

CHILD FATALITY REVIEW



Washington State Department of
CHILDREN, YOUTH & FAMILIES



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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

- R.M.

Date of Child's Birth

- 74.13.515 2018

Date of Fatality

- November 23, 2019

Child Fatality Review Date

- April 1, 2020

Committee Members

- Mary Anderson Moskowitz, Ombuds, Office of Family and Children's Ombuds
- Tarassa Froberg, Child Protective Services and Family Voluntary Services Program Manager, DCYF
- Loyal Higinbotham, Sexual Assault Unit Sergeant, Everett Police Department
- Kathryn Busse, BS, Child Protective Services Supervisor, DCYF
- Clay Eakin, MS, SUDP, MAC, Evergreen Recovery Center

Facilitator

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

Executive Summary

On April 1, 2020, 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 R.M. and [74.13.5] family. [74.13.5] will be referenced by [74.13.5] initials throughout this report.³

On November 22, 2019, a Child Protective Services (CPS) intake screened in for the family assessment response (FAR)⁴ program, requiring a response within 72 hours. The intake alleged that the oldest child in the home had an altercation with his stepfather and was punched under the eye. No mark or swelling was observed by the referent. The blended family also included three other children, with R.M. being the youngest.

On November 25, 2019, the assigned FAR case worker went to the school to interview [74.13.515], the child who was punched by his stepfather. School personnel reported that he was not in attendance due to [74.13.515]'s infant [74.13.515] passing away over the weekend. The FAR case worker contacted law enforcement to confirm a 911 call was made from the home and request a copy of the police report. The FAR case worker called in an intake reporting the allegation that R.M. died.

The Department received a November 23, 2019, law enforcement report that verified the death of R.M. According to the report, the father called 911 after discovering the infant was not breathing and was cold to the touch. Law enforcement completed an initial death investigation and a new CPS investigation was generated to further assess the safety of the other children in the household. On December 11, 2019, the medical examiner called the Department with information that R.M.'s toxicology came back positive for methadone. It was noted by the medical examiner that this may have contributed to the death, but further investigation was necessary.

The CFR Committee includes members with relevant expertise selected from diverse disciplines within DCYF and the community. Committee members have not had any involvement or contact with R.M. or [74.13.5] family. The Committee received relevant case history to include CPS intakes and case notes. On the date of the CFR, the Committee interviewed the FAR case worker and supervisor who were assigned the case in May 2019. The FAR case worker assigned to the November 2019 intake is no longer employed by DCYF and was not interviewed. The DCYF CPS/FAR case worker and supervisor who were involved with the family in 2016 are no longer employed by DCYF.

¹Effective 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.

²A 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).

³The names of the deceased child's parents are not used in this report because neither parent has been charged with a crime in connection with the fatality incident. The names of the deceased child and her siblings are also not used in this report because they are subject to privacy laws. See RCW 74.13.500.

⁴Family Assessment Response (FAR) is a Child Protective Services alternative response to a screened in allegation of abuse or neglect that focuses on the integrity and preservation of the family when less severe allegations of child maltreatment have been reported.

Case Overview

R.M.'s family first came to the Department's attention in 2016 when three intakes were received by the Department, and were screened out due to standard criteria for screening. Allegations included supervision issues in the home, frequent late attendance at school and according to the oldest child, [REDACTED], he was being hit on the bottom. The family at that time included the mother, stepfather and two children ([REDACTED] and [REDACTED]).

On November 17, 2016, an intake screened in for family assessment response requiring face-to-face contact with the alleged victims within 72 hours. The allegation reported that the two children had been locked out of the home without an immediate response by either parent. The referent also said they often heard the stepfather and sometimes the mother yelling. Both children reportedly appeared fearful.

