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 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

- R.G.

Date of Child's Birth

- [redacted] 2021

Date of Fatality

- December 2021

Child Fatality Review Date

- February 15, 2022

Committee Members

- Patrick Dowd, JD, Office of the Family and Children's Ombuds, Director
- Faaluaina Pritchard, Asia Pacific Cultural Center, Director
- Pam Hubbard LMHC, CDP, Evergreen Recovery Center, Co-Occurring Disorder Counselor Supervisor
- Vickie Stock, MSML, Department of Children, Youth, and Families, Child Welfare QA/CQI Manager

Observer

- Vanessa Prante, Department of Children, Youth, and Families, Caseworker

Facilitator

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

Executive Summary

On February 15, 2022, the Department of Children, Youth, and Families (DCYF)[1] convened a Child Fatality Review (CFR)[2] to examine DCYF's practice and service delivery to R.G. and [redacted] family.[3] [redacted] will be referenced by [redacted] initials throughout this report.

At the time of R.G.'s death [redacted] was five months old and lived with maternal relatives pursuant to an open Family Voluntary Services (FVS)[4] case and a Voluntary Placement Agreement (VPA)[5]. On the morning of December 7, 2021, R.G. was found face down in blankets after apparently having fallen from the couch. The night before, her primary caregiver placed [redacted] in a Boppy pillow.[6] R.G. and four other children had been sleeping on the same couch in the living room. Emergency services was called and R.G. was transported to a local hospital. Medical staff determined R.G. was deceased.

A diverse Committee (Committee) was assembled to review this case and to evaluate DCYF's service delivery to the family. The Committee included community partners and DCYF staff. Before the review none of the Committee members had any direct knowledge of or involvement with the family. Committee members received copies of the DCYF case history that included intakes, case notes, law enforcement reports, and DCYF risk assessment tools and assessments. On the day of the review the Committee interviewed a caseworker, supervisors, and the area administrator.

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 responsible for child welfare; and the Department of Early Learning for childcare and early learning programs. For purposes of this report, any reference to DCYF and events that occurred before July 1, 2018, shall be considered a reference to DSHS.

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)]." 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 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 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 The names of R.G.'s parents are not used in this report because neither parent has been charged with a crime in connection with the fatality.

4 See FVS policy at https://www.dcyf.wa.gov/policies-and-procedures/3000-family-voluntary-services-fvs.

5 See VPA policy at https://www.dcyf.wa.gov/4300-case-planning/4307-voluntary-placement-agreement.

6 Boppy is a brand name of a pillow used for feeding infants, propping up for sitting, or tummy time.

Case Overview

In 2007 R.G.'s mother first came to the attention of the DCYF. DCYF has received twelve intakes involving neglect allegations, parental substance use, sexual contact between siblings, physical abuse, and domestic violence. DCYF also received information expressing concerns about significant mental health issues, including RCW 70.02.020. Including R.G., the mother had four children. In addition to R.G., the father has five other children. None of his children lived with him. DCYF became legally involved with one of the mother's children and in 2015 the child became legally free for adoption. The mother's two other children who were born before R.G. lived with either their father or relatives.

After R.G. was born the hospital reported to DCYF that the mother had not obtained prenatal care and an umbilical cord test was positive for methamphetamine and morphine. This resulted in a Child Protective Services (CPS) Risk Only[7] intake.

A DCYF caseworker made contact with R.G. three days after the intake was received. By that time R.G.'s mother had been discharged from the hospital. The hospital social worker told the DCYF caseworker that unless there were transportation issues, the parents visited every afternoon around 2:00 pm. R.G. was previously intubated but at the time of the initial contact RCW 74 was breathing normally. R.G. was born prematurely at 33 weeks, was experiencing withdrawal symptoms, and RCW 74 was being fed through a tube. At the time of R.G.'s birth her mother refused to provide a urine sample. The hospital social worker said the parents appeared to be under the influence. Upon discharge, the parents planned to live with R.G. at their hotel room. They had all infant related items except for a bed.

The following day the caseworker attempted to make contact with the parents at their RCW 74.13.515 hotel room. The hotel attendant told the caseworker that no one by the parents' names was staying at that location. On June 24, 2021, the caseworker spoke with R.G.'s mother by telephone. They discussed the reasons for DCYF's involvement and arranged to meet at the hospital the following day.

