WASHINGTON STATE
Department of
Children, Youth, and Families

CHILD FATALITY REVIEW

December 2018

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FULL REPORT

CHILD

- Y.B., aka Y.G.

DATE OF CHILD'S BIRTH

- RCW 74.15.515 2018

DATE OF FATALITY

- June 2018

CHILD FATALITY REVIEW DATE

- October 11, 2018

COMMITTEE MEMBERS

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EXECUTIVE SUMMARY

On October 11, 2018, the Department of Children, Youth, and Families[1] (DCYF) convened a Child Fatality Review (CFR).[2] The purpose of the review was to assess DCYF's practice and service delivery to Y.B. and RCW 74.1 family.[3] Y.B. was also known to DCYF as Y.G. and is referenced so throughout DCYF case records. However, RCW 74.15 will be referenced in this report by the initials of RCW 74.1 legal name, Y.B., as stated on RCW 74.1 birth certificate.

On June 5, 2018, DCYF received a call stating that Y.B. had passed away while in the care of RCW 74.1 mother. Y.B. had been taken to the hospital via ambulance and was declared deceased at the hospital. At the time of RCW 74.1 death, Y.B. was living with RCW 74.1 alleged father, there was an open Family Voluntary Services (FVS) case with the DCYF, and the family had agreed that Y.B.'s mother would not be allowed unsupervised contact with the child. A Child Protective Services (CPS) investigation regarding Y.B.'s death concluded that both the mother and alleged father were negligent, resulting in a founded finding for negligent treatment and/or maltreatment being assessed for each of them.

The CFR Committee (Committee) included members selected from diverse disciplines within the community with relevant expertise including individuals from the Office of the Family and Children's Ombuds, substance abuse treatment, a children's hospital, and child welfare. The Committee members did not have any involvement or contact with this family.

Prior to the CFR, each Committee member received a summary of DCYF's involvement with the family and DCYF case documents with no redaction (e.g., intakes, investigative assessments, and case notes in their entirety). Supplemental sources of information and resource materials were available to the Committee at the time of the CFR. These included relevant state laws and DCYF policies.

The Committee interviewed the CPS worker, the FVS supervisor, and the area administrator. The CPS supervisor and FVS worker were not interviewed because both had terminated their employment with DCYF prior to the CFR. The Committee chose not to interview the CPS worker and supervisor of the fatality investigation.

[1] 1 Effective July 1, 2018, the DCYF of Children, Youth, and Families (DCYF) replaced the DCYF of Social and Health Services (DSHS) Children's Administration (CA), the state agency responsible for child welfare, and the DCYF of Early Learning. The fatality happened prior to July 1, 2018, therefore CA or DSHS may be referenced in the report.

[2] Given its limited purpose, a 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] Y.B.'s parents are not named in this report because they have not been charged in an accusatory instrument with committing a crime related to a report maintained by the DCYF in its case and management information system. [Source-Revised Code of Washington 74.13.500(1)(a)]

FAMILY CASE SUMMARY

On [redacted], 2018, DCYF received a call stating that the mother gave birth to Y.B. but had [redacted], admitted to ongoing [redacted], and was interested in getting into [redacted]. Y.B. [redacted] at [redacted] birth. This intake was assigned for a CPS Risk Only[4] investigation.

The CPS worker made contact with the mother and Y.B. the following day. Y.B. was [redacted], but the hospital did not have concerns regarding the child's mother and the care she was giving to her [redacted] while in the hospital. The CPS worker was able to discuss the mother's history of [redacted] with her and obtained information from the mother regarding her supports as well as the name of the child's alleged father and his contact information. The mother stated that she and the alleged father were no longer a couple and she has not yet signed the birth certificate.

The CPS worker made many diligent efforts to contact relatives and other collateral support persons for the mother. She also contacted the alleged father. As part of that contact, the alleged father provided his parole officer's name and contact information.