The FAR case worker made multiple unsuccessful attempts to contact the mother at the family home by initiating telephone contact, mailing letters to request contact and drop-ins at the home. The documentation indicates that no attempts were made to contact the biological father or stepfather. Both children were interviewed in their school setting. They reported that they had lost three different house keys, which led to them being locked out of the home. [REDACTED] told the FAR case worker that he was crying and worried that his mother may be dead because they never had to wait for more than a few minutes for her to arrive home. The younger brother expressed surprise to the FAR case worker about his brother crying and said it was not because [REDACTED] was afraid, but because [REDACTED] was eager to play his video game. The FAR case worker did not identify any bruises or marks on either child and both children indicated they felt safe at home. The FAR case worker also spoke with the school counselor who did not report any concerns for either of the children. No safety concerns were identified and the risk was assessed as low. Due to a lack of parental response, the case was submitted for closure as incomplete in January 2017.

On May 31, 2019, an intake screened in for a family assessment response with a 72-hour response time. On this date the family also included two younger children, [REDACTED] and R.M. These children were born subsequent to the Department's 2016 involvement with the family. The allegation reported that for a few weeks the oldest child, [REDACTED], had been taking food out of the garbage at school. His response to school personnel was that he was trying to help his family by bringing home food because they have a lot of bills. School personnel also learned the custodian had been giving him snacks. Because the custodian was currently on leave, the school sent additional food home with [REDACTED]. The younger brother's school counselor also called reporting that [REDACTED] was coming to school hungry. In addition, [REDACTED] appeared stressed and was frequently crying at school following a visit to his biological father's home earlier in the year. He made a statement about wanting to [REDACTED].

On May 31, 2019, the FAR case worker unsuccessfully attempted to see the family at their home. The FAR case worker also left a telephone message for the mother to call, but the mother did not immediately return the call. On June 3, 2019 the FAR case worker conducted initial face-to-face visits with [REDACTED] and [REDACTED] at their respective schools. In addition to meeting with the children, the FAR case worker also met with school counselors at the middle and elementary schools. [REDACTED] said he was getting enough food at home, but that he is a picky eater and sometimes "binge" eats junk food. He also said that he feels safe at home. The school counselor's only identified concern for [REDACTED] was that [REDACTED] had been eating out of the trash. It was noted that he [REDACTED].

13.50.100). During his interview, 74.13.515 reported that there is food in the home, but sometimes his parents do not cook. He also shared that his older brother eats all the good things for their lunches, so he does not take a lunch to school. When asked if he is hungry during the day he stated he eats two sandwiches for breakfast. During the interview, 74.13.515 did express concerns about losing privileges at home and that he may have lied, but appeared to be confused about what he may have lied about.

The FAR case worker spoke with the stepfather who acknowledged he was aware of the concerns and they had been speaking with 74.13.515 about the concerns. The following day, the FAR case worker met with the entire family at their home. Initially, the stepfather refused to allow the FAR case worker in the home to complete a walkthrough to assess the safety of the home environment. He stated that he knows his rights and did not have to allow the worker inside the home. Eventually, the family did allow the FAR case worker in the kitchen to verify there was adequate food in the home. The family was able to show how the food was stored and that snack items were locked up so that 74.13.515 would not be able to eat them at one time. The parents said this behavior was an ongoing issue. 74.13.515 was reported as having a diagnosis of 74.13.520 and 74.13.520. He was taking medications for these diagnoses. The mother reported 74.13.515 was scheduled to see his doctor next week and she would address these concerns with the doctor as well.

In addition to addressing the older children's issues, the FAR case worker assessed the younger children as well. The FAR case worker did not observe marks, bruises or anything of concern involving the younger children. The FAR case worker reviewed both Safe Sleep⁵ and the Period of Purple Crying⁶ with the parents. The mother and father said that they were co-sleeping with the youngest infant, R.M., and adamant they would continue to do so. The FAR case worker reiterated the Safe Sleep practice and offered to purchase a co-sleeper. The mother agreed, but later the FAR case worker realized this item could not be purchased by the Department and offered a portable crib as an alternate resource. The mother declined and said they already had a crib.

In July 2019, the Department recommended case closure after the completion of the safety and risk assessment. The risk was calculated as moderately high, but services were not offered because the family had already arranged counseling services for the oldest child to address his emotional and behavioral needs.

