WASHINGTON STATE
Department of
Children, Youth, and Families

CHILD FATALITY REVIEW

December 2018

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FULL REPORT

CHILD

- E.T.

DATE OF CHILD'S BIRTH

- RCW 74.15.515 2017

DATE OF FATALITY

- July 2018

CHILD FATALITY REVIEW DATE

- October 18, 2018

COMMITTEE MEMBERS

- Mary Moskowitz, JD, Ombuds, Office of the Family and Children's Ombuds
- Amy Boswell, Child Protective Services (CPS) Program Manager, Department of Children, Youth, and Families
- Melanie Terrill, CPS/Family Assessment Response Supervisor, Department of Children, Youth, and Families
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EXECUTIVE SUMMARY

On October 18, 2018, the Department of Children, Youth, and Families[1] (DCYF or Department) convened a Child Fatality Review (CFR)[2] to assess the Department's practice and service delivery to E.T. and [redacted] family.[3] [redacted] will be referenced by [redacted] initials throughout this report.

On July 7, 2018, the Department received a telephone call from a hospital alleging E.T. was neglected by [redacted] mother and her boyfriend. Paramedics brought E.T. to the hospital where [redacted] was declared deceased. E.T.'s mother reported that in the morning, shortly after she awakened, she observed E.T. and determined [redacted] was unresponsive. The mother's boyfriend started chest compressions and called 911. The mother shared details of the events from the previous evening and that morning. The mother stated she felt something was wrong because she did not check on her child before bedtime. Law enforcement was contacted and started an investigation. This intake was assigned for a Child Protective Services (CPS) investigation. At the conclusion of the CPS investigation, the Department issued founded findings for negligent treatment or maltreatment to both the mother and her boyfriend.

At the time of [redacted] death, E.T. lived with [redacted] mother, maternal grandfather, maternal step-grandmother, and the maternal step-grandmother's teenage child. There had been two recent CPS/Family Assessment Response (FAR) assessments regarding E.T.[4] On May 10, 2018, those assessments were approved for closure.

The CFR Committee (Committee) included members selected from diverse disciplines within the community with relevant expertise including individuals from the Office of the Family and Children's Ombuds, law enforcement, and child welfare. Extensive efforts were made to include a person from the deaf and hard of hearing community to also sit on the Committee. Those efforts were unsuccessful. The Committee members did not have any involvement or contact with E.T. or [redacted] family.

The Committee interviewed the CPS worker, the CPS supervisor, and the area administrator. Due to the Committee's responsibility to focus on events prior to the critical incident, the Committee chose not to interview the CPS worker who investigated the fatality. When the first intake was received, the CPS worker was supervised by an interim supervisor. This person did not have any recollection of the case and was not asked to attend the review. At the time of the second intake, the CPS worker's primary supervisor had returned and was present throughout the conclusion of the case.

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[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 early learning programs).

[2] Given its limited purpose, a 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] E.T.'s parents and the mother's boyfriend are not named in this report because they have not been charged in an accusatory instrument with committing a crime related to a report maintained by the Department in its case and management information system. [Source-Revised Code of Washington 74.13.500(1)(a)]

[4] https://www.dcyf.wa.gov/practices-and-procedures/2332-child-protective-services-family-assessment-response.

FAMILY CASE SUMMARY

On April 8, 2018, the Department received an anonymous call reporting that E.T.'s mother was using RCW 13.50.100 in the presence of her RCW 74.15.313 -month old child. The caller reported the mother drives with the baby after she RCW 13.50.100 and the caller is concerned for the baby's health and safety. The caller also said the father does not use drugs and does not want the mother RCW 13.50.100 around the baby. The caller reported the mother does not comfort the baby when RCW 74 cries and expects the father to do all of the work when he is home. The father told the caller he is overwhelmed. The caller also reported the parents often engage in verbal altercations but there is no physical violence. This intake was screened in for a 72-hour CPS/FAR assessment.

The assigned CPS worker called the mother's phone number and left a message requesting the mother return her call. The CPS supervisor assisted the worker in looking up an alternative telephone number for E.T.'s maternal grandfather. The CPS worker called the grandfather. He provided information, including the fact that the mother and child lived with him and the fact that the mother is deaf. The grandfather told the CPS worker he is the one who takes care of the child. The CPS worker requested from the department that a sign language interpreter be present for the initial face-to-face meeting with the mother, which was scheduled for April 10, 2018. The CPS worker did not receive a response to her request.

