CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

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- M.K.

Date of Child's Birth

- January 2023

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- September 18, 2024

Committee Members

- Derek Murphy, M-RAS, SUDP, CSC, Director of Clinical Services, Olalla Recovery Services
- Stephanie Widhalm, MSW, LICSW, MHP, CMHS, CCATP-CA, Children's Advocacy Center Director and Forensic Interviewer, Partners with Families and Children
- Mary Moskowitz, JD, Ombud, Office of Family and Children's Ombuds
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Facilitator

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Executive Summary

On September 18, 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 M.K. and RCW 74 family. The child, M.K., will be referenced by RCW 74 initials throughout this report.[2]

On May 29, 2024, law enforcement notified DCYF that 16-month-old M.K. died in RCW 74 home. Law enforcement found heroin and fentanyl on the counter in the kitchen as well as drug paraphernalia within reach of M.K. and RCW 74 five-year-old sibling. This intake screened in for a Child Protective Services (CPS) investigation. 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.

During the CPS investigation pertaining to M.K.'s death the King County Medical Examiner's office notified DCYF that M.K. had methamphetamine and fentanyl in RCW 74 system at the time of RCW 74 death. Both M.K.'s mother and father were found to be negligent as to both M.K. and RCW 74.13.515 The parents received founded findings of negligence from DCYF.

Prior to M.K.'s death, DCYF received eight intakes regarding RCW 74 family. Of the eight intakes, five screened in for CPS investigations and the three others did not screen in. The allegations in the screened in intakes included concerns for lack of supervision and parental substance use.

A CFR Committee was assembled to review DCYF's involvement and service provision to M.K. and RCW 74 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 M.K. 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 some of the DCYF staff who were involved in the case since 2022.

Case Overview

M.K.'s family first came to the attention of DCYF in 2021. At that time M.K.'s mother and father had a two-year-old son. Two intakes were received in 2021 alleging lack of supervision and concerns for parental substance use. A FAR assessment was completed. The parents were provided with concrete goods (i.e. door alarm, safety kits, doorknob covers, lockbox, etc.). The parents each agreed to provide an oral swab and both tested positive for methamphetamine, morphine, codeine, and heroin. The caseworker contacted the child's pediatrician and a relative who owned and lived on the same property as the parents. RCW 13.50.100 RCW 13.50.100 The caseworker referred the family to

[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] M.K.'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.

community services for early intervention. The parents did not cooperate with the caseworker's request to comply with a substance use assessment. The case was closed without further intervention due to a lack of identified immediate danger to the child's safety.

In April 2022, DCYF screened in a CPS intake regarding the parents' using substances in the presence of their three-year-old RCW 74.13 The caller, a relative, reported domestic violence (DV) occurred a year earlier when the father threw the mother into something (unknown what she hit). The relative also said the parents are not adequately feeding the child. The relative called DCYF while on their way to the parental home. The parents agreed to allow the relative to care for their child while they entered inpatient substance use treatment.

The relative lived in a different part of Washington state than the parents and therefore the case was opened in two different DCYF regions at one time. DCYF has six regional areas that group counties together. A courtesy caseworker was assigned to contact the child and relative in western Washington while the other caseworker contacted the parents in eastern Washington. The case closed in August 2022, RCW 13.50.100

In October 2022, an intake screened in for a FAR assessment. This intake alleged parental substance use and identified that the mother was pregnant. RCW 13.50.100 The assigned caseworker contacted a relative, the same relative from the case in April, RCW 13.50.100

RCW 13.50.100 The caseworker arranged for transportation for both parents to their withdrawal management programs. The caseworker had contact with the mother's substance use treatment provider to verify engagement with treatment prior to case closure. The mother's treatment provider told the caseworker that they had contact with the father's substance use treatment provider to verify he was entering a treatment program as well.

Due to internal DCYF fiduciary issues the case was not able to completely close until January 2023.