On [redacted], 2018, DCYF held a Family Team Decision Meeting (FTDM). The child had not yet been released from the hospital but was expected to be discharged soon. Y.B. remained hospitalized due to [redacted]. Because of the mother's recent [redacted], DCYF determined Y.B. would not be safe if placed with [redacted] mother without another person living in the home and supervising contact. Different placement options were discussed during the FTDM, and the first priority was placement of Y.B. with [redacted] mother if an in-home safety plan could be completed where the mother was never unsupervised with the child. If the mother did not have sufficient supports available to supervise her contact with the child in the home at all times, then a second option was placement with the child's alleged father. If neither option was available, then DCYF would request the mother and alleged father voluntarily place the child in out-of-home care under a voluntary placement agreement. The FTDM also included the mother's agreement to provide [redacted]. DCYF referred the mother for [redacted] between April 26 and May 25, but as of May 4, the mother had [redacted].

When the CPS worker contacted the people the mother identified as supports, they were not willing to participate. Since DCYF did not identify any safety threats regarding the child's alleged father and he agreed to care full-time for his [redacted] the mother and alleged father agreed for the child to be placed with him and that the mother would not be allowed to have unsupervised contact with the child. The mother and alleged father also signed a family action plan stating this.

At the time of the agreement to place the child with the alleged father, he lived with his sister. The CPS worker made contact with the alleged father's sister, but she asked that the CPS worker call her back another time. Before the CPS worker could call back, the alleged father asked the CPS worker to not contact his sister again, stating he would lose his housing but would not provide any further explanation. However, he denied that statement during a later discussion. The CPS worker consulted with her supervisor who directed her to assess the alleged paternal aunt through a search in Famlink, which is the DCYF's case management system. The search showed that [redacted]

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

On May 11, 2018, the CPS worker conducted a walk-through of the home where the alleged father lived. The CPS worker discussed the Period of Purple Crying and safe sleep with him.[5] The worker discussed in detail how to handle situations that may arise if Y.B. became inconsolable and walked through what safe sleep should look like in his home. The CPS worker also discussed community resources, housing, and childcare resources. The alleged father identified family friends that would care for Y.B. while he was at work. The CPS worker again reiterated that the mother could not have unsupervised contact with Y.B. as agreed to in the family action plan. The CPS worker also left a background check form for the alleged paternal aunt to fill out and return since the alleged father said she also lived in this house. After leaving the alleged father's house and prior to driving out of the driveway, the CPS worker called the mother and gave her an update. She also reiterated that she could not have unsupervised contact with Y.B., to which the mother agreed.

On May 16, 2018, the CPS worker received a message from the mother stating that the alleged father was requesting a paternity test. The CPS worker called the mother back, the mother reported that she was receiving supervised visitation and attending Y.B.'s pediatrician appointments with the alleged father. The mother also provided the pediatrician's name and location to the CPS worker. The mother further stated she was receiving RCW 13.50.100 [redacted]. The mother also indicated she has been providing RCW 13.50.100 [redacted]. The mother refused the offer of voluntary services to assist with parenting. The CPS worker then called the alleged father. He agreed to voluntary services to include an in-home provider, Project Safe Care, to address housing and parenting and to see if he qualified for a childcare subsidy through the state.

On May 16, 2018, the CPS worker completed the Structured Decision Making Risk Assessment (SDM) tool which indicated a moderate level for future risk.[6] This same day, the case was staffed with the FVS supervisor and FVS workers. The case transferred to FVS on May 22, 2018.

On May 22, 2018, the FVS worker spoke with the alleged father. He was offered paid childcare through DCYF because he indicated that he was struggling to cover the cost himself. However, he chose to have Y.B. receive care from a friend instead.

