CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

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CONTENTS

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Full Report

Child

- H.M.

Date of Child's Birth

- September 2024

Date of Fatality

- September 7, 2024

Child Fatality Review Date

- February 10, 2025

Committee Members

- Elizabeth Bokan, JD, Deputy Director, Office of the Family and Children's Ombuds
- Kristin Lester, RN, BSN, Public Health Nurse, Spokane County Public Health
- Danelle Stone, MSW, CWTAP Faculty Field Instructor, Eastern Washington University
- Sandy McCool, MSW, Intake/Investigations Program Manager, Department of Children, Youth, and Families
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Facilitators

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

Executive Summary

On February 10, 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 H.M. and [redacted] family. H.M. will be referenced by [redacted] initials throughout this report.[2]

On September 5, 2024, DCYF received a call from the children's hospital reporting the imminent death of H.M. H.M. was placed on life support following a critical incident that occurred in [redacted] home. The mother reported that H.M. was breastfed around midnight and then placed in the bassinet next to the mother's side of the bed. The mother tucked a light blanket over H.M.'s midsection and underneath [redacted] Around 3:30am, the mother picked up H.M. from the bassinet and found [redacted] to be unresponsive. The mother stated that the blanket was not covering H.M.'s face when she picked [redacted] up out of the bassinet. The mother called 911 and Emergency Medical Services responded and provided resuscitation for 80-90 minutes before taking H.M. to the local hospital. H.M. was transported from the local hospital to the children's hospital where [redacted] was placed on life support. Law Enforcement reported to DCYF that the condition of the home was cluttered and very dirty with a smell of cat urine throughout the house. The doctors classified this incident as being suspicious because H.M. was recently discharged from the hospital after birth with no medical concerns. Two days following the incident in the home, H.M. passed away at the children's hospital. An autopsy was conducted.

This information resulted in a Child Protective Services (CPS) investigation. Allegations of abuse or neglect that meet legal sufficiency result in a screened-in intake to either CPS or Family Assessment Response (FAR).[3]

H.M. was tested for drugs at birth and after the critical incident. Both drug tests were negative for substances. A brain bleed was found while H.M. was at the children's hospital, however the cause of the hematoma is undetermined as it could have occurred at the time of birth.

At the time of this fatal event, there was an open CPS Risk-Only[4] case involving the family. H.M. was living with [redacted] mother, mother's boyfriend, maternal uncle and two siblings. H.M. has five half-siblings with [redacted] mother and father.

[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] The names of H. M's parents are not used in this report because neither parent has been charged with a crime in connection with the fatality. H.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.

[4] CPS Risk Only is an intake that alleges imminent risk of serious harm and there are no allegations of child abuse or neglect. See: https://www.dcyf.wa.gov/practices-and-procedures/2200-intake-process-and-response

A Child Fatality Review (CFR) 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 partners. Committee members had no prior direct involvement with H.M. or RCW 74. 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 Staff assigned to this case in 2024.

The autopsy results were not available at the time of the fatality review. The CPS investigation related to the fatality of H.M. remains open pending the autopsy results.

Case Overview

Below is a summary of events and the agency response provided to H.M. and RCW 74. family up to the point of the fatality. The information documented in this section is not fully inclusive of all contacts and actions by DCYF staff.

The family has history with the Department starting in 2011 which includes seven CPS Investigations, four Family Assessment Response (FAR) assessments, one request for Family Reconciliation Services (FRS)[5] and 9 intakes that did not meet criteria for agency response. Three of the CPS Investigations concluded with findings[6] of negligent treatment and physical abuse as to the mother. Allegations have included substance use impacting parental capacity, negligent treatment, and physical abuse.

In 2011, H.M.'s family came to the attention of DCYF after a report was made RCW 74.13.515 This was screened out because there was not a specific allegation of child abuse or neglect.

In June 2012, RCW 74.13.515 Due to no specific allegation of child abuse or neglect, this was screened out for further investigation.

In July 2012, the Department opened a CPS Risk-Only[7] investigation after allegations that both the mother and maternal grandmother were using methamphetamines. The mother was arrested for violating a no contact order. The maternal grandmother was caring for the mother's two children, age 1 and age 2. The maternal

[5] Family Reconciliation Services (FRS) are voluntary services designed to resolve problems related to family conflict, at-risk youth or a child who may need services. "These services are provided to alleviate personal and family situations which present a serious and imminent threat to the health and stability of the family and reunify the family, maintain the family unit or avoid out-of-home placement." See DCYF Practices and Procedures 3100. Family Reconciliation Services.

