CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

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Full Report

Child

- A.M.

Date of Child's Birth

- September 2023

Date of Fatality

- May 8, 2024

Child Fatality Review Date

- August 29, 2024

Committee Members

- Lindsay Barcklay, MSW, LICSW, CMHS, SUDP, CCTP, Therapist, Barcklay Counseling
- Dave Thomson, Field Administrator Section 4, Department of Corrections
- Cristina Limpens, MSW, Senior Ombuds, Office of Family and Children's Ombuds
- Derek Murphy, M-RAS, SUDP, CSC, Director of Clinical Services, Olalla Recovery Services
- Melissa Hall, MSW, Indian Child Welfare Child Protective Services Supervisor, Department of Children, Youth, and Families

Facilitator

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

Executive Summary

On August 29, 2024, the Department of Children, Youth, and Families (DCYF) convened a Child Fatality Review (CFR)[1] to examine DCYF's practice and service delivery to A.M. and [redacted] family. The child, A.M., will be referenced by [redacted] initials throughout this report.[2]

On May 9, 2024, law enforcement notified DCYF that eight-month-old A.M. was shot and killed by [redacted] father. A.M.'s mother was present but could not stop the child's father. A.M.'s father was under the influence of substances, was hallucinating and killed his [redacted] A.M.'s father is awaiting trial for Murder. This information resulted in a screened-in Child Protective Services (CPS) investigation. Allegations of abuse or neglect that meet the legal sufficiency result in a screened-in intake to either CPS or Family Assessment Response (FAR).[3] FAR intakes are an alternative response to CPS investigations. The allegations in FAR intakes are lower risk than those in CPS investigations.

At the time of A.M.'s death [redacted] lived with [redacted] mother and father. DCYF had been involved with the family after A.M.'s birth and closed out that case in November 2023. A.M.'s mother had two previous intakes under her name. Neither intake met legal sufficiency and they were closed at screening.

A CFR Committee was assembled to review DCYF's involvement and service provision to A.M. and [redacted] family. The Committee included members with relevant expertise selected from diverse disciplines within DCYF and community partners. Committee members had no prior direct involvement with A.M. or [redacted] family. Before the review, the Committee received relevant case history from DCYF. On the day of the review, the Committee had the opportunity to interview some of the DCYF staff who were involved in the 2023 case.

Case Overview

DCYF first learned about A.M.'s family in 2007. A.M.'s mother's first born [redacted] was placed in relative care through the Puyallup Tribe of Indians. DCYF was not involved in that case except for financial payments. In 2020 DCYF received an intake with allegations of sexual abuse RCW 74.13.515 The alleged offender was a family member. This intake screened out and was sent to law enforcement.

On September 8, 2023, a hospital called to report that A.M. had been born and [redacted] mother tested positive for methamphetamines and cannabis. The hospital reported that [redacted] mother did not obtain any prenatal care and stated she had only relapsed one time due to an inability to work her construction job due to her pregnancy and feeling stressed. The mother also shared that she stopped using medications for post-traumatic stress and depression due to her pregnancy. The hospital did not have any concerns regarding A.M.'s father. This intake screened out.

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[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)]." 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 of the circumstances surrounding the near 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.

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

[3] For information about DCYF intakes, see: https://www.dcyf.wa.gov/policies-and-procedures/2200-intake-process-and-response.

The next day the hospital called again. A.M.'s urine test results were positive for amphetamines and there was a pending test for both mother and baby regarding fentanyl. The caller expressed concern for the baby's well-being without DCYF intervention or assessment. This intake screened in for a CPS investigation.

The caseworker contacted the mother and A.M. at the hospital. A.M.'s mother was cooperative with the CPS caseworker and signed releases of information for her probation officer, prenatal care provider, and previous substance use treatment provider. They discussed safe sleep and Period of Purple Crying®.[4] The mother reported obtaining prenatal care through the Puyallup Tribal clinic.

