CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

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CONTENTS

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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

- F.F.

Date of Child's Birth

- October 2024

Date of Fatality

- December 22, 2024

Child Fatality Review Date

- March 4, 2025

Committee Members

- Mary Anderson Moskowitz, JD, Ombuds, Office of the Family and Children's Ombuds
- Melissa Hoogendoorn, Supervisor, Department of Children, Youth, and Families
- Tessica Welch, Supervisor, Department of Children, Youth, and Families
- Stephanie Widhalm, MSW, LICSW, MHP, CMHS, Children's Advocacy Center Director / Forensic Interviewer, Partners with Families and Children
- Ida Keeley, Consultant

Facilitator

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Finalized Date: May 5, 2025
Approved for distribution by Paul Smith, Critical Incident Practice Consultant

Executive Summary

On March 4, 2025, the Department of Children, Youth, and Families (DCYF) conducted a Child Fatality Review (CFR)[1] to examine DCYF's practice and service delivery to F.F. and [redacted] family. F.F. is referenced by [redacted] initials throughout this report.[2]

On December 18, 2024, DCYF received three reports from two different medical facilities reporting that F.F. had injuries suspected of being non-accidental physical trauma. F.F. was brought to the emergency room, "limp, blue, and not breathing". CPR was administered and F.F. began breathing on [redacted] own again. Through x-rays, it was determined that F.F. had healing fractures of [redacted] clavicle and fifth and sixth rib. F.F. was transported to Mary Bridge Children's Hospital and their team reported F.F. had a suspected skull fracture and said [redacted] may not survive. Additionally, it was reported F.F. had been taken to the emergency room in November 2024 by the father due to an injury to F.F.'s mouth. This information was not reported to DCYF by the hospital at the time of the incident. On December 22, 2024, F.F. was pronounced as having brain death and passed away following the removal of life support.

At the time of F.F.'s passing DCYF had an open case with F.F. and [redacted] family. A new case opened to investigate the circumstances of F.F.'s death and concluded with the mother being assigned founded finding[3] of negligent treatment and the father being assigned founded findings of negligent treatment and physical abuse. F.F.'s father was arrested on December 18, 2024, with pending charges of felony homicide by abuse and murder in the second degree.

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 the 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.

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

[3]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."

Case Overview

Prior to F.F.'s death, DCYF received four calls reporting concerns for the welfare of the children in the family to include RCW 7 older sibling, RCW 74.13. The reports led to two CPS investigations, one prior to F.F.'s birth and one related to F.F.'s birth, a Family Voluntary Services (FVS)[4] case, and a Child Family Welfare Services (CFWS)[5] case to provide ongoing, court-ordered services. This summary is intended to provide an overview and may not include every detail of the case or agency action.

In June 2023, a CPS investigation was assigned when DCYF received a report alleging possible physical abuse of RCW 74.13.52 age 2 months. Medical professionals reported that RCW 74.13.520 Medical professionals reported these injuries to be highly suggestive of non-accidental trauma and said the parents' reports did not match the injuries. Two additional reports were received during the open investigation related to the father reporting that he dropped RCW 74.13. and did not access medical care despite potential injuries and the likelihood that RCW 74. was in significant pain as reported by the medical child abuse expert. Medical professionals reported that the father's explanation of dropping RCW 74.13. was still not plausible to have caused the extent of RCW 74. injuries. A concurrent law enforcement investigation was also taking place. The CPS investigation was open from June 23 to August 21, 2023, and concluded with the mother being assigned a founded finding of negligent treatment and the father being assigned founded findings of negligent treatment and physical abuse. The case remained open through FVS and then CFWS for ongoing court-ordered service provision.

During the CPS investigation, a family team decision making meeting was held to identify strengths, address concerns, and develop a plan. Based on the safety assessment, the mother and father were offered a 90-day voluntary placement agreement,[6] so that RCW 74.13. could be placed in-out-home care to address RCW 74. immediate need for safety and so the parents could participate with parenting instruction. The parents agreed RCW 74.13.515 RCW 74.13.515 The parents were referred to Promoting First Relationships (PFR)[7] parenting instruction.

