CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

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CONTENTS

Full Report

Child

- D.M.

Date of Child's Birth

- December 2022

Date of Fatality

- October 16, 2024

Child Fatality Review Date

- February 4, 2025

Committee Members

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Executive Summary

On February 4, 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 D.M. and [redacted] family. The child, D.M., will be referenced by [redacted] initials throughout this report.[2]

On October 16, 2024, DCYF was notified by three different sources that D.M. died. None of those sources were law enforcement or the medical examiner's office. However, based on the information that all three sources provided as well as a collateral contact that DCYF intake made to law enforcement, DCYF opened a 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 D.M's death, the family had an open CPS case due to domestic violence and parental substance use. D.M.'s father was incarcerated at the time of [redacted] death.

During the investigation DCYF learned that D.M. died due to the toxic effects of buprenorphine. D.M.'s mother had found a pill on the floor at the maternal grandmother's home. D.M.'s mother picked the pill up and placed it on a counter. It is believe that D.M. ingested that pill. The pill belonged to the maternal grandmother. While the ingestion occurred at the grandmother's home D.M. passed away at the mother's boyfriend's home later the same day. The DCYF investigation resulted in a founded finding for negligent treatment or maltreatment by D.M.'s mother.

Prior to D.M.'s death, DCYF received 15 intakes regarding the family. Of the 15 intakes, nine met sufficiency for a CPS investigation or FAR assessment.

A CFR Committee was assembled to review DCYF's involvement and service provision to D.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 D.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 speak with staff who were assigned to this case in 2023 and 2024 as well as multiple area administrators and the current regional administrator who was previously an area administrator.

Case Overview

The information documented in this section is not fully inclusive of all contacts and actions by DCYF staff.

[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] D.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.

D.M.'s parents had significant history with DCYF as children. Both parents were exposed to significant violence and parental substance use as children. DCYF first became aware of the parents, in a parenting role, in 2020. An intake in 2020 alleged that D.M.'s parents had a one-month old child at the time of the intake. The caller alleged that the parents lacked skills to keep their baby safe. The baby fell off a bed and while the parents said the baby was fine and emergency services cleared RCW 74.13 the caller remained concerned. The intake screened in for a CPS investigation and was closed without concerns. In August 2021, a relative called to report concerns that the father was controlling the mother. This did not meet sufficiency for assignment and was screened out. In July 2022, a FAR assessment was assigned due to allegations of parental substance use, lack of supervision, and neglect of D.M.'s RCW 74.13.515 During that assessment the caseworker documented significant violence at the home of D.M.'s paternal grandparents between D.M.'s father and step-grandfather. D.M.'s mother was pregnant with D.M. during this case. The parents and D.M.'s RCW 74.13.515 moved in with the maternal grandfather and the case closed.

On October 24, 2023, DCYF was told that D.M.'s father pulled the baby by the arm and leaves D.M. unattended. The caller also reported that D.M.'s father drinks alcohol daily and he is "drunk by 8 p.m." D.M.'s father had been incarcerated multiple times and when he is away the children's mother does well caring for them. That information resulted in a CPS investigation.

During the initial contact on October 25, D.M. was observed to have a bruise on RCW 7 right cheek. There was no explanation noted for the injury. On November 1, the caseworker observed a scab on D.M.'s forehead. D.M.'s mother said the scab was from when D.M. slipped and hit RCW 7 head. There is no documentation about how ambulatory D.M. was at that time. However, RCW 7 was not walking at the time of RCW 7 death.

During the investigation the parents denied the allegations. The caseworker requested medical records for the children and law enforcement records pertaining to the parents, D.M.'s maternal uncle and maternal grandmother. During that investigation D.M.'s father was arrested. The initial call to law enforcement was regarding domestic violence but the arrest was made after the father, who was intoxicated, damaged the law enforcement officer's vehicle. D.M.'s mother denied the domestic violence allegations when interviewed by law enforcement.

The caseworker met with D.M.'s father in jail. He denied the allegations and denied any physical altercations with the RCW 74.13.51 mother. He stated that upon his release he planned to engage in outpatient substance use treatment for his alcohol abuse. He stated that he started drinking more after he was stabbed by a friend. The caseworker encouraged the father to obtain counseling related to this trauma and encouraged the father to seek out support.

The caseworker closed the case indicating that the mother denied that the domestic violence negatively impacted her. The medical provider did not observe any injury to D.M. and the parents denied all the other allegations. The case closed in January 2024.

