CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

October 2021

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CHILDREN, YOUTH & FAMILIES

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October 2021

Full Report

Child

- S.M.

Date of Child's Birth

- RCW 74.13.515 2016

Date of Fatality

- March 24, 2021

Child Fatality Review Date

- July 28, 2021

Committee Members

- Michelle Cutlip, MSW, Alliance for Child Welfare Excellence, Regional Education and Training
- Steven Bryant, MSW, Department of Children, Youth, and Families, CPS Quality Assurance Program Manager
- Patrick Dowd, JD, Office of the Family and Children's Ombuds; Director
- Heather Lemery, MSW, LICSW, MHP, Spokane Native Project, SUDP
- Ronna Washines, Yakama Nation Tribal Prosecutors Office, Prosecutor

Facilitator

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

Executive Summary

On July 28, 2021, the Washington State Department of Children, Youth, and Families (DCYF) convened a Child Fatality Review (CFR)[1] to assess the agency's service delivery to S.M. and RCW 74. family.[2]

On March 24, 2021, the agency learned of S.M.'s death from RCW 74.13.515. S.M., RCW 74. mother, and mother's partner were killed in a vehicular accident. The autopsy of the mother's partner revealed that the partner tested positive for substances, causing the partner to be driving while impaired.

The CFR Committee (Committee) includes members with relevant expertise selected from diverse disciplines within the community. Committee members did not have any involvement or contact with S.M. or RCW 74. family before the fatal incident. An area administrator for the agency Indian Child Welfare unit from Region 1 and an agency tribal liaison for Region 1 were invited to participate as Committee members, but due to scheduling, could not attend. A program and support services director from the Healing Lodge of the Seven Nations was invited but was also unable to attend. The Committee received a case chronology and other relevant documents, including intakes, case notes, medical records, and other agency documents maintained in the DCYF's electronic computer system.

The Committee interviewed a Child Protective Services (CPS) investigative caseworker, CPS supervisor, and area administrator who were assigned to interventions occurring in 2020.

Case Overview

Shortly after the birth of S.M. in 2016, the agency received notification from the hospital that S.M.'s mother was using marijuana. The report screened out because it did not meet legal sufficiency for intervention.

On Oct. 19, 2020, the agency received two reports alleging neglect to S.M. and RCW 74. younger sibling. One report was made by the landlord and the other by law enforcement. S.M.'s mother and other adults were reported as being intoxicated and involved in a physical domestic violence incident. Local law enforcement responded, finding S.M.'s mother and her partner unresponsive and the children unsupervised. Law enforcement reported they administered Narcan medication in an attempt to stabilize and/or resuscitate the unresponsive adults. The Narcan treatment stabilized the adults, and they were transported to a local hospital for further observation and treatment. For their care and supervision, S.M. and RCW 74. sibling were taken by law enforcement to the maternal grandparents. The agency opened an investigation. Because the family was living within RCW 74.13.515 land and is affiliated with the RCW 74.13.515 Tribe, the agency supervisor sent an email notice with the reported details to the RCW 74.13.515 office.

[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 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 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 agency employees or other individuals.

[2] The relatives and family who are not charged are not named in this report because they are subject to privacy laws. See RCW 74.13.500.

[3] For more information, see **http://www**RCW 74.13.515.

On Oct. 20, 2020, the assigned caseworker made initial contact with S.M.'s mother. S.M. and RCW 74. sibling were with their grandparents. The mother told the caseworker that her partner was not living in the home and only came to the house for visits. The mother denied fighting or consuming any substances other than marijuana and alcohol. The mother had an observable bruise on her left eye area. The mother blamed her brother's girlfriend for kicking her in the face when she was sleeping. The mother agreed to participate in substance use services.

The caseworker then traveled to the grandparents' home. The grandparents were concerned the caseworkers were there to place the children into foster care. The grandparents attempted to contact the tribal council and tribal law enforcement to prevent the agency from taking their grandchildren. The caseworker deescalated the situation and informed the grandparents the agency was not placing the children but gathering information about the incident and checking on the children's safety. The grandparents told the caseworker their son's girlfriend was responsible for the reported incident that occurred at S.M.'s home. The grandparents told the caseworker they would be an available placement option and would seek custody if needed. The caseworker told the Committee that telephonic contact with RCW 74.13.515 occurred just after the visit with the grandparents but was not documented in case notes. The caseworker recalled the conversation as it focused on the interaction with the grandparents and the challenges the caseworker initially faced at their home.

On Nov. 12, 2020, the caseworker called S.M.'s mother who reported being sober, not allowing her brother and his girlfriend to visit, and completing her substance use assessment. The assessment recommended RCW 74.13.520. S.M.'s mother reported no concerns about her children.

On Nov. 16, 2020, the caseworker completed a safety assessment[4] that was approved by the supervisor. No safety threats were identified.

On Dec. 16, 2020, the caseworker completed an unannounced home visit. The children appeared well, and the caseworker did not observe any noticeable distress or hazards in the home. At this time, S.M.'s mother had yet to begin her recommended RCW 74.13.520 services. S.M.'s mother self-reported that she and her partner were no longer together, and she was still not speaking to her brother.

On Dec. 16, 2020, the agency completed the investigative assessment,[5] determined the neglect allegations to be unfounded, and closed the case.

The fatal incident occurred on March 27, 2021. S.M., RCW 74. mother, RCW 74. mother's partner (who was driving), and an unrelated adult in a separate vehicle were killed in a car accident. S.M.'s younger sibling was seriously injured with near-fatal injuries. S.M.'s sibling was taken to a local hospital and eventually transferred to RCW 74 father's care. The suspected cause of the accident was the fact that the mother's partner was intoxicated. The mother was also intoxicated.

