CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

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CONTENTS

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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

- B.S.

Date of Child's Birth

- October 2024

Date of Fatality

- November 6, 2024

Child Fatality Review Date

- February 19, 2025

Committee Members

- Patrick Dowd, JD, Director, Office of the Family and Children's Ombuds
- Michelle Balcom, MSW, Early Learning Program Manager, Department of Children, Youth, and Families
- Madeline Renner, Social Service Specialist IV, Department of Children, Youth, and Families
- Kolleen Seward, Substance Use Disorder Clinical Director, Partners with Families and Children
- Betsy Ward, Clinical Program Manager, King County Parent-Child Assistance Program

Facilitator

- Leah Mattos, MSW, Critical Incident Review Specialist, Department of Children, Youth, and Families

Executive Summary

On February 19, 2025, the Department of Children, Youth, and Families (DCYF) conducted a Child Fatality Review (CFR)[1] to examine DCYF's practice and service delivery to B.S. and their family. B.S. is referenced by RCW 7 initials throughout this report.[2]

On November 8, 2024, DCYF learned that B.S. had died on November 6, 2024, when the assigned caseworker was making attempts to locate RCW 7 mother and father. Per the law enforcement report received by DCYF on November 8, law enforcement and emergency medical services responded to the family's home, where B.S. was found on the floor, with dried blood around RCW 7 nose and mouth and circular bruising on RCW 7 forehead. It was documented that a hammer lay nearby and appeared to match the size and shape of the bruising on RCW 7 forehead. B.S. was pronounced dead. The father was present at the home, stating he returned from work to find the mother on the phone with 911 and B.S. unresponsive. He said the mother left the home due to having an active felony warrant with extradition requirements. Based on law enforcement interviews with the mother and father it was not clear what the circumstances were that may have led to B.S.'s death. B.S.'s manner of death as determined by the medical examiner is homicide.

At the time of B.S.'s death, DCYF had an open Child Protective Services (CPS) case with the family. The information related to B.S.'s death was included with the open case to investigate the circumstances of RCW 7 death. At the time of this report, the CPS investigation remains open with a concurrent law enforcement investigation.

A CFR Committee (Committee) was assembled to review DCYF's involvement and service provision to the family. The Committee included members with relevant expertise selected from diverse disciplines within DCYF and community partnerships. Committee members had no prior direct involvement with the family. Before the review, the Committee received relevant case history from DCYF. On the day of the review the Committee had the opportunity to speak with DCYF field staff who were involved with supporting the family.

[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 CFR should not be construed to be a final or comprehensive review of all 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 to replace or supersede investigations by courts, law enforcement agencies, or other entities with legal responsibility to investigate or review some or all the circumstances of a child's fatal injury or near fatal injury. Nor is it the function or purpose of a CFR to recommend personnel action against DCYF employees or other individuals. "The restrictions [described in this paragraph, and the paragraph immediately above,] do not apply in a licensing or disciplinary proceeding arising from an agency's effort to revoke or suspend the license of any licensed professional based in whole or in part upon allegations of wrongdoing in connection with a minor's death or near-fatality reviewed by a child fatality or near-fatality review team." See RCW 74.13.640(4)(d). See: https://app.leg.wa.gov/RCW/default.aspx?cite=74.13.640.

[2]B.S.'s name is not used in this report because RCW name is subject to privacy laws. See RCW 74.13.500.

Case Overview

B.S.'s mother and her three children have been the subject of nine reports to the agency expressing concerns about the family's welfare. The reports led to two CPS risk-only[3] investigations and two CPS-Family Assessment Response (CPS-FAR)[4] cases, an alternate pathway in CPS, while five calls did not meet criteria for agency response. This summary is intended to provide an overview and may not include every detail of the case or agency action.

From 2016 to 2019, case involvement was with the mother's oldest child. Reports indicated concerns about the mother's ability to care for her due to the mother's substance use. RCW 74.13.515 In 2019, at the point of case closure for the final case involving B.S.'s oldest sibling the child was in the care of her father. The family was recommended by DCYF to complete a parenting plan through juvenile family court.

