WASHINGTON STATE Department of Children, Youth, and Families

Child Fatality Review

J.T.

RCW 74.15.515 **2017**
Date of Child's Birth

April 2018
Date of Fatality

July 10, 2018
Child Fatality Review Date

Committee Members
Elizabeth Bokan, Ombuds, Office of the Family and Children's Ombuds
Ashley Robillard, Sexual Assault Unit Detective, Tacoma Police Department
Stuart King AA/CDP, Chemical Dependency Provider, MultiCare Health System
Brandy Otto, Office Chief, Department of Children, Youth, and Families
Chad Baker, Child Protective Services Supervisor, Department of Children, Youth, and Families

Observer
Amanda Sutherland, Child Protective Services worker, Department of Children, Youth, and Families

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

Table of Contents

Executive Summary 3
Family Case Summary 3-6
Committee Discussion 6-7
Findings 7-8

Executive Summary

On July 10, 2018, the Department of Children, Youth, and Families[1] (DCYF or Department) convened a Child Fatality Review (CFR)[2] to assess the Department's practice and service delivery to J.T. and RCW 74. family.[3] The child will be referenced by RCW 74. initials in this report.

On April 30, 2018, Children's Administration (now DCYF) received an intake stating that J.T.'s mother had called 911 saying, "I think my baby is dead." Paramedics arrived and performed cardiopulmonary resuscitation on J.T. and transported RCW 74.15. to a hospital where RCW 74 was declared deceased. J.T.'s mother told the caller that she had fed RCW 74.15.5 laid down for a nap at 10:00 a.m. with J.T. in the same bed and woke four hours later. When she woke up, she realized that she had rolled over on top of J.T. At the time of RCW 74. death, the Department had an open Children Protective Services (CPS) investigation alleging concerns for substance abuse by J.T.'s mother and neglect of J.T.

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, law enforcement, substance abuse treatment and child welfare. There was an observer from DCYF as well. The Committee members and observer did not have any involvement or contact with this family.

Prior to the CFR, each Committee member received a summary of the Department's involvement with the family and unredacted Department case documents (e.g., intakes, investigative assessments and case notes). Supplemental sources of information and resource materials were available to the Committee at the time of the CFR. These included relevant state laws and Department policies.

The Committee was unable to interview the CPS worker and supervisor as both staff members left employment with the Department prior to this review. The CPS worker left the Department while the CPS case was open and prior to the fatality. The CPS supervisor left the agency after the fatality but prior to the fatality review.

---

[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. The fatality here happened prior to July 1, 2018, and therefore CA or DSHS may be referenced in this 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] J.T.'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 Department in its case and management information system. [Source-Revised Code of Washington 74.13.500(1)(a)]

Family Case Summary

The mother first came to the attention of the Department on March 7, 2014. At that time the mother was RCW 13.50.100 on RCW 13.50.100 and the intake caller reported a history and current use of RCW 13.50.100 Another intake was received on March 31, 2014, indicating that the mother RCW 13.50.100 . On May 20, 2014, the mother called to report that she was RCW 13 and had RCW 13.50.100 . She also reported that she was attending RCW 13.50.100 . All three 2014 intakes were screened out because the RCW 13.50.100 .

On September 23, 2014, the Department received an intake stating that the mother was RCW 13.50.100 and RCW 13.50.100). That investigation was RCW 13.50.100 . A RCW 13.50.100 and the RCW 13.50.100 . The mother's RCW 13.50.100 .

On February 9, 2016, the Department received a report from law enforcement detailing an interaction with the mother. The mother reported she was RCW 13.50.100 . During this contact the mother stated she was RCW 13.50.100 and wanted to get into a RCW 13.50.100 . This intake was screened out because the RCW 13.50.100 . On March 7, 2016, the mother's RCW 13.50.100 .

On May 26, 2016, an RCW 13.50.100 worker for the Department received an email stating that the mother RCW 13.50.100 . This case was screened in for an CPS Risk Only assessment.[4] A RCW 13.50.100 as to RCW 13.50.100 and RCW 13.50.100 .

During the RCW 13.50.100 , she failed to RCW 13.50.100 s ordered. At the time the mother RCW 13.50.100 , she claimed she was RCW 13.50.100 and that the Department RCW 13.50.100 . A Family Team Decision Meeting (FTDM) had been scheduled for December 1, 2017, to discuss the mother's RCW 13.50.100 . Prior to the scheduled FTDM, the maternal grandmother stated that the mother was RCW 13.50.100 and was RCW 13.50.100 . After the mother RCW 13.50.100 the FTDM regarding her RCW 13.50.100 was canceled.

