CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

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Full Report

Child

- J.S.R.

Date of Child's Birth

- RCW 74.13.515 2022

Date of Fatality

- January 24, 2023

Child Fatality Review Date

- March 20, 2023

Committee Members

- Deborah Lurie, JD, Ombuds, Office of the Family and Children's Ombuds
- Nancy Kucklick, Quality Practice Specialist, Department of Children, Youth, and Families
- Arthur Fernandez-Scarberry, Program Manager, Department of Children, Youth, and Families
- Daniel Rivera, Clinical Supervisor, Level II, Catholic Community Services

Facilitator

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

Finalized Date: May 4, 2023
Approved for distribution by Paul Smith, Critical Incident Supervisor

Executive Summary

On March 20, 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 J.S.R. and RCW 74. family. J.S.R. will be referenced by RCW 74. initials throughout this report.[2]

On January 24, 2023, law enforcement and the medical examiner notified DCYF that J.S.R. passed away. It was reported that the mother was intoxicated and bed sharing with five-week-old J.S.R. The mother said she drank eight beers before going to sleep, while the father said she drank more like 18 to 20 beers. The father said at 4:00 a.m., J.S.R. was asleep on RCW 74.1 back. When the mother woke at 9:45 a.m., J.S.R. was on RCW 74. stomach and was not breathing. The father started CPR while waiting for emergency services. J.S.R. was pronounced dead at the scene.

At the time of J.S.R.'s death, the family had an open Child Protective Services (CPS) investigation. DCYF assigned an additional CPS investigation to investigate the circumstances related to J.S.R.'s death. Law enforcement also opened a case.

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. On the day of the review, a Domestic Violence (DV) expert had an unexpected conflict and was not able to participate with the review as planned. Committee members had no prior direct involvement with J.S.R. 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 J.S.R.'s birth, DCYF received three intakes reporting concerns for the welfare of J.S.R.'s older sibling, RCW 74.13.515 who was approximately two months old at the time. The concerns alleged the mother was using alcohol to the point of intoxication, DV in the home, and neglect of the RCW 74.13.515 In October 2021, DCYF assigned a CPS investigation.

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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] J.S.R.'s name is not used in this report because his/her name is subject to privacy laws. See RCW 74.13.500.

DCYF made approximately 17 unsuccessful in-person attempts to locate the family and made multiple contacts by phone, including collateral contacts. Approximately two weeks later, in November 2021, the CPS caseworker made initial contact with the father and RCW 74.13.515 The caseworker had the opportunity to speak with the father and mother, and observed RCW 74.13.515 The caseworker discussed Safe Sleep[3] and Period of Purple Crying.[4] The caseworker spoke with the father about the allegations of excessive alcohol use and DV. The father said he and the mother both drank alcohol, but said the mother had not drank in three weeks. He said there was one altercation three weeks ago when she was intoxicated, and he left the home with RCW 74.13.515 in response. The caseworker scheduled a time for a follow-up appointment.

An additional face-to-face visit occurred with the family in their home the following week. The caseworker spoke with each parent about DV. The mother denied DV. The father said the mother was physical with him one time before. The father said he was not concerned about ongoing DV. The father said he had support from both sides of the family.

The caseworker requested and reviewed law enforcement reports and medical records for RCW 74.13.515 An early learning staffing was facilitated by the Child Welfare Early Learning Navigator[5] (CWELN), who spoke with the father about early learning opportunities for RCW 74.13.515 Resources were provided to the father via email and a phone message was left for the mother discussing the resources.

In December 2021, the caseworker attempted a health and safety visit at the family's home and also at the address of the father's brother, where the father said he often went with RCW 74.13.515 There were no responses at either address.

In January 2022, the caseworker made additional attempts to complete a health and safety visit. The caseworker received a call from the mother, who said the father and RCW 74.13.515 were at the paternal grandmother's home and that the caseworker could visit them there. The caseworker discussed the infant's development, spoke with the father about Safe Sleep and the Period of Purple Crying again, and observed the infant's sleep environment.

A monthly supervisor review took place documenting next steps, which included completion of the investigative assessment and sending the father community-based resources such as legal resources and a local program supporting fathers.

