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

- K.F.P.

Date of Child's Birth

- [redacted] 2019

Date of Fatality

- November 4, 2022

Child Fatality Review Date

- February 9, 2023

Committee Members

- Cristina Limpens, MSW, Senior Ombuds, Office of the Family and Children's Ombuds
- Rachelle St. Peter, MSW, Supervisor, Department of Children, Youth, and Families
- Kari Jellison, Quality Practice Specialist, Department of Children, Youth, and Families
- Betsy Ward, Clinical Program Manager, King County Parent Child Assistance Program
- Michelle Hedges, MSW, Critical Incident Review Specialist, Department of Children, Youth, and Families

Facilitator

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Finalized Date: May 23, 2023
Approved for distribution by Paul Smith, Critical Incident Practice Consultant

Executive Summary

On February 9, 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 K.F.P. and RCW 74. family. K.F.P. will be referenced by RCW 74. initials throughout this report.[2]

On November 4, 2022, DCYF was contacted by law enforcement and the medical examiner to report the death of K.F.P. RCW 74. cause of death was initially unknown, and no obvious trauma was observed. Law enforcement reported finding drug paraphernalia throughout the K.F.P.'s home, including Fentanyl pills. The condition of the home was considered "hazardous," and law enforcement placed K.F.P.'s surviving siblings into protective custody. On November 7, 2022, K.F.P.'s toxicology report returned positive for Fentanyl.

K.F.P. and RCW 74. family had been involved with DCYF in the prior 12 months through an open Child Family Welfare Services (CFWS) case involving RCW 74. older half-sibling and a Child Protective Services (CPS) investigation. DCYF closed the family's case on November 3, 2022, and was notified of K.F.P.'s death the following day. K.F.P.'s death generated a new CPS investigation.

A diverse 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 K.F.P. 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 supported the family.

Case Overview

In August 2018, the family came to DCYF's attention RCW 74.13.520 A CPS investigation took place, and the case transitioned to Family Voluntary Services (FVS)[3] for ongoing support and service provision. The mother participated in a substance use disorder (SUD) evaluation and urinalysis testing and completed an intensive outpatient SUD treatment program. The family was also referred to a Public Health Nurse.

In March 2019, the FVS case was submitted for closure after the mother successfully completed her recommended services. In August 2019, the family became involved with DCYF again after the birth of K.F.P. 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]K.F.P.'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 Family Voluntary Services (FVS), see: https://www.dcyf.wa.gov/policies-and-procedures/3000-family-voluntary-services-fvs.

CPS investigation was assigned due to the mother and K.F.P. testing positive for opiates at birth. A family team decision-making meeting (FTDM)[4] was held. DCYF filed a dependency petition requesting out-of-home care for K.F.P., RCW 74. older sibling, and RCW 74. older half-sibling due to ongoing concerns about substance use impacting parental abilities.

During a September 2019 court hearing, RCW 13.50.100 K.F.P. and RCW 74. older sibling were placed in the care of their father, who was residing with the maternal relative. The mother was court-ordered to participate in a SUD evaluation. The case was transferred to CFWS for ongoing service provision and monitoring.

In November 2019, the court dismissed the dependency case for K.F.P. and RCW 74. older sibling. The children remained in the care of their father, who was determined to be a protective parent. K.F.P., RCW 74. older sibling, and the father remained living with the maternal relative. RCW 13.50.100 RCW 13.50.100 DCYF made efforts to locate K.F.P.'s older half-sibling's father and attempted to engage the mother with her court-ordered services. The mother was allowed to have liberal visitation with K.F.P.'s older half-sibling in the relative caregiver's home.

In 2020, RCW 13.50.100 The mother completed a SUD evaluation and Family Preservation Services (FPS). The mother was not participating in the court-ordered urinalysis testing. DCYF facilitated shared planning meetings to address the family's identified needs and to discuss case planning. No new intakes were received in 2020.

