CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

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Full Report

Child

- M.H.

Date of Child's Birth

- RCW 74.13.515 2020

Date of Fatality

- March 9, 2021

Child Fatality Review Date

- June 16, 2021

Committee Members

- Patrick Dowd, JD, Director, Office of Family and Children's Ombuds
- Jasmine Hodges, MA, Quality Practice Specialist-Safety Team, DCYF
- Stephanie Widhalm, MSW, LICSW, MHP, CMHS, Children's Advocacy Center Director/Forensic Interviewer, Partners with Families and Children
- Elizabeth Hampp, Housing Manager, You Belong Community

Facilitator

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

Executive Summary

On June 16, 2021, the Department of Children, Youth, and Families (DCYF) convened a Child Fatality Review (CFR)[1] to examine DCYF's practice and service delivery to M.H. and RCW 74. family. M.H. will be referenced by RCW 74. initials throughout this report.[2]

On March 9, 2021, DCYF received a telephone call from law enforcement reporting the death of M.H. and asking whether the family had a Child Protective Services (CPS) history. The officer reported responding to a 911 call from the parents who said M.H. was not breathing. Upon arrival, M.H. was found deceased in RCW 74. car seat on the floor. On the date of M.H.'s death the mother was residing in M.H.'s father's home. The mother was previously residing in a transitional living facility. The mother said that she recently moved from the facility because the other residents continuously complained she was not caring for M.H. or RCW 74. twin sibling. On the date of M.H.'s death, there was a CPS case pending closure.

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. Committee members had no prior direct involvement with M.H. or RCW 74. 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 had been involved with the family.

Case Overview

On October 16, 2020, M.H. and RCW 74. twin sibling came to the attention of DCYF when a call was received reporting the mother may need services. In RCW 74.13.515 2020, at RCW 74.13.520 gestation, the mother gave birth to twins. Because of the premature birth, the twins were cared for in the Neonatal Intensive Care Unit (NICU). M.H. remained in the NICU RCW 13.50.100 . It was reported that the mother had a troubled childhood and was residing in transitional housing before the babies' birth. Because there was no allegation of abuse or neglect, DCYF did not screen in for investigation.

On December 5, 2020, DCYF received a call from a confidential referrer who reported concerns about M.H. and RCW 74. twin sibling not gaining weight and crying for extended periods of time. The report also indicated that the mother was limiting the amount of formula given to M.H. and RCW 74. sibling. Additionally, it was reported the mother had recently been hospitalized for concerns of RCW 74.13.520, RCW 74.13.520, and may have been taking medications for RCW 74.13.520.

[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 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. 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 M.H.'s parents are not used in this report because neither parent has been charged with a crime in connection with the fatality incident. M.H.'s name is also not used in this report because RCW 7 name is subject to privacy laws. See RCW 74.13.500.

This intake screened in for a CPS investigation with a 24 hour response.

On December 5, 2020, DCYF's initial response was provided by an after-hours caseworker. The caseworker met with the mother and the infants at the transitional living house. The caseworker told the mother about the allegations and concerns about the infants' feeding routine and lack of weight gain. The mother shared that M.H. had been diagnosed with Gastroesophageal Reflux Disease (GERD) and was taking medication. The mother said that M.H. spits up frequently and that [redacted] twin, [redacted]. The mother provided the caseworker with the infants' primary care doctor's name and stated that the doctor had not expressed a concern about their weight. The mother also said that both of the [redacted] weighed [redacted] at their last check-up.

The caseworker spoke with the mother about her support system, which included the transitional living house staff, a therapist, and her grandmother. The caseworker discussed Safe Sleep[3] and viewed the crib that was located in the mother's room. The mother denied that both infants sleep in the crib together and said that she also uses a bassinet, which was upstairs during the visit. The caseworker did not view the bassinet. The caseworker also discussed the Period of Purple Crying[4] and other related infant safety information. The mother acknowledged an understanding and said that she had previously taken a Period of Purple Crying class. The caseworker observed a diaper change for both infants and did not see any concerning marks or injuries. The caseworker spoke with staff at the transitional living home who expressed concerns for the mother due to her being a single mother of premature twins and who was continuing to learn parenting skills. The staff described the types of supports offered to the mother and babies. The staff person told the caseworker that if additional concerns arose, they would call CPS.

