CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

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Contents

Full Report

Child

- O.T.

Date of Child's Birth

- RCW 74. 2020

Date of Fatality

- September 2020

Child Fatality Review Date

- December 10, 2020

Committee Members

- Mary Moskowitz, JD, Office of the Family and Children's Ombuds, Ombuds
- Aushenae Matthews, Domestic Abuse Women's Network, Shelter Supervisor and Advocate
- Ruth Wolbert-Neff, SUDP, Tacoma Pierce County Health Department, Substance Use Disorder Treatment Provider
- Chris Kerns, MSW, Excellence in Child Welfare the Alliance, Regional Education and Training Administrator for Regions 5 and 6
- Paul Kallmann, MSW, Department of Children, Youth, and Families, Quality Practice Specialist Region 5
- Kelly Boyle, Department of Children, Youth, and Families, Statewide Intake and Safety Program Manager

Observer

- Doug Savelesky, Department of Children, Youth, and Families, Child Welfare QA/CQI Administrator

Facilitator

- Libby Stewart, DCYF, Critical Incident Review Specialist

Executive Summary

On December 10, 2020, the Department of Children, Youth, and Families (DCYF) convened a Child Fatality Review (CFR)[1] to assess DCYF's service delivery to O.T. and RCW 7 family.[2] RCW 7 will be referenced by RCW 7 initials throughout this report.

On September 19, 2020, DCYF received an intake from a law enforcement officer. The officer reported the death of RCW 74.13.515-old O.T. It was established O.T. and RCW 7 mother were bed sharing, and the mother woke to find O.T. was not breathing. O.T.'s mother mentioned RCW 7 had a recent surgery. Law enforcement did not place O.T.'s sister in protective custody. This intake was screened in for a CPS investigation. Another intake was received that same day with similar details. However, the additional intake included that O.T.'s mother initially told investigators O.T. had been sleeping in RCW 7 crib, but that she later admitted to bed sharing. The referent reported the mother had a history of using illegal drugs, including methamphetamines. The second intake was screened out because the allegations had already been reported.

The CPS investigation related to O.T.'s death resulted in a founded finding for O.T.'s mother for negligent treatment or maltreatment as to O.T. and RCW 7 sister. O.T.'s finding was related to RCW 7 death. Specifically, that O.T.'s mother agreed to a Plan of Safe Care, including safe sleep, which she failed to follow and resulted in the death of RCW 74.13.515, O.T. The finding also stated that O.T.'s mother had been actively using methamphetamines at the time of RCW 7 death. O.T.'s sister's finding was related to a hair follicle test that indicated she had methamphetamines and amphetamines in her body.

The CFR Committee (Committee) included members with relevant expertise selected from diverse disciplines within the community. Committee members have not had any involvement or contact with O.T. or RCW 7 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 and CPS caseworker. The CPS caseworker's supervisor was ill and could not participate in the review on December 10, 2020.

Case Overview

On RCW 74.13.515, 2020, DCYF received an intake that alleged O.T.'s mother tested positive for methamphetamines at RCW 7 birth. O.T.'s mother denied knowingly using methamphetamines. She admitted to marijuana use and thought maybe it had been laced with methamphetamines. The mother also discussed with hospital staff RCW 74.13.520. The hospital reported the mother received late prenatal care. The hospital believed that RCW 13.50.100 may have

[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 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 hears only 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.

[2] No one has been criminally charged related to O.T.'s death; therefore, no one is named in this report.

prevented timely prenatal care. O.T.'s father allegedly [redacted], and O.T.'s mother [redacted]. It was further alleged that O.T.'s father [redacted]. This intake was screened in for a Risk Only CPS investigation.[3]

On [redacted], the assigned CPS caseworker contacted the hospital social worker. The CPS caseworker learned that both the mother and O.T. tested positive for methamphetamines. The CPS caseworker tried to call the mother, but the mother did not answer. Her voicemail was full and not accepting more messages.

