CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

October 2021

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Committee Members

- Mary Anderson Moskowitz, J.D., Ombuds, Office of Family and Children's Ombuds
- Tara Camp, Statewide CFWS Program Manager, DCYF
- Mike Stamp, Missing from Care Locator, DCYF
- Nikki Brown, Chief Program Officer, Community Youth Services

Facilitator

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

Executive Summary

On July 22, 2021, the Washington State Department of Children, Youth, and Families (DCYF) convened a Child Fatality Review (CFR)[1] to examine DCYF's practice and service delivery to J.G. and [redacted] family. J.G. will be referenced by [redacted] initials throughout this report.[2]

J.G. was born in [redacted] 2020. On Feb. 17, 2021, DCYF learned from law enforcement and the medical examiner that J.G. died. Following a 911 call, law enforcement reported responding to the caregiver's home, Ms. Nina Perez and Mr. Michael Bernard.[3] Law enforcement observed that J.G. was unresponsive and was pronounced dead by paramedics. J.G.'s mother was not present at the time of J.G.'s death. At the time of [redacted] death, J.G. was under the care of [redacted] mother's friends. The caregiver reported they put J.G. to bed on Feb. 16, and in the early morning, discovered J.G. was unresponsive. The caregiver told law enforcement J.G. was dropped off at the home in soiled clothing. [redacted] had dandruff and a red mark on the back of [redacted] neck. The caregivers also reported they were not provided enough formula to feed J.G. The caregiver gave [redacted] apple sauce and baby oatmeal. The medical examiner reported that at the time of the caregiver's call, there was insufficient information to determine whether maltreatment was the cause of death. An autopsy was scheduled for Feb. 18.

At the time of J.G.'s death, DCYF had an open Child Family Welfare Services (CFWS) case involving J.G.'s mother. She [redacted]. There was also an open CFWS case for J.G.'s older sibling.

For purposes of J.G.'s death, DCYF assigned a Child Protective Services (CPS) case for investigation. The autopsy identified the manner of death as negligent homicide. On Aug. 6, 2021, and as a result of J.G.'s death, Ms. Perez and Mr. Bernard were arrested for second degree felony murder. Criminal charges are pending.

A diverse Committee was assembled to review DCYF's involvement and service provision to the family. The Committee included members with relevant expertise selected from diverse disciplines within DCYF and community partnerships. On the day of the review, there was a Committee member cancellation due to an unexpected family emergency. Committee members had no prior direct involvement with J.G. or [redacted] family. Before the review, the Committee received relevant case history from DCYF. On the day of the review, the Committee had the opportunity to interview DCYF caseworkers, supervisors, and area administrators who were involved with the family.

[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)]." 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.

The Committee has no subpoena power or authority to compel attendance and generally hears only 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 fatal injury. Nor is it the function or purpose of a CFR to recommend personnel action against DCYF employees or other individuals.

[2] The names of J.G.'s parents are not used in this report because neither parent has been charged with a crime in connection with the fatality. J.G.'s name is also not used in this report because [redacted] name is subject to privacy laws. See RCW 74.13.500.

[3] Ms. Nina Perez and Mr. Michael Bernard are named in this report because they were charged with committing a crime that is related to the information described under the Executive Summary section above. RCW 74.13.500(1)(a).

Case Overview

Child welfare involvement with J.G.'s mother RCW 13.50.100 . RCW 13.50.100 . The mother's RCW 13.50.100 . In 2018, the mother's RCW 13.50.100 . The mother RCW 13.50.100 . She RCW 13.50.100 was assigned a DCYF caseworker.

During RCW 13.50.100 , J.G.'s mother has given birth to three children. The first child, RCW 74.13.515 ., was born in 2018 and was removed from the mother's care in 2019 due to neglect. This child RCW 13.50.100 . In 2019, J.G.'s mother gave birth to a second child who died shortly after birth. In late 2020, J.G. was born.

The mother RCW 13.50.100 at the time of J.G.'s birth. The mother engaged in court-ordered services through her RCW 13.50.100 case. Services included independent living supports, weekly counseling sessions, Wraparound Intensive Services (WISe),[4] and a parenting course. Because the mother RCW 74.13.520 before J.G.'s birth, supervised visitation with RCW 74.13.515 . was occurring in the home. On Dec. 2, 2020, RCW 74.13.515 caseworker met with the mother and discussed the mother's future plans.