In February 2022, CPS completed the investigative assessment. RCW 74.13.515 was in the care of the father, who was residing in a separate home following his separation from the mother. The father was identified as a protective parent with familial support. The mother was assigned a founded finding of negligent treatment of RCW 74.13.515 The case was submitted for closure.

On December 30, 2022, DCYF received a report from the father with concerns that the mother was not meeting the basic needs of RCW 74.13.515 and newborn, J.S.R., and had been physically rough with RCW 74.13.515 The father

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[3]For information about Safe Sleep, see: https://safetosleep.nichd.nih.gov/safesleepbasics/about. Last accessed on March 23, 2023.

[4]For information about Period of Purple Crying, see: http://www.purplecrying.info/what-is-the-period-of-purple-crying.php. Last accessed on March 23, 2023.

[5]For information on Child Welfare Early Learning Navigators (CWELN), see: https://www.dcyf.wa.gov/news/child-welfare-early-learning-navigators.

said the mother was drinking to intoxication and breastfeeding J.S.R., and had drank throughout the pregnancy. He said she was bedsharing with the newborn and refused to use the crib or swing. The intake caseworker asked if the mother was left alone with the children, and the father said she was when she "chases him out of the apartment." The intake caseworker attempted to get additional details, but it was documented that both children were crying and that the caseworker was not able to obtain additional details about the frequency and duration of the father being out of the home. A CPS investigation was assigned.

The CPS caseworker made two attempts to complete an initial face-to-face visit at two different known addresses for the family. There was no response at either address.

On January 3, 2023, the caseworker conducted an initial face-to-face visit with J.S.R. at the family's home. The caseworker was also able to observe J.S.R.'s older sibling during the visit and spoke with both parents. The father expressed his concerns about the mother's drinking and said she bedshared with J.S.R. The father said the mother would drink throughout the day and usually drank 18 beers daily. The father said that he was currently unemployed and had a work-related injury that prevented him from moving around the house. The father denied the caseworker's offer for services and daycare referral, but agreed to accept a pack and play for J.S.R. to sleep in.

The mother told the caseworker that she was on leave from her job. The mother denied a history of substance abuse when the caseworker discussed the allegations with [RCW 74.13] The caseworker asked if the mother was willing to complete a substance use disorder (SUD) assessment, but she declined. She also declined to provide a urinaylsis. She declined other services offered by DCYF, but did agree to accept a pack and play. The caseworker spoke with the mother about Safe Sleep and the Period of Purple Crying.

The caseworker delivered a pack and play to the family later that afternoon. The following day, the father texted the caseworker pictures of J.S.R. sleeping in the pack and play.

On January 5, 2023, a monthly supervisor review took place. Tasks to be completed were recorded as: request medical records for the children, complete background checks for the parents, safety assessment, Structured Decision Making Risk Assessment®,[6] present danger assessment, and an early learning staffing.

On January 12, 2023, an early learning staffing was held to discuss resources available to the family. An Early Support for Infants and Toddlers[7] referral was completed.

On January 24, 2023, law enforcement and the medical examiner's office notified DCYF that J.S.R. had passed away. It was reported that [RCW 74.13] had been bedsharing with [RCW 74.13] mother. The mother admitted to drinking alcohol prior to going to sleep. At the time of this report, there was an ongoing CPS investigation into the circumstances surrounding J.S.R.'s death.

[6]For more information about Structured Decision Making Risk Assessment®, see: https://www.dcyf.wa.gov/policies-and-procedures/2541-structured-decision-making-risk-assessmentrsdmra.

[7]For more information on DCYF's Early Support for Infants and Toddlers Program, see: https://www.dcyf.wa.gov/sites/default/files/pdf/ESIT-policies-procedures.pdf.

Committee Discussion

The Committee identified positive efforts made by DCYF staff who worked with this family. For example, the Committee noted that in the first CPS case, the CPS supervisor gave clear clinical direction, the field staff made diligent efforts to locate the family, a field staff member spoke directly with the mother about a relapse prevention plan and encouraged the family to utilize their natural supports, and efforts to educate the parents about Safe Sleep were documented throughout the life of the case. With the recent case, the Committee commended the caseworker on addressing the family's immediate need to have a safe sleep environment for J.S.R. by returning to the family's home with a pack and play the same day as the initial face-to-face meeting.