In August 2023, an internal DCYF staffing was held and the case transferred to an FVS caseworker to continue providing support to the family. In September 2023, RCW 74.13.515 The case transferred to a CFWS caseworker.

In October, November, and December 2023, service provision continued with the family while RCW 74.13.515 RCW 74.13.515 RCW 74.13.5 was reported to be receiving all the necessary follow-up medical care required and was healing from RCW 74. injuries. During this period, the caseworker completed a domestic violence assessment with each parent separately, two shared planning meetings were held to review the case progress and needs, and concrete goods were provided to the mother and father to assist in meeting their basic needs and to support

[4]For information on Family Voluntary Services (FVS), see: https://www.dcyf.wa.gov/policies-and-procedures/3000-family-voluntary-services-fvs.

[5]Child and Family Welfare Services (CFWS) caseworkers assume responsibility of a child welfare case after a dependency petition has been filed with the court.

[6]For information on Voluntary Placement Agreements, see: https://dcyf.wa.gov/4300-case-planning/4307-voluntary-placement-agreement.

[7]For information on Promoting First Relationships (PFR), see: https://pfrprogram.org/who-we-are/. Last accessed on March 7, 2025.

family time visits. RCW 74.13.515 by the court as to both parents and services were court-ordered for each parent. In late December 2023, the case was transferred to a different CFWS caseworker and supervisor. DCYF received notification that the father would be charged with criminal mistreatment in the second degree, with an arraignment scheduled for January 2024.

In January 2024, criminal proceedings began with the father RCW 74.13.515 Both parents continued their participation with parenting instruction. The parents experienced housing and employment instability during this month and concrete goods were provided to assist in meeting their basic needs in addition to providing connections to community-based resources.

From February to June 2024, RCW 74.13.515 was observed at the relative caregiver's home and during visitation. During this period the visitation between RCW 74.13.5 and the mother continued, and the mother continued participating with parenting instruction. Concrete goods were provided to the mother and father to assist with their basic needs.

In July 2024, RCW 74.13.515 The father began participating with visitation that included parenting instruction. The father was re-referred to fatherhood engagement services.

From August to September 2024, there were ongoing efforts for collaboration with the caseworker, family time supervisor, and parenting instruction provider to develop a support plan RCW 74.13.515 In September, the father successfully completed parenting instruction. The mother reported becoming employed and was working on obtaining housing through a coordinated entry program in the county where the family resided. During a conversation with the mother the caseworker asked the mother if she was pregnant, which she denied.

In October 2024, the prosecuting attorney communicated with the caseworker regarding the father's pending criminal case, which was near conclusion. F.F. was born and there was no intake reported by the hospital regarding RCW 74 birth. The ongoing caseworker reported the birth of the baby to intake, which screened-in for a CPS risk-only investigation.[8] The investigation was assigned to the ongoing CFWS caseworker and supervisor.

During the CPS investigation, the caseworker met with the mother, the father, observed the infant, and saw the family during family time to include RCW 74.13. Additionally, the caseworker made collateral contacts to include the family time visit supervisor, who reported no concerns about the parent's interactions with the newborn. The family was provided with infant supplies as the mother said this pregnancy was a surprise. The family reported that F.F. was born RCW 74.13.520 and medical follow-up had been scheduled.

In November 2024, the caseworker completed an unannounced visit to the family's home to drop off goods and observe F.F. The caseworker said they would meet with the family the following week to complete parent interviews. The family time visit supervisor reported the family was missing approximately half of the

[8]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". For more information about CPS Risk Only Investigations, see https://www.dcyf.wa.gov/practices-and-procedures/2200-intake-process-and-response.

scheduled visits and that visits were taking place in the community because the home did not have heat at this time. The caseworker followed up to provide concrete goods to help the family get portable heaters. The child safety assessment was completed with F.F. assessed as safe in [redacted] parent's care with high risk.

