CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

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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

- L.N.

Date of Child's Birth

- October 2022

Date of Fatality

- July 6, 2024

Child Fatality Review Date

- September 25, 2024

Committee Members

- Patrick Dowd, JD, Director, Office of the Family and Children's Ombuds
- Lori Blake, MSW, QA/CQI Administrator, Department of Children, Youth, and Families
- Jessica Curry, MS, Region 1 Programs Supervisor, Department of Children, Youth, and Families
- Lisa Ostler, RN, BSN, NC-BC, Community Health Nurse II, Child Death Review and Violence/Injury Prevention, Thurston County
- Angela Brumfield, Substance Use Disorder Professional, Quinault Wellness Center

Facilitator

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

Finalized Date: November 20, 2024
Approved for distribution by Paul Smith, Critical Incident Practice Consultant

Executive Summary

On September 25, 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 L.N. and their family. L.N. is referenced by RCW 7 initials throughout this report.[2]

On July 6, 2024, a hospital social worker contacted DCYF to report that L.N. was involved in a drowning incident at RCW 7 home. Initially, the referrer said that RCW 7 prognosis was considered serious but unknown. Three days later, on July 9, 2024, L.N. passed away following the removal of life support.

The explanation of the incident that led to L.N.'s death is summarized as follows from information gathered by DCYF. The father dropped L.N. and RCW 7 older sibling off at the home of the maternal relatives where the mother resides with the children on the morning of July 6. There are varying accounts of what occurred that morning, but the children were not received by an adult. The children went into the backyard where there is a five foot, above ground pool, which L.N. got in via the ladder. The older sibling went into the home to tell an adult that L.N. was drowning. L.N. was found unresponsive and emergency services were contacted.

The family had prior Child Protective Services (CPS) involvement with DCYF, and a new case was assigned to investigate the circumstances of L.N.'s death. At the time of this report, the DCYF investigation remains open. A law enforcement investigation was also assigned and DCYF has no information regarding possible criminal charges.

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 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.

Case Overview

Prior to the death of L.N., DCYF received three calls reporting concerns for the welfare of the children L.N. and RCW 7 older sibling, RCW 74.13 Allegations have included concerns of negligent treatment related to parental substance use (mother), unmet medical needs, and allegations of physical abuse due to unexplained bruising. In 2023, a

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

CPS-Family Assessment Response[3] (CPS-FAR) case was assigned. During the open CPS-FAR case a CPS investigation was assigned concurrently. The case(s) were open from June 2023 to December 2023. The CPS investigation concluded as unfounded. In 2024, a CPS-FAR case was assigned and was open from January 2024 to May 2024. The parents were identified as co-parenting, from separate households. The father had a partner with whom he was parenting another young child, while expecting a new baby. The mother had support from her family in caring for the children. All three cases closed with the children being assessed as safe in their parent's care. No ongoing services were recommended by the agency.

This report is intended to provide a summary of events and agency response and may not include every case detail.

In June 2023, a CPS-FAR case was assigned due to a report that the mother of L.N. and RCW 74.13 was experiencing housing instability and using alcohol. An incident was reported where the mother was intoxicated and hit L.N.'s head on a door frame at a family gathering and drove L.N. under the influence. During the CPS-FAR case, the caseworker completed a face-to-face visit with L.N. and RCW 74.13.5 interviewed the mother, father, and father's partner, and made collateral contacts with the referrer. Initially, it was noted that L.N.'s older sibling was residing out of state with a relative but returned to RCW 7 mother's care during the open case.

In September 2023, while the CPS-FAR case remained open, a CPS investigation was assigned concurrently due to the daycare reporting that L.N., now 11 months old, had unexplained bruising on RCW 7 inner thighs that resembled finger marks and a bruise on RCW 7 forehead. During the CPS investigation the caseworker(s) completed initial face-to-face visits with the children, interviewed the parents, and made collateral contacts with the daycare and relatives, and completed a medical consultation with a child abuse doctor. The parents did not provide a clear explanation for L.N.'s bruising but the medical consultation said the injuries were consistent with accidental trauma for an infant with L.N.'s developmental abilities.

In December 2023, the CPS-FAR Family Assessment and CPS Investigative Assessment were completed. The children were assessed as safe in their mother and father's care with an assessment of low risk. No services were recommended or provided by DCYF. Prior to the case closure a caseworker completed a final health and safety visit with the children at their daycare. The daycare director said they were concerned the children were in the car without car seats. The caseworker reached out to the mother offering car seats for both children but did not receive a response. The case was closed.

In January 2024, a CPS-FAR case was assigned when a report was received that L.N. and RCW 74.13 had "horrible" diaper rashes causing pain, peeling skin, and open red spots that may be a severe yeast rash. The childcare staff reported this had been an ongoing issue and the family had been asked to send diaper cream but never had. Due to workload needs within this office the initial contact with the family was completed by the assigned caseworker while the remaining work was completed by caseworkers who were assisting with casework coverage.