⁵Safe Sleep is a nationwide campaign to promote safe sleeping habits for children. Safe sleep practice can reduce the risk of SIDS. According to the National Institute of Child Health and Human Development, the top 10 safe sleep guidelines are: 1) Always place your baby on his or her back to sleep, for naps and at night. 2) Place your baby on a firm sleep surface, such as on a safety-approved crib mattress, covered by a fitted sheet. 3) Keep soft objects, toys, and loose bedding out of your baby's sleep area. 4) Do not allow smoking around your baby. 5) Keep your baby's sleep area close to, but separate from, where you and others sleep. 6) Think about using a clean, dry pacifier when placing the infant down to sleep. 7) Do not let your baby overheat during sleep. 8) Avoid products that claim to reduce the risk of SIDS because most have not been tested for effectiveness or safety. 9) Do not use home monitors to reduce the risk of SIDS. 10) Reduce the chance that flat spots will develop on your baby's head: provide "Tummy Time" when your baby is awake and someone is watching; change the direction that your baby lies in the crib from one week to the next; and avoid too much time in car seats, carriers, and bouncers. [Source: A Parent's Guide to Safe Sleep] <https://www.healthychildren.org/english/ages-stages/baby/sleep/pages/a-parents-guide-to-safe-sleep.aspx>

⁶The Period of Purple Crying is a method to help parents understand the time in their baby's life where there may be significant periods of crying. During this phase of a baby's life they can cry for hours and still be healthy and normal. The Period of Purple Crying begins at about 2 weeks of age and continues until about 3-4 months of age. See <http://www.purplecrying.info/what-is-the-period-of-purple-crying.php>.

On September 17, 2019, the Department received a report that [74.13.515] told school staff that he and his brother were home alone and used a gun from the safe to scare away an intruder. The school officer spoke to [74.13.515] who reported he is not aware of a gun, but that food is locked up because of his older brother. The mother reported to the school officer there is not a gun in the safe. This information did not require a response from the Department. On October 2, 2019, a report was made to the Department indicating [74.13.515] was still taking and eating food out of the garbage. The referent stated there is something “off” about the child and that he is not in counseling. The referent was also concerned the child [13.50.100]. This information was screened out as there was no reported child abuse or neglect and the Department did not investigate.

On November 22, 2019, the Department received a report that [74.13.515] said he had a fight with his stepfather about his cell phone and he was punched in the face under his right eye. The referent did not observe a mark, redness or bruising. However, [74.13.515] reported soreness. This intake screened in for a family assessment response intervention, requiring face-to-face contact with the alleged victim within 72 hours. On November 25, 2019, the Department case worker went to [74.13.515] school to complete an in-person visit and it was reported that he was not at school due to the death of his younger sibling. The mother contacted the school to report their youngest child died from Sudden Unexpected Infant Death (SUID).⁷ The school’s behavioral specialist met with the FAR case worker and shared that [74.13.515] reported concerns about the stepfather using drugs and that his mother had temporarily made the stepfather leave. The behavior specialist indicated that [74.13.515] said he would now have to take on more responsibility since his stepfather was out of the home.

The Department case worker contacted law enforcement to request a copy of the police report and received confirmation regarding the 911 call that reported the death of R.M. An intake was called in regarding the infant’s death. On December 11, 2019 the Department was contacted by the medical examiner’s office with a report that R.M.’s toxicology came back positive for methadone and that this may have contributed to the infant’s death.

Committee Discussion

In addition to interviewing the FAR case worker and supervisor who were assigned to the case in May 2019, the Committee also reviewed the Department’s case file including relevant CPS intakes, case notes and family assessments.

The Committee strongly believes the Department could have not been aware that an incident of this nature would occur based on the Department’s prior involvement with the family. Previous intakes received by the Department referenced challenges associated with the oldest child’s mild behavioral challenges and parental supervision.

