CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

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CONTENTS

Nondiscrimination Policy

The Department of Children, Youth, and Families (DCYF) does not discriminate and provides equal access to its programs and services for all persons without regard to race, color, gender, religion, creed, marital status, national origin, sexual orientation, age, veteran's status, or the presence of any physical, sensory, or mental disability.

Full Report

Child

- M.M.

Date of Child's Birth

- [redacted] 2021

Date of Fatality

- Sept. 7, 2021

Child Fatality Review Date

- Dec. 1, 2021

Committee Members

- Shannon Sullivan, MSW, Alliance for Child Welfare Excellence, Continuing Education Specialist
- Patrick Dowd, JD, Office of the Family and Children's Ombuds; Director
- Shelley Little, RN, BSN, CCM, IMH-E®, Benton-Franklin Health District, Public Health Nurse
- Christopher Mejia, MSW, Department of Children Youth and Families, CPS Quality Assurance Program Manager

Facilitator

- Cheryl Hotchkiss, Department of Children, Youth, and Families, Critical Incident Review Specialist

Executive Summary

On Dec. 1, 2021, the Department of Children, Youth, and Families (Agency) convened a Child Fatality Review (CFR)[1] to assess the Agency's service delivery to M.M. and [redacted] family.[2]

On Sept. 15, 2021, the Agency learned about M.M.'s death from [redacted] Child Protective Services. M.M. died eight days earlier while in the care of [redacted] parents. M.M. was allegedly found unresponsive after sleeping on the couch with [redacted] mother. At the time of the writing of this report, law enforcement was still in the process of investigating M.M.'s toxicology and autopsy reports to confirm whether there was a suspected exposure or ingestion to methadone and/or other substances.

A diverse committee was assembled to review DCYF's involvement and service provision to the family. The CFR Committee (Committee) included members with relevant expertise selected from diverse disciplines within the community. Committee members did not have any involvement or contact with M.M. or [redacted] family before the fatal incident. The Committee received a case chronology and other relevant documents, including but not limited to intakes, case notes, medical records, and other Agency documents maintained in the Agency's electronic computer system.

The Committee interviewed a Child Protective Services (CPS) investigative caseworker and CPS supervisor who were assigned to a 2021 intervention.

Case Overview

M.M. was born in [redacted] 2021. On [redacted] 27, DCYF received information that M.M. was experiencing withdrawal symptoms. M.M.'s parents both had a history of drug use. DCYF opened an investigation and after-hours caseworkers went to the hospital. The after-hours caseworkers learned that both parents were recovering from methamphetamine and/or opiate addictions. The mother told medical staff she was engaged in methadone clinic services at an [redacted] clinic. The parents were living in Washington, but the [redacted] clinic was the nearest clinic to the parents' residence. The parents were residing with the maternal grandfather. The medical staff reported no behavior concerns by the parents or concerns for M.M. while [redacted] was under the parents' care. The hospital's medical staff said the parents were very appropriate and attentive to M.M.'s needs. Medical staff reported providing safe sleep instructions two different times. The DCYF after hours caseworkers also discussed safe sleep[3] with the parents.

On Aug. 30, the primary caseworker made initial telephonic contact with M.M.'s mother. The caseworker discussed a Plan of Safe Care[4] (PSC) and M.M.'s mother agreed to the plan. The caseworker discussed safe sleep and the mother said that she had previously watched videos on the subject. The caseworker spoke with the maternal grandfather who agreed to follow the PSC and allow M.M. and [redacted] parent to live with him.

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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)]." 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 the Agency 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 Agency employees or other individuals.

[2] No one is named in this report because no one has been charged with a crime in connection with the fatal injuries. See RCW 74.13.500.

[3] For a description of Safe Sleep Guidelines, see: https://www.nichd.nih.gov/sites/default/files/2019-02/Safe_Sleep_Environ_update.pdf

[4] For a description of Plan of Safe Care, see: https://www.dcyf.wa.gov/1100-child-safety/1135-infant-safety-education-and-intervention

On Aug. 31, the assigned caseworker visited the parents, grandfather, and M.M. at the home. The caseworker reviewed the PSC and safe sleep guidelines with all the adults. The parents and grandfather agreed with the plan and safe sleep guidelines. For purposes of crisis planning, the plan required the mother to establish medical care for M.M. at the local clinic, maintain a safe and stable home, comply with safe sleep guidelines, use the local RCW 74.13.515 medical facility for medical emergencies, engage in WIC and First Steps for parenting support and resources, and view and comply with a video on Period of PURPLE Crying. The mother also agreed, if necessary, to connect with DCYF Family Voluntary Services. The mother and grandfather agreed to be responsible for ensuring M.M. would be under the constant care of an adult. The caseworker observed a bassinet and safe sleep area for M.M.

