CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

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Contents

Nondiscrimination Policy

The Department of Children, Youth, and Families (DCYF) does not discriminate and does provide 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

- L.W.

Date of Child's Birth

- [redacted] 2019

Date of Fatality

- July 2019

Child Fatality Review Date

- November 7, 2019

Committee Members

- Patrick Dowd, JD, Director, Office of the Family and Children's Ombuds
- Molly Rice, DCYF, Quality Practice Specialist, Region 2
- Stephanie Widhalm, MSW, LICSW, MHP, CMHS, Partners with Families and Children, Children's Advocacy Center Director and Forensic Interviewer
- Jamie Huguenin, Department of Corrections, Community Corrections Supervisor

Facilitator

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

Executive Summary

On November 7, 2019, the Department of Children, Youth, and Families (DCYF)[1] convened a Child Fatality Review (CFR)[2] to assess DCYF's service delivery to L.W. and [redacted] family.[3] [redacted] will be referenced by [redacted] initials throughout this report.

On July 22, 2019, DCYF received a call reporting [redacted] month old L.W. died when [redacted] father accidentally drove the family truck over L.W. This occurred in a remote area while the family was picking berries and chopping wood. Both parents were present during the accident. L.W. was in [redacted] stroller when the mother moved [redacted] behind the back wheel of the truck. At the time, the parents were also operating the truck's winch to remove a stump. Unaware the mother placed L.W. behind the rear truck wheel, the father entered the truck to move it and unknowingly ran over his [redacted] causing [redacted] death. The mother reported she dropped the remote to the winch and ran to her [redacted] She started screaming and a woman nearby heard her and came to help. The woman drove L.W. and [redacted] mother down the hill to an area with cellular phone service. L.W.'s father followed in the truck. While driving, the father drank a bottle of alcohol. The mother reported the father consumed a small amount of the bottle while they were working. The father reported he was so upset that he drank a significant amount while driving down the mountain. This intake was assigned for a Child Protective Services (CPS) investigation. Earlier that same day, DCYF closed out a Family Voluntary Services (FVS) case that pertained to this family.

Law enforcement arrested the father and he was criminally charged for the death of his [redacted] However, the charges were eventually dismissed. After the CPS investigation was completed, DCYF entered a founded finding for negligent treatment against L.W.'s father.

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 L.W. 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 area administrator, CPS supervisor and CPS worker. The CPS worker was also the FVS worker for the family.

Case Overview

On [redacted] 2019, DCYF received a call stating L.W. was born the day before. During the pregnancy, the mother had consistent prenatal care. The mother reported she [redacted] in November but had been clean since that time, [redacted]. The caller reported there were no other concerns and the baby appeared to be healthy. Due to the mother having previously given

[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 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]There are no current criminal charges regarding the death of L.W., therefore no parent is identified by name in this report.

birth to another child RCW 13.50.100 and the history of both parents with DCYF, this case was opened for a CPS Risk Only assessment.[4]

Before making contact with the parents, the CPS worker staffed the case with her supervisor and area administrator. Based on the information contained in the current intake, the family's history and the CPS worker's prior knowledge of the parents, a decision was made allowing L.W. to stay with 74.13.5 parents if they were willing to engage in a safety plan and voluntary services.

The CPS worker went to the hospital and met with the parents and L.W. They discussed a safety plan for discharging L.W. home with 74.13.5 parents and the13.50.100 . The mother disclosed that she believed she13.50.100 . The mother also said she 13.50.100 . She also told the CPS worker that during that period of her life she was RCW 13.50.100 . The mother shared that she has changed, RCW 13.50.100 and was healthy at this time.

L.W.'s mother also shared that74.13.520 . The mother also reported 74.13.520 . She did not plan on having any other children and appeared motivated to keep L.W.

During this contact, the mother was forthcoming regarding her other children, her struggles RCW 13.50.100 . She agreed to voluntary services. The maternal grandmother agreed to be a part of a safety plan that would allow the parents and baby to move in with her while they engaged in voluntary services. The plan included random urinalysis testing for both parents. L.W.'s father asked that his parents be included in the plan RCW 13.50.100 . He stated his parents are very strict and they make him provide a clean urinalysis before they allow contact with the children.

