CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

July 2019

Washington State Department of
CHILDREN, YOUTH & FAMILIES

Contents

Full Report

Child

- R.H.

Date of Child's Birth

- [redacted] 2018

Date of Fatality

- March 19, 2019

Child Fatality Review Date

- June 20, 2019

Committee Members

- Patrick Dowd, Director, Office of the Family and Children's Ombuds
- Nicole Labelle, Programs Administrator, DCYF
- Amy Person, MD, Pediatrician, Benton-Franklin Health District
- Toni Razote, Supervisor, DCYF
- Drew Florence, Sergeant, Richland Police Department
- Jessica Strawn, Continuing Education Specialist, Alliance for Child Welfare Excellence, University of Washington

Facilitator

- Cheryl Hotchkiss, Critical Incident Review Specialist, DCYF

Executive Summary

On June 20, 2019, the Department of Children, Youth, and Families[1] (DCYF) convened a Child Fatality Review (CFR)[2] to assess DCYF's service delivery to R.H. and [redacted] family.[3] The child's initials are used throughout this report to maintain confidentiality.

On March 19, 2019, R.H. died. At the time R.H. was in a court-ordered placement with [redacted] paternal grandmother. The grandmother reportedly called emergency 911 and attempted resuscitation efforts until emergency responders arrived. On the same day, the grandmother also called the assigned worker and reported she found R.H. in a nonresponsive condition in [redacted] playpen. After 911 emergency arrived, R.H. was transported to the hospital. R.H. did not respond to the hospital's resuscitation efforts and was eventually taken off life support. The 911 emergency responders reported no concerns for abuse or neglect. On March 27, 2019, the assigned worker reviewed the police department's report and concluded there was no information in the report suggesting criminal activity caused R.H.'s death. The assigned worker also talked to the local coroner who at the time could not determine a cause of death, noting there were no signs of soft tissue trauma, broken bones, illness or airway blockage. The coroner did not believe criminal activity caused R.H.'s death.

On April 8, 2019, the local police department notified the assigned worker that R.H.'s toxicology analysis tested positive for Fentanyl. Accordingly, law enforcement requested immediate removal of all the children from the grandmother's home. It was determined that at the time of R.H.'s death the following people were living with R.H. and [redacted] grandmother: R.H.'s father, R.H.'s twelve-year-old aunt, R.H.'s four older siblings and the grandmother's boyfriend. At the time of R.H.'s death, DCYF was unaware of the fact that R.H.'s father and grandmother's boyfriend were also living in the home. At the time of the review, there had been no arrests or criminal charges filed against anyone that had been residing in the home or caring for R.H.

The CFR Committee (Committee) includes members with relevant expertise selected from diverse disciplines within the community. Committee membership includes the director of the Office of the Family and Children's Ombuds, a pediatrician, a law enforcement sergeant, a DCYF Child Protective Services (CPS) program administrator, a DCYF supervisor and a staff member with the Alliance for Child Welfare Excellence. None of the Committee members had any previous direct knowledge of or involvement with this family.

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[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 respons ble for child welfare, and the Department of Early Learning for childcare 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 CFR or child near fatality review (CNFR) should not be construed to be a final or comprehensive review of all circumstances surrounding the death or near 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 or CNFR 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 fatality. Nor is it the function or purpose of a CFR or CNFR 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." RCW 74.13.640(4)(d).

[3] There are no known criminal charges filed against the parents that are related to this incident. Accordingly, the parents are not identified by name in this report. The names of the children are also subject to privacy laws. See RCW 74.13.500.

At the beginning of the review, each committee member received a family genogram, a case chronology, a summary of DCYF involvement with the family and un-redacted DCYF case documents (*e.g.*, intakes, investigative assessments and case notes). Supplemental information sources and other resource materials were also available. These included medical reports, relevant state laws and DCYF policies.

The Committee interviewed the licensing home study worker[4], the CPS assigned worker, the assigned Child and Family Welfare Service worker (CFWS[5]) and the worker's supervisor. The Committee also reviewed the case file documents and discussed department actions, activities, decisions and possible areas for practice improvement. The Committee's findings and recommendations are included at the end of this report.