The FAR case worker reported that during her interview with the step-father he disclosed a history of substance abuse and served jail time for prior offenses approximately a decade ago. Despite this history,

⁷Sudden unexpected infant death (SUID) is a term used to describe the sudden and unexpected death of a baby less than one-year-old in which the cause was not obvious before investigation. These deaths often happen during sleep or in the baby’s sleep area. See <https://www.cdc.gov/sids/about/index.htm>.

the FAR case worker did not identify any concerns related to substance use, nor was it identified as a concern in the then-current intake. The Committee discussed the Department's use of urinalysis testing for clients. From the perspective of a substance use treatment provider it would have made sense to complete a urinalysis to establish a baseline for the individual based on their past reported substance use. The Department's use of urinalysis testing is a single tool that can be used to obtain information that may be considered later for purposes of safety and case planning. Substance use on its own would need to be directly tied to child abuse or neglect to warrant the Department further intervening, which in this case it was not. The Committee did not identify missed indicators of possible problematic substance use based on the information gathered from the parents. The FAR case worker and supervisor were able to explain their rationale for not requesting urinalysis testing because it was not a concern identified in the intake, and it was not an issue that presented itself with the other information gathered from interviews with the parents, children and school personnel. Also, given this was a voluntary intervention to which the family agreed, it was unlikely they would have consented to submit urinalysis testing.

The Committee believes there were strong efforts made by the FAR case worker to engage the family. Based on the information reviewed and gathered during the interview with the FAR case worker, the Committee believes critical thinking was utilized and applied appropriately, and the Department was culturally responsive to the family. The FAR case worker was respectful of the family's beliefs, while still addressing the allegations and safety of all children in the household. This is evidenced by the FAR case worker obtaining access to the family's home despite the initial refusal by the stepfather to allow the worker to complete a walkthrough. The FAR case worker patiently worked with the family to explain everyone's role, the purpose of the intervention and the need for a safety assessment. The FAR case worker was then allowed to complete a walkthrough of the kitchen, which allowed for an assessment of the identified concerns reported in the intake.

Another strength identified by the Committee was the FAR case worker's use of databases to gather information to complete foundational work about the family and case. The FAR case worker also did a nice job documenting all databases searched and the results in one cohesive case note. The Committee discussed how important it is for Department case workers to have access to a variety of databases to be able to gather information to fully assess a family.

The Committee also highlighted the strong documentation associated with the 2016 case, as well as the case in May 2019. The documentation was detailed and provided a comprehensive picture of the concerns and how they were addressed. The FAR case worker was able to share additional information about recommendations to the family about community-based services. Although that information was not documented, the Committee recognizes there is typically more work completed on a case than is actually documented.

Safe Sleep became a concerning intervention issue for the Department and Committee. With this in mind, more information about how this was addressed was gathered from the FAR case worker and supervisor. There was clear messaging provided by the Department that included multiple telephone and in-person conversations with the family. Safe Sleep literature was also provided. The Department offered the family a co-sleeper but when the worker later learned it was not an item the Department can purchase, the Department offered an alternative resource that would have provided a Safe Sleep environment.

With both the 2016 and May 2019 case, the Committee felt there was a missed opportunity due to the lack of contact between the Department and the older children's biological father. There were no documented efforts to contact the biological father in 2016. In May 2019, the FAR case worker was aware the biological father resided out of state, but did not recall having contact with him. The Committee speculated that contact with him could have provided a more well-rounded assessment not only of the children, but also the larger family dynamic.

During the May 2019 intervention, the mother reported that in addition to the supports the oldest child had in place through his school setting, he was also taking medications and seeing a counselor. The Committee would have liked to see the case worker make contact with the counselor to verify the child was in services. The Committee also felt that contact may have been an opportunity to gather information that could have impacted service planning for the child and family.

Findings

The Committee concludes the Department should have made contact with the oldest children's biological father for purposes of both the 2016 and 2019 interventions. This may have provided additional information about the children, their needs and the family dynamic. This also would have been consistent with the Department's efforts for fatherhood engagement. The Committee also finds the Department should have made contact with the counselor the mother said the oldest child was seeing for mental health services.

Recommendations

The Committee did not make any recommendations.