On June 29, 2021, the caseworker and parents met at the hospital. The parents shared historical information about their childhoods, mental health struggles, substance use struggles, and other aspects related to the parents and their capabilities and struggles. Both parents agreed to provide a urinalysis. They both stated the test results would be negative for any substances.

On July 7, 2021, the assigned caseworker arrived at the parents' hotel room. The caseworker told the parents the urinalysis test results are positive for each parent. During the meeting and instead of filing a dependency petition, the caseworker offered a VPA as an option. The VPA was offered because of the positive urinalysis, the mother's history with DCYF, and the parents' admission that they both used substances since taking the urinalysis. The parents agreed to the VPA. A VPA was prepared that was scheduled to expire on August 7, 2021. The parents identified the maternal grandparents as their identified placement resource. The parents also agreed to complete a substance use assessment. The caseworker provided the parents with resources to call and schedule the assessments. While the caseworker was present the father called an agency and scheduled an intake appointment.

[7] See: https://www.dcyf.wa.gov/practices-and-procedures/2200-intake-process-and-response.

The next day a Family Team Decision Meeting (FTDM) was held. RCW 13.50.100 the maternal grandfather was not a placement option. Consequently, the family selected the mother's cousin and her parents to be the placement resource. All three adults lived together with the cousin's three adopted children and the cousin's adult brother. The three adopted children were all adopted through DCYF.

On July 13, 2021, the case transferred from CPS to Family Voluntary Services (FVS). On July 16, 2021, the CPS and FVS caseworkers met with the parents. The parents agreed to FVS. They discussed the parents' substance use assessments and identified they needed housing resources. The parents also wanted a Parent-Child Assistance Program worker. Visitation between R.G. and RCW 74. parents was occurring through the relative placement.

A July 27, 2021, supervisor case note shows that both parents completed their substance use assessments. It was noted that there was a payment concern associated with the mother's need for inpatient treatment. She tried to find a location that would allow RCW 74.13.515 to be placed with her. The father was assessed for outpatient treatment but had not identified a provider.

A mid-August case note reveals the parents separated and the mother was still seeking an inpatient treatment provider. The mother was hoping to attend RCW 74.13.520 in Yakima, Washington. An August 20, 2021, supervisor case note stated the VPA was extended to September 8, 2021, and the father was not in compliance with treatment and urinalysis testing requirements. The September 22, 2021, supervisor case note indicates the VPA was extended again to October 4, 2021. The case note also indicates the mother's treatment bed date was delayed to October 3, the day before the VPA was scheduled to expire. The caseworker was advised to obtain another extension to allow the mother to stabilize at RCW 74. treatment facility before R.G. was placed with her.

On September 28, 2021, a pre-filing staffing occurred. These staffings occur when DCYF is considering the filing of a dependency petition. Present at the staffing was the area administrator, supervisors, caseworkers, and the DCYF Safety Program Manager. The case notes indicate they were scheduled to discuss another VPA extension. The case notes also indicate that during the staffing DCYF determined the parent(s) are unable to control their behaviors, their behaviors impact child safety, and there is a substantial amount of family support for the parents and the safety of R.G. During the staffing the staff learned there is a "PI" (Pacific Islander) support group that works with families in the dependency process. They also exploredpossibility of a safe return home and the implementation of a new safety plan, including a plan for when the mother would enter into treatment. DCYF concluded the goal should be to implement another VPA so that the mother may settle into her treatment ; and at an appropriate time determined by the treatment provider, place R.G. with the mother. It was also documented that the filing of a dependency petition would be necessary if there was not a safety plan or the mother failed to check into treatment.

On September 29, 2021, the caseworker was given the names of two people associated with the Samoan community. The caseworker called both people and left messages requesting a return call.

On September 30, 2021, the mother, father, caseworker, and another person all signed a safety plan. The safety plan does not clearly identify the name or role of the other person who signed the plan.

On October 1, 2021, another FTDM occurred. The FTDM notes indicate that R.G. would be returned to [redacted] mother's care on the same day as the FTDM. The FTDM indicated a safety plan was identified but not documented in the FTDM notes; and the mother would enter inpatient substance use treatment on October 3. At that time another VPA would be implemented, R.G. would return to relative care; and when the treatment facility determines it was appropriate, R.G. would be placed with [redacted] mother.

