QUARTERLY CHILD REVIEW RCW 74.13.640 JANUARY–MARCH 2020

Washington State Department of
CHILDREN, YOUTH & FAMILIES

Washington State Department of CHILDREN, YOUTH & FAMILIES

Contents

Executive Summary

This is the Quarterly Child Fatality Report for January through March 2020, provided by the Department of Children, Youth, and Families (DCYF) to the Washington State Legislature. RCW 74.13.640 requires DCYF to report on each child fatality review conducted by the department and provide a copy to the appropriate committees of the Legislature.

Child Fatality Review — Report

(1) (a) The department shall conduct a child fatality review in the event of a fatality suspected to be caused by child abuse or neglect of any minor who is in the care of the department or receiving services described in this chapter, or who has been in the care of the department or received services described in this chapter within one year preceding the minor's death.

(b) The department shall consult with the Office of the Family and Children's Ombudsman to determine if a child fatality review should be conducted in any case in which it cannot be determined whether the child's death is the result of suspected child abuse or neglect.

(c) The department shall ensure that the fatality review team is made up of individuals who had no previous involvement in the case, including individuals whose professional expertise is pertinent to the dynamics of the case.

(d) Upon conclusion of a child fatality review required pursuant to this section, the department shall within one hundred eighty days following the fatality issue a report on the results of the review, unless an extension has been granted by the governor. A child fatality review report completed pursuant to this section is subject to public disclosure and must be posted on the public web site, except that confidential information may be redacted by the department consistent with the requirements of RCW 13.50.100, 68.50.105, 74.13.500 through 74.13.525, chapter 42.56 RCW and other applicable state and federal laws.

(2) In the event of a near fatality of a child who is in the care of or receiving services described in this chapter from the department or who has been in the care of or received services described in this chapter from the department within one year preceding the near fatality, the department shall promptly notify the office of the family and children's ombuds. The department may conduct a review of the near fatality at its discretion or at the request of the office of the family and children's ombuds.

In October 2011, SHB 1105 was passed by the Legislature and signed into law by Governor Gregoire. The revised child fatality statute (RCW 74.13) became effective October 22, 2011, and requires the department to conduct fatality reviews in cases where a child’s death is suspected to be caused by abuse or neglect. This eliminated conducting formal reviews of accidental or natural deaths unrelated to abuse or neglect. The revised statute requires the department to consult with the Office of Family and Children’s Ombuds (OFCO) if it is not clear that the fatality was caused by abuse or neglect. The department can conduct reviews of near-fatalities or serious injury cases at the discretion of the department or by recommendation of OFCO. The statutory revision allows the department access to autopsy and post mortem reports for the purpose of conducting child fatality reviews.

This report summarizes information from completed reviews of two child fatalities and one near-fatality[1] that occurred in the first quarter of 2020. All child fatality reviews can be found on the **Child Fatality & Serious Injury Reports** page of the DCYF website.

The data in this quarterly report includes both child fatalities and near fatalities from three of the six regions (DCYF divides Washington State into six regions). Previous quarterly fatality reports reflect three regions when child welfare was administered within the Department of Social and Health Services: Children's Administration.

DCYF Region	Number of Reports
Region 1	0
Region 2	0
Region 3	1
Region 4	1
Region 5	0
Region 6	1
Total Fatalities and Near Fatalities Reviewed During First Quarter 2020	3

This report includes Child Fatality Reviews (exhibit A) and Near Fatality Reviews (data only) conducted following a child's death or near-fatal injury that was suspicious for abuse and neglect, and the child had an open case or received services from DCYF within the 12 months prior to the child's death or injury. A critical incident review consists of a review of the case file, identification of practice, policy or system issues, recommendations and development of a work plan, if applicable, to address any identified issues. A review team consists of a larger multidisciplinary committee, including community members whose professional expertise is relevant to the family history. The review committee members may include legislators and representatives from OFCO.

The following charts provide the number of fatalities and near-fatalities reported to DCYF as well as the number of reviews completed and those that are pending for calendar year 2020. The number of pending reviews is subject to change if DCYF discovers new information by reviewing the case. For example, DCYF may discover that the fatality or near-fatality was anticipated rather than unexpected, or there is additional DCYF history regarding the family under a different name or spelling.

[1] Near-fatality reviews are not subject to public disclosure and not posted on the public website, nor are the reviews included in this report.

Child Fatality Reports for Calendar Year 2020			
Year	Total Fatalities Reported to Date Requiring a Review	Completed Fatality Reviews	Pending Fatality Reviews
2020	3	1	2

Child Near-Fatality Reports for Calendar Year 2020			
Year	Total Near-Fatalities Reported to Date Requiring A Review	Completed Fatality Reviews	Pending Fatality Reviews
2020	9	1	8

The child fatality reviews referenced in this Quarterly Child Fatality Report are subject to public disclosure and are **posted on the DCYF website**.

