CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

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CONTENTS

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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

- O.S.

Date of Child's Birth

- RCW 74.13.515 2023

Date of Fatality

- January 20, 2024

Child Fatality Review Date

- May 1, 2024

Committee Members

- Patrick Dowd, JD, Director, Office of the Family and Children's Ombuds
- Angie Keith, Supervisor, Department of Children, Youth, and Families
- Antonia Bancroft, Tribal Liaison Indian Child Welfare Consultant Region 6, Department of Children, Youth, and Families
- Robert Smith, Indian Child Welfare Program Manager, Department of Children, Youth, and Families
- Arden James, MBA, SUDP, Pregnant and Parenting Women Manager, Therapeutic Health Services
- Jeremiah Donier, Management Analyst 5, Washington Fatherhood Council
- Jessica Lowe, Child Advocacy Center Team Director, YMCA of Jefferson County

Consultant

- Jessica Humphries, Family Services Manager, Jamestown S'Klallam Tribe

Facilitator

- Leah Mattos, MSW, Critical Incident Review Specialist, Department of Children, Youth, and Families

Finalized Date: October 22, 2024
Approved for distribution by Paul Smith, Critical Incident Practice Consultant

Executive Summary

On May 1, 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 O.S. and [redacted] family. O.S. is referenced by [redacted] initials throughout this report.[2]

On January 20, 2024, following a law enforcement search for O.S. and [redacted] father, DCYF was notified that O.S. had been found deceased. On Friday, January 19, 2024, the DCYF caseworker assigned to O.S.'s case, had been contacted by the family friend where O.S. and [redacted] father had been residing to say that O.S.'s whereabouts were unknown, and the father may be hiding [redacted] from Child Protective Services (CPS). It was reported the mother had not seen O.S. since her return to the community on January 18 and the family friend last saw O.S. with [redacted] father on January 17.

Later, DCYF received information related to O.S.'s death from the prosecuting attorney, which included details from the law enforcement investigation and autopsy, which is summarized here. The father reported to law enforcement he had fallen asleep (on Jan. 17) while holding O.S. in a recliner and woke up to find [redacted] face down and unresponsive. The father told law enforcement he panicked and decided to hide O.S. in a local park. The toxicology report showed the presence of a low amount of methamphetamine, possibly due to environmental exposure, but the route of exposure is unknown. The medical examiner and toxicologist could not authoritatively state the methamphetamine played a role in O.S.'s death. The manner and cause of death is unknown. No criminal charges were filed.

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. Outside of the Tribal consultant, the Committee members had no prior direct involvement with the 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)]." 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] O.S.'s name is not used in this report because [redacted] name is subject to privacy laws. See RCW 74.13.500.

Case Overview

Prior to the death of O.S., DCYF received three calls reporting concerns for the welfare of O.S.'s family. Two reports led to a CPS risk-only investigation[3] while one report did not meet the criteria for response as the information had previously been reported. Below is a summary of case contacts and involvement with the family.

In December 2023, a CPS risk-only investigation was assigned when DCYF received a report that O.S. and RCW 74 mother had tested positive for fentanyl at RCW 74 birth. The referrer said the mother required a lot of assistance in caring for the infant, was frequently nodding off, and the family did not have a plan to care for O.S. once RCW 7 was discharged from the hospital. The mother was identified as participating in an inpatient substance use disorder (SUD) treatment program.

On December 27, 2023, a courtesy supervision caseworker for the county where the mother gave birth was assigned to complete the initial contact with the family. Following completion of the initial contact, the courtesy supervision caseworker notified the primary assigned field office. No additional contacts were made by the courtesy supervision caseworker.

On December 28, 2023, a Family Team Decision Making meeting (FTDM)[4] was supposed to occur to address strengths and concerns regarding O.S.'s family, as well as to develop a plan on how to support the family. Because the mother's attorney was not available, the meeting was rescheduled.

On December 29, 2023, an internal agency consultation occurred and the FTDM was held. The mother had previously denied Native ancestry, but at the FTDM she was confirmed to be an enrolled tribal member at the beginning of the meeting. The Tribe was contacted and joined the FTDM along with both parents, extended family, the mother's attorney, the assistant attorney general for DCYF, and hospital staff. Both the mother and father said they were willing to continue with their respective SUD treatment programs and agreed to participate in in-home parenting instruction. The father said he would be residing with a family friend who would be willing to complete a home walk-through and provide supervision for O.S. upon RCW 74 discharge from the hospital while DCYF verified the father's SUD treatment participation. DCYF received a second call from a medical professional at the hospital sharing information that had been previously reported at O.S.' birth. Because this call provided duplicative information, no additional response was required by DCYF. DCYF completed a home walk-through of the family friend's home. The caseworker reviewed Safe Sleep[5] and Period of Purple Crying[6] with the family friend and reminded her that O.S. could not be left alone with the father until he provided a negative urinalysis.

[3]A CPS Risk Only investigation should be screened in when there are "reports [that] a child is at imminent risk of serious harm and there are no [child abuse or neglect] allegations". For more information about CPS Risk Only Investigations, see https://www.dcyf.wa.gov/practices-and-procedures/2200-intake-process-and-response.