The October 3, 2021, case note said that on October 1 R.G.'s mother moved into the relatives' home. The mother signed a VPA before the anticipated October 3 inpatient treatment date. However, on October 3 the mother did not go to the treatment facility but did leave the relatives' home. Between October 3 and October 11 the caseworker communicated with the mother by text. On October 11 the caseworker told the mother that the DCYF court worker was working on the dependency petition. She also asked the mother for an update regarding her treatment. The mother did not respond to the text.

On October 14, 2021, the caseworker conducted the required monthly health and safety visit. During that visit the caseworker discussed with the mother's cousin the next steps regarding the legal process. The caseworker asked the cousin if the family would prefer to obtain legal guardianship on their own or if they would prefer DCYF file a dependency petition. Later, the caseworker was told the family preferred that DCYF file a dependency petition.

On October 26, 2021, the caseworker texted that another Samoan community resource was available to help ensure the mother's cultural connection was supported. The case note indicated the community resource would meet with the mother if she could provide proof of a COVID-19 vaccination. [redacted]

A November 23, 2021, case note indicates the mother failed to appear for a November 8 inpatient bed date.

On December 7, 2021, DCYF intake received a telephone call on behalf of a local fire department. The fire department had responded to a call involving a five-month-old child with "cardiac arrest." The initial request from the emergency responders asked for child care assistance so the adults could either go to the hospital or to allow them to grieve. The referral source called back to report that family was arriving and the infant, identified at that time as R.G., was transported to a local hospital. Because there were no allegations of abuse or neglect this intake was screened out. The intake indicated confusion regarding the case information because the address listed in DCYF's computer datatbase, Famlink, differed from that provided by the referral source. R.G. was later declared deceased at the hospital.

After more details were obtained about the death of R.G. a new intake pertaining to R.G. was created and assigned for investigation. Identified concerns included that R.G. was placed by DCYF with relatives and the provider may have created an unsafe sleep environment that resulted or contributed to R.G.'s death. This investigation was closed as unfounded.[8] Law enforcement did not pursue an investigation pertaining to R.G.'s death. At the time of the review the medical examiner's report had not been completed.

[8] 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 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."

Committee Discussion

R.G. had a large and close-knit Samoan family. The family was very involved, vocal, and supportive of R.G.'s safety and each other. The Committee believes the family was given too much control over some of the decisions pertaining to this case. Examples include allowing the parents to decide which treatment providers to use and allowing the relatives to decide whether they wanted to file for guardianship or if they preferred DCYF to file a dependency petition. Specific to the treatment providers, the Committee believes more direction and structure was needed for the parents to engage in services in a more timely manner. The staff involved in this case had a different opinion. DCYF staff are taught to consider, respect, and integrate aspects of each family's culture when working with them. DCYF staff believed the family's decisions and actions were controlled by what they believed was in R.G.'s and RCW 74. parents' best interest. Therefore, DCYF staff allowed the family to create the plans moving through this case.

The Committee disagrees with multiple VPAs and would have preferred that DCYF file a dependency petition at either the beginning of the case or at least after the first VPA expired. DCYF staff believed the family knew what was best for R.G. and RCW 74. parents and they could safely maintain R.G. in relative care and at the same time support the mother's treatment efforts. The staff believed court intervention should be the last option. The staff were aware of the court's desire to reduce the need for an out-of-home placement and the need for legal intervention.

Identifying and incorporating a family's culture into the case is not only respectful but expected for all DCYF staff. However, it was not until three months into the case that the family's culture was first identified. This was documented in a case note during the pre-filing staffing. After this subject was first discussed the caseworker provided the mother with culturally appropriate information. The Committee discussed that while supporting the parents with culturally appropriate advocates is appropriate, DCYF should also have access to experts who DCYF may collaborate with about the flow and actions within a case. This is addressed further in the Recommendation section below.

R.G.'s mother had a documented lengthy struggle with substance use and unmet mental health needs. Both needs were untreated at the time of R.G.'s birth. Co-Occurring disorders can be incredibly challenging to treat. It was discussed that in Washington State, finding providers who adequately treat co-occurring disorders is a struggle. Caseworkers are sometimes unable to locate treatment resources and have to rely upon multiple providers to treat each condition separately. According to the Committee's subject matter expert, it usually takes a very long time to successfully assess, treat, and stabilize a person with co-occurring disorders. The Committee opined that this case required a much longer process than would have been appropriate in FVS.

