CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

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CONTENTS

Nondiscrimination Policy

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

- D.L.

Date of Child's Birth

- February 2024

Date of Fatality

- July 25, 2024

Child Fatality Review Date

- October 17, 2024

Committee Members

- Elizabeth Bokan, JD, Deputy Director, Office of the Family and Children's Ombuds
- Sandy McCool, Statewide Intake & Investigations Program Manager, Department of Children, Youth, and Families
- Wyndi Horness, Supervisor, Department of Children, Youth and Families
- Stephanie Widhalm, MSW, LICSW, MHP, CMHS, Children's Advocacy Center Director, Partners with Families and Children
- Christie Pelz, LASW, CMHS, SUDP, Mental Health Clinical Director, Partners with Families and Children
- Yoland Peter, Wellness Navigator, Pacific Islander Community Association of Washington

Facilitator

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

Executive Summary

On October 17, 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 D.L. and their family. D.L. is referenced by RCW 7 initials throughout this report.[2]

On July 22, 2024, a law enforcement officer contacted DCYF to report that D.L. had been taken to the hospital after being found unresponsive by RCW 7 grandmother, who had returned home following an out-of-town trip. D.L. was diagnosed with a brain bleed and medical staff said RCW 7 was unlikely to survive due to lack of neuroactivity. When the referrer asked the mother, who had been with D.L., and what happened, it was reported that she said, "I abused my child". The mother was arrested for assault of a child with pending criminal charges. On July 25, 2024, D.L. passed away.

In the last 12 months, the family had an open Child Protective Services (CPS) case. A new CPS case was opened to investigate the circumstances surrounding D.L.'s death.

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, community partnerships, and cultural relevance. 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.

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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)]." 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] D.L.'s name is not used in this report because RCW name is subject to privacy laws. See RCW 74.13.500.

Case Overview

Prior to the death of D.L., DCYF received eight calls reporting concerns for the welfare for D.L.'s family to include [redacted] older sibling, [redacted] The reports led to two CPS investigations, one prior to D.L.'s birth and one related to D.L.'s birth. Below is a summary of events and agency response provided to the family through the CPS investigations. This summary is intended to provide an overview and may not include every case detail.

In June 2023, a CPS investigation was assigned when DCYF received a report alleging possible physical abuse by D.L.'s mother of [redacted] older sibling. The referrer said the mother "slapped" the 2-year-old but was not certain if the child obtained injuries. The mother was reported to smoke marijuana and drink alcohol.

The CPS investigation was open from June 28, 2023, through August 14, 2023. During the investigation the caseworker(s) met with the mother, the father, spoke with relatives, and observed the child.

The father said he had primary custody of [redacted] with the mother visiting [redacted] periodically but denied having a formal parenting plan through court and said he and the mother were not in a relationship. The father denied the mother hitting [redacted] and said she had hit him during the incident. The father said the mother had experienced hallucinations following the birth of [redacted] which he described as common in the family's culture. The mother and grandmother also denied that the mother hit [redacted] stating the mother had hit the mother's younger sibling. [redacted]s mother told the caseworker she was focusing on her mental health and periodically visited [redacted] Prior to case closure the mother and father were provided with bus passes and a guide with community-based resources. [redacted] was assessed as safe in [redacted] father's care, with a moderate risk assessment. DCYF did not recommend any additional services, and the case was submitted for closure.

In February 2024, following DCYF receiving four calls reporting concerns for the mother and newborn, D.L., a CPS investigation was assigned. The mother had given birth to D.L. and was scheduled to be discharged back to RCW 74.13.520 where she was receiving psychiatric care. The hospital said the family's plan was for the father to care for D.L. upon [redacted] discharge but that the father had been difficult to reach and was considering other relatives to care for D.L. In March, three additional calls were received reporting that the mother had discharged from the hospital and had taken D.L. from the relatives who had been caring for [redacted]

The CPS investigation was open from February 9, 2024, through May 17, 2024. During the investigation the caseworker spoke with the referrer, the mother, the father, relatives, medical professionals, and observed D.L. and [redacted] older sibling in the family's home. Additionally, monthly supervisor reviews were held. Resources were provided for the family to create a safe sleep[3] environment for D.L.