An initial face-to-face was completed with the children the day after the report was received and no active rash or open sores were observed on either child. L.N. was documented to have minor redness in RCW 7 leg fold.

[3]For information on CPS Family Assessment Response (CPS-FAR), see: https://www.dcyf.wa.gov/policies-and-procedures/2332-child-protective-services-family-assessment-response.

The daycare facility said the mother signed an approval for the daycare to apply diaper cream on the children. During the case monthly supervisor reviews took place, interviews were conducted with the mother, the father, the father's partner, and an additional health and safety visit at the children's childcare was completed. The second visit was at a new childcare facility that the children had started attending. The childcare provider's only concern was that L.N. had started biting [redacted] sibling. A referral for Birth to Three services was completed for L.N. and both children were referred for Working Connections Childcare. The family was provided with a Visa gift card to purchase a toddler bed, mattress, bedding and other toddler supplies they identified as needing.

In May 2024, the CPS-FAR family assessment response was completed. The children were assessed as safe in the care of their mother and father with a moderate risk. No additional services were recommended, and the case was submitted for closure.

On July 9, 2024, following a drowning incident at the family's home L.N. passed away. At the time of this report there is an ongoing CPS investigation. DCYF has no additional information regarding the law enforcement investigation.

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

The Committee learned from the field staff about the workload needs of this office over the last year. It was reported that approximately 90% of the CPS program staff are new in their roles. Based on the conversation with the field staff, the Committee felt it was apparent the staff all care about their work and can articulate best practice, but pointed out how it may be difficult to apply best practice given the number of new field staff and supervisors. The Committee believed that workload challenges such as these may lead to important factors or tasks being overlooked but it is not for lack of caring about their work. This led the Committee to discussing ideas on how to support field offices when they are experiencing high turnover by considering what is currently available through training and coaching opportunities, as well as the availability of support offered through other programs or offices. A DCYF Committee member pointed out that it can be difficult to balance the competing interests of offices within a region due to many offices experiencing similar workload needs. While the Committee did not identify one solution to address workload needs, they placed value on the concept of mentoring and shadowing opportunities for field staff and supervisors with an understanding that this may place undue pressure on experienced field staff to provide that support.

The Committee discussed how information was gathered during the two assessments. Within this conversation the Committee addressed their belief on how field staff view CPS investigations versus CPS-FAR cases. The Committee was of the belief that CPS-FAR may be thought of differently or diminished, leading to an assessment that is less comprehensive despite that both CPS investigations and CPS-FAR case assignments

are under the CPS umbrella. The Committee did highlight the importance of engaging families through the assessment process. The Committee identified strong engagement efforts throughout the case involvement, specifically during parent interviews conducted during the second case. The Committee recognized the challenge in multiple caseworkers attempting to engage families over time and pointed out that historical trauma may be triggered through CPS involvement, so appreciated the time spent with the family to listen and validate their feelings.

The Committee reviewed the assessments completed for this family and identified that there was a heavy reliance on the family's self-reports without gathering a significant amount of collateral information from outside sources. It was also identified that in the 2024 case, where multiple casework staff had been involved that there may have been a reliance on work the prior caseworker completed without completing a full re-assessment upon case assignment to a new caseworker. One area emphasized was related to the mother's reported alcohol use and how information was gathered. **The mother may have benefited from additional conversation about her alcohol use to gather a clearer picture of her use, how it may have impacted her and others, and to assess if she had a need for recovery services.** The field staff told the Committee the mother denied her alcohol use being problematic and the Committee was curious about what that meant to the mother, as an individual's definition of dependence may vary by their personal experience. Additionally, they suggested it may have been beneficial to request law enforcement records as it had been reported that the mother had two driving while under the influence charges. The Committee suggested that while alcohol was not identified as a concern in the second case it may have been worthwhile to check-in further with the mother on this topic to assess and address any needs during that period.

While the Committee believed that L.N.'s death was a tragic accident, they took time to discuss ideas on providing additional education and resources to both field staff and families about safety hazards. The Committee spoke with the field staff about what typical practice is around addressing home safety hazards and wondered if additional training may be beneficial. The Committee inquired if a checklist may be helpful in reviewing potential home hazards with families. The field staff said there is a home walkthrough checklist utilized for resource caregiver homes (relative or kinship homes), but they discussed the difference in assessing a biological family's home versus a home utilized for out-of-home placement. The Committee had multiple perspectives about the use of checklists with some individuals feeling this may be a way to provide guidance and consistency when assessing home hazards, while others believed the use of a checklist may discourage curiosity and critical thinking. The Committee members all valued the use of curiosity within the assessment process and identified that this is a nuanced set of skills that caseworkers may develop as they become more experienced. The Committee believed that caseworkers cannot be experts in all areas and discussed the value in community-based resources and partnerships where families may be able to access ongoing support and educational resources outside of CPS. **This family may have benefited from receiving educational support services related to age-appropriate child safety and supervision needs.**