The CPS caseworker arrived at the hospital and met with O.T. and [redacted] mother. The caseworker discussed Period of Purple Crying[4] and Infant Safe Sleep.[5] The caseworker observed a diaper change after O.T. woke up. O.T.'s mother stated they live with the mother's two-year-old daughter, the maternal grandmother, and the maternal aunt. The father of O.T.'s sister was not involved in her life and had never met his daughter. O.T.'s mother provided O.T.'s father's name and stated he was not on the birth certificate. She reported that he [redacted]. She stated [redacted] caused her to delay prenatal care. The parents were together for four months before separating on February 14, 2020. O.T.'s father moved to [redacted].

O.T.'s mother said she had been [redacted]. She said [redacted]. They discussed the mother's substance use history. O.T.'s mother said she had been using marijuana for "years" and the only other drug she had used was [redacted] in 2015. O.T.'s mother agreed to random urine tests.

That same day, the caseworker received a voicemail message from the maternal grandmother. The caseworker called her back but did not reach her. The caseworker sent the mother a text with information about a [redacted] resource and the urine test. O.T.'s mother texted the caseworker asking for a home visit. When the caseworker went to the mother's home, no one answered.

On July 27, the caseworker called the mother and set up an appointment to conduct a walkthrough of the home. An appointment was set for that afternoon. They also discussed a Plan of Safe Care. Plan of Safe Care is a requirement when a newborn has been identified as substance-affected by a medical physician. Although O.T. had not been identified as substance-affected, caseworkers may nevertheless utilize this process and develop as a support to families. During the walk through, the caseworker learned that the maternal grandmother, O.T.'s mother, and O.T.'s sister all shared a bed. There was not enough room in the home for the sister's bed. O.T. had a bassinet to sleep in. The home was documented as clean, and no safety hazards were identified. The caseworker observed O.T.'s sister. She was two-and-a-half years old. She appeared to be healthy and comfortable with her mother. She did not

[3] CPS Risk Only is an intake that alleges imminent risk of serious harm, and there are no allegations of child abuse or neglect. See: https://www.dcyf.wa.gov/practices-and-procedures/2200-intake-process-and-response

[4] The Period of Purple Crying is a method of helping parents understand the time in their baby's life where there may be significant periods of crying. During this phase of a baby's life they can cry for hours and still be healthy and normal. "The Period of Purple Crying begins at about 2 weeks of age and continues until about 3-4 months of age." See: http://www.purplecrying.info/what-is-the-period-of-purple-crying.php.

[5] See: https://www.dcyf.wa.gov/1100-child-safety/1135-infant-safety-education-and-intervention

interact verbally with the caseworker. O.T.'s mother reported that her daughter had been attending daycare until February or March.

On July 29, the caseworker received a call from the hospital social worker stating the mother did not show for her postpartum follow-up appointment. The hospital had also tested O.T.'s meconium, and the results were positive for methamphetamine. Meconium is an infant's first bowel movement. The meconium is a dark, tar-like substance and often holds toxins for longer periods of time. It is often used for testing when a mother has a positive toxicology screen at a child's birth and the child's first urine after birth is negative. A follow-up conversation with the hospital social worker occurred that day. The hospital social worker told the caseworker that O.T.'s meconium results were "critical level" and it was "unlikely that this was ingested one time accidentally." The social worker told the DCYF caseworker that "the levels go from detected to positive and then critical and that critical indicates a substantial level was present." The caseworker called O.T.'s mother and left a voicemail message regarding the missed appointment.

On July 30, the caseworker reached out to the location where she had referred the mother for her urine test in order to get an update on the results. She learned later that day that the referral process had changed. The agency provided the caseworker with the new process, and the caseworker texted the mother with that information. The urine test came back with a positive result for cannabinoids, delta-9-tetrahydocannabinol (THC). Cannabinoid is the "chemical that is responsible for the psychoactive effects of cannabis."[6]

Also on July 30, the caseworker received a text from O.T.'s mother stating she scheduled a medical appointment for O.T. and herself for August 11 and that she had an appointment on July 31 with Women Infant Children (WIC).[7] The caseworker texted the mother back and requested that O.T. be seen by a medical provider sooner since the mother missed RCW 7 follow up appointment. The caseworker suggested that the mother take O.T. to the hospital where she gave birth.

On August 5, the caseworker received notification that O.T.'s mother failed to show for her random urine test. The caseworker reached out to O.T.'s mother and told her she was adding two more random urine tests.

