CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

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Nondiscrimination Policy

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

- X.P.B.

Date of Child's Birth

- [redacted] 2023

Date of Fatality

- March 25, 2023

Child Fatality Review Date

- July 31, 2023

Committee Members

- Patrick Dowd, JD, Director, Office of the Family and Children's Ombuds
- Kaaren Heikes, Regional Administrator, Department of Children, Youth, and Families
- Nancy Kucklick, Quality Practice Specialist, Department of Children, Youth, and Families
- Megan Boyer, CA, Manager, Stillaguamish Tribe of Indians
- Leah Legee, Parent for Parent, Multicultural Child and Family Hope Center
- Arden James, MBA, SUDP, Pregnant and Parenting Womens Manager, Therapeutic Health Services

Facilitator

- Leah Mattos, MSW, Critical Incident Review Specialist, Department of Children, Youth, and Families

Executive Summary

On July 31, 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 X.P.B. and [redacted] family. X.P.B. is referenced by [redacted] initials throughout this report.[2]

On March 25, 2023, DCYF was notified by law enforcement that X.P.B. had passed away in [redacted] home under suspicious circumstances. Emergency responders were called to the home when X.P.B.'s mother found [redacted] unresponsive with blood coming from [redacted] nose and mouth. X.P.B. had reportedly been sleeping on a pillow on the mother and her partner's bed. Law enforcement reported concerns with inconsistencies in the mother's report and about the condition of the home stating, "the house is filthy with cannabis and trash and food mixed together." [redacted] The autopsy determined X.P.B.'s cause of death as unexplained sudden death (intrinsic and extrinsic factors identified) with the manner of death undetermined.

At the time of X.P.B.'s death, the family had an open Child Protective Services Family Assessment Response (CPS-FAR)[3] case. The case had been open for eight days prior to X.P.B.'s death, at which time the case was converted to a CPS investigation.

A CFR Committee (Committee) was assembled to review DCYF's involvement and service provision to the 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 X.P.B. 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 speak with DCYF field staff who were involved with supporting the family.

Case Overview

Between 2018 and 2022, DCYF received multiple intakes on three different cases involving X.P.B.'s mother and her family. The family includes her children, [redacted] (5), [redacted] (3), X.P.B. (2 months), their three fathers and her parents. [redacted] The mother resides in her parents' home with

[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)]." Given its limited purpose, a CFR should not be construed to be a final or comprehensive review of all 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 to replace or supersede investigations by courts, law enforcement agencies, or other entities with legal responsibility to investigate or review some or all the circumstances of a child's fatal injury or near fatal injury. Nor is it the function or purpose of a CFR to recommend personnel action against DCYF employees or other individuals. "The restrictions [described in this paragraph, and the paragraph immediately above,] do not apply in a licensing or disciplinary proceeding arising from an agency's effort to revoke or suspend the license of any licensed professional based in whole or in part upon allegations of wrongdoing in connection with a minor's death or near-fatality reviewed by a child fatality or near-fatality review team." See RCW 74.13.640(4)(d). See: https://app.leg.wa.gov/RCW/default.aspx?cite=74.13.640.

[2]X.P.B.'s name is not used in this report because [redacted] name is subject to privacy laws. See RCW 74.13.500.

[3]For information on CPS Family Assessment Response (CPS-FAR), see: https://www.dcyf.wa.gov/policies-and-procedures/2332-child-protective-services-family-assessment-response.

her three siblings who are minors. A summary of allegations includes reports of prenatal substance exposure RCW 13.50.100 unaddressed mental health needs for the mother, substance use, family conflict, violence in the home between family members, an inability to meet the needs of the children, and concerns about the conditions of the home creating an unsafe environment.

The reports led to six CPS investigations and three CPS-FAR cases, while six intakes screened-out and did not meet criteria for response. DCYF addressed concerns during each intervention and assessed the children as safe prior to case closure. RCW 13.50.100 DCYF provided the mother with community based mental health resources and concrete goods to include cleaning supplies and safety gates for the home. The mother declined all other DCYF services offered. The CPS investigations concluded with unfounded findings.

In 2023, DCYF received a confidential intake reporting concerns about the welfare of newborn X.P.B. and RCW 74.13.51 The concerns related to the mother's history of alcohol abuse and mental health needs and that she was not receiving treatment or taking medications. The referrer said the condition of the home was always problematic but believed the condition of the home had become unsafe. The referrer stated X.P.B. had a runny nose and RCW 74.13.51 was unkempt with matted hair. A CPS-FAR case was assigned.

The caseworker went to the family's home that evening. The caseworker spoke with the mother and grandmother and documented that they were verbally aggressive towards the caseworker as they explained the purpose of their visit. The grandmother called the grandfather, who was put on speakerphone and informed the caseworker they were not allowed in their home. The caseworker offered to complete a virtual walk-through, but the family refused. The family, including all the children in the household, met with the caseworker in the parking area of their residence.

The caseworker requested to complete a body check of the X.P.B. and RCW 74.13.51 No marks or bruising were noted. The caseworker interviewed both the mother and grandmother. Both denied the allegations. X.P.B.'s mother denied that she would harm her children. The mother was asked about her mental health needs. The mother reported a diagnosis of RCW 70.02.020 and noted she takes medication. The mother and grandmother said they smoke cannabis outside of the home and keep the cannabis locked up. Both denied any domestic violence in the home. The caseworker spoke with the grandmother's three minor children. No concerns or unmet needs were identified.

