CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

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CONTENTS

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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

- RCW 74.1 [redacted]

Date of Child's Birth

- RCW 74.13 515 [redacted] 2022

Date of Fatality

- May 24, 2023

Child Fatality Review Date

- August 22, 2023

Committee Members

- Cristina Limpens, MSW, Senior Ombud, Office of the Family and Children's Ombuds
- Ebony Morgan, MSSW, Dependency Supervisor, Pierce County Juvenile Court
- Jessica Vargo, adoptive and foster parent
- Anna Thompson, MSW, LICSW, Program Director, Olive Crest
- Rebecca Taylor, MSW, Interim Policy, Quality and Data Systems Administrator
- Mel Morris, Licensing Division Program Manager, Department of Children, Youth, and Families

Facilitator

- Libby Stewart, Critical Incident Review Specialist, Department of Children, Youth, and Families

Executive Summary

On August 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 [redacted] family, and [redacted] licensed foster care placement [redacted] will be referenced by [redacted] initials throughout this report.[2]

On May 24, 2023, [redacted] died. He had been left in [redacted] foster mother's car. The foster mother drove to work but forgot that he was in the car. When she returned to her car at the end of her workday, she found him in the vehicle, deceased. A licensing division child protective services (LD/CPS) investigation was initiated as well as a law enforcement investigation.

A CFR Committee (Committee) was assembled to review DCYF's involvement and service provision to [redacted]s biological family and foster 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 [redacted] 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 interview the private agency licensing staff assigned to [redacted]s foster family, DCYF licensing staff and child welfare staff involved with [redacted]s family, and the foster family.

Case Overview

On July 13, 2021, [redacted]s future foster parents applied to become licensed foster parents through a private child placing agency (private agency). Private agencies provide foster parents with added supports including case managers. When a person or family is licensed through a private agency, DCYF assigns a regional licensor. However, the regional licensor rarely, if ever, has contact with the foster family. DCYF relies on the private agency to adhere to requirements for licensing foster parents. It is DCYF's responsibility to approve and hold the foster care license, review any investigations of licensing infractions, and issue provider infractions based on investigations. The regional licensors also provide technical support and training to private agencies.

On December 6, 2021, DCYF received a complaint that the family was caring for foster children from another foster home without being licensed. This complaint did not meet the threshold for a LD/CPS investigation. They were counseled by DCYF licensing staff regarding the situation.

[redacted] was born in [redacted]2022. Due to parental substance use and inability to care for [redacted] mother signed a voluntary placement agreement.[3] [redacted] was discharged from the hospital in May of 2022 and was placed in a

[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 of 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 of 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.

[redacted]s name is also not used in this report because his name is subject to privacy laws. See RCW 74.13.500.

[3] For more information about voluntary placement agreements, see https://www.dcyf.wa.gov/4300-case-planning/4307-voluntary-placement-agreement

foster home. [redacted] was referred for [redacted] On September 12, 2022, a dependency petition was filed. [redacted]s mother then entered family recovery court.[4]

On August 29, 2022, [redacted] was taken by [redacted] foster parents to an emergency department. He was admitted and treated for [redacted] The hospital called DCYF and an intake was created. The intake was closed due to no allegations of abuse or neglect nor any licensing violations being reported. Then on December 6, 2022, another intake was received. This intake stated that the foster family obtained a [redacted] for [redacted] without notification to [redacted] biological parents. A "not valid" finding was made under WAC 110-148-1555, which addresses immunization requirements for children in foster care.

DCYF records as of May 16, 2023, stated that [redacted] was a typically developing child, other than he was not walking as of that date. He attended monthly occupational therapy. [redacted] also regularly attended child care because both foster parents were employed. He would wake up every day at 1:30 AM and would require a backrub or drink prior to going back to sleep. Also in May of 2023, [redacted]s mother was discharged from family recovery court due to non-compliance with the program requirements.

On May 24, 2023, [redacted] died. An intake was assigned to LD/CPS to investigate [redacted] death and law enforcement also initiated an investigation.

Committee Discussion

The Committee identified this situation as one that cannot be stopped by training on some specific action. Rather, there are multiple ways that people have tried to combat possibly forgetting a child in a car. Some of those ways include putting a purse or bag in the back seat to remind yourself to check, a car seat alarm, stickers to remind the driver, etc. They discussed that this incident may have been impacted by stressors experienced by the foster mother, but there was no identified correlation between any actions or inactions by DCYF staff or the private agency staff. A recent article in Consumer Reports[5] states, "[f]orgetting a child is not a negligence problem but a memory problem" However, even with this information, the added factor of this occurring to a child in the legal care and authority of DCYF comes with increased scrutiny.

The foster family had two children placed in their home. One of the children had behavioral challenges and the foster family was open about those challenges with the private agency staff and that child's DCYF caseworker. The private agency worked with the foster family on strategies to handle the behaviors, referred the family for in-home parenting support through Triple P[6], and provided resource material for the foster parents to read. [redacted]s DCYF caseworkers were not aware of the stressors the foster parents were experiencing.

The Committee discussed that contractually, private agencies are supposed to provide each child's DCYF caseworker a quarterly report. The report has over 30 items identified to be addressed. The focus of those items is the child and the child welfare case involving that child. There was discussion that including information in the report regarding overall family functioning, family being the foster family and everyone

[4] For more information about the Pierce County Family Recovery Court, see https://www.piercecountywa.gov/765/Family-Recovery-Court

[5] To read the article, https://www.consumerreports.org/cars/car-safety/anyone-could-forget-kids-in-hot-car-forgotten-baby-syndrome-a3901940661/

[6] Triple P, Positive Parenting Program is an evidence based, contracted, in-home parenting program.

living in the home, may lead to more open dialogue about stressors facing foster families. However, it was not identified as something that would have prevented this fatality, but was rather a way for more fluid and transparent sharing of information between everyone involved with a foster family.

