CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

March 2022

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CHILDREN, YOUTH & FAMILIES

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March 2022

Full Report

Child

- M.E.

Date of Child's Birth

- RCW 74.1 2021

Date of Fatality

- Sept. 23, 2021

Child Fatality Review Date

- Dec. 2, 2021

Committee Members

- Mary Anderson Moskowitz, JD, Ombuds, Office of Family and Children's Ombuds
- Tarassa Froberg, Statewide CPS-FVS Program Manager, DCYF
- Jennifer Gorder, Quality Practice Specialist, DCYF
- Betsy Ward, Clinical Supervisor, Parent Child Assistance Program

Facilitator

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

Executive Summary

On Dec. 2, 2021, the Department of Children, Youth, and Families (DCYF)[1] convened a Child Fatality Review (CFR)[2] to examine DCYF's practice and service delivery to M.E. and [redacted] family. M.E. will be referenced by [redacted] initials throughout this report.[3]

The medical examiner contacted DCYF to report M.E. died on Sept. 23, 2021, and indicated it was a presumed co-sleeping incident. The referrer reported that the mother shared the following event timeline. M.E. woke up at 5 a.m. hungry and fussy, was fed formula, swaddled, and placed on [redacted] back next to the mother in bed. The mother said she was awakened at 3 p.m. by her three-year-old child. M.E. was discovered lying face down next to the mother. The mother did not have a phone to contact emergency services and asked a neighbor to call 911. Emergency services pronounced M.E. dead at 3:45 p.m. The referrer reported the home was cluttered with an overturned bed in the living room and limited walking space around the bed. There was an infant crib across from the mother's bed, but it was full of clothing and baby items. At the time of M.E.'s death, the family had an open case for a Child Protective Services (CPS) investigation.

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. One day prior to the review, a Committee member from a domestic violence agency opted out of the review due to a potential conflict of interest. All other Committee members had no prior direct involvement with M.E. 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 speak with DCYF caseworkers, supervisors, and area administrators who were involved with the family.

Case Overview

M.E.'s mother [redacted] RCW 13.50.100 [redacted]. M.E.'s mother came to the attention of CPS as a parent in 2013. In addition to M.E., she is also the mother of [redacted] (11), [redacted]. (3), and [redacted] (1).

Prior to the birth of M.E., CPS received eight calls on the family alleging the following: substance use concerns associated with the births of [redacted]. and [redacted]., a concern for ongoing substance use, a history of domestic violence (DV) with her partner(s), suspected physical abuse [redacted], and conflict with her neighbors. The conflict

[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. For purposes of this report, any reference to DCYF and events that occurred before July 1, 2018, shall be considered a reference to DSHS.

[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)]." 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 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 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]The names of M.E.'s parents are not used in this report because neither parent has been charged with a crime in connection with the fatality. M.E. and [redacted] siblings names are also not used in this report because their names are subject to privacy laws. See RCW 74.13.500.

with the neighbors included theft allegations, vandalism to the neighbor's home, and a physical altercation allegedly started by a neighbor that caused possible injuries to one of the mother's children.

Three intakes did not meet the criteria for investigation, three were assigned for CPS investigation, and two were assigned to Family Assessment Response (FAR).[4] During the various interventions, the children were assessed as safe in the home. During one intervention, RCW 74.1 moved to her father's home' and, to DCYF's knowledge, has remained in his care. Community-based services have been offered, including a referral to a Public Health Nurse (PHN), Parent Child Plus[5] services, and child care. Clothing vouchers for the children were also provided. In some instances, the mother minimally responded to caseworker attempts to engage, or she declined offered services. No founded findings[6] were issued as a result of the CPS investigations.

On Aug. 5, 2021, DCYF received a report regarding the birth of M.E, the mother's fourth child. The referrer, a medical provider, disclosed that M.E. was born in RCW 74.1. The medical provider reported that a meconium testing toxicology report recently returned positive for methamphetamine and cannabis. The provider also reported that M.E. was seen for a RCW 74.13.520 and RCW 74.13.520 at urgent care. The clinic staff attempted to reach the mother for a follow-up appointment without a response. A CPS investigation was assigned with a 24-hour response.

On Aug. 6, 2021, the assigned CPS caseworker tried to contact the mother by telephone and attempted an unannounced visit at the family home. After the worker was unable to see M.E. and the family, the CPS supervisor requested an after-hours caseworker attempt an initial face-to-face visit at the home. There was no documentation that the after-hours caseworker contacted the family. The CPS caseworker continued to make unsuccessful efforts to contact the mother via telephone, email/social media, written correspondence, and unannounced home visits.

On Aug. 18, 2021, 13 days after the CPS caseworker began initiating attempts to contact the mother, the mother responded. The mother reported taking M.E. to a medical appointment the day before and stated she was staying at the father's home, only coming to and from her home to pick up necessary items. The mother said she was unable to meet that day because she was preparing to go on a camping trip for the next five days. The CPS caseworker contacted the mother, asking that she meet with the caseworker before the scheduled trip.