That same day, RCW 13.50.100(7)(c) called in an intake alleging that the maternal grandmother and aunt were "bad into drugs" and stating his concern because the grandmother was staying in the same home as O.T. He also RCW 13.50.100 continued to allege that the mother used methamphetamines and abused RCW 74.13.520 pills, RCW 13.50.100, RCW 13.50.100, RCW 13.50.100 RCW 13, and neglected her daughter. RCW 13.50.100(7)(c) said he would call law enforcement and request a welfare check. He also RCW 13.50.100. This intake was screened out, stating the decision was made because RCW 13.50.100(7)(c) had not seen the mother or O.T. for over six months and the allegations were not legally sufficient to investigate neglect.

[6] https://adf.org.au/drug-facts/cannabinoids/

[7] The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) provides federal grants to states for supplemental foods, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and non-breastfeeding postpartum women, and to infants and children up to age five who are found to be at nutritional risk. https://www.fns.usda.gov/wic

On August 6, the caseworker received a text from O.T.'s mother. She said O.T.'s father was back in town RCW 13.50.100 . O.T.'s mother stated she was going to RCW 13.50 and had been trying to speak with a RCW 13.50.100 advocate through the RCW 13.50.100 RCW 13.50.100 RCW 13.50.100 . The caseworker responded to the mother, asking for verification and when the mother connected with the RCW 13.50.100 .

On August 11, DCYF received another intake. This intake was from a pediatrician who saw O.T. and RCW 7 mother that morning. The pediatrician was concerned for O.T., stating that the mother "doesn't appear to have a good understanding of basic baby care," "didn't bring formula, diapers or other provisions," and that when O.T. was fussing, the mother told the pediatrician that O.T. had not eaten in four hours. The mother also responded to O.T. by saying, "No thank you," when RCW was crying. The pediatrician stated that this was not developmentally appropriate for a newborn. The pediatrician also stated the mother was "unskillful" when handling RCW 74.13.515 . O.T. had gained weight and there were no other signs of physical abuse. The mother did not appear overly frustrated or anxious and her affect was appropriate. The intake worker decided this intake would be a CPS/Family Assessment Response (FAR)[8] case, but the intake supervisor changed the screening decision and screened it out. The intake supervisor stated the allegations did not meet the definition for child abuse or neglect.

Also on August 11, the mother failed to show for her urine test. The caseworker called O.T.'s mother and left a voicemail message. She then texted O.T.'s mother about the missed test and said she would need to provide a hair follicle test. Later that same day, the caseworker called the mother again and left another voicemail message with more details about the hair follicle test.

On August 13, the caseworker noted that she had not received any returned calls or text responses from O.T.'s mother. The caseworker left voicemail messages for the maternal grandmother and aunt asking for them to call her back.

On August 17, the maternal aunt and caseworker exchanged voicemail messages, and the caseworker tried to reach O.T.'s mother again. Later, O.T.'s mother texted the caseworker back, apologizing for not reaching back out to the caseworker. The mother said she had been dealing with O.T.'s father and law enforcement and that she went to her aunt's home in RCW 74.13.515 . The caseworker reminded the mother of the hair follicle test that was required by August 25.

On August 19, the caseworker received a text from O.T.'s mother stating she would cooperate with the hair follicle test. The caseworker also received a call from the maternal aunt. The aunt shared that she believed O.T.'s mother was loving and attentive and did not leave the children for periods longer than what an appointment time would entail. The aunt was not concerned about the mother's drug use and did not have any concerns to share. The aunt shared that O.T.'s father was back. She said they RCW 13.50.100 . After that call concluded, the caseworker texted O.T.'s mother asking for a copy RCW 13.50.100 .

O.T.'s mother failed to show for her hair follicle test on August 25.