Committee Discussion

The Committee believes the 2020 assessments and interventions lacked critical thinking by the assigned caseworkers and supervisors. The Committee believes the caseworker relied primarily on the mother's self-reports and did not seek additional assessment information from available resources. The Committee voiced

[4] For more information, **see https://www.dcyf.wa.gov/1100-child-safety/1120-safety-assessment**.

[5] For more information, see **https://www.dcyf.wa.gov/practices-and-procedures/2540-investigative-assessment**.

concerns the agency did not assess the mother's denial of opiate use, given the necessary use of Narcan stabilization medication. The substance use professional on the Committee said Narcan will only work to stabilize a person who has overdosed on opioid drugs. Narcan will not work to repair damage or overdose for any other substances.

Some Committee members believe the caseworker's telephonic contact with RCW 74.13.515 was limited and focused primarily on the initial conflict at the grandparent's residence. The Committee discussed the agency's and tribal representatives' past efforts to address undue influence. Some Committee members perceived the caseworkers' call to the RCW 74.13.515 to be focused primarily on the initial conflict at the grandparent's home instead of for the purpose of assessment, collaboration, and information gathering. For purposes of information sharing collaboration and service coordination, the RCW 74.13.515 representative emphasized the importance of contacting and involving the RCW 74.13.515 Tribal Prosecutors office in addition to RCW 74.13.515. The Committee understands that a memorandum of understanding between the agency and RCW 74.13.515 continues to be developed and has not been formalized.

For purposes of a safety and risk assessment, the Committee believes the supervisor only relied on information provided by the assigned worker but did not formally review the other available information. The Committee believes the caseworkers should have been directed to seek additional information, analyze gathered information, amend inaccurate assessments, and request a shared planning meeting[6] or Family Team Decision Making meeting (FTDM).[7] Immediately after case assignment and due to the severity of the mother's condition and children's needs, the Committee also believes the supervisor should have directed the assigned CPS caseworker to hold a shared planning meeting or FTDM. Some Committee members noticed that the supervisor completed the SDMRA[8] risk assessment instead of the assigned caseworker. The Committee believes the risk assessment was inaccurately completed due to a lack of comprehensive information related to the daily functioning of the family.

The Committee believes the agency missed an opportunity for an FTDM once the mother failed to fully engage in substance use services. The Committee opined that the agency could have gathered more assessment information if there had been a shared planning meeting or FTDM that included both parents, tribal representatives from the prosecutor's office, RCW 74.13.515, extended family members, the landlord, and law enforcement. As it relates to their ability to protect the children, the Committee discussed the importance of collaboration and communication to better assess the parents' individual functioning and household function.

The Committee believes the gathered information did not result in an accurate assessment of service needs or child safety. The Committee considers the agency's response to be incident-focused, and it did not meet the minimum assessment policy requirements. The Committee noted the agency focused primarily on the mother for purposes of service engagement and case-related communication. There was no agency engagement with S.M.'s father for purposes of the assessments, service delivery, or case planning. The Committee believes the agency had limited knowledge about the father's daily impact, household support, or resources. During the interventions, the agency could have more actively sought out, attempted to engage, or involve the father. The Committee believes the agency should have contacted and interviewed the mother's partner, brother, brother's girlfriend, tribal representatives, law enforcement, and landlords. For purposes of an overall

[6] For a description of the shared planning meeting process, see **https://www.dcyf.wa.gov/1700-case-staffings/1710-shared-planning-meetings**.

[7] 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**.

[8] For more information, see **https://www.dcyf.wa.gov/policies-and-procedures/2541-structured-decision-making-risk-assessmentrsdmra**.

accurate assessment of the children's safety and home functioning, the Committee also believes the caseworker missed multiple opportunities during the initial contacts to gather additional information.

Some Committee members believe domestic violence in the home was not effectively screened nor assessed. The Committee believes this led to minimal inquiry about ongoing domestic violence and did not meet the domestic violence screening policy[9] requirements.

Findings

During the investigation of the 2020 report, the Committee found the agency failed to make or attempt contact with the children's biological father.[10]

The Committee believes the caseworker and supervisor lacked critical thinking. The Committee found that the risk, safety, investigative, and domestic violence assessments were inaccurate because there was insufficient information gathered to complete a comprehensive assessment. The caseworker did not completely consider or collaborate with the law enforcement agency that made the initial report in 2020 or with the tribal prosecutor's office. The Committee believes these resources may have provided pertinent cultural and familial assessment information. The Committee found the information available from these resources would have improved the accuracy of the overall assessment. Specifically, the caseworker could have interviewed the mother's partner, brother, brother's girlfriend, S.M.'s extended relatives, S.M.'s father, tribal law enforcement, the landlord, tribal council or prosecutors office, and the substance use provider. The Committee also believes evidence of a lack of critical thinking included the agency's oversight to fail to convene a Family Team meeting or internal case consultation with program managers.

Recommendations

The Committee learned that as a result of various training and policy improvements, the agency is addressing clinical supervision, assessment supervision, safety assessment, and efficacy statewide. The Committee recommends the area administrator determine what available trainings, if any, would benefit the caseworker and supervisor to attend for practice improvement and improving critical thinking skills. The Committee understands the regional administration has taken steps to address and implement this recommendation.

In an effort to improve practice and address case-specific deficiencies identified in the findings, the Committee recommends that in addition to potential attendance at available trainings, the caseworker and supervisor may benefit from a one on one consultation with the regional program manager or deputy regional administrator. The Committee understands the regional administration has taken steps to address and implement this recommendation.

[9] For more information, see **https://www.dcyf.wa.gov/1100-child-safety/1170-domestic-violence**.

[10] For more information, see **https://www.dcyf.wa.gov/policies-and-procedures/2331-child-protective-services-cps-investigation**.