When the DCYF child welfare staff met with the Committee, they did not recall receiving any quarterly reports from the private agency regarding [redacted] However, they did share there was frequent and helpful communication between the private agency staff and DCYF child welfare staff. This writer also contacted the court appointed special advocate supervisor for [redacted] They stated there were no concerns identified for [redacted]s care or case plan by their advocate or office. When the private agency licensing staff and DCYF regional licensing met with the Committee they shared that they did not have any concerns that would have warranted intervention with the foster family beyond what was already happening.

The Committee discussed that this type of tragedy is not a regular occurrence, even nationwide. According to a TCPalm.com article from July 19, 2023[7], there were 33 "child hot car deaths" nationwide in 2022 and as of the publishing of the article 12 so far in 2023. The article said the average number of deaths per year due to children being left in a hot car is 38, according to kidsandcars.org. The Committee discussed that some newer vehicles have warning systems alerting the driver to check the backseat, or alarms for car seats to help avoid this type of tragedy. This topic is addressed further by a recommendation made in the Recommendation section below.

Some Committee members discussed that foster families often want to help so many children and at times they struggle to realize it may not be the correct decision to increase capacity or accept a placement. This was discussed by some Committee members in this case because the family struggled at first to create space in their home for a child older than 1 year of age. The foster parents' own children experienced some struggles prior to increasing capacity. It was also discussed that some DCYF licensing and private agency staff identified that the issues were easily resolved, and the private agency licensing staff and DCYF approved an increase in capacity.

Regardless of capacity or challenges faced by the foster family, there were no identified deficiencies with the foster parents. [redacted]s foster mother routinely left her bag in the back as a reminder that [redacted] was in the back seat, but that day her routine was altered.

The Committee also brought up the extra pressure that being a foster parent creates for a person and a family. Foster parents are required to attend trainings, meetings specific to children placed in their home, comply with licensing requirements, meetings scheduled in their own home, appointments for children placed in their home, etc. On top of those activities and more, this family was experiencing long COVID, adjusting to a new and stressful job, and made the difficult decision to have the older foster child moved to a different foster home. The Committee discussed that being a foster parent is inherently stressful and hopefully reminders or devices to remind drivers, as identified in the recommendation section below, may help to mitigate some of the risk.

[7] https://www.tcpalm.com/story/news/state/2023/07/19/hot-car-deaths-florida-us-rear-seat-reminder-systems-models-available-how-they-work-babies-toddlers/70421178007/

The Committee also discussed that it may be helpful if child care providers, like schools, call if a child is not present for care and the caregiver has not alerted the provider ahead of time. After the review was completed one of the Committee members conducted inquiries into the concept of asking child care providers about notifications to parents/caregivers if a child does not show for child care. Due to a multitude of reasons, that concept was identified as not feasible.

This case had multiple child welfare caseworkers assigned between [redacted] RCW 74.13 's birth until [redacted] RCW 74. death. The Committee discussed that each time a case is transferred to a new DCYF caseworker or private agency case manager, there is a higher likelihood of information being lost or lapses in continuity between the assigned worker and the parties involved. This was not discussed as a contributing factor in this case, but as a general challenge faced by child welfare agencies and private child placing agencies alike. Turnover and vacancies often add to the stress felt by employees working in those roles.

The Committee also discussed possibly recommending an update to the initial training received by new child welfare workers. That training is currently called Regional Core Training. The discussion addressed educating the new staff regarding what private agencies are required to do for child welfare cases, including contractually required quarterly reports for each child placed in one of their foster homes. This is not currently part of the training curricula. However, this was not a unanimous recommendation. As it relates to this case, the Committee identified that it would not have contributed one way or the other to the critical incident. However, they discussed that increasing the knowledge and expanding the information obtained or contained in the quarterly reports may be beneficial for future cases. Currently, the contractually required aspects of the quarterly reports focuses on the child in out-of-home placement and their family's case; it does not include the dynamics within the placement and any challenges they may be facing.

Recommendations

The Committee members agree that DCYF's clients can benefit as a whole from the Committee's efforts to provide comprehensive discussion and analysis of the case. While recommendations stem from the many aspects of this case, there is no correlation between the death of [redacted] RCW 74.1 and the recommendations. The purpose of recommendations is to help DCYF improve their overall case procedures and practices.

1. DCYF should evaluate car seat alarms and other devices that provide a reminder to check the back seat of a car for children in car seats. The evaluation should include whether these devices should be required by foster parents who have children that require car seats. The evaluation should include assessing if DCYF could pay for those devices as opposed to requiring providers to purchase the devices themselves.
2. DCYF should review current trainings and/or policies regarding monthly health and safety visits to identify whether caseworkers receive information regarding what should be expected of private agencies and their case managers. This should include the contractually required quarterly reports as well as a discussion regarding all children in the home. This case involved a school-aged child in the foster home as well as [redacted] RCW 74.1 The other child had significant behavioral issues. Between those behavioral issues, the foster parent struggling with long-COVID, and starting a new job, there was a lot of stress in the home. The Committee identified that this was addressed well by private agency licensor in this case, but it also drew attention to the need for DCYF child welfare caseworkers to critically think about

all aspects of the needs of the children on their caseload. This includes understanding the stress level the placement provider may be under.