CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

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Full Report

Child

- P.J.

Date of Child’s Birth

- January 2024

Date of Fatality

- June 25, 2024

Child Fatality Review Date

- November 5, 2024

Committee Members

- Patrick Dowd, JD, Director, Office of the Family and Children’s Ombuds
- Shawn Sivly, Family Services Program Manager, Department of Children, Youth, and Families
- Katie Nosworthy, Supervisor, Department of Children, Youth, and Families
- Meg Hatlen, APNS, Parent Child Health, King County Public Health
- Katie Strozyk, Opioid Response Coordinator, Thurston County Public Health & Social Services

Facilitator

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

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

Executive Summary

On November 5, 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 P.J. and their family. P.J. is referenced by their initials throughout this report.[2]

On June 25, 2024, law enforcement notified DCYF of P.J.'s death. The initial report said P.J. had been co-sleeping with RCW 74. mother and older sibling on a soft surface. The report also noted that the home the family was residing in had a house fire in the kitchen approximately a week ago, making the home unlivable due to the conditions. DCYF received additional information from the medical examiner's report indicating P.J. died of sudden infant death syndrome, had been in an unsafe sleep environment, tested positive for rhinovirus, and had positive toxicology for methamphetamine. The cause and manner of death were undetermined.

The family had prior involvement with Child Protective Services (CPS) in the last year, with the most recent case closing in April 2024. A new case was assigned to investigate the circumstances leading to P.J.'s death. The CPS investigation concluded with the mother being assigned a founded finding of negligent treatment of P.J.

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

From 2009 to 2024, DCYF received nine calls reporting concerns about the welfare of P.J.'s family. Five reports led to four CPS investigations and one CPS-Family Assessment Response (CPS-FAR)[3] case, an alternate pathway within CPS. Three reports did not meet criteria for agency response as no child abuse or neglect was

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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]P.J.'s name is not used in this report because RCW name is subject to privacy laws. See RCW 74.13.500.

[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.

reported. A summary of allegations included lack of age-appropriate supervision and medical care, lack of prenatal care, and substance related concerns at the birth of three of the four children.

From 2009 to 2011, the agency had multiple contacts with the mother and her oldest child. In 2009, a CPS investigation was assigned due to allegations of neglect related to the child's medical care. The case closed the following month with the child being assessed as safe in their mother's care with no recommendations for ongoing services. In 2010, a CPS investigation was assigned again due to allegations of neglect due to missed medical appointments for the child. RCW 13.50.100 [4] In 2011, the case was closed following the mother completing the services.

From 2012 to 2018 the agency had no contact with the family.

In 2019, a CPS case was assigned at the birth of the mother's second child due to allegations of prenatal substance exposure and lack of prenatal care. The investigation carried over to 2020. The children were assessed as safe, and the case was submitted for closure with no recommendation for ongoing services. The mother was provided with a guide to access resources in her community.

In 2021, a report was received regarding the birth of the mother's third child. The intake reported lack of prenatal care, and the mother tested positive for THC. No agency response was required as no allegations of child abuse or neglect were reported.

From 2022 to 2023, DCYF did not have contact with the family.

In February 2024, a CPS risk-only[5] investigation was assigned when a report was received regarding P.J. and RCW 74. mother testing positive for substances (fentanyl, amphetamine, and THC) at birth. The case was open from February 2024 to April 2024.

Below is a summary of events and agency response provided in the months prior to case closure. This summary is intended to provide an overview and may not include every case detail. Additionally in 2024, DCYF received two reports related to P.J.'s oldest sibling, neither of which reported child abuse and neglect, so did not require agency response.

During the CPS investigation related to P.J.'s birth, the agency had contact with the mother, relatives, medical professionals and saw three of the four children. The caseworkers had multiple in-person contacts with the mother and P.J. Monthly supervisor reviews occurred five times. A plan of safe care was developed to address the infant and mother's needs, and a shared planning meeting was held to discuss concerns, address needs, and develop a plan. The mother was provided with concrete goods including infant supplies, a bassinet, gas

[4] For information on Family Voluntary Services (FVS), see: https://www.dcyf.wa.gov/policies-and-procedures/3000-family-voluntary-services-fvs.

[5] A CPS Risk Only investigation should be screened in when there are "reports [that] a child is at imminent risk of serious harm and there are no [child abuse or neglect] allegations". For more information about CPS Risk Only Investigations, see https://www.dcyf.wa.gov/practices-and-procedures/2200-intake-process-and-response.

vouchers, and a cell phone with minutes. The three youngest children were referred to the Working Connections Childcare program, providing subsidized childcare for eligible families.

The initial agency contact with the family occurred at the hospital. The caseworker spoke with the mother and observed P.J., who was being observed on eat, sleep, console protocol[6] for 72 hours. The mother said the father had not been to the hospital and had been hospitalized himself RCW 74.13.520 She said they were not together. The mother reported her other children were in the care of relatives.

Prior to P.J.'s hospital discharge, a caseworker completed a home walk-through of the maternal relative's home where the mother would be residing with P.J. A bassinet was provided, and the caseworker offered to help the grandmother set up the bassinet, but she declined. The caseworker documented that there were no safety concerns in the home. The caseworker dropped off a car seat for the mother at the hospital prior to discharge. A plan of safe care was developed with the mother. Following the infant's discharge the mother completed a urinalysis test. The result from the urinalysis test was returned to the caseworker approximately 20 days later and was recorded as positive for fentanyl. An additional urinalysis test was requested.