On January 18, 2024, after the previous investigation had closed, a relative called reporting neglect of D.M. (one -year-old) and D.M.'s three-years-old RCW 74.13.515 The intake was screened out.

On April 19, 2024, a person called DCYF to report concerns for parental substance use and unstable housing for the family. The caller also reported that D.M. was born prematurely and recently had such a bad cavity

that it was observable to people looking at the child. RCW 74 cheek swelled due to the cavity and RCW 7 was given antibiotics. The parents did not attend to the recommended dental follow up and the child was in pain. D.M.'s RCW 74.13.515 was born with a vision condition and the parents have not followed through with medical care. The caller also reported that they are concerned that RCW 74.13.515 mother has cognitive delays and RCW 70.02.020 the father has mental health disorders and abuses alcohol, and both parents are addicted to cannabis dabs. Dabs are a concentrated form of cannabis. This intake screened in for a CPS investigation.

The next day the family was contacted by an after hours caseworker at a hotel where they were staying. The parents said they were following up with the dental concern but that it was the older child not D.M. They also said that D.M. was the child with the vision condition and that they had an appointment scheduled. They confirmed that D.M. was born prematurely and was receiving physical therapy. The RCW 74.13.5 were observed to be dirty but no other physical concerns observed. The parents showed the responding after hours caseworker a lockbox where they store their cannabis.

On April 24, 2024, the assigned CPS caseworker texted D.M.'s mother to schedule an in-person meeting. The caseworker documented seeing the family on May 8, at a hotel. The parents said they were moving to a family shelter.

On May 9, 2024, a child care provider called DCYF. The provider said that the RCW 74.13.51 father told her he had been stabbed by a person he thought was a friend but did not provide any other details. The provider also expressed concerns because the children were in full diapers with dark, smelly urine and that the skin in the diaper area was irritated. D.M.'s RCW 74.13.515 presented with physical concerns for injuries or irritation RCW 74.13.515 and RCW 7 said it hurt, and D.M.'s legs were swollen and warm to the touch. The provider told the parents they needed to have the children medically evaluated for concern of severe dehydration and "goopy" eyes. This information resulted in a new CPS investigation.

The next day the caseworker who was already assigned to the family, went to the family's residence. The parents said they were taking the children to urgent care that same day. The older child's eyes were observed to have discharge and both RCW 74.13. had a diaper rash. The next documented contact wasn't until May 30, after three other intakes were received by DCYF.

On May 28, a person called DCYF and reported that two weeks prior they observed the parents to be nodding off due to substance use and neglect of the children by their parents. This resulted in a new CPS investigation. Two days later, a hospital employee from the emergency department reported that the RCW 74.13.51 mother was admitted for alcohol abuse and attempted suicide after walking into traffic. The mother also had lacerations on her arms. The caller reported that a month prior the mother was under the influence of methamphetamines. The hospital reported that the mother was being placed on a five-day hold. That intake screened out. A second intake was received that day alleging that D.M.'s father got into a physical fight with his stepfather and that the parents were allegedly using substances. This intake screened out.

On May 30, a DCYF Child Welfare Early Learning Navigator (CWELN) caseworker who specializes in helping family's access early learning services documented that she worked on an application for the RCW 74.13.5 to attend Head Start. Also on May 30, the CPS caseworker went to the paternal grandmother's home to see the RCW 74.13.5 and their father. The grandmother stated she was hoping her landlord would allow the RCW 74.13.5 and their mother to stay at the home. The grandmother stated she could not have her son live with them because he gets

violent and is argumentative. The caseworker met separately with the [redacted] father. D.M.'s father denied the allegations.

On June 5, the CWELN documented that an in-home session with a Head Start family home visitor was scheduled for the following Monday at the paternal grandmother's home.

The CPS caseworker contacted the [redacted] mother and paternal grandmother on June 10 and 13. The [redacted] father was not physically going to the paternal grandmother's home but he was harassing the [redacted] mother by text. The paternal grandmother expressed concern for the mother's mental health. The mother said that she significantly decreased her cannabis use.

On June 18, the caseworker went to the paternal grandmother's home. The caseworker met with the mother, children, and paternal grandmother. The [redacted] mother said that she was working twice weekly with a home visitor with Head Start and scheduled an appointment in July for D.M.'s vision concern. The mother shared that she was on an [redacted] and was trying to get an appointment with a mental health therapist.

