **https://www.nichd.nih.gov/sites/default/files/2019-04/Safe_to_Sleep_brochure.pdf., and https://www.dcyf.wa.gov/safety/safe-sleep. *For information about crib safety, see http://www.cpsc.gov**.

[5]The Period of Purple Crying is a method of helping parents understand the time in their baby's life where there may be significant periods of crying. During this phase of a baby's life they can cry for hours and still be healthy and normal. "The Period of Purple Crying begins at about 2 weeks of age and continues until about 3-4 months of age." See: **http://www.purplecrying.info/what-is-the-period-of-purple-crying.php**.

paternal and maternal relatives to obtain their perspective on how the parents were caring for the baby. The maternal great-grandmother did not report concerns and said T.B.G.'s mother is frequently in contact with her to ask developmental questions. The paternal grandmother reported some concerns and frustration that T.B.G.'s mother is in frequent contact with her to check-in but did not express concerns for T.B.G. She acknowledged the challenges the mother and father were facing, indicating they are young but trying to independently care for themselves and T.B.G.

On May 1, 2020, the CPS caseworker and mother spoke following the baby's medical appointment. T.B.G. had all of [redacted] immunizations updated, and options were discussed with regard to [redacted]. To address [redacted], T.B.G. was referred to a [redacted] specialist and [redacted]. The mother told the doctor that their roommate asked them to move because of the CPS involvement. The doctor gave the mother resource ideas, and the CPS caseworker also sent the parents a local area resource guide. The CPS caseworker told the mother the crib would likely not be delivered until the week of May 8, 2020, but for the interim, she could drop off a pack and play crib. The mother responded that she could get a pack and play crib from a friend and declined the caseworker's offer.

The CPS caseworker also spoke with T.B.G.'s doctor who confirmed the information reported by the mother. The doctor expressed concerns about the possibility of the family losing their housing. The doctor also said she believes the mother could benefit from infant care coaching that may be provided by the public health nurse. However, because of the COVID-19 pandemic, the proposed coaching would have to be limited to virtual visits. The CPS caseworker and doctor did not believe the virtual coaching would be as effective as in-person interaction. Also, on May 1, 2020, a supervisory review of this case was conducted. The supervisory review identified the following next steps: confirm T.B.G.'s sleeping environment with the parents, complete assessments, and complete the investigative assessment.

The CPS caseworker continued to collaborate with the PHN and the OT. The OT also offered to provide the family with housing resource ideas. During a conversation with the PHN on May 5, 2020, the PHN shared that she believed more attention was needed for the mother's mental health, especially due to the mother's lack of local family support. The PHN agreed to help the mother schedule the baby's six-month well-child examination. On May 5, 2020, the CPS caseworker spoke with the mother who reported that the family was seeking their own apartment. They were also considering moving back to [redacted] so they could receive support from her family. T.B.G.'s mother confirmed they did receive the pack and play crib and it was being used by T.B.G. while [redacted] was sleeping. During this conversation, the CPS caseworker again asked the mother about her mental health needs [redacted]. The mother denied [redacted]. They also discussed the possibility of DCYF offering support services to the family; the mother agreed to consider it, but reported feeling overwhelmed by the number of providers that were already assisting the family.

On May 9, 2020, law enforcement notified the agency of the death of T.B.G. The mother reported the baby fell off the bed while she was sleeping. The baby had been sleeping in an infant seat on top of the bed. [redacted] was found face down on the floor, on a pile of clothes and a plastic bag. Efforts to revive T.B.G. were unsuccessful. Law enforcement reported there was not a safe sleep environment for the baby, and there was not a pack and play crib in the home. Law enforcement did not conduct a full investigation. The medical examiner concluded that T.B.G.'s death was accidental. It was noted by the medical examiner that had the baby been more developmentally on task and able to roll over, [redacted] may have been able to prevent asphyxiation. As a result of this fatality, a CPS investigation was generated and was completed. Due to the failure to utilize a safe sleep

environment and provide adequate supervision to ensure T.B.G.'s safety, founded findings for neglect were entered against both parents.

Committee Discussion

After interviewing the caseworker and supervisor, the Committee commends their efforts to assist the parents and to protect T.B.G. The Committee recognizes the caseworker's and supervisor's excellent work during the short time (11 days) the case was open before T.B.G.'s death. Also noted by the Committee were the difficulties faced due to the COVID-19 pandemic and how the CPS caseworker was still able to complete effective work. This was the case despite some of the barriers that have not historically been in existence for DCYF and the community. This case should be highlighted as a model example for how CPS investigations should be implemented.