Case Overview

R.H.'s parents both have a CPS history involving 13.50.100 , 13.50.100 , 13.50.100 and 13.50.100 . In August 2018, R.H. and 74.13.517 four siblings were placed into DCYF custody after DCYF determined there were supervision issues, a failure to provide sufficient medical care, unknown men wandering in and out of the hotel room where the mother was staying and drug paraphernalia accessible to the children. The children's father was unavailable because he was in jail. Based on these circumstances a court issued an order directing DCYF to place the children in out-of-home care. On August 28, 2018, DCYF placed the children with their paternal grandmother. The placement was temporary pending approved background checks and an approved home study.[6]

After the children were placed with the grandmother, the grandmother told DCYF that her boyfriend was not residing in the home. However, there were indicators he either lived in the home or frequently stayed at the home. DCYF also had information indicating that after the father's October 10, 2018 release from jail, the father was frequently at the grandmother's home and possibly spending the night. The grandmother, grandmother's boyfriend and father all denied these reports and did not provide any insight into these concerns. Because of their age and development the youngest children, including R.H., were unable to provide any clear information on these issues. R.H.'s two oldest siblings denied the allegations.

On January 23, 2019, a Family Team Decision meeting (FTDM) was held and all parties were again reminded that without prior DCYF approval, neither the father nor any other adult was allowed to reside in the home or have access to the children. The grandmother's boyfriend agreed to complete a background check. All parties were aware DCYF could not approve a home study without the required paperwork and cooperation. DCYF staff also told the parties DCYF could not recommend continued placement in the grandmother's home without an approved home study. Despite repeated requests by

[4]The Division of Licensed Resources licenses foster homes and completes home studies for relative and suitable person placements.

[5]Child and Family Welfare social workers assume responsibility for child welfare care after the children have been removed from their caregivers and a dependency petition filed.

[6] See DCYF Policy No. 45274 and Policy No. 5110 for a description of the home study process. DCYF Policy No. 45274 may be viewed at https://www.dcyf.wa.gov/4527-kinship-care-searching-placing-and-supporting-relatives-and-suitable-other-persons/45274. DCYF Policy No. 5110 may be viewed at https://www.dcyf.wa.gov/5100-applying-foster-parent-or-unlicensed-caregiver/5110-completing-home-study.

DCYF, the grandmother and her boyfriend failed to complete the necessary home study paperwork and background check requirements.

On February 27, 2019, a second FTDM occurred. This second meeting discussed childcare issues, the grandmother's failure to complete the home study paperwork and her boyfriend's failure to submit a completed background check application. The meeting participants also discussed concerns that the father was staying in the home. During the meeting, the grandmother admitted that on one occasion the father did spend the night. After hearing this, DCYF reminded the grandmother the father cannot be at the home without DCYF permission. She was also told that a secondary placement plan would be initiated if she continued to ignore DCYF's placement requirements.

On March 06, 2019, DCYF initiated Family Preservation Services to help the grandmother organize her household functioning and complete the necessary home study requirements. During this process, it was determined the grandmother's boyfriend did have a criminal history that disqualified him from being a placement resource or having unsupervised access to R.H. and 74.13.51 siblings. In the days and weeks before R.H.'s death, the licensor and primary assigned worker maintained contact with each other, continued to visit the home and refer the family for services.

Committee Discussion

The Committee chose to limit the records review to the time-period R.H. was under 74.13.51 grandmother's care. While prior DCYF history was available, such history was not the Committee's primary focus. The Committee agreed with DCYF interactions and assessment prior to the placement and with the decision to petition for out-of-home care.

The staff interviews were helpful with regard to the Committee's understanding of how the local DCYF office works to achieve policy measures and gather child safety information. The Committee learned that frequent communications about the child's placement requirements occurred between the licensing worker, the placement provider, the parents, the assigned workers and supervisors. During the home study process the licensor, assigned workers and supervisors frequently communicated by email, in-person and telephone. For example, in one instance while the licensing worker was assessing the household sleeping arrangements, R.H.'s sibling disclosed 74.13.51 father slept on the top bunk bed in 74.13.51 room. Shortly after hearing this information the licensing worker told the primary worker and supervisors about this disclosure.

The Committee recognizes the importance Region 2 places on communication between licensing staff and primary assigned staff. The Committee believes frequent communication between staff should be considered a best practice and all regions within the state should mirror the Region 2 process. The Committee also recognizes that although communication occurred and multiple efforts to engage the grandmother were made, the grandmother continued to avoid the home study process. Her behavior delayed the home study assessment process. The Committee learned from DCYF staff that if a relative placement provider fails to complete the required home study paperwork or background check requirements, Region 2 issues a non-compliance letter to the placement on the 45th day after the child is placed with the provider and a second letter on the 90th day. Licensing staff also send an email to the assigned worker and supervisor summarizing the home study status, including any concerns about the placement.

