CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

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Full Report

Child

- R.G.

Date of Child’s Birth

- RCW 74.13 2022

Date of Fatality

- October 28, 2022

Child Fatality Review Date

- February 28, 2023

Committee Members

- Patrick Dowd, JD, Director, Office of the Family and Children’s Ombuds
- Betsy Tulee, ICW Program Consultant, Department of Children, Youth, and Families
- Sandy McCool, Quality Practice Specialist, Department of Children, Youth, and Families
- Kerri Zanoni, Substance Use Disorder Therapist, Puyallup Tribal Health Authority

Facilitator

- Leah Mattos, MSW, Critical Incident Review Specialist, Department of Children, Youth, and Families

Finalized Date: April 4, 2023
Approved for distribution by Paul Smith, Critical Incident Supervisor

Executive Summary

On February 28, 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 R.G. and RCW 74. family. R.G. will be referenced by RCW 74. initials throughout this report.[2]

On October 28, 2022, law enforcement and the medical examiner notified DCYF that R.G. had died. R.G. was found unresponsive and turning blue and emergency services were called. According to the father, the family shares a bed (both parents, R.G., and RCW 74. older sibling). He woke at 2:30 a.m. to check on R.G. and found RCW 74. on RCW 74. stomach and not breathing. The initial call from the medical examiner did not identify a cause of death and said that was to be determined. R.G.'s initial toxicology returned positive for Fentