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

- E.S.

Date of Child's Birth

- February [redacted] 2023

Date of Fatality

- March 9, 2024

Child Fatality Review Date

- May 16, 2024

Committee Members

- Roshelle Cleland, Director of Advocacy/Victim Advocate, Lutheran Community Services
- Mary Moskowitz, JD, Ombud, Office of Family and Children's Ombuds
- Qytrice Rouina, DATC I Treatment Services, Tacoma-Pierce County Health Department
- Michelle Hetzel, MSW, Statewide CFWS Program Manager, Department of Children, Youth, and Families

Facilitator

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

Executive Summary

On May 16, 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 E.S. and RCW 74 family. The child, E.S., will be referenced by RCW 74 initials throughout this report.[2]

On March 9, 2024, DCYF was notified that E.S. died while at RCW 74 parents' home. This resulted in a law enforcement investigation and a Child Protective Services (CPS) investigation.

At the time of his death, E.S. and RCW 74 two siblings were in out-of-home care. In August 2023, the children were placed in out-of-home care after E.S. ingested fentanyl while in the care of RCW 74 father. DCYF conducted a child near fatality review for E.S. in October 2023 due to RCW 74 fentanyl ingestion. On March 9, the children were at their parents' home for their first overnight visit. E.S. died that first evening.

An autopsy revealed that E.S. ingested a lethal dose of methadone. Both of E.S.'s parents were prescribed methadone as a treatment modality for their opioid addictions. However, neither parent should have been in possession of this medication on the day of E.S.'s death. The CPS investigation resulted in founded findings for negligent treatment or maltreatment for both parents.

A CFR Committee was assembled to review DCYF's involvement and service provision to E.S. and RCW 74 family. The Committee included members with relevant expertise selected from diverse disciplines within DCYF and community partnerships. Three of the four Committee members were also Committee members for the previous October 2023 child near fatality review regarding E.S. The new Committee member was chosen because she is the Child and Family Welfare Services (CFWS) statewide program manager, and the children were placed in out-of-home care and the case was assigned to a Child and Family Welfare Services (CFWS) caseworker at the time of the death. Committee members had no prior direct involvement with E.S. 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 interview DCYF staff who worked with the family between August 2023 and March 2024. At the time of the review, the primary CFWS caseworker was no longer employed by DCYF and therefore was not present at the review meeting.

Case Overview

RCW 74.13.515

E.S. has two older half-siblings. The children each share the same mother but have different fathers. E.S.'s parents were living together prior to E.S.'s birth and continued to live together through March 2024. RCW 74.13.515

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

RCW 74.13.515

Prior to E.S.'s birth, DCYF received multiple intakes regarding concerns of parental substance use and DV. In 2020, DCYF filed a dependency petition regarding E.S's RCW 74.13.515 RCW 7 was placed in out-of-home care. E.S.'s RCW 74.13.51 was in the legal custody of the maternal grandmother. That legal arrangement did not involve DCYF. The children's mother subsequently entered inpatient substance use treatment and E.S.'s RCW 74.13.515 was placed back with the mother at the treatment facility. The mother entered Family Recovery Court (FRC) through the juvenile dependency process.

At some point in 2021, E.S.'s parents began a relationship. During this relationship there was DV between the parents. This issue was discussed at a shared planning meeting. Shared planning meetings are meetings involving the legal parties to a case, natural supports, and service providers where differing aspects of the case are discussed. The team discussed ongoing support for the family when the dependency case was dismissed. The dependency case was dismissed in December 2021.

Two more intakes were received in April 2022. One intake did not meet legal sufficiency and was screened out. The other intake was assigned for a Family Assessment Response (FAR) assessment. FAR is an alternative pathway within CPS for lower-risk allegations of maltreatment that are screened in for assessment. The parents told the caseworker they were moving to Eastern Washington. The mother did not comply with a request for a urinalysis, but did tell the caseworker that she had relapsed. The mother shared that in previous cases with DCYF, they created a plan where the mother was required to find an appropriate person to watch over her child if she were to use substances. Therefore, the mother sent RCW 74.13.515 to stay with a friend. The case was closed after the caseworker made collateral contacts and completed her assessment.

On February 11, 2023, DCYF received another intake. This intake alleged that the mother tested positive for fentanyl at the birth of her third child, E.S. The mother admitted to using fentanyl the day she gave birth, stating she relapsed at 37 weeks gestation. The family reported they were living at a shelter. The maternal grandmother picked up E.S.'s siblings prior to E.S.'s birth. It was reported that E.S.'s siblings had been living with their mother for the past year. This intake met legal sufficiency for a CPS investigation.