On September 12, 2023, DCYF held a Family Team Decision Making meeting (FTDM).[5] The team included the parents, hospital staff, and a relative. The team identified an action plan that included: a walk-through of the family's home, concrete goods (diapers, formula, vouchers for clothing, etc.), urinalysis, and a Plan of Safe Care.[6]

Following the FTDM the caseworker went to the parent's home. She conducted the walk-through, discussed early learning services, provided lock boxes (with substance use pamphlets and two boxes of naloxone, an opioid reversal medication), bottles, gas cards and shopping gift cards for food and clothing. The paternal aunt was also present and participated in the creation of the Plan of Safe Care document.

The initial urinalysis completed by the mother was positive for fentanyl but after a confirmatory test, the result was negative for all tested substances. The mother's second urinalysis was also negative.

On September 19 the caseworker referred the family to Early Support for Infants and Toddlers[7] and later the caseworker referred the family for child care.

The mother completed a substance use assessment and started treatment. She did not continue to attend treatment after she struggled with some interactions at the group. On October 27 the mother provided a urinalysis. The initial result was positive for fentanyl. A confirmatory test could not be completed due to an insufficient specimen amount.

The case was closed on November 6, 2023. The mother was in compliance with her probation and there were no reported concerns from the paternal aunt or pediatrician's office for A.M.'s well-being and safety.

On May 9, 2024, law enforcement notified DCYF that eight-month-old A.M. was shot and killed by [RCW 7] father. A.M.'s mother was present but could not stop the child's father. A.M.'s father was under the influence of substances, was hallucinating and killed his [RCW 74.13] A.M.'s father is awaiting trial for murder. This information resulted in a screened-in Child Protective Services (CPS) investigation.

[4] For information pertaining to DCYF policy regarding Period of Purple Crying and safe sleep, see: https://www.dcyf.wa.gov/1100-child-safety/1135-infant-safety-education-and-intervention.
[5] For information about Family Team Decision Making meetings, see: https://www.dcyf.wa.gov/1700-case-staffings/1720-family-team-decision-making-meetings.
[6] For information about Plan of Safe Care, see: https://www.dcyf.wa.gov/1100-child-safety/1135-infant-safety-education-and-intervention.
[7] For information about Early Support for Infants and Toddlers, see: https://www.dcyf.wa.gov/services/child-development-supports/esit.

Committee Discussion

The Committee met with the CPS supervisor and the area administrator from the September 2023 CPS case. The caseworker was unavailable for the review but did participate in a pre-review meeting with this facilitator.

The Committee discussed the case prior to the DCYF staff joining. Committee members identified that the casework and case notes were completed well and they were pleased with the supports provided by DCYF. The Committee appreciated that the caseworker conducted her required domestic violence screening and followed the policy interviewing the parents separately.

The caseworker also documented asking the parents about any weapons in their home, which the parents denied. The Committee identified that this is a very good question to ask and also appreciated that DCYF staff cannot search a home to verify the accuracy of statements made by the parents regarding weapons. This was pertinent to this case because the fatality was the result of the father shooting and killing his [redacted]

The Committee was made aware that the DCYF had followed up on the urinalyses results to discuss them further (initial positive results and negative upon confirmation) but the calls were not returned.

The Committee positively identified the interviewing skills of the caseworker to include asking about trauma histories of the parents but then also clearly having reviewed the history available to her in the computer database, Famlink, which was then used to correctly complete the Structured Decision Making Risk Assessment tool (SDM). The SDM is a tool utilized by DCYF staff to help identify future risk of CA/N to children.

The Committee also appreciated the clear documentation regarding safe sleep, Period of Purple Crying, collaterals that were appropriate and pertinent to the case, and the creation of the Plan of Safe Care even though it was not required for this case.

The Committee also discussed and appreciated that the caseworker worked hard to be available and flexible to meet with A.M.'s father. A.M.'s father had a very challenging work schedule that interfered with contact during regular business hours.

One Committee member shared from his perspective that both parents were compliant with their probation through Department of Corrections. And that this outcome was absolutely unforeseen by the probation officer as well as understanding that DCYF could not have predicted this fatality.