On Dec. 8, 2020, a virtual WISe treatment team meeting occurred. RCW 74.13.515 caseworker attended the meeting. The mother reported she remained at her relative's home and had all that she needed to care for J.G. On Dec. 14, 2020, a monthly supervisory review occurred. The review noted J.G. was not in foster care because the mother was doing well and meeting J.G.'s needs. There was no intake associated with J.G.'s birth.

On Dec. 16, 2020, DCYF received an intake reporting the mother left J.G. with a friend. The mother failed to indicate when the friend could expect the mother to return to pick up her child. The report describes how the friend eventually left J.G. with the father and the fact that the mother eventually returned home. The intake referenced the mother's frequent history of leaving RCW 74.13.515 with individuals. RCW 13.50.100 . The intake was not assigned for investigation because the concern did not indicate any child abuse or neglect.

On Dec. 17, 2020, a supervisory review occurred. The review referenced J.G.'s birth and that health and safety visits would occur when the caseworker meets with the mother. On Dec. 21, 2020, the assigned caseworker conducted a health and safety visit. J.G. was observed during the visit, and no concerns were noted. On Jan. 4, 2021, a supervisory review for J.G.'s mother's case occurred. The case note reported that the mother remained RCW 13.50.100 with a relative caregiver and that she was considering her educational and future plans. The case note mentioned the mother was having difficulties with the father but was meeting J.G.'s needs.

On Jan. 12, 2021, and while in the presence of RCW 74.13.515 . and J.G., RCW 74.13 515 caseworker met with the mother. The caseworker spoke with the mother about the Period of Purple Crying,[5] the importance of emotional regulation, and prioritizing her mental health due to possible frustration with prolonged infant crying. The

[4]"WISe" means Wraparound with Intensive Services. For additional information see: **https://www.hca.wa.gov/health-care-services-supports/behavioral-health-recovery/wraparound-intensive-services-wise.** Last accessed on July 20, 2021.

[5]For information about Period of Purple Crying, see: **http://www.purplecrying.info/what-is-the-period-of-purple-crying.php**. Last accessed on July 22,2021.

mother reported she was not bothered by J.G.'s crying. No bruises or marks were observed on J.G. The mother said J.G.'s father was less involved than she initially anticipated.

On Jan. 14, 2021, the caseworker conducted a health and safety visit for J.G.'s mother. The caseworker observed no safety concerns and reported J.G.'s mother appeared to be adapting to the parenting of two children. The caseworker referred the mother to community-based resources to obtain basic care supplies. On Jan. 17, 2021, the mother left a message for her caseworker requesting funds for milk for J.G. She made this request pending her ability to obtain her voucher for the Women, Infant, and Children Nutrition Program (WIC).[6] On Jan. 19, 2021, the caseworker contacted the mother and left a message responding to the mother's request.

On Jan. 26, 2021, a virtual WISe treatment team meeting was held. In attendance were both the mother's caseworker and RCW 74.13.515 caseworker. The mother was attentive to J.G.'s needs throughout the meeting. The mother requested assistance to complete a parenting plan and said J.G.'s father was not involved. The mother's parent partner offered to assist with the parenting plan. The mother also reported having difficulties with obtaining RCW 13.50.100 and requested help to obtain J.G.'s birth certificate and social security card. The mother said she had been attending parenting classes but missed a session due to J.G. having a medical issue.

On Jan. 28, 2021, the mother contacted her assigned caseworker. The mother told the caseworker that during the second week of February, she intended to travel to California to meet a friend. The caseworker asked for additional details about whom she was planning to visit. The mother reported she was seeing a male friend. The caseworker said that if the mother goes to California, she would like to know where she will be staying. The mother reported that for the time she would be away, she would be canceling her scheduled visits with RCW 74.13.515.

On Feb. 3, 2021, a monthly supervisory review occurred. The case note referenced the mother being involved in a new relationship, maintaining RCW 13.50.100, and "working well" with RCW 74.13 515 RCW 13.50.100 case. On Feb. 6, 2021, the mother's caseworker spoke with the mother via FaceTime to answer a question regarding whether any individuals claimed her on their taxes. During the conversation, J.G. was being bathed and appeared to enjoy the water, and was smiling and making noises. The caseworker did not observe any bruises or marks during this interaction.

