CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

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Contents

Full Report

Child

- L.N.

Date of Child's Birth

- [redacted] 2019

Date of Fatality

- May 2019

Child Fatality Review Date

- March 4, 2020

Committee Members

- Ruth Wolbert-Neff, Tacoma Pierce County Health Department, Substance Use Disorder Professional Drug and Alcohol Treatment Counselor II
- Jon Pfister, Vancouver Police Department, Detective Sergeant
- Stephanie Frazier, DCYF, Region 6 Safety Administrator
- Kelly Boyle, DCYF, Statewide Intake and Safety Program Manager

Consultant

- Thomas Angier JD, DCYF, Assistant Attorney General

Facilitator

- Libby Stewart, DCYF, Critical Incident Review Specialist

Executive Summary

On March 4, 2020, the Department of Children, Youth, and Families (DCYF) convened a Child Fatality Review (CFR)[1] to assess DCYF's service delivery to L.N. and [redacted] family.[2] [redacted] will be referenced by [redacted] initials throughout this report.

In May 2019, [redacted]-old L.N. died while in the state of [redacted] In mid-January 2020, this author reviewed an [redacted] Department of Human Services [redacted] DHS) Critical Incident Review Team (CIRT) report involving L.N.[3] The report stated that the medical examiner's (ME) toxicology report from L.N.'s autopsy was positive for [redacted]. The ME was unable to determine if the positive toxicology contributed to L.N.'s death. This author recognized some aspects of L.N.'s death based on an Administrative Incident Reporting System (AIRS)[4] notification that was received on May 24, 2019. The AIRS notification was based on an intake called in by [redacted] regarding L.N.'s death. Based on the information contained in the [redacted] DHS CIRT report and the fact that there was an open Child Protective Services (CPS) assessment with DCYF at the time of L.N.'s death, this incident qualified for a DCYF CFR.

The [redacted] DHS CIRT report also stated that L.N. died while bed-sharing with [redacted] mother. The report contained information that L.N.'s mother admitted she drank alcohol the night before L.N.'s death. She also said she regularly used [redacted] and occasionally used [redacted] DHS determined that L.N.'s death was the result of the mother's negligence. No arrests were made regarding L.N.'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 L.N. 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 case worker who assessed the May 7, 2019 intake, her supervisor and the area administrator. The Committee also spoke with an assistant attorney general (AAG).

Case Overview

On May 7, 2019, DCYF received a report alleging that L.N.'s mother was intoxicated and tried to run over L.N.'s father while L.N. was in the vehicle. The allegations also stated the mother drank heavily, and while intoxicated would often bed share with L.N. The father reportedly tried to discuss these concerns with the mother, but she continued her behavior. This intake was assigned for CPS/Family Assessment Response (FAR) assessment.

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[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 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.

[2] No one has been criminally charged related to L.N.'s death; therefore, no one is named in this report.

[3] This CIRT report can be found at: https://www [redacted].

[4] See: https://www.dcyf.wa.gov/6000-operations/6302-administrative-incident-reporting

On May 7, 2019, the CPS case worker called L.N.'s father. The father said the mother had a long-time drinking problem and drank during her pregnancy with L.N. He said the mother's family brought her alcohol to the hospital when she delivered L.N. The father also said he struggled with alcohol use in the past but had control over his use. He stated he had a family history of alcoholism as well.

The father said that on April 21, 2019, the mother was drunk and tried to run him over while their 74.13.515 was in the car. The father did not call police but said he had a video of the event. He also stated that a few days later, the mother called him to pick up L.N. The father stated that when he arrived he was assaulted by the mother's boyfriend.

The father also said he has two other children. Neither child lived with him. One child is being raised by the father's grandmother and the other child is being raised by that child's mother.

Due to the mother living in Washington State yet frequenting 74.13.515 State, the CPS worker requested police reports from two agencies in 74.13.515 (74.13.515 County and 74.13.515 Police Bureau) and two agencies in Washington State (74.13.515 County and 74.13.515 Police Department).

On May 8, 2019, the CPS worker contacted 74.13.515 DHS to see if it had any history regarding this family. The CPS case worker was told there was an open CPS case. The DCYF CPS case worker contacted the 74.13.515 DHS CPS worker and was told there was an allegation of 13.50.100 .

On May 9, 2019, the assigned CPS worker made an unannounced home visit to the mother's Washington home. The CPS case worker observed the home to be clean and orderly and did not observe any behaviors that caused concern the mother was intoxicated. The CPS case worker observed a portable crib and discussed safe sleep with the mother. The mother shared that at times L.N. would take naps on the mother's bed. The mother denied ever bed-sharing with 74.13.515 after she had been drinking or when she was under the influence of any substance. The mother denied the allegations in the intake as well as the information the father shared during his telephone call with the CPS case worker. The mother also said the father was a drug dealer, confidential informant for law enforcement, pimp and affiliated with gangs. The mother identified family in 74.13.515 that supported her and stated she 13.50.100 . She told the CPS case worker she was rarely in 74.13.515 and planned to move back to 74.13.515 74.13.515 soon.