Eight days later, law enforcement notified DCYF that X.P.B. passed away in his home. A CPS investigation was conducted related to the circumstances surrounding X.P.B.'s death. The investigation concluded with CPS assigning the mother a founded finding[4] of negligent treatment of X.P.B. while the allegations of physical abuse were unfounded. RCW 13.50.100

[4]RCW 26.44.020(14) defines "founded" as follows: "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."

Committee Discussion

The Committee had the opportunity to speak with field staff from the office who worked directly with the family. The discussion with the field staff allowed the Committee to inquire about case specific details in addition to learning more about field staffs' experiences providing child welfare services to families.

One aspect touched on by the Committee was related to the voluntary nature of DCYF's interactions with families. This led to a robust conversation by the Committee discussing the role of DCYF and the limitations of the agency's work. For example, the caseworker spoke to the Committee about the family denying them access to complete a walkthrough of their home and how they attempted to work with the family to try and obtain access to assess the home environment. The Committee appreciated the caseworker's efforts to engage the family and offer the family alternatives, such as a virtual walkthrough. Despite this, the family still denied the caseworker access to their home. The Committee highlighted that although the caseworker did not have an opportunity to view X.P.B.'s sleep environment, that the discussion about Safe Sleep[5] and Period of PURPLE Crying[6] is crucial considering the vulnerability of newborns and infants.

The Committee also had an extensive conversation about DCYF's assessment of child safety and how parent engagement impacts assessment. The Committee wondered if, at the point of an intake, a family's historical unwillingness to engage with DCYF should be factored into the screening decision with consideration for the investigation pathway versus the FAR pathway. The Committee inquired of the field staff what their process is for changing a FAR case to a CPS investigation and learned that this typically occurs when a family refuses to participate with a field office. The Committee wondered if it would have been appropriate to consider screening or changing the case from the FAR pathway to a CPS investigation due to the historical patterns of limited engagement. A Committee member pointed out that regardless of the case assignment (CPS investigation or CPS-FAR) the agency has the same tools and resources available to engage, assess, and provide supports and services.

The Committee spoke about the nature of chronic neglect when there are allegations related to the condition of the home posing concerns for the children(s) well-being. The Committee inquired if the field staff felt they were able to gain an understanding of the origin of the concerns related to the condition of the home and speculated if there was an underlying cause. One component the field office shared with the Committee is how they work to address bias related to allegations about home conditions because of the subjective nature of the allegation. The field staff elaborated about how they assess for child safety in relationship to concerns about the home environment. One Committee member inquired about how or if DCYF may be able to articulate imminent physical harm, terminology outlined in the Keeping Families Together Act[7], related to chronic neglect cases. It was suggested that in instances of chronic neglect that it may be beneficial for the

[5]For information about Safe Sleep, see: https://safetosleep.nichd.nih.gov/safesleepbasics/about. Last accessed on August 14, 2023.

[6]For information about Period of PURPLE Crying, see: http://www.purplecrying.info/what-is-the-period-of-purple-crying.php. Last accessed on August 14, 2023.

[7]For information about HB 1227 Keeping Families Together Act, see: https://www.wacita.org/hb-1227-keeping-families-together-act/#:~:text=HB%201227%20requires%20that%20courts,relatives%20and%20suitable%20other%20persons. Last accessed on August 14, 2023.

field office to consult with the Assistant Attorney General (AAG) for further guidance. Through this discussion the field staff shared how the assessment and articulation of imminent[8] physical harm is part of their daily dialogue when discussing cases. The field office shared how they utilize internal staffings to help guide the assessment of imminent physical harm.

The Committee also discussed the voluntary nature of service provision and that DCYF can offer suggestions for services available through DCYF and community-based agencies, but without a court order cannot require a parent to participate with services. The Committee identified the mother's mental health as a need throughout the various cases. The Committee understood the mother may have declined to share the details of her mental health treatment but felt it may have been beneficial to attempt engaging her in a discussion about any barriers to accessing services, medication refills, and referrals to community-based services. One Committee member suggested that the mother may have benefited from a referral to the Parent Child Assessment Program (PCAP)[9], which provides long-term case management and support services to mothers.

The Committee strategized on how to reduce barriers for DCYF field staff engaging with families and highlighted the important role that parent allies can play in building a partnership with a family. The Committee identified that parent ally partnerships are available to families served through DCYF when they have ongoing court involvement, but this is not typically available when families are involved with CPS (non-court involved cases). The Committee suggested that a partnership between a DCYF caseworker and parent ally may help increase a family's willingness to engage with a CPS intervention. The Committee considered possible barriers with this idea, such as funding and potential confidentiality concerns but saw value in the agency exploring a model that pairs a CPS caseworker and parent ally together to engage families. However, the Committee also recognized that there may be limitations to this model and that some families may still be unwilling to engage even with this additional support.

Recommendations

The Committee's recommendations come from a comprehensive review and discussion of the many aspects of the case. The recommendations and corresponding discussion were unrelated to the fatality of X.P.B. The Committee respectfully recommended DCYF consider the following to comprehensively improve practice.

- DCYF to consider developing a model where a CPS caseworker and parent ally are jointly working together to support families involved with CPS to reduce barriers to parent participation and engagement. This recommendation may consider the following, but is not limited to these suggestions:
  - Consideration to hire/contract with parent allies who would be assigned to each field office to assist CPS caseworkers navigating contacts with families.
  - Partnering with community-based organizations who provide parent ally programs to create opportunities for enhanced partnership to support DCYF's CPS programs.

[8]DCYF can only seek court-ordered removal, and the court can only order a child removed, when there is imminent risk of physical harm. See RCW 13.34.050 (2023)

[9]For information about Parent-Child Assistance Program (PCAP), see: https://pcap.psychiatry.uw.edu/. Last accessed on August 14, 2023.