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

- J.L.

Date of Child's Birth

- [redacted] 2008

Date of Fatality

- August 31, 2023

Child Fatality Review Date

- November 16, 2023

Committee Members

- Derek Murphy, M-RAS, SUDP, CSC, Director of Clinical Services at Olalla Recovery Centers
- Mary Moskowitz, JD, Ombuds at the Office of the Family and Children's Ombuds
- Sgt. Brad Turi, Special Assault Unit with King County Sheriff's Office
- Lindsey Barcklay, MSW, LICSW,CMHS, SUDP, CCTP, Therapist and Clinical Director at Domestic Abuse Women's Network
- Sandy McCool, MSW, Intake and CPS Program Manager at Department of Children, Youth, and Families
- Selena Deer, MSW, Region 6 Quality Practice Specialist at Department of Children, Youth and Families

Facilitator

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

Executive Summary

On November 16, 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 J.L. and RCW 74. family. J.L. will be referenced by RCW 74. initials throughout this report.[2]

On August 31, 2023, law enforcement notified DCYF that J.L. had died of an apparent overdose. J.L. and RCW 74. 13-year-old sister were reportedly left home alone for several days. Law enforcement was at the home six days earlie RCW 74.13.520 Law enforcement was looking for RCW 74. father and believed that the father had the four-year-old and one-year-old siblings with him. The mother's whereabouts were unknown. This information resulted in a Child Protective Services (CPS) investigation. The information provided at the time of the intake did not identify what substance J.L. RCW 74.143.515 ingested. Information obtained during the CPS investigation identified fentanyl as the ingested substances for both children.

DCYF had closed a Family Assessment Response (FAR)[3] assessment in April 2023. That assessment focused on parental substance use, truancy, and parental mental health.

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 did not have any involvement with J.L. 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 the DCYF staff who worked the case prior to J.L.'s death.

Case Overview

In March 2014, DCYF received information alleging that RCW 13.50.100 The father told the school the mother is medicated and unable to care for the children due to mental health issues. The father also said he works two jobs and is not home often. RCW 13.50.100 RCW 13.50.100 The information led to a CPS investigation and the case was closed in May as unfounded for neglect.

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

[3] "FAR is a CPS alternative response to a screened-in allegation of abuse or neglect. FAR focuses on children and youth safety along with the integrity and preservation of families when lower risk allegations of maltreatment have been screened-in for intervention." For more information about FAR, see: https://www.dcyf.wa.gov/policies-and-procedures/2332-child-protective-services-family-assessment-response.

DCYF received three more intakes in September and October 2014. All three intakes did not meet the threshold for CPS investigation assignment and were screened out. RCW 13.50.100 [redacted]

In January 2015, an intake screened in for a CPS investigation. RCW 13.50.100 [redacted] The parents did not cooperate with the investigation and the case was closed as unfounded.

The following year, a school called DCYF with concerns of neglect RCW 13.50.100 RCW 13.50.100 This intake did not screen in for a CPS investigation.

In February 2016, the children witnessed RCW 13.50.100 Law enforcement responded and the children went to stay with their maternal grandmother. The father showed up at that grandmother's home, but law enforcement responded to the grandmother's home and arrested the father. One of the children alleged that their father was using methamphetamines. This information screened in for a CPS investigation. The investigation resulted in an unfounded finding for neglect.

The next month, law enforcement contacted DCYF to coordinate an investigation. The father of the children was allegedly RCW 13.50.100 and the mother was not cooperating. The CPS investigation resulted in a founded finding as to the mother only. RCW 13.50.100 RCW 13.50.100 [redacted] Law enforcement closed their case with no criminal charges because the investigation revealed that the father did not have any part RCW 13.50.100 A Family Team Decision Making meeting (FTDM) was held and the mother accepted voluntary services. The parents were divorced at this time and the mother and children moved in with the maternal grandparents. A Public Health Nurse (PHN) worked with the mother, children, and grandparents. The PHN told the caseworker the mother was managing the children's medical needs well and enrolling the children in school. The case closed in October.

DCYF received three intakes in February 2019. The first two alleged neglect, parental substance use issues, violations of the no-contact order from the previous domestic violence incident, and concerns the maternal grandfather was forcing the family to engage in a "religious cult." The first two intakes were screened out. The third intake made the same allegations, but also included that one of the children had been struggling with a cough for over two weeks with no medical care and that the mother was hospitalized RCW 70.02.020 This intake screened in for a FAR assessment. The assessment documented that one of the children has a RCW 70.02.020 This was confirmed by the child's specialist clinic. The mother told the caseworker that she was trying to dismiss the no-contact order and denied seeing or speaking to the father for the past six months. The mother disclosed that she was diagnosed with RCW 70.02.020 RCW 70.02.020 and is prescribed medications. The case closed in April.

On February 1, 2021, DCYF received the following information. RCW 13.50.100 RCW 13.50.100 J.L.'s IEP also addressed RCW 74.[redacted] social, emotional, and behavioral needs. Although the children were enrolled in school, they rarely attended school. The school was concerned about sexualized behaviors, heavy makeup, and inappropriate clothing. RCW 13.50.100 RCW 13.50.100 The school staff also heard a baby crying often in the background while the children attended class through Zoom. The school staff have repeatedly tried to engage the parents, but the parents do not reciprocate. This intake screened in for a FAR assessment.

The mother told the caseworker that she lived alone with the children (ages 15, 10, 12, 12, and 1) in a four-bedroom home. The parents were not currently in a relationship but planned to be upon dismissal of the no-contact order. The case closed in May.

DCYF received three intakes in December 2021. All three intakes were screened out. Allegations included lack of school attendance, parental substance use, neglect, and that J.L. was vaping.

On January 1, 2022, DCYF was informed that the mother was pregnant and due in March. The allegations also stated that both parents struggle with substance use and that the father recently lost his job due to his substance use. There was reportedly very little food in the home because the parents used their money for drugs. The reporter stated that the children have "cognitive issues" and rarely attend school, and the parents fight often. This information resulted in a FAR assessment.

DCYF received another intake which screened in for a FAR assessment shortly after the caseworker contacted the mother. The intake stated that RCW 74.143.515 were found to have Suboxone and other pills in their possession. J.L. told the responding law enforcement officer that the pills belonged to RCW 13.50.100 RCW 13.50.100 told the officer that RCW 74.143.515 was lying and that RCW 74.143.515 had been using drugs for quite some time. RCW 74.1[redacted] RCW 13.50.100 also stated that their father is using drugs again, but because their mother was pregnant, she was not using drugs.

The mother told the caseworker that she was prescribed suboxone and had been taking her suboxone for four years. The mother stated the father is going to the same treatment provider that the mother received her dosing from. The mother stated she intended to keep her suboxone locked up after the incident. The mother did not comply with the caseworker's request for a urinalysis. Due to a lack of signed releases of information, the caseworker was unable to verify the parents' attendance at medical appointments and/or treatment. The caseworker noted that the children's mother said RCW 74.143.515 were scheduled for substance use assessments. There is no further mention of the assessments or a request of the assessments prior to case closure. The case closed in March 2022.

On February 2, 2023, DCYF received another intake regarding lack of school attendance, parental and youth substance use, and debilitating mental health issues as to the mother. This intake was assigned for a FAR assessment.

When the caseworker went to the family home, the mother, and all children except the oldest child (then 17-years-old) were in the home. [redacted] The caseworker spoke with the three oldest (twin 14-year-olds and 11-year-old) children alone. The two youngest children (3-years-old and 10-months-old) were not old enough for the caseworker to interview. The family was not very cooperative after this first contact. However, the mother did admit that her husband was using substances, but denied that he used substances in their home. She said she does not allow it in the home or around their children.

The mother signed a release of information form to allow the caseworker to contact her suboxone provider. The provider's office stated the mother had been receiving dosing consistently since 2017. At the time of the contact, the mother did not have a suboxone-related case manager . The father refused to cooperate with the caseworker. The case closed in April 2023.

On August 31, 2023, DCYF was notified that J.L. had passed away due to a suspected drug overdose [redacted]

Committee Discussion

After reviewing the DCYF case history and speaking with the caseworker and supervisor assigned to the most recent open case prior to the fatality, the Committee discussed differing aspects of the case. That conversation included systemic challenges faced by DCYF staff which are represented in this section. The Committee appreciated the challenges facing caseworkers and supervisors in all cases, but also the added challenges when youth are using substances.