The next contact by DCYF was on July 15. The caseworker called the mother's telephone and left a voicemail message. She then called the paternal grandmother who stated that she did not know where the parents and children were staying and that she spoke with the mother the previous weekend.

On July 16, 2024, a person called to report that the [redacted] and their mother were staying with the maternal grandmother. The caller reported the children were dirty and D.M.'s bottle had curdled milk. D.M. was not wearing [redacted] prescribed eye patch for [redacted] vision issue and that [redacted] feet were swollen and [redacted] ankle would not bend. The caller asked the maternal grandmother if they could take D.M. to the hospital to be evaluated and the grandmother declined their offer. D.M. also appeared to have thrush in [redacted] mouth and had a decreased appetite. This information resulted in a new CPS investigation.

The caseworker who was already working with the family was assigned to the new investigation. She made contact at the maternal grandmother's home on July 16. The mother excitedly shared with the caseworker that the parents reconciled even though their families did not want them to. The caseworker told the mother that she needed to take D.M. to urgent care.

The next documented contact occurred on July 30. The family moved to a paternal aunt's home. During that contact the caseworker documented that the children's father discussed his substance use issue and that he completed an assessment. The assessment recommended three weekly group meetings, urinalyses, and engagement with a mental health program through the same facility.

On August 15, the paternal aunt called the caseworker and informed her that the family had moved out. The relatives told them to move because the parents were sneaking out to use cannabis and stopped taking care of the children. The family was scheduled for an intake at a local shelter. That same day a different relative called DCYF intake and reported concerns. The relative alleged the parents were using methamphetamines, were homeless, the father was recently released from a mental health facility, and that he was "abusive." The caller hung up before the call finished. This information was screened out.

Four days later the caseworker confirmed that the family was accepted into the shelter. On August 21, the caseworker met with the family at the shelter. They discussed mental health and substance use services. The

case note indicated the caseworker was going to close the case. Prior to the case closing, another intake was received by DCYF and screened out on August 22. That screened out intake was from a local emergency department. D.M.'s mother was strangled, spit at, kicked, and hit by the father, in the presence of the children while they were at the shelter. The mother also tested positive for amphetamines at the hospital. The next day the CPS supervisor wrote a case note indicating there was no information about how the drug use was affecting parenting and that the children were not injured during the domestic violence incident. The supervisor closed the case.

On August 27, 2024, a new CPS investigation was opened due to D.M.'s father's arrest related to domestic violence. The caller reported the children were also left unsupervised at the shelter and when the children were returned the parents were difficult to wake. Shelter staff were concerned that the parents appeared under the influence and that their room smelled like cannabis. The father had sores on his face and was very aggressive. The caller also said that D.M. was usually left in a stroller and appeared to have developmental delays. Maternal relatives also reached out to the caller asking about whether they were mandated reporters. Both the caller and the relatives (per the caller) expressed a desire for the family to receive supports to keep the children safe.

On August 28, the new CPS caseworker confirmed that D.M.'s father was incarcerated on charges related to the assault. The caseworker then met with the mother and children at the shelter. During that interaction D.M.'s mother minimized the domestic violence. The mother also admitted to using substances with the father until she stopped "cold turkey" a couple days prior but stated she is still consuming cannabis. D.M.'s mother also shared previous mental health diagnosis as a teenager but did not acknowledge any recent concerns even though it was documented in DCYF documents. She did admit to being overwhelmed caring for RCW 74.13.515 The caseworker requested law enforcement records.

The caseworker texted with the mother on September 13, and then again on September 17. During the second texting conversation the mother told the caseworker that she was asked to leave the shelter because she did not adhere to their curfew requirements. D.M.'s mother said she was going between a friend and her mother's homes. She denied using substances.

On September 20, the caseworker met the mother and RCW 74.13.5 at the maternal grandmother's home. The maternal grandmother and D.M.'s maternal uncle were also home. D.M.'s mother admitted that her RCW 70.02.020 RCW 70.02.020 worsened while she was staying at the shelter and that the night before, September 19, her was so significant that she called for mental health support. D.M.'s mother also admitted to consuming alcohol daily until five days prior and she said her last methamphetamine use was on August 27. During this conversation the mother expressed concerns for D.M. not walking and needing to get RCW 74.1 in to physical therapy. D.M.'s RCW 74.13.515 was noted to have a small bruise near RCW 7 right eye. The RCW 74.13.51 mother said RCW 7 pulled something off the table and it hit RCW 7 eye.

