# CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

DECEMBER 2021

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CHILDREN, YOUTH & FAMILIES

## CONTENTS



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# Full Report

## Child

- V.S.M.

## Date of Child's Birth

- [redacted] 2019

## Date of Fatality

- May 25, 2021

## Child Fatality Review Date

- Sept. 21, 2021

## Committee Members

- Cristina Limpens, MSW, Ombuds, Office of Family and Children's Ombuds
- Paul Kallman, MSW, Quality Practice Specialist, DCYF
- Alima Virtue, License Exempt Specialist, DCYF
- Dawn McColgan-Knowles, LMHC, SUDP, MCIRT MHP Therapist, Comprehensive Life Resources
- Christine Mitchell, Detective, Redmond Police Department

## Facilitator

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

## Executive Summary

On Sept. 21, 2021, the Department of Children, Youth, and Families (DCYF) convened a Child Fatality Review (CFR)[1] to examine DCYF's practice and service delivery to V.S.M. and RCW 7 family. V.S.M. will be referenced by RCW 7 initials throughout this report.[2]

On May 23, 2021, DCYF was notified by a consulting doctor that V.S.M. had been admitted to RCW 74.13.515 on May 19, 2021, with a fractured skull, brain bleed, fractured breastbone, and spinal injuries. The doctor shared concerns for possible non-accidental trauma based on V.S.M.'s injuries and the mother's self-report of the accident. The mother reported that during supervised visitation in her home, V.S.M. had fallen from a second-story window approximately eighteen to twenty feet high. The mother reported holding V.S.M. near an open window when RCW 7 suddenly kicked RCW 7 leg, knocking the screen window out and falling through the window to the sidewalk below. While on life support the hospital performed two brain death assessments. The assessments confirmed that V.S.M. was brain dead. On May 25, 2021, V.S.M. was taken off life support. The medical examiner reported to DCYF that an autopsy was pending.

At the time of V.S.M.'s death, DCYF did not have an open case with the family. However, there was a prior Child Protective Services (CPS) case within twelve months of May 25, 2021; the date V.S.M. was pronounced dead. The prior case was concluded and closed with no recommendations for ongoing services provided by DCYF. At the time of this incident, V.S.M.'s parents were separated and residing in different households. There was a temporary parenting plan in place allowing weekly supervised visitation in the mother's home with V.S.M. and RCW 7 sibling.

A CPS investigation of V.S.M.'s death was assigned. As a result of the CPS investigation, CPS issued founded findings[3] against the mother for the negligent treatment maltreatment[4] of V.S.M. At the time of this report, there was an ongoing law enforcement investigation.

A diverse committee was assembled to review DCYF's involvement and service provision to the family. The Committee included members with relevant expertise and cultural significance selected from diverse disciplines within DCYF and community partnerships. Committee members had no prior direct involvement with V.S.M. or RCW 7 family. Before the review, the Committee received relevant case history from DCYF. On the

[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.

[2] The names of V.S.M.'s parents are not used in this report because neither parent has been charged with a crime in connection with the fatality. V.S.M.'s name is also not used in this report because RCW name is subject to privacy laws. See RCW 74.13.500.

[3] "'Founded' means the determination following an investigation by the department that, based on available information, it is more likely than not that child abuse or neglect did occur. "RCW 26.44.020(14). See also WAC 110-30-0020.

[4] "'Negligent treatment or maltreatment' means an act or a failure to act, or the cumulative effects of a pattern of conduct, behavior, or inaction, that evidences a serious disregard of consequences of such magnitude as to constitute a clear and present danger to a child's health, welfare, or safety…." RCW 26.44.020(19).

day of the review, the Committee had the opportunity to interview the DCYF caseworker, supervisors, and area administrator who were involved with the family.

## Case Overview

On June 1, 2020, a hospital social worker contacted DCYF reporting concerns that V.S.M.'s mother presented at the hospital with "manic symptoms" and was attempting to leave the hospital against medical advice. The mother reportedly called 911 to report not feeling safe at the hospital but was not placed on an involuntary hold. The mother reported to hospital staff that she was experiencing relationship problems with V.S.M.'s father and was suspicious the father was abusing [redacted]-month-old V.S.M. and [redacted]-month-old sibling, A.M. The mother was unable to provide any additional details about the abuse or the reasons for her suspicions. A CPS risk-only investigation[5] was assigned with a 24-hour response time.