On January 19, 2018, an intake was received from a "friend of a friend" stating that the mother was using RCW 13.50.100 and RCW 13.50.100 in the presence of her child, J.T., and that she would leave RCW 74.15 in a car seat for long periods of time. This intake was assigned for a CPS investigation.

---

[4] Risk Only reports are when a child is at imminent risk of serious harm and there are no allegations of abuse or neglect https://www.dshs.wa.gov/ca/practices-and-procedures-guide/2200-intake-process-and-response

Another intake was received on January 22, 2018, alleging similar allegations. This intake was screened out because the first intake had already been assigned for investigation.

On January 22, 2018, the assigned CPS worker made contact with the mother, J.T. and the paternal grandfather. The mother, father and J.T. lived with the paternal grandfather. There were no concerns noted during this home visit. The CPS worker discussed Period of Purple Crying and safe sleep with the mother while the grandfather was present. J.T. appeared to be doing well and no injuries were noted during a diaper change. The mother called the father during this contact and the CPS worker spoke with the father by phone. The father stated he would meet with the CPS worker another day as he was working in Seattle that day.

The mother denied the allegations contained in the intake and said she has been clean for well over a year. She said she has contact with her mother regularly, and she agreed to provide a urinalysis. The mother also provided J.T.'s pediatrician information to the CPS worker. The CPS worker spoke with the paternal grandfather who stated he had never seen the mother use drugs in the home. He stated he helped with rocking J.T. to sleep and that he had no concerns regarding J.T.'s care.

The mother failed to provide the urinalysis on the following day, stating she did not have transportation. The CPS worker requested law enforcement reports for the parents for the previous six months at their current residence. On January 24, 2018, the CPS worker received an email from an attorney stating he was representing the parents. The CPS worker left a voice mail message for the attorney requesting a return call on February 22, 2018.

Between February 22nd and February 26, 2018, the CPS worker called the father and maternal grandmother requesting a call back. The CPS worker verified that J.T. was seeing a pediatrician and that the pediatrician had no concerns. The CPS worker also checked the parents' histories through multiple databases covering both Department and criminal histories. The CPS worker learned that the mother and father had criminal history from multiple years, most recently 2016 for the father and 2017 for the mother. There was CPS history for the mother regarding RCW 13.50.100 but no CPS history for the father. There was no history in any of the Department or criminal databases regarding the paternal grandfather.

On February 27, 2018, the CPS worker spoke with J.T.'s father. He denied the allegations about the mother's substance abuse and her leaving the child in a car seat for long periods of time and said he did not have any concerns for J.T. During this conversation, the CPS worker learned that the father had attended RCW 13.50.100 when he was nineteen years old, but the father denied any criminal history after 2012. Unrelated to this case, the CPS worker chose to end his employment with the Department around this time. The CPS supervisor then assigned the case to herself and resumed case activity.

The CPS supervisor made telephone contact with the mother. During their conversation on March 12, 2018, the supervisor discussed the current situation and case closure. The mother

stated her attorney told her to not provide a urinalysis. The CPS supervisor explained that based on the mother's history, she was not comfortable closing the case out without a clean urinalysis and that she was going to staff the case at a Child Protection Team (CPT) meeting. The supervisor called the father, at the request of the mother, to discuss the case. The supervisor then called and texted the parents five different times before finally reaching the father on April 23, 2018. The father stated they believed the case was closed and the supervisor reiterated the concerns and the upcoming staffing at the CPT. The CPS supervisor then requested J.T.'s birth records from the hospital.

On April 26, 2018, the CPS supervisor texted the mother, who did not respond. The following day the CPS supervisor went to the home but no one answered the door. On April 30, 2018, the CPS supervisor mailed letters to the mother and father inviting them to attend the CPT scheduled for May 8, 2018.

Later that same day, the Department received an intake regarding J.T.'s death. This intake was screened in for a CPS investigation. Three subsequent intakes were received regarding the death and were screened out because there was already an open investigation.

During the CPS investigation regarding J.T.'s death, the Department learned that the mother had a felony warrant with Department of Corrections (DOC) and the father had multiple warrants as well. Law enforcement stated that the home had holes in the bedroom and bathroom and that the maternal grandmother told them that there was RCW 13.50.100 between the parents. The parents refused to cooperate with the CPS investigation regarding J.T.'s death. The Medical Examiner's report has not been completed prior to the completion of this report and the CPS investigation remains pending.

