CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

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CONTENTS

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Full Report

Child

- B.B.

Date of Child's Birth

- RCW 74.13.515 2022

Date of Fatality

- March 20, 2023

Child Fatality Review Date

- August 15, 2023

Committee Members

- Elizabeth Bokan, JD, Deputy Director, Office of the Family and Children's Ombuds
- Chris Tippett, SUDP, RTC, Clinical Director, The Center for Alcohol and Drug Treatment
- Lori Eastep, MSW, LICSW, Therapist, Grassroots Therapy Group
- Tarassa Froberg, CPS-FVS Program Manager, Department of Children, Youth, and Families
- Stacie Morales, MSW, Supervisor, Department of Children, Youth, and Families

Facilitator

- Michelle Erickson, MSW, Critical Incident Review Specialist, Department of Children, Youth, and Families

Finalized Date: March 14, 2024
Approved for distribution by Paul Smith, Critical Incident Practice Consultant

Executive Summary

On August 15, 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 B.B. and RCW 7 family. B.B. will be referenced by RCW 7 initials throughout this report.[2]

On March 20, 2023, DCYF received a report from a medical examiner that B.B.'s mother had called 911 to report B.B. was in RCW 7 crib unresponsive, with blue lips, and cold to the touch. Law enforcement found paraphernalia in the mother's room that she shared with B.B. but reported to DCYF they did not have reason to believe the mother was at fault. The report met criteria for a risk only[3] investigation. During B.B.'s autopsy a toxicology screen was completed. The toxicology report came back positive for fentanyl. B.B.'s cause of death was determined to be fentanyl poisoning. On May 31, 2023, upon completion of the medical examiner's report, a new report was made to DCYF with allegations of neglect by both of B.B.'s parents. This report met criteria for a CPS investigation and both parents received founded findings[4] in that investigation. RCW 13.50.100 RCW 13.50.100

At the time of B.B.'s death, the family had an open Child Protection Services (CPS) investigation with DCYF. A few days prior to B.B.'s death a DCYF caseworker had informed B.B.'s mother they were closing a Family Voluntary Services (FVS)[5] case with the family that had been open since January 2023.

A 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 B.B. or RCW 7 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.

[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]The names of B.B.'s parents are not used in this report because neither parent has been charged with a crime in connection with the fatality. B.B.'s name is also not used in this report because RCW name is subject to privacy laws. See RCW 74.13.500.

[3] CPS Risk Only is an intake that alleges imminent risk of serious harm and there are no allegations of child abuse or neglect. See: https://www.dcyf.wa.gov/practices-and-procedures/2200-intake-process-and-response

[4] …" Founded means: Based on the CPS investigation, available information indicates that, more likely than not, child abuse or neglect did occur as defined in WAC 388-15-009. Unfounded means: The determination following an investigation by CPS that, based on available information, it is more likely than not that child abuse or neglect did not occur or there is insufficient evidence for the department to determine whether the alleged child abuse did or did not occur as defined in WAC 388-15-009. RCW 26.44.020" See: https://www.dcyf.wa.gov/practices-and-procedures/2540-investigative-assessment .

[5] "Family Voluntary Services (FVS) allows parents to voluntarily engage in services to increase their protective capacities and meet the child's safety, health, and well-being needs." See: https://www.dcyf.wa.gov/practices-and-procedures/3000-family-voluntary-services-fvs.

Case Overview

Prior to the critical incident, DCYF received 30 reports on B.B.'s family. Of those 30 reports, 14 met criteria for CPS investigation or Family Assessment Response (FAR)[6].

The family first became involved with DCYF in 2014 RCW 13.50.100 At the close of this investigation, all allegations were determined to be unfounded. The family was involved again early the next year RCW 13.50.100 RCW 13.50.100 This investigation closed with unfounded findings as well.

The family became involved again RCW 13.50.100 in May 2016. A report met criteria for a risk only CPS investigation. RCW 70.02.020 The mother was on a Subutex program and reported she had stopped using heroin RCW 70.02.020 There were also reports that the father was using heroin. The case closed about two months later after the caseworker confirmed the mother was engaged in substance use disorder (SUD) treatment and providing urinalysis tests free of unexpected substances. The caseworker assessed the mother as having a safe place to live for her newborn. The caseworker reported the mother and father to be living separately from one another. The caseworker also referred the mother and infant to the public health nurse prior to closing the case.

The family was involved once more in 2016 RCW 13.50.100 The report met criteria for FAR services. The mother was referred for early learning resources and domestic violence resources; the father had recently gotten out of jail but was not living in the home. Additionally, the caseworker provided the mother with a pack and play sleep space as there were concerns that she was co-sleeping with RCW 13.50.10 who was still an infant. The case closed, and the family did not come back to the attention of DCYF again until 2018.

In November 2018, DCYF received a report RCW 13.50.100 The report met screening criteria for FAR services. During this involvement the assigned caseworker identified the maternal uncle was living with the family and was not a safe caregiver. The caseworker was also concerned about the hygiene of the children and the home. The mother had the maternal uncle move out of the home and successfully completed an in-home parenting program.

In 2019 and 2020, DCYF received three reports about the family that did not meet screening criteria for child abuse or neglect.

The family was not investigated again until July 2021 when DCYF received a report of lack of supervision of the children, an unsafe and unclean living environment, unsecured guns in the home, and the mother and maternal uncle using alcohol and heroin. The mother was living in a home with the maternal uncle again. An ex-girlfriend of the maternal uncle was reporting concerns. She alleged she had been a victim of domestic

[6] "Family Assessment Response (FAR) is a Child Protective Services (CPS) alternative response to an investigation of a screened-in allegation of child abuse or neglect. FAR focuses on child safety along with the integrity and preservation of the family when lower risk allegations of child maltreatment have been screened in for intervention." See: https://www.dcyf.wa.gov/practices-and-procedures/2332-child-protective-services-family-assessment-response

violence in her relationship with the maternal uncle and the mother had assaulted her as well. After two months, this investigation closed unfounded with no recommendations for services. The caseworker reported that both the mother and the maternal uncle provided urinalysis tests free of unexpected substances. The caseworker assessed the home as safe and documented the guns were locked up.

In December 2021, DCYF received three reports that met criteria for CPS investigation within six days. RCW 13.5 RCW 13.50.100 Of the allegations made in the three reports in December 2021, the mother received a founded finding for neglect for exposing RCW 13.50 to marijuana and domestic violence and leaving the children in the care of grandparents without creating a safe plan for them.

RCW 13.50.100 the mother participated in 60 days of random urinalysis testing which all returned free of unexpected substances, participated in a domestic violence support group, she followed up with referrals to get the children into counseling, and she did some parenting services. The mother lived in a housing program from April to June 2022; however, she left abruptly in June when concerns of her falling asleep and possibly using illicit substances were reported. The mother completed a urinalysis test which returned free of unexpected substances. She soon moved into housing that she had secured. The case closed in August 2022 following a visit with the family in their new housing. The case was not required to remain open for six months following the children's return home because the legal cases had never reached dependency status.

B.B. was born in RCW 13.50.100 2022 and DCYF did not receive any reports. In September 2022, DCYF received two reports regarding the older children from the school. Initially, the first report met screening criteria for CPS investigation; however, the local office utilized secondary screening authority to override this decision and did not investigate the report. This report included concerns that the older children were out of control in the school and the mother was described as "out of it" and non-responsive to the school and the children when she came to respond. The school was concerned the mother was having a mental health, medication, or substance use issue. There were two more reports in October 2022 that did not meet criteria for intervention.

In November 2022, DCYF received two reports with allegations of physical abuse RCW 13.50.100 concerns about the children's hygiene, and allegations the mother drove the children under the influence of marijuana. Both reports met CPS investigation screening criteria. The caseworker assessed the mother to need parenting assistance and the boys to have hard to manage behaviors. The caseworker started referring the family for services, which included transferring the case to the FVS pathway. In January 2023, DCYF received another report that met criteria for a CPS investigation. The report included allegations of insufficient food in the home. All allegations from November 2022 and January 2023 were investigated and completed with unfounded findings. RCW 13.50.100 father had returned to the home at this time as well.

The FVS caseworker developed a case plan with the family and worked to engage them in services. The mother minimally engaged in services, but no-showed often when providers were scheduled to come to her home.

On March 10, 2023, DCYF received a report that RCW 13.50.100 . The school also reported the mother often appeared high or not fully alert, and the older children were missing a lot of school and sleeping at school frequently. This investigation was assigned to a new CPS caseworker who started making attempts to see the children right away. After several attempts over several days, the CPS caseworker connected with the older boys at school three days following the initial report. The children did not report anything warranting an immediate safety concern. The CPS caseworker visited the home on March 14, 2023, and saw the mother and B.B. The caseworker documented no safety concerns at the home. The CPS caseworker discussed safe sleep with the mother and observed B.B.'s sleep space to be safe. On March 15, the CPS caseworker asked the mother to complete urinalysis testing. The mother did not show up for her urinalysis test.

On March 16, 2023, the FVS caseworker sent the mother a text telling her the FVS case would be closing.