[8] "Family Assessment Response (FAR) is a Child Protective Services (CPS) alternative response to an investigation of a screened-in allegation of child abuse or neglect. FAR focuses on child safety along with the integrity and preservation of the family when lower risk allegations of child maltreatment have been screened in for intervention." See: https://www.dcyf.wa.gov/practices-and-procedures/2332-child-protective-services-family-assessment-response

On September 18, the caseworker called the maternal grandmother and a message indicated that the call could not be completed. The caseworker then called the daycare that O.T.'s sister previously attended. The former teacher to O.T.'s sister stated they had some concerns that O.T.'s sister smelled strongly of "smoke" RCW 13.50.100 . The daycare chose to conduct a home visit; during that visit, O.T.'s mother seemed to be "dozing off." When they addressed this with the mother, she said she had a lot going on and O.T.'s sister RCW 13.50.100 . They staffed their concerns and did not feel that it rose to the level necessary to call in to DCYF intake. The mother had a boyfriend at that time. After they broke up, the mother moved to her aunt's home, and the staff saw an improvement RCW 13.50.100 . She stopped attending the daycare soon after.

The caseworker also called the family medicine physician. She was told that O.T.'s sister had been at the emergency department in December of 2019 RCW 74.13.520 but was otherwise a healthy child who was up to date on her immunizations. The caseworker called O.T.'s pediatrician and verified that O.T. had been seen four times in August. O.T.'s sister was last seen by a different provider in January of 2020.

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During the investigation into O.T.'s death, DCYF RCW 13.50.100 . RCW 13.50.100 . The medical examiner's report stated O.T.'s manner of death was accidental and the cause of death was asphyxia with overlay as an underlying cause. Also mentioned in the report as "other significant conditions" was: "Failure to Thrive, pyloric stenosis (surgically correct), in-utero drug exposure, chronic smoke exposure." There was a section in the report called, "How Injury Occurred" which stated, "Sudden unexplained infant death in unsafe sleep environment of co-sleeping with adult and excessive bedding."

The CPS investigation related to O.T.'s death resulted in a founded finding for O.T.'s mother for negligent treatment or maltreatment as to O.T. and RCW 7 sister. O.T.'s finding was related to RCW 7 death. Specifically, that O.T.'s mother agreed to a Plan of Safe Care, including safe sleep, which she failed to follow and resulted in the death of O.T. The finding also stated that O.T.'s mother had been actively using methamphetamines at the time of RCW 7 death. O.T.'s sister's finding was related to a hair follicle test that indicated she had methamphetamines and amphetamines in her body.

Committee Discussion

The Committee discussed the caseworker's caseload and workload. While the caseload for the CPS caseworker was not high, the workload was challenging. The CPS caseworker's workload included filing dependency petitions on other cases and locating a missing child who had ingested methamphetamines.

The area administrator also shared that the office had struggled with an increase in transient families that often crossed the border into Oregon, at times to avoid DCYF contact. The state border issues add another layer of frustration because DCYF staff cannot enter the border states to conduct work related to DCYF cases, and often the bordering states are not willing to assist with requests for courtesy assistance.

The Committee debated a recommendation requiring Safety Framework[9] training when staff move from one position to another, as well as having a mentor or coach go into the field with them to help with the transition and new learning. This CPS caseworker transferred from Child and Family Welfare Services (CFWS) to CPS. When asked, she said that she was not offered a coach or mentor to go into the field with her to assist with her transition and to help solidify her skills within CPS. One of the Committee members shared that the Alliance, the contracted provider that provides training to DCYF staff, is currently working on a Safety Framework training, but at this time, there is no training available.

The Committee discussed that the Structured Decision Making Risk Assessment tool (SDM) was not accurate. The SDM is a required tool used by CPS caseworkers to obtain an "objective appraisal of the risk to a child." Per DCYF Policies and Procedures 2541, the SDM is to be completed no longer than 60 days after an intake is received. If the score is high and a child is determined to be "safe," then DCYF shall offer services; when the score is moderately high and a child is identified as "safe," then DCYF should consider offering services unless there has been an "observable, verifiable and describable change" that has reduced the risk within the family. The SDM was completed on September 4 with a moderately high score. While the SDM was completed within the 60-day timeframe, the Committee believed there was not enough information gathered and confirmed to indicate that O.T. was safe.

Part of the discussion about safety within O.T.'s home addressed the history RCW 13.50.100 to which O.T.'s mother was exposed RCW 13.50.100. Within her family of origin, including the maternal grandmother who lived with O.T., there was alleged drug use by the maternal grandmother, RCW 13.50.100 RCW 13.50.100 RCW 13.50.100 RCW 13.50.100. Since O.T.'s maternal grandmother was living in the same home and there were allegations of current substance abuse by RCW 7 mother, the mother's history RCW 13.50.100 was relevant to the current risk posed to O.T. and RCW 7 sister. The Committee discussed that the caseworker relied on the mother's statements as facts and did not verify the information. The Committee understood the mother presented well and that she was difficult to engage, but they wanted to see a more in-depth assessment throughout the case.

