CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

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- September 21, 2023

Committee Members

- Shelley Little, BSN, RN, Public Health Nurse, Benton-Franklin Health District
- Elizabeth Bokan, JD, Deputy Director, Office of the Family and Children's Ombuds
- Erika Thompson, foster and adoptive parent, Director of The Wishing Well Foundation
- Shane Wherry, Licensing Division Area Administrator, Department of Children, Youth, and Families
- Julie Hardison, CFWS Supervisor, Department of Children, Youth, and Families

Facilitator

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

Executive Summary

On September 21, 2023, the Department of Children, Youth, and Families (DCYF) convened a Child Fatality Review (CFR)[1] to examine DCYF's practice and service delivery to M.R.S., RCW 74. family, and RCW 74. licensed relative placement. M.R.S. will be referenced by RCW 74. initials throughout this report.[2]

On June 18, 2023, M.R.S. died. Law enforcement and DCYF were notified of RCW 74. death and began independent investigations. A forensic pathologist identified RCW 74. death as homicidal negligence resulting from untreated 3rd degree burns covering 30% of RCW 74. body. Those untreated burns resulted in streptococcal sepsis. As a result of the licensing division (LD) child protective services (CPS) investigation a founded finding for negligent treatment was made as to both caregivers at the time of RCW 74. 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 and community partnerships. Committee members did not have any involvement with M.R.S. 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 interview the DCYF LD staff and child welfare (CW) staff involved with M.R.S. and RCW 74. family.

Case Overview

DCYF was notified on three different dates of concerns for M.R.S. prior to RCW 74. birth. The concerns included substance use by the mother while pregnant with M.R.S, no prenatal care, and no plan to obtain future prenatal care. The father was also reportedly under the influence of substances. While still pregnant, the mother was admitted to the hospital. In the mother's hospital room, hospital staff found foil in the hospital room, observed a burnt smell, and the parents were trying to hide something (suspected by hospital staff to be fentanyl). The last intake stated the pregnant mother was hospitalized for a drug overdose. DCYF screened out this information at intake due to the alleged victim not having been born at the time of the report.

On RCW 74.13.515 2021, DCYF received another intake stating that M.R.S. was born and in the neonatal intensive care unit because the staff did not believe RCW 74. was safe to room-in with RCW 74. parents. The mother had not requested to see RCW 74.13.515 since the birth. The hospital planned to keep the newborn for approximately five days to observe RCW 74. for possible withdrawals. That intake screened-in for a CPS investigation.

The CPS caseworker contacted the mother at the hospital. M.R.S.'s mother was not cooperative during the interview and the biological father was not present. The mother did provide contact information for the paternal relatives.

[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 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] M.R.S.'s name is also not used in this report because RCW name is subject to privacy laws. See RCW 74.13.500.

The initial contact was on a Friday. The caseworker learned that over the weekend the parents visited their child one time. The father refused to hold the baby. At some point over the weekend, the hospital gave M.R.S. a rescue dose of morphine due to RCW 74. withdrawal symptoms and placed a nasogastric (NG) tube because RCW 74. had disorganized feeding. An NG tube is a small plastic tube that runs from the nose to the stomach for feeding purposes.

Contact was made with paternal relatives, but they were unable to take placement of M.R.S. RCW 13.50.100 RCW 13.50.100 DCYF held a family team decision meeting. Relatives were present but the parents did not appear. The meeting resulted in a recommendation that DCYF file a dependency petition and place M.R.S. in foster care after RCW 74. discharge from the hospital.

Multiple attempts were made to contact RCW 74. biological mother and father. Shortly after the filing of the dependency petition DCYF was made aware that M.R.S.'s biological mother was legally married to another woman and that the other legal mother's adult daughter was interested in placement of M.R.S. After legal consultation and involvement of the biological parents' attorneys, DCYF moved M.R.S. from non-relative foster care to the relative placement on April 6, 2021. At the time of RCW 74. placement in relative care, the relatives were participating in the home study process through LD. LD was aware of the plan to place M.R.S. with RCW 74. relatives prior to the completion of the home study.

In July of 2022, M.R.S. suffered multiple seizures. RCW 74.1 was taken to a local hospital and flown to RCW 70.02.020 RCW 70.02.020 The relative placement was fully engaged in RCW 74. medical care and spent most of the hospital stay in Seattle so they could maintain their relationship and engage in RCW 74. medical care. M.R.S suffered developmental setbacks due to RCW 74. illness. Once discharged, M.R.S. was referred to supportive, therapeutic services in RCW 74. local area. There was no information identifying the origin of the seizures.

In October of 2022, the case was transferred to a different caseworker. RCW 13.50.100 RCW 13.50.100 Sometime around June 14 through 16, M.R.S. sustained serious life-threatening burns while in RCW 74. relative placement. The assigned caseworker had telephonic contact with the relative placement on June 15. There was no mention of any injury to M.R.S. The relative placement did not seek medical care for M.R.S.'s burns and RCW 74. died on June 18, 2023.

Committee Discussion

The Committee identified some areas for improvement but did not connect any of the improvement opportunities to M.R.S.'s death.

LD completed a timely and detailed home study on the relative placement. Once completed the LD licensor sent the home study to the assigned CW caseworker and supervisor. However, the CW caseworker and supervisor did not review the home study. The Committee debated whether they should recommend requiring CW staff read the home studies they are sent but ultimately did not make that recommendation. They strongly suggested it would be best if the caseworkers read the home studies, so they were more familiar with aspects of the placements they work with. Specific to this case was the historical information about RCW 13.50.100 within the relative placements relationship and the husband's history RCW 13.50.100

RCW 13.50.100 The Committee also discussed that HB 1227[3] may lead to more relative or fictive kin placements that would not have previously been approved, therefore knowing the background by reading the home studies will be even more important.

There was discussion regarding the lack of reporting by the placement and CW staff. There were multiple areas identified by the Committee when contact with intake and/or LD should have occurred. Those instances included when M.R.S. was sent to RCW 70.02.020 in 2022, when the placement changed the caregiver roles (the husband started working outside the home), the pregnancy announcement, the birth of the couple's third child, and when M.R.S. was burned. All those changes should have been reported to the licensor. The hospitalization and burn should have been reported to intake as well.

The Committee discussed that had there been education or reminders to the placement regarding the need to notify licensing and call intake regarding the hospitalization in 2022, maybe the placement would have realized the importance of immediately notifying intake, CW, and LD staff when M.R.S. was burned. However, the Committee also considered that the relative placement was purposefully hiding the injury and that is why they did not report it.

There were multiple areas within the CW documentation where questions were posed by Committee members. The CW staff had answers to the questions posed by the Committee, but the Committee identified that documenting conversations and actions by caseworkers and the supervisor would be beneficial for anyone else reading the case and for possible future involvement of the family with DCYF.

Recommendations

The Committee members agree that DCYF's clients can benefit as a whole from the Committee's efforts to provide comprehensive discussion and analysis of the case. While recommendations are made about the many aspects of this case, there is no correlation between M.R.S.'s death and the recommendations. The purpose of recommendations is to help DCYF improve their overall case procedures and practices.

The first recommendation is that DCYF remind child welfare staff, statewide, of the need to notify the licensing division of changes with a placement such as a new person in the home, child injuries/hospitalizations, pregnancy, caregiver changes, etc. Child welfare should consult with licensing division regarding the wording sent to child welfare staff.

The second recommendation is that The Alliance message out through Caregiver Connection a reminder to all caregivers about the need to report to intake and notify licensors of injuries to children.

[3] For information about HB 1227 see: https://www.wacita.org/hb-1227-keeping-families-together-act/.