CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

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Nondiscrimination Policy

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.B.

Date of Child's Birth

- RCW 74.13.5 2023

Date of Fatality

- August 26, 2023

Child Fatality Review Date

- October 12, 2023

Committee Members

- Cristina Limpens, MSW, Senior Ombuds, Office of the Family and Children's Ombuds
- Jasmine Hodges, MA, Child Safety Program Manager, Department of Children, Youth, and Families
- Melissa Wood, MS, BCBA, Adults with Disabilities Program Manager, Department of Children, Youth, and Families
- Lori Vanderburg, LMFT, Executive Director, Dawson Place Child Advocacy Center
- Wendy Burchill, Healthy Communities Specialist & Child Fatality Review Coordinator, Snohomish County Health Department

Facilitator

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

Executive Summary

On October 12, 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 L.B. and RCW 74. family. L.B. is referenced by RCW 74. initials throughout this report.[2]

On August 27, 2023, DCYF was notified by law enforcement that L.B. died on August 26. The officer said L.B.'s two older siblings were placed in protective custody following the arrest of their mother and father due to probable cause in the death of L.B. The law enforcement report alleged the father admitted to pushing L.B.'s face into the mattress to get RCW 74. to stop crying. The mother was reportedly present at the time this occurred. The parents called emergency services when they saw L.B.'s face was discolored, and RCW 74. body was cold. At the time of this report DCYF has not received a copy of L.B.'s autopsy.

L.B.'s family had prior involvement with Child Protective Services (CPS). The most recent case was closed in June 2023. A new CPS case was assigned to investigate the circumstances surrounding L.B.'s 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 had no prior direct involvement with L.B. 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 field staff who were involved with supporting the family.

Case Overview

Prior to L.B.'s death, DCYF received six calls reporting concerns of negligent treatment of the family's three children. Three reports led to two CPS-Family Assessment Response[3] (CPS-FAR) cases and one CPS risk-only[4] investigation. Three calls did not report an allegation of abuse or neglect, or the allegation had previously

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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] L.B.'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.

[4] 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.

been reported and did not require DCYF intervention. A summary of the allegations includes lack of medical follow-up for the children, unmet developmental needs, and lack of prenatal care and resources to care for the newborn (L.B.). Each case concluded with the family being referred to community-based services.

In January 2021, a CPS-FAR case was assigned due to a report RCW 13.50.100

Through the CPS-FAR assessment the caseworker spoke to the referrer, the mother, the father; observed both children; and made health contacts. RCW 13.50.100 The caseworker provided household goods to assist the family in creating a child-safe environment in the home and supplies for the newborn. The caseworker provided the family with a community-based resource list. The children were assessed as safe. In March 2021, the case was submitted for closure.

In July 2021, a CPS-FAR case was assigned due to a report RCW 13.50.100

The caseworker made immediate contact with the family in July and observed both children, documenting no concerns RCW 13.50.100 From August through December, the caseworker attempted to contact the parents by phone, letter, and unannounced visits to the home to schedule interviews. The caseworker referred the case to parent locator services in effort to locate current contact information for the family. In December, the mother contacted the caseworker, and the mother and father agreed to complete a phone interview with the caseworker. RCW 13.50.100 The children were assessed as safe in their parents' care and the CPS-FAR case was submitted for closure in December 2021.

In April 2023, a CPS risk-only investigation was assigned following a report from a hospital professional about the birth of L.B. The referrer reported the mother had limited prenatal care, was not following hospital directives about Safe Sleep[5] by covering the infant's face with blankets, and had provided conflicting information about what resources she had to provide a safe sleep environment for the infant at home. It was reported the mother had a history of RCW 74.13.520 An additional intake was received reporting the family did not have an infant car seat,

[5]For information about Safe Sleep, see: https://safetosleep.nichd.nih.gov/safesleepbasics/about. Last accessed on October 19, 2023.

the family car cannot accommodate car seats for all three children, and that the family needed help addressing barriers to getting L.B. to RCW 74. newborn check-up.

An afterhours caseworker attempted to contact the family at the hospital but did not make contact because the family was in the process of discharging. The caseworker went to the family's home but was not able to enter the locked building and was not able to reach the family by phone. A second afterhours caseworker went to the home and was able to gain access to the apartment building. The caseworker completed an initial face-to-face meeting with the parents and children. The caseworker reviewed Safe Sleep and provided information about Period of Purple Crying.[6] The mother denied the allegations reported by the referrer. The family said they had a pack and play but it was not set up. The caseworker assisted the father in reading the directions and putting the pack and play together prior to leaving the home. The mother reported Native Ancestry and this information was recorded.

During the CPS investigation, the assigned caseworker made health contacts, contacted the parents, and attempted to contact a family member. The caseworker completed a referral for an infant car seat and infant supplies, which were provided to the family. A Native American Inquiry Referral[7] (NAIR) was submitted to confirm the mother's Native Ancestry. At the time of case closure, three tribes had responded indicating no tribal involvement, and one tribe had not responded.

The caseworker spoke with the father who reported feeling the hospital was biased against him and the mother because they are not married. L.B.'s newborn check-up was missed, but rescheduled and the caseworker was able to verify that L.B. was seen by a medical professional with no concerns noted. The family declined services offered by DCYF. The CPS risk-only investigation concluded with the children assessed as safe. The family was provided suggestions for community-based resources. The case was closed in June 2023.

In August 2023, DCYF was notified that L.B. had died and that RCW 74. parents were arrested with pending charges of Murder in the Second Degree. A new CPS investigation was assigned and RCW 74.13.515 were placed in out-of-home care with on-going services offered to the family through Child Welfare Family Services[8] (CFWS).