On Sept. 15, 2021, DCYF learned that while with RCW 7 parents, M.M. died in RCW 74.13.515 eight days earlier. RCW 74.13.515 CPS was told the family recently moved to RCW 74.13.515 into a friend's home. The friend is known to law enforcement for drug-related activity. M.M.'s mother was allegedly co-sleeping with M.M. on a cushioned chair when M.M. died. The RCW 74.13.515 CPS worker informed DCYF that law enforcement was investigating whether M.M. ingested or was exposed to methadone. If there was ingestion or exposure, law enforcement will investigate whether the possible ingestion or exposure was a possible contributor and/or cause of M.M.'s death. At the writing of this report, no charges have been filed and the toxicology results are pending.

Committee Discussion

The Committee recognizes DCYF was involved with this family for a limited amount of time before the fatality. The Committee also understands DCYF was unaware of the family's move to RCW 74.13.515 The Committee believes the caseworker and supervisor were working within the required policies and practices during the limited intervention.

The Committee believes there were opportunities for improvement during the limited intervention with this family. For purposes of the initial assessment and creation and implementation of the Plan of Safe Care, the assigned case worker primarily relied on information from the mother and grandfather. The Committee views the plan as minimally helpful for purposes of providing emergency and routine supports for the family to enhance safety for M.M. There was limited DCYF engagement with M.M.'s father for purposes of plan involvement, and DCYF had limited knowledge about the father's daily impact on the family household. As it relates to an overall accurate assessment of the child's safety and home functioning, the Committee also believes that during the initial contacts the caseworker might have been able to gather additional individual and household functioning information from both parents and their supports.

The Committee believes the plan should have included the following: dates for provider first follow up appointments, involvement by both parents, a full description of the grandfather's role as a family support, and clarification on chemical dependency and post partem supports. The Committee also observed that the WIC and First Steps provider contact information should have been included in the plan. The Committee heard from the supervisor that the local office was receiving additional training and support from regional program managers to enhance development and the efficacy of these plans. The Committee did not make a finding or recommendation related to this topic.

The Committee discussed the importance of collaboration and communication related to the ability to protect M.M. and to better assess the parents' individual and household function. The Committee learned from the caseworker and supervisor that one of the parents' providers located in RCW 74.13.515 refused to supply information

to DCYF even if the parent signs and agrees to a release of information. The provider would only notify the client/parent that DCYF attempted to contact the provider. The Committee recognized and appreciated DCYF's efforts to communicate with the substance use provider.

The Committee discussed the communication constraints that may limit substance use providers from sharing information if there is not a signed information release or when a release is rescinded by a client. Discussion about the necessary legal requirements for DCYF's information release forms caused the Committee to consider what improvements DCYF could make to the forms. Some Committee members who participated in prior CFRs observed there have been prior CFR Committee discussions and recommendations about the DCYF forms. The Committee learned about a prior recommendation on this topic that has yet to be implemented.

The Committee learned that some substance use providers throughout Washington state often refuse to share information with DCYF even if they have all the necessary forms and/or signed information releases. The Committee believes that for DCYF to protect children, DCYF needs access to parental substance use treatment records. This is a statewide issue and, according to some Committee members, it is also a public health issue. The Committee discussed that, due to state and federal laws, DCYF does not always have the authority to make legal changes to facilitate access to substance use treatment records. The Committee discussed the state legislative process and legal amendments necessary to facilitate access to the substance use treatment records. The Committee understands the treatment provider in this case was an RCW 74.13.515 provider. The Committee understands that regardless of potential legal changes for records access within Washington, RCW 74.13.515 providers may still not be required to provide such records. The Committee believes the local Area Administrator should contact the specific RCW 74.13.515 provider to attempt to resolve communication barriers and improve relationships between the provider and the local DCYF office.

The Committee briefly discussed the role of the Area Administrators statewide to communicate and reach out to local community providers when issues arise that impact DCYF's ability to gain access to child safety information. The Committee members opined that without parental substance use information, DCYF child safety assessments cannot be complete and/or accurate. To effectively and accurately assess child safety, the Committee opined that DCYF should have the legal authority to receive and share parent substance use treatment information.

The Committee discussed whether DCYF should have conducted a Family Team Decision Making meeting (FTDM)[5] before M.M. was discharged from the hospital. The Committee learned from staff that an FTDM was unnecessary because the parents were observed to be bonding with M.M., displaying appropriate behaviors at the hospital, and meeting M.M.'s caretaking needs. The caseworker and supervisor explained that FTDMs are scheduled when DCYF is considering placement. The information gathered and assessed at the time of M.M.'s discharge did not warrant placement or an FTDM. The Committee did not make an FTDM finding.

Findings

The Committee finds that the local office was experiencing communication barriers with the substance use clinic in RCW 74.13.515 on a regular basis.

[5] For a description of the family team decision making meetings process, see https://www.dcyf.wa.gov/1700-case-staffings/1720-family-team-decision-making-meetings.

Recommendations

The Committee recommends that the local Area Administrator contact the director of the [redacted] clinic to identify communication issues and attempt to develop rapport. At the writing of this report, the local Area Administration and regional administration had taken notice of the recommendation and informed the writer that the recommendation will be implemented.