CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

Washington State Department of
CHILDREN, YOUTH & FAMILIES

CONTENTS

Full Report 1
Executive Summary 2
Case Overview 2
Committee Discussion 5
Recommendations 6

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

- A.R.

Date of Child's Birth

- RCW 74.13.5 2022

Date of Fatality

- May 2023

Child Fatality Review Date

- July 19, 2023

Committee Members

- Patrick Dowd, JD, Director, Office of the Family and Children's Ombuds
- Lindsey Barcklay, MSW, LICSW, CMHS, SUDP, CCTP, Therapist and Clinical Director, Domestic Abuse Women's Network
- Luanne Marshall, Licensing and Kinship Coordinator, University of Washington Alliance CaRES
- Stephanie Frazier, Intake and Safety Administrator Region 6, Department of Children, Youth, and Families
- Alissa Copeland, MA, Early Learning Program Manager, Department of Children, Youth, and Families

Facilitator

- Libby Stewart, Critical Incident Review Specialist, Department of Children, Youth, and Families

Finalized Date: Oct. 18, 2023
Approved for distribution by Paul Smith Critical Incident Practice Consultant

Executive Summary

On July 19, 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 A.R. and RCW 74. family. A.R. will be referenced by RCW 74. initials throughout this report.[2]

On May 7, 2023, DCFY received a telephone call stating A.R. was taken to the emergency department by RCW 74. mother. A.R. was not breathing. RCW 74.1 was given epinephrine and naloxone and received 44 minutes of cardiopulmonary resuscitation. RCW 74.1 was then intubated. A.R.'s mother reported she uses fentanyl and other substances. The mother further reported her RCW 74.13.515 could have accessed those substances while the mother was sleeping. This information resulted in a Child Protective Services (CPS) investigation.

Prior to the intake on May 7, 2023, there were six previous intakes regarding allegations of abuse or neglect RCW 13.50.100 Of those six intakes, five met the legal threshold to screen-in for either a CPS investigation or Family Assessment Response (FAR). FAR is an alternative response within the CPS designation. RCW 13.50.100

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 A.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 interview DCYF staff who were assigned to the case.

Case Overview

Between 2011 and 2022, there were three intakes received regarding A.R.'s mother RCW 13.50.100 Two of the intakes were investigated by CPS and one was screened-out due to reporting historical information only. The two investigations were closed after the investigations concluded. In September 2018, the second CPS investigation ended RCW 13.50.100

On RCW 74.13.515 2022, DCYF received a telephone call from a hospital. The hospital reported A.R. was born at 32-weeks gestation and the mother did not obtain prenatal care. At A.R.'s birth, the results of the mother's drug test indicated she had methamphetamines in her system. The mother self-reported using heroin and fentanyl.

[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 of 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 only from Agency 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 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.

[2] A.R.'s name is also not used in this report because RCW name is subject to privacy laws. See RCW 74.13.500.

The hospital also reported the mother was not tending to her RCW 74.13 515 and could not stay awake to answer questions. This information screened-in for a CPS Risk Only investigation. Risk Only investigations do not have a finding associated with the allegations in the intake once the investigation has concluded.

The caseworker met with the mother at the hospital. The mother said she wanted to engage in intensive outpatient treatment RCW 74.13.520 She reported using fentanyl throughout her pregnancy. She said she previously completed inpatient treatment in Tacoma in 2017 and did follow-up outpatient treatment as well. The CPS caseworker called A.R.'s father's telephone number and left a voicemail message.

On May 10, 2022, a Zoom meeting was held with the mother and RCW 74.13 520 Hospital staff. The mother was compliant with inpatient treatment services and visiting her RCW 74.13 515 at the hospital. A discharge plan was created for the mother to leave inpatient treatment when A.R. was ready for discharge. They would move into a "highly controlled community based program" and the mother would continue with intensive outpatient treatment. They also discussed other community-based supportive services for the mother when she left inpatient treatment. The mother denied the offer for Family Voluntary Services through DCYF.

On May 18, 2022, A.R. and RCW 74. mother moved into community-based housing, and she engaged in outpatient substance use treatment services. After one month of treatment and receiving a positive report from the treatment provider regarding the mother's progress, the CPS caseworker submitted the case for closure.

On Aug. 6, 2022, less than two months after the case closed, DCYF received another intake. This intake screened-in for a CPS Risk Only investigation. The mother was alleged to have left the facility overnight and left A.R. in the care of a person identified as an inappropriate caregiver.

The mother denied these allegations. On August 7, 2022, the mother left the facility. A.R. and RCW 74. mother and moved in with the maternal grandmother. A.R.'s mother did admit to relapsing three weeks prior and that she stopped attending treatment groups. A.R.'s mother also admitted using fentanyl when she left the shelter.