On the morning of April 10, 2018, the following persons were present when the CPS worker arrived for the face-to-face meeting: E.T., both of RCW 74. parents, the maternal grandfather, his wife (maternal step-grandmother), and her teenage child. The maternal step-grandmother provided sign language interpretation. The worker discussed Period of Purple Crying, safe sleep, and the allegations. The CPS worker told the mother that she had been referred for a urinalysis test. The CPS worker observed a diaper change and reviewed the child's sleeping environment. The family shared that E.T. was up to date with RCW 74. medical needs and discussed RCW 74. routine care. The grandparents provided the mother with a sleeping monitor that vibrates and flashes, through an application on her phone, if E.T. rolls over while RCW 74 is sleeping. The step-grandmother stated she is purchasing a bracelet that the mom can wear that will vibrate if the baby moves. The family explained how they meet E.T.'s needs when RCW 74 cries. They said E.T. is allowed to cry for five minutes before they respond. This plan is to allow the mother time to respond. If the mother does not respond, then one of the other family members will assist with E.T.'s immediate needs. The mother denied current RCW 13.50.100 use.

After the worker completed contact with the mother and her family, the worker followed the father to his residence. The father lives with his mother. The worker discussed safe sleep if E.T. stays at his home. The mother's family indicated that the father visits at the maternal grandparent's home only. The family has not allowed E.T. to leave their home with only RCW 74. father. The paternal grandmother did not speak English and was not utilized as a collateral contact.

The worker contacted the pediatrician's office and verified E.T. was up to date on RCW 74. immunizations. The worker also sent an email to the mother and her stepmother providing a description of available resources and services. The worker made sure the resources could provide services utilizing American Sign Language (ASL). The worker also reviewed the Department's computer records system to determine whether the father, mother, maternal grandfather, or maternal step-grandmother have a record of any documented history with the Department. The worker also emailed the father with information about resources for fathers.

At the time the worker referred the mother for a urinalysis, the worker was unaware that she had to specifically request the urine be tested for RCW 13.50.100 The Department had previously

removed RCW 13.50.100 from the regular testing panel. Therefore, the negative urinalysis provided by the mother did not test for RCW 13.50.100 use. This was not known to the worker until after the case was closed on May 10, 2018.

On April 13, 2018, the father called to speak with the worker. The father was very distressed. Ultimately the worker called the father back after giving him time to calm down. The father told the worker that they all lied to her. He stated they lied about the mother's and maternal grandparents' RCW 13.50.100 use. He also told the worker that the mother slept with E.T. in the same bed. The worker again encouraged the father to seek services for possible counseling, parenting classes, and custody related legal advice or assistance from the Divine Alternatives for Dads Services.[5]

The day after speaking with the father, the RCW 13.50.100 called in an intake. The intake's allegations were based on the April 13, 2018, statements made by the father to the worker. The allegations stated that the maternal grandparents RCW 13.50.100 and drive with the baby in the car, and that it is a big secret and no one wants to talk about it. The allegations also allege the mother fails to adequately protect E.T. This intake was assigned as a CPS/FAR assessment. This intake was assigned to the current CPS/FAR worker.

The CPS/FAR worker and her supervisor conducted an unannounced home visit. When they arrived, they shared the information in the intake. The family once again denied the allegations. The CPS worker and supervisor conducted a walk-through of the home. The case was closed after the unannounced home visit.

On July 7, 2018, the Department received a telephone call from a hospital reporting that E.T. had been brought by ambulance to a hospital and was declared deceased. On the evening of July 6, 2018, E.T. had been with RCW 74. mother and her boyfriend at an event and they stayed the night with friends. This intake was assigned for a CPS investigation; and as of the writing of this report, remains an open law enforcement investigation. After a CPS investigation, the Department issued founded findings against the mother and her boyfriend for the negligent treatment or maltreatment of E.T. that resulted in RCW 74. death.

[5] https://www.aboutdads.org/

COMMITTEE DISCUSSION

After interviews were completed with Department staff, the Committee discussed the case further. The Committee briefly discussed the Department's current policies pertaining to CPS investigations and FAR. The Committee also discussed the fact that CPS investigations and FAR are functions of CPS, with child safety being the paramount concern under both functions. The Committee discussed that one way to create a more fluid approach to policies for CPS investigations and CPS/FAR assessments would be for them to be contained in a shared policy heading.