Near-fatality reports are not subject to public disclosure and are not posted on the public website, nor are the near-fatality reviews included in this report.

Notable First Quarter Findings

Based on the data collected and analyzed from the two child fatalities and one near-fatality during the first quarter, the following were notable findings:

- Two of the three cases referenced in this report were open at the time of the child's death or near fatal injury.
- In all three of the cases, the children were three years old or younger at the time of death or near fatal injury.
- There were no deaths of infants due to unsafe sleep environment.
- In the two child fatalities, both were suspicious for inflicted injury.
- One near-fatality case was due to an overdose of opiates. This child was three years old at the time of the incident.
- One fatality had been closed for eight months prior to the child's death. All other cases referenced in this report were open when the death or near fatal injury occurred.
- Two children referenced in this report were White, one was African American.
- Substance abuse and physical abuse were identified risk factors in two of the three cases; domestic violence was a significant risk factor identified in one case in this report.
- DCYF received intake reports of abuse or neglect in each of the cases in this report prior to the death or near fatal injury of the child. In one of the cases, there were two prior reports made regarding the family. In another fatality case, there was one intake report on the family prior to the critical incident. In the one near fatality case, the department received three prior reports.

Due to the small sample of cases reviewed, no statistical analysis was conducted to determine relationships between variables.

Exhibit A

Child Fatality Reviews

The child fatality reviews referenced in this Quarterly Child Fatality Report are subject to public disclosure and are **posted on the DCYF website**.

Exhibit A contains the following child fatality reviews from the first quarter of 2020:

- **S.M. Child Fatality Review**
- **A.H. Child Fatality Review**

CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

October 2019

Washington State Department of
CHILDREN, YOUTH & FAMILIES

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Nondiscrimination Policy
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.

CHILD FATALITY REVIEW

Washington State Department of
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Full Report

Child

- A.H.

Date of Child's Birth

- [redacted] 2018

Date of Fatality

- September 2019

Child Fatality Review Date

- December 19, 2019

Committee Members

- Lafaitele Lydia Faitalia, Washington State Commission on Asian Pacific American Affairs, Commissioner
- Loyal Higinbotham, Everett Police Department, Sergeant Sexual Assault Unit
- Nina Meyers, DCYF, Child Protective Services Supervisor
- Elizabeth Bokan, JD, Office of the Family and Children's Ombuds, Ombud

Observer

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

Facilitator

- Libby Stewart, DCYF, Critical Incident Review Specialist

Executive Summary

On Dec. 19, 2019, the Department of Children, Youth, and Families (DCYF)[1] convened a Child Fatality Review (CFR)[2] to assess DCYF's service delivery to A.H. and [redacted] family.[3] [redacted] will be referenced by [redacted] initials throughout this report.

On Sept. 14, 2019, DCYF received a telephone call reporting that two men, A.H. and A.H.'s mother arrived at a hospital. One of the men left the hospital immediately after arriving. When [redacted] arrived, A.H. was not breathing and [redacted] skin was bluish in color with a large bruise on [redacted] left eye and bruising on [redacted] lower back. The hospital staff was unable to resuscitate [redacted] and [redacted] was pronounced dead at the hospital. At the hospital, law enforcement initiated a death investigation and interviewed all adults. This information screened in for a child protective services (CPS) investigation. After the CPS investigation was completed, DCYF entered a founded finding for physical abuse and negligent treatment against A.H.'s mother. The criminal investigation had not concluded at the time the CPS case was closed.

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 A.H. 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 CPS worker, her supervisor, the family voluntary services (FVS) worker and her supervisor.

Case Overview

On Oct. 10, 2018, DCYF received a telephone call reporting that during the previous week, A.H.'s mother brought the baby to the father's worksite. It was a hot day and the baby was wrapped in blankets and had a lot of clothing on. The baby appeared to be in distress, so the site supervisor asked the parents to take the baby's clothes and blankets off. The baby had a heat rash from head to toe and some skin discoloration that may have been bruises. The caller reported the parents did not appear to understand how distressed the baby was. On October 10, the father was at a work meeting and was asked about the baby. He reported he did not know how the baby was doing because they had given [redacted] to friends for a month. This intake was screened in for a CPS investigation, Risk Only.[4]

On Oct. 11, 2018, the CPS worker initiated contact with the parents at their home. The parents reported the heat rash was healed and they were given a cream to put on A.H.'s body. The parents stated A.H. was staying for a month with [redacted] maternal grandparents who are located in 74.13.515 The mother

[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 child care 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]No one has been criminally charged related to A.H.'s death, therefore no one is named in this report.

