CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

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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

- A.F.

Date of Child's Birth

- RCW 74.13.515 2022

Date of Fatality

- August 8, 2023

Child Fatality Review Date

- November 14, 2023

Committee Members

- Patrick Dowd, JD, Director, Office of the Family and Children's Ombuds
- Kim Stankovich, Substance Use Disorder Professional, The Healing Lodge of the Seven Nations
- Alissa Copeland, MA, Early Learning Program Manager, Department of Children, Youth, and Families
- Betsy Tulee, ICWA Consultant/Tribal Liaison, Department of Children, Youth, and Families
- Shasta Cano-Martin, Director of Child Welfare, Lummi Nation
- Rusty Barnett, M.Ed., LMHC, CMHS, MHP, NCC, Clinical Supervisor, Lutheran Community Services NW

Facilitator

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

Executive Summary

On November 14, 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.F. and RCW 7 family. A.F. will be referenced by RCW 74 initials throughout this report.[2]

On August 8, 2023, the hospital reported to DCYF that A.F.'s mother found RCW 74.1 face down and purple. A.F.'s mother started CPR and then called 911. When law enforcement arrived at the home, they took over CPR until medics arrived and transported A.F. to the hospital emergency department. Upon arriving at the hospital A.F. was revived by CPR and Narcan. A.F.'s toxicology screen came back positive for Fentanyl. A.F.'s mother told hospital staff the parents had gone out and come home at two in the morning. She reported waking up at 10:00 A.M. and feeding A.F. then they both went back to bed. When A.F.'s mother woke up two hours later she noticed A.F. was purple and not breathing. A.F.'s mother reported there was Fentanyl in the home but did not have any details as to how A. F. was exposed to it.

A.F. was medevac'd to a larger hospital where the following day it was determined RCW 7 had experienced severe neurological injury and would not likely have any meaningful recovery. A.F.'s parents chose to compassionately stop life preservation efforts. A.F. passed away on August 10, 2023.

The case was closed at the time of A.F.'s fatality; however, in the year prior DCYF investigated A.F.'s family twice. One of those investigations was regarding A.F.

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 A.F. 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 speak with DCYF field staff who were involved with supporting the family.

Case Overview

A.F.'s parents have two children together, RCW 13.50.100

When A.F.'s father was involved with DCYF RCW 13.50.100 the

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

allegations consisted of parental substance use. A.F.'s father's drug of choice at the time was heroin. There were also concerns about his mental health. Prior to A.F.'s birth RCW 74 family was involved with DCYF twice.

RCW 13.50.100 in 2019 RCW 13.50.100

The report met criteria for a risk-only[3] CPS investigation. DCYF worked together with the tribal social worker to engage A.F.'s parents in services. The case was open for about a month while the parents moved into a tribal housing program and engaged in substance use disorder (SUD) treatment programs.

The family next came to the attention of DCYF in June of 2020 when they were requesting a larger unit in their housing program and were asked to complete urinalysis testing. A.F.'s mother's urinalysis test came back positive for morphine and marijuana and the housing program reported the results to DCYF. The report met criteria for Family Assessment Response[4] (FAR). A.F.'s parents agreed to work with DCYF in the FAR pathway. The caseworker worked closely with the tribal social worker to engage the family while the case was open for 45 days. The parents reported they relapsed due to the stress of COVID quarantine and relied on the paternal grandmother to watch A.F.'s older brother for them while they used.

While the case was open the parents provided urinalysis tests that were positive for marijuana and prescribed Suboxone only. A.F.'s mother reengaged in outpatient SUD treatment. A.F.'s father was engaging in medication for opiate use disorder (MOUD) treatment not outpatient or inpatient SUD treatment as was recommended for him at the time. The family had to move from their housing program due to the positive urinalysis test. At the end of the case, they had moved in with the father's uncle and his wife who was an SUD professional.

In October 2022 A.F.'s mother was pregnant with A.F. and was not compliant with her MOUD treatment program. To help engage A.F.'s mother, the SUD provider dropped off diapers for A.F.'s older brother at the family's residence. The provider called DCYF to report that the residence where the family was living was a shared residence with many families that was unsanitary. Additionally, they reported A.F.'s mother RCW 13.50.100 RCW 13.50.100 appeared to be padlocked into the family's room while A.F.'s father left to work. The report met criteria for a CPS investigation and a case opened. The caseworker worked with a tribal social worker to investigate the allegations. Twelve days later A.F. was born with a positive toxicology screen for cocaine and A.F.'s mother was known to have used Fentanyl prior to delivery. This report met criteria for a risk-only CPS investigation.