In 2020, a CPS risk-only case was assigned when B.S.'s mother gave birth to her second child with B.S.'s father. RCW 74.13.520 B.S.'s mother's toxicology was positive for amphetamines, opioids, THC, and methadone. She admitted to a recent relapse. B.S.'s father was also suspected of using substances based on his presentation at the hospital. RCW 74.13.515 The father reportedly participated with a court-ordered substance use program ordered through criminal court, but did not sign a release to allow DCYF to obtain those records. In 2021, the mother and father's parental rights were terminated, RCW 74.13.515

In 2022, a report was received with concerns for the mother's oldest child's safety indicating the mother and her boyfriend are using drugs and passing out in their car at the maternal grandmother's home when they come to visit the child RCW 74.13.515 The referrer said they called law enforcement, but nothing came from it. This report did not require agency response as no child abuse or neglect was reported.

In 2024, prior to B.S.' birth, DCYF received two reports from the mother's probation officer that she was using methamphetamines while pregnant. These reports did not require agency response because B.S. had not been born.

On October 17, 2024, a CPS risk-only case was assigned when DCYF was notified about the birth of B.S. B.S. was being cared for in the neonatal intensive care unit due to feeding challenges that required a feeding tube. The mother reported that she did not receive prenatal care until late in her pregnancy as she had planned to

[3]A CPS Risk Only investigation should be screened in when there are "reports [that] a child is at imminent risk of serious harm and there are no [child abuse or neglect] allegations". For more information about CPS Risk Only Investigations, see https://www.dcyf.wa.gov/practices-and-procedures/2200-intake-process-and-response.

[4]For information on CPS Family Assessment Response (CPS-FAR), see: https://www.dcyf.wa.gov/policies-and-procedures/2332-child-protective-services-family-assessment-response.

terminate the pregnancy. The mother reported that she had recently been attending a community-based methadone treatment program.

On October 18, 2024, the assigned CPS caseworker completed an initial face-to-face visit with B.S. at the hospital, spoke with medical staff, and attempted to see the parents at their home. There was no response at the door, but the caseworker reached the mother by phone and set up a time to meet her and the father. Additionally, the caseworker left a message for the mother's community corrections officer. The medical staff said the mother's last fentanyl use was on August 15, 2024, and confirmed she had been participating with substance use disorder (SUD) treatment services.

On October 21, 2024, the caseworker corresponded with the mother's community corrections officer, who said the mother had an extradition warrant from a neighboring state. B.S.'s umbilical cord testing returned positive for methadone and morphine and no additional substances. The mother called the caseworker and requested to move the visit to the following day.

On October 22, 2024, a parent interview with B.S.'s mother occurred at the family's home. The father was not present. The mother shared her history of substance use, reporting that her longest time of sobriety was when she was incarcerated for a year. The caseworker discussed her current substance use treatment services and her criminal matters, encouraging her to resolve her outstanding warrant with her attorney. The mother denied any mental health needs or domestic violence with her partner. The mother said she and the father have a big support group and have supplies to care for B.S. when he is discharged from the hospital. The caseworker corresponded with the hospital social worker who reported no concerns for the family other than the mother's disclosure of prenatal substance use.

On October 24, 2024, the caseworker spoke with the mother's SUD treatment provider who said the mother was engaged with group and her appointments, reporting that she previously worked with the mother who seemed "to have completely turned things around". The caseworker confirmed the father completed supervision with the Department of Corrections in 2021 and spoke with the father's probation officer who said he was compliant with his probation requirements including SUD treatment. Probation said the father was doing well since he was released from jail in April 2024. The caseworker spoke with a family friend who reported no concerns for either the mother or father parenting B.S. The caseworker attempted to contact the mother by phone, but she did not respond. The caseworker stopped by the family's home to speak with the mother in person, expressing the importance of communication. The caseworker inquired if the mother had heard from the Parent-Child Assistance Program (PCAP), which offers a three-year program of parenting support, and the mother said they would confirm if she was accepted into the program this week. The caseworker asked the mother to have the father respond to the caseworker. The caseworker spoke with the father to schedule a time for a visit the following day.

