CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

July 2021

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July 2021

Full Report

Child

- D.B.

Date of Child's Birth

- RCW 74.13.515 2020

Date of Fatality

- Oct. 19, 2020

Child Fatality Review Date

- Jan. 27, 2021

Committee Members

- Cristina Limpens, MSW, Office of the Children and Families' Ombuds, Senior Ombuds
- Stephanie Widhalm, MSW, LICSW, MHP, CMHS, Partners with Families and Children, Children's Advocacy Center, Director
- Molly Rice, BSW, Department of Children, Youth & Families, Quality Practice Specialist
- Carole Pickett, MA, Supervisor, Harbor Counseling LLC

Facilitator

- Cheryl Hotchkiss, Department of Children, Youth & Families, Facilitator

Executive Summary

On Jan. 27, 2021, the Department of Children, Youth, Families (DCYF, agency) convened a Child Fatality Review (CFR)[1] to assess the agency's service delivery to D.B. and RCW 7 family.[2]

On Oct. 21, 2020, the agency received notification from a local hospital that the parents had taken D.B. to the father's home and practiced unsafe sleeping arrangements resulting in D.B.'s death. The parents and responsible relatives failed to follow the agency's agreed safety plan that included safe sleep practices and the prohibition of unsupervised contact between the parents and D.B. During the writing of this report, the law enforcement investigation was pending and toxicology results from the medical examiner had not been received. Medical records cite D.B.'s cause of death as cardiac arrest.

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 D.B. or RCW 7 family prior to the fatality. The Committee received a case chronology and other relevant documents, including intakes, case notes, medical records, and other agency documents maintained in the agency's electronic computer system.

The Committee interviewed a Child Protective Services (CPS) investigative caseworker and CPS supervisor.

Case Overview

After D.B. was born in RCW 74.13.515 2020, the agency opened a CPS investigation because D.B.'s mother tested positive for RCW 74.13.520 and RCW 74.13.520 On Sept. 1, 2020, the primary CPS caseworker and a senior caseworker made initial contacts with the hospital staff, the mother, the father, and two grandparents. The mother denied drug use despite her positive test at the hospital. She did not take responsibility for her positive test despite contrary evidence. D.B.'s mother was provided education on drugs that she tested positive for and that refuted her denials. While speaking with the CPS caseworkers at the hospital, the father was observed having perpetual eye movement, constricted pupils, conversing in half sentences, and having limited recall regarding historical times and dates. The father denied drug use and disclosed a history of RCW 13.50.100 services stemming from a previous relationship. The parents agreed to complete urinalysis testing and attend a Family Team Decision Making Meeting (FTDM).[3] The CPS caseworkers obtained the names and contact information of multiple relatives for collateral contacts and family support.

On Sept. 2, 2020, an FTDM was held. The parents admitted to recent RCW 74.13.520 use. The mother said she uses RCW 74.13.520 once per month. The meeting participants and agency agreed that D.B. would live with RCW 7 mother at the maternal grandmother's home once RCW 7 was discharged from the hospital. Both

[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 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 the agency or its contracted service providers.

The Committee has no subpoena power or authority to compel attendance and generally only hears from agency employees and service providers. It does not hear the points of view of the child's parents and relatives, or of other individuals associated with the child. A CFR is not intended to be a fact-finding or forensic inquiry or to replace or supersede investigations by courts, law enforcement agencies, or other entities with legal responsibility to investigate or review some or all of the circumstances of a child's near fatal injury. Nor is it the function or purpose of a CFR to recommend personnel action against agency employees or other individuals.

[2] No one is named in this report because no one has been charged with a crime in connection with the fatal injuries.

[3] For a description of the family team decision making meetings process, see **https://www.dcyf.wa.gov/1700-case-staffings/1720-family-team-decision-making-meetings**.

parents agreed to participate in family voluntary services (FVS),[4] including Intensive Family Preservation Services (IFPS),[5] substance use assessments and services, home visitations, and a safety plan.[6] The safety plan was developed and the parents and maternal grandmother agreed to the terms. The safety plan included terms and conditions that required the parents to (1) demonstrate sobriety; (2) demonstrate the ability to safely care for D.B.; (3) participate in IFPS while adhering to provider recommendations; (4) ensure D.B. attend all medical and health appointments; (5) agree that prior agency approval of D.B.'s caregivers is required; (6) agree that the maternal grandmother will have responsibility for the care and supervision of D.B. (parents must be supervised when with D.B.); and (7) agree that all caregivers must ensure a safe sleep environment for the child. D.B. was discharged from the hospital on the same date as the FTDM.

On Sept. 22, 2020, the IFPS provider reported that the mother was engaging and doing well in services, and being appropriate with D.B. The provider believed the mother would do well for a day or two if she was allowed to care for D.B. on her own. The provider notes show there were conversations with the parents about safe sleep practices.

On Sept. 23, 2020, a supervisory case review[7] note indicates that safe sleep was discussed with all safety plan participants. Also discussed was the father's lack of engagement in IFPS services and substance use services. It was noted that the safety plan needed to be modified because the maternal grandmother was going to return to work. The supervisor indicated that the caseworker should coordinate with the IFPS provider to allow the mother some unsupervised contact with D.B. after the collateral contacts indicated no outstanding concerns. It was suggested that the extended family may be possible support resources while the grandmother was at work.