After the CPS investigation was complete, the case transferred to Family Voluntary Services (FVS). The family struggled with stable housing and substance use allegations. Both parents continued to struggle with substance use but maintained contact with the caseworker.

On August 21, 2023, E.S. ingested fentanyl while in RCW 7 father's care. All three children were placed in protective custody by law enforcement. DCYF filed dependency petitions for each child and the children were placed in out-of-home care. Originally, the children were placed together in one of the RCW 74.13.51 paternal grandmother's home in Western Washington. That placement only lasted one week. The children were then placed in a court ordered placement with a family friend.

In September 2023, E.S.'s mother once again entered FRC. She then checked into an inpatient treatment facility. The court ordered that the children be placed with the mother at her inpatient treatment facility. However, due to a COVID outbreak, this did not occur. The mother left treatment prior to completion. In October, the mother began another inpatient treatment program in Eastern Washington. RCW 74.13.515 were

moved from their placement in Western Washington to a placement in Eastern Washington. During a visit at the treatment facility with their mother, the mother called and asked the foster mother to pick RCW 74.13.515 up early. After RCW 74.13.515 left, E.S.'s mother again left treatment prior to completion.

In December, E.S.'s mother told the caseworker that she was pregnant. The pregnancy ended in a miscarriage that was emotionally and physically very challenging for her, as well as emotionally challenging for E.S.'s father. E.S.'s mother once again entered inpatient treatment in Eastern Washington.

E.S.'s mother graduated from inpatient treatment on January 11, 2024. She moved back to Western Washington and resided in a sober living environment while completing intensive outpatient treatment. During January and February, the parents had extended visitation RCW 74.13.515 Some visits occurred in Eastern Washington, and some occurred in Western Washington.

On February 6, 2024, a shared planning meeting occurred. During this specific meeting, the group discussed the parents' progress with services. E.S.'s father had just started a second phase within FRC, meaning he completed intensive outpatient services and was next set to complete outpatient services, which are less frequent than intensive outpatient services. E.S.'s mother had not completed phase one yet. She was not consistently attending meetings for her intensive outpatient services. The treatment provider asked the parents to provide better communication when either parent was going to miss a meeting or treatment session. Both parents were waiting to start mental health services. One of the other fathers on the case was also at the shared planning meeting. He shared that he was working on locating stable housing and had caught up on his child support payments.

During a March 4, 2024, shared planning meeting, the parties discussed services and visitation. E.S.'s father and mother were present. The two other fathers were invited but did not attend this meeting. E.S.'s mother was reportedly more consistently attending her intensive outpatient treatment meetings during the previous month. She was also working with a sobriety sponsor. E.S.'s father continued to attend his outpatient treatment services. The group identified a transition plan. This meeting occurred on a Monday. The first overnight visit for all three children was scheduled to take place during the following Friday through Sunday. E.S.'s RCW 74.13.51 had been visiting with the mother and E.S.'s father on an almost daily basis but had not technically changed placement. RCW 74.13.515 were going to move back to Western Washington in April to stay with a relative while they transitioned back into E.S.'s parents' physical care. The caseworker reported that she completed an updated safety assessment[3] and the court appointed special advocate (CASA) also agreed with this plan.

On Friday, March 9, during the first overnight visit, E.S. died. The medical examiner found a lethal amount of methadone in E.S.'s body through an autopsy. Both of E.S.'s parents were taking methadone as part of their substance use treatment plan. They would go to a facility Monday through Friday to receive their daily dosing. On Saturdays, they would receive a methadone dose for that day and one for Sunday. E.S.'s parents should have obtained and taken their Friday dose at the clinic prior to receiving E.S. for RCW 7 overnight visit.

[3] A safety assessment is a comprehensive assessment used to identify if there are safety threats and if so, whether a safety plan needs to be created. For more information regarding safety assessment, see: https://www.dcyf.wa.gov/1100-child-safety/1120-safety-assessment.

Committee Discussion

This section includes the Committee's discussions and considerations related to the case. While the scope of the review process only includes DCYF's work on the case, some discussion occurred regarding court partners in this case and the family's involvement in FRC. The Committee appreciated hearing from the CFWS supervisor regarding the case progression between the two ingestion events. The Committee understood that the primary CFWS caseworker no longer worked for DCYF, which was a disadvantage for this review process.

