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 4

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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

- R.W.

Date of Child's Birth

- September 2019

Date of Fatality

- December 27, 2023

Child Fatality Review Date

- February 29, 2024

Committee Members

- Patrick Dowd, JD, Director, Office of the Family and Children's Ombuds
- Derek Murphy, M-RAS, SUDP, CSC, Director of Clinical Services, Olalla Recovery Centers
- Bev Rowland, M.Ed., MHC, CMHS, DMHS, Clinical Manager, YVFWC – Behavioral Health Services
- Alissa Copeland, MA, Early Learning Program Manager, Department of Children, Youth, and Families
- Patricia Erdman, MSW, LICSW, Interim Executive Director, The Alliance University of Washington
- Sandy McCool, MSW, Intake and Child Protective Services Investigations Program Manager, Department of Children, Youth, and Families

Facilitator

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

Executive Summary

On February 29, 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 R.W. and RCW 74. family. R.W. will be referenced by RCW 74. initials throughout this report.[2]

On December 29, 2023, DCYF was notified that on December 27, 2023, four-year-old R.W. died after ingesting fentanyl. Law enforcement was investigating RCW 74. death. At the time of RCW 74. death, R.W. and RCW 74.13.515 were staying with their parents in a motel. DCYF opened a Child Protective Services (CPS) investigation into R.W.'s death.

Law enforcement arrested both parents in connection with R.W.'s death. Law enforcement placed R.W.'s RCW 74.13.515 in protective custody. DCYF filed a dependency petition because the parents could not safely care for the child in their home.

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 had no prior direct involvement with R.W. 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 involved in the case.

Case Overview

There was a total of 11 intakes regarding this family prior to R.W.'s death. The allegations included parental substance use, neglect of the children, domestic violence (DV), and parental mental health crises.

Both the maternal and paternal relatives were involved with the children and parents. The family members helped, both in housing and caring for the children, as well as trying to help the parents obtain substance use treatment. There was also a period of time that the children's father was incarcerated due to violating a no contact order involving the children's mother.

DCYF received the first intake regarding this family in April 2022. The first two intakes alleged parental substance use and were screened out. Screened out intakes are intakes where the allegations do not meet the threshold for an investigation or assessment.[3]

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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] R.W.is not named in this report because RCW name is subject to privacy laws. See RCW 74.13.500.

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

In February 2023, law enforcement reportedly placed R.W. and RCW 74.13.515 in protective custody. Law enforcement reported to DCYF that the mother was experiencing a mental health crisis and was also using substances. This intake screened in for a CPS investigation.

When the CPS caseworker contacted law enforcement, she learned that law enforcement did not complete the protective custody action and instead had left the children with their maternal uncle. The maternal uncle told law enforcement that his sister, the children's mother, and the children had been living with him.

The CPS caseworker interviewed the maternal uncle. He shared concerns regarding his sister's substance use and untreated mental health struggles. He stated the mother would hallucinate and then try to leave with her children in the middle of the night. He expressed a desire to file for guardianship of the children to protect them from harm. The caseworker provided the uncle with three community resources to contact in order to file for guardianship.

On March 4, 2023, Oregon Department of Human Services (Oregon DHS), Oregon's equivalent of DCYF, called DCYF to report that Umatilla Police Department (located in Oregon) reported concerns for R.W. after RCW 74. mother experienced another mental health crisis. The mother told employees at a truck stop that she had been kidnapped and raped and she wanted someone to call law enforcement. When law enforcement arrived, they observed that the mother was very upset and said that she was going to call the Federal Bureau of Investigations and the U.S. Secret Service. The report also stated that at some point while responding, law enforcement observed a distraught, young child in the mother's car. That child was R.W.; there was no indication that RCW 74.13.515 was also present.

The responding law enforcement officer ran the license plate on the car that R.W.'s mother was driving. The car was identified as a stolen vehicle from Pasco, Washington. The officers called Pasco Police Department. During that call, the Umatilla officer was informed of prior interactions between Pasco police officers and R.W.'s mother. During a previous interaction with Pasco officers, R.W.'s mother was experiencing a mental health crisis and had made allegations that she was kidnapped and raped. The Pasco officer also shared that on March 3, 2023, family members reported that R.W.'s mother went to the maternal uncle's home, stole his vehicle, and took RCW 74.13.515 from the maternal uncle's residence.