A.R.'s mother stated she wanted to re-engage in treatment. She also provided an oral swab for substance testing, presented by the CPS caseworker. The caseworker sent a message to A.R.'s father through Facebook.

The caseworker referred the family for a Child Protection Team meeting (CPT).[3] The CPT recommended that A.R. stay in RCW 74. mother's care and custody; DCYF and the mother created a safety plan prioritizing infant safety, should the mother relapse; DCYF follow up with family supports to make sure they understand early detection/intervention for the mother; DCYF discuss roles and options for ensuring child safety with the family members; and DCYF encourage the family to pursue individual and family counseling to support healthy roles and boundaries within the family. The recommendations were addressed by the caseworker and the case was closed at the end of September 2022.

On Dec. 27, 2022, DCYF received a telephone call stating that A.R.'s mother was using substances again and this was observed RCW 13.50.100 This intake screened-in for a CPS/FAR assessment.

[3] "Child Protection Teams provide confidential, multi-disciplinary consultation and recommendations to the Department (DCYF) on cases where there will not be an FTDM, and there is a risk of serious or imminent harm to a young child and when there is a dispute if an out-of-home placement is appropriate." For more information about Child Protection Teams, see: https://www.dcyf.wa.gov/1700-case-staffings/1740-child-protection-teams-cpt

The assigned CPS caseworker went to the family's home. The mother and A.R. were living with the maternal grandmother, the grandmother's husband, and the mother's two older daughters. RCW 13.50.100 told the caseworker that the mother had been smoking methamphetamine and fentanyl in the home and that RCW 13.50.100 RCW 13.50.100 saw the mother's paraphernalia.

The caseworker interviewed RCW 13.50.100 RCW 13.50.100 discussed observing a negative behavioral change RCW RCW 13.50.100 and this coincided with smelling what they believed were drugs being smoked in the home. RCW 13.50 RCW 13 50.100 saw the mother smoking a substance out of an empty pen and then searched the home and found drug paraphernalia.

The mother told the caseworker that she had inpatient treatment set up in Spokane and was waiting for a bed date. The mother said she planned on taking A.R. with her to inpatient treatment. The mother provided an oral swab testing for substance use. The results, received on Jan. 11, 2023, indicated she had recently used fentanyl.

On Jan. 3, 2023, the caseworker contacted the inpatient treatment center in Spokane. She left a voicemail message. She again called on Jan. 9, 2023, and left a voicemail message. On Jan. 10, 2023, the caseworker reached an employee at the facility. They said the mother would not have a bed date until February and then stated the mother needed an updated assessment.

On Jan. 19, 2023, the caseworker contacted the grandmother. The grandmother stated her daughter left the grandmother's home on Dec. 28, 2022, the day the caseworker was last at their home. The mother took A.R. with her. The caseworker left a voicemail message on the mother's cell phone and requested a call back.

On Jan. 20, 2023, the caseworker texted the mother and requested the mother contact the caseworker. On Feb. 1, 2023, the caseworker contacted the maternal grandmother. The grandmother had not heard from her daughter since the last time the caseworker spoke with the grandmother. That same day the caseworker texted the mother again. A.R.'s mother responded stating she and the baby were safe and healthy. She said she was staying at an RCW 13.50.100 hotel and that she still planned on going to inpatient treatment. The mother said she was not using, was "on subs," meaning taking a medication-assisted treatment drug to combat her opioid addiction, and that a friend's father was paying for her hotel room. The caseworker also tried to locate A.R.'s father by searching databases available to her.

On Feb. 8, 2023, the caseworker received a telephone call from the inpatient treatment provider. They had a bed date of Feb. 15, 2023, for the mother. The caseworker texted the mother. The mother did not respond. On Feb. 15, 2023, the treatment facility verified that the mother did not check in. On March 1, 2023, the caseworker contacted the maternal grandmother. The grandmother had not heard from the mother. She agreed to attend a Family Team Decision Meeting (FTDM) on March 8, 2023. The FTDM was scheduled because of concern for imminent danger of A.R. related to RCW 74. mother's substance use. The mother did not attend the FTDM.

On May 7, 2023, A.R. was brought to the hospital by RCW 74. mother. A.R. died the next day.

Committee Discussion

The Committee discussions included both strengths observed by Committee members as well as areas that improvement could occur. Those discussions are highlighted below.

