# CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

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## CONTENTS

Full Report ..... 1
Executive Summary ..... 2
Case Overview ..... 2
Committee Discussion ..... 5
Recommendations ..... 7

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# Full Report

## Child

- F.C.

## Date of Child's Birth

- RCW 74.143.515 2007

## Date of Fatality

- November 5, 2023

## Child Fatality Review Date

- January 31, 2024

## Committee Members

- Elizbeth Bokan, JD, Deputy Director, Ombuds at the Office of the Family and Children's Ombuds
- Bev Rowland, M.Ed., LMHC, CMHS, DMHS, Clinical Manager, Yakima Valley Farmworkers Clinic – Behavioral Health Services
- Derek Murphy, M-RAS, SUDP, CSC, Director of Clinical Services, Olalla Recovery Centers
- Katrina Tangedahl, MSW, Region 1 Regional Programs Consultant, Department of Children, Youth, and Families
- Ryann Charvatt, MSW, Region 1 Safety Administrator, Department of Children, Youth and Families
- Jasmine Hodges, MA, Child Safety Statewide Program Manager, Department of Children, Youth, and Families

## Facilitator

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

## Executive Summary

On January 31, 2024, the Department of Children, Youth, and Families (DCYF) convened a Child Fatality Review (CFR)[1] to examine DCYF's practice and service delivery to F.C. and RCW 74. family. F.C. will be referenced by RCW 74. initials throughout this report.[2]

On November 14, 2023, a DCYF Child Protective Services (CPS) caseworker called to speak with F.C.'s mother to discuss the ongoing CPS investigation concerning substance use by her 16 year-old RCW 74.143.515 F.C. F.C.'s mother notified the caseworker that F.C. passed away due to a drug overdose on November 5. A relative then got on the telephone call, because the mother was too distraught to continue speaking, and told the CPS caseworker that it is believed that F.C. obtained the drugs from RCW 74. father.

The CPS caseworker obtained the law enforcement report regarding the overdose, and then called DCYF intake to report F.C.'s death. This report resulted in a screened-in CPS investigation.

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 did not have any contact or involvement with F.C. or RCW 74. family. On the day of the review, the Committee had the opportunity to interview DCYF staff who worked the case during the two years prior to F.C.'s death.

## Case Overview

DCYF first engaged with the family at F.C.'s birth. F.C. was placed on a hospital hold because RCW 74. tested positive for opiates and cannabis at birth. RCW 74. mother also had positive toxicology screens throughout her pregnancy for both substances. Shortly after F.C.'s birth, a public health nurse called DCYF with concerns about the mother's mental health, specifically RCW 70.02.020

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

The nurse stated that F.C. was accidentally hit by RCW 74. mother's elbow when the mother became violent with the father while he was holding F.C.

In October 2007, F.C.'s paternal grandfather reported to DCYF that his son (F.C.'s father), F.C., and F.C.'s mother lived in the grandfather's converted garage. The grandfather stated the father works a lot, and the mother did not care for F.C. The grandfather also reported that his son, the father, was arrested related to a domestic violence incident. RCW 13.50.100 The intake was assigned for a CPS investigation. The investigative assessment stated that F.C. was well cared for and appeared developmentally on track. The assessment also stated the mother agreed to participate in a substance abuse assessment and follow up on any recommendations. She obtained employment and was taking medications RCW 70.02.020 RCW 70.02.020 The assessment also stated that F.C.'s father was employed and "appears to be free from substance abuse issues" and participated in a substance use assessment but the results were not known to the department at the time of case closure and was identified as inconclusive regarding the reported allegations. The case closed the end of November 2007.

In April 2009, a court-appointed special advocate for F.C. called DCYF and reported that at the prior hearing (hearing date not documented), the mother appeared under the influence of substances. The mother admitted to taking prescribed pain medications and then driving herself and F.C. to the courthouse. The advocate shared the mother's last two drug tests were positive for cannabis and opiates, and she was recently in a 28-day treatment facility for substance use.

A week after the call, RCW 13.50.100(7)(c) called DCYF to report that the judge had awarded custody of F.C. to F.C.'s father. She stated the advocate, the previous caller, is a family friend of F.C.'s father, and the father has a pending domestic violence (DV) charge and a previous deferred sentence for a criminal assault case. RCW 13.5 RCW 13.50.100(7)(c) also stated the father still consumes alcohol "all the time."