On May 23, 2018, the FVS worker conducted an in-person health and safety visit.[7] The FVS worker assessed for observable safety threats, discussed safe sleep, and provided the alleged father with safe sleep and Period of Purple Crying documents. The alleged father denied co-sleeping with the child and stated that he had watched the Period of Purple Crying video previously. The FVS worker observed a diaper change and discussed the child's RCW 13.50.100 [redacted] with the alleged father, though there were no concerns about RCW 13.50.100 at that time. The FVS worker also provided the alleged father with diapers and formula. The alleged father stated that Y.B. was not consistently sleeping, was constipated and eating well but was consistently RCW 74.13.520. He stated he was unfamiliar with the needs of RCW 74.13.520 children prior to his experience with Y.B. The FVS worker stated she would follow-up with a nurse to provide additional assistance for the alleged father. The worker also stated that he could access the nurse's line through the pediatrician's office. Coinciding with the alleged father's statements, the FVS worker observed the child having RCW 74.13.520 during the 30-minute visit.

Also during this visit, the alleged father signed releases of information for Project Safe Care, the pediatrician's office, his parole officer, and a public health nurse. While still agreeing to the

[5] https://www.dcyf.wa.gov/1100-child-safety/1135-infant-safety-education-and-intervention
[6] https://www.dcyf.wa.gov/practices-and-procedures/2541-structured-decision-making-risk-assessmentrsdmra
[7] https://www.dcyf.wa.gov/4400-concurrent-tanf-benefits/4420-health-and-safety-visits-children-and-monthly-visits-caregivers

services, the alleged father expressed concern about his ability to schedule all of the necessary appointments around his work schedule. He also stated that he was planning on seeking a paternity test but regardless of the outcome was attached to the child and may seek third party custody if he is in fact not [redacted] biological father. The FVS worker also discussed the supervised contact by the mother. The alleged father indicated she usually visits at the daycare providers' home and that he and the mother do not get along well. The alleged father provided the FVS worker with his day care providers' names and stated he would share the family action plan with them. The alleged father also discussed the conditions of his parole.

On May 25, 2018, the FVS worker called and spoke with a pediatric nurse regarding Y.B.'s observed [redacted] The nurse recommended that the child be seen by a medical provider. The FVS worker texted that information to the alleged father and recommended that he take the child into urgent care.

On June 4, 2018, the FVS worker faxed a referral for the public health nurse to work with the alleged father and Y.B. The following day, DCYF received a call stating Y.B. had passed away while in [redacted] mother's care. The alleged father admitted to hospital staff that he had left Y.B.in the care of [redacted] mother for the "last couple of days" because he could not find anyone else to watch [redacted] The alleged father told the hospital staff that the mother told him she had placed their child face down on a "pile of blankets." Law enforcement was notified but did not pursue a criminal investigation. At the conclusion of the CPS investigation, both parents received founded findings for negligent treatment and/or maltreatment related to Y.B.'s death.

COMMITTEE DISCUSSION

The Committee discussed their experience with hospital staff upon discharge of RCW 74.13.520 [redacted] newborns and a lack of hospital training to fathers regarding what they may experience and expect while caring for their child. This discussion included how the focus usually includes the mother only regarding instructions and cautions but that including both of the children's parents would seem appropriate.

Another point of discussion included the documentation throughout the case. The Committee discussed that the Investigative Assessment (IA) indicated that Y.B was safe under the mother's care and that the SDM was showing moderate for future risk.[8] The intent of the CPS worker was to show that DCYF did not believe that Y.B. was safe in RCW 74.1 [redacted] mother's care but it was not documented correctly. The Committee discussed how the case documentation read, that it did not fit the policy requirements for transferring a case to FVS (this is further discussed in the findings section below). The documentation regarding the FTDM was also not clear to the Committee. The documentation indicates that the placement decision was for Y.B. to remain in the hospital until medically ready for discharge, and upon discharge Y.B. would then be placed in out-of-home care on a voluntary basis and the placement recommendation was a medical facility.

In contrast, based on the staff interviews, the Committee understood the plan had actually been that upon discharge, Y.B. would be placed with RCW 74.1 [redacted] mother if a suitable supervision plan could be created and, if not, placed with the alleged father. If placement with the alleged father was not possible, only then would the parents have been asked to sign a voluntary placement agreement which would result in Y.B. being placed in out-of-home care.

