WASHINGTON STATE
Department of
Children, Youth, and Families

CHILD FATALITY REVIEW

January 2019

www.dcyf.wa.gov

FULL REPORT

CHILD

- C.P.

DATE OF CHILD'S BIRTH

- [redacted] 2018

DATE OF FATALITY

- August 2018

CHILD FATALITY REVIEW DATE

- November 15, 2018

COMMITTEE MEMBERS

- Patrick Dowd, JD, Director, Office of the Family and Children's Ombuds
- Amy Boswell, Child Protective Services/Family Assessment Response Program Manager, Department of Children, Youth, and Families
- Ruth Wolbert-Neff, CDP, Drug and Alcohol Treatment Counselor 1, Tacoma-Pierce County Health Department
- Melanie Terrill, CPS/FAR Supervisor, Department of Children, Youth, and Families

FACILITATOR

- Libby Stewart, Critical Incident Review Specialist, Department of Children, Youth, and Families

CONTENTS

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 15, 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 C.P. and [redacted] family.[2] [redacted] will be referenced by [redacted] initials throughout this report.

On August 9, 2018, DCYF received a call stating C.P. had passed away while bed sharing with [redacted] parents. DCYF was told that the parents woke up just before 2:00 p.m. and discovered that their [redacted] was unresponsive. Emergency services responded to the scene after being called by the parents. Emergency services declared C.P. deceased at the scene. No resuscitative measures were taken by the responding emergency services personnel. Law enforcement observed drug paraphernalia in the bedroom where C.P. passed away as well as in the living room. The residence was known to law enforcement because of prior drug activity. The August 9, 2018, call to DCYF resulted in a child protective services (CPS) investigation. There had already been an open CPS/Family Assessment Response (FAR) assessment in progress at the time of C.P.'s passing. The same CPS worker assigned to the CPS/FAR assessment conducted the investigation related to C.P.'s death. As a result of the CPS investigation, founded findings for negligent treatment or maltreatment were entered against both parents.

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, substance abuse, and child welfare. A law enforcement detective previously agreed to attend and participate as a Committee member. However, on the morning of the scheduled review, her circumstances changed and she was unable to attend or participate. The Committee members did not have any involvement or contact with C.P. or [redacted] family.

The Committee interviewed the CPS worker and her supervisor. The Committee also reviewed a packet of information provided to them which included DCYF intakes, case notes, and assessments/investigation materials. The Committee also received the following information on the day of the scheduled review:

- Historical DCYF records about [redacted]
- Historical DCYF records about [redacted]
- Medical records pertaining to C.P.'s birth that were obtained after [redacted] death
- A law enforcement report regarding the fatality
- A 2014 [redacted] County Superior Court document regarding [redacted]

[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] C.P.'s family members 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

Between October 2004 and July 2018, there were 13 intakes received by DCYF regarding C.P.'s mother and her children. The intakes' allegations included RCW 13.50.100 by the parents, RCW 13.50.100, RCW 13.50.100 of the mother, RCW 13.50.100, and RCW 13.50.100 . None of the 13 intakes assigned for investigation resulted in a founded finding. C.P. has four half-siblings. Three of RCW 74 half-siblings share the same father. Those children were in the care and custody of their maternal grandmother at the time of C.P.'s passing. C.P.'s oldest half-sibling has been in the care and custody of her father since 2001.

During the CPS investigations prior to C.P.'s birth, DCYF conducted Child Protection Team (CPT)[3] staffing on September 22, 2011, and March 3, 2012. Both times the CPTs recommended case closure. Services were not offered to the family until the March 2012 CPS investigation. However, the parents failed to engage in the offered in-home services, and it was noted in the Investigative Assessment[4] that the maternal grandparents intervened and took physical custody of the three children. At the time of the grandparents' intervention, they indicated an intent to file for legal custody.

On RCW 74.13.515, 2018, another intake was created. This intake was based on a report that C.P.'s mother had given birth to a baby RCW 74.13 and the mother was RCW 13.50.100 for the unnamed child (later named C.P.). The mother disclosed RCW 13.50.100 but said she RCW 13.50.100 . The RCW 13.50.100 . This intake was screened out.

Another intake was received on July 30, 2018. This intake reported that the mother, her boyfriend, and five children all resided together. The caller also reported that the mother's oldest child disclosed that the mother and family did not have a stable place to live, both the mother and her boyfriend were using RCW 13.50.100 the mother admitted she is "RCW 13.50.100 ," that the child RCW 13.50.100, and C.P. is neglected by RCW 74 parents. This intake was screened in for a CPS/FAR assessment.

