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

- N.H.

Date of Child's Birth

- [redacted] 2022

Date of Fatality

- December 19, 2022

Child Fatality Review Date

- March 22, 2023

Committee Members

- Cristina Limpens, MSW, Senior Ombuds, Office of the Family and Children's Ombuds
- Paul Kallmann, MSW, Quality Practice Specialist, Department of Children, Youth, and Families
- Brandy Johannesson, CPS Supervisor, Department of Children, Youth, and Families
- Cathy Assata, Substance Use Disorder Department Director, Center for Human Services

Facilitator

- Leah Mattos, MSW, Critical Incident Review Specialist, Department of Children, Youth, and Families

Executive Summary

On March 22, 2023, the Department of Children, Youth, and Families (DCYF) convened a Child Fatality Review (CFR)[1] to examine DCYF's practice and service delivery to N.H. and RCW 74. family. N.H. will be referenced by RCW 74. initials throughout this report.[2]

On December 20, 2022, the medical examiner's office notified DCYF that N.H. had died on December 19, 2022. It was reported that N.H. had been put in the bathtub by the mother and grandfather due to a soiled diaper. The referrer said they were unclear about who was supposed to be watching N.H. The mother returned to find N.H. floating in the water with RCW 74. legs and arms extended. Emergency medical services responded and administered CPR for approximately one hour, but N.H. was not able to be revived and was pronounced dead at the scene. The referrer said the mother had a fentanyl[3] abuse problem and there was burnt foil and clear baggies of powder located in the home. The medical examiner reported to DCYF that N.H. passed away from asphyxia (drowning) and acute fentanyl intoxication. The manner of death is homicide.

In the prior year, N.H. and RCW 74. family were involved with Child Protective Services (CPS), but did not have an open case at the time of N.H.'s death. DCYF assigned a new CPS case to investigate the circumstances surrounding N.H.'s death. Law enforcement also opened a case.

A CFR Committee (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, the parent ally set to serve on the Committee had an emergency and was not able to participate as planned. Committee members had no prior direct involvement with N.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 speak with DCYF field staff who were involved with supporting the family.

Case Overview

In February 2022, DCYF received a report that at the time of N.H.'s birth, RCW 74. mother tested positive for methadone and marijuana. The referrer said the mother reported substance use, including fentanyl, opiates, and methamphetamines, and most recently used approximately 10 days prior. The referrer said the mother

[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 CFR should not be construed to be a final or comprehensive review of all 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 to replace or supersede investigations by courts, law enforcement agencies, or other entities with legal responsibility to investigate or review some or all the circumstances of a child's fatal injury or near fatal injury. Nor is it the function or purpose of a CFR to recommend personnel action against DCYF employees or other individuals. "The restrictions [described in this paragraph, and the paragraph immediately above,] do not apply in a licensing or disciplinary proceeding arising from an agency's effort to revoke or suspend the license of any licensed professional based in whole or in part upon allegations of wrongdoing in connection with a minor's death or near-fatality reviewed by a child fatality or near-fatality review team." See RCW 74.13.640(4)(d). See: https://app.leg.wa.gov/RCW/default.aspx?cite=74.13.640.

[2]N.H.'s name is not used in this report because RCW name is subject to privacy laws. See RCW 74.13.500.

[3]For information about Fentanyl, see: https://www.cdc.gov/opioids/basics/fentanyl.html. Last accessed on March 28, 2023.

has been connected to services, such as the Parent-Child Assistance Program[4] (PCAP), substance use disorder (SUD) treatment, and Women, Infants, and Children[5] (WIC). A CPS risk-only[6] case was assigned.

On February 15, 2022, the assigned CPS caseworker contacted the referrer, who reported N.H. was doing well and was continuing to be monitored. The caseworker conducted an initial face-to-face visit with the mother and grandmother at the hospital. The grandmother identified herself as a support person for the mother and said the mother and N.H. would be residing in her home. The caseworker confirmed a time to complete a walkthrough of the grandmother's home. The mother told the caseworker about her participation with SUD treatment services, but acknowledged having "slip ups." The mother said she wanted to stay sober and was participating with medication-assisted treatment. The caseworker also observed N.H., who was doing well and was anticipated to be discharged following 96 hours of monitoring.

