CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

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Committee Members

- Cristina Limpens, MSW, Senior Ombudsman, Office of the Family and Children's Ombuds
- Dave Thomson, Field Administrator Section 4, Washington State Department of Corrections
- Roza Bockleman, LICSW, SUPD, CMHS, GMHS, Clinical Social worker/Therapist, MultiCare
- Sandy McCool, MSW, Quality Practice Specialist Region 4, Department of Children, Youth, and Families
- Tarassa Froberg, MSW, Statewide Child Protective Services and Family Voluntary Services Program Manager

Facilitator

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Approved for distribution by Paul Smith, Critical Incident Practice Consultant

Executive Summary

On November 17, 2022, 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.L. and RCW 74. family. RCW 74.1 will be referenced by RCW 74. initials throughout this report.

On September 19, 2022, DCYF was notified that M.L., RCW 74. sister, the children's mother, and the mother's brother were involved in a car accident. M.L. was critically injured. RCW 74.13 mother died at the scene. The uncle was uninjured and M.L.'s sister was injured by not hospitalized. On October 13, 2022, M.L. succumbed to infections related to the car accident. There was an open Child Protective Services (CPS) case at the time of the car accident.

A diverse CFR Committee (Committee) was assembled to review this case and to evaluate DCYF's service delivery to the family. The Committee included community partners and DCYF staff. Letters were sent to all possible Tribes related to this case. They were invited to have a Tribal representative participate in the review. DCYF did not receive any communication from any Tribes as a result of the letters. A DCYF Indian Child Welfare/Tribal Liaison reviewed the case and met with the Committee members. Committee members received copies of the DCYF case history including intakes, investigative assessments, assessment tools, and case notes.

The Committee did not meet with any staff during this review. The most recently assigned caseworker and supervisor were no longer employed by DCYF.

Case Overview

M.L.'s family first came to the attention of DCYF on November 26, 2018. A CPS intake was screened in, meaning it met the legal threshold for a CPS investigation, regarding allegations of neglect. It was alleged that RCW 13.50.100 . The assigned CPS caseworker went to the mother's address. No contact was made with the mother and the case note that was created did not provide details to show an assessment of child safety was conducted. No other case work was documented regarding that intake.

On April 25, 2019, DCYF received information RCW 74.13.515

[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 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 from only DCYF employees and service providers. It does not hear the points of view of the child's parents and relatives, or 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.

RCW 74.13.515 This intake was assigned for a CPS investigation to the same caseworker who was assigned the 2018 CPS investigation.

A second intake was received on April 25, 2019. RCW 74.13.515 This intake did not meet legal sufficiency and was screened out.

The assigned caseworker contacted M.L.'s mother the next day. The case note had limited information but did include that the mother denied the allegations. The caseworker also documented reaching out to the local law enforcement agency to see if they planned on pursuing criminal charges regarding the allegations. The case note states law enforcement was not pursuing criminal charges.

The caseworker's supervisor searched for records pertaining to the alleged RCW 13.50.100 She was unable to locate any such detail. Contact with the family was not again attempted until May 13, 2019. The person who answered the door said the mother was not home.

On May 14, 2019, the assessment tools utilized by CPS caseworkers were submitted for approval regarding the 2018 intake. This was approved by the supervisor. The Investigative Assessment (IA) was closed as 'unable to complete investigation, no finding.'

Regarding the April 2019 intake, the caseworker called a Department of Corrections (DOC) office to discuss one of the mother's roommates. The DOC officer stated they did not have concerns for the mother's roommate.

The caseworker received emails from the mother denying the allegations. There was a case note that the caseworker met with the mother's siblings and their father who no longer lived in the same home as M.L.'s sister or mother.

On June 19, 2019, the caseworker went to an address RCW 13.50.100 . A business card was left in the door jam.

No documented case activity occurred again until October of 2019. On October 22, 2019, the supervisor entered a supervisory case note that stated the mother became unhoused and moved in with another family with an open CPS case. There was no indication of location or the other family, nor of how that information was obtained.

The next time a case note was created was November 25, 2019. This was again a supervisory case note. No new information was provided. On December 30, 2019, another supervisory case note was entered with no new information.

On January 3, 2020, the CPS caseworker attempted contact at a mailing address for the mother. The elderly woman who answered the door said she had not seen them for a while and believed the child was living with the maternal grandmother. The caseworker then contacted the child's pediatrician. No concerns were noted

by the pediatrician. The caseworker then called the telephone number for the maternal grandmother. No return call was received.