[6] " Founded means: Based on the CPS investigation, available information indicates that, more likely than not, child abuse or neglect did occur as defined in WAC 388-15-009. Unfounded means: The determination following an investigation by CPS that, based on available information, it is more likely than not that child abuse or neglect did not occur or there is insufficient evidence for the department to determine whether the alleged child abuse did or did not occur as defined in WAC 388-15-009. RCW 26.44.020" See: https://www.dcyf.wa.gov/practices-and-procedures/2540-investigative-assessment .

[7] CPS Risk Only is an intake that alleges imminent risk of serious harm and there are no allegations of child abuse or neglect. See: https://www.dcyf.wa.gov/practices-and-procedures/2200-intake-process-and-response

grandmother is noted for having multiple findings of child abuse as to her own children RCW 74.13.515 RCW 74.13.515 The no-contact order was quashed. The mother was released from jail and moved in with the maternal grandparents. The biological father also began residing with the family. The children's basic needs appeared to have been met, and the case was closed in September 2012.

In December 2016, DCYF received a call with allegations that the 6-year-old RCW 74.13.51 and 5-year-old RCW 74.13.515 had sores on their heads due to headlice. The school reported that the children had attendance issues and there were concerns that the family might not have water in the home due to broken pipes. This call was screened in for a CPS-FAR[8] case. The Department provided lice treatment for the children, and it was proven to be effective. The Department provided the family with clothing vouchers because the children needed warmer clothing for the weather. The children were assessed as safe and the case closed in January 2017.

In May 2017, the Department opened a CPS Risk-Only investigation with allegations of neglect as to the 5-year-old RCW 74.13.515 The youth reported that the mother was allowing RCW 74.1 to watch "scary and inappropriate movies, with naked people making weird noises and killing people". The child disclosed that RCW 7 mother allowed RCW 74.1 to play with her "fake wiener" that was in her bedside drawer. At the time of the investigation, the mother was incarcerated at the county jail due to unpaid fines. The RCW 74.13.515 and RCW 74.13.51 were residing with the maternal grandparents. Both children were interviewed and neither disclosed any child abuse or neglect while in the care of their grandmother. RCW 74.13.520 No inappropriate touching was disclosed. During the investigation, the younger 3-year-old RCW 74.13.51 was residing with RCW 74. father. Efforts to contact the father were unsuccessful, however the child was seen in the Early Head Start Program. RCW 74.1 was clean and well-groomed, and the Early Head Start Program had no concerns. The children were found to be safe and cared for. The CPS investigation was closed as unfounded.

In 2018, a referral was made RCW 74.13.515 his referral was screened out because there were no allegations of child abuse or neglect.

In May 2019, a referral screened in as a CPS-FAR case after the RCW 74.13.515 reported to school that RCW 7 and RCW 7 older RCW 74.13.51 watched their younger RCW 74.13.51 while their mother went to the store. The referent had concerns that the mother could be overwhelmed caring for the three children. In meeting with the mother, she denied being overwhelmed but found joy in caring for her children. The Department provided a food voucher and diapers for the family. This case closed in September 2019 after the children were assessed as safe.

In March 2021, a case was assigned to CPS-FAR due to alleging concerns of physical abuse of the 10-year-old-RCW 74.13.515 by RCW 74. mother. It was reported that the mother slapped RCW 74.13.515 across the face and "made RCW 74. tooth wiggly". There were additional concerns that the mother was drinking alcohol in front of the children. RCW 74.13.515 was living with grandmother and visiting RCW 74. mother on the weekends. The mother reported that she was having difficulty establishing housing, so she was allowing her RCW 74.13.515 to stay with their

[8] "Family Assessment Response (FAR) is a Child Protective Services (CPS) alternative response to an investigation of a screened-in allegation of child abuse or neglect. FAR focuses on child safety along with the integrity and preservation of the family when lower risk allegations of child maltreatment have been screened in for intervention." See: https://www.dcyf.wa.gov/practices-and-procedures/2332-child-protective-services-family-assessment-response

grandmother during the week. During the weekends, the kids would stay with their mother. When interviewing the ten-year-old RCW 74.13.515 stated that mother slaps on the cheek, but it doesn't leave marks. RCW 74.13.515 said that tooth was loose before mother slapped The mother admitted drinking alcohol, but did not believe her drinking was problematic. The mother declined service referrals offered to her by DCYF. The family was provided with resources, and the children were assessed as safe at the time of the case closure. In November 2021, a call with concerns RCW 74.13.515 This referral was screened out due to no allegations of child abuse or neglect.