The Committee opined that the parents may have needed more time to demonstrate their sobriety before overnight visits occurred for E.S. and RCW 74.13.515. E.S.'s RCW 74.13.51 had been visiting the parents almost daily for long periods with unsupervised contact. However, RCW 74.1 is older than E.S. and RCW 74.13.515, and therefore considered less vulnerable. The Committee identified that the recent non-compliance reports on February 16 and February 23, along with a missed urinalysis for E.S.'s mother, were concerning. A safety assessment completed on March 4, 2024, indicated both parents had many negative urinalyses and no positive urinalyses between January 2, 2024, and the completion of the safety assessment. The document also stated that E.S.'s father had graduated from intensive outpatient treatment to outpatient treatment in February 2024 and that E.S.'s mother graduated from inpatient treatment on January 11, 2024. However, the document also stated a walkthrough of the home was conducted on February 6, 2024, which was a full month before the first overnight visit. The Committee members discussed a desire to read documentation on how the assessment of the parents' and children's safety resulted in this transition plan, outlining what behavioral changes had occurred. However, the Committee understood that all parties, as well as the FRC judge, substance use professional, relatives, foster parent, and CASA agreed with the plan for overnight visits and ultimately a transition to return the children home.

When discussing documentation, the Committee also identified specific documentation they wanted to see being used in a case like this. The documentation they specifically identified included: a relapse prevention plan; discussion of safe storage of methadone carries (when methadone is dispensed at a facility to be taken at a different time and location by the patient) with the parents and treatment providers; a walkthrough of the home when the children arrived for their first overnight visit; and a plan for checking in on the family during this first overnight visit. The Committee was also concerned about the assigned CFWS caseworker taking leave during such a crucial event—the first overnight visit. The Committee understands that caseworkers have a right to utilize their accrued leave and that management also has the right to deny leave if there is a business need to do so. The Committee would like DCYF to consider that if a caseworker is on leave during a crucial time, such as in this case, then a plan for coverage during that time should be created prior to the caseworker's leave.

The Committee discussed that groupthink or confirmatory bias may have contributed to the decision making in this case as well. The parents are reportedly very likeable, and the caseworker spent a significant amount of time with them. She would not only visit them at their home often, but would also assist them with making necessary telephone calls for services, consistently obtaining concrete goods for them, and driving them to appointments. While these practices are often seen as positive, supportive, and show active efforts to reunify a family, the Committee also discussed that in this case it may have been enabling the parents as opposed to empowering.

Part of the Committee's groupthink or bias conversation included concerns about how the parent's mental health was assessed and treated. The emphasis, in relation to services provided prior to the death, appeared to be regarding substance use only. E.S.'s mother has a long history of trauma which started in childhood. She additionally suffered a miscarriage that was both emotionally and physically difficult a month prior to the first overnight visit. The Committee believed the parents may have benefited from more engagement in mental health services.

This case involved one mother, three fathers, and a maternal grandmother who was the legal custodian of one of the children. The Committee identified that the large number of parties to this case would be challenging on its own. Additionally, placement changes and challenges with coordinating visitation across the state made this case very difficult to manage.

The DCYF staff told the Committee that FRC in this county utilizes an online system to store all of the documents related to a person's case. The regular practice is for the DCYF caseworker to obtain appropriate documents at the conclusion of a case and upload those documents to Famlink. Famlink is the computer program used by DCYF. The Committee discussed that it would seem appropriate for the caseworker to obtain certain documents when they are created and upload them to Famlink, or to have the assigned caseworker create a case note detailing what the document says, instead of waiting until the end of the case to receive and upload FRC documents to Famlink. The discussion identified that a person reading the case file without firsthand knowledge of the case would benefit from being able to access relevant FRC information used to support certain decisions, such as starting overnight visits.

The Committee discussed whether HB 1227[4] played a role in what the Committee identified as a shortened timeframe to start overnight visits. HB 1227, also known as the Keeping Families Together Act, has had the impact of decreasing the number of dependency petition filings statewide. Although HB 1227 amended only the legal standard for placing a child in out-of-home care before a dependency and disposition order, some DCYF staff noted they felt that since HB 1227's enactment, there has been an increased pressure to more quickly return children to their parent's care throughout a dependency case. The Committee members appreciated the difficult task of balancing child safety against the harm of separation from parents/legal guardians.

[4] For information about HB 1227, see: https://www.wacita.org/hb-1227-keeping-families-together-act/.