On February 16, 2022, the caseworker completed a walkthrough of the grandmother's home. The grandmother showed the caseworker a bassinet and pack and play. The caseworker noted that the home was free of any safety concerns.

On February 17, 2022, a Family Team Decision Making Meeting[7] (FTDM) was held to discuss a plan for N.H.'s discharge. A safety plan was developed to mitigate the safety threat, which included the grandmother checking on the mother and N.H. a minimum of three times daily and notifying the caseworker if the mother was engaged in active substance use. The mother and grandmother agreed to the plan, and it was determined that N.H. would remain in [redacted] mother's care, residing in the grandmother's home. The caseworker received a call from the hospital social worker reporting that N.H. was doing well and was anticipated to discharge that evening. In preparation for discharge, the caseworker met with the mother and grandmother at the hospital. They reviewed and signed the safety plan and completed a Plan of Safe Care[8] identifying how N.H's. well-being needs would be met. [redacted] The caseworker observed N.H. and did not note any concerns.

On February 25 and March 3, 2022, the mother completed urinalysis testing. Both results were negative for all substances.

On March 7, 2022, a monthly supervisor review took place. Documented tasks to be completed included an early learning staffing, staffing with the Family Voluntary Services[9] (FVS) program, complete case notes, and

[4]For information on Parent-Child Assistance Program (PCAP), see: https://pcap.psychiatry.uw.edu/. Last accessed on March 28, 2023.

[5]For information on Women, Infants, and Children (WIC), see: https://doh.wa.gov/you-and-your-family/wic. Last accessed on March 28, 2023.

[6]A CPS Risk Only investigation should be screened in when there are "reports [that] a child is at imminent risk of serious harm and there are no [child abuse or neglect] allegations." For more information about CPS Risk Only Investigations, see https://www.dcyf.wa.gov/practices-and-procedures/2200-intake-process-and-response.

[7]For information about the Family Team Decision Making (FTDM) meetings process, see: https://www.dcyf.wa.gov/1700-case-staffings/1720-family-team-decision-making-meetings.

[8]For information about Plan of Safe Care, see: https://www.dcyf.wa.gov/safety/plan-safe-care.

[9]For information on Family Voluntary Services (FVS), see: https://www.dcyf.wa.gov/policies-and-procedures/3000-family-voluntary-services-fvs.

obtain a release of information to contact the mother's SUD provider. The mother provided another urinalysis test, which was negative for all substances.

On March 10, 2022, a supervisory staffing took place between the CPS and FVS programs to discuss case transfer. The staffing concluded that the case would remain with the CPS caseworker and would not transfer to FVS due to the mother being involved in community-based services that were meeting her recovery needs and residing with a supportive relative. The mother completed two additional urinalysis tests, and both were negative for all substances.

On March 23, 2023, the caseworker completed a health and safety visit with the mother and N.H. When asked the mother told the caseworker she remembers Safe Sleep[10] and Period of Purple Crying.[11] The caseworker observed N.H.'s sleep environment and did not note any concerns. The caseworker also did not identify any unmet needs.

On March 30, 2023, the caseworker completed a health and safety visit with the mother, grandmother, and N.H. The only concern the family brought up was the accountability of needing to call daily for the mother's random urinalysis tests, but the mother said that her SUD provider would start completing urinalysis testing for her. The mother and caseworker spoke with the mother's SUD peer counselor who reported that the mother was actively engaged and attending all meetings. The mother and caseworker called her PCAP worker who also reported no concerns and said the mother was very engaged with services. The caseworker received copies of records from the mother's SUD provider.

On April 4, 2022, a monthly supervisor review occurred noting the case would be submitted for closure. The investigative assessment was completed identifying N.H. as safe in RCW 74. mother's care.