Due to workload needs of the office, an additional caseworker was assigned to assist with the case and attempted to contact the mother. The caseworker attempted a visit at the mother's address and learned from the property manager the mother had been evicted due to nonpayment and did not leave a forwarding address. Additional contacts were made to locate the mother. The caseworker received a call back from P.J.'s maternal uncle and the mother, who said she was staying with her brother. The following day, the caseworker completed a home visit with the mother, P.J., and two of RCW 74. older siblings in the relative's home. The mother inquired about shelter options and the caseworker said they would submit a referral to a local family shelter. The caseworker inquired about P.J.'s primary care doctor and the mother said she was trying to set this up.

The caseworker attempted to follow-up with the mother about P.J.'s medical care plan as well as the requested urinalysis due to a report the mother missed the urinalysis test. The caseworker contacted the mother who said she would complete a urinalysis test that day and said she set up a meeting with the shelter. Upon following up with the urinalysis site, it was reported that the mother did not complete the urinalysis testing.

A shared planning meeting was held to discuss concerns, needs, and develop a plan. The mother agreed to participate with a substance use disorder assessment and follow recommendations, complete random urinalysis testing, follow-through with P.J.'s medical care and follow-up with the shelter regarding housing. It was noted that the agency would locate and assess the father and assess the needs of the other children, with a referral being submitted for childcare. Two days later, the caseworker drove the mother to complete a urinalysis test. The reported urinalysis results were negative.

[6]For additional information on Eat, Sleep, Console Protocol; see: https://doh.wa.gov/newsroom/state-agencies-announce-changes-policy-and-best-practices-infants-and-parents-affected-substance-use. Last accessed on November 14, 2024.

Prior to case closure, the caseworker made multiple contacts with health care professionals to verify if the mother had coordinated medical care for P.J. A doctor's appointment was scheduled for P.J. and the mother confirmed an upcoming appointment for the older children RCW 74.13.520 The mother said she had a tour scheduled at the childcare facility. At the time of case closure the mother was still working with the shelter but had not been admitted to the program.

In April 2024, the case was submitted for closure. P.J. was assessed as safe in RCW 74. mother's care and no recommendations were made for ongoing DCYF services.

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 workload challenges they have experienced in this office over the last year. Multiple caseworkers assisted with this case due to the workload needs and the Committee identified both positive and potentially negative aspects of co-case carrying assignments. For example, they discussed how co-case carrying may enhance shared consultation opportunities, but also considered that it may create a group think dynamic. The mother was reported to have stronger responsiveness to one caseworker and the Committee was curious as to why this may have been. Although it was not clear, the Committee suggested a few variables, such as engagement style, personality type, or how case management was handled that may have impacted the mother's engagement.

Despite the workload challenges, the Committee was able to identify areas of positive practice. For example, the Committee appreciated the effort the caseworker(s) made to build a relationship with the mother, focus on her strengths, and offered services and support to reduce barriers the family was experiencing. The Committee believed the caseworkers cared about the mother and demonstrated empathy for her. However, the Committee wondered if bias may have impacted the caseworker's assessment of the mother because of her compliance and generally positive reception of the caseworker's interactions.

The Committee discussed various aspects of the assessment process related to the mother, father, and children. The father's voice was not included in the assessment and may have been beneficial in gathering historical information about the family functioning and possible paternal support that could have been offered to the mother and children. The Committee emphasized the importance of spending equivalent time assessing mothers and fathers.

The Committee pointed out areas of additional information gathering related to the mother and her functioning that it may have been beneficial to include in the assessment. Such as further exploration of her domestic violence history, which may have provided insight into why the father was not included in the assessment, further assessment of the maternal relatives and their roles, and the mother's substance use

history to include possible underlying cause for the substance use. The Committee identified that there can be barriers with information sharing between DCYF and substance use disorder agencies but believed it is also typical practice to make collateral calls to family members to verify information that parents are self-reporting. The Committee wondered if it was because the field staff did not intend to pursue a court case if some of this information gathering may have been overlooked in the assessment.

The Committee suggested that when high level needs exist for a family, such as housing, that it can be difficult to focus on other domains, such as mental health and other well-being needs of a family. The Committee pointed out that many plans were developed throughout this case but saw limited evidence of follow-through or demonstrated progress prior to case closure. The mother needed ongoing support to assist with the family's need for stable housing and her ongoing recovery services (SUD/mental health), which may have been best addressed through bringing together the family with their relative and community supports to solve problems in how to move forward.

The Committee believed that further assessment of all four of the children's needs was warranted to determine what developmentally appropriate services and supports could be offered, with prioritization on medical care for all the children. The Committee recognized that accessing medical care can be difficult due to systemic challenges but believed there should have been additional emphasis on P.J. receiving timely medical follow-up given that RCW 74. was a prenatally exposed, prematurely born infant. The Committee appreciated that the agency supported the mother's wish to have P.J. and two of RCW 74. older siblings receive medical care with the same provider but acknowledged the barriers and delays this may have created in accessing care for all the children. The Committee believed that DCYF was in possession of information about P.J.'s oldest sibling's needs but felt this may have been overlooked given that they were not able to see the youth in person prior to the case closure and due to the mother's presentation, that she was handling the youth's needs.

While the Committee addressed many different systemic challenges through the discussion, they strongly emphasized the importance of field staff understanding historical trauma, the mistrust it can create within systems, and how trauma impacts executive functioning and manifests behaviorally. The Committee wondered if the agency's prioritization of tasks may lead to overlooking individual's trauma impacts which could provide a more comprehensive understanding of their actions and behaviors. Lastly, the Committee pointed out the importance of field staff having access to resources and training related to the vicarious trauma they may experience in their work, so they have the tools to understand and address this.