WASHINGTON STATE
Department of
Children, Youth, and Families

CHILD FATALITY REVIEW

February 2019

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FULL REPORT

CHILD

- T.K.

DATE OF CHILD'S BIRTH

- RCW 74.13.515 2018

DATE OF FATALITY

- July 2018

CHILD FATALITY REVIEW DATE

- November 8, 2018

COMMITTEE MEMBERS

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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 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 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 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.

EXECUTIVE SUMMARY

On November 8, 2018, the Department of Children, Youth, and Families[1] (DCYF) convened a Child Fatality Review (CFR) to assess DCYF's practice and service delivery to T.K. and RCW 74 family.[2] T.K. will be referenced by RCW 74 initials throughout this report.

On July 5, 2018, DCYF received a call stating RCW 74.13 month-old T.K. had passed away. This intake was screened in for a Child Protective Services (CPS) investigation. At the time of RCW 74 death, T.K. lived with RCW 74 mother and maternal grandmother. There was an open Family Voluntary Services (FVS) case with DCYF at the time of RCW 74 death.

The CFR Committee (Committee) included members selected from diverse disciplines within the community with relevant expertise including individuals from the Office of the Family and Children's Ombuds, domestic violence advocacy, substance abuse, and child welfare. The Committee members did not have any involvement or contact with T.K. or RCW 74 family.

The Committee interviewed two DCYF staff. At the time of the CPS investigation immediately after the child's birth, another DCYF employee was providing coverage for the CPS supervisor. That person and the FVS supervisor were interviewed by the Committee. Due to the Committee's responsibility to focus on events prior to the critical incident, the Committee chose not to interview the CPS worker who investigated the fatality. The CPS worker and FVS worker both ended their employment with DCYF prior to this review.

[1] Effective 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 early learning programs).
[2] T.K.'s parents and the mother's boyfriend are not named in this report because they have not been charged in an accusatory instrument with committing a crime related to a report maintained by the Department in its case and management information system. [Source-Revised Code of Washington 74.13.500(1)(a)]

FAMILY CASE SUMMARY

On RCW 74.13.515, 2018, DCYF received an intake following T.K.'s birth because the mother told hospital staff that she used RCW 13.50.100 during the pregnancy and she was not currently connected with any treatment programs. Both the mother and T.K. tested RCW 74.13.520 at RCW 7 birth. T.K.'s mother told hospital staff that she uses drugs to RCW 13.50.1. It was also reported that T.K.'s father uses drugs, there is domestic violence between the parents, and a restraining order had been filed by T.K.'s mother against T.K.'s father. This intake was assigned as a CPS Risk Only investigation.[3] This is the first child for both parents.

The assigned CPS worker made contact with the mother and T.K. the following day at the hospital. A Family Team Decision Making (FTDM) meeting was scheduled for two days later on RCW 74.13.515, 2018, and the hospital agreed to delay T.K.'s discharge until after that meeting.[4]

The FTDM occurred as scheduled on RCW 74.13.515, 2018, and the decision was to allow the mother and baby to discharge to the maternal grandmother's home with voluntary services to start. The mother stated she self-referred for an assessment by a substance abuse treatment provider and would be starting intensive outpatient (IOP) treatment four days later on RCW 74.13.515, 2018. The mother is required to attend three classes a week and provide weekly urinalysis, attend Narcotics Anonymous groups, and enroll in parenting classes as part of her IOP. The father reported he had been ordered, by a court not through DCYF, to take anger management and domestic violence classes. The CPS worker agreed to make a public health nurse (PHN) referral within five days of the FTDM. Both parents agreed to complete random urinalyses for DCYF and the maternal grandmother agreed to let DCYF know if the mother presents a danger to T.K., does not provide adequate care for T.K., or relapses.

On March 12, 2018, the CPS worker completed a safety plan with the mother, maternal aunt, and maternal grandmother. That same day, the CPS worker conducted a walkthrough of the maternal grandmother's home. After the safety plan and walkthrough occurred, the CPS worker contacted the hospital to let them know they could discharge T.K. to RCW 7 mother.

Despite deciding at the FTDM to engage the family in voluntary services, the case did not transfer to FVS until April 2018. On April 10, 2018, the FVS worker called the mother and left a voicemail message requesting a return call. The FVS worker did this again on April 11 but did not receive a return call from the mother either time. On April 16, 2018, the FVS reached the mother by telephone. The mother reported she was looking into domestic violence (DV) shelters because her mother's home was too crowded. The mother also reported she needed a DV advocate. The FVS worker told the mother she would bring resources with her to the first home visit. The mother also reported she considered dropping the restraining order against the father so they could co-parent, but she wanted to make sure he was no longer using drugs before taking this step. The mother also reported that she would prefer to do inpatient treatment but was still attending IOP. The FVS worker also spoke with the grandmother who asked for a letter to support the addition of T.K. and RCW 7 mother in the grandmother's home due to RCW 13.50.100 housing restrictions.