In December, [redacted] and both parents were found in compliance with court-ordered services and making progress. [redacted] The caseworker observed the family during a family time visit with both F.F. and [redacted] present. A monthly supervisor review occurred, stating that F.F.'s case would transfer to FVS for ongoing service provision for F.F.'s case, [redacted]

On December 18, 2024, the agency received three calls reporting that F.F. had been brought to the emergency room non-responsive with concerns for non-accidental physical trauma. On December 22, 2024, F.F. passed away. [redacted]

Committee Discussion

The Committee had the opportunity to speak with field staff who were involved in supporting the family. This discussion provided a chance for the Committee to learn about case specific details, typical office practice and resources, and system challenges. The Committee identified positive aspects of the casework practice and discussed opportunities for improvement. Improvement opportunities are defined as the gap between what the family needed and what they received from the child welfare system. Improvement opportunities may also identify systemic barriers. The Committee discussed several aspects related to casework practice with an emphasis on assessment, service provision, and support for field staff.

The Committee inquired about the training opportunities and support available to field staff, specifically around assessing and providing service provision for serious physical injury cases. One specific area of challenge reported by the field staff is access to the Child Abuse Interviewing and Assessment (CAIA)[9] training and other training related to physical injury cases. This training is prioritized for field staff who complete CPS investigations due to the interviewing curriculum provided in the training. One CFWS field staff said they have been waiting for five years to complete this training due to limited availability and prioritization of CPS field staff. The Committee opined that the child welfare system may benefit from consideration of moving away from CPS only-trainings, such as with CAIA, and create training opportunities available across child welfare programs for shared learning. The Committee also inquired about the service array available for cases where there has been a non-accidental physical injury of a child, learning that there are not specific services geared towards physical injury cases. The Committee pointed out that it can be difficult to identify needs and provide support if it is unclear what led to the injury or the root cause of the incident occurring, which may impact service delivery.

[9]For information on Child Abuse Interviewing and Assessment training, see: https://cpe.socialwork.uw.edu/alliance-courses/content/child-abuse-interviewing-and-assessment. Last accessed on March 7, 2025.

Although outside the scope of this review, the Committee did discuss that following F.F.'s admission to the hospital in December DCYF learned that RCW 7 had been seen for a RCW 74.13.520 (sentinel injury)[10] in November 2024, that was not reported by the hospital to the child abuse hotline. The field staff believed this was critical information that would have warranted agency response due to the nature of the injury. The Committee considered ideas for the agency to increase collaboration with medical professionals and hospitals. It was suggested that the medical consultation doctors that DCYF contract with provide training and education regarding child abuse to local hospitals, which may increase understanding about sentinel injuries.

The Committee spoke at length regarding the assessment following the birth of F.F. and the case assignment of the CPS risk-only investigation. The CPS risk-only investigation was assigned to the ongoing CFWS caseworker and supervisor who had been overseeing and providing service provision for RCW 74.13.515 case. The Committee discussed the pros and cons of having a CFWS caseworker complete an investigation. In some instances, they agreed that it may be beneficial because of a pre-established relationship with the family, in other instances they identified it may negatively impact the working relationship between the caseworker and family. Both the CFWS caseworker and supervisor acknowledged this was the first time they had been assigned to an investigation and said they sought support within their office and regionally to ensure they were following the necessary steps of an investigation.

The Committee highlighted the importance of training field staff across programs with an emphasis on assessing child safety regardless of what program a caseworker works in. Based on the conversation with field staff the Committee wondered if some CFWS caseworkers may equate child safety with a parent's compliance and progress on court-ordered services because of the strong emphasis on court-ordered services within the CFWS program. The Committee believed the agency had done a good job of outlining the expectations and behavioral change needed from the mother and father for consideration of RCW 74.13.5 to return home and would have liked to see those expectations of behavioral change considered in the assessment of F.F.'s case. The Committee believed the caseworker and supervisor may have benefited from additional guidance provided from their regional supports to help inform their practice related to the investigative process. The area administrator shared with the Committee there is now a protocol in place to provide regional support to CFWS caseworkers who are assigned new investigations on open cases.