On Aug. 19, 2021, the CPS caseworker met with the mother and M.E. However, the mother refused to allow the meeting to occur in her home. The meeting occurred on the road near the mother's apartment building. The CPS caseworker did not observe any marks or bruises on the baby. The mother reported the RCW 74.13.520 on M.E.'s RCW 74.13.520. The mother declined the CPS caseworker's offer to refer the mother to a PHN to assist with M.E.'s RCW 74.13.520.

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

[5]For additional information about Parent Child Plus, see: https://www.parentchildplus.org/state/wa/. Last accessed on December 3, 2021.

[6]"'Founded' means the determination following an investigation by the department that, based on available information, it is more likely than not that child abuse or neglect did occur." RCW 26.44.020(14). See also WAC 110-30-0020.

On Aug. 23, 2021, the CPS caseworker attempted to complete an initial face-to-face with the mother's other children, RCW 74.13.515. and RCW 74.1 There was no answer at the home. The mother contacted the CPS caseworker and scheduled an appointment for the following day. A monthly supervisor review occurred.

On Aug. 24, 2021, the CPS caseworker arrived at the home to complete a subject interview with the mother and an initial face-to-face visit with RCW 74.13.515 and RCW 74.1 The CPS caseworker believed they awakened the mother, who asked them to give her a moment. The CPS caseworker waited approximately an hour before being allowed in the home. The CPS caseworker observed the mother to be overwhelmed and the home to be messy but did not document safety concerns. The CPS caseworker observed M.E.'s sleeping space, a bassinet located on the floor. The mother denied the allegation that she had not followed up with M.E.'s medical care and provided an update about the children's medical appointments.

On Sept. 8, 2021, the CPS caseworker received and reviewed medical records for all three of the children. On Sept. 15, 2021, an early learning staffing[7] was held. The recommendations for support included (1) a PHN referral; (2) a Women, Infants, & Children (WIC) referral; (3) an Early Supports for Infants and Toddlers (ESIT) evaluation for M.E.; (4) enrollment for RCW 74.13.515 in the Early Childhood Education and Assistance Program (ECEAP)/Headstart; (5) a referral to Intercultural Children and Family Services (ICCFS); and (6) post-partum supports for the mother. The Early Learning coordinator made an ESIT referral.

On Sept. 20, 2021, a monthly supervisory review took place. The supervisory review noted that the CPS caseworker spoke with the mother about Safe Sleep[8] and Period of Purple Crying.[9] It was also noted that M.E. had a safe sleep environment. Next steps were noted as sharing the early learning staffing recommendations with the mother, completing a subject interview with the father, making collateral contacts with the mother's providers, and requesting the mother complete a urinalysis. On Sept. 21, 2021, the CPS caseworker contacted the mother to request a urinalysis test.

On Sept. 23, 2021, DCYF was notified that M.E. died. The medical examiner contacted DCYF to report the death and indicated it was a presumed co-sleeping incident. Based on this report, a CPS investigation was assigned. The CPS investigation of M.E.'s death concluded with founded findings entered against the mother for negligent treatment/maltreatment. No criminal charges have been filed against the mother at this time. A law enforcement case remains open pending the toxicology and finalized autopsy report results.

The mother entered a voluntary substance use disorder (SUD) treatment program following M.E.'s death. The family court RCW 13.50.100 . This was an agreed order by both the mother and father. RCW 74. remains in the care of her father.

[7]For information about DCYF's early learning coordination plan, see: https://www.dcyf.wa.gov/sites/default/files/pdf/pdg-GoalsStrats-ELCoordPlan.pdf. Last accessed on December 7, 2021.

[8]For information about Safe Sleep, see: https://safetosleep.nichd.nih.gov/safesleepbasics/about; https://www.nichd.nih.gov/sites/default/files/2019-04/Safe_to_Sleep_brochure.pdf; and https://www.dcyf.wa.gov/safety/safe-sleep. Last accessed on December 3, 2021.

[9]For information about Period of Purple Crying, see: http://www.purplecrying.info/what-is-the-period-of-purple-crying.php. Last accessed on December 3, 2021.

Committee Discussion

During the Committee review process, the Committee identified casework they felt demonstrated positive efforts to engage and connect the family with resources. For example, in an April 2020 case involving M.E.'s older siblings, the caseworker made community-based service referrals for the parent even though the mother received support services through her housing program. The Committee highlighted the early learning staffings conducted by DCYF as providing a wealth of resources for families and learned about how the office shares this information with the parents.

Additional identified positive practices included the August 2021 case. The caseworker was persistent in the efforts to locate and connect with the mother despite the mother's continual efforts to avoid DCYF meetings. On one particular occasion, the caseworker waited at the mother's door for over an hour before the mother allowed them in to complete the home visit. It was also noted that this caseworker made efforts to complete a specialized DV assessment[10] with the mother, which was the first time this occurred during DCYF's involvement with the family.

The Committee also identified areas they considered improvement opportunities, starting with DCYF's first involvement with the family. One particular area was related to information gathering from relevant collateral contacts and records requests. The Committee identified the maternal grandparents as supportive and would have liked to have seen more consistent contact with the grandparents throughout DCYF's involvement with the mother.