On June 1, 2020, the CPS caseworker responded to the home. The mother, father, V.S.M., and [redacted] sibling (A.M.) were all present. The caseworker met privately with the father. He expressed concerns for his wife's mental health and confusion about why his wife is asking for a divorce and making statements that he has been abusive to A.M. He denied domestic and physical violence in the home. The father did not identify safety concerns related to the care of the children and told the caseworker the family has a large support network. The caseworker attempted to meet with the mother privately, but she refused to meet without the father present. The mother described the events that occurred before June 1. She denied physical violence in the home but said her husband could say hurtful things. The mother said she has a mental health therapist to address [redacted]. Both V.S.M. and A.M. were sleeping throughout the visit. The caseworker observed the children to be clean, dressed appropriately, and free of injuries or bruises. The caseworker planned to further assess the family during the next home visit.

On June 2, 2020, a supervisory staffing was held with the caseworker to review the information gathered. Next steps were identified, including making additional collateral contacts, developing a plan for times when the father is out of the home, and completing DCYF required assessments. The caseworker contacted the mother's mental health therapist. The caseworker also contacted the father, who reported another incident from the night prior to June 2. The caseworker assisted the father with developing a plan for him to continue assessing the safety and well-being of V.S.M. and A.M. He was also provided with the contact information for the mobile crisis unit. The father called the caseworker to report he was taking his wife to the hospital. The children remained in the care of the nanny with friends checking in on them.

On June 3, 2020, DCYF received two additional reports describing continued concerns for the mother's mental health. It was reported the mother assaulted the nanny on the evening of June 3. The mother was taken to the hospital, and due to her delusional and disorganized thinking, she was held on a 72-hour involuntary evaluation hold.[6] The mother made statements about the father [redacted] and possibly

[5]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". See: https://www.dcyf.wa.gov/practices-and-procedures/2200-intake-process-and-response.

[6]For a description of a 72-hour involuntary evaluation hold, See: https://www.dshs.wa.gov/bha/division-state-hospitals/civil-commitment-inpatient-services. Last accessed on September 21, 2021.

RCW 13.50.100. The caseworker contacted the hospital social worker to gather more information about the mother's current status and inquire about the RCW 13.50.100 allegations. The hospital social worker said the mother's statements were likely not credible due to the psychosis she was experiencing. The mother reportedly appeared confused when the staff tried to gather more information about her concerns. She denied the father would have done that. The caseworker spoke with the father to learn additional details about the events leading to the mother's hospitalization. The father also shared his expectations for the mother and did not want her to return to the home until she was stabilized with treatment and medications. The caseworker agreed to send the father information about obtaining a no-contact order.

On June 4, 2020, the caseworker conducted a home visit with the father, V.S.M., and A.M. Both children were awake during the visit. The caseworker was able to observe the interactions and bonding between the father and children. No concerns were noted. The caseworker had the opportunity to speak with two family friends and the children's nanny to learn their perspective and what supports they were providing to the family. The caseworker also had email correspondence with the father about the no-contact order he requested between the mother and children. The caseworker assessed no present danger[7] and no active safety threat.[8] On June 5, 2020, the caseworker conducted a review of records received from law enforcement.

On June 8, 2020, a supervisory review was conducted. On June 9, 2020, the caseworker communicated with the hospital social worker about the mother's discharge plan. The caseworker spoke with the father about DCYF's recommendations for supervised visitation between the children and the mother once she is discharged and comply with all treatment recommendations. The father said he had already arranged to be home for the next four to six months. The father agreed to comply with any recommendations made by DCYF. The caseworker contacted the doctor for V.S.M. and A.M. and confirmed both children were up to date on medical care.