In 2021, five shared planning meetings were held to discuss the mother's court-ordered services and lack of compliance with urinalysis testing. K.F.P.'s father had also been asked to complete a urinalysis test, which he did not comply with. In March 2021, DCYF received a report stating the mother was still struggling with substance use and was now allowed overnight visits in the relative caregiver's home with all three children. The caller reported that the grandmother was the caregiver for the children and had a memory problem that impacted her getting them to their appointments. A CPS investigation was assigned and concluded with an unfounded finding.[5]

In 2022, DCYF continued to monitor the case involving RCW 13.50.100 the mother's court-ordered services. There were continued concerns about the mother's non-compliance and lack of demonstrated progress with regard to her completing urinalysis testing. DCYF held an internal staffing to review the case and RCW 74.13.515, RCW 13.50.100 RCW 13.50.100 Multiple shared planning meetings were held throughout the year to address the needs of the family. There were identified concerns that the father of K.F.P. was refusing DCYF's request to complete a background check and an

[4]For information about the family team decision making (FTDM) meetings process, see: https://www.dcyf.wa.gov/1700-case-staffings/1720-family-team-decision-making-meetings.

[5]RCW 26.44.020(29) defines "unfounded" as follows: "the determination following an investigation by the department that available information indicates that, more likely than not, child abuse or neglect did not occur, or that there is insufficient evidence for the department to determine whether the alleged child abuse did or did not occur."

updated urinalysis test. K.F.P.'s father reported this was due to not having government-issued identification. DCYF field staff attempted to assist the father in obtaining identification, but he was not successful in doing so. There were reported concerns that the mother was residing in the home with the maternal relative and K.F.P.'s father.

In June 2022, DCYF received a report RCW 13.50.100 The referrer, RCW 13.50.100(7)(c) RCW 13 50.100(7)(c) learned the relative caregiver had moved to an adult family home due to health concerns. A CPS investigation was assigned. The CFWS and CPS caseworker attempted to contact the family, but initially, the family was not responsive to the attempts. The CPS caseworker completed an initial face-to-face visit with all three children. It was noted that they could not complete a full interview due to K.F.P. and RCW 74. older sibling's ages. Based on the family's joint CPS and CFWS assessment, no active safety threat was identified. RCW 13.50.100 RCW 13.50.100

Over the next four months, DCYF continued to monitor the family and complete health and safety visits. No new concerns arose during that time. DCYF continued to attempt to engage the mother with completing urinalysis testing, but she did not comply.

On October 18, 2022, the DCYF caseworker and a caseworker intern completed the last health and safety visit with the family in the home. The caseworker noted that the room where the family slept was "disorganized and dirty" and that a cockroach was observed on a kitchen wall. During the visit, the mother fed the children and told the caseworker she had placed a grocery delivery order. The mother confirmed a plan to enroll all three children in a nearby daycare program.

On October 21, 2022, a shared planning meeting was held to discuss next steps. DCYF asked the mother to complete one urinalysis test prior to case closure. No active safety threats had been identified and it was noted that the case was at the sixth-month marker for monitoring. On October 26, 2022, a final supervisor review took place identifying the case would be recommended for closure. The mother was requested to complete a urinalysis test by October 28, which she did not complete. RCW 13.50.100 RCW 13.50.100

On November 4, 2022, DCYF was notified that K.F.P. had died. An initial cause of death was unknown, but it was suspected that RCW 74. ingested a harmful substance. On November 7, 2022, the toxicology testing for K.F.P. returned positive for Fentanyl. The CPS investigation of K.F.P.'s death concluded with the mother and father being assigned founded findings[6] for negligent treatment of K.F.P. and RCW 74. siblings.

Committee Discussion

The Committee identified many positive aspects of the casework and ongoing efforts to engage the family. The Committee was impressed with the supervisors' longevity in their roles and in providing support to this family. The Committee noted how consistency in field staff can improve continuity of care offered to a family. The Committee identified persistence as a strength of the casework, which was observed through continued

[6]RCW 26.44.020(14) defines "founded" as follows: "the determination following an investigation by the department that, based on available information, it is more likely than not that child abuse or neglect did occur."

efforts to engage the mother and to locate and engage K.F.P.'s older half-sibling's father throughout the duration of the case. The Committee also noted frequent use of shared decision meetings in this case, including an internal DCYF staffing, to help address barriers with the case moving forward. Overall, it was noted that appropriate collateral contacts were made and the documentation was detailed and reflective of DCYF's efforts with the family.