On June 22, 2023, DCYF received information that the parents and their two children, five-month-old M.K. and RCW 74.13.515 were removed from a shelter facility due to fentanyl use. The parents were smoking fentanyl in the room with their children present. The caller reported that the parents were engaged in outpatient substance use treatment, that mother was diagnosed with an RCW 74.13.520 RCW 74.13.520 and that the father was diagnosed with RCW 74.13.520 Both parents were receiving mental health care through the same provider as their substance use treatment. This resulted in a CPS investigation.

After conducting the CPS investigation, the case transferred to a Family Voluntary Services (FVS) caseworker. That caseworker left DCYF employment shortly after being assigned and the case transferred to the other FVS caseworker in that office.

Due to the parents' willingness to engage in voluntary services DCYF did not believe it had sufficient grounds to file a dependency petition as there was not probable cause to believe that the child was in imminent physical harm due to child abuse or neglect. Nor were there facts sufficient at that time to establish that either of the children had no parent capable of adequately caring for the child.

The parents continued to attend substance use treatment but also continued to have positive tests for substances including, but not always limited to fentanyl. The parents openly admitted to the FVS caseworker that they continued using substances. The caseworker did not have any information other than the parental substance use to identify immediately physical danger to the children's safety.

M.K.'s parents continued to regularly communicate and cooperate with the DCYF caseworker and community agencies they worked with. There were no concerns for child safety identified by the caseworker during the regular and unannounced home visits nor by any community providers that the family interacted with. The parents remained in compliance with their substance use treatment, per the treatment provider. In January 2024 DCYF closed the FVS case.

On May 29, 2024, law enforcement notified DCYF that 16-month-old M.K. died in [RCW 7 home and drugs were found within reach of M.K. [RCW 74.13.515] A law enforcement investigation as well as a CPS investigation were conducted.

Committee Discussion

The Committee met with a majority of the staff who worked on the case between 2022 and January 2024. The Committee discussed multiple aspects related to the case events as well as systemic issues that may have impacted DCYF staff.

The Committee discussed concerns for DCYF staff and their well-being. Specifically related to how workload, critical incidents, and critical incident reviews such as this one can negatively impact a staff member and then what DCYF has done to support the staff. The Committee acknowledges and appreciates that there have been significant gains related to the creation of the Resiliency Support Team and the behavioral health contracts for staff who are impacted by critical incidents. However, the Committee also discussed that DCYF staff should be considered as impacted as law enforcement are when they are involved in critical incidents and that consideration should be given to not assigning cases, requiring an appointment with a mental health therapist, mandatory leave, etc.

Harm reduction kits and how those items in the kits are discussed by the caseworkers with the families was discussed by the Committee. The Committee learned about the recently delivered high potency synthetic opioid training that was created by program managers. The Committee opined that further training should be created and provided to DCYF field staff regarding the conversations, how to have them and the content, when delivering items in the harm reduction kits. Those discussions should include safe storage of medications used to help people experiencing substance use, naloxone use and steps after administering, among other topics. After the review, during a debrief with this writer, some staff shared that ongoing, periodic refresher trainings pertaining to harm reduction efforts and domestic violence would be beneficial to staff.

Part of the discussion about the conversations related to the harm reduction efforts included motivational interviewing techniques. DCYF has provided training to staff and this was shared with the Committee.

However, further conversation included whether DCYF can maintain fidelity of the model if they do not make changes to caseload and workload. In order to maintain fidelity DCYF staff need to have more time available to them to engage in motivational interviewing during many of the contacts staff have with families, not just initial contacts.

Also related to caseload was a discussion about FVS caseload sizes. The Committee was told that DCYF had not reassessed and reduced the caseload number per caseworker as had been done for other case load types. The identified number to cap FVS caseloads is 20 families per caseworker. The Committee discussed this with the staff they spoke with and both identified that this number is not manageable. FVS cases are often discussed as high risk cases and require multiple contacts per month with often each family member and multiple services providers, and safety plan participants, etc. The Committee believes that DCYF should reassess and reduce the identified caseload per FVS caseworker.