The CPS caseworker discussed her belief that, looking back on the case, she relied too heavily upon the aunt's perspective and statements. The Committee agreed with the caseworker's opinion and appreciated her ability to have that insight and her willingness to be vulnerable and discuss that perspective. There was also a discussion about relatives involved in DCYF cases and their understanding and knowledge about substance use and misuse. Often, family members may believe they have an understanding of what to look for and the signs of use, but DCYF does not offer any education or educational resource for this. It is challenging for staff to have a good understanding of a person's

[9] Child Safety Framework supports and enhances DCYF's practice model of Solution Based Casework. The framework focusses on assessing safety of children throughout the life of a case and includes gathering questions, the 17 Safety threats, the safety threshold questions and more.

education and to do so might be very time consuming, which creates an extra burden and workload for staff. The Committee also discussed that this issue has been raised in prior reviews, but no action had been taken by DCYF.

RCW 13.50.100 was identified as a dynamic within this family. The Committee discussed that while offering a resource to the mother for assistance was positive, (such as the RCW 13.50.10), a more comprehensive approach could have been beneficial. Providing multiple resources, being present with the mother to make phone calls to those resources, and asking the mother to sign a release of information with a RCW 13.50.100 advocate or agency so that two-way conversations could occur about the mother and her children's safety may have been beneficial as well. The Committee understood the mother was evasive, which made communication more difficult for the CPS caseworker. However, documentation of such efforts would have shown a stronger understanding of the risk RCW 13.50.100 can pose to child safety.

An intake from August 11 screened out. A majority of the Committee believed the August 11 intake should have screened in. However, the dissenting discussion indicated there was neither an allegation of abuse or neglect within the intake nor imminent harm identified to qualify it for a Risk Only intake. The CPS caseworker did not follow up on the intake. The area administrator shared that she discussed the need for follow up with a supervisor covering assignments on August 11, but that message and emphasized concern by the area administrator was not conveyed to the CPS caseworker. It is regular practice and an expectation that screened out intakes are incorporated in the assessment or investigation process by the assigned CPS caseworker. The Committee also discussed the possibility that if the CPS caseworker had called the referent back, the Committee may have learned about O.T.'s surgery. The Committee felt had the information about RCW 7 surgery been known it would have raised RCW 7 vulnerability and level of risk. The Committee member who specializes in substance use treatment shared that it is quite common for infants exposed in utero to methamphetamines and other toxic substances to have O.T.'s intestinal challenges that sometimes require surgery, as O.T.'s did.

The area administrator shared that based on this case, the office now staffs all screened out intakes for children birth to one year of age. They do so to try to ensure that no further risk is missed. The area administrator also shared that after they reviewed the case post-fatality, they identified that an FTDM would have been appropriate. The Committee agreed and believed this should have occurred based on the mother's failure to both engage and stay in regular contact with DCYF, and her failure to comply with urine tests.

Findings

The Committee identified areas where casework could have improved. The areas below were not identified as attributing to the death of O.T.

DCYF did not comply with Policies and Procedures RCW 13.50.100. Specifically, the specialized RCW 13.50.100 assessment was not completed and documented.

The Committee believed more collateral contacts should have occurred. Examples of those collaterals are: Maternity Support Services, the pediatrician who called in an intake, O.T.'s mother's prenatal provider, utilizing Famlink to learn about trauma history in the family of origin, trying to contact O.T.'s father, and O.T.'s mother's RCW 13.50.100 provider. Maternity Support Services are voluntary, preventive

services for women who are pregnant or have given birth. Often, this service is available for the first year of a child's birth.

The Committee believed a substance use assessment should have been requested at the beginning of the case based off information contained in the intake and the mother's continued denial that she knowingly used methamphetamines.

The Committee identified that DCYF did not attempt to assess or engage O.T.'s father. DCYF also did not assess the maternal grandmother who lived in the home and was part of the Plan of Safe Care.

The Committee did not make any recommendations.