On April 19, 2018, the FVS worker conducted her first home visit with T.K., RCW 7 mother, and RCW 7 maternal grandmother. When she arrived, the worker observed T.K. asleep on the mother's mattress. The worker asked if anyone had discussed safe sleep to which the mother responded yes, but the mother also indicated that T.K. would not sleep in RCW 7 bassinet. The FVS worker

[3] https://www.dcyf.wa.gov/practices-and-procedures/2200-intake-process-and-response
[4] https://www.dcyf.wa.gov/1700-case-staffings/1720-family-team-decision-making-meetings

discussed the risk of suffocation and death related to co-sleeping and bed sharing. They also discussed the mother's feelings of RCW 13.50.100 and RCW 13.50.100 The mother reported that she was receiving mental health and substance abuse treatment. The mother also provided the contact information for the child's pediatrician. The FVS worker and the mother discussed how the PHN met with the mother earlier that same day. The FVS worker provided the mother with 20 bus tickets, the letter requested for the maternal grandmother for RCW 13.50.100 housing, DV resources, housing resources, and supportive resources for T.K.'s mother to engage in groups with other new mothers to build healthy relationships.

On April 20, 2018, the FVS worker called the father and left him a message asking him to return the telephone call, but the FVS worker never heard back. On May 3, 2018, the FVS worker received a call from T.K.'s mother stating she and T.K. were in need of emergency shelter because the maternal grandmother was verbally abusive. The FVS worker provided the mother with a resource to call and the worker called the YWCA and discussed shelter options with the program manager. The FVS worker went out to the home that same day to talk with the mother and conducted a health and safety visit. During this visit, the mother reported she obtained a new Pack 'n Play that T.K. enjoyed sleeping in. The worker and the mother again went over safe sleep, and the mother reported she was no longer bed-sharing with her RCW 74.1 and that she was getting more sleep than she had been since the child was born.

The FVS worker was able to make contact with the father on May 4, 2018. He agreed to FVS services at that time. The FVS worker met with T.K.'s father on May 7, 2018. They discussed the no-contact order between the parents, that he wanted to set up visits with his RCW 74.13 his lack of follow through with the requested urinalysis tests, and that the worker recommended he complete a chemical dependency assessment. Six days later, the worker was notified that T.K.'s father had been arrested, which the worker confirmed by reviewing jail roster information online. T.K.'s mother told the FVS worker she was sad about the father's arrest and the worker discussed the mother's mental well-being with her and suggested activities she could do to cheer herself up. The mother also discussed other stressors within her household with the FVS worker pertaining to her sister and niece. The FVS worker provided guidance to the grandmother regarding this issue.

Between May 10 and May 23, 2018, the FVS worker provided the mother with more community resources to support healthy parenting including community events and domestic violence supports. The FVS worker also communicated with the PHN regarding T.K. and RCW 7 mother. The PHN stated she did not have any concerns for the family at that time. The worker also reviewed the inmate roster and learned that T.K.'s father had been released from jail. She then texted the father with information for a chemical dependency assessment and requested the father's contact information and an email address.

On May 24, 2018, the FVS worker conducted another health and safety visit. During this visit, the FVS worker observed T.K. gently shake while RCW 7 was sitting up. The mother stated RCW 7 tremors had ended a month prior but due to increased fussiness and the observed tremors by the FVS worker, the mother reached out to the PHN who stated it may just be RCW 7 age. During the health and safety visit, the mother also said she connected with a DV advocate but had not yet completed her mental health assessment, which contradicted the mother's prior statements to the FVS worker indicating she had completed the assessment. The mother further explained to the FVS worker how she has been avoiding the mental health assessment because she did not like to talk about her trauma history. The worker and mother then completed the FVS case plan. The FVS worker followed up with the mother regarding her mental health assessment on June 4, 2018, at which point the mother stated she still had not completed it yet. The FVS worker contacted the mother's chemical dependency counselor and asked for his help in encouraging the mother to complete the mental health assessment.

On June 16, 2018, the FVS worker contacted the mother again, who at that point indicated she had completed her mental health assessment. They also discussed other case activities. On June 18, the worker completed another health and safety visit at the mother's home, and the FVS worker reported no concerns for the child's safety.