On April 20, 2022, an early learning staffing took place to discuss possible services for N.H. A referral was completed for home-based early head start through a local provider.

On December 20, 2022, the medical examiner notified DCYF that N.H. had died the day prior. The medical examiner reported that RCW 74. was left unattended in the bathtub, and when the mother returned to the bathroom, N.H. was found floating in the bathtub. Emergency medical services made efforts to revive N.H. for approximately one hour. N.H. was pronounced dead at the scene. At the time of this report, the CPS investigation regarding the circumstances of N.H.'s death is still pending.

Committee Discussion

The Committee commended the caseworker on their efforts with this family and discussed positive aspects of their work. The Committee pointed out the timeliness in response and the inclusiveness in working with both the mother and the grandmother. Other positives included the caseworker's review of services for the mother, including a staffing for consideration of FVS, an early learning staffing to connect N.H. with services, and providing the family with concrete goods to meet the family's identified needs. Lastly, the Committee

[10]For information about Safe Sleep, see: https://safetosleep.nichd.nih.gov/safesleepbasics/about. Last accessed on March 28, 2023.

[11]For information about Period of Purple Crying, see: http://www.purplecrying.info/what-is-the-period-of-purple-crying.php. Last accessed on March 28, 2023.

appreciated the caseworker's decision to hold an FTDM to have an open dialogue about the identified needs and to develop a plan to address the family's needs.

The Committee learned from this office about the hardships they have experienced, particularly in maintaining and hiring new employees. A Committee member pointed out that the workforce crisis has been a common theme across DCYF offices statewide. The Committee inquired about the caseworker's length of time with the agency, which was approximately six months at the time this case was assigned. The Committee asked the caseworker about what training and supports were available to them following completion of Regional Core Training (RCT). The caseworker said he was able to shadow another caseworker in the field on one occasion, and his supervisor accompanied him in the field one time. The Committee pointed out that due to amplified caseloads and high vacancies at the office, it may be difficult to prioritize completion of supplemental trainings and offer coaching and supports after RCT. The Committee discussed the importance of supporting caseworkers with on-site training once they are assigned cases, so that they can learn the intricacies of the work. The Committee also discussed the value in targeted trainings, for both new employees and seasoned field staff, as they create an opportunity for new learning and may address quality assurance.

The Committee discussed suggestions on how to address current vacancies, particularly for this office and region. The assigned caseworker, now approximately 18 months into their career, told the Committee they currently have 55 cases. The Committee talked about how when caseloads are this high, child safety is the focus and that other tasks may fall by the wayside. The Committee expressed the importance of the offices being staffed appropriately to meet the workforce demands and suggested that regional support positions and non-case carrying positions be designated for field work with a goal of providing coverage and lowering caseload size.

The Committee also discussed the needs of the mother and N.H. The Committee was interested in how the agency assessed the mother's parenting skills and abilities, given that this was her first child. The Committee heard from the caseworker that they did not observe apparent concerns and the relative caregiver did not report any concerns about the mother's parenting. The Committee learned from the caseworker that the mother's PCAP worker was teaching her about developmental milestones. The caseworker shared that when he and the mother spoke with the PCAP worker, there were no identified concerns about the mother's parenting.

The Committee appreciated that the mother was well connected with community-based recovery services and understood the agency's decision not to offer FVS to the family. The Committee found it helpful that the caseworker had obtained a copy of the mother's completed SUD evaluation, which they were aware could be challenging due to a variety of systemic barriers. The Committee learned from the caseworker about the mother's identified triggers to substance use, but wondered how a relapse plan was developed to support the triggers. The Committee understood that development of a relapse prevention plan would not be within the purview of a DCYF caseworker's role, but highlighted the importance of talking about relapse in relation to child safety. The mother may have benefited from additional discussion and planning related to keeping N.H. safe should she relapse.

Recommendations

The Committee did not develop any recommendations.