The Committee also talked about whether the documentation throughout the case could have been more thorough. The Committee noted that the first intake was the first case assigned to the CPS worker, and as such, the CPS worker did a very good job for her first assessment. However, there were areas the Committee believed could have been bolstered by guidance from the CPS worker's supervisor. This is further discussed in the findings section below.

The Committee discussed the need for the Department to provide staff training regarding working with clients who speak ASL. Sometimes, cases that involve ASL speaking clients can provide a more complex case situation and require a deeper knowledge of how to assess child safety. This topic is further discussed in the recommendation section below.

When the area administrator addressed the Committee, she said that she believes it would have been best practice to have requested urinalyses tests from the grandparents based on the allegations in the second intake. The Committee agrees with this statement. The Committee discussed that while a urinalysis is only a snapshot in time, it is a tool that is readily used by Department staff for situations involving allegations of substance use and abuse.

FINDINGS

The Committee did not identify any critical errors made by DCYF during the two CPS/FAR assessments. However, the Committee discussed areas not related to E.T.'s passing in which Department practice could be improved. Those recommendations are addressed below.

The Committee identified the intent and training by the Department has been for department staff to exclude the use of family members to provide sign language interpretation. Department staff normally require certified ASL interpreters when interacting with hearing impaired clients. In this case, the CPS worker requested an ASL interpreter for the initial face-to-face contact but one was not available and a family member was used instead. This approach is consistent with policy 4330.[6] Subsequent contact did not include a request by Department staff for an interpreter until the investigation of E.T.'s death. The Committee believes that each time the Department had planned contact with the mother, there should have been a request for an ASL certified interpreter. The Committee also noted that utilizing a family member for interpretation services may compromise clear and impartial communication between the client and Department staff.

Taking into consideration this case was the first case assigned to the CPS worker, the Committee believes the work completed by her was well done. However, the Committee identified areas of her investigation that were lacking in information that are normally necessary to assess child safety. The Committee also believes the areas that were lacking detail should have been caught and corrected by the supervisor during supervisory review and at case closure. For example, the CPS supervisor went with the CPS worker when she met with the mother and her family to assess the April 14, 2018, intake. The Committee noted that this contact could have been an opportunity for the supervisor to demonstrate a more in-depth gathering of details to assist with assessing the overall safety and risk to E.T.

The CPS worker did work to assess the substance abuse allegations by requesting a urinalysis from the mother, but not other household members. Utilizing results from random urinalysis testing is one tool Department staff have to assess the use or abuse of substances. Also, the maternal step-grandmother has a teenage daughter who lives in the same home. That person was not included in the household constellation (in the electronic case file) and was not interviewed as a part of the investigation. After the review and during a discussion with the CPS worker, she shared that she started to put information about the household into the system but was told by a supervisor (who is no longer employed by the Department) she could not do this. The CPS worker is now aware she can and should add all persons that live in the residence.

The April 14, 2018, intake (second intake) did not include the grandparents as subjects, though they are discussed in the body of the intake. The supervisor could have shown the assigned worker how to add the grandparents to the intake, which would have also allowed them to be included in urinalysis testing to aid in determining the validity of the allegations.

The second and third intakes did not identify the mother's primary language as ASL. Even though the third intake clearly identified this in the body of the allegation section and there was a note on the first page of the intake, it still needed to be appropriately identified under the language tab for E.T.'s mother.

[6] https://www.dcyf.wa.gov/4300-culturally-relevant-services/4330-serving-persons-disabilities

RECOMMENDATIONS

DCYF should create a Quick Tip to remind staff about policy 4320 requiring the use of interpreters.

DCYF should also create or obtain a training for staff that work with or may work with ASL speaking clients. The Committee discussed that when department staff assess child safety for clients that are deaf, there may be additional areas to consider as it relates to parenting and daily functions based on many differing aspects for that family (i.e. who is deaf, were they born deaf, is there exposure for children of deaf parents to spoken language, etc.). The Committee suggests a voluntary training be made available to staff, such as an easy to access e-learning.

The Department should review policy 4320 and 4330 and evaluate if changes can be made to make the policies consistent with each other, and to state that staff must first try to utilize certified interpreters in all situations, including cases involving hearing impaired clients. A revised policy should also provide guidance to the worker with regard to what should be done if an ASL certified interpreter is unavailable, or if the hearing impaired client refuses to use a certified ASL interpreter and instead wants a family member or friend to interpret. When this evaluation has been completed the Department should communicate clarifications regarding interactions with ASL speaking clients to all staff to comply with state and federal requirements.