Knowing that R.G. would need to enter into another VPA, the Committee believes it was inconsistent with the intent and purpose of VPAs when the staff agreed to a safety plan that allowed R.G.'s mother to move in with the family and take custody of R.G. before entering inpatient treatment. The mother had not stabilized, had not engaged in supportive services, and even though RCW 74. was staying with relatives, the Committee did not agree with placing R.G. with RCW 74.1 The staff indicated they worked creatively with the tools provided to them and believed their safety and risk assessment satisfied policy threshold requirements to safely move forward. The office even included the statewide Safety Program Manager in the discussion and planning.

The Committee notes that when R.G.'s mother failed to enter inpatient treatment the family asked DCYF to file a dependency petition. It was more than a month after the mother failed to enter treatment that R.G. died. The Committee believes there was sufficient time during that period for DCYF to have filed the dependency petition.

R.G.'s father was not on the birth certificate but was legally considered a presumed father at the time of R.G's death. At the beginning of the case both parents stated he was the father and he was initially engaged in services at the time of the first VPA. At some point prior to the mother leaving for treatment the parents separated and the father no longer engaged with the caseworkers. The Committee believes more effort to engage the father should have occurred.

Findings

The DCYF Voluntary Placement Agreement policy states that a VPA is to not exceed 90 days. During this case there were multiple extensions to the initial VPA and more than one VPA was utilized. The total time R.G. was in relative placement under the authority of the VPAs far exceeded 90 days. The Committee strongly suggests that when the first VPA ended DCYF should have filed a dependency petition. This is the case despite the family's verbalized support for the parents, willingness to provide placement, and the mother's verbal desire to engage in services. The Committee believes there was a lack of urgency in this case. A dependency petition pertaining to R.G. was never filed.

For purposes of a Family Voluntary Services case, DCYF's FVS policy directs there should be a written case plan created and shared with the family within 15 days of the assignment to FVS. This process did not occur. If this process had been followed, the process may have helped to identify other appropriate services that may have helped with engaging R.G.'s father. The Committee opined that while there were some identified services designed to help the mother (engage in substance use treatment), there were other appropriate services that may have also helped. In particular, a paramount concern identified by the Committee involved the further evaluation and support related to the parents' mental health. The Committee understands that DCYF identified substance use as the mother's presenting issue. However, both the mother and father shared very concerning mental health diagnosis. Co-occurring treatment needs are significant and only certain treatment providers are qualified or able to treat those types of cases. The further gathering of information would have been appropriate. Asking the parents to sign a release of information to gather records pertaining to diagnosis and any previous treatment may have been helpful to assess appropriate mental health needs and services.

R.G. and [RCW 74] family are Samoan. The assigned staff do not share the same cultural background and did not have any specific supports or training pertaining to Samoan families. DCYF gave a significant amount of control to the mother and family with regard to services, service providers, and legal intervention issues. The Committee member representing the Samoan culture described how there are nuances within the culture that require DCYF to engage culturally appropriate supports for the family. The Committee member also observed that DCYF must collaboratively work with the family. Some attempted collaborative efforts were made at the end of September after a pre-filing staffing, but that was three months into the case. It was noted by the Committee that when those supports did not work further collaboration efforts did not occur. Specific to the Samoan culture, the Committee learned that families are embarrassed to ask for resources and that it would have been more appropriate for DCYF to have taken more control by determining services and appropriate providers while at the same time considering the parents' input.

Recommendations

The Committee understands that trainings and policy currently exists that require DCYF to consider the family and individual's cultural needs. These needs should be integrated into the services provided by DCYF. The Committee believes a stronger approach should to be taken. Like Indian Child Welfare cases, the Committee recommends DCYF provide similar emphasis on engagement and collaboration with cultural experts or representatives within agencies and communities. This may be accomplished by encouraging the cultural experts and representatives to attend staffings such as FTDMs/shared planning staffings and other meetings. This may also be accomplished by encouraging the cultural experts and representatives to collaborate on trainings for staff to learn about other cultures. DCYF should also work to identify appropriate local agencies that may collaborate with staff and support DCYF clients.