In July 2016, DCYF received a telephone call stating that F.C.'s mother told the caller the father was abusing pain medication to the point that F.C. made a comment to RCW 74. father about his use. This intake was screened out.

In July 2017, a hospital social worker called DCYF reporting that F.C. was brought to the hospital by RCW 74. mother because the father injured F.C.'s thumb and "choked RCW 74.143 because he was angry with RCW 74.143.515 The paternal grandparents had to intervene. There were no external marks noted on F.C.'s neck and the x-rays of RCW 74. thumb were negative. This intake was assigned for a CPS investigation. The investigation resulted in an unfounded finding of physical abuse by F.C.'s father.

In April 2019, RCW 13.50.100(7)(c) reported to DCYF that F.C.'s mother was recently granted custody. F.C. messaged RCW 74. paternal relatives because RCW 74. was scared. F.C. reported to RCW 74. relatives that RCW 74. was forced to sleep in a camper outside and not in the home with the other residents. The mother planned to home-school RCW 74.143.515 and had unenrolled F.C. from school. This intake was screened out.

In May 2019, a wraparound service provider with WISe[3] called DCYF and reported that F.C.'s mother provided F.C. with cannabis. F.C. told the service provider that RCW 74. mother told RCW 74. that it would help with RCW 74. anxiety and depression. F.C. also reported that RCW 74. mother allowed RCW 74. to drive their vehicle with the mother in the passenger seat. The service provider discussed the issues with the mother. This intake was assigned for a Family Assessment Response (FAR).[4]

During the FAR assessment, F.C. emailed RCW 74. caseworker stating that RCW 74. father was angry. He left red marks on RCW 74. wrists and arms when he grabbed RCW 74.1 RCW 74.1 wrote that RCW 74. father and grandparents lied to law enforcement about this and about verbal abuse from RCW 74. father. This information screened out.

Also during the FAR assessment, F.C. told RCW 74. caseworker that RCW 74. father was drinking a lot and would drive RCW 74. around while he was under the influence. This information screened in.

In October 2019, F.C.'s mother called DCYF and requested assistance filing an At Risk Youth[5] (ARY) petition. F.C. was not attending school or counseling. F.C. was supposed to be in counseling RCW 70.02.020 This was assigned for Family Reconciliation Services (FRS).[6]

The next day, RCW 13.50.100(7)(c) called DCYF to report the mother said the father had drinking, control, and anger problems. That information was screened out. Then, two weeks later, the mother called again regarding F.C. not going to school and testing positive for cannabis. The mother again requested help with an ARY petition. DCYF case notes indicate that F.C. did not meet the criteria for an ARY petition. The FRS case closed but the case remained open to FAR until February 26, 2020. At the time of case closure F.C. and RCW 74. mother were involved with community services.

In July of 2021, RCW 13.50.100(7)(c) called DCYF. She reported that F.C.'s parents are aware that RCW 74. is in a relationship with a 20 year-old man. This man was also living in the same home as F.C. and F.C.'s mother. She also reported the father lives in a "drug home" and that F.C. goes to visit him there. The paternal grandparents told RCW 13.50.100(7)(c) they had visited the home and observed drug paraphernalia. RCW 13.50.100(7)(c) also reported the parents were aware that F.C. was using cannabis and were not trying to discourage RCW 74. use. This information was assigned for a CPS investigation.

F.C. did not cooperate with the CPS investigation. Neither did RCW 74. father. The caseworker spoke with the paternal aunt, maternal and paternal grandmothers, and F.C.'s mother. The case was closed as unfounded.

[3] WISe is a wraparound, voluntary service to help children and their families with intensive mental health care. For more information about WISe see: https://www.hca.wa.gov/free-or-low-cost-health-care/i-need-behavioral-health-support/wraparound-intensive-services-wise

[4] Family Assessment Response (FAR), "Far is a CPS alternative response to a screened-in allegation of abuse or neglect. FAR focuses on children and youth safety along with the integrity and preservation of families when lower risk allegations of maltreatment have been screened-in for intervention." For more information the FAR policy see: https://www.dcyf.wa.gov/policies-and-procedures/2332-child-protective-services-family-assessment-response.

