# CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

Washington State Department of
CHILDREN, YOUTH & FAMILIES

## CONTENTS

# Full Report

## Child

- S.N.

## Date of Child's Birth

- October 2023

## Date of Fatality

- December 2, 2023

## Child Fatality Review Date

- August 20, 2024

## Committee Members

- Qytrice Rouina, SUDP, Tacoma-Pierce County Health Department
- Kelli Robinson, MBA, Director, Our Sisters' House
- Elizabeth Bokan, JD, Deputy Director, Office of Family and Children's Ombuds
- Selena Deer MSW, Region 6 Quality Practice Specialist, Department of Children, Youth, and Families

## Facilitator

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

## Executive Summary

On August 20, 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 S.N. and RCW 7 family. The child, S.N., will be referenced by RCW 7 initials throughout this report.[2]

On December 4, 2023, a deputy coroner called DCYF to report that six-week-old S.N. died. S.N.'s parents called emergency services at 8 a.m. and reported that they woke to find RCW 74.13.515 "discolored and not breathing." The deputy coroner also reported that S.N.'s five-year-old RCW 74.13.515 was in the home. This initial intake was screened out based on the fact that there were no reported allegations of abuse of neglect.

A second intake was received later that day. The information reported was duplicative from the intake received earlier but this second intake screened in for a Child Protective Services (CPS) investigation. It is unknown why there were differing screening decisions made. Allegations of abuse or neglect that meet the legal sufficiency result in a screened-in intake to either CPS or Family Assessment Response (FAR).[3] FAR intakes are an alternative response to CPS investigations. The allegations in FAR intakes are lower risk than those in CPS investigations.

At the time of S.N.'s death, the family had an open Child Family Welfare Services (CFWS) case. CFWS cases are when there is legal intervention by DCYF regarding a child. RCW 13.50.100 The initial investigation regarding S.N.'s death was closed; however, on April 26, 2024, DCYF received the coroner's report which stated S.N.'s cause of death was combined toxic effects of fentanyl and methamphetamine with a contributory condition of unsafe sleep environment (co-sleeping with an adult and placed on RCW 7 stomach) and the manner of death was undetermined. A critical incident review committee was convened based on this new information.

Prior to S.N.'s death, DCYF received 12 intakes regarding RCW 7 family. Of the 12 intakes, six screened in for CPS investigations. Two of the 12 intakes pertained to S.N. One intake was received after S.N. was born but did not screen in. The second intake stated that S.N.'s umbilical cord testing showed that at birth S.N. was positive for fentanyl, gabapentin, methadone, and cannabinoids. S.N.'s mother was prescribed methadone at that time.

A CFR Committee was assembled to review DCYF's involvement and service provision to S.N. and RCW 7 family. The Committee included members with relevant expertise selected from diverse disciplines within DCYF and community partners. Committee members had no prior direct involvement with S.N. or RCW 7 family. Before the

[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 near 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] S.N.'s name is not used in this report because RCW name is subject to privacy laws. See RCW 74.13.500.

[3] For information about DCYF intakes, see: https://www.dcyf.wa.gov/policies-and-procedures/2200-intake-process-and-response.

review, the Committee received relevant case history from DCYF. On the day of the review, the Committee had the opportunity to interview some of the DCYF staff who were involved in the case since 2022.

## Case Overview

In 2013 DCYF was notified that S.N.'s mother gave birth to her first child, RCW 13.50.100 [redacted] The investigation closed without services offered or referred by DCYF.

In August 2014 DCYF became involved when the mother was arrested for driving under the influence. She had RCW 13.50.100 [redacted] A Family Voluntary Services (FVS) case was briefly opened but neither parent of the children cooperated. The case was closed in October 2014.

In February 2016 DCYF received an intake RCW 13.50.100 [redacted] Another intake was received RCW 13.50.100 [redacted] Both intakes were screened out. In March 2018, RCW 13.50.100 [redacted] RCW 13.50.100 The intake states that this child's mother, also S.N.'s mother, had a newborn RCW 13.50.100 at home. This intake screened in. During that investigation the caseworker documented that S.N.'s mother identified as being sober for six months and was seeing a mental health clinician. After the investigation concluded the case was closed.

In September and December 2019 two more intakes were received and screened out. RCW 13.50.100 [redacted]

In February 2022, the mother was again involved in a driving accident. RCW 13.50.100 [redacted] Neither the mother nor father of this child were cooperative with the CPS investigation. The investigation closed with no further action by DCYF.

An intake was received in March 2023. RCW 13.50.100 [redacted] This intake was screened out.

In April 2023 DCYF received allegations of parental substance use by S.N.'s mother and her boyfriend (who is S.N.'s father). RCW 13.50.100 [redacted]

RCW 13.50.100 [redacted]

She and her boyfriend (S.N.'s father) both participated in substance use treatment. The substance use

treatment provider would not regularly provide requested documents to DCYF even when a valid release of information was completed.