On February 9, 2024, the caseworker met with the mother and relatives at the hospital. The father was not present. The maternal grandfather informed the caseworker that the paternal relative and his partner, who were present, would care for the infant. The mother said she understood and agreed with this plan. The mother said she was hospitalized RCW 74.13.520 and the nurse, who was with her from the psychiatric hospital, said the mother would be referred to outpatient mental health services once she completed the

[3]For information about Safe Sleep, see: https://safetosleep.nichd.nih.gov/safesleepbasics/about. Last accessed on November 1, 2024.

psychiatric hospital stay. It was reported that the mother and father were not in a relationship and that the father was in a relationship with another woman.

Following the hospital visit, the caseworker conducted a home walkthrough of the paternal relative's home. The caseworker provided the family with supplies for the infant, including a pack and play. The caseworker documented that D.L. would sleep in the pack and play in the caregiver's bedroom.

On February 28, 2024, the caseworker completed an interview with the father at his home. The father said his relatives would continue to care for D.L. The father said he and the mother were no longer in a relationship and he initially had questioned the paternity of D.L. but believed he was D.L.'s father. The father said he has visited D.L. and believes the relatives are taking good care of [redacted] Following the interview, the caseworker completed a health and safety visit with D.L. at the relative's home. The relative said D.L. had gone to the pediatrician with no concerns noted. The relative reported speaking to the mother's social worker at the psychiatric hospital and that there was no plan for discharge. The relatives indicated a willingness to keep the infant in their care and the caseworker documented providing the relatives with information on how to obtain guardianship through family court.

On March 19, 2024, DCYF received calls reporting that the mother had been discharged from the hospital and, with the grandmother, went to the relative's home and took custody of D.L. The caseworker went to the maternal relative's home and completed a visit with the mother, the grandparents, and observed D.L. The mother was documented as being attentive to D.L.'s needs. The caseworker discussed sleeping arrangements for D.L. and said they would bring the family a pack and play when the mother responded that she planned to co-sleep with the infant. The mother said that she had an outpatient mental health appointment scheduled and confirmed she would take her prescribed medications. D.L.'s grandfather said they would ensure the mother attended her appointments. The grandfather was documented as stating that he believed D.L. should have remained in the care of [redacted] paternal relatives but the grandmother wanted D.L. to reside with [redacted] mother. The grandfather said between him, his wife, and their older child someone would be home with the mother and D.L.

On March 20, 2024, the caseworker delivered a pack and play to the family and spoke with the mother and grandmother about safe sleep. The grandmother told the caseworker she had quit her job to be home with the mother and D.L. The mother's mental health needs were discussed, and the grandmother said the mother was diagnosed with RCW 74.13.520 and prescribed medications. It was documented that the mother was told that if she did not comply with out-patient mental health services that the least restrictive alternative[4] order, allowing her to remain in the community may be revoked. The grandmother said she would take the mother to her mental health appointments.

On March 25, 2024, and April 23, 2024, monthly supervisor reviews were documented. On April 24, 2024, a health and safety visit at the mother's home was completed by the caseworker. It was documented that the mother, D.L., and [redacted] older sibling resided at the grandparents' home. The caseworker attempted to speak

[4]For information on least restrictive alternative, see https://www.dshs.wa.gov/faq/what-less-restrictive-alternative-lra. Last accessed on November 1, 2024.

with [redacted] but [redacted] did not engage with the caseworker. The mother told the caseworker she had attended her mental health appointments.

On May 3, 2024, the caseworker attempted to contact the father to discuss the second allegation that had been reported (March 19, 2024). On May 7, 2024, the caseworker completed a visit at the father's home. The father said he was aware the mother had taken custody of D.L. and was initially documented as saying "no good" when asked what he thought about this but then said as long as the mother remained at the grandparent's home, he believed the children were safe. The father said he had visited [redacted] but not D.L. The caseworker provided information about how to complete a parenting plan through family court.

On May 9, 2024, the caseworker confirmed the mother was engaged in mental health services, although the provider said they had only seen the mother one time. The provider said there had been scheduling challenges but there was another appointment scheduled for the following week.

On May 16, 2024, the caseworker spoke with D.L.'s pediatrician and no concerns were noted with D.L.'s next appointment scheduled for June. The caseworker completed a health and safety visit with the mother and her two children at the grandparent's home. The caseworker attempted to speak with D.L.'s older sibling but [redacted] would not engage. The caseworker did not document any observed concerns for the children and noted that the mother was attentive to the children. The mother told the caseworker she had been taking her medications as prescribed and the grandmother confirmed.