The Committee discussed at length how DCYF assessed and gathered information about the mother's mental health, substance use, and DV history. The Committee learned from speaking with the caseworkers that the mother was challenging to engage in at times and provided limited information. The Committee understands that DCYF relies heavily on parent self-report but believes more effort could have been made to verify the mother's reports through collateral contacts. This may have provided valuable information and helped DCYF have a better understanding of the mother's progress in services, current functioning, and identification of any unmet needs. Examples of records the Committee discussed were medical records for the children, mental health and SUD records for the mother, and law enforcement reports.

The Committee believes a shared planning meeting[11] in 2020 and/or 2021 may have been beneficial for the family. This may have provided an opportunity to increase communication among the family, extended family, providers, and DCYF caseworkers. It may have also provided an opportunity to address discrepancies reported by the various stakeholders and for everyone to learn about and discuss the concerns, the family's identified needs and supports the family was receiving.

Throughout DCYF's involvement with the mother, she was residing at a housing program that was providing support services. From meeting with the caseworkers, the Committee learned more about the specifics of this particular program. For purposes of the continuation of services and ongoing monitoring, the Committee

[10]For information about the specialized domestic violence assessment, see: https://www.dcyf.wa.gov/1100-child-safety/1170-domestic-violence. Last accessed on December 3, 2021.

[11]For information about Shared Planning Meetings, see: https://www.dcyf.wa.gov/1700-case-staffings/1710-shared-planning-meetings. Last accessed on December 3, 2021.

believes DCYF placed great weight on the mother's involvement with the housing program. For example, when the mother self-identified substance misuse and willingness to go to treatment, DCYF closed the case after the housing program offered assistance to obtain treatment services. The Committee speculated whether it may have been beneficial for DCYF to remain involved to confirm the mother's participation in treatment.

Another area discussed related to the housing provider's report to DCYF that the mother's substance use was not impacting her ability to parent safely. The Committee wondered about the housing program staff's capacity, experience, and knowledge to contribute to the assessment of child safety. The Committee would have liked DCYF to have gathered more details from the provider about the provider's feedback about child safety. For purposes of a DCYF open case, the Committee emphasized it is not the role or responsibility of outside agencies or providers to assess child safety. The Committee firmly believes it is DCYF's responsibility. The Committee also wondered if the mother's motivation to participate in treatment may have diminished due to the housing program's child safety statements.

The Committee discussed inaccuracies with the Structured Decision Making Risk Assessment® (SDM-RA)[12] throughout DCYF's various interventions with the family. Even with the inaccuracies, the SDM-RA score(s) allowed DCYF to provide the family services. The Committee wondered why DCYF services were not offered to the family and again wondered if reliance on the housing program to provide services may have factored into service provision decision-making. The Committee considered whether it would be beneficial for DCYF to have a system in place to internally staff cases for services for a family with a history of multiple DCYF interventions.

The Committee commended the Safe Sleep documentation, which included documented discussions with the parent and observations of the sleep space(s) throughout the various interventions. The Committee also learned from discussion with the caseworkers that the housing program coached the parent about Safe Sleep. For purposes of the August 2020 case, the Committee did identify a missed opportunity to provide in-the-moment coaching to the parent about Safe Sleep. The caseworker reported observing the bassinet filled with items and asked the mother to remove them but did not help the mother remove the items at that moment to create a Safe Sleep environment.

Lastly, the Committee appreciates the local office's candor associated with the struggles experienced in 2021. The office has experienced high turnover with caseworker staff and the hiring of new candidates. This has led to a significant number of vacancies. The Committee recognizes that staff vacancies impact the entire office, especially the caseworkers who do direct fieldwork.

Findings

The Committee identified the following findings:

1. A lack of relevant collateral contacts to verify the information reported by the parent(s). The Committee would have liked to have seen the following collateral contacts made with each new case:

[12]The Structured Decision Making Risk Assessment® (SDM-RA®) is a household-based assessment focused on the characteristics of the caregivers and children living in that household. By completing the SDM-RA following the Safety Assessment, the worker obtains an objective appraisal of the risk to a child. The SDM-RA informs when services may or must be offered. See: https://www.dcyf.wa.gov/practices-and-procedures/2541-structured-decision-making-risk-assessmentrsdmra. Last accessed on December, 3, 2021.

a. Communication with the maternal grandparents
b. Increased efforts to locate and communicate with the father(s)
c. A request for law enforcement records and incident reports from the mother's housing program
d. Provider records for the mother's SUD and mental health treatment
e. Medical records for all the children to verify medical needs were addressed

2. The Committee believes a specialized DV assessment was warranted based on the reported domestic violence history between the mother and M.E.'s father. This did not occur on any of the open 2017 to 2020 cases.

3. With regard to the items observed in [redacted] bassinet during the August 2020 health and safety visit, the Committee finds the caseworker missed an opportunity to provide in-the-moment coaching to the parent about Safe Sleep by helping the mother remove the items and creating a Safe Sleep environment.

Recommendations

The Committee recommends that the DCYF Substance Use Disorder Program Manager consider developing a SUD Protocol to aid caseworkers in uniformly assessing child safety impacts related to parent/caregiver substance use.