On June 11, 2020, the hospital social worker informed the caseworker that a family meeting had been held to prepare for the mother's discharge. The hospital social worker reported the family developed an appropriate support plan utilizing community-based resources and their extensive natural support system. The caseworker provided DCYF's expectations for the family to the hospital social worker, including the mother not having unsupervised time with the children. The mother was discharged home from the hospital.

On June 17, 2020, the caseworker contacted the parents to complete a check-in. The father said his sister was in the home supporting the family and that the mother was doing well and taking her medications daily. The mother said she was getting back to her routine but reported it was difficult not to be the primary person

[7]For information about Present Danger, see: https://www.dcyf.wa.gov/1100-child-safety/1110-present-danger. Last accessed on September, 21, 2021.

[8]"A threat of danger is a specific family situation or behavior, emotion, motive, perception or capacity of a family member that threatens child safety. The danger threshold is the point at which family functioning and associated caregiver performance becomes perilous enough to be perceived as a threat or produce a threat to child safety. The safety threshold determines impending danger…Safety threats are essentially risk influences that are active at a heighten degree and greater level of intensity. Safety threats are risk influences that have crossed a threshold in terms of controllability that has implications for dangerousness. Therefore, the safety threshold includes only those family conditions that are judged to be out of a caregiver's control". See https://www.dcyf.wa.gov/sites/default/files/pdf/SafetyThresholdHandout.pdf. See also https://www.dcyf.wa.gov/sites/default/files/pdf/17SafetyThreats.pdf.

responsible for feeding and putting the children to sleep. The caseworker shared information about the upcoming shared planning meeting[9] and what the parents may expect.

On June 19, 2020, a shared planning meeting was held. In attendance were both parents and their family supports. The family developed an action plan to address the family's ongoing needs. This included a plan for the mother's therapeutic care and medication management, a mental health crisis response plan, and a plan for the supervision and support of the children. The caseworker discussed available in-home services offered by DCYF to support the family. The parents were willing to learn more about the Family Preservation Services[10] program.

On June 30, 2020, the investigative assessment was completed identifying no active safety threat. A structured decision-making risk assessment was completed with a score of moderate, and an action plan was developed and implemented by the family. The mother was connected with community-based mental health services. The father was assessed as protective and providing for the supervision and care needs of V.S.M. and A.M. The family's natural supports, for whom the caseworker completed background checks, were also assessed as protective and providing for the children's supervision and care needs. The family declined services offered by DCYF. The case was recommended for closure.

On May 23, 2021, DCYF was notified by medical professionals that V.S.M. had been admitted to RCW 74.13.515 in critical condition, with an unlikely prognosis for recovery due to a fall from a second-story window. V.S.M. had skull fractures, a brain bleed, a fracture of RCW 74 sternum, and spinal fractures. The RCW 74.13.515 )[11] team evaluated V.S.M.'s injuries from the fall and the mother's self-report of the event. The RCW 74.13.51 team expressed their suspicion that V.S.M.'s injuries may be non-accidental based on the injuries and the mother's description of the incident. On May 25, 2021, V.S.M. was taken off life support.

The CPS investigation of V.S.M.'s death concluded with founded findings entered against the mother for negligent treatment/maltreatment. The mother was provided with therapeutic community-based resources. The father was also provided with therapeutic community-based resources for himself and A.M. The father's home was assessed as safe because he had an appropriate support plan in place through family members and natural supports. The temporary parenting plan allowing the mother supervised visitation was suspended. The DCYF case was submitted for closure.

[9]For information about Shared Planning Meetings, see: https://www.dcyf.wa.gov/1700-case-staffings/1710-shared-planning-meetings. Last accessed on September 21, 2021.

[10]For information about Family Preservation Services, see: https://www.dcyf.wa.gov/1700-case-staffings/1710-shared-planning-meetings. Last accessed on September 21, 2021.

[11]For information about RCW 74.13 see: https:// RCW 74.13.515 /. Last accessed on September 21, 2021.

## Committee Discussion

The Committee had the opportunity to meet with the caseworker, supervisors, and area administrator who were previously involved with the family. The Committee commended the caseworker on the efforts to complete a detailed, comprehensive assessment. This included the caseworker's efforts to contact all relevant collateral contacts and to complete timely, detailed case notes outlining the work process. The Committee also noted the caseworker's extensive efforts to engage the family throughout the investigation.