On May 17, 2024, a final monthly supervisor review took place. The CPS investigative assessment was completed with unfounded findings.[5] D.L. was assessed as safe in [redacted] mother's care with a moderately high risk. No DCYF services were recommended for the family. The caseworker sent the mother a letter outlining her after-care plan to include ongoing medical, dental, and educational care for the children, age-appropriate supervision, and continue with recommended mental health services and medication. The case was submitted for closure.

Approximately 10 weeks later, DCYF was notified of the critical incident that led to D.L.'s death. A CPS investigation was assigned, which concluded with the mother being assigned a founded finding[6] of physical abuse.

Committee Discussion

The Committee had the opportunity to speak with field staff who were involved with supporting the family. This discussion provided an opportunity 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

[5]RCW 26.44.020 (29) defines "Unfounded" as follows: means the determination following an investigation by the department that available information indicates that, more likely than not, child abuse or neglect did not occur, or that there is insufficient evidence for the department to determine whether the alleged child abuse did or did not occur. https://app.leg.wa.gov/rcw/default.aspx?cite=26.44.020.

[6]RCW 26.44.020(14) defines "founded" as follows: "the determination following an investigation by the department that, based on available information, it is more likely than not that child abuse or neglect did occur."

between what the family needed and what they received from the child welfare system. Improvement opportunities may also identify systemic barriers.

Based on the Committee's review of the case file and discussion with the field staff, the Committee believed this case was complex, but not identified as such. The Committee discussed how and what information was gathered during the assessment process and identified areas where they would have liked to see more curiosity, such as in obtaining the mother's criminal records. The Committee inquired how field staff know when they have enough information gathered to accurately assess safety and through this conversation with field staff gained additional insight behind the case decision making, which may not have been fully reflected in the case documentation. The assessment of child safety and family needs may have been further enhanced through additional information gathering and further exploration of the extended family's functioning and their identified role(s) in supporting the mother, father, and children. Additional information may have provided a more comprehensive assessment of the family needs and the support they had in place.

The Committee discussed additional aspects of the assessment process and consultation resources available to field staff, including how postpartum depression and parent-child bonding are evaluated. The Committee acknowledged the challenges faced by field caseworkers as they are not necessarily subject matter experts in all domains and inquired about training and consultation resources available to field staff regarding mental health and perinatal-postnatal assessment. It was identified that training opportunities related to Parent-Child Interaction Feeding and Teaching Scales (PCI Scales)[7], which assess bonding and attachment, are accessible but may not be available to every DCYF office statewide at this time. The Committee suggested that DCYF field staff may benefit from the agency developing internal mental health consultation for field workers to inform their assessment of safety and risk related to parental mental health needs.

In addition to considering how to provide more specialized consultation for caseworkers, the Committee asked about what supports field supervisors receive in their respective roles. The Committee learned from the field supervisor that often more consultation is occurring between field staff and supervisors than what may be documented in the case file. The Committee sensed that this team was very supportive of one another and utilizes each other for support and consultation frequently. The Committee discussed potential barriers in supervisor's addressing complacency and ensuring best practice is being followed. The Committee suggested that the agency should consider how to prioritize training to support growth and development of field supervisors.

The caseworker shared with the Committee about their personal philosophy and practice around engaging families and incorporating their cultural values into the assessment. The Committee expressed appreciation for how the caseworker engaged with and demonstrated respect for the family and their culture. While the Committee appreciated the caseworker's efforts to engage with the family and prioritize kinship care, they also emphasized the importance of field staff utilizing the tools within the framework of assessing child safety and providing guidance and structure to families that are in line with typical agency practice. The Committee suggested that the placement with the relative following D.L.'s hospital discharge may not have been common agency practice but also understood this was the family's placement preference. The Committee suggested the family needed transparency and additional communication to ensure they understood that the placement

[7]For information about Parent-Child Interaction (PCI) Feeding and Teaching Scales, see: https://www.pcrprograms.org/parent-child-interaction-pci-feeding-teaching-scales/. Last accessed on November 1, 2024.

of D.L. with relatives was a family plan with no formal agency structure and to further identify roles and responsibilities of all family members. The family may have benefited from a formalized plan being developed by the agency. Again, the Committee stressed the importance of additional information gathering from within a family as well as from community providers and partners to help inform the assessment process.