On October 25, 2024, the caseworker received a call from the father explaining that he had to go into work early and rescheduled to meet later in the week. The caseworker inquired about what the plan would be if the mother was arrested on her outstanding warrant, and he said their family friend would help them to care for B.S. The father reported apprehension regarding CPS involvement with his family.

On October 28, 2024, a monthly supervisor review was held. Next steps included completing an interview with the father, contacting the mother's attorney, contact collaterals, assessing child safety, and completing the safety and risk assessment.

On October 29, 2024, the caseworker received oral swab toxicology results for the mother, which was positive for methamphetamine. The caseworker completed an unannounced visit at the family's home and spoke with the mother and observed B.S., who had been discharged from the hospital a few days prior. The mother admitted using methamphetamines after B.S.'s birth and her discharge from the hospital. The caseworker requested she continue to complete random drug tests, which she agreed to. The caseworker encouraged her to be honest with her SUD treatment provider and B.S.'s father about her use. The caseworker spoke with the mother about services, and she said she would prefer to work with the Nurse Family Partnership that the hospital had referred her to.

On October 30, 2024, the caseworker was contacted by the mother's SUD treatment provider who reported the mother failed her urinalysis and missed her group meeting the previous night. The caseworker attempted to contact the mother by phone but did not receive a response back.

On October 31, 2024, the caseworker completed a visit with the father at the family's home. The mother was not present and reported to be at her SUD group. The caseworker observed B.S. sleeping in a bassinet. The caseworker discussed with the father what his plan would be if the mother continued to use substances. He inquired about daycare options for B.S. The caseworker discussed available services with the father, who said he did not want the mother to get overwhelmed with her current community-based services and would like to see how things go. The father said he had been sober since April and that he graduated from his SUD treatment program last week. The father denied mental health needs or domestic violence in his relationship.

On November 4, 2024, the caseworker went to the family's home to make contact and there was no answer.

On November 5, 2024, the caseworker went to the family's home to request the mother complete an oral swab. B.S. was observed and no concerns were noted. The mother said she had missed her one-on-one SUD appointment and planned to reschedule when she attended her group that night. The caseworker inquired about B.S.'s primary care appointment and offered the mother a bus pass or to drive the mother and B.S. if they did not have access to the family car for the appointment. The mother confirmed that she had been accepted into PCAP and did not need anything further. The caseworker corresponded with the mother's SUD treatment provider who said they were concerned the mother did not attend her one-on-one appointment. The caseworker received the oral swab results for the father, which were positive for methamphetamine, amphetamine, fentanyl, opiates, and oxycodone. The caseworker went back to the family's home unannounced but there was no answer. The caseworker called the mother and left a message requesting a return call.

On November 6, 2024, the caseworker went the family's home to discuss the father's oral swab results and provide the mother with a bus pass. There was no response at the door. The caseworker left a message for the mother requesting a return call.

On November 7, 2024, the caseworker attempted to contact both parents by text and phone call without response. The caseworker spoke with the hospital social worker who confirmed the family had been referred to Early Support for Infant and Toddlers (ESIT).

On November 8, 2024, the caseworker requested a time slot for a family team decision making meeting. The caseworker left a message for the father and his assigned community corrections office requesting a call back. The caseworker spoke with the mother's SUD treatment provider who reported she had missed her group all week reporting childcare challenges. The SUD treatment provider said that law enforcement came to the facility on Nov. 6 indicating that the mother had left the scene of a crime after calling 911. The caseworker requested law enforcement reports. The caseworker spoke with the father's probation officer who read a police report to the caseworker from Nov. 6 indicating that B.S. was found deceased in the home following a 911 call.

On November 8, 2024, an intake was reported to include the law enforcement reports from the response to the family's home when B.S. was found deceased. There has been an ongoing CPS investigation related to the death of B.S. At the time of this report the investigation remains pending.

