CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

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Full Report

Child

- A.H.

Date of Child's Birth

- [redacted] 2018

Date of Fatality

- September 2019

Child Fatality Review Date

- December 19, 2019

Committee Members

- Lafaitele Lydia Faitalia, Washington State Commission on Asian Pacific American Affairs, Commissioner
- Loyal Higinbotham, Everett Police Department, Sergeant Sexual Assault Unit
- Nina Meyers, DCYF, Child Protective Services Supervisor
- Elizabeth Bokan, JD, Office of the Family and Children's Ombuds, Ombud

Observer

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

Facilitator

- Libby Stewart, DCYF, Critical Incident Review Specialist

Executive Summary

On Dec. 19, 2019, the Department of Children, Youth, and Families (DCYF)[1] convened a Child Fatality Review (CFR)[2] to assess DCYF's service delivery to A.H. and [redacted] family.[3] [redacted] will be referenced by [redacted] initials throughout this report.

On Sept. 14, 2019, DCYF received a telephone call reporting that two men, A.H. and A.H.'s mother arrived at a hospital. One of the men left the hospital immediately after arriving. When [redacted] arrived, A.H. was not breathing and [redacted] skin was bluish in color with a large bruise on [redacted] left eye and bruising on [redacted] lower back. The hospital staff was unable to resuscitate [redacted] and [redacted] was pronounced dead at the hospital. At the hospital, law enforcement initiated a death investigation and interviewed all adults. This information screened in for a child protective services (CPS) investigation. After the CPS investigation was completed, DCYF entered a founded finding for physical abuse and negligent treatment against A.H.'s mother. The criminal investigation had not concluded at the time the CPS case was closed.

The CFR Committee (Committee) includes members with relevant expertise selected from diverse disciplines within the community. Committee members have not had any involvement or contact with A.H. or [redacted] family. The Committee received relevant documents including intakes, case notes and other DCYF documents maintained in DCYF's electronic computer system.

The committee interviewed the CPS worker, her supervisor, the family voluntary services (FVS) worker and her supervisor.

Case Overview

On Oct. 10, 2018, DCYF received a telephone call reporting that during the previous week, A.H.'s mother brought the baby to the father's worksite. It was a hot day and the baby was wrapped in blankets and had a lot of clothing on. The baby appeared to be in distress, so the site supervisor asked the parents to take the baby's clothes and blankets off. The baby had a heat rash from head to toe and some skin discoloration that may have been bruises. The caller reported the parents did not appear to understand how distressed the baby was. On October 10, the father was at a work meeting and was asked about the baby. He reported he did not know how the baby was doing because they had given [redacted] to friends for a month. This intake was screened in for a CPS investigation, Risk Only.[4]

On Oct. 11, 2018, the CPS worker initiated contact with the parents at their home. The parents reported the heat rash was healed and they were given a cream to put on A.H.'s body. The parents stated A.H. was staying for a month with [redacted] maternal grandparents who are located in 74.13.515 The mother

[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 the Department of Early Learning for child care and early learning programs.

[2]"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.

[3]No one has been criminally charged related to A.H.'s death, therefore no one is named in this report.

[4]Screen in CPS Risk Only reports when a child is at imminent risk of serious harm and there are no CA/N allegations. See: https://www.dcyf.wa.gov/practices-and-procedures/2200-intake-process-and-response

provided her parents' address to the CPS worker, and said the grandparents do not have a phone. According to the CPS worker's documentation, the parents appeared to have some developmental delays. A courtesy request was made for DCYF staff to contact the maternal grandparents in 74.13.515

That same day, a CPS worker contacted the maternal grandparents at the grandparents' home. A.H. was sleeping when the worker arrived. The worker educated the grandparents regarding the condition A.H. was found sleeping in. The worker observed a concerning mark on A.H.'s face, and the grandparents said 74.13.51 scratched 74.13.51 self. The CPS worker was concerned that it was not a scratch and asked the grandparents to have A.H. seen by a physician. The grandparents agreed. The CPS worker discussed safe sleep,[5] offered a Pack 'n Play and clothes. The grandparents were receptive to the worker's safe sleep advice, the Pack 'n Play and clothes.