Law enforcement arrested the mother for possession of a stolen vehicle. Oregon DHS contacted the maternal uncle. Law enforcement gave R.W. to RCW 74. maternal uncle. This intake also screened in for a CPS investigation.

DCYF received two more intakes in April 2023. Both intakes screened out. The mother again took her children from the maternal uncle's home. On May 4, DCYF received an intake from law enforcement. Law enforcement responded to a home where R.W., RCW 74. mother, and RCW 74.13.515 were staying with one of the mother's friends. R.W.'s mother and her friend got into a fight and law enforcement was called. Law enforcement observed two methamphetamine pipes within reach of the children. Law enforcement did not place the children in protective custody.

During DCYF's investigation, maternal and paternal relatives told DCYF about ongoing concerns regarding the mother's substance use and unmet mental health needs. The family members tried for over a year to help stabilize the mother and children and would often care for the children for extended periods of time. The

relatives said there were instances of the mother coming to their homes late at night, where she would appear to be hallucinating and would take her children from the relative's homes. The maternal uncle expressed the desire to have legal custody of the children in order to provide them with a safe and stable home until their mother could safely care for them.

DCYF staff informed the Committee of significant turnover and vacancies during this time. This resulted in multiple caseworkers working on this investigation. On July 10, 2023, the case closed with an unfounded finding regarding the allegations reported to DCYF. At the time of case closure, the children were staying with their maternal grandmother.

On August 4, 2023, the paternal grandmother called DCYF. She reported that the maternal grandmother told her that R.W.'s mother, R.W., and R.W.'s RCW 74.13.515 had been staying at the maternal grandmother's home. The children were to remain at that home while the mother went through detox and entered an inpatient substance use treatment program. The mother left the treatment facility the same day she arrived. The mother then took the children from the maternal grandmother's home in the middle of the night. The mother and children were reportedly staying in a small trailer with several other people. The paternal grandmother did not know the names of the other people, nor did she know the address where they were living. The paternal grandmother reported the family members believe the mother is using fentanyl. The paternal grandmother also reported that her son, the children's father, was incarcerated. Specific dates of each reported event were not documented. The intake caseworker and supervisor closed the intake stating there were no specific allegations of abuse or neglect.

On August 10, 2023, a hospital called DCYF to report that R.W. was diagnosed with pneumonia. The hospital reported that the paternal grandmother was originally caring for R.W., but after two weeks of R.W. being sick and the paternal grandmother not knowing how to care for RCW 74.13 she took R.W. to the maternal grandmother. The maternal grandmother immediately took R.W. to the hospital. Prior to the paternal grandmother having the children, they were living with their mother and mother's boyfriend in a small trailer. The grandmother suspected the adults were using fentanyl in the presence of the children. The hospital completed a toxicology screen for R.W. but did not test for fentanyl. The test was negative for all other substances. Discharge paperwork stated that if R.W.'s condition had been left untreated, it could have resulted in a fatality. This intake was screened in for a CPS investigation.

R.W.'s location was not in the area covered by the DCYF office the case was assigned to. Therefore, a courtesy caseworker was assigned to conduct the initial face-to-face contact with R.W and RCW 74.13.515 R.W. was observed to be pale, weak, and covered in suspected mosquito bites. R.W. exhibited speech delays and the caseworker was told RCW 74.1 had been referred for speech therapy. R.W. did not speak directly to the caseworker. RCW 74.13.515 told the caseworker that RCW 7 and RCW 74.13.515 got sick very quickly at the home they were staying at with their mother. RCW 74.13.515 stated that RCW 7 had a headache and sore throat. They were staying with their mother, her boyfriend, and the boyfriend's parents.

DCYF learned that R.W.'s mother was incarcerated the day before the August 10 intake. R.W.'s mother admitted to fentanyl and methamphetamine use and stated she needed substance use treatment. She was asked to provide urinalyses on two separate occasions but did not cooperate. The case was submitted for

closure on November 22, 2023, as unfounded. At the time of case closure, the children were staying with relatives and the mother told DCYF staff that she did not plan on removing the children from the relatives.