The Committee discussed the details of the safety and structured decision-making risk assessment (SDM-RA).[12] The Committee considered the possibility of an active safety threat and wondered if that led to DCYF's expectation of the mother having no unsupervised time with the children following her hospital discharge. The caseworker told the Committee the assessment's conclusion that the safety threat had been eliminated was based on the father being protective and providing for the supervision of the children either by himself or his natural supports. The Committee agreed there was not an active safety threat at the time of case closure. The Committee also believed the caseworker's assessment of risk through the SDM-RA was accurate.

The Committee respects the caseworker's rapid efforts to respond and assess the family situation at the beginning of the case. However, the Committee did wonder why the case was closed so soon after the mother's hospital discharge and the development of a plan that was going to be implemented by the family. The Committee members unanimously agreed they would have liked the case to have remained open to monitor how the parents were managing the plan they developed, even if it was just for a few additional weeks. The Committee learned additional details directly from the caseworker and supervisor about the decision to close the case and understood the rationale, but still would have liked additional monitoring to have occurred, given the caseworker was well within the timeline for CPS case closure.[13] The Committee agreed that even had the case remained open for additional monitoring; it likely would not have changed the outcome.

The Committee praised the caseworker for their efforts to engage the family with the CPS investigative process. However, the Committee asked why the family declined DCYF services, opting for community-based services instead. The Committee's subject matter expert wondered if the caseworker provided the specific details of the services offered and whether the caseworker explained that families from all cultural backgrounds participate in DCYF services.

The Committee believes the caseworker is knowledgeable about mental health resources in the community and utilized appropriate mental health contacts to gather information. The Committee examined the training the DCYF workforce receives related to mental health needs and child safety assessments. The Committee understands that training related to mental health needs and child safety assessments are available to DCYF staff but wondered if this is prioritized in the training matrix as required training. A Committee subject matter

[12]The Structured Decision Making Risk Assessment® (SDM-RA®) is a household-based assessment focused on the characteristics of the caregivers and children living in that household. By completing the SDM-RA following the Safety Assessment, the worker obtains an objective appraisal of the risk to a child. The SDM-RA informs when services may or must be offered. See: https://www.dcyf.wa.gov/practices-and-procedures/2541-structured-decision-making-risk-assessmentrsdmra. Last accessed on September 21, 2021.

[13]For information about DCYF CPS policy, see: https://www.dcyf.wa.gov/policies-and-procedures/2331-child-protective-services-cps-investigation. Last accessed on September, 21, 2021.

expert likened the training needs to that of how DCYF caseworkers plan for supporting parents with substance use disorder by discussing relapse prevention planning and building upon a parent's support network. To enhance the workforce's mental health knowledge, the Committee's subject matter expert suggested DCYF consider the Mental Health First Aid training[14] model.

After the Committee learned about the various practices within the region in which V.S.M. was residing, a DCYF Committee member pointed out inconsistencies across DCYF practice depending on the county. Differences in practice included using the term family action plan and DCYF involvement in family court proceedings. This led the Committee to wonder about statewide information sharing consistency and dissemination across the agency. The Committee speculated that pertinent changes and the rationale for those changes might at times not be received by the field offices from DCYF headquarters, leading to inconsistency in practice.

Last, the Committee asked about agency-wide supports offered to child welfare field staff. The Committee recognizes the challenges this work presents and possible secondary trauma impacts caseworkers may experience. The caseworker and supervisor spoke about agency-wide resources available to caseworkers. Examples of these are DCYF's Peer Support[15], Employee Assistance Program, and the extensive support network offered through the area administrator and supervisors at the particular offices.

## Findings

The Committee did not identify any findings.

## Recommendations

The Committee did not make any recommendations.

[14]For information about mental health training, see: https://www.mentalhealthfirstaid.org/.

[15]For information about DCYF Peer Support, see: http://intranet.dcyf.wa.gov:8090/drupal-8.4.0/personnel/peer-support. Last accessed on September 21, 2021.