S.N.'s mother became pregnant with S.N. Both the mother and S.N.'s father provided documentation from their substance use treatment provider stating they were in compliance and providing negative urinalysis. During this time S.N.'s mother refused to provide any oral substance testing through DCYF but S.N.'s father complied with requested testing.

A shared planning meeting occurred on August 14. The parties present at that meeting agreed that if the mother took care of her outstanding criminal warrants that overnight visits could start. Although the requirement regarding the warrants was not requested by DCYF, it was court ordered and so included in the planning meeting discussion. The DCYF caseworker referred the family for Family Preservation Services, an in-home provider to assist with activities and stabilization in the home. S.N.'s mother did not comply with this service. S.N.'s father was also asked to resolve his pending criminal matters related to driving without proper interlocking device. Neither parent had a valid driver's license, and they were not allowed to drive S.N.'s RCW 74.13.51 in a vehicle.

On October 17, 2023, DCYF received an intake from a hospital. The hospital reported that S.N. was born and the mother tested positive for methadone and cannabis. The hospital did not test for fentanyl but stated testing would occur at some point. The hospital reported prenatal care starting in the fifth month of pregnancy and the care was inconsistent. That intake screened out.

On October 19, the caseworker received a telephone call from RCW 13.50.100 RCW 13.50.100 RCW 13.50.100 reported she believed that S.N.'s father was under the influence of substances while at the hospital. The caseworker called S.N.'s mother about these concerns and the mother said she wasn't sure if he was using substances or not.

On October 20, S.N.'s father agreed to an oral swab to test for substances. This test was positive for methamphetamine and fentanyl. This is also the day that S.N. and RCW 7 mother were discharged from the hospital.

On October 25 DCYF received another intake. S.N.'s umbilical cord test returned positive for fentanyl, gabapentin, methadone, and cannabinoids. S.N.'s mother was prescribed only methadone. That evening an after hours caseworker went to the family's home. S.N.'s paternal grandmother's boyfriend answered the door while holding S.N. He was there with S.N. and S.N.'s mother. S.N.'s mother spoke with the caseworker. She provided information about S.N.'s pediatrician and RCW 7 medical appointments. She shared the instructions provided by the pediatrician regarding a feeding schedule to help S.N. gain weight. The after hours caseworker observed and discussed safe sleep and Period of Purple Crying®.[4] The caseworker texted the mother the following day to check in.

On November 6, 2023, the caseworker had communication with S.N.'s mother (the case note does not state whether this was by telephone or text). During this exchange, S.N.'s mother said that the father admitted to a

[4] For information pertaining to DCYF policy regarding Period of Purple Crying and safe sleep, see: https://www.dcyf.wa.gov/1100-child-safety/1135-infant-safety-education-and-intervention.

one day relapse but did not respond when the caseworker asked what the plan regarding the relapse was moving forward.

DCYF held a Family Team Decision Making meeting (FTDM)[5] on November 9. RCW 13.50.100 RCW 13.50.100 Present for the meeting was the caseworker, caseworker's supervisor, the mother, court appointed special advocate, mother's attorney, and the assistant attorney general assigned to the case. The FTDM notes are not consistent with the intake received on October 19. The notes state that S.N. had negative substances testing at birth. The notes also did not include information pertaining to S.N.'s father's positive oral test for methamphetamine and fentanyl and how that was to be addressed. RCW 13.50.100 RCW 13.50.100 The court appointed special advocate requested a safety plan to be created by November 15 RCW 13.50.100 The safety plan was not completed.

On November 15, the caseworker went to the family's home. S.N.'s mother provided the caseworker with a negative urinalysis result from the same day and a letter from the substance use treatment provider stating that she was compliant with all meetings and had provided negative urinalysis since June. S.N.'s father gave the caseworker permission to discuss his positive (methamphetamine and fentanyl) oral swab in the presence of S.N.'s mother. The father said he reached out to his treatment counselor after his relapse and that they adjusted his methadone dosage.

The parents shared that the paternal grandmother had been staying with them and that the father is not left alone with S.N. The parents and caseworker discussed what the plan would be for both S.N. and RCW 74.13.515 if the parents were to use substances. The caseworker walked through the home and did not observe any safety threats to S.N. or RCW 74.13.515

RCW 13.50.100 On November 22, a different caseworker went to the family's home for an announced home visit. The mother and children were present. S.N.'s father was in the garage and did not interact or participate with this visit. S.N.'s mother told the caseworker that she graduated from intensive outpatient treatment but is still attending some meetings, providing urinalysis, and receiving methadone dosing.