On January 16, 2020, the supervisor completed a supervisory case note stating the case has been approved for closure as 'unable to locate.'

Then on September 8, 2022, two more intakes were received and screened out. The intakes alleged RCW 74.13.515 [redacted]

On September 10, 2022, RCW 70.02.020 [redacted]

An afterhours caseworker met with the mother at the hospital. RCW 74.13.515 [redacted]. She told the caseworker that she would not engage RCW 74.13.515 [redacted] The afterhours caseworker attempted to contact M.L.'s sister but the mother would not cooperate.

On September 12, 2022, the assigned CPS caseworker RCW 74.13.515 [redacted] observed M.L., and conducted a walk-through of the family home. She created a Plan of Safe Care[2] with the mother and included the maternal grandmother as a plan participant. The caseworker observed M.L. at the hospital and discussed the case with hospital staff. RCW 74.13.515 [redacted]

The caseworker documented that she also staffed the case for ongoing services with the plan to transfer the case to Family Voluntary Services. There was no documentation of attempts to communicate with any Tribes, no other attempts to contact family, including M.L.'s sister, grandmother or M.L.'s father, nor were any collaterals attempted prior to the critical incident on September 19, 2022.

Committee Discussion

The Committee discussed that there were multiple opportunities for DCYF to complete a comprehensive, global assessment of the family between when the case first opened in 2018 until it closed in 2020. The documented attempts at contact and information contained in the case notes and other documents related to CPS investigations did not meet the policy requirements. The investigations were closed out as 'unable to locate,' but there was not an explanation to what attempts were made to complete those investigations or to contact

[2] For more information regarding a Plan of Safe Care see: https://www.dcyf.wa.gov/1100-child-safety/1135-infant-safety-education-and-intervention

the family. Some collaterals were made but the documentation did not show the level of curiosity and critical thinking that the Committee expected. The initial face-to-face contacts by the CPS caseworkers did not gather adequate information to meet policy requirements and there was a lack of urgency.

The Committee member from the Department of Corrections (DOC) shared that collaboration with DOC is possible and helpful, and that DOC officers can go with DCYF staff to family's homes.

Other concerns identified by the Committee included late entry of case notes, investigations not completed in a timely manner, not including the fathers in the investigations, and during the 2022 case the recently screened-out intakes were not incorporated. RCW 74.13.515 [redacted]

The Indian Child Welfare Act (ICWA)[3] and the DCYF policies related to ICWA were not adhered to either[4]. Not only is there a legal requirement to following the policies related to ICWA but often times those tribal connections help to support struggling families. In this particular case, DCYF was aware that the mother had previously accessed RCW 74.13.515 services through local tribes.

DCYF received two screened out intakes just prior to the birth of M.L. Those intakes alleged RCW 74.13.515 [redacted] They did not meet the legal threshold to screen in for an investigation or assessment but they should have been incorporated into the September 2022 investigation. There were no attempts to see M.L. at [redacted] home after [redacted] was discharged, and prior to the critical incident. Even though there was a short period of time between M.L.'s birth and the critical incident, this was concerning to the Committee members because of RCW 74.13.515 [redacted] and a lack of assessment of the persons living in the family home.

During the September 2022 investigation the mother shared RCW 74.13.515 [redacted] However, there was not a sense of urgency regarding the need for supports and assessment by DCYF regarding the mother's RCW 74.13.515

M.L.'s mother was also very clear that she would not practice safe sleep and planned on bedsharing with her newborn daughter. The mother provided differing details regarding her RCW 74.13.515 [redacted] raised concerns for the Committee regarding her ability to maintain safety for her children.

[3] To learn more about ICWA see: https://www.bia.gov/bia/ois/dhs/icwa

[4] To learn more about DCYF policies related to ICWA see: https://www.dcyf.wa.gov/indian-child-welfare-policies-and-procedures

Recommendations

The Committee made recommendations pertaining to aspects discussed in this review. There is no direct correlation between the recommendations and the fatal event. The purpose of the recommendations is to help DCYF improve their case procedures and practices.

DCYF should work with the Substance Use Program Manager to discuss a way to help support staff in creating plans for families experiencing substance use. This is not a safety plan but rather a harm reduction plan for parents who are continuing to use while caring for their children.