On Oct. 6, 2020, the assigned caseworker noted that the IFPS was ready for closure, and the Parent-Child Assistance Program (PCAP)[8] was approved for the next three years. The caseworker documented that the mother's substance tests were negative and that there was no evidence the father participated in substance testing or assessments.

On Oct. 20, 2020, the assigned caseworker received a message from a child speech development provider that D.B. died over the weekend. The grandmother reported to the provider that D.B. died from sudden infant death syndrome (SIDS) while in the care of the mother and father at the father's home. The grandmother told the provider that according to the mother, it was permissible for the mother and D.B. to be at the father's home. The assigned worker made a report to the agency on Monday, Oct. 21, 2020, about D.B.'s death.

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[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] Intensive Family Preservation Services (IFPS) are "Provided to families whose children, without intervention, are at *imminent risk* of entry into the dependency system due to child abuse, neglect, family conflict, or threats of harm to health, safety, or welfare. See **https://app.leg.wa.gov/ReportsToTheLegislature/Home/GetPDF?fileName=IFPSFPS_4b0935b1-70dd-4233-b2d6-598768cc82ac.pdf**. IFPS services are "Also provided to help reunify children with their families." Id. IFPS is also "Focused on providing intensive therapeutic services and building connections with supportive community programs so families in crisis may be able to remain together safely. Services are available within 24 hours of referral and offered for up to 90 days." Id. See also **https://www.dcyf.wa.gov/4500-specific-services/4502-intensive-family-preservation-services-ifps-family-preservation**.

[6] "A safety plan is a written agreement between the family and DCYF that identifies how safety threats to a child will be immediately controlled and managed in the child's home. Safety plans are effective as long a threat to a child's safety exists and the caregiver's protective capacities are insufficient to protect the child." See: **https://www.dcyf.wa.gov/1100-child-safety/1130-safety-plan**.

[7] For a description of the supervisor case review process, See **https://www.dcyf.wa.gov/4600-case-review/46100-monthly-supervisor-case-reviews**.

[8] "The Parent-Child Assistance Program (PCAP) is an award-winning, evidence-informed home visitation case-management model for pregnant and parenting women with substance use disorders. PCAP goals are to help mothers build healthy families and prevent future births of children exposed prenatally to alcohol and drugs." See **https://depts.washington.edu/pcapuw/.**

Committee Discussion

Favorable discussion of the caseworker's documentation occurred throughout the Committee's discussion. The Committee heard from the primary caseworker that not all of the contacts made during the investigation were entered into the computer database. Regardless, the Committee appreciated the case notations that were entered. The Committee opined that the documentation of an initial conversation with the parents' challenging explanations about substances in the mother's and D.B.'s urine was necessary. The Committee appreciated that the documentation provided a clear picture of what occurred and how policy standards were met for the family's initial child safety assessment. The Committee heard from the supervisor that an experienced caseworker was sent with the primary caseworker to assist and support during the initial contacts. The primary caseworker was considered a novice in investigative casework. The Committee viewed this decision as impressive, commending the supervisor's ability to recognize needs and support the caseworkers.

The Committee noted that the child was not seen in the home of the grandparents or parents and that perhaps that would have provided useful information. The caseworker added that relying on the grandmother and IFPS provider to monitor the safety plan may have led to some ambiguity of the agency's role and safety plan requirements. The Committee agreed with the primary caseworker that it is important to emphasize the roles and specific responsibilities of the participants in the plan. The Committee was concerned that the plan relied on the grandmother to identify and report the mother's concerning behaviors. The Committee was unsure of the grandmother's ability to identify concerning behaviors, noting that the grandmother had not been aware of the mother's drug use prior to D.B.'s birth. The Committee added that the IFPS provider's role in the safety plan was unclear. The Committee believed that specifics related to D.B.'s physical safety as well as expectations regarding contact between the child and each parent should have been clearly outlined and monitored. The Committee believed that additional contact and assessment of the father may have benefited the overall family assessment and safety plan.

The Committee opined that it is necessary for caseworkers to actively monitor safety plans. The Committee believes that ineffective and/or insufficient safety planning and monitoring is a concerning trend within the agency. During the discussion about available training for caseworkers and supervisors, the Committee discussed the disconnect between what is learned in the training versus how the training concepts are applied to actual cases. The Committee was provided information from the facilitator and DCYF program that the agency is facilitating conversations with training partners and internal workgroups focused on the safety framework. The Committee believes the agency should continue to actively address safety planning and monitoring with supervisors and caseworkers.

Findings

The Committee finds that the safety plan monitoring policy was not followed in this case and that many agency staff are not proficient in developing effective safety plans. However, this did not play a role in, or cause the death of D.B.

Recommendations

The Committee heard from the agency that various safety assessment and planning trainings are available to supervisors and staff. In addition, the agency is in the process of forming workgroups to address the topic of safety assessment and planning efficacy. The Committee had no recommendations.