During a conversation between the FVS worker and the mother on June 27, 2018, the mother indicated she was considering moving to Oregon. The mother stated she had a positive and supportive family there. After speaking with the mother, the FVS worker attempted to contact the father and left a voicemail message asking for a return call. The FVS worker also went to the mother's home later that same day to conduct another health and safety visit. When the worker arrived, the mother and T.K. were both asleep. Based on what the FVS worker observed, they had both fallen asleep while the mother was breastfeeding. When the FVS worker discussed this with the mother after she woke up, the mother stated this happens often but generally, the maternal grandmother comes in and will move the child to RCW 74 own bed. The FVS worker expressed that falling asleep with the child while breastfeeding was dangerous and could lead to accidental suffocation of T.K. The mother shared that she had decided to move to Oregon at the beginning of July. The FVS worker addressed how the mother could obtain services in Oregon.

On July 5, 2018, T.K.'s mother texted the FVS worker to notify her that T.K. had passed away. An intake was created regarding the child's death, and it was assigned for a CPS investigation. The mother reported she had been bed sharing with T.K. and when she woke up she found RCW 74 with blood and foam coming out of RCW 74 mouth and RCW 7 was not breathing. The mother reported that she then called emergency services. The mother reported that the Medical Examiner said T.K. may have had a seizure while sleeping. The mother further stated she did not roll over on RCW 74.3 and that she believed RCW 74 death was not her fault. The family preservation services (FPS) worker was there with the family. The FVS worker spoke with the FPS worker and they discussed safety planning regarding the mother and maternal grandmother's mental well-being.

On July 11, 2018, the assigned CPS investigator made contact with the mother and maternal grandmother at their residence. They discussed T.K.'s passing and supports for the mother and grandmother. The mother stated that when she went to bed the night before the child's death, she had brought T.K. to bed with her to breastfeed. She stated this was a regular occurrence. It was also regular practice for the grandmother to come in during the night and remove T.K. from the bed and put RCW 74.3 in RCW 7 bed. However, this last evening the grandmother did not wake up and move T.K. from the mother's bed after the mother fell asleep.

The mother told the CPS investigator that she knew about safe sleep and that the FVS worker and PHN both discussed it with her. The mother had also been given a Pack 'n Play so that she would have a separate sleep environment for T.K. The grandmother interrupted at one point during the mother's conversation with the CPS investigator stating that she felt the mother was being attacked for her sleep situation. The CPS worker tried to ask the mother about how she was coping with the child's death, but the mother started to withdraw. The CPS investigator subsequently ended the interviews. A founded finding for neglect and/or maltreatment was made against the mother regarding T.K.'s death.

COMMITTEE DISCUSSION

The Committee discussed many aspects of the case. The Committee highlighted the positive relationship between the FVS worker and the mother. The fact that the mother notified the FVS worker of T.K.'s passing showed that she trusted the FVS worker and had a good working relationship with her.

There was a discussion about how people or parties are notified of a critical incident on an open case, specifically how there was no notification provided to the PHN after T.K.'s death. As a result, the PHN unknowingly called the mother to make her next appointment after the child died. The Committee stated their hope was that all people who were working with the family (providers, legal parties, etc.) would receive notice so that there would not be a repeat of what occurred in this case.

The Committee struggled with the founded finding related to T.K.'s death. The Committee discussed that there is no law stating a person cannot bed share or co-sleep with their child. They agreed if other identified risk factors had been known, such as substance use the night before or medications which caused a parent to sleep deeply and not easily wake or sleeping on an air mattress, and that the parent or caregiver had been educated on the topic that then it might be appropriate to make the finding. However, in this case, there were no such documented risk factors. There is no documentation of whether the mother was even asked about the events the evening before the child died or asked whether she had consumed alcohol or used substances before breastfeeding the night before the child was found deceased. This part of the Committee's discussion is further addressed in the recommendation section below.

There was a lengthy discussion surrounding trauma-based training and interventions for the families that DCYF interacts with which are not provided to the Department's own staff. The Committee was very saddened to learn that the FVS worker had left her employment with DCYF related to this fatality and another critical incident, which both occurred within a very short period of time. The issue of turnover within DCYF was discussed and the Committee noted that DCYF should make changes regarding how business is conducted and staff are supported after a critical incident. The hope of the Committee was that when a critical incident occurs, staff are met with more trauma-informed support and that turnover related to critical incidents will decrease. This discussion also included the current option for staff to utilize Peer Support[5] and the Employee Assistance Program.[6]

Based on the CPS investigator's observation of the mother sleeping on an air mattress during the fatality investigation, the Committee discussed the following about this topic. The Committee acknowledged that the majority of CFRs involving an unsafe sleep element include at least one, if not numerous, discussions by the assigned DCYF staff with the parent or caregiver regarding safe sleep and ways to ameliorate identified unsafe sleep environments, yet many families who were provided this information still chose to bed share with their child. The Committee members discussed that offices purchase Pack 'n Plays for many families that DCYF interacts with. However, the Committee noted that they are not aware of DCYF offering to purchase mattresses when/if it is identified that a family uses air mattresses or other sleeping arrangements other than a bed. The Committee discussed that due to the high correlation of child fatalities of newborn/infant children and bed sharing, DCYF should consider making a concerted effort to assist families in obtaining non-inflated mattresses.