The Committee expressed concerns about the home study process. In particular, the DCYF staff that were interviewed and some DCYF Committee members reported that the home study process can take up to one-hundred twenty (120) days for a placement resource to complete the necessary paperwork after the initial request[7] is made to licensing by the CPS or CFWS worker. The Licensing Division has performance goals which include a target of 70 % of applications being completed within 120 days.[8] Although there is no Washington Administrative Code (WAC) for licensing timeframes for unlicensed caregivers, as was the grandmother in this case, the Committee was concerned that staff expressed confusion about timeframes in the home study process. The Committee does not understand why it takes more than thirty days for a placement resource to complete the necessary paperwork. To encourage child safety, permanence and well-being in an unlicensed placement the Committee believes DCYF should consider adding to its policy a requirement that all home study information must be received by DCYF within thirty days of the placement date. The Committee also discussed non-compliance issues involving a parent or other adult spending time at the home without DCYF permission or unsupervised and a parent's or other adult's failure to submit to a background check when required or requested to do so. The Committee understands the challenges DCYF faces when clients are not forthcoming about the persons frequenting or staying in the home. Further, the Committee recognizes DCYF is limited to requesting background checks on persons who formally reside in the home and/or on the property or who have unsupervised contact with the children. The Committee wonders what it would take to get the law and policy amended to expand to persons who frequent the home or who have even supervised contact. The Committee discussed that often DCYF cannot be certain if providers will adhere to the supervision requirements.

The Committee also discussed the requirement that during the home study process a court order must normally be issued before a child's placement can be changed. For purposes of protecting a child's safety and welfare, the Committee recognizes the difficult legal challenges facing DCYF if it is determined necessary to remove a child (or children) from a relative who has historically been the protective stabilizing force in the child's life. This legal challenge maybe even more difficult if the relative placement has completed all or part of the placement requirements. With regard to R.H., the Committee agreed it was unlikely a court would have ordered a placement change removing R.H. from the grandmother. With this in mind, the Committee discussed whether a change in the existing home study requirements currently contained in policy would positively affect future placement proceedings.

The Committee understands DCYF staff never saw the father at R. H.'s home. This is the case despite the fact that on a number of different occasions CPS workers, CFWS workers, CHET[9] screening workers, licensing workers, the guardian ad litem and other service providers visited the home. Some of these visits were unannounced. The Committee believes that without the benefit of hindsight it is understandable DCYF did not fully recognize the fact that the grandmother was not being forthcoming about her boyfriend and the father's presence at the home. Some Committee members believe the assigned worker should have more assertively inquired of the grandmother (and collaterals) as to her

[7] Under subsection (3) of current DCYF Policy No. 45274 (*Placements with Unlicensed Relatives or Suitable Persons*) the caseworker must "provide the unlicensed caregiver with the appropriate forms needed to request a home study. Once the documents have been completed, the caseworker will submit the required documents to DLR within 30 days of the placement." Subsection (2) of the Procedures section says the following: "In those limited instances where the unlicensed caregiver is being referred for a home study after the placement occurs, the caseworker must submit the information to DLR within **30 days** of placement…." Similarly, Policy No. 5110 (*Completing the Home Study*) also requires that the home study referral be made within thirty days of the start of the placement. Under the procedures section of this policy the department is required to "Follow-up with the applicant a minimum of every 30 calendar days if there are outstanding application materials."

[8] See (http://insideca.dshs.wa.gov/intranet/pdf/programs/PERFORMANCEGOALS.pdf).

[9] CHET stands for "Child Well-Being Health and Education Tracking". Children under DCYF's legal authority who are expected to remain in care for thirty (30) days or more must receive a well-being screen that assesses child's health, educational, emotional, behavioral, cultural, and developmental needs.

boyfriend and R.H's father being in the home. Other Committee members believed the assigned workers' response was reasonable based on available information at the time.

The Committee recognizes the extensive efforts and diligence the assigned worker devoted to the CFWS assessment before R.H.'s death. The Committee also considered the value of interviewing the assigned staff, versus receiving a verbal case activity recollection. This discussion focused on the fact that some information communicated to the Committee could not be located in the DCYF case record.

Findings

Based on a review of the case documents and interviews with staff, the Committee did not identify any findings or critical errors made by Department staff directly linked to, or that attributed to, the child's death.

The Committee found that having a non-negotiable 30 day home study document submission policy for all required paperwork including but not limited to background checks of non household members who have frequent contact with the children, may reduce non-compliance issues and/or assist DCYF in making placement changes which may benefit a child's safety, permanency and wellbeing.

Recommendations

In recognition of the Region 2 positive communication efforts between primary DCYF staff and licensing staff, the Committee encourages DCYF to consider amending policy requirements so that statewide communications mirror the communications occurring in Region 2. DCYF may also want to consider whether it should implement a 30-day document submission policy. If DCYF decides to do this, the Committee recommends the required completion date be 30 days from the placement date and to include allowance for background checks on persons who frequent the home or who have supervised and unsupervised contact with the children.