Committee Discussion

The Committee had the opportunity to speak with field staff who worked directly with the family in the 2023 case. The discussion with the field staff allowed the Committee to inquire about case-specific details in addition to learning more about the field staff's experiences providing child welfare services to families. The Committee discussion focused on strategizing how to provide additional resources and support to field staff who are directly serving children and families.

Through its review, the Committee identified positive aspects of the work, such as how in each of the three cases the caseworkers consistently did a good job educating the family about Safe Sleep and Period of Purple

[6]For information about Period of PURPLE Crying, see: https://dontshake.org/purple-crying. Last accessed on October 19, 2023.

[7]For information about Native American Inquiry Referral, see: https://www.dcyf.wa.gov/indian-child-welfare-policies-and-procedures/3-inquiry-and-verification-childs-indian-status.

[8]Child and Family Welfare Services (CFWS) caseworkers assume responsibility of a child welfare case after a dependency petition has been filed with the court.

Crying. The Committee also pointed out strong documentation, specifically in the first CPS-FAR case that provided a comprehensive overview of the family. The Committee was impressed with the reflections the field staff shared about their work and believed that these types of reflective processes promote good practice.

The Committee discussion focused on how to ensure field staff have the resources they need to assess and meet the needs of the families they serve. The Committee felt strongly that the agency needs to prioritize increasing system support available to field staff. One example discussed was additional resources and guidance needed for supporting parents with suspected or identified disabilities. The Committee discussed that despite three DCYF cases with the family it was still unclear if the mother had an unmet need regarding a suspected cognitive disability. The 2021 M.A.S.C. decision[9] outlined the agency's requirement to investigate if there is a suspicion or known disability. It was noted by the Committee that there is not specific guidance for child welfare field staff on how to investigate, respond, and offer services to an individual if they have a suspected disability. However, DCYF does have an administrative policy (6.03)[10] which outlines how DCYF staff are to provide equal access to individuals with disabilities. The Adults with Disabilities Program Manager shared with the Committee what she is currently doing to expand opportunities for field staff to receive case consultation and guidance through DCYF's Americans with Disabilities Act (ADA) Accessibility Program.[11] The Committee encouraged the agency to provide messaging to field staff about the Adults with Disabilities Program Manager's role and the supports they can offer. Also, the Committee suggested it may be beneficial to develop a tip sheet for field staff on working with parents who have suspected or diagnosed disabilities.

Another suggested resource for field staff was to have (consistent) access to an assessment tool which assesses parent-child interactions, such as the Parent-Child Interaction (PCI) Feeding and Teaching Scale.[12] The Committee believed this would be beneficial in identifying needs and helping guide service provision offered by the agency. However, the Committee recognized potential barriers to system-wide implementation of a new tool. One Committee member pointed out that consideration of the type of assessment tool used would be important to ensure that it does not only consider normative parent interactions.

The Committee also spoke about the assessment of safety and risk and the recent change in the law due to the implementation of the Keeping Families Together Act (House Bill 1227).[13] The Committee agreed the assessment of safety was correct for this family and did not identify that court intervention should have been requested. However, the Committee did speculate if requesting court intervention with the children remaining in their parent's home may increase the opportunity for a family to participate and engage with services.

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[9]For information about M.A.S.C., see: https://law.justia.com/cases/washington/supreme-court/2021/98905-2.html. Last accessed on November 21, 2023.

[10]For information about Administrative Policy 6.03, see: chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/http://intranet.dcyf.wa.gov:8090/drupal-8.4.0/sites/default/files/Admin-6.03.pdf.

[11]For information about DCYF's ADA Accessibility Program, see: https://www.dcyf.wa.gov/ada.

[12]For information about Parent-Child Interaction (PCI) Feeding and Teaching Scales, see: https://www.pcrprograms.org/parent-child-interaction-pci-feeding-teaching-scales/. Last accessed on October 19, 2023.

[13]For information about House Bill 1227 Keeping Families Together Act, see: https://www.wacita.org/hb-1227-keeping-families-together-act/#:~:text=HB%201227%20requires%20that%20courts,relatives%20and%20suitable%20other%20persons. Last accessed on October 19, 2023.

The Committee discussed the role and responsibility of DCYF and the use of community pathways to support families. A Committee member pointed out that DCYF's initial notification of this family screened out because the report did not allege child abuse or neglect. Although the Committee was aware this family had been previously connected to beneficial community-based services in their area prior to agency involvement, the Committee discussed ideas on how to prevent families from further interacting with the child welfare system. The Committee questioned whether the child welfare pathway should be necessary to help connect families to needed services and supports. It was suggested that the agency consider developing a plan to connect families with screened-out intakes to community navigators who would assist in connecting the family to supports and services with a goal of preventing further interaction with the child welfare system.

Although the Committee highlighted the value in resourcing field staff with the tools needed to do their job, they also talked about the system demand mismatch that exists with current workload expectations. The Committee learned from the field staff about the staff shortages they experienced during the last year leading to increased caseload size. The field staff shared about the emphasis on engaging with families to best meet their needs and how this work takes time. The Committee discussed how in this case, the family appeared reluctant to engage, and did not accept the offered services. The Committee speculated if engagement with families may increase if caseworkers had more time to spend getting to know families and building a relationship where they may be able to effectively gather information to identify needs.

Recommendations

The Committee's recommendations below come from a comprehensive review and discussion of the many aspects of the case. The recommendations and corresponding discussion were unrelated to the death of L.B.

1. DCYF should consider developing a child welfare policy providing guidance for field staff on how to investigate, respond, and provide services if a parent has a suspected or diagnosed disability.
2. DCYF should consider partnership with a community-based agency (or agencies) to respond to screen-out intakes by connecting families with appropriate community-based resources to help prevent further involvement with the child welfare system.