[5] At-Risk-Youth refers to when a parent or guardian believes the child needs court intervention to help maintain control of the child and alternatives to court involvement have already been attempted. For more information See: https://app.leg.wa.gov/rcw/default.aspx?cite=13.32A.191.

[6] Family Reconciliation Service cases are related to family conflict, at-risk youth, or when a youth may need services. For more information, see: https://www.dcyf.wa.gov/policies-and-procedures/3100-family-reconciliation-services.

The next intakes were received by DCYF on November 28, 2022. The allegations were that F.C. had self-harming behaviors; RCW 13.50.100 the mother was not obtaining help for F.C.'s suicidal ideation and suicide attempt; and lastly that the mother told a teacher that F.C. had been drugged and RCW 13.50.100 but the mother did not report this to law enforcement. RCW 13.50.100 RCW 13.50.100 One intake was screened in for a FAR assessment and the other was screened out.

The caseworker reached the mother by telephone regarding the screened in FAR assessment. F.C. was present with RCW 74. mother during the telephone call. F.C. spoke briefly with the caseworker and refused to cooperate with any of the caseworker's questions. RCW 74.1 did say RCW 74.1 was not suicidal and did not attempt suicide, but that RCW 74.1 did self-harm. RCW 74.1 said RCW 74.1 would refuse to meet with the caseworker and would refuse any services. The mother stated she did not want to participate in FAR.

The caseworker then spoke with a mental health provider who verified that F.C. was seen at their clinic and had a follow-up appointment scheduled. The caseworker also spoke with F.C.'s teacher who did not have any other information to share, other than her concern that the mother seemed "off."

The CPS supervisor staffed the case with the area administrator who agreed to close out the FAR assessment.

On January 30, 2023, an emergency hospital employee called DCYF to report concerns for F.C.'s mental health. F.C. was at the hospital stating RCW 74. felt suicidal due to family conflict. RCW 74.1 admitted to cannabis use that same day as well. The hospital staff looked up F.C.'s Facebook page and observed a post about RCW 74. being intoxicated with a picture of RCW 74. looking down from a roof top. While at the hospital, F.C. was combative and threw RCW 74. phone at a nurse and banged RCW 74. head on the wall. A local mental health crisis response worker met F.C. at the hospital and cleared F.C. to be discharged home to RCW 74. mother. The intake worker asked if a physician or nurse practitioner had asked that this incident be reported to DCYF, and the caller stated no. The caller was just frustrated by their perception that the crisis response agency does not take appropriate actions when a child is in distress, like F.C. This intake was screened out.

Then, on September 28, 2023, a school resource office received information from RCW 13.50.100 RCW 13.50.100 RCW 13.50.100 reported that he used to live with F.C. and RCW 74. mother. He said that F.C. posted a video on TikTok, in which F.C. was smoking, using a glass device that had white residue inside. There was also a picture of a blue cube, indicative of the appearance of fentanyl and methamphetamines. RCW 13.50.100 told the office that both of F.C.'s parents have used drugs for a long time, often in front of F.C., and that F.C. obtains RCW 74. drugs from RCW 74. father. This screened in for a FAR assessment.

On September 29, 2023, the caseworker went to the mother's home. The mother reported that she and F.C. were sick and could not meet with him. The caseworker asked F.C. to go onto the balcony so that he could physically observe RCW 74. and briefly speak with RCW 74.1 The caseworker contacted the mother for a follow-up visit, but they were reportedly sick for two weeks. An appointment was scheduled for October 19.

On October 19, the caseworker met with F.C. and RCW 74. mother. The mother denied RCW 13.50.100 allegations and stated that she has been sober for seven years. She also stated that she obtains Suboxone[7]

[7] Suboxone, also known as buprenorphine and naloxone is used to treat opiate addiction. For more information see: https://www.drugs.com/suboxone.html.

from a local provider. When F.C. joined the conversation, RCW 74. admitted that RCW 74. had snuck out of RCW 74. mother's home, saw RCW 74. father, and that he gave RCW 74. methamphetamine. The mother expressed to both F.C. and the caseworker that she will not allow F.C. to have unsupervised contact with RCW 74. father. They did not request any services.