On December 8, 2020, a daytime CPS caseworker assumed the case assignment. The worker immediately attempted to contact the mother, but was unable to contact her. During the month of December, the caseworker unsuccessfully attempted contact five more times. The caseworker spoke with the transitional living facility and asked the facility to help the mother respond to the caseworker's contact efforts. The caseworker also requested the infants' health records but was unsuccessful due to a technical problem at the medical facility.

On January 7, 2021, a supervisory review was conducted indicating no safety threat had been identified and the infants were up to date on their medical appointments. The transitional living programs helped the mother get to and from appointments and provided daily oversight of the mother and infants. It was also noted that the transitional living home staff were mandated reporters and they had no current concerns. On January 10, 2021, the investigative assessment was completed identifying the efforts to contact the mother and describing the current transitional housing arrangement.

[3]For information about safe sleep, please refer to: 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. For information about crib safety, see http://www.cpsc.gov.

[4]For information about Period of Purple Crying, please refer to http://www.purplecrying.info/what-is-the-period-of-purple-crying.php.

On January 13, 2021, DCYF received a call reporting the mother was not providing the necessary care for her infants and was requiring others in the transitional living home to provide assistance. The allegations included excessive infant nighttime crying, the mother's failure to feed the infants, leaving the infants unsupervised in swings in the living area and going back to bed, and failing to frequently change the infants' diapers. The failure to frequently change their diapers caused the infants to have urine-soaked bedding and clothing. This intake screened in for a CPS investigation with a 24-hour response time.

On January 14, 2021, the CPS caseworker contacted the transitional living program to discuss the concerns. The program provided additional details, including the mother's failure to feed the infants when they were crying and using a pacifier instead. The program reported the infants were not kept clean and had raw bottoms from diaper rash. M.H. had developed sores in [redacted] neck creases. It was also reported that the mother gets "mad" with M.H. because [redacted] has GERD. The caseworker learned that 911 has been called due to M.H. vomiting out of [redacted] nose. The program also shared that the mother went to the mental health hospital because she forgot to take her medication.

The CPS caseworker also met with the mother at the transitional living home. The mother denied the reported allegations stating she only allowed the infants to cry for a maximum of 10 minutes. The mother described the infants' daily routine. The mother also reported that she went to the doctor because of M.H.'s skin sores and was prescribed a cream. She reported that M.H. has a specialty appointment scheduled with [redacted]. The mother told the CPS caseworker she took M.H. to the [redacted] emergency department due to vomiting and was told she would need to wait for [redacted] scheduled appointment. The mother said that since their birth, the father had been minimally involved with the infants. The father's parents wanted to be involved with the children, but due to the pandemic were not leaving their senior home. The mother reported having a [redacted] diagnosis. However, after experiencing [redacted], she went to the hospital to have her medications adjusted. The mother reported her condition was stable. The mother agreed to sign a release of information so the CPS caseworker could request the records.

The CPS caseworker saw the infants, observed a diaper change, and did not see any significant concerns. M.H.'s neck was slightly red, but there were no open sores or diaper rash. The CPS caseworker discussed Safe Sleep and the Period of Purple Crying, and the mother acknowledged understanding. The CPS caseworker observed that the sleep environments included a crib and bassinet. The CPS caseworker did not identify any safety concerns.

On January 19, 2021, the mother's mental health records were requested. On February 23, 2021, the CPS caseworker spoke with the babies' primary care physician. It was shared that due to transportation problems the mother had to re-schedule a few appointments. The physician reported the mother was attentive, but struggles feeding M.H. To prevent upsetting M.H.'s stomach, she feeds [redacted] smaller amounts more frequently. The physician stated the mother could benefit from parenting assistance, but had not seen evidence of neglect.

On February 25, 2021, a supervisory review occurred. The review noted no safety threats but concluded that there was a moderately high risk. The review determined the next step was to contact the father. The CPS

caseworker made two unsuccessful attempts. On March 9, 2021, the investigative assessment was completed, reviewed by the supervisor, and approved for case closure.

At 5:26 pm on March 9, 2021, DCYF was notified of M.H.'s death. A CPS investigation was assigned to a DCYF office in an adjacent county because the mother had moved without the caseworker's knowledge. The law enforcement investigation into M.H.'s death is open and active at the time of the review and writing of this report. The CPS investigation also remains open and without a finding. The CPS investigation's outcome will be impacted by the law enforcement investigation.

Committee Discussion

During the review process, the Committee had the opportunity to interview caseworkers, supervisors, and area administrators. The Committee identified positive practices during DCYF's work with this family. The Committee also identified areas where they saw missed opportunities to further assess the parent and infant's needs.

Throughout DCYF's involvement with this family, the Committee appreciated the strong description of how present danger was assessed. The Committee agreed that the after-hours caseworker provided a strong assessment of present danger as well as comprehensive exploration of concerns given their limited scope in the role as an after-hours caseworker. The Committee also recognized that the caseworker assigned to the second CPS investigation made attempts to gather more information for the family assessment. The caseworker made appropriate collateral contacts and worked to gather relevant records. The caseworker who was involved with the second CPS investigation made thorough efforts to gather more information, including obtaining records and communicating with collateral contacts.

The Committee had a robust conversation about what they believe encapsulates a thorough, comprehensive assessment and areas where the Committee saw opportunity for improvement. Key areas identified by the Committee included relevant collateral contacts, gathering detailed information, and collaboration with community partners. An underlying component woven throughout this conversation was the fact the mother resided in a transitional living facility and how DCYF navigated, worked, and collaborated with the agency.

The Committee discussed DCYF's responsibility to assess a parent's living environment, in particular, while a parent is residing in facility-based housing. The Committee wondered about DCYF's responsibility as it relates to assessing a transitional living program, and, whether the program was meeting the parent's needs. The Committee learned about DCYF's interactions with the facility and its staff. However, the Committee felt the caseworkers could have asked the staff more targeted questions about their concerns. The Committee also felt it may have been helpful to ask for more detail about the services and supports offered by the facility. For example, parenting support groups were offered, but it was not clear what skills the parent may have been learning through this service. Because the facility was reporting on the mother's mental health status, the Committee also wondered about the facility staff's qualifications. The Committee wondered whether the staff had been trained as mental health professionals.

The Committee also considered DCYF's roles and responsibilities, versus the transitional living facility's roles and responsibilities. The facility assured DCYF they would report any additional concerns to DCYF, but the Committee wondered if the facility had an exhaustive knowledge about what types of concerns to report. For

example, before M.H.'s death, the family moved from the transitional living facility. This was not reported to DCYF until after M.H's death. The Committee emphasized the importance for DCYF to clearly communicate its role, expectations, and any anticipated next steps for DCYF case planning, such as case closure. The facility may have relied on DCYF to continue providing support to the parent, while DCYF may have relied on the facility to report concerns.

The Committee noted additional concerns associated with the mother's temporary residence at the transitional living home. First, the facility reported the facility's address is confidential in order to support domestic violence victims. This is the case despite the fact that the after-hours caseworker accessed the facility with relative ease. On the other hand, the initial CPS investigator opted not to complete an unannounced visit when the mother was non-responsive to their phone calls. The supervisor reported this was due to the belief that DCYF would be denied access to the facility. Based on the after-hours caseworker's success in scheduling an unannounced visit, the Committee believes the initial CPS caseworker could have made efforts to attempt to coordinate a visit. Second, there was a reference in the case history to domestic violence between the mother and father. Also, the transitional living facility asked, and the initial CPS caseworker agreed, to not contact the father due to domestic violence concerns. The Committee felt the domestic violence history warranted further investigation. Third, the Committee believes DCYF should have made reasonable efforts to contact and notify the father about the (initial) CPS investigation.