Among others, one area of this investigation's strength was the collaboration between the CPS caseworker and the medical staff. The CPS caseworker applied what she learned from the medical experts to help guide the investigation, identify what questions should be directed to the parents, and what to look for medically. To ensure there was a continued dialogue in order to ensure T.B.G.'s medical needs were appropriately addressed, the CPS caseworker's contacts with the medical team were extensive and continual. This is a good example of effective collaboration. The Committee also commented on the documentation's thoroughness, timeliness, and how the documentation made a record of the efforts to reach out to all the important collateral contacts. It was also noted by the Committee that the CPS caseworker and supervisor were open to learning from this case and continuing to improve their practice.

The Committee discussed the education provided by DCYF pertaining to Safe Sleep and whether there was anything the agency could have done differently. The Committee felt the agency made appropriate efforts to address this concern regarding co-sleeping education for the parents. The CPS caseworker followed-up with the family to ensure they had set up a safe sleep environment, and the mother confirmed this had been done. A picture was requested of the sleeping environment, but the mother failed to follow through with this request. The CPS caseworker also spoke with the paternal grandmother to confirm T.B.G. had a safe sleep environment. The grandmother resided in the same community as the parents and confirmed that T.B.G. did have a safe sleep environment. Contrary to what the parents told the CPS caseworker, subsequent law enforcement photographs identified that T.B.G. did not actually have a safe sleep environment. Before T.B.G.'s death, the agency ordered a crib, mattress, and a few other household supplies for the family. However, due to the COVID-19 pandemic there were shipping delays that caused the items to not arrive before T.B.G.'s death. The agency also offered an immediate solution by offering to provide a pack and play crib. This was declined because the mother said they already had access to a pack and play crib. Based on reports by the parents that they allowed T.B.G. to sit in RCW 7 chair on the top of the bed to watch television, the Committee suspects that even if the family had a safe sleep environment, they still would have likely placed T.B.G. in RCW 7 chair on top of the bed. The CPS caseworker reported she believes the family made a poor decision that impacted T.B.G.'s safety. The Committee agrees with this statement.

This case demonstrates the importance for DCYF caseworkers to emphasize early, and often, infant safety to the parents. An example from this case includes the CPS caseworker's discussion with the parents about making sure their baby was appropriately buckled in RCW 7 infant seats and swings and not placing T.B.G. in a seat or swing on top of other surfaces. The Committee appreciates the fact that the CPS caseworker recommended to the mother the evidence-based program known as the Project Safe Care Program. This

program would have continued to address safety proofing the home, ensuring the parents were meeting T.B.G.'s developmental needs, addressing T.B.G.'s day-to-day supervision needs, and addressing planned and unplanned emergent situations.

The COVID-19 pandemic presented additional challenges to this case because the pandemic has led to significant practice changes for not only DCYF caseworkers but also providers. The Committee discussed at length the differences between in-person visits in a family's home and virtual visits in a family's home. During the initial visit, the CPS caseworker saw the family face-to-face. However, all other providers involved with the family and T.B.G. were only able to conduct virtual visits. The Committee believes that the quality of interactions associated with virtual visits is significantly hindered. For example, even if a parent agrees or is able to show a virtual video of their home environment or a baby's safe sleep environment, the virtual video is limited to what the parent is willing to show or reveal. Another consideration is the provider's ability to effectively model parenting and infant care. The modeling work is normally conducted during home visits and is typically provided by the OT and PHN. Here, the OT and PHN were unable to conduct home visits.

The Committee noted the OT meeting with the mother and T.B.G. occurred while T.B.G. was sleeping. Even if the visit is a virtual visit, the Committee believes it is critical that a baby be awake and able to interact with the provider and parent. Modeling is a large component of new parent education, and the Committee discussed the limitations associated with attempting to model behavior through a virtual visit. It was suggested by one Committee member that providers should be utilizing personal protective equipment (PPE) and still conducting in-person visits for families who may be identified as having higher needs. Under normal circumstances, DCYF caseworkers collaborate with providers who conduct in-home visits. However, due to the COVID-19 pandemic, the lack of provider in-person visits limits the quality of information a DCYF caseworker is able to gather from the providers.

The Committee discussed the importance of unannounced in-person visits. Unannounced visits are typically conducted by DCYF caseworkers. These types of visits are important because otherwise unknown information may be gathered from the visit. The CPS caseworker was able to complete only one unannounced visit during the time the case was open. The CPS caseworker reported she observed a significant decline in the home's condition between the initial visit and the home's condition 11 days later on the date T.B.G. died.

