WASHINGTON STATE
Department of
Children, Youth, and Families

CHILD FATALITY REVIEW

March 2019

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FULL REPORT

CHILD
- C.W.S.

DATE OF CHILD'S BIRTH
- RCW 74.13 2018

DATE OF FATALITY
- September 2018

CHILD FATALITY REVIEW DATE
- December 13, 2018

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EXECUTIVE SUMMARY

On December 13, 2018, the Department of Children, Youth, and Families[1] (DCYF) convened a Child Fatality Review (CFR) to assess DCYF's service delivery to C.W.S. and RCW 74 family.[2] Initials of the child are used throughout this report to maintain confidentiality.

On September 6, 2018, an intake was received stating C.W.S. passed away at RCW 74 home the previous night. C.W.S. lived with RCW 74 parents, brother, and maternal grandparents. The death was under investigation with law enforcement but there was no evidence of trauma or neglect. This intake was assigned for a Child Protective Services (CPS) investigation. At the time of C.W.S.'s death, the family had an open Family Voluntary Services (FVS) case with DCYF.

During the CPS investigation regarding the fatality, DCYF learned that C.W.S. had been fed and was then placed face down onto a bed by RCW 74 father. The maternal grandmother later checked on C.W.S. and RCW 74 was unresponsive. Emergency services were contacted. The father admitted to law enforcement he used RCW 13.50.100 and had been doing so during the family's open FVS case. The father also said he believed the mother was using RCW 13.50.100 and that she was RCW 13.50.100 After the intake, a RCW 13.50.100 with regard to C.W.S.'s brother who is still residing in the family home. With regard to C.W.S.'s death, DCYF entered a founded finding against the father for negligent treatment or maltreatment.

The CFR Committee (Committee) included members selected from diverse disciplines within the community with relevant expertise including individuals with the following backgrounds: an Ombuds from the Office of the Family and Children's Ombuds, a chemical dependency professional, a juvenile court advocate, and child welfare. The Committee members did not have any involvement or contact with C.W.S. or RCW 74 family.

The Committee interviewed the CPS investigator, the FVS worker, their supervisor, and the area administrator.

PURPOSE OF A REVIEW

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 child fatality or near-fatality review (CFR/CNFR) 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/CNFR 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/CNFR to recommend personnel action against DCYF employees or other individuals. Information discovered through the review may be used in DCYF disciplinary actions such as revocation or suspension of a child care license.

[1] Effective July 1, 2018, the Department of Children, Youth, and Families (DCYF) is the state agency responsible for child welfare and early learning programs (the Department of Social and Health Services Children's Administration was the prior authority).
[2] C.W.S.'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 DCYF in its case and management information system. [Source-Revised Code of Washington 74.13.500(1)(a)].

CASE SUMMARY

On April 18, 2018, DCYF received an intake stating that because of RCW 13.50.100 pertaining to RCW 13.50.100, C.W.S.'s mother was admitted to a hospital. At the hospital, the mother RCW 13.50.100 and admitted to RCW 13.50.100. The hospital also reported that the mother received RCW 13.50.100. The mother has a long history of substance abuse. The mother and her boyfriend have a 2-year-old son and recently moved into her mother's home. This intake was screened out.

On RCW 74.13.515, 2018, C.W.S. was born and the hospital called to report concerns related to the mother's substance abuse. The mother's substance abuse history dates from 2009 to present, and she recently RCW 13.50.100. Due to RCW 74.13.520 displayed by C.W.S. after RCW 74.1 was born, C.W.S. remained in the hospital for observation. The mother reported that C.W.S.'s father, who is also the father of her older child, uses illegal substances. This intake was assigned for a Risk Only assessment.[3]

While at the hospital, the assigned CPS worker made contact with the parents. Both parents discussed their substance abuse history and housing issues. They said the maternal grandmother knows about their past substance abuse history but does not know about their current use. The parents also reported that the grandmother provides the mother with RCW 74.13.520 when the mother experiences RCW 13.50.100 issues. The mother previously possessed a prescription for RCW 74.13.520 but allowed it to expire. From this original prescription, the grandmother saved the remaining RCW 74.13.520. Because of the maternal grandmother's concerns pertaining to her daughter's substance abuse, the maternal grandmother has provided the mother with home urinalysis tests. The parents said the grandfather does not know about the father's substance abuse history or recent substance abuse by the mother. If he was aware of this the parents believe he would not allow them to live in the home.

A Family Team Decision Meeting (FTDM)[5] was held on May 11, 2018. The parents, maternal grandmother, C.W.S.'s brother, medical staff, and DCYF staff were present at the FTDM. At the conclusion of the FTDM, the parents agreed to engage with FVS and signed safety and action plans. The action plan includes substance abuse assessments for the parents, urinalysis tests for the parents, and a walk-through of the family home by the CPS worker. The parents agreed to be honest with DCYF to ensure child safety and safety plan participants agreed to adhere to the safety plan.