The CPS worker who contacted the parents, contacted the referent to discuss the intake. The referent expressed additional concerns about the fact that the parents are young and it appears the father often doesn't know how to care for the baby. The referent said there are many people at the worksite that are concerned about the father's functioning.

On Oct. 12, 2018, the CPS worker made another contact with A.H. at the grandparents' home. The grandparents said they did not have any concerns for their 74.13.515 when 74.13.51 was under 74.13.51 parents' care, they would be returning A.H. to 74.13.51 parents in three days and the grandmother reported she goes over to the parents' home every few weeks and stays for two weeks at a time. Despite staying with the parents for two weeks at a time, the grandparents have no concerns if the parents parented full-time without the grandparents' assistance. The scratch appeared to be healing.

On Oct. 18, 2018, with A.H. present, the CPS worker interviewed both parents. The worker discussed safe sleep and the Period of Purple Crying (PPC).[6] The mother reported she has previously seen the PPC video and is aware of what safe sleep means. The mother reported that A.H. may sleep on the mother for naps, otherwise 74.13.51 sleeps in 74.13.51 crib. A.H. had scratches on both sides of 74.13.51 cheeks and appeared to have dry skin. The worker observed a diaper change and observed a rash but no bruising.

During the interview, the mother denied any CPS history as a child, indicated she had no history of mental health issues and no criminal, medical or substance use issues. She said she has previously used 13.50.100 but has control of her use. She denied domestic violence. The mother reported that when she saw the rash on 74.13.515 she took 74.13.51 to the doctor. The mother was able to provide the prescribed cream the doctor told her to use. The mother declined an offer for DCYF parenting classes, but did request vouchers for baby items.

During the interview, the father also denied any mental health issues, criminal history, medical conditions or domestic violence. He also declined the parenting classes offer, and provided the same history regarding the rash.

The CPS worker conducted a walk-through of the home. There was a 13.50.100 odor in the bathroom, but no other concerns were identified. The worker requested that the mother take A.H. to the emergency room to have the scratches and rash looked at. The parents agreed to this request.

[5] See: https://www.cdc.gov/vitalsigns/safesleep/index.html
[6] See: http://www.purplecrying.info/

Photographs were taken of A.H. and uploaded into FamLink, DCYF's electronic child welfare database.

The CPS worker requested medical records. Upon receiving the records, the CPS worker reviewed them and found no concerns. The CPS worker contacted the parents' WorkFirst case manager[7] and invited the worker to attend a meeting with the parents to discuss FVS. The CPS worker also connected with the Community Services Office (CSO) workers to discuss the family's needs and concerns.

On Oct. 25, 2018, the CPS worker attempted an unannounced home visit to meet with the parents, discuss FVS and drop off vouchers. No one answered the door. On the following day, the CPS worker was able to meet with the mother and A.H. at their home. While the previously observed scratches appeared to be healing, A.H. appeared to have new scratches on [redacted] head. The mother reported A.H. scratched [redacted] self during bath time.

On Oct. 30, 2018, the case was transferred to the FVS worker. The FVS worker immediately initiated email contact with the mother. The email notified the mother that the case was transferred and that she would like to meet with the parents. On Nov. 6, 2018, the FVS worker conducted a health and safety visit at the parents' home. The mother and A.H. were present but the father was at work. The FVS worker observed an unsafe sleep environment and discussed this with the mother. The mother told the FVS worker that to make more room she puts the Pack 'n Play away during non-sleep times. The mother was able to verbalize safe sleep practices. She denied bed-sharing with A.H.

The FVS worker offered voluntary services. However, the mother declined the offer. During a diaper change, the FVS worker observed a small, dark mark on A.H.'s buttock. The mother said this was a birthmark. The FVS worker asked if this was documented in the medical records and the mother was unsure. They called the primary care clinic who reported the mark is not documented in the clinic's notes. The mother agreed to take [redacted] to the clinic for examination the same day the FVS worker observed the mark. The FVS worker also texted the CPS worker to ask about the mark. The CPS worker did not recall seeing it and reported there was no mention of the mark when she reviewed all the medical records. The FVS worker discussed the need to have this documented in the child's medical record and the mother indicated she understood and agreed.