One area the Committee identified that could have been expanded during this investigation was the assessment of the parents' roommate. DCYF caseworkers are required to assess all individuals who reside at the family home or who may have unsupervised access to the child. The Committee recognizes this case was only open for 11 days and efforts were started to assess this individual. The Committee would have liked to see additional follow-up with regard to the roommate. The CPS caseworker did interview the parents' roommate, who was very guarded about sharing information about himself and the parents. During the Committee's interview of the CPS caseworker, the worker said the roommate was displeased about the parent's involvement with CPS [redacted RCW 13.50.100]. For information gathering purposes, the Committee understands that the CPS caseworker did a database search for the parents, but not the roommate. The Committee would have liked to have seen a database search for the roommate. Again, the Committee does recognize the short time period this case was open before the death of T.B.G., and understands the search may have occurred if there had been more time to do so.

Marijuana use was identified as a concern during the initial visit with both the parents and the roommate. The CPS caseworker told the Committee that she gathered initial information, discussed safety measures that

were needed in the home to protect T.B.G., and offered a lockbox for marijuana storage. The lockbox was ordered on the same date as the initial visit. The CPS caseworker also told the Committee she had a plan that had been staffed with her supervisor, including a request for a urinalysis sample from the father in an effort to establish a marijuana usage baseline. Depending on the urinalysis result, the CPS caseworker was prepared to refer the father for additional services. A urinalysis did not occur because of the limited length of time the case was open. The Committee believes the caseworker was on the right track for how to address this issue.

The Committee had a thought-provoking discussion about marijuana use and how DCYF addresses such use. Issues discussed included how to assess substance use, including marijuana, as it relates to the ability to parent, and the fact that parents may not be truthful about their substance use due to fear of ongoing CPS involvement. Another stigma associated with marijuana is that because it is now legal in Washington State, it may be felt that is no longer an issue as it relates to parenting. The Committee identified a few areas they believe are important for continuing to improve DCYF's work associated with substance use. First, the use of a harm-reduction model that does not include shaming or blaming but is based on trauma-informed care and information gathering. Second, the use of education and how agencies, such as DCYF, are educating clients about the risks associated with marijuana use and parenting. One Committee member mentioned their belief that most parents want substance use education and want to be the best parents possible. The Committee believes DCYF has an obligation to provide this type of information to parents who are involved with CPS.

The Committee had an extensive conversation about the impacts and difficulties the COVID-19 pandemic has had on DCYF, community providers, medical professionals, and parents. This discussion was woven into all aspects of the topics the Committee reviewed. The COVID-19 impacts are caused in part by the rapid changes in practice experienced by DCYF to keep families, communities, and DCYF staff safe. The CPS supervisor for this case agreed with the Committee that caseworkers are unsung heroes as a result of the pandemic. For example, despite the pandemic, caseworkers have still been going out to families' homes to investigate and protect the most vulnerable populations. DCYF has faced additional challenges, including training delays due to the COVID-19 response. These delays have led to staff shortages. In this particular office and unit, there were only two CPS investigators who were available to complete investigations because other new hires had been waiting to attend mandatory training since January 2020. Those trainings were finally completed in August 2020. Due to another DCYF office's staff shortage, the office discussed in this report was also supporting the other office with CPS investigations.

Findings

The Committee finds there was nothing the agency could have done to prevent the tragic death of T.B.G.

The Committee finds that the work done on this case is an example of how policy and practice should be implemented to complete thorough and effective investigations. The CPS caseworker demonstrated strong investigative skills, effective collaboration with community-based providers, and excellent documentation skills.

Despite the very short length of time this case was open (11 days), the Committee would have liked to have seen a more thorough assessment of the parents' roommate. While there was an initial discussion with the roommate, who was guarded and shared limited information, there was no further follow-up. The Committee would have liked for the CPS caseworker to complete a Famlink and database check on this individual, in addition to running an NCIC Code X background check.

Recommendations

In an effort to continue moving casework practice forward, the Committee makes the following recommendations:

DCYF should identify evidence-based literature about marijuana use and the impacts on parenting. Once identified, the literature should be made widely available and shared with field offices so that DCYF caseworkers can disseminate this information to the families and clients served by DCYF.

It is recommended that DCYF policy specifically address virtual home visits with families to ensure the agency is able to assess safety to the best of its ability. The policy should include language specifically allowing DCYF to request that parents be able to show their home environment, including a safe sleep environment. A picture of the home/safe sleep environment is less preferable but also acceptable. The policy should include language about the agency's response, including allowing for an in-person visit if a parent refuses to allow a virtual visit or refuses to send pictures of the home environment. Under this in-person visit option, the caseworker must wear personal protective equipment (PPE). If a virtual visit is impossible because the parent does not have the necessary technology, the agency should work to provide technological access to facilitate the visit.