Committee Discussion

The author of this report spoke with the area administrator, CPS supervisor who handled the case until J.T.'s death and the CFWS supervisor for the mother's RCW 13.50.100 prior to this review. Information from those discussions were shared with the Committee members.

The Committee discussed the challenges posed with Risk Only intakes. Specifically regarding this case, the Committee discussed that the mother's history of substance abuse was significant, yet when the CPS worker observed the home, child and mother in January of 2018, there did not appear to be any current, obvious threats to the child's safety. The mother's failure to comply with the request for a urinalysis, coupled with her long history of substance abuse, concerned the Committee. The Committee believed that the request for a CPT was appropriate.

As part of the discussion regarding Risk Only cases, the Committee discussed that the FTDM scheduled in December of 2017 before J.T. was born should have taken place since building relationships with relatives and parents is very important to the work of the Department. However, the Committee discussed how it is vital that statements made by relatives and

parents are verified through corroboration and collaterals because the safety of children is paramount. The CPS worker reached out to the maternal grandmother but she did not return that call. Contact with the maternal great grandmother as well as the paternal relatives, after the initial contact with the paternal grandfather, would also have been appropriate. Another avenue that could have been pursued as a collateral would have been the use of National Crime Information Center (NCIC). The Committee speculated that this may have alerted the CPS worker and supervisor to the fact that parents had recent criminal activity and may have led them to contact with the mother's DOC officer.

There was discussion that many times clients present barriers to providing urinalysis or making appointments that are requested by the Department. In this case, the mother stated she did not have transportation to provide the requested urinalysis. The Committee noted that further discussion with the mother regarding how to ameliorate that barrier would have been appropriate. The mother clearly made the well-child checks as documented by the pediatrician's office. The mother also stated her mother visited her often and the paternal grandfather, with whom the parents and J.T. lived, also had transportation.

The issue of staff longevity and turnover was also discussed. With longevity and experience, a person is able to build their confidence in how to discuss difficult topics. It is the hope that experienced staff more readily take into consideration recent history with the Department and how that plays into risk as opposed to relying on identified safety threats alone. This was also discussed regarding the mother's RCW 13.50.100 and the choice to cancel the FTDM RCW 13.50.100. The mother made it clear that she did not want the Department involved in her RCW 13.50.100 child's life and the maternal relatives said they believed the mother was clean and doing well, but the Committee noted that there was no current unbiased documentation of the mother's change because she refused to participate in services, complete a urinalysis, or maintain contact with the Department. The Committee discussed how having difficult discussions with parents regarding the RCW 13.50.100 while another child's birth is pending is not easy, and the ability for a worker to have difficult conversations usually comes with experience and education. The Committee discussed that additional training on difficult discussions is an area which the Department could improve upon.

Findings

The Committee did not identify any critical errors made by the Department during this investigation. There were areas identified by the Committee where practice could improve. Those areas are discussed in this section.

The first intake regarding J.T. was received on January 19, 2018. The CPS worker made face-to-face contact with the mother and J.T. on January 22, 2018. There were multiple attempts made to contact the parents via phone and even email but no other in person attempts were made

until April 27, 2018. A health and safety visit should have been attempted in March and April prior to April 27.[5]

The Committee noted the directive provided by the area administrator to the CFWS supervisor regarding an FTDM prior to the closure of the previous RCW 13.50.100 case was appropriate and should have been followed. The Committee discussed that while this is not a policy that this is a good standard of practice.

The Committee noted that there did not appear to be a sense of urgency regarding the risk to J.T. While the mother and her family stated she was not using or abusing substances, there was no corroboration of those claims. There was, however, a lengthy history of proven RCW 13.50.10 use and failure to comply with court ordered services in the previous RCW 13.50.100 leading to the RCW 13.50.100 . The Committee also stated that it would have been appropriate to staff the case with an Assistant Attorney General at the time the parents discontinued contact with the Department and when the mother refused to provide a urinalysis.

Recommendations

The Committee did not make any recommendations regarding this review.

Nondiscrimination Policy

The Department of Social and Health Services 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.

[5] Children in CA custody, or with a Child Protective Services (CPS) or Family Reconciliation Services (FRS) case open beyond 60 days or receiving family voluntary services (FVS) must receive private, individual face-to-face health and safety visits every calendar month. https://www.dshs.wa.gov/ca/4400-concurrent-tanf-benefits/4420health-and-safety-visits-children-and-monthly-visits-caregivers-and-parents