RCW 13.50.100

On December 4, 2023, the coroner reported S.N.'s death to DCYF. The parents reported waking up and finding S.N. discolored and not breathing. Law enforcement started a criminal investigation. DCYF assigned a CPS investigation related to S.N.'s death. Another intake was received two days later. This intake provided more details including that law enforcement found drug paraphernalia (methamphetamine pipe), fentanyl pills and fentanyl powder. RCW 74.13.515

The initial investigation related to S.N.'s death was closed prior to DCYF receiving the toxicology reports from the crime lab. On April 26, 2024, DCYF received the coroner's report. The report stated S.N.'s cause of death was combined toxic effects of fentanyl and methamphetamine with a contributory condition of unsafe sleep

[5] For information about Family Team Decision Making meetings, see: https://www.dcyf.wa.gov/1700-case-staffings/1720-family-team-decision-making-meetings.

environment (co-sleeping with an adult and placed on [redacted] stomach) and the manner of death was undetermined.

## Committee Discussion

The Committee met with a majority of the staff who worked on the case between 2022 and December 2023. The Committee discussed multiple aspects related to the case events as well as systemic issues that may have impacted DCYF staff.

The Committee heard from the DCYF staff regarding significant challenges due to turnover in the office. This led to larger caseloads and increased workload. There was also a time when the area administrator was on extended leave and the office did not have a consistent person covering and present physically in their office during that time. The Committee opined that those systemic issues may have contributed to why staff did not document or have the ability to document decisions that were made throughout this case. The Committee learned from the DCYF staff who attended the review that discussion and staffings did occur at integral times, such as S.N.'s birth, but they were not documented. And that the documentation would have assisted a person reading the case to gather a complete appreciation for why events occurred.

The Committee was very concerned about the staff's discussion regarding how they are treated by the dependency court and court partners. The staff shared examples of being verbally mistreated and bullied. Even after the Committee was informed by the DCYF staff that this issue has recently started improving the Committee was very concerned about the toll this takes on worker's well-being as well as possible subconscious bias it could play in decision making. The Committee discussed that DCYF staff are expected to be trauma informed and conduct their work in that manner and that DCYF staff should be treated in a professional and respectful manner.

The Committee identified that S.N.'s mother and [redacted] would have benefited from receiving mental health services. S.N.'s mother had a significant trauma as a child and adult. [redacted] The CFWS caseworker told the Committee that there were barriers to obtaining mental health counseling for the child, related to the relative's schedule.

The Committee also discussed that the case may have been positively impacted by more comprehensive, ongoing assessments and collaterals. Specific examples included: contacting S.N.'s pediatrician after [redacted] birth and prior to [redacted] death to obtain the provider's perspective on [redacted] care and growth; conducting an assessment of S.N.'s paternal grandmother who lived with the family for a while after [redacted] birth and by speaking with her to

learn more about S.N.'s father; more frequent in person contact after S.N.'s birth; and assessing for domestic violence and the possible impact that violence, even historical violence, may have had on all of the family members.

RCW 13.50.100 During that time the mother and S.N.'s father said they attended substance use treatment. The specific treatment provider routinely does not cooperate with DCYF even when the client has signed a release of information. And in this case the information provided by the treatment provider did not provide a comprehensive understanding of what skills and progress they made during contacts with the provider. S.N.'s mother refused DCYF's request for oral swab testing. The DCYF staff also reported that this treatment provider routinely tells clients to not cooperate with DCYF. This was concerning to the Committee. The Committee member with expertise related to substance use treatment shared that it is the responsibility of a treatment provider to assess for needs related to mental health and DV. Which in this case both mental health and DV was identified as a significant need for S.N.'s mother.

RCW 13.50.100 Four days after S.N.'s birth, S.N.'s father had an oral swab that tested positive for methamphetamine and fentanyl. Five days after the positive oral swab DCYF learned that S.N.'s umbilical cord tested positive for fentanyl and other substances. RCW 13.50.100 RCW 13.50.100

The staff discussed that the mother said she had not used substances since she was four months pregnant and they in turn did not have a concern about the positive cord result. However, the Committee was concerned and believed that further follow up with a subject matter expert would have been appropriate and beneficial to fully assessing the children's safety. The Committee discussed that a request for S.N.'s birthing records and verification of what substances were given to RCW 74 mother during labor would have assisted in a comprehensive assessment of S.N.'s safety.

The Committee pondered how safe S.N. was in home with RCW 7 parents due to multiple issues including the lack of cooperation by the substance use treatment provider and therefore an inability to verify substantive behavioral changes by the parents regarding substance use, the parent's lack of cooperation with the contacted in-home service provider, S.N.'s father's continued substance use, and the mother's untreated mental health needs and especially after RCW 7 paternal grandmother left the home.

The Committee discussed concerns for the level of stress the parents may have felt with S.N.'s birth and then RCW 13.50.100 They identified that including the RCW 13.50.100 would have helped to build a shared understanding of events and expectations for all of the parties involved. There was also concern that the FTDM note identified that a safety plan would be created RCW 13.50.100 but that one was never actually created.

RCW 13.50.100