After the FTDM on May 11, the CPS worker conducted a walk-through of the parents' home, observed C.W.S.'s sleep environment, and reviewed with the mother the safe sleep practices and procedures. The CPS worker reviewed with both parents the Period of Purple Crying (PPC).[6] The CPS worker had a private conversation with the father. He provided details about his family, history of RCW 13.50.100, and substance use history. That same day, the CPS worker contacted the hospital and provided approval for C.W.S. to be discharged to RCW 74 parent's care after C.W.S.'s feeding issues resolved. The CPS worker also requested medical records for C.W.S.

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[3] Screen in CPS Risk Only reports when a child is at imminent risk of serious harm and there are no CA/N allegations. https://www.dcyf.wa.gov/practices-and-procedures/2200-intake-process-and-response

[4] RCW 74.13.520

[5] Family Team Decision Making (FTDM) meetings follow the Shared Planning Meeting model of engaging the family and others who are involved with the family to participate in critical decisions regarding the removal of child(ren) from their home, placement stabilization and prevention and reunification or placement into a permanent home. https://www.dcyf.wa.gov/1700-case-staffings/1720-family-team-decision-making-meetings

[6] The *Period of PURPLE Crying* begins at about two weeks of age and continues until about 3-4 months of age. There are other common characteristics of this phase, or period, which are better described by the acronym *PURPLE*. All babies go through this period. It is during this time that some babies can cry a lot and some far less, but they all go through it. http://www.purplecrying.info/what-is-the-period-of-purple-crying.php

On May 11 and May 17, the father provided random urinalysis samples. Both samples tested RCW 13.50.100. The mother's random urinalyses for the same dates were RCW 13.50.100

On May 14, 2018, the FVS worker conducted a health and safety visit at the family's home. Both parents and both children were present. Multiple phone contacts were attempted between this date and June 13, 2018, when the next health and safety visit occurred. During the June 13 health and safety visit, the father expressed frustration with the fact that the case remained open. The FVS worker told the father that despite numerous DCYF attempts to contact (phone calls and texts) the parents, the parents did not respond. The FVS worker discussed concerns with the parents about child safety and parental substance use. At that time, the mother admitted to using again. The mother said she and the father left the children with the maternal grandmother and did not return home until the following day. The mother also said she missed her substance abuse evaluation and rescheduled it for June 21. The FVS worker spoke with the mother about triggers for using, postpartum depression, and the Parent-Child Assistance Program (PCAP).[7]

During the next health and safety visit on June 21, the mother admitted to missing her second substance abuse evaluation. There was further discussion regarding the mother's ambivalence with regard to abstaining from RCW 13.50.100. The FVS worker also discussed supportive resources within the community. The next in-person contact occurred on June 26. The mother was ill so the FVS worker met with the father and children. The FVS worker discussed, among other issues, that if another urinalysis tested positive the case would need to change from voluntary to legal intervention.

On July 13, the FVS worker met with the parents and children at a park. During this health and safety visit, the FVS worker specifically documented a discussion with both parents regarding safe sleep. They also discussed the parents' continued drug use. The parents stated that when they use they are leaving the children with the maternal grandmother. The FVS worker discussed PCAP and a chemical dependency evaluation for the mother. The father said he does not find meetings or other typical recovery supports helpful but prefers to read books. The FVS worker indicated she would try to purchase books for the father. The FVS worker and father discussed the father's mental health needs, including the fact that the worker thinks the father is using drugs as a way to cope with his unmet mental health needs. There was also discussion about the possibility that DCYF may file a dependency petition.

The next in-person meeting was on July 24 at the family home. The same topics were addressed as had been discussed during the previous contacts. The paternal grandfather died between the July 24 visit and the next visit on August 28. After the grandfather's death, the parents did not make themselves available for an in-person meeting until August 28.

On August 28, the FVS worker exchanged text messages with the parents. The FVS worker told the parents she would be at their home that morning. Instead, the parents said they would meet the FVS worker at her office later that afternoon. The parents failed to appear for the scheduled meeting.

On August 19, the worker called the father and asked that the parents submit to a urinalysis. The father said the test would be positive because both parents used drugs. An FTDM was scheduled for the following day. However, the meeting did not occur until August 30. Attendees at the meeting included the parents, the maternal grandmother, the children, the FVS worker, and FVS supervisor. After discussing the case and engaging the grandmother in the discussion about the parents continued drug use, the parents were given another opportunity to voluntarily

[7] https://depts.washington.edu/pcapuw/ .

engage in services. After the August 30 meeting, the FVS worker attempted numerous times to contact the parents by calling and texting them. However, they did not respond until September 5 when the father stated he could only text her.