On Feb. 10, 2021, RCW 74.13 515 caseworker conducted a home visit with the mother and J.G. The caseworker did not observe any marks or bruises on J.G. The caseworker asked about J.G.'s current routine and again discussed the principles of Period of Purple Crying. The mother did not report any concerns about J.G.'s feeding, sleeping, or care routine. The mother said that during the next week she was scheduled to travel with friends to California to visit her current boyfriend. The caseworker asked about the plan for J.G.'s care and was told J.G. would be staying with the RCW 74.13.515, who she felt could meet RCW 7 needs. The caseworker asked the mother to notify her when she returned and wished her safe travels.

On Feb. 17, 2021, law enforcement and the medical examiner's office notified DCYF of J.G.'s death. The medical examiner ruled J.G.'s manner of death negligent homicide. On Aug. 6, 2021, and as a result of J.G.'s

[6] "WIC" means the Women, Infants, and Children Nutrition Program (WIC). For information about WIC, see: https://www.doh.wa.gov/youandyourfamily/wic. Last accessed on July 22, 2021.

death, Ms. Perez and Mr. Bernard were arrested for second degree felony murder. Criminal charges are pending.

Committee Discussion

The Committee met with caseworkers, supervisors, and area administrators who were involved with this family. The Committee identified this case as complex RCW 13.50.100 . The themes discussed by the Committee relate to communication and youth engagement in foster care.

All the Committee members have expertise related to supporting youth in foster care. The Committee discussed the importance for youth to have their voices heard and did not want to diminish the importance of the youth viewpoint and choice. However, the Committee believes case planning for the mother was significantly influenced because she was a parent herself and rapidly approaching the age of adulthood. The Committee wondered how this may have impacted the ongoing safety assessment and the parental capabilities assessment.

Due to her relatively recent stability, the Committee speculated the caseworkers may have been very cautious when approaching difficult conversations with the mother. As compared to what they experienced in the past, the caseworkers and supervisors said that at the time of J.G.'s birth, the mother was more stable and engaged with services. This stability was identified as positive progress and led to J.G. remaining in the mother's care. The Committee wondered if the caseworkers may have been concerned about potentially disrupting the mother's stability if she did not agree with something the caseworkers suggested, or if firm boundaries were implemented, the firm boundaries may remind the mother DCYF was still responsible for her safety and well-being. The Committee believes DCYF still needed to engage in difficult and transparent conversations with the mother.

During the caseworker interviews, an area administrator expressed the belief the mother would have traveled out of state regardless of DCYF's expectations. The Committee agreed the mother would likely have continued with her trip as an unaccompanied, RCW 13.50.100 minor. Because the mother was not traveling with her caregiver, the Committee expressed concern that DCYF had limited knowledge of the mother's travel plans, including who she would be traveling with, the travel timeframe, and where she would be staying. The Committee believes DCYF had a responsibility to gather information about the mother's plans and to follow the guidelines for approving travel as described in DCYF Policy 5800,[7] especially given the travel guidance related to the COVID-19 pandemic. Also, the Committee would have liked the caseworker to have clear communication with the mother about potential consequences for traveling without approval, including the possibility of a missing from care law enforcement report being filed. Despite the fact that DCYF did not have legal authority over J.G., the Committee believed the caseworkers should have gathered more details about the mother's travel plans and her plan for J.G.'s care while she was gone.

The other travel-related concern was related to the mother's RCW 13.50.100 history.[8] To properly assess the mother's safety, the Committee believes the agency's questions about the mother's travel plans were insufficient. The Committee wondered who was paying for the mother's travel and

[7] For information about DCYF Policy 5800, see: **https://www.dcyf.wa.gov/5000-case-support/5800-approving-client-travel-and-transportation-activities**. Last accessed on October 5, 2021.

[8] RCW 13.50.100 Last accessed on July 22, 2021.

whether this could have been an indicator of the mother again being in a high-risk RCW 13.50.1 situation. The Committee discussed the vulnerabilities of youth RCW 13.50.100, even when they are nearing adulthood.

The Committee believes communication could have been enhanced with regard to a number of different subject areas. This included discussion about internal DCYF collaboration, utilization of shared decision making meetings, communication with J.G.'s caregiver, and written documentation. The Committee questioned the mother's case assignment to one office and the assignment of RCW 74.13 515 case to a different office within the same county. For purposes of case planning and ongoing safety assessment, the Committee wondered if this may have led to a disconnect and insufficient communication between offices. The Committee believes regular communication between the caseworkers may have been beneficial to discuss progress, concerns, joint case planning development, and improved continuity of care for both the mother and her children.