On March 20, 2023, DCYF received a report from the medical examiner that the mother had called 911 at 7:40 a.m. to report that B.B. was unresponsive, cold to the touch, with blue lips in RCW 7 crib. Initially there was no indication of child abuse or neglect, and the report met criteria for a risk only CPS intervention. Although there was paraphernalia found in the mother's room that she shared with B.B., law enforcement did not have reason to believe the mother was at fault. A toxicology screen was done when B.B.'s autopsy was completed. The toxicology report came back positive for fentanyl. B.B.'s cause of death was fentanyl poisoning. On May 31, 2023, upon completion of the medical examiner's report, a new report was made to DCYF with allegations of neglect by both of B.B.'s parents. This report met criteria for a CPS investigation and both parents received founded findings in that investigation. RCW 13.50.100

Committee Discussion

The Committee first discussed the case's complex history and complex issues of domestic violence, SUD and difficulty engaging parents. The Committee believed the family needed an experienced caseworker with strong SUD knowledge who could engage the family and complete an informed, behavioral assessment of SUD. The Committee learned from the field staff available to meet with them on the day of the review that most of the caseworkers who worked on the case in the year prior to the critical incident were fairly new to DCYF. Additionally, the Committee learned the field office had been functioning at a reported 50 percent vacancy rate at the front end programs (CPS, FAR and FVS) for several years. The Committee recognized a vacancy rate like this leads to high turnover of caseworkers, caseworkers with little experience, caseworkers with high case loads and supervisors forced to carry cases. The Committee further dicussed the effects high vacancy and high turnover rates have on safe decision making. The Committee suggested inexperience and exhaustion amongst caseworkers and supervisors can lead to fight or flight decision making and interventions that are incident focused rather than based on global assessments.

The Committee believed the field staff working on the case in the year prior to the critical incident were focusing on important aspects of the case but perhaps not always the most important aspects of the case. The Committee believed there were opportunities to engage the mother in discussions about relapse and returning to SUD services based on obvious signs of marijuana use and reported signs of potential use of other drugs. The SUD professional on the Committee spoke about marijuana, despite its legality, still being an

addictive drug. The SUD professional on the Committee further stated that if a person who struggles with addiction to any drug is using marijuana, then they have returned to addictive patterns and therefore have relapsed. Additionally, the Committee felt there was too much reliance on urinalysis testing to confirm or disprove substance use. The Committee believed the family would have benefitted from a global assessment of substance abuse informed by history, collateral contacts and behavioral observations.

While meeting with the field staff on the day of the review, the Committee learned the caseworkers in the year prior to the critical incident were primarily focused on concerns about the older children's behaviors. The Committee posited that the older children's behavior and their mother's inability to manage them was the focus of the reports made in late 2022 and early 2023; however, there were additional concerns being reported about behavioral signs of the mother possibly using substances. The Committee perceived the field staff to have categorized the case as being about the children's behaviors and focused on that rather than signs of other possible issues. The Committee believed this focus hindered critical thinking. However, in this instance the Committee also recognized that due to the afore-mentioned issues around vacancy rates and turnover, the teams working the case may have been too overwhelmed or too new to be able to see signs beyond the concerns about the boys' behaviors.

The Committee reflected on the case involvement in 2021 and 2022, prior to B.B.'s birth when the older children were RCW 13.50.100 outside the family home. The Committee noted that a Family Team Decision Making meeting was not held prior to the older children returning home to their mother. The Committee felt that would have been beneficial to the family at that time in the case. The Committee also felt that given the older children's behavioral needs during that involvement, a referral for family therapy to work on repairing attachment and bond would have been helpful to the mother and children.

The Committee noted strengths they saw in practice as they reviewed this case as well. The Committee appreciated the efforts of a supervisor to accompany a caseworker in the field on one occasion. The Committee believed this was a good example of shared decision making, training efforts, and supportive supervision. The Committee noted a thorough CPS to FVS meeting that was inclusive of many appropriate field staff and well documented in a case transfer note. Finally, the Committee was pleased to see strong parent engagement of the father and an attempt to engage the mother in SUD services in the last CPS investigation initiated prior to the critical incident.

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 B.B.'s fatal event. The Committee respectfully recommended that DCYF consider the following recommendations to help DCYF and its staff comprehensively improve practice.

In discussion with the field staff, the Committee learned this field office had been functioning at a reported 50 percent vacancy rate at the front end programs (CPS, FAR and FVS) for several years. The Committee recognized this vacancy rate leads to high turnover of caseworkers, caseworkers with little experience, caseworkers with high case loads and supervisors forced to carry cases. The Committee respectfully recommends DCYF prioritize efforts to recruit and retain caseworkers.

The Committee respectfully recommends DCYF include the following in SUD training: Caseworkers, including intake caseworkers, should consult an SUD expert or the DCYF SUD Lead when they encounter information in a case such as a report of a child describing a specific smell when their caregiver smokes something.