DCYF received two referrals on the family in 2022. In May, a referral screened in as a CPS Risk-Only after the mother gave birth to her fifth child. The mother did not receive prenatal care during this pregnancy. The mother and newborn tested positive for methamphetamines at the time of the birth. The mother denied methamphetamine use, but admitted to cannabis and tobacco use during pregnancy. The hospital monitored the baby for withdrawal symptoms. The three oldest children were living with their grandmother while the fourth child lived with father. The mother reported being homeless after losing a housing opportunity during Covid. She was on two emergency housing wait lists through the housing authority. She hoped to find a housing voucher that would accommodate all her children so that they could all return to living with her. She admits that she and her mother argue, so they cannot reside at the same house. The mother agreed to participate in Family Voluntary Services. She was engaged with a P-CAP[9] worker and was referred to Incredible Years, an evidence-based parenting instruction program. The mother did not complete the Incredible Years parenting program due to missing multiple appointments. She was given the opportunity to be re-referred for the program, but the mother declined, and the voluntary services case was closed.

In July 2023, a CPS case was screened in for investigation regarding physical abuse. It was reported that the mother slapped the 10-year-old RCW 74.13.515 across the face. A medical consult (MedCon)[10] occurred in September indicating that the bruising across the child's face was consistent with an adult hand slap. The medical consultant mentioned that a trauma informed care approach in all environments would likely make a difference in the child's behaviors and life. The case was still open when a CPS-FAR referral was made in October 2023 with concerns that the older children are late for school frequently as they are responsible for caring for themselves and their youngest sibling. It was reported that the mother spends most of her time in the bedroom. The mother reported that she spent time making jewelry in her bedroom. She denied using substances but admitted smoking cigarettes in her room. The Department provided the family with clothing vouchers. After completion of the investigation, the children were assessed as safe with moderately high risk and the case was closed in January 2024.

In March 2024, intakes reported to DCYF were specific as to the mother and her 13-year-old RCW 74.13.515 Concerns were made that RCW 74.13.515 Allegations were made that the mother slapped and hit the 13-year-old. The following day, the mother

[9] The Parent-Child Assistance Program (PCAP) is an evidence-informed home visitation case-management model for pregnant and parenting women with substance use disorders. See: https://pcap.psychiatry.uw.edu/ .

[10] DCYF Medical Consultants (MedCons) are medical professionals with specific training pertaining to child abuse and neglect. These are contracted physicians with DCYF whose purpose is to assist with child abuse or neglect evaluations and assessments.

requested Family Reconciliation Services (FRS)[11] to help her address RCW 74.13.515 behavior. Efforts were made to coordinate services with the mother, but she did not follow through with appointments or return phone calls.

In April 2024, a report was made that the mother had asked an uncle to come over and spank the children with a belt. The 13-year-old RCW 74.13.515 had welts, and the 12-year-old RCW 74. had a handprint on RCW 7 arm. Due to the number of physical abuse allegations and due to the lack of follow through by the mom, the Family Reconciliation Services closed to allow for the CPS investigation to be completed. The social worker provided the mother with a copy of the Washington state laws around child abuse and neglect, a CPS pamphlet, and discussed unreasonable use of force with her. The allegations of physical abuse were founded. No additional services were offered, and the case was submitted for closure in July 2024.

In September 2024, following H.M.'s birth, a CPS Risk-Only case was opened. The hospital made the report due to the mother's history of methamphetamine use along with testing positive for methamphetamines while pregnant on 06/25/2024. The mother reported that she last used methamphetamines prior to 6/25/2024. At the time of H.M.'s birth, the mother had a negative toxicology screen. The mother had prenatal care during pregnancy. The hospital observed the mother to be attentive and bonding with H.M. Once the Department had the opportunity to have the initial contact with H.M., meet with the mother, speak with the hospital staff, and facilitate a walk-through of the home, H.M. was discharged from the hospital, and RCW 74. went home with RCW 74. mother. The Department provided concrete goods to support H.M. at the time RCW 74. was discharged from the hospital. Two days later, the critical incident with H.M. occurred in RCW 74. home.

Committee Discussion

The Committee met to discuss the casework leading to the critical incident. 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 the case specific details, typical office practice and resources, and systemic 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.

It was important to understand the office dynamics at the time of the critical incident. In September 2024, the office had multiple vacancies as well as some newly hired employees. The clerical position was vacant, and the office was getting support from clerical staff from a different office. At times, this created a delay in support for the staff. Despite the new staff and the current vacancies, the office culture consisted of an environment that had a high level of psychological safety. Psychological safety requires active listening, acknowledging other's contributions, and fostering an environment where everyone's voice can be heard. Psychological safety is crucial for fostering collaboration and growth as it allows individuals to feel safe about sharing ideas,

[11] Family Reconciliation Services (FRS) are voluntary services designed to resolve problems related to family conflict, at-risk youth or a child who may need services. "These services are provided to alleviate personal and family situations which present a serious and imminent threat to the health and stability of the family and reunify the family, maintain the family unit or avoid out-of-home placement." See DCYF Practices and Procedures 3100. Family Reconciliation Services.

taking risks and learning from mistakes without fear. Staff were open and invested in participating in the critical review process. Staff asked questions and expressed a desire to learn. Staff talked about highlights and challenges where improvement could be made.