The Committee acknowledged that the father was not cooperative with DCYF staff, and the mother was inconsistent in her cooperation. A lack of cooperation or engagement can negatively impact the ability of DCYF staff to adequately assess child safety. Included in that discussion was the need for assigned caseworkers to review and properly utilize available historical information. There was a lengthy history of intakes and open cases with this family, including historical information regarding sexually reactive behaviors, developmental needs, parental mental health, and domestic violence. Reviewing and utilizing critical thinking to apply historical information is beneficial to completing a comprehensive, non-incident focused assessment of child safety.

Also included in the historical documentation was information about previous involvement or contacts with relatives and other sources that may have been beneficial collateral contacts. There were historical records that provided a clear pattern of concern for untreated mental health and substance use for a parent, as well as domestic violence.

The Committee believed the family would have benefited from a more in-depth assessment of the interpersonal violence that occurred between the parents. The violence resulted in a legally enforceable no-contact order. The parents reunited, but there was no follow up regarding how they mended their relationship or how it had changed. There were also opportunities to ask the older children questions regarding their parents and their relationship.

DCYF staff have access to shared decision making resources such as triage or Safe Child Consultations.[4] The Committee believes the family chaos and the parents' unwillingness to cooperate at times resulted in an inadequate assessment regarding substance use, domestic violence, and the children's medical/social needs. It can be beneficial to share these challenging cases with others at DCYF to receive suggestions for how to proceed.

RCW 13.50.100 provided statements that identified longer-standing substance use concerns for J.L. DCYF was aware that J.L. was expected to complete a substance use assessment. However, DCYF staff were not aware that not all schools or school districts require anything beyond a verbal statement of completion of the substance use assessment for a child to return to school. The Committee believed that J.L. may have benefited from further assessment of RCW 74. substance use needs. This may have been accomplished by asking for a copy of the assessment and further conversations about the issue with J.L. and RCW 74. parents. Also, discussing how to use Narcan and providing it to the family may have been helpful. The Committee believes that DCYF staff may benefit from more education and support surrounding youth substance use.

The Committee identified that clinical supervision supports caseworkers in completing accurate investigations and assessments. According to DCYF policy No. 46100, "Clinical Supervision includes building caseworker's competencies, encouraging self-reflection and critical thinking skills, and building on training to support caseworker decision-making." Based on conversations with the supervisor and caseworker, along with reviewing the case records, the Committee believed that the clinical supervision could have been stronger and should include coaching on curiosity as well as how to act upon information a youth has disclosed to a caseworker in order to meet the youth's needs more productively.

There was discussion about how fentanyl is perceived by the courts and community partners. The Committee discussed that Fentanyl is not and should not be treated like other substances. Fentanyl's lethality is much higher compared to other substances and should be treated with higher scrutiny when considering child safety. The Committee discussed caseworkers would benefit from assistance with articulating the child safety concerns regarding fentanyl use when engaging in legal intervention.

Recommendations

The Committee members agree that DCYF's clients can benefit as a whole from the Committee's efforts to provide comprehensive discussion and analysis of this case. While the following recommendations were made based on the Committee's discussion of J.L.'s case, these recommendations are not solely based on J.L.'s case. The purpose of the recommendations is to help DCYF improve their overall case procedures and practices.

1. DCYF should create an intranet page regarding substance use disorders. The page should include links to trainings or information about how to obtain trainings regarding substance use; what to look for when doing a walk-through of a home; what to do if a caseworker encounters substances or paraphernalia, and a reminder to use precautions; the opioid pamphlet (DCYF 0112); photos of paraphernalia and substances; and testing information, among other resources. There should also be

[4] For information about Safe Child Consultations, see: https://www.dcyf.wa.gov/practice/practice-improvement/HB-1227.

information about how to talk with youth about their own suspected or confirmed substance use and resources specific assisting to youth with substance use issues.

The intranet page would be a one-stop-shop to aid staff who are seeking information about substance use and how that interacts with their work as a DCYF employee. This site would be available to all DCYF staff, not just child welfare employees.

2. The Committee identified that fentanyl is a uniquely powerful substance that affects people very differently than other substances. Because fentanyl's potency and HB 1227[5], the Committee recommends that DCYF draft examples of written documents for staff to use, such as dependency petitions or pick up orders, that outline the unique safety threats that fentanyl use poses to child safety which cannot be mitigated by the circumstances unique to a specific family. This information should also be available to staff on the above-mentioned intranet page.

[5] For information about HB 1227, see: https://www.dcyf.wa.gov/practice/practice-improvement/HB-1227.