The Committee discussed that the assessment of the alleged father, including his suitability and desire to parent Y.B., was not adequately documented. The Committee believed that further discussion with the alleged father regarding his ability, desire, and support in caring for Y.B. would have been appropriate. The Committee also discussed how DCYF tries to avoid informal placements, yet one occurred in this case since the alleged father was not the child's legal parent. During the CPS investigation, the CPS worker recalled that the mother told her that she had put the father's name on the birth certificate, but this was not corroborated. The alleged father questioning paternity later on was another concern to the Committee regarding his commitment to providing safe and stable care to Y.B. After the CFR was completed, this writer requested the area administrator to review the birth certificate. This is where the legal last name was found to be different than documented in DCYF's records and that there is no father listed for Y.B.

Part of assessing for suitability of placement also includes assessing all persons who live in that home, and the Committee discussed that the assessment of the alleged father's sister could have been more comprehensive. The Committee would have liked to have seen a more aggressive approach to understanding the alleged aunt's thoughts and willingness to have Y.B. placed in her home. She would also have been a good collateral contact in assessing the suitability of the alleged father.

The Committee discussed the use of the family action plan in this case. The Committee discussed that the family action plan included parental promises and that the document is no longer available in Famlink. The Committee discussed that DCYF likely discontinued use of the document but the timeframe was unknown. It was shared that some offices have printed copies of the document and complete it in a handwritten form, and therefore are possibly not aware

[8] https://www.dcyf.wa.gov/practices-and-procedures/2540-investigative-assessment

that it is no longer available in Famlink. After the CFR concluded, this writer reached out to the CPS program manager who indicated that the family action plan had been discontinued, but there may have been confusion regarding how this was messaged out to the field. The CPS program manager shared this information again with the CPS/Intake Leads on November 7, 2018.

During the staff interviews, the area administrator identified a missed opportunity to include Y.B.'s childcare providers in the case plan and as a collaborative partner in this case. The area administrator stated after Y.B. passed away, she requested training for all of her staff on how to create safety plans.

FINDINGS

The Committee reached full consensus that there were no critical errors made by DCYF that would have affected the outcome of this case. However, the Committee discussed areas, not directly correlated to Y.B.'s passing, where DCYF practice could be improved. Those findings are addressed below.

The transfer of the case from CPS to FVS needed some clarification. The FVS policy indicates that a CPS case can transfer to FVS if the case meets four different requirements.[9] This case did not meet those requirements based on the information in the completed CPS investigation, but the Committee did not disagree with the case moving to FVS based on the Committee's understanding of the case as presented by the staff during their interviews. Nonetheless, the Committee discussed how the SDM should have been overridden to show a moderately high risk based on the circumstances of the case and the child should have been shown as unsafe in the mother's home, which could then have been mitigated by a safety plan and placement with the alleged father had paternity been established. However, placing the child with an individual who was not the child's legal parent was therefore an informal placement that the Committee determined should not have occurred.

A plan of safe care was not completed on this case but should have been completed per DCYF policy.[10]

The Committee believed that there needed to be two medical collaterals completed. The first was after Y.B. was discharged from the hospital since the mother reported the child had pediatric appointments. The Committee believed that the worker should have corroborated the mother's assertions. Second, the Committee believed that the FVS worker should have followed up and corroborated with medical staff that Y.B. was seen regarding [redacted] RCW 74.13.520

[9] https://www.dcyf.wa.gov/practices-and-procedures/3000-family-voluntary-services

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

RECOMMENDATIONS

The Committee reached full consensus that there were no critical errors made by DCYF and that DCYF staff should receive training on identifying RCW 74.13.520 in newborns and infants that were RCW 74.13.520, including the next steps after identifying or hearing reports of RCW 74.13.520 and how to discuss this with parents and/or caregivers.