The Committee learned from the supervisor and RCW 74.13.515 caseworker that prior to the birth of J.G., they consulted with the Assistant Attorney General (AAG) assigned to RCW 74.13.515 case. After meeting with the AAG, DCYF decided to not file a dependency petition. In light of the decision not to file a dependency petition, the Committee believes a Family Team Decision Meeting (FTDM)[9] would have been appropriate. The Committee believes this may have allowed for shared decision-making to include both offices. It may have also led to creating an open dialogue with the mother, her caregiver, and her supports. This dialogue may have identified safety concerns, needs, and plan development.

The Committee believes another missed opportunity involved the lack of contact with the mother's caregiver. Pursuant to policy, health and safety visits include monthly communications with the child and caregiver.[10] After J.G. was born, the mother's caseworker had very limited contact with the mother's caregiver and the caregiver was never present during a health and safety visit. The Committee believes this would have been an opportunity to gather more information about the mother's approach to the parenting of J.G., to learn about potential concerns, and to identify any supports the caregiver may have needed to care for the mother. It may have also provided an opportunity for the caseworkers to corroborate the information provided by the mother. Given the RCW 13.50.100 of RCW 74.13.515., the Committee did express a concern that the mother was babysitting the caregiver's children. The Committee believes DCYF should have discussed this with the caregiver.

The Committee learned additional case details from meeting with the caseworkers and supervisors. Much of the additional information was not documented in the case record. For example, the supervisor did not document the consultation with the AAG regarding the DCYF decision to not file a dependency petition on behalf of J.G. The supervisor told the Committee that DCYF changed their practice so that these conversations are documented in the future. Both caseworkers provided verbal updates to the Committee about Safe Sleep[11] conversations they had with J.G.'s mother and also viewed J.G.'s sleep environment. None of these contacts were documented in a case note. The RCW 13.50.100 was the referrer for the Dec. 16, 2020 intake and reported they addressed the concerns with the mother. The Committee believes this should have been

[9] "Family Team Decision Making (FTDM) meetings follow the Shared Planning Meeting model of engaging the family and others who are involved with the family to participate in critical decisions regarding the removal of children from their home, placement stabilization, and prevention and reunification or placement into a permanent home." See: **https://www.dcyf.wa.gov/1700-case-staffings/1720-family-team-decision-making-meetings**. Last accessed on July 22, 2021.

[10] For more information about Health and Safety Visits with Children and Youth, and Monthly Visits with Parents and Caregivers, see: **https://www.dcyf.wa.gov/4400-concurrent-tanf-benefits/4420-health-and-safety-visits-children-and-youth-and-monthly-visits**. Last accessed on July 22, 2021.

[11] For information about Safe Sleep, see: **https://safetosleep.nichd.nih.gov/safesleepbasics/about**.

recorded in a case note. The Committee highlighted the importance of case documentation describing the details of conversations with parents, children, and caregivers.

The Committee discussed DCYF's decision not to file a dependency petition on behalf of J.G. This is in light of the fact that J.G.'s older sibling was in out-of-home care, the vulnerabilities of a newborn, and the risk given the mother's case history. The Committee was unable to conclusively determine whether DCYF should have moved forward with filing a dependency petition.

Findings

The Committee identified the following findings:

The Committee believes an FTDM should have been held following J.G.'s birth to encourage communication with the parent, the parent's caregiver, and their support team. This may have allowed a venue for the FTDM attendees to share concerns, needs, and address any additional supports that may have been beneficial to the mother, J.G., and the mother's caregiver.

The Committee identified that Policy 4420 (Health and Safety Visits with Children and Youth and Monthly Visits with Parents and Caregivers) was not followed. Monthly caregiver contacts with the mother's caregiver did not occur during health and safety visits.

The Committee identified that DCYF should have gathered details pertaining to the mother's travel plans to determine if permissions could have been granted for travel under DCYF Policy 5800. The Committee believes the caseworker should have filed with law enforcement a missing from care report as the mother's specific whereabouts were unknown to the caseworker.

Recommendations

The Committee recommends DCYF consider adopting a statewide practice requiring monthly case collaboration between caseworkers and supervisors for cases that may be handled by multiple DCYF offices. The purpose of this communication goal is to provide additional opportunities for shared decision-making and enhance the continuity of care provided to the child(ren) and family. It is recommended the case collaboration be documented in a case note, regardless of whether it occurs by virtual meeting, in-person, telephone, or email.