The Committee discussed that the FVS policy says if a case is being transferred from CPS to FVS, the case must transfer within three days.[7] In this case, that did not occur because the CPS investigative casework was not yet completed when everyone agreed to voluntary services during the FTDM. The Committee noted that the CPS worker had not completed the required work in order for the case to transfer to the FVS worker, and the Committee discussed how it would be difficult for an FVS worker to receive an incomplete case. But the Committee also discussed its concern for a delay in services to the family since the case was not transferred within three days. Also discussed was the high turnover this office had experienced during the

[5] http://intranet.dcyf.wa.gov:8090/drupal-8.4.0/personnel/peer-support
[6] https://des.wa.gov/services/hr-finance-lean/employee-assistance-program-eap
[7] https://www.dcyf.wa.gov/practices-and-procedures/3000-family-voluntary-services

time period the case was open for services, and staff in the CPS units were receiving two to three intakes per day. The Committee noted this level of new assignments was not sustainable. The office has been able to stabilize more since that time, but the Committee acknowledged that the turnover and case assignment, prior to the fatality, was an infeasible workload.

FINDINGS

The Committee did not identify any critical errors made by DCYF during the CPS investigation or the FVS case. However, the Committee discussed areas not related to T.K.'s passing in which Department practice could be improved. Those recommendations are addressed below.

While safe sleep discussions occurred between the FVS worker and the mother, CPS did not document discussion of Period of Purple Crying or Safe Sleep.[8]

CPS did not comply with policy regarding the assessment of Domestic Violence.[9]

The Committee believes that there could have been an enhanced assessment of safety for T.K. during the initial CPS investigation, had other collaterals been completed. Those collaterals could have included contact with law enforcement, obtaining law enforcement or court records pertaining to contact and protection or no-contact orders, as well as requesting records from T.K.'s pediatrician and discussions with the pediatrician and/or nurse regarding T.K.'s care and tremors.

The CPS worker stated to her supervisor that she made a referral for Project Safe Care per Policy 1135, however, there was no documentation regarding this. This delayed supportive services to the mother and T.K.

DCYF policy regarding safety planning includes the directive that staff must assess the suitability and reliability of potential safety plan participants to include reviewing the individual's information in FamLink.[10] This did not occur while this case was open to CPS or FVS.

RECOMMENDATIONS

The Committee discussed that DCYF is inconsistent statewide regarding CPS assignment and investigative findings related to unsafe sleep deaths. The Committee recommends that DCYF discuss this issue with the Attorney General's Office and work to find a consistent directive for field staff regarding this issue.

The Committee recommends that DCYF staff should receive training on identifying tremors in newborns and infants that were exposed to substances in utero, the next steps after identifying or hearing reports of tremors, and how to discuss this with parents and/or caregivers.

The Committee identified that many families who come into contact with DCYF use marijuana recreationally. The consumer most often attributes use to self-medication related to physical ailments or mental health issues. The Committee recommends that all DCYF staff receive mandatory training regarding the impacts of marijuana exposure to children (in utero and use post-birth by parents); the research-supported benefits of marijuana; effects of marijuana on adults, adolescents, and children; differing ways to use/ingest marijuana; how marijuana use

[8] https://www.dcyf.wa.gov/1100-child-safety/1135-infant-safety-education-and-intervention
[9] https://www.dcyf.wa.gov/1100-child-safety/1170-domestic-violence
[10] https://www.dcyf.wa.gov/1100-child-safety/1130-safety-plan

impacts the body; and assessing child safety when a caregiver is using marijuana. The mother used RCW 13.50.100 prior to T.K.'s birth and the father admitted to using during the case.

The Committee identified the need for more trauma-informed care of staff who experience a critical incident, such as a fatality or near-fatality. The Committee believes there should be a person or team of people that can be dispatched to the impacted DCYF office to provide onsite emotional support immediately or within 24 hours of a critical incident. This is beyond how the current Peer Support model functions. The Committee also believes staff should be treated similarly to other first responders in that staff should be relieved of taking new assignments and possibly case responsibilities for a period of time after the critical incident. The Committee also believes that paid leave should be available to DCYF staff as needed for staff to support their emotional well-being when necessary.