On September 6, DCYF received an intake from the Medical Examiner's (ME) office reporting that C.W.S. had passed away the previous night. Law enforcement was involved but there did not appear to be any trauma or neglect identified by law enforcement or the ME's investigator. This intake was assigned for a CPS investigation.

At the conclusion of the CPS investigation, the father was issued a founded finding for negligent treatment or maltreatment based on his placement of C.W.S. in an unsafe sleep environment. After learning more about the extent of the parents' drug use from the law enforcement investigation DCYF also RCW 13.50.100 with regard to C.W.S.'s brother.

COMMITTEE DISCUSSION

The Committee is aware that DCYF policy does not require social worker discussions about the Period of Purple Crying and safe sleep with all adults or caregivers in the home. The Committee believes it may have been appropriate for this discussion to have occurred between the social worker and grandparents. This is the case because the maternal grandmother was identified as a care provider for the children when the parents were using drugs. She was providing more care than just intermittent babysitting.

The Committee struggled with balancing assigned casework and the need for training. The Committee believes line staff do not have enough time to attend trainings on a regular basis if they are also required to comply with policy and practice expectations. While the Committee considered the idea of case carrying staff attending Safety Framework training on a regular basis, the decision was made to recommend supervisors attend the training because the supervisors are the individuals that decide to approve or disapprove case transfers and closures.

The Committee also discussed that despite the fact that the FVS worker is obtaining her chemical dependency credentials and is becoming knowledgeable about substance abuse, most of the staff are not receiving such training. There was also discussion about the fact that staff previously had access to co-housed chemical dependency professionals (CDP). However, this access is no longer available. In the past, it was helpful to have the co-housed CDPs' immediate availability to discuss case questions or situations with staff, and in some cases, respond in the field with staff. That in-field response removed many barriers for parents who were struggling with substance abuse issues.

The Committee discussed a missed opportunity to have a more robust discussion with the family during the second FTDM. During the meeting, there may have also been a missed opportunity to share with the family a written case plan about appropriate next steps. However, the Committee recognizes that with the substantial number of children assigned to the FVS worker it is understandable that these actions did not occur. The Committee also recognizes that more likely than not those actions would not have had any impact on the fatality.

During the staff interviews, staff identified barriers to accomplishing certain case tasks within the community. Staff reported there are no local sites that offer random urinalysis on Fridays and there are no locations for color based random urinalysis. Meaning, that without the color based random urinalysis system, staff must create a random system for each case and make contact with the clients each time. On the other hand, the color system allows a color to be assigned to each client. The client then calls in each morning to the urinalysis site to see if their color is

randomly called for that day. Staff also reported it is challenging to find substance abuse assessment providers for clients. This issue was not as significant when there were co-housed CDPs. The staff also discussed a lack of locally available in-home providers for other supportive services connected with DCYF.

FINDINGS

The CFR Committee found no critical errors. However, there were areas identified for improved case practice. Those areas are noted below:

- DCYF missed an opportunity to assess the family further by not including the maternal grandfather. The maternal grandfather was not included in the FTDMs or as a collateral contact.
- The Committee believes additional collateral contacts could have enhanced the assessment of the case. The Committee identified thorough reading of the hospital records, talking with the maternal grandfather, checking in with the maternal grandmother with regard to the safety plan, and attempting to talk with C.W.S.'s brother may have provided more information about the family's situation. The staff stated they asked the family for contact information for other relatives at the FTDMs, but the family stated there were not any.
- The Committee believes the FVS worker had too many children assigned to her caseload. The FVS worker had 55 children assigned to her the day C.W.S. passed away. The Committee believes the FVS worker did a very good job with her documentation based on the size of her caseload.

RECOMMENDATIONS

The Committee made the following recommendations:

- DCYF should consider providing substance abuse training that includes information about typical behavior patterns displayed by users of specific types of drugs (e.g. heroin, methamphetamine, heavy marijuana use, etc.). This training may provide workers with the potential to better assess the caregiver's situation as it relates to child safety. The Committee recommends this training be provided by a subject matter expert from the substance abuse field.
- DCYF employees should attend updated Safety Framework training once they have been promoted to a supervisory position. Likewise, they should also receive updated Safety Framework training if they change disciplines within supervision, such as moving from CPS to CFWS.
- For purposes of caseload calculations, FVS caseloads should be calculated based on the number of children, not by family.
- DCYF should consider changing DCYF Policy No. 1135 (Infant Safety Education and Intervention) to require all adults residing in the home receive PPC and safe sleep education. This education requirement should also apply to anyone within the home who is providing care for the child or children that are also involved with DCYF. This would not include situations such as a homeless shelter, residential treatment centers, etc.