The Committee discussed what they learned about the mother's history of substance use and how DCYF utilized that information to assess her parental capacity. The Committee understood the decision-making utilized by the field office to move forward with case closure but still felt as if they had some unanswered questions about the mother, given her lack of compliance with the court-ordered urinalysis testing. The Committee appreciated the field office's diligence in addressing the mother's reported barriers to completing a urinalysis test by offering her rides, offering bus tickets, and changing the urinalysis testing sites to reduce transportation barriers.

The Committee learned additional information through conversation with field staff that this county is well-resourced and has access to multiple sites to complete urinalysis testing. The Committee asked if this office utilizes oral fluid testing to complete toxicology testing. This field office said that a staff member had been assigned to help create access in their office, but oral fluid testing had not yet become a regular practice. The DCYF Committee members indicated that the current training required for use of oral fluid testing is lengthy, which may be a barrier to field offices utilizing this resource. The Committee wondered if it may be helpful to have current field offices using oral fluid testing as regular practice offer support and mentorship to DCYF offices newly utilizing this resource. The Committee believed that utilizing oral fluid testing may reduce barriers to an individual completing a toxicology test. The Committee acknowledged that had oral fluid testing has been offered to the parents, they may have declined to participate.

The Committee also appreciated that the caseworker completed thorough home checks, including asking where marijuana was stored and confirming that K.F.P.'s father had a lockbox. After K.F.P.'s death, DCYF learned that the family had Narcan in their home, but given that they did not attempt to use it when K.F.P. was found unresponsive, they wondered about their knowledge of using Narcan for young children. The Committee discussed the importance of educating families about how to access Narcan and providing resources to inform them about how and when to use it. The parents may have benefited from being provided with educational resources about Narcan and using Narcan for children.

The Committee sensed that DCYF felt their hands were tied about how they could support this family. One component of this discussion was related to the hardship the office faced with court partnership in this particular county. The field staff reported the challenge in collaborating with the court and legal partners and said they did not feel seen as child safety experts by the court. The Committee discussed how the challenging relationship with the court and legal parties might influence field staff's decision-making. The Committee learned about the shift in practice that is occurring, leading to more children remaining in their parents' care. The Committee recognized that this may lead to DCYF monitoring more high-risk cases, which may feel uncomfortable to field staff. The Committee wondered how this might impact the retention of field staff.

The Committee discussed the perceived avoidance the family demonstrated in engaging with DCYF. One Committee member identified that avoidance could be related to fear and suggested that this may lead to families being unwilling to disclose their substance use habits. The parents may have benefited from additional, straightforward conversations to address their fears in order to create an open and honest dialogue about safety planning around substance use. The Committee also discussed ideas about engaging with families who may be reluctant to participate. A Committee member suggested the idea of incentivizing parental progress, compliance, and demonstrated behavioral change and wondered if positively reinforcing a parent for their efforts may help create opportunities for engagement. The Committee brainstormed how this could work and identified that this should not be used as a way to gatekeep resources that a family may need. The Committee suggested items that may be a "want" for the family or provide enrichment to the parent or family beyond meeting basic needs.

Recommendations

The Committee's recommendations 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 K.F.P. The Committee respectfully recommended DCYF consider the following to comprehensively improve practice:

The Committee recommended that DCYF consider revising the oral fluid testing training for field staff. The Committee suggested the training be condensed in order to reduce time as a barrier for staff becoming trained. The Committee also suggested utilizing field staff who are currently using oral fluid testing as part of their regular practice to assist in mentoring field offices who are not currently using oral fluid testing.

The Committee recommended DCYF consider incentivizing parents' compliance and progress as a way to engage families and positively reinforce behavioral change. The Committee stated that there would need to be a clear boundary between concrete goods, which are items a family needs, versus an incentive. An incentive would not be tied to a basic need and would be an item a family may want. The Committee suggested field offices make incentive items readily available for the purpose of rewarding a family when a service (court ordered or voluntary) is completed or the family is meeting other milestone markers in their case plan.