The next documented contacts occurred on October 7 and 10. A different DCYF staff member reached out to the mother regarding childcare. The mother did not respond until October 10, but she only responded to say that she was still looking for child care. The CPS caseworker also texted the mother on October 10, and she did not respond until October 13.

The CPS caseworker interviewed D.M.'s father on October 9. D.M.'s father was still in custody. The father expressed concerns for the [redacted] stating that their mother loves them but does not focus enough on the [redacted] that she would benefit from mental health counseling, and that he recently heard she is drinking alcohol excessively. They also discussed the father's mental health and substance use needs. He minimized the domestic violence. D.M.'s father also said that D.M. needed assistance because [redacted] was not walking yet and that [redacted] was supposed to be wearing an eye patch for vision issues.

On October 13, the mother texted the caseworker asking for help. She said she had been very depressed and was hospitalized twice recently for drinking too much alcohol and wanting to hurt herself. She also said that her mother would no longer allow them to stay at her home and they would eventually return to a shelter. The [redacted] mother said that she was going to go to the paternal grandmother's home for a week though before going back to a shelter.

The next day the caseworker met the mother and children at the maternal grandmother's home. The caseworker brought diapers per the mother's request. They discussed substance use and mental health concerns. D.M.'s mother said she had an appointment with someone from a mental health agency on October 18. The caseworker faxed a request for medical records on October 15.

D.M. died on October 16. DCYF intake received three different intake calls from relatives and family friends regarding D.M.'s death and concerns they had prior to the death, regarding the mother's substance use and mental health needs. The local medical examiner and law enforcement did not call DCYF intake regarding the death.

Committee Discussion

The Committee met with DCYF staff who were involved with this family in 2023 and 2024. The Committee appreciated the insightful review completed by staff and that they themselves identified areas of change or difference in their current practice. Some of those identified areas included documentation within supervisory case notes, more documentation regarding following up on screened out intakes, verification of statements made by the parents, as well as photographing documented injuries. They appreciated that staff were willing to be vulnerable during the challenging process.

The DCYF staff identified that curiosity could have been greater at times and that more curiosity may have led to a more comprehensive assessment of the family's needs. The Committee identified that in order to support a more comprehensive, less incident focused assessment, more collateral contacts and verification of parental statements would have been helpful. The subject areas that could have been impacted most included domestic violence, parental substance use, parental mental health needs, and dental and medical needs of the children.

The Committee was concerned that the family's significant history with DCYF, parents when they were children as well as their history as parent's themselves, was not identified. Specifically related to substance use, violence, and mental health needs. The Committee believes those issues did in fact impact their parenting. This was evidenced by the identified repeated issues related to unmet and inconsistent medical care for the children. D.M. was 22-months-old at the time of [redacted] death and [redacted] was not walking and [redacted] had vision issues along with repeated swollen appendages.

The Committee heard from some DCYF staff about the pressure to close cases within certain timeframes. There are statutory timeframes and DCYF policy identified timeframes for closing out CPS investigations and FAR assessments. There was a robust conversation amongst the Committee members about how and why this is necessary as well as acknowledging that the way this is communicated to areas administrators, supervisors, and caseworkers can be challenging. The Committee discussed the hope that the DCYF leadership could find a way to discuss this in a way that staff do not feel the need to close cases without fully addressing child safety or in lieu of offering services which would require an open case with DCYF.

The Committee believed that offering shared planning staffings or conducting internal staffings prior to the closure of the case in August 2024 and when it opened back up days later may have been beneficial to the family. The Committee discussed that the family would have benefited from case management and engagement in services to help with stabilization, which could possibly have occurred if the case transferred to FVS. This was emphasized even more due to the significant chronicity of the case including the generational abuse and neglect within both sides of the family. Specific services that were discussed included urinalyses or oral swab testing of the adults and requesting and obtaining medical records to assess the children's physical well-being.

The Committee heard from DCYF staff regarding staffings and contacts that were not documented. The Committee appreciated the insight that detailed documentation of staffings and other actions would have benefited a person reading the case to fully capture what occurred. While this process does not adhere to the saying, "if it wasn't documented it didn't happen," it is challenging for a person reading the case to grasp the entirety with missing documentation.