[4]Screen in CPS Risk Only reports when a child is at imminent risk of serious harm and there are no CA/N allegations. See: https://www.dcyf.wa.gov/practices-and-procedures/2200-intake-process-and-response

provided her parents' address to the CPS worker, and said the grandparents do not have a phone. According to the CPS worker's documentation, the parents appeared to have some developmental delays. A courtesy request was made for DCYF staff to contact the maternal grandparents in 74.13.515

That same day, a CPS worker contacted the maternal grandparents at the grandparents' home. A.H. was sleeping when the worker arrived. The worker educated the grandparents regarding the condition A.H. was found sleeping in. The worker observed a concerning mark on A.H.'s face, and the grandparents said 74.13.51 scratched 74.13.51 self. The CPS worker was concerned that it was not a scratch and asked the grandparents to have A.H. seen by a physician. The grandparents agreed. The CPS worker discussed safe sleep,[5] offered a Pack 'n Play and clothes. The grandparents were receptive to the worker's safe sleep advice, the Pack 'n Play and clothes.

The CPS worker who contacted the parents, contacted the referent to discuss the intake. The referent expressed additional concerns about the fact that the parents are young and it appears the father often doesn't know how to care for the baby. The referent said there are many people at the worksite that are concerned about the father's functioning.

On Oct. 12, 2018, the CPS worker made another contact with A.H. at the grandparents' home. The grandparents said they did not have any concerns for their 74.13.515 when 74.13.51 was under 74.13.51 parents' care, they would be returning A.H. to 74.13.51 parents in three days and the grandmother reported she goes over to the parents' home every few weeks and stays for two weeks at a time. Despite staying with the parents for two weeks at a time, the grandparents have no concerns if the parents parented full-time without the grandparents' assistance. The scratch appeared to be healing.

On Oct. 18, 2018, with A.H. present, the CPS worker interviewed both parents. The worker discussed safe sleep and the Period of Purple Crying (PPC).[6] The mother reported she has previously seen the PPC video and is aware of what safe sleep means. The mother reported that A.H. may sleep on the mother for naps, otherwise 74.13.51 sleeps in 74.13.51 crib. A.H. had scratches on both sides of 74.13.51 cheeks and appeared to have dry skin. The worker observed a diaper change and observed a rash but no bruising.

During the interview, the mother denied any CPS history as a child, indicated she had no history of mental health issues and no criminal, medical or substance use issues. She said she has previously used 13.50.100 but has control of her use. She denied domestic violence. The mother reported that when she saw the rash on 74.13.515 she took 74.13.51 to the doctor. The mother was able to provide the prescribed cream the doctor told her to use. The mother declined an offer for DCYF parenting classes, but did request vouchers for baby items.

During the interview, the father also denied any mental health issues, criminal history, medical conditions or domestic violence. He also declined the parenting classes offer, and provided the same history regarding the rash.

The CPS worker conducted a walk-through of the home. There was a 13.50.100 odor in the bathroom, but no other concerns were identified. The worker requested that the mother take A.H. to the emergency room to have the scratches and rash looked at. The parents agreed to this request.

[5] See: https://www.cdc.gov/vitalsigns/safesleep/index.html
[6] See: http://www.purplecrying.info/

Photographs were taken of A.H. and uploaded into FamLink, DCYF's electronic child welfare database.

The CPS worker requested medical records. Upon receiving the records, the CPS worker reviewed them and found no concerns. The CPS worker contacted the parents' WorkFirst case manager[7] and invited the worker to attend a meeting with the parents to discuss FVS. The CPS worker also connected with the Community Services Office (CSO) workers to discuss the family's needs and concerns.

On Oct. 25, 2018, the CPS worker attempted an unannounced home visit to meet with the parents, discuss FVS and drop off vouchers. No one answered the door. On the following day, the CPS worker was able to meet with the mother and A.H. at their home. While the previously observed scratches appeared to be healing, A.H. appeared to have new scratches on [redacted] head. The mother reported A.H. scratched [redacted] self during bath time.

On Oct. 30, 2018, the case was transferred to the FVS worker. The FVS worker immediately initiated email contact with the mother. The email notified the mother that the case was transferred and that she would like to meet with the parents. On Nov. 6, 2018, the FVS worker conducted a health and safety visit at the parents' home. The mother and A.H. were present but the father was at work. The FVS worker observed an unsafe sleep environment and discussed this with the mother. The mother told the FVS worker that to make more room she puts the Pack 'n Play away during non-sleep times. The mother was able to verbalize safe sleep practices. She denied bed-sharing with A.H.