DCYF worked with the family for two months. The parents shared they relapsed and agreed to a safety plan until they could enter treatment. At the time the case closed A.F.'s mother had entered inpatient SUD treatment and had both children with her. A.F.'s father was planning to enter an SUD detox program. The investigation was unfounded as to the allegations of the home being unsanitary and RCW 13.50.100 being padlocked in the room RCW 13.50.100

[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] "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

The family next came to the attention of DCYF on August 8, 2023, when A.F.'s mother called 911 to report she found A.F. face down and purple. A.F.'s mother additionally reported to law enforcement she smoked Fentanyl until 2 am then went to bed. A.F.'s mother said she woke up to feed A.F. at 10 am then RCW 7 went to sleep on her. When A.F.'s mother woke up at 12 pm she found RCW 74.1 face down and purple. At this point she started CPR and called 911. Emergency services arrived and transported A.F. to the hospital. A.F. was revived with CPR and Narcan at the local hospital. A.F. was eventually medevac'd to a larger hospital where it was determined the following day RCW 7 had experienced severe neurological injury and would not likely have any meaningful recovery. A.F.'s parents chose to compassionately stop life preservation efforts. A.F. passed away on August 10, 2023.

Committee Discussion

On the day of the review the Committee met with the field staff that worked on this case in the year prior to the critical incident. This review was emotional as the primary caseworker had a strong rapport with A.F.'s family and mourned RCW 74 loss. The Committee was sensitive to the caseworker's experience as they met. The Committee was appreciative of their conversation with the field staff.

The office leadership first shared some context of how things were going for this office at the time they were involved with the family. The first two times the office worked with the family, prior to A.F.'s birth was a more stable time for the office in terms of staffing and leadership; however, the second time they worked with the family was during the COVID pandemic and quarantine which was a particularly difficult time to connect with families and ensure services were delivered and needs were met. Office leadership explained the investigation in the year prior to A.F.'s fatality was at a time the office was experiencing transition in several layers of leadership as well as several caseworker vacancies. At the time the caseworker had the case prior to A.F.'s fatal event, the supervisor left DCYF and the worker was being supervised by a back up supervisor. The caseworker was also taking a lot of difficult cases because they were one of the only experienced caseworkers in the unit. Additionally, at the time the caseworker had this case they were also managing another very challenging case on their caseload with many emergencies. The Committee appreciated learning this context from the office leadership.

The Committee noted several strengths in the work done with A.F. and RCW 74 family. The Committee appreciated the strong collaboration with tribal caseworkers from the start of each investigation and throughout each investigation. The Committee noted ample documentation of collateral contacts to verify information throughout the investigations. The Committee saw strong evidence of a good rapport with the family, even with A.F.'s father who was suspicious of DCYF. The Committee mentioned one place where the strong rapport with the parents was most evident was in the honesty from the parents around their substance use. The Committee liked seeing ongoing efforts to involve relatives in case planning and collateral information gathering. Finally, the Committee recognized that all the investigations included the required work completed appropriately rather than just to check a box as is sometimes seen.

The Committee and the field staff had a robust discussion around housing resources in the community. The field staff noted that finding housing resources is a struggle when helping the families. In their discussion the Committee noted housing as an ongoing issue for A.F.'s family. The Committee wondered if there had been

more stable housing options or housing resources that did not rely on urinalysis testing, if this family would have experienced more stability.

The Committee and the field staff discussed the decision to close the case when mom and the children left to inpatient SUD treatment. The caseworker and supervisor explained they decided to close the case because the children were safe with the mother in a treatment center and the treatment center knew to call in a report if they left early against treatment recommendations. They did not feel there was any reason to keep the case open longer. The Committee later discussed cases such as this being a risk when the family returns from treatment and DCYF is no longer involved for support. The Committee wondered if there was a better way to ensure there is support for the family after they finish a treatment program while not prolonging case closure and increasing caseloads.

Finally, the Committee discussed the difficulty of the work DCYF caseworkers are facing at present. The field staff shared the increase in fatalities and near fatalities of children and parents they are experiencing, which sometimes leads to critical incident reviews. The Committee discussed the burnout these experiences create, especially for caseworkers who are more experienced in work units where they end up with more cases because they are the only ones with experience. The tribal representative on the Committee shared some of the strategies their tribe has implemented to focus on well-being such as all day, mandatory self-care events like a beach day or other such retreat or cultural activities focused on taking care of one's mental health and well-being.

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

- DCYF should consider a policy or practice change implementing supportive closure meetings involving the family and their support systems at the time of case closure for families with high-risk cases. The Committee believes ensuring a high-risk family's natural supports understand the risks and safety issues present at the time of case closure could increase child safety and connection to community support. The Committee also sees this as an opportunity for DCYF to celebrate families completing their work with DCYF.
- DCYF should prioritize supporting the mental health and well-being of their work force and recognition of the traumatic work they're doing. The Committee acknowledges the work force is facing a significant increase in the number of critical incidents along with the stress of the Fentanyl epidemic and the aftermath of the COVID pandemic. The Committee feels DCYF needs to prioritize the mental health and well-being of the work force as they deal with the confluence of these difficult issues. The Committee took particular concern with the work force having to use their own leave following a critical incident and felt a different leave option following a critical incident may be more supportive.