The Committee was questioning whether evidence based and other contracted providers through DCYF should be required to discuss naloxone (access, how to obtain, how to use it, and steps after administering it) with families they are contracted to work with. The Committee identified that it should not only be on the shoulders of DCYF staff to discuss these issues and that some people might be more open to listening and engaging in these conversations with people other than their DCYF caseworker.

After the review concluded the staff who initially worked with the family in 2022, who are stationed in eastern Washington, discussed the lack of providers available to them due to the ruralness of their area. The staff shared that they only have one type of provider, intensive family preservation services, that has to drive at least an hour and a half and only has openings for two families at a time. The staff discussed that they often have to be creative and take into consideration the absolute necessity of this service when working with families in their counties.

One Committee member who works for DCYF specializes in early childhood services. She shared information that is accessible online to DCYF staff regarding lactation guides (substances used by a breastfeeding parent) and conversation guides regarding family support programs and early learning programs in Washington state. These resources were shared with the staff who participated in the review as well.

The Committee also discussed the ongoing impacts of HB 1227[4] and SB 6109[5]. HB 1227 began around the same time that Washington state started to see fentanyl impacting child safety. The Committee appreciates that efforts have been made through SB 6109 to amend how HB 1227 impacted DCYFs efforts to protect children when fentanyl or other high potency synthetic opioids are being used by people who are providing care for children. However, the Committee also discussed that there remain areas where SB 6109 is causing frustration or confusion, specifically the term ‘great weight’ when discussing when a court determines whether a child remains in the care of their parent/guardian or is placed in out-of-home care.

The Committee believes that this possible confusion or differing interpretations from judicial officer to judicial officer may contribute to continued frustration for DCYF staff who believe an active safety threat exists and

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

[5] For more information about SB 6109, see: https://lawfilesext.leg.wa.gov/biennium/2023-24/Pdf/Bill%20Reports/Senate/6109-S2.E%20SBR%20FBR%2024.pdf?q=20241001132648.

children are not able to safely remain in the physical care of their parent/guardian. The Committee also discussed that it may be beneficial for DCYF to have further discussions statewide, and including their legal counsel, about utilizing in-home dependency action to assist with child safety.

The Committee discussed possible biases that may come into play when interacting with families. One bias that was discussed pertaining to this family was how sometimes when a parent or parents are 'likeable' it can be easier for a caseworker or provider to overlook or not question certain aspects of a situation. The Committee understood that multiple caseworkers in the last two years identified that the mother specifically was engaging and likeable and the Committee was concerned that this may have contributed to less curiosity or less work to confirm information she provided. The Committee appreciates that this is often a bias that is not easily identified when you are working with a person or family and can be tricky to be aware of in general.

Another topic of discussion by the Committee but not related to the critical incident was domestic violence. DCYF has a policy requiring that domestic violence is assessed at different times throughout a case. The caseworker in 2022 gathered law enforcement records and there was some information gathered at different times throughout the case pertaining to domestic violence but the Committee identified that the intent of the DCYF policy no. 1170 Domestic Violence[6] was not met. While it isn't identified as a contributing factor in this case the Committee discussed that it is a crucial aspect of child safety. The Committee also discussed that DCYF does not currently have a program manager who is specifically identified to specialize in domestic violence and it has been quite some time since any significant guidance has been given to the field staff.

After the review, during a debrief with this writer, some staff shared that ongoing, periodic refresher trainings pertaining to harm reduction efforts and domestic violence would be beneficial to staff. It was also shared that having a place to find information about DV, questions to ask, subject matter experts identified, that could be easily accessed online would be greatly beneficial to DCYF employees.

[6] For more information regarding DCYF policy no. 1170 Domestic Violence, see: https://www.dcyf.wa.gov/1100-child-safety/1170-domestic-violence.