CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

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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

- E.P.

Date of Child's Birth

- RCW 74.13.515 2020

Date of Fatality

- November 24, 2021

Child Fatality Review Date

- May 5, 2022

Committee Members

- Patrick Dowd, JD, Director, Office of Family and Children's Ombuds
- Melissa Sayer, MSW, Licensing Division Statewide Safety Administrator, DCYF
- Devon Jenkins, MSW, Safety & Monitoring & Licensing Division CPS Supervisor, DCYF
- Ericka Russell, MSW, Adoptions Area Administrator, DCYF
- Shanell Brown, BSN, RN, Nursing Consultant, Office of Family & Community Health Improvement, Department of Health
- Erika Thompson, Licensed Foster Parent and Foster Parent 1624 Consultation Team Lead

Facilitator

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

Executive Summary

On May 5, 2022, the Department of Children, Youth, and Families (DCYF) convened a Child Fatality Review (CFR)[1] to examine DCYF's practice and service delivery to E.P. and RCW 74. family. E.P. will be referenced by RCW 74. initials throughout this report.[2]

On Nov. 29, 2021, a DCYF caseworker learned that E.P. died from a suspected accidental drowning on Nov. 24, 2021. The caller reported that the family visited relatives and stayed in their travel trailer. The mother made a bed for E.P. in the bathtub rather than using an available pack and play for sleep. E.P. reportedly turned on the faucet and drowned while the family slept.

There was no open DCYF case at the time of E.P.'s death. However, a prior case closed upon E.P.'s September 2021 adoption finalization. A Licensing Division (LD) Child Protective Services investigation was assigned. At the conclusion of the investigation, DCYF issued a negligent treatment or maltreatment[3] founded finding[4] against the mother. The father was issued an unfounded finding.

A diverse 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 E.P. or RCW 74. family. Before the review, the Committee received relevant case history from DCYF. On the day of the review, the Committee had the opportunity to interview DCYF caseworkers, supervisors, and area administrators who were involved with the family.

Case Overview

In January 2020, E.P.'s biological family first came to DCYF's attention after DCYF received a report that E.P.'s mother had RCW 74.13.520. E.P.'s older sibling was in the care of a relative. A CPS-Family Assessment Response (FAR) case was opened and led to DCYF filing a dependency petition on behalf of E.P.'s older sibling,

[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 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 CFR 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 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 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 E.P.'s parents are not used in this report because neither parent has been charged with a crime in connection with the fatality. E.P.'s name is also not used in this report because RCW name is subject to privacy laws. See RCW 74.13.500.

[3] "'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).

[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." RCW 26.44.020(29) defines "unfounded" as follows: "the determination following an investigation by the department that available information indicates that, more likely than not, child abuse or neglect did not occur, or that there is insufficient evidence for the department to determine whether the alleged child abuse did or did not occur."

RCW 74. . RCW 74. . was placed in out-of-home care and assigned an ongoing caseworker from the Child Family Welfare Services (CFWS) program.

In RCW 74.13.515 2020, E.P. was born. DCYF received a report that E.P. was born blue and not breathing on RCW 74. own. E.P. required resuscitation efforts and intubation. The mother admitted to using RCW 74.13.520 and RCW 74.13.520 throughout her pregnancy. E.P.'s toxicology report revealed a positive test for RCW 74.13.520 and RCW 74.13.520 A CPS risk-only[5] investigation was assigned and led to DCYF filing a dependency petition. E.P. was placed in licensed foster care following RCW 74. discharge from the hospital.

In November 2020, E.P. was transitioned to a different licensed foster home. In January 2021, RCW 74. sibling was moved to the same home. The foster home had been licensed since 2016 and previously adopted two children placed through DCYF and one child through a private adoption.

DCYF offered court-ordered services and visitation to E.P.'s mother and father. DCYF made attempts to engage both the mother and father. Neither made themselves available to participate in services and did not regularly communicate with DCYF.

In May 2021, the court signed a termination of parental rights order making E.P. and RCW 74.1 legally free. A shared planning meeting was held. The foster family expressed their desire to move forward with adoption for both E.P. and RCW 74. . E.P.'s ongoing needs for medical and developmental services were reviewed. The foster parent understood that E.P. was expected to have ongoing developmental needs.

E.P. and RCW 74.1 's case transferred from CFWS caseworker to adoptions. DCYF continued to complete monthly health and safety visits in E.P.'s home. DCYF monitored E.P.'s health and well-being, including the foster parents' participation in services for E.P. The foster parents also shared service updates with DCYF.

In August 2021, the foster family's updated adoptive home study was completed by a home study worker. The adoptive home study did not identify any concerns or unmet needs. The home study recommended the family adopt E.P., RCW 74.1 ., and one other child who was under the family's care.

In September 2021, the adoption of E.P. and RCW 74.1 was finalized. In October 2021, DCYF dismissed the dependency and submitted the case for closure.

In early November 2021, the foster parent contacted the safety and monitoring (SAM) licensor.[6] The foster parent requested a modification of the foster home license to allow for the placement of an additional child who was in the home. At the time of this request, the SAM licensor was informed of the finalized adoptions. Before modifying the license pursuant to the foster parent's request, the SAM licensor consulted with her supervisor and completed a virtual walk-through of the foster family home to ensure there was adequate space.

On Nov. 24, 2021, the foster mother emailed the SAM licensor requesting the foster home license be closed.

[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 information about safety and monitoring (SAM) licensors, see: https://www.dcyf.wa.gov/services/foster-parenting/licensing-restructure-update. Last accessed on May 16, 2022.