On August 2, 2018, the CPS/FAR worker contacted the mother. Upon the worker's arrival to the mother's location, the mother's sister stopped the worker in the parking lot. The worker explained the reason for her visit and the mother's sister assisted with getting the mother to speak to the worker. The mother was described as defensive. She stated that C.P. is the only child living with her, and the other children are living with the maternal grandmother in RCW 74.13.515. During this visit, the worker was able to see C.P. and did not observe any concerns. The mother's sister shared that the mother and C.P. lived with her at her residence. The sister said that she did not have any concerns about the mother, that she appeared to be doing well with C.P., and when she is at her home she knows there is no drug use occurring. The worker learned that C.P.'s father is married to a different woman and that woman has a positive relationship with C.P.'s mother. The father's wife sometimes provides care for C.P.

After the meeting with the mother, the worker contacted the maternal grandmother. The maternal grandmother confirmed that she has custody of three of C.P.'s siblings. She said she was recently in Washington to see C.P. and did not have any concerns regarding RCW 74 care while with RCW 74 mother at the aunt's home. The worker also reached out to RCW 74.13.515 CPS. There was no information found for the maternal grandmother and the children. The worker requested a health and safety check to confirm that the children residing with the maternal grandmother were safe.

[3] https://www.dcyf.wa.gov/1700-case-staffings/1740-child-protection-teams-cpt
[4] https://www.dcyf.wa.gov/practices-and-procedures/2540-investigative-assessment

On August 9, 2018, DCYF received an intake stating that the Medical Examiner's office was working with the sheriff's office regarding the death of C.P. The mother stated she went to bed between 4:00 - 4:30 a.m. and at some point C.P.'s father joined them. She woke just before 2:00 p.m. and found that C.P. was unresponsive. Emergency services were called but C.P. was declared deceased at the residence. The investigating officers found drug paraphernalia in the bedroom and living room and stated the home was a known residence for drug use. This intake was assigned for a CPS investigation. At the conclusion of the investigation, C.P.'s parents received a founded finding for negligent treatment or maltreatment.

COMMITTEE DISCUSSION

The Committee discussed with the worker and supervisor the reasons for not asking the mother and father to provide a urinalysis during the August 2, 2018, contact. The CPS worker and supervisor stated the worker was trying to build trust based on the mother's presentation at the initial contact and due to the long history the mother had with DCYF. Other factors that influenced the decision to not request a urinalysis included the fact that the mother appeared to be coherent and did not appear to be under the influence, the home was in order, and the mother's sister provided positive information regarding safety. The Committee concluded the explanation given to be an appropriate basis for not requesting a urinalysis.

There was also a discussion about whether DCYF can "flip" (transfer) an intake from CPS/FAR to CPS investigations. It was determined that the answer to this question is yes. However, each office has a different CPS unit structure. Some CPS units are FAR units only and some CPS units contain investigative workers and FAR workers that conduct both CPS functions. The CPS supervisor reported she has struggled with some FAR staff who are resistant to taking cases that need to move to investigations because the staff are reluctant to conduct investigations related to more serious allegations. The Committee discussed that this is an issue facing other CPS units around the state. The Committee also discussed new DCYF staff must be informed that they may be required to interact with and handle cases involving significant trauma. New staff must also be informed that even though a case may come in as a FAR assessment, there are frequently other more significant traumas that may be revealed during the assessment process.

The Committee also expressed concerns about the mother's extensive history involving prior drug use and mental health needs. The CPS worker and supervisor were aware of this history and were clearly mindful of this in the approach taken with the family before the fatality. Notwithstanding this, with regard to the RCW 74.13.515, 2018, intake the Committee was concerned that the mother's prior history demonstrated a need for a CPS investigation as compared to a FAR assessment.

FINDINGS

The Committee found there were no critical errors made by DCYF during the assessment that pertains to C.P. There were no other findings related to this review.

RECOMMENDATIONS

The Committee discussed that DCYF is inconsistent statewide with regard to CPS assignments and investigative findings pertaining to unsafe sleep incidents. 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 identified the need for more trauma-informed care that should be made available to staff that 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 currently functions. The Committee also believes that staff should be treated similarly to other first responders by relieving them from taking new assignments and possibly case responsibilities for a specified period of time after the incident. The Committee also believes they should be given paid leave to support their emotional well-being.

The Committee does not agree with the current standard for assessing intakes regarding a family's chronicity and whether the case is a CPS investigation or FAR assessment. The Committee believes DCYF should re-evaluate this and take into consideration the entirety of a family's chronicity as opposed to just considering the last 12 months.