The Committee discussed the tools available to field caseworkers to inform and guide their assessment process. The Committee discussed the required safety and risk assessment tools utilized by the agency but was also aware of Parent-Child Interaction (PCI) Feeding and Teaching scales[11], which are not required as part of the current assessment process. PCI scales assess attachment and bonding between child and caregiver(s). When asked about how field staff assess attachment and bonding, they reported relying on their observations between children and caregivers, stating they do not have individuals certified to complete PCI assessments in their region. The Committee wondered how utilization of a consistent assessment tool, such as PCI, may be beneficial to the assessment as it would remove the reliance of personal observation by individual

[10]For information about sentinel injuries, see: https://www.casey.org/sentinel-injuries-study/#:~:text=Sentinel%20injuries%2C%20such%20as%20bruising,severe%20abuse%20in%20the%20future. Last accessed on March 7, 2025.

[11]For information about Parent-Child Interaction (PCI) Feeding and Teaching Scales, see: https://www.pcrprograms.org/parent-child-interaction-pci-feeding-teaching-scales/. Last accessed on March 7, 2025.

caseworkers, which may differ from person to person. The Committee suggested the agency consider prioritizing training and certification for caseworkers to complete PCI assessments and negotiate capacity to do so across the state.

An additional tool discussed that was not utilized for F.F.'s case was that of shared decision-making which brings families and community professionals together to discuss safety concerns, strengths and needs, and develop plans. The Committee valued shared decision-making, specifically noting the importance of including those with subject matter expertise that may provide guidance and inform decision making. The Committee discussed the use of a Multi-Disciplinary Team (MDT), which is accessed through community partnerships or Family Team Decision Making meetings (FTDM), which are facilitated by DCYF. The agency also utilizes internal consultation to help identify safety threats, risk, and to address barriers. F.F. and RCW 7 family needed a shared decision-making meeting following RCW 7 birth to bring individuals together to discuss concerns, identify needs, and develop a plan to address child safety.

The Committee discussed what they believed were identified needs for the mother and father based on their review of the case file and discussion with the field staff. The Committee acknowledged that when individuals are facing challenges meeting their basic survival needs it can be very difficult to address higher level needs. One area of curiosity was about the mother and father's reported cannabis use. The Committee noted inconsistent reporting throughout the duration of the case regarding their individual use patterns and would have liked the mother and father to establish a baseline by completing a urinalysis test. This may have provided an opportunity for additional discussion with the mother and father about their patterns of cannabis use. A Committee member emphasized the importance of caseworkers familiarizing themselves with the case history through review of the file to help inform and guide their inquiry in the assessment process. The Committee also emphasized the importance of utilizing outside sources to verify parent self-reports in addition to seeking consultation or subject matter expert opinions related to substance use and potential treatment needs. The mother identified using cannabis at one point to address her mental health, which the Committee felt warranted additional attention. The mother may have benefited from additional conversation to identify if she had an unmet mental health or maternal health need that could have been addressed through a community-based referral to services.

The Committee spoke to the field staff about their assessment of domestic violence (DV) between the mother and father, identifying that there may have been power and control dynamics, but that both the mother and father denied DV in their relationship. The father had been identified as having "anger issues" for which he previously participated with anger management (prior to DCYF involvement). The Committee discussed that anger management is no longer a service offered through the DCYF service continuum and that individuals are now referred to community-based mental health services. Additional information gathering related to the father's prior anger management assessment may have informed the assessment process and/or identified an unmet need, which may have been best addressed through a referral for a psychological evaluation.

The Committee believed the agency made efforts to provide culturally responsive casework by connecting the family to a caseworker with similar heritage. While this was noted as positive, a Committee member also pointed out that in smaller cultural communities this may create challenges or impact bias but did not believe that was the case in this instance. The Committee also noted that throughout the life of the case efforts were

made to learn about the parents' cultural heritage and values. The field staff shared that both the mother and father identified as non-traditional, while their family members identified as traditional to their cultural heritage. Based on the assessment, documentation, and discussion with the field staff, the Committee would have liked to see additional exploration of the extended family dynamics given the references to mother and father having conflict with paternal and maternal family members.

Lastly, the Committee had a conversation with the field staff about the support they have access to in their roles and what may be additionally beneficial. The Committee appreciated the field staff's candor regarding the challenges with child welfare work and the opportunity for shared learning through this discussion.