On May 10, 2019, the CPS worker made a referral for a crib and mattress for the mother. The CPS case worker was not sure whether L.N.'s mother picked up the items.

On May 24, 2019, L.N.'s father contacted DCYF and said that L.N. died while in the care of 74.13.51 mother in 74.13.515 The father said the mother called him around 1:00 that morning and sounded intoxicated. She wanted to see him and said she was going to drive. He told the mother he would send an Uber to pick up her and the baby. The father heard the baby crying in the background. The mother said she had been babysitting while her friend and sister were out. Later that same morning, the father received a call from a hospital stating his 74.13.515 had died. The mother's friend told the father that when she walked into the room (where they were staying), she saw blood coming from L.N.'s mouth and the mother asleep next to 74.13.515 This intake was screened in for a DCYF CPS investigation.

Also on May 24, 2019, DCYF created an intake regarding an event reported to law enforcement. The event occurred and was reported to law enforcement on May 7, 2019. The law enforcement report

stated that the father reported the mother was drunk and tried to run him over with a car while their 74.13.515 was in the car. The report stated the father showed the police officer video footage of the incident. The officer documented that he could see from the video that L.N. was in the car while the mother was driving. This intake was screened out as the allegations were already reported.

The May 7, 2019 intake was closed out after L.N.'s death. DCYF closed out the May 24, 2019 investigation without a finding. This decision was made because the death occurred in 74.13.515 During the time the investigation was open, law enforcement told the assigned CPS case worker there was an 74.13.520 found during the autopsy and that it was believed this contributed to or caused L.N.'s death. The DCYF investigation was closed prior to receiving the medical examiner's toxicology report. It is only upon review of the 74.13.515 DHS CIRT report that DCYF learned the 74.13.520 did not contribute to or cause L.N.'s death

Committee Discussion

The Committee appreciated how well prepared the CPS worker was for the review. The Committee identified that the CPS case worker asked good questions of the parents during her contact, requested records from appropriate sources early in the assessment, made timely and appropriate contact with 74.13.515 DHS and addressed safe sleep multiple times with the mother.

The Committee discussed the screening decision regarding the May 9, 2019 intake. There was some thought that the allegations constituted imminent risk and should have been assigned as a CPS investigation. The Committee discussed that the CPS case worker more than likely would have approached the case in the same manner and that the screening decision would have impacted only the time between the assignment and initial face-to-face. The Committee viewed the CPS case worker's choice to conduct an unannounced home visit as positive and utilizing critical thinking, even though it did not fully adhere to the FAR policy.

The Committee discussed at length the issue relating to families who frequently go between the states that border Washington, Oregon and Idaho. This issue specifically impacted this case because the CPS case worker was not able to go to 74.13.515 to observe the grandmother's home where the mother would often go. In addition, because the death occurred in 74.13.515 DCYF could not make a finding or complete its investigation of L.N.'s death. An AAG provided the Committee with information indicating that, specific to this case, DCYF staff could not physically go into 74.13.515 to conduct social work. There were questions raised by the Committee about the difference between physically going into another state and calling persons in another state or country, but those questions were not resolved. The Committee also struggled with other aspects of this discussion and addressed it in the recommendation section below.

The Committee discussed that the CPS case worker's caseload was too high. At the time of the May 7, 2019 intake, the CPS case worker's caseload was 47 intakes. At the time of the review, the CPS case worker had 40 intakes. While the CPS case worker had a high caseload, the Committee did not believe there was any correlation between the high caseload and L.N.'s death.

Findings

The Committee did not identify any critical errors. This case was open for 17 calendar days, which is a small amount of time considering that a CPS case worker has 60 days to complete an assessment.

The Committee identified that a urinalysis from L.N.'s mother should have been requested as part of the assessment process. This is based on the allegations in the May 7, 2019 intake. The Committee understands that utilizing a urinalysis is only a tool used in assessments completed by DCYF. There was also some discussion that a urinalysis of the father, based on the mother's statements, would have been appropriate.

Recommendation

The Committee recommends that DCYF work with DCYF's legal team and neighboring states (Oregon and Idaho) to discuss how cases that move between state lines can have a more fluid and comprehensive assessment. The Committee believes if there was a reciprocal memorandum of understanding, or something similar, DCYF cases would be more comprehensive, completed in a more timely manner and closure may occur more quickly.