The main issue identified during this case was the mother's struggle with substance use. The Committee discussed that the intake prior to A.R.'s death included concerns for the well-being of A.R.'s siblings and grandparents living in the home while A.R.'s mother smoked fentanyl, as well as when the family members found the paraphernalia and disposed of it. There was a robust discussion about education and conversations with families when there is alleged fentanyl use and how they should protect themselves from exposure, when to seek medical care, and that staff should consider what precautions they too are taking when conducting walk-throughs of homes.

DCYF has a policy regarding when a Plan of Safe Care (POSC)[4] is necessary. Specifically on this case, the caseworker stated she did not create a POSC with the family because A.R. was not diagnosed as substance affected. The Committee discussed that a POSC may have helped support the mother in obtaining and maintaining supportive services for herself and her RCW 74.13.515 They also discussed that DCYF is conducting updated trainings regarding the POSC and clarified that a formal diagnosis is not necessary. Instead, prenatal exposure and identified symptoms of substance-affected infants should be taken into consideration.

The Committee discussed that while it may not have impacted the case, they desired more efforts to contact A.R.'s father throughout the case and A.R.'s mother during the case prior to the fatality. The caseworker was able to speak to some efforts that were not documented, but the Committee felt even more were necessary. They also identified that making contacts at possible locations where the mother was staying should not have been left to the grandmother. The grandmother did not notify the caseworker when the mother left her home during the 2023 investigation. While it was helpful that the grandmother offered to try to locate the mother, the caseworker should also have covered all the same locations.

An FTDM was held prior to closing the 2023 investigation. The Committee discussed that possibly holding an FTDM earlier, such as during the initial contact in 2023 based on the chronicity of the mother's substance use, may have been helpful. The Committee also acknowledged that it may not have stopped the mother from leaving the grandmother's home after the caseworker left.

The Committee also discussed that verification of statements made by A.R.'s mother would have been helpful, such as statements that A.R. was up to date with pediatric appointments and that the pediatrician did not have concerns. Requesting law enforcement reports regarding A.R.'s mother and father also may have been helpful. The mother also stated that her RCW 74.13.515 who lived with that RCW 74.13.515 father was not aware of A.R. and the father did not want the mother to tell RCW 74.13 Further assessment of the reasoning behind that and contact with that child's father may have been beneficial in understanding some of the dynamics at play.

The Committee discussed that at times during this case the span of supervision for supervisors was too large. When a supervisor has too many caseworkers to supervise, the effectiveness of supervision and ability to conduct clinical supervision is often decreased. This also was discussed in respect to area administrators and

---

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

their span of supervision of supervisors. Related to that discussion was one identified concern regarding closing out an investigation or assessment with items identified by supervisors and documented in supervision case notes that were left incomplete, yet the case was still closed.

Some Committee members discussed their appreciation of documentation related to identifying an unsafe sleep environment and taking actions to rectify it immediately. The Committee discussed that the mother was a victim of violence in previous relationships. This was documented in RCW 13.50.100 RCW 13.50.100 The Committee discussed that the mother may have benefited from further engagement by the caseworker and possibly assisting her with supports surrounding RCW 13.50.100 RCW 13.50.100 The lethality associated with RCW 13.50.100 is much higher and warranted follow up. Gathering history and details regarding RCW 13 is one part of the specialized assessment, but the next step to integrate that information is also necessary. The history of violence in this case was significant, and follow-up regarding supportive mental health or survivor supports may have been helpful to the mother.

Recommendations

The Committee members agree that DCYF's clients can all benefit from the Committee's efforts to provide comprehensive discussion and analysis of the case. While recommendations are made about the many aspects of this case, there is no correlation between the death of A.R. and these recommendations. The purpose of these recommendations is to help DCYF improve their case procedures and practices.

The Committee made the following recommendations:

1. DCYF should request legislative funding so that all offices have a Child Welfare Early Learning Navigator. The Committee discussed that this position has proven to be beneficial in engaging families with supportive services and resources and that may have been beneficial to A.R. and RCW 74. family. This can also help support the assigned caseworkers.

2. DCYF should create an intranet page regarding substance use disorders. The page should include links to trainings or information about how to obtain trainings regarding substance use; what to look for when doing a walk-through of a home; what to do if you encounter substances or paraphernalia and a reminder to use precautions; the opioid pamphlet (DCYF 0112), photos of paraphernalia and substances; and testing information, among other resources. In essence, this intranet page would be a one-stop-shop to aid staff who are seeking information about substance use and how that interacts with their work as a DCYF employee. Ideally, this site would be available to all DCYF staff, not just child welfare employees.

3. The Family Practice Model will include practice profiles regarding working with families experiencing substance use and one for supervising workers who are handling cases involving substance use. The Committee would like to see guidance for supervisors on when to seek out subject-matter experts and how to provide clinical supervision regarding how substance use may impact child safety.