The Committee heard from the field staff most recently assigned to work with this family about the hardships their office has faced regarding the workforce. For example, the CPS program has been operating with an approximately 50% vacancy rate. It was shared that the vacancies remain challenging to fill due to a lack of applicants and/or qualified candidates, despite continual efforts to recruit and hire new staff. The Committee spoke about how workforce challenges such as these pose obstacles to field staff. One Committee member vocalized that systemic change is needed at a statewide level to provide appropriate compensation to professionalize this work and demonstrate value to the agency's employees. The Committee acknowledged that this systemic change may be beyond DCYF and would likely require support at the legislative level.

The Committee also discussed the high caseloads reported by the field office, which impacted new employees, such as the most recent caseworker assigned to work with the family. The field staff shared how new employees are not being afforded a capped or limited caseload following regional core training (RCT), which is recommended to allow the caseworker to build capacity to carry a full caseload. Rather, new employees are being assigned full caseloads immediately due to need. The Committee empathized with the challenge of a new caseworker being assigned a high caseload when they are still in the learning phase of their career, knowing that it can be challenging for even a seasoned caseworker to manage a high caseload.

One particular aspect the Committee considered that may be impacted by high caseload size is reviewing prior case history. The Committee spoke with the field staff about their typical practice in reviewing prior history. Field staff acknowledged that reviewing prior case history was best practice, but said there was often limited time to do so before attempting initial contact with a family. The field staff said the priority was seeing the child and family in person. The assigned caseworker said they did not review the case history prior to their initial contact with the family. The Committee wondered if the caseworker reviewing the case history would have led to a different response when interacting and assessing the family. The Committee identified the lack of knowledge related to the family's prior CPS history as a potential disconnect in completing a thorough assessment of the family's current needs and in assessing child safety.

Based on the conversation about the importance of reviewing CPS case history, the Committee suggested that DCYF create a means for caseworkers to more quickly access pertinent information that may enhance their knowledge and help determine an appropriate course of action. The Committee believed it could be beneficial if intakes were completed in a uniform manner that would include bullet points or checkboxes identifying the present safety concerns, in addition to providing a narrative. The Committee also discussed that it would be

beneficial if, within the intake, caseworkers could link to historical case history for a family, including information about prior case outcomes and services offered through other interventions.

The Committee believed that both the mother and father had unaddressed behavioral health needs that may have warranted further intervention. The father was identified as a protective factor because he called in an intake reporting the concerns about the mother. The Committee speculated that the father may have felt powerless to change the situation and was reaching out to DCYF for assistance, which led to the Committee wondering about his capacity to be protective.

The Committee's SUD expert identified that the mother may have had an undiagnosed alcohol use disorder. The Committee discussed cases involving a parent using alcohol, a legal substance, versus an illegal substance and wondered if bias may have impacted critical thinking about the mother's substance use. The mother declined participation with SUD services, and the Committee considered alternatives for how DCYF may have responded to this. The Committee agreed that it may have been beneficial to facilitate a family team decision making meeting[8] (FTDM). An FTDM may have provided an opportunity for the family and agency to come together to address the concerns, create a support plan for the parents, and address the safety and well-being needs of the children.

Recommendations

The Committee's recommendations come from a comprehensive review and discussion of the many aspects of the case. The recommendation and corresponding discussion were unrelated to the death of J.S.R. The Committee respectfully recommended DCYF consider the following to comprehensively improve practice:

The Committee recommended that DCYF consider the following with the intent of creating a more streamlined and uniform system for caseworkers to have access to historical and current case concerns and information through the intake reporting form. It was recommended that DCYF consider the following changes to the intake reporting format:

- Checkboxes and/or bullet points that clearly articulate the reported safety threats or risk in each intake, including an opportunity for a narrative.
- Information about historical case information with the possibility of linking to prior case information and case outcomes from the intake.
- Access to a link to prior interventions and services offered to the family by the agency from the intake report.

In the absence of being able to make immediate changes to the current reporting system, the Committee respectfully recommended this be considered for future reporting systems with an interim suggestion that current intakes be recorded to include bullet points of the identified safety threat and/or risk in an easily readable format.

[8]For information on Family Team Decision Making Meetings, see: https://www.dcyf.wa.gov/1700-case-staffings/1720-family-team-decision-making-meetings.