The Committee talked about the difficulties of conducting the Child Fatality Review without knowing the actual cause of death from the autopsy reports. This Child Fatality Review was conducted five months after the critical incident had occurred in effort to allow time for the autopsy to be completed. At the time of the review, the autopsy results had not yet been made available to DCYF staff and H.M.'s actual cause of death remains unknown. The CPS investigation with the family remained open. The staff explained how keeping an investigation open while waiting for autopsy results to return could create workload issues for staff. With open CPS investigations, staff are required to complete monthly health and safety visits with the children in the home, participate in monthly supervisory case reviews along with other case management duties. The amount of time that it is taking to get autopsy reports back and the requirement to keep the investigation open pending the autopsy reports was identified as a systemic barrier.

The Committee reviewed the services offered to the family between the time of H.M.'s birth and the two days leading up to the critical incident. The mother was already working with a P-CAP worker through the Nurse Family Partnerships. Through this resource, she had access to a mental health provider. The mother was utilizing community resources for housing services. In addition to the identified community resources, the Department provided the family with concrete goods including a car seat, diapers, wipes, and a bassinette. Given the mother's extensive substance use history, the Committee inquired whether there had been a missed opportunity to refer the mother to services for substance use. The Department was aware that the mother had a history of substance use and had previously offered resources for help with substance use disorders. The mother declined services in the past. At the time of H.M.'s birth, the mother self-reported that she was refraining from substance use. She completed a drug test, which was negative for substances. In the short time that the case had been open, the Department did not have sufficient evidence of current drug use and maintained focus on H.M. discharging from the hospital to a safe home environment with [redacted] family.

The Committee identified and appreciated the detail that was placed into the documentation and case work. The Department was thorough in the engagement efforts with the mother. The case notes objectively described the walk-through of the house and the in-depth discussion with the mother. The Department spoke with the mother about safe sleep[12], observing and intervening when safe sleep is not present, The Period of Purple Crying®[13], and safety around the cats in the home. The Committee recognized that the mother's voice and perspective was included in the documentation and specifically called this out as positive work conducted on the case.

The Committee was curious about the discrepancy of the condition of the home as described by DCYF staff and by law enforcement. During the walk-through of the home, DCYF staff thoroughly noted that the house was clean and safe. In contrast, law enforcement observed the home to be cluttered and very dirty with a distinct odor likely from cat's urine. DCYF staff shared that law enforcement had a history of working with the

[12] For information about safe sleep, see: https://dcyf.wa.gov/1100-child-safety/1135-infant-safety-education-and-intervention.

[13] For information about Period of Purple Crying®, see: https://dontshake.org/purple-crying.

mother, which could have created bias in their observation of the conditions of the home. It was noted that the description of the conditions of the home by law enforcement did not rise to the level for concerns of neglect. This situation suggests a future opportunity for DCYF to connect with law enforcement partners and share resources such as the recent DCYF Mandatory Reporting Training[14].

The Committee would have liked to have seen more communication with the collateral contacts. Further contact with law enforcement may have clarified what the mother's involvement with law enforcement looked like. There was discussion about the difficulty of having collateral contact with the assigned P-CAP worker as they were not interested in working with DCYF. DCYF Staff shared that this type of experience with P-CAP workers is not common and generally, there is more open communication and a stronger collateral contact between DCYF and the P-CAP worker.

The Committee identified that a global assessment with a wholistic focus on engaging with family members would have been beneficial. The mother's boyfriend needed to be actively engaged in helping and supporting the mom with the care of the child from day one. The staff provided insight into the work leading to the critical incident. Because the critical incident occurred days after H.M. was discharged from the hospital, there had not been much time to engage all family members. The boyfriend was not at the hospital at the time of the initial interview and the initial work was with mom who identified as the main caregiver for H.M. Leading up to the incident, the social worker was focused on making sure that H.M. could be discharged to a safe home environment. The social worker started by completing a walk-through of the home and making sure that the mother thoroughly understood safe sleep practices. The mother's boyfriend did not make himself available during this time and the social worker had not had the opportunity to successfully assess his level of support that he provided to the mother.

[14] Community members can complete the Mandatory Reporting eLearning through the Alliance for Professional Development – https://cpe.socialwork.uw.edu/alliance-courses/content/mandatory-reporter-elearning#group-tabs-node-course-default3