On Nov. 11, 2018, the FVS worker conducted an unannounced home visit. The worker attempted to email the mother but did not receive a response. The mother and A.H. were home. The mother provided the FVS worker with medical documentation about the examination and mark, as well as statements from the provider that a photograph was taken and placed in the medical record. The FVS worker observed a diaper change and did not see any change to the mark. The mother continued to state she did not want to engage in any services with DCYF. She shared that her mother was coming to stay for a visit. The FVS worker again observed unsafe sleep at the home and discussed this with the mother. The mother was again able to state what safe sleep practices were and that the items in the Pack 'n Play were there just to get them off the floor.

On Nov. 13, 2018, the FVS worker sent another email to the mother. There was no response to this email. The FVS worker conducted another unannounced home visit on Nov. 15, 2018. The mother and A.H. were home. A.H. was observed during a diaper change. There were no concerns noted, and the

[7] "WorkFirst is Washington's welfare reform program designed to help parents get what they need to prepare for and go to work. It is a partnership between state agencies and communities to work together to provide the necessary services and resources families need to be successful." See: https://workfirst.wa.gov/about-us

spot on A.H.'s buttock remained the same. Safe sleep was again discussed as the FVS worker observed continued concerns. The FVS worker discussed voluntary services again and mentioned having a meeting to discuss the services. The mother continued to state she did not want services. The FVS worker called her supervisor and discussed this with the supervisor and mother. The mother requested that her case be closed. After some discussion, the supervisor agreed that DCYF would close the case.

On Sept. 14, 2019, DCYF received a telephone call regarding A.H.'s death.

Committee Discussion

There has been a growing number of 74.13.515 residents moving to Washington. Just over 10 years ago, A.H.'s mother and maternal grandparents moved from the 74.13.515 to the United States. The mother was about 9 years old when she moved to the U.S. Concerning translation and education services, there appears to be limited resources available to assist this population. As an example, there are only two certified interpreters for the entire state of Washington. The Committee also learned about many other areas related to persons coming from the 74.13.515 that may have impacted interactions and engagement with this family. However, the Committee was very clear in its conclusion that these issues did not contribute to A.H.'s death. The Committee addresses this issue in the recommendation section below.

The Committee believes it would have been appropriate for DCYF to have conducted individual interviews with the parents about domestic violence, follow up with the father regarding the mother's statements about him using 13.50.100 in the home and obtain additional assessments of the parents' functioning capabilities. The Committee also discussed that it would have been appropriate to request a urinalysis based on the smell of 13.50.100 in the home.

Also discussed was the challenge faced by DCYF due to some law enforcement agencies changing to how the criminal investigations of child deaths are conducted. Some law enforcement agencies have decided to have their homicide units investigate child deaths when previously these cases were investigated by units that worked closely with DCYF CPS workers. This change has contributed to a loss of communication, cohesive and collaborative investigations. This case was one where this challenge was presented. It did not impact the DCYF case significantly but was discussed by the Committee.

The Committee also discussed the consistent and persistent discussion and documentation about safe sleep issues. The unannounced home visits and continued attempts to engage the parents in voluntary services were also examples of positive case practice. The Committee appreciated that while there was not an identified need to offer voluntary services through the Structured Decision Making Tool,[8] the CPS and FVS workers believed the parents would benefit from the ongoing support and continued to try and engage the parents.

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

Findings

The Committee finds that both the CPS and FVS workers did a very good job engaging with the mother. There was clear and consistent contact and good documentation of those conversations.

Recommendations

The Committee did not believe any lack of education or understanding surrounding the 74.13.515 community impacted this case. However, the Committee was educated about the continued migration of this community to Washington State and the complexities surrounding this. The Committee recommends that DCYF obtain training and/or education for staff regarding the 74.13.515 and this population's culture. This training should be available statewide for staff and could be provided by an expert or offered in an e-learning format.