On November 14, 2023, the caseworker called F.C.'s mother with the intent of obtaining contact information for the father and completing further collateral contacts. During that telephone call the caseworker was notified that F.C. died of an apparent overdose.

## Committee Discussion

The Committee discussed the importance of comprehensive assessments for all child welfare cases. The discussion included reviewing and understanding DCYF's history related to the family members, and specifically in this case, the significant chronicity. The family first interacted with DCYF after F.C.'s birth. During her pregnancy, F.C.'s mother used substances. After F.C.'s birth, parental substance use, violence, and mental health issues were prevalent. There were also allegations the parents' provided substances to F.C. RCW 74.143.515 RCW 74.143.515

Knowing that history, the Committee believes that further assessment of the parents' substance use, or sobriety would have been appropriate, even when there were no allegations of substance use in the applicable intakes. The mother told the caseworkers that she was receiving medications to support her sobriety. The Committee believes that further assessment and verification of that information would have helped to identify ways to better support the mother's expressed intent to help F.C. with RCW 74. mental health and substance use needs.

Further assessment and adherence to DCYF policy No. 1170[8],regarding assessing for DV, was another topic discussed. The Committee opined that while F.C.'s parents did not present themselves as a couple, there was still a lot of communication between them and F.C. often visited RCW 74. father. Therefore, the Committee believed that assessing for DV, including interpersonal as well as family violence, was necessary. There were allegations that F.C.'s father had been angry with RCW 74. and strangled RCW 74.1 as well as injuring RCW 74. hand. The Committee discussed the level of lethality based on the strangulation was incredibly high, and further assessment for safety and supportive services would have been appropriate.

Also included in that conversation was further assessment or documentation of assessment attempts regarding F.C.'s father. The Committee understood the family as a whole was often uncooperative with DCYF staff. However, more attempts utilizing collateral contacts or databases to obtain possible contact information for the father was warranted.

The Committee discussed that while it was positive that F.C. was honest about using drugs given to RCW 74. by RCW 74. father, this disclosure should have been followed up by conversations about assessment and supports. Knowing that F.C. came home from school at midday, and that RCW 74. mother was working away from the home, left questions about structure and supervision. The mother appeared blindsided by the disclosure, so following up with her to discuss planning for an assessment for RCW 74.143.515 as well as continued interactions

[8] For information regarding DCYF Policy No. 1170, see: https://www.dcyf.wa.gov/1100-child-safety/1170-domestic-violence.

with F.C.'s father, may have been beneficial. Additionally, the Committee determined that follow up with law enforcement regarding the new information about where F.C. obtained the drugs and who provided them would have been helpful.

The Committee identified a different perspective pertaining to the closure of the November 2022 FAR assessment. The DCYF staff who attended the review shared their understanding that if a family did not want to participate in a FAR assessment, and collateral contacts were made that identified no concern for abuse or neglect, that the case could be closed. They also shared that they staffed that situation with their area administrator, who supported the decision to close the case. They further provided that this had not been the only incident where this happened, though there were few occurrences of closing a case after a parents' refusal to participate.

Discussion about the interpretation of DCYF Policy No. 2332[9], Child Protective Services Family Assessment Response, included identification of this same decision occurring a handful of times in another region as well. The policy states to consult with a supervisor "[i]f the parents or guardians decline or interfere with the Initial Face to Face (IFF) and safety assessment of the children or youth," or "[t]o determine if cases need to be transferred to CPS investigation." The Committee did not agree that this situation warranted closing the case prior to verifying that F.C. and [redacted] mother followed through with services to address F.C.'s mental health needs beyond the initial appointment. The supervisor shared with the Committee that he realized he should have documented the staffing with his area administrator and the decision to close the case in a case note.

## Recommendations

The Committee recognizes the area administrator for this case began her role in August 2023. The Committee appreciates her commitment to continuous improvement. The Committee recommends the area administrator address the identified areas of improvement from this review by utilizing resources such as case consultations with Quality Practice Specialists and Regional Programs Consultants; targeted trainings for identified areas of improvement; and policy reviews for staff as applicable.

[9] For information regarding DCYF Policy No. 2332, see: https://www.dcyf.wa.gov/policies-and-procedures/2332-child-protective-services-family-assessment-response.