On December 29, 2023, R.W. died due to ingesting fentanyl. She was in the care of her mother and father. RCW 74.13.515 was also with the parents. They were staying in a motel room. RCW 74.13.515 was placed in protective custody and the parents were arrested.

Committee Discussion

The Committee appreciated hearing the perspective of the DCYF staff who worked on, or supervised staff who worked on, the case. The staff shared challenges they encountered during this case. One of the main challenges was the high level of turnover and vacancies.

The Committee specifically identified the courtesy caseworker's case note as thorough, detailed, and helpful to the reader in understanding R.W.'s presentation and the circumstances at that time. The case note also identified that the maternal grandmother spoke Spanish and that the caseworker was a certified Spanish-speaking employee.

The Committee opined that the family could have benefited from addressing the chronicity of certain issues in each of the assessments. The Committee believes that understanding the repeated concerns and allegations related to the mother's substance use and her untreated mental health needs, as well as repeatedly taking the children from the relatives' care and how that played into the safety of and risk to the children, may have been helpful in identifying active safety threats. They also believed that more engagement or documented efforts to engage the father or his relatives in assessment of child safety may have been beneficial.

The current area administrator shared that since she took over leadership in August 2023, she has identified areas of practice where her staff could benefit from updated training and guidance. The Committee appreciated that the area administrator has already engaged internal and external partners for those trainings.

The Committee identified the co-occurring nature between the mother's unmet mental health and substance use needs and that she may have benefited from assessments targeted at addressing an individual's co-occurring disorder. According to the Substance Abuse and Mental Health Services Administration, "[p]eople with mental illness are more likely to experience a substance use disorder than those not affected by a mental illness. According to a national survey from 2022 identified approximately 21.5 million adults in the United State have a co-occurring disorder."[4] The Committee discussed that Washington State does not have enough providers who specialize in treating this type of disorder and that DCYF child welfare staff would benefit from a strong understanding of the challenges facing individuals with a co-occurring disorder.

The Committee also believed that as part of a comprehensive family assessment, further identification of domestic violence and the role that could have played in assessing R.W. and RCW 74.13.515 safety may have been helpful. It additionally would have been helpful for DCYF staff to understand the added assistance that early learning navigators can offer families and staff. Child welfare early learning navigators contact parents

[4] Co-Occurring Disorders and Other Health Conditions, SAMHSA (Mar. 29, 2024), https://www.samhsa.gov/medications-substance-use-disorders/medications-counseling-related-conditions/co-occurring-disorders (last visited May 8, 2024).

who have a child between birth and age five who have an open child welfare case. The navigators can help connect a family to services such as child care, Early Childhood Education and Assistance Program, Head Start, home visiting, Early Support for Infants and Toddlers, and early intervention services. DCYF has not received funding to have a navigator in each office, but each office can contact a regional navigator to assist with cases that qualify.

The Committee discussed what they believed clinical supervision of case-carrying staff should include. During that discussion, they identified that coaching staff at all levels, both new and experienced, would be beneficial. These coaching components should be captured in the monthly case review case notes drafted by supervisors. The Committee also considered how helpful it might have been to have a closing case note summarizing what occurred during an investigation or assessment. The Committee opined that when a case is newly assigned often times the caseworker and supervisor do not have time to read the entire case history. Therefore, entering a case note at case closure that summarizes what occurred during the case; what services were offered; whether the parent or guardian complied with services; and whether an active safety threat was identified and how that was ameliorated, among other things, would be beneficial.

The Committee addressed the impact of HB 1227 when discussing multiple aspects of child welfare casework.[5] The Committee understood that DCYF provided an initial training to staff regarding what HB 1227 was and identified changes to practice. The Committee believes that field staff would benefit from ongoing, short-duration information sessions that will assist staff in applying HB 1227 requirements to child welfare practice and realistic examples to help facilitate learning.

The Committee believed there were at least two different times during the case at issue here where an active safety threat was present and met the threshold for further intervention, such as offering a voluntary placement agreement or filing a dependency petition. The Committee acknowledged that the staff believed, based on their experiences in previous cases, that the court would have denied the dependency petition. However, the Committee believes that even if the dependency petition was denied, filing the petition would more than likely have been an appropriate response.

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