On Nov. 29, 2021, a child welfare caseworker who had been previously assigned to E.P.'s case learned that E.P. died on Nov. 24, 2021. An LD CPS investigation was assigned to investigate the circumstances surrounding E.P.'s death. Consequently, DCYF issued a founded finding of negligent treatment or maltreatment against the mother. The foster father was assigned an unfounded finding. The autopsy identified the cause of death as drowning and hypothermia. The manner of death was accidental.

Committee Discussion

The Committee met and spoke with field staff from Child Welfare Family Services (CFWS), Adoptions, Adoption Support, and the Licensing Division (LD). This enriched the Committee's understanding of the respective staff's assigned work. The Committee discussion focused on work specific to LD, child welfare, and the collaboration between the two.

The Committee talked at length about foster parent training requirements. Foster parents are required to take core training. However, once the core training is completed, the foster parents are able to decide which ongoing training to attend. LD field staff told the Committee they may recommend specific trainings to foster parents should a concern arise, but the recommended trainings are not required. The Committee discussed the benefits of developing tailored training plans. The Committee believes tailored training plans may increase foster parents' knowledge and capacity to meet the developmental needs of the children under their care.

The Committee discussed Safe Sleep[7] and the fact that safe sleep training is mandatory for foster parents who provide infant care. The Committee understands that despite efforts to provide Safe Sleep education, parents and caregivers may not always choose to utilize safe sleep environments. The Committee also understands E.P.'s death occurred outside of the family's home, and there had not been any previously documented concerns about the foster home.

The Committee learned from the SAM licensors that a walk-through is typically conducted when a foster family has a travel trailer on their property. The Committee's LD subject matter expert reported that travel trailer walk-throughs are not a statewide standard practice nor a current LD requirement.

The Committee believes there are benefits to viewing a foster parent's travel trailer but is reluctant to recommend making this a requirement given all the existing requirements foster parents must satisfy. The Committee did agree it would be advantageous for SAM licensors to have conversations with foster parents about the use of travel trailers, including sleeping arrangements. A Committee member discussed the belief that the use of travel trailers should fall under the prudent parenting guidelines[8], similar to circumstances such as foster parents traveling and staying in hotels.

The Committee discussed their concern about the foster parent's failure to report E.P.'s death to DCYF. The Committee discussed that foster parents are required to report the death of a child but also acknowledged the traumatic events this family experienced. The Committee wondered why law enforcement did not report

[7]For information about Safe Sleep, see: https://safetosleep.nichd.nih.gov/safesleepbasics/about; https://www.nichd.nih.gov/sites/default/files/2019-04/Safe_to_Sleep_brochure.pdf; and https://www.dcyf.wa.gov/safety/safe-sleep. Last accessed on May 6, 2022.

[8]For information about Prudent Parenting, see: https://www.dcyf.wa.gov/publications-library/CWP_0078. Last accessed on May 12, 2022.

E.P.'s death to CPS. With regard to reporting practice, the Committee suggested it may be worthwhile for DCYF to collaborate with the local law enforcement agency that responded to E.P.'s death.

The Committee spoke with the CFWS program staff and Adoption field staff about their efforts to engage E.P.'s biological family. The Committee believes it may have been helpful to document additional details about the relative search and any additional follow-up that occurred with the maternal and paternal family. The Committee identified the important role DCYF can play in a child's well-being by supporting and building family connections.

The Committee observed that E.P.'s case quickly moved to permanency. The Committee discussed if a focus on following the permanency-related timeline requirements may have outweighed an objective assessment of what was in the best interest of E.P. However, the Committee understands the caseworkers did not have concerns about the foster parents' ability to meet E.P.'s needs. The Committee did not make a conclusion about what was in E.P.'s best interest

The Committee wondered if both the LD and child welfare field staff may have been impacted by a favorable bias towards the foster family. Field staff from both LD and child welfare reported the foster parents were responsive to DCYF requests, followed requirements, and communicated well. The Committee discussed whether that may have possibly led to DCYF overlooking family support needs but did not identify specific unmet needs

The Committee wondered if the foster family understood the supports that may have been available to them through the LD and child welfare programs. The Committee speculated the lack of requests for support and services may have led to the family being under the radar. The Committee believes it would have been beneficial for the LD and child welfare field staff to document conversations about the various supports DCYF may offer the family and how to access those supports.

The Committee observed that both the LD and child welfare field staff relied heavily on the foster parent's self-report. The Committee learned about developmental and medical supports in place for E.P. Some of the supports were provided virtually due to the COVID-19 pandemic. The Committee highlighted their belief about the importance of gathering information from many sources and not just caregiver self-reports. The Committee also considered whether DCYF should explore how support and services offered through a virtual setting can be improved.

The Committee discussed the collaboration, communication, and information sharing between the licensing division and child welfare field staff. The Committee learned from conversations with field staff that communications did occur between the LD and adoptions field staff. Overall, the Committee believes more communication between the LD and child welfare field staff may be beneficial to each team's work.

For purposes of improving collaboration between DCYF divisions, increased communications about adoption finalizations is one specific area identified by the Committee for improvement. DCYF's current documentation system does not provide an automatic alert to LD when a foster home adoption is finalized. Foster families are required to provide the notification, which does not always occur. If the SAM licensor is not informed about the status of completed adoptions, the licensing capacity of a foster home is not modified, which diminishes

LD's ability to assess foster home placement capacity. The Committee considered various ideas related to how to increase communication between LD and adoptions but understands that additional DCYF staff may need to be included in this conversation.

Findings

The Committee believes DCYF could have more effectively documented the relative search efforts and attempts to engage E.P.'s maternal and paternal biological family.

Recommendations

The Committee respectfully recommends that DCYF convene a workgroup between the Licensing Division and Adoptions to develop a communication process to notify the LD when an adoption is finalized in a licensed foster home.