The Committee highlighted positive practice areas, including initiating relevant collateral contacts to assist with the safety assessment. The Committee also identified areas that additional information gathering may have occurred. The Committee appreciated that the second CPS caseworker requested the mother's mental health records and learned from the caseworker there are barriers to access when requesting records from the local mental health provider, even when a release of information has been signed by the parent. The Committee believed the information in these records may have helped to assess the mother's ongoing needs. Given that the records were not received, the Committee felt more targeted questions directed to the mother could have been asked, including details about her counseling and medication schedule. To assist with addressing her needs, the Committee believes a shared planning meeting may have been an opportunity to wrap supports around the mother. The Committee recognizes that based on the mother's resistance to CPS, she may have declined to participate.

In addition to wanting more detailed information about the mother's needs, the Committee would have liked to have seen more detailed information about M.H. and [redacted] sibling. For example, the Committee wanted more detailed information about upcoming medical appointments, the feeding schedule, and M.H.'s medication schedule and routine. The Committee believes this information may have been helpful to identify and evaluate the family's needs, and build appropriate supports so the mother could meet the identified needs. The Committee appreciates the initial CPS caseworker's efforts to request medical records and make relevant contacts with M.H. and [redacted] sibling's doctor.

The Committee also discussed the infant safety assessment and DCYF's approach to communicating with parents about Safe Sleep and the Period of Purple Crying. The Committee reviewed the case file's documented conversations and noted additional infant safety discussions occurred betweeen the mother and DCYF. The Committee wondered if instead of only documenting that the safe sleep discussion occurred, it would be

beneficial for the caseworkers to include in the documentation a description of the actual discussion. The Committee also discussed the relationship between infant safety and postpartum depression. The Committee recognizes that DCYF caseworkers cannot be experts in all areas, but wondered how DCYF may improve efforts to support mothers experiencing postpartum depression.

Findings

The following key areas were identified as findings through the course of this review.

The Committee identified a strong approach to how present danger was assessed throughout DCYF's contacts with the family. The Committee believes the initial assessment completed by the after-hours worker addressed all of the present danger elements, which was continued throughout DCYF's contacts with the family.

The Committee believes there were missed opportunities to gather relevant information to complete an accurate and comprehensive safety assessment. The Committee believes the following subject areas may have benefited from more attention and information gathering:

- A clear outline of both infants' needs, including M.H.'s medical care needs, medication schedule, and detailed feeding schedule.
- Additional assessment and support related to the mother's mental health and well-being. This includes obtaining information about (1) the mother's hospital discharge that was based on a verbal report from the mother, (2) records requested from the hospital, (3) the mother's medications, (4) schedule, and (5) participation in any other services.
- The domestic violence history between the parents. Pursuant to policy, a domestic violence assessment was appropriate.

Recommendations

In an effort to build DCYF's collaboration with community partners and service providers in this region, the Committee recommends: (1) that DCYF's roles and responsibilities be clarified with the various stakeholders (2) DCYF emphasize to the stakeholders the importance and urgency of information sharing, and (3) DCYF describe to the stakeholders the impacts on child safety when information is not timely shared.

The Committee recommends this region develop a formal plan that describes how to respond when a community provider refuses to release records to DCYF. Recommendations for this plan include a description for when it is appropriate to notify DCYF's chain of command about the refusal. It was also suggested that regional leadership (area administrators) work with community based providers and partners to educate the providers and partners about DCYF's roles and responsibilities, and how DCYF uses the records to assess child safety.