The FVS worker offered voluntary services. However, the mother declined the offer. During a diaper change, the FVS worker observed a small, dark mark on A.H.'s buttock. The mother said this was a birthmark. The FVS worker asked if this was documented in the medical records and the mother was unsure. They called the primary care clinic who reported the mark is not documented in the clinic's notes. The mother agreed to take [redacted] to the clinic for examination the same day the FVS worker observed the mark. The FVS worker also texted the CPS worker to ask about the mark. The CPS worker did not recall seeing it and reported there was no mention of the mark when she reviewed all the medical records. The FVS worker discussed the need to have this documented in the child's medical record and the mother indicated she understood and agreed.

On Nov. 11, 2018, the FVS worker conducted an unannounced home visit. The worker attempted to email the mother but did not receive a response. The mother and A.H. were home. The mother provided the FVS worker with medical documentation about the examination and mark, as well as statements from the provider that a photograph was taken and placed in the medical record. The FVS worker observed a diaper change and did not see any change to the mark. The mother continued to state she did not want to engage in any services with DCYF. She shared that her mother was coming to stay for a visit. The FVS worker again observed unsafe sleep at the home and discussed this with the mother. The mother was again able to state what safe sleep practices were and that the items in the Pack 'n Play were there just to get them off the floor.

On Nov. 13, 2018, the FVS worker sent another email to the mother. There was no response to this email. The FVS worker conducted another unannounced home visit on Nov. 15, 2018. The mother and A.H. were home. A.H. was observed during a diaper change. There were no concerns noted, and the

[7] "WorkFirst is Washington's welfare reform program designed to help parents get what they need to prepare for and go to work. It is a partnership between state agencies and communities to work together to provide the necessary services and resources families need to be successful." See: https://workfirst.wa.gov/about-us

spot on A.H.'s buttock remained the same. Safe sleep was again discussed as the FVS worker observed continued concerns. The FVS worker discussed voluntary services again and mentioned having a meeting to discuss the services. The mother continued to state she did not want services. The FVS worker called her supervisor and discussed this with the supervisor and mother. The mother requested that her case be closed. After some discussion, the supervisor agreed that DCYF would close the case.

On Sept. 14, 2019, DCYF received a telephone call regarding A.H.'s death.

Committee Discussion

There has been a growing number of 74.13.515 residents moving to Washington. Just over 10 years ago, A.H.'s mother and maternal grandparents moved from the 74.13.515 to the United States. The mother was about 9 years old when she moved to the U.S. Concerning translation and education services, there appears to be limited resources available to assist this population. As an example, there are only two certified interpreters for the entire state of Washington. The Committee also learned about many other areas related to persons coming from the 74.13.515 that may have impacted interactions and engagement with this family. However, the Committee was very clear in its conclusion that these issues did not contribute to A.H.'s death. The Committee addresses this issue in the recommendation section below.

The Committee believes it would have been appropriate for DCYF to have conducted individual interviews with the parents about domestic violence, follow up with the father regarding the mother's statements about him using 13.50.100 in the home and obtain additional assessments of the parents' functioning capabilities. The Committee also discussed that it would have been appropriate to request a urinalysis based on the smell of 13.50.100 in the home.

Also discussed was the challenge faced by DCYF due to some law enforcement agencies changing to how the criminal investigations of child deaths are conducted. Some law enforcement agencies have decided to have their homicide units investigate child deaths when previously these cases were investigated by units that worked closely with DCYF CPS workers. This change has contributed to a loss of communication, cohesive and collaborative investigations. This case was one where this challenge was presented. It did not impact the DCYF case significantly but was discussed by the Committee.

The Committee also discussed the consistent and persistent discussion and documentation about safe sleep issues. The unannounced home visits and continued attempts to engage the parents in voluntary services were also examples of positive case practice. The Committee appreciated that while there was not an identified need to offer voluntary services through the Structured Decision Making Tool,[8] the CPS and FVS workers believed the parents would benefit from the ongoing support and continued to try and engage the parents.

[8] The Structured Decision Making Risk Assessment (SDMRA) is a household-based assessment focused on the characteristics of the caregivers and children living in that household. 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

Findings

The Committee finds that both the CPS and FVS workers did a very good job engaging with the mother. There was clear and consistent contact and good documentation of those conversations.

Recommendations

The Committee did not believe any lack of education or understanding surrounding the 74.13.515 community impacted this case. However, the Committee was educated about the continued migration of this community to Washington State and the complexities surrounding this. The Committee recommends that DCYF obtain training and/or education for staff regarding the 74.13.515 and this population's culture. This training should be available statewide for staff and could be provided by an expert or offered in an e-learning format.