Committee Discussion

The Committee had the opportunity to speak with field staff who were involved in supporting the family. The discussion provided a chance for the Committee to learn about case specific details, typical office practice and resources, and system challenges. The Committee identified positive aspects of the casework practice and discussed opportunities for improvement. Improvement opportunities are defined as the gap between what the family needed and what they received from the child welfare system. Improvement opportunities may also identify systemic barriers. The Committee discussed several aspects related to casework practice with an emphasis on engagement, assessment and service provision. The Committee also discussed what they identified as potential administrative needs for the agency and child welfare field staff.

The Committee highlighted strong engagement by the caseworker with both the mother and father. The Committee stated that it was clear throughout the case involvement that the caseworker valued building and preserving a trusting relationship with the family to encourage their participation in the assessment process. The Committee spoke with the field staff about the office's typical practice around considering filing a dependency court action and opined that in this case it may have been more difficult to get the family to engage long-term through the structure of dependency court.

The Committee discussed how maternal health needs were assessed for this case, noting the hospital did not record concerns for potential postpartum depression (PPD)[5]. The Committee inquired about the agency's typical practice related to assessing maternal health needs and what support and resources are available to field staff to inform their assessment of new parents. It was identified that there is support regionally and at headquarters to help inform and guide the use of Plan of Safe Care[6] and other resources for newly parenting

[5]For information on Postpartum depression, see: https://www.mayoclinic.org/diseases-conditions/postpartum-depression/symptoms-causes/syc-20376617. Last accessed on February 25, 2025.

[6]For information on Plan of Safe Care, see: https://dcyf.wa.gov/safety/plan-safe-care.

people, but that there can be a disconnect with information sharing between support staff and field staff. The Committee emphasized the importance of the agency bridging gaps between those who hold knowledge at headquarters and those in the field by creating more accessible information sharing opportunities.

Another aspect of the assessment discussed the mother and father's substance use and child safety. The Committee considered the family's history of substance use throughout their involvement with DCYF and the outcomes of the prior cases. The Committee pointed out that on the surface things appeared to be going well and the caseworker was diligent in their follow-up to gather information about the parents' progress, as well as addressing concerns as they arose. A Committee member wondered, with hindsight, if something was missed by an SUD provider at some point and placed value on information sharing across systems, such as was done on this case. The Committee discussed the difficulty in predicting a prognosis with how substance use may impact child safety and rather placed value on considering how trauma history may impact outcomes or create a risk of relapse.

The Committee discussed the multiple layers of support and expertise, across systems which may be needed to help families get healthy and considered the service provision offered to this family. The mother and father both had SUD treatment supports, and the mother was connected to PCAP. The Committee wondered if a parent ally or peer support may have been beneficial to the mother in navigating her role as a new parent. The Committee discussed how peer support is typically accessed for families, either through a community pathway or through participation with the dependency court, but that this is not a support that DCYF offers through the service array available to families. Again, the Committee discussed trauma impacts families may experience from system involvement with child welfare and emphasized the importance of field staff being knowledgeable about providing a trauma informed approach.[7]

The Committee appreciated the opportunity for shared learning between the agency and system partners through this review process, stating that it helps (community partners) better understand the role of the agency and the limits within child welfare. The Committee believed the agency is tasked with balancing many competing interests, which they pointed out must be challenging. For instance, the Committee heard from the field staff about the challenge of balancing their immediate caseload needs while being able to participate and engage with training opportunities. The Committee suggested, if the agency does not have something developed already, that they consider creating a professional development team to strategize how to effectively meet the learning needs of field staff. The Committee pointed out the importance of field staff having opportunities to engage in meaningful learning whether that be less formal information sharing within the agency or formal trainings. While the Committee did not have a specific solution on how to address the complex workload needs, they wondered how or if efficiencies can be considered to promote caseworker's spending more time engaging with and assessing families. Lastly, the Committee pointed out the value of creating spaces for child welfare staff to speak about the challenges that exist within the work, in a trauma-informed manner.

[7]For information on trauma and guidance for a trauma-informed approach, see: https://library.samhsa.gov/product/samhsas-concept-trauma-and-guidance-trauma-informed-approach/sma14-4884. Last accessed on February 25, 2025.