The parents engaged in Project Safe Care[5] and provided random urinalysis testing. There was ongoing contact by the service providers as well as the CPS/FVS worker. On July 22, 2019, the case was submitted for closure. Later that same day DCYF received the intake regarding L.W.'s death.

Committee Discussion

This case has emotionally impacted the Committee members which caused them to have sincere concerns for the well-being of the staff that worked with L.W. and 74.13.5 family. The emotional impact from critical incidents on DCYF staff consumed a large portion of the Committee's discussion. The absence of a policy and procedure regarding how these types of cases are handled, in a way that shows the

[4] Screened in CPS Risk Only reports involve cases in which a child is at imminent risk of serious harm and there are no CA/N allegations.

[5] "Safe Care is an evidenced-based home visitation program aimed at reducing child maltreatment among families with a history of maltreatment or risk factors for maltreatment. Safe Care is a weekly home-based service lasting 18-20 sessions for families with a child from age birth to 5 years. The expected outcome is to increase parents' understanding and management of child illness and injuries, increase home safety, and improve and enhance safe parenting skills. The provider reviews the safety plan each week. There is no afterhours support for the family." See DCYF Evidence Based Practices-Description and Directory https://www.dcyf.wa.gov/services/child-welfare-providers/evidence-based-practices.

importance of trauma informed practice, led to the recommendation described in the Recommendations section below.

This concern was also highlighted when discussing the child fatality review requirements. The Committee did not view L.W.'s death as neglectful or abusive. The Committee believes the death was an accident. This was discussed because the founded finding for neglect necessitated this CFR and the fact that being involved in a CFR often adds stress to the participating staff. The Committee discussed whether this may have been unnecessary stress to the staff that was involved in this case from the beginning.

Another aspect that was discussed was the fact that the CPS worker assigned to this case at the birth of L.W., was one of two CPS workers in the office. This CPS worker has extensive knowledge and experience in this role and is often given more difficult cases. The cumulative effect of higher risk cases on an ongoing basis is a concern for the Committee. The Committee appreciates the fact that in this case the CPS worker was not assigned to the investigation regarding L.W.'s death. This often occurs for a number of reasons but they were thankful it did not happen in this case. The Committee believed that this would have added to the emotional toll this case already had on this worker.

The Committee discussed the positive relationship the CPS/FVS worker has with L.W.'s mother. This is illustrated by the relationship built and documented in the case file. This is also supported by the fact that after her [redacted] death, L.W.'s mother reached out to the CPS worker for support and continues to do so. The Committee recognizes and appreciates the CPS worker's efforts to establish a positive rapport with the mother.

The Committee would have liked to have seen more documentation regarding the assessment of the father, specifically regarding his trauma history, parenting capabilities and functioning/coping. With regard to the mother, there was good documentation about these areas.

The Committee also discussed whether the CPS worker should have made substance use referrals. This was countered with the fact that the CPS worker has maintained her qualifications and certification as a substance use professional (also known as a chemical dependency professional) and this specialty gives her additional tools to rely on when assessing the need for such a referral. Many CPS workers who do not have this qualification will utilize urinalysis testing as the first step before referring parents or caregivers for full assessments. For example, it is common practice within DCYF that a parent will be referred for a full substance use assessment if the parent has been referred for random urinalysis testing and he or she either fails to provide the urinalysis or if the test results are positive for drugs or alcohol.

Findings

The Committee finds that in this case, DCYF made no critical errors.

There was a finding that a domestic violence assessment was not conducted pursuant to DCYF practices and procedures policy 1170. The Committee was very clear that this finding in no way had any impact on the critical incident. However, it was something that was discussed because of the parents' trauma history [redacted].

Recommendations

Recognizing the emotional toll on DCYF staff when a child fatality or near-fatality occurs, the Committee recommends that DCYF submit a request to the legislature to fund a critical incident protocol. The Committee believes a funded protocol similar to those used by many law enforcement agencies would be appropriate. Key components of a DCYF critical incident protocol should include directives that relieve the involved staff from new responsibilities and a triage team to provide protected time for the worker(s) and supervisor(s) to address their secondary trauma needs. The critical incident protocol would be in addition to any Peer Support or other emotional support programs available to DCYF staff.