[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]For information about Safe Sleep, see: https://safetosleep.nichd.nih.gov/safesleepbasics/about. Last accessed on May 21, 2024.

[6]For information about Period of PURPLE Crying, see: https://dontshake.org/purple-crying. Last accessed on May 21, 2024.

On January 2, 2024, the primary caseworker documented that O.S. had been discharged from the hospital to the father over the weekend. The caseworker contacted the father and family friend to coordinate a home visit. The caseworker completed a visit in the home with O.S. and the family friend; however, the father was not present. During the visit, the caseworker educated the family friend on how to create a safe sleep environment for O.S. The caseworker later returned to the home to provide necessary goods, including a fire extinguisher, lock box, and infant supplies. The case note documented the father as not being present during the second visit to the home.

On January 3, 2024, the caseworker attempted to contact the father. She spoke with the family friend who said the father was not at home. The caseworker asked the family friend to have the father contact her.

On January 4, 2024, the caseworker spoke with O.S.'s doctor who confirmed that O.S. had an appointment scheduled for that day. The caseworker confirmed the appointment with the family friend and offered transportation assistance. The caseworker arrived at the home and observed the father interacting with O.S. No concerns were noted about the interactions. The caseworker transported the father and O.S. to the medical appointment.

On January 5, 2024, the caseworker and Tribal caseworker from the mother's Tribe met with the family friend and O.S. at the family friend's home. The caseworker documented that a safety plan was reviewed and signed by the father. The caseworker noted that the father went to the restroom for an extended period and was still there when the caseworker left the home.

On January 8, 2024, the caseworker had internal communication with the DCYF Native American Inquiry Referral team and requested law enforcement records.

On January 11, 2024, DCYF received the father's negative urinalysis results, which the father had provided a sample for on January 5. The caseworker received a call from the father's treatment provider reporting concerns he had canceled his weekly appointment and seemed "overwhelmed" during O.S.'s check-up. The doctor scheduled a follow-up appointment for O.S. the following week. The caseworker shared this information with the Tribal caseworker by email. Also discussed was the plan for the mother to be discharged from her SUD inpatient program on January 18. A referral was submitted for in-home parenting instruction for the parents.

On January 12, 2024, the caseworker completed an unannounced home visit at the family friend's home. The caseworker documented detailed information about O.S.'s feeding schedule, provided suggestions to the family friend on how to keep the infant warm, and reviewed safe sleep again. The caseworker documented that the father was in the bathroom during the entire visit and did not participate. The caseworker asked the family friend to have the father contact the caseworker.

On January 15, 2024, the caseworker received a call from O.S.'s doctor's office indicating the father canceled O.S.'s appointment. The caseworker scheduled a new medical appointment for the following day. The caseworker contacted the father via text and shared that O.S. is at risk of being admitted to the hospital due to lack of weight gain and the missed medical appointment. The caseworker told the father the appointment had been scheduled for the following day. The father expressed frustration about the caseworker rescheduling

the appointment and the caseworker documented apologizing to the father and offering to talk about how to communicate with the father more effectively. The caseworker inquired about the father's missed urinalysis, and in response he told the caseworker he was switching providers so he and O.S.'s mother could participate in services through the same provider. The caseworker offered gas cards to assist with transportation. The caseworker was contacted by the family friend requesting to check-in and the caseworker responded to confirm their availability.

On January 16, 2024, the caseworker corresponded with the Tribal caseworker by email regarding case updates, including the medical updates for O.S. and the doctor's office reporting concerns for the father possibly relapsing due to the missed urinalysis test.

On January 17, 2024, the caseworker communicated with the family friend via text. The family friend requested to speak in person. The caseworker and family friend met at the DCYF office. She expressed concerns that the father was purchasing urine to pass his urinalysis test and that the father gets frustrated with O.S. when [RCW 7] is crying. The family friend denied observing the father being harmful to O.S. The caseworker documented telling the family friend a FTDM would be set up to discuss the case. The caseworker sent a text to the father to remind him of the urinalysis test that was scheduled for that same day. Later, the father's treatment provider notified the caseworker that the father did not attend his urinalysis appointment. The caseworker received email communication from the Tribal caseworker including a request to schedule an FTDM to address the concerns.

On January 18, 2024, the caseworker corresponded with the family friend via text regarding the mother's discharge and the family's whereabouts. The family friend stated the mother and father were at her home without O.S. The family friend was told by the father that O.S. was with an aunt. The caseworker contacted the mother multiple times to set up a time to check in. The caseworker documented consulting with her supervisor about the father's lack of compliance with SUD treatment and how both parents were scheduled for intakes with an outpatient SUD treatment provider the following morning. A monthly supervisor review occurred.

On January 19, 2024, the family friend texted the caseworker in the morning stating the mother had O.S. in her care. Approximately an hour later, the caseworker received a call from the family friend stating the mother did not have O.S. and that the mother did not know where [RCW 7] or the father were. The family friend said she had not seen O.S. since January 17. DCYF documented attempts to contact the parents by phone; made in-person attempts to locate them; corresponded with the Tribal caseworkers and relatives; held an internal supervisory staffing; and contacted law enforcement to assist in locating O.S. and [RCW 7] family. Both parents were reported to have missed their SUD intake. An additional intake was called in by DCYF reporting O.S.'s whereabouts as unknown, which was assigned for a CPS risk-only investigation. A dependency petition and writ of habeas corpus was filed with the court allowing for O.S. to be placed in DCYF's care when located. This information was also provided to a DCYF after-hours caseworker to assist with continued search efforts.

On Saturday, January 20, 2024, the caseworker supervisor documented making attempts to contact the mother, a relative, and law enforcement. Law enforcement shared the father had been located and O.S. had been found deceased. No additional details about [RCW 7] death were provided at that time.

Committee Discussion

The Committee spoke with field staff who had previously been involved with the family. This discussion provided an opportunity for the Committee to learn about case specific details, typical office practice and resources, and system challenges. The Committee identified positive aspects of the casework practice and discussed opportunities for improvement. Improvement opportunities are areas where a family's needs may have been unmet by the system, or a system barrier was identified.

The Committee believed there was more urgency needed in agency collaboration and response to support this family. One specific area discussed was Tribal collaboration and coordination. The Committee believed coordination with the Tribe at the onset of the case may have been beneficial in supporting the family and identifying any unmet needs, as well as identifying roles and responsibilities between DCYF and the Tribe. The Committee discussed active efforts[7], which are efforts focused on preserving or reuniting an Indian child with their family, and believed there may be a broad misunderstanding in the field about how to provide active efforts beyond monetary support to a family. Based on the caseworker telling the Committee this was the first Indian Child Welfare case assigned to them, the Committee believed the caseworker may have benefited from additional supervisory guidance and support.

The Committee discussed with the field staff the assessment of parental substance use in relation to child safety, how information is gathered, and barriers to treatment that may exist. One identified barrier shared from the field staff in this case was the father's refusal to sign a release of information so DCYF could obtain his SUD treatment records. The Committee believed the father required an observed urinalysis test as it was unclear if the urinalysis sample provided was observed. The Committee discussed with the field office their interpretation of missed urinalysis tests, which would be considered positive. The Committee believed at the point of the mother's discharge from SUD treatment, obtaining her discharge summary may have provided helpful information related to her ongoing treatment needs. A Committee member stated their belief that there is a general lack of understanding in communities about the dangers and lethality of fentanyl and that policy makers need to be informed so they can urgently respond.

The Committee reviewed the safety plan and concluded the focus was service oriented rather than identifying specific behavioral expectations and supports for the individuals providing care to O.S. Given the concerns that arose related to caring for a newborn, missed medical appointments (father and child), and the father's behavioral presentation, additional details in the safety plan may have been beneficial. For example, the father and family friend may have benefited from the safety plan detailing specific, measurable, and observable behaviorally oriented tasks in addition to expectations related to communication with DCYF.

The family may have benefited from early learning support resources, such as completion of the Plan of Safe Care and referrals to community-based services targeted at providing support to parents and infants, which may enhance child safety and well-being. The Committee heard from the field staff about the support system the mother and father had in place through their extended family. The Committee was curious about community-based support and services in their area. The field staff said there can be barriers with accessing

[7]For information on Active Efforts, see: https://www.dcyf.wa.gov/node/967.

DCYF-contracted services due to the physical location, but they do have access to early learning supports in their community. The caseworker had referred the parents for an in-home parenting education program scheduled to begin upon the mother's completion of her inpatient SUD program. The Committee recognized that families may get overwhelmed when navigating through systems, juggling appointments, and balancing their hierarchy of needs, and wished there was the ability to bring all needed support and services to families in an effort to reduce barriers to accessing services.

The Committee spoke at length about the impacts of the Keeping Families Together Act (House Bill 1227)[8], a law that went into effect on July 1, 2023. This discussion included interpretation of the law as well as its practical application, including assessment of imminent physical harm[9], which is required by the new standard. The field office shared their view that different courts may apply different standards for removing a child from their parents' care. The Committee speculated how this may impact DCYF's consideration for requesting court involvement. One specific aspect discussed was the standard to request court oversight, with the child remaining in the parent's care. Some Committee members believed the standard for requesting court oversight, with the child remaining in the parent(s) care would be lower than requesting court oversight with out-of-home placement. The field office believed the standard is the same for both and emphasized the overall higher standard imposed by HB 1227. Through their discussion, the Committee speculated that there may be a broad lack of understanding in the field about the need to continually assess for imminent physical harm throughout the life of a case.

[8]For information about House Bill 1227 Keeping Families Together Act, see: https://www.wacita.org/hb-1227-keeping-families-together-act/#:~:text=HB%201227%20requires%20that%20courts,relatives%20and%20suitable%20other%20persons. Last accessed on May 21,2024.

[9]DCYF can only seek court-ordered removal, and the court can only order a child removed, when there is imminent risk of physical harm. See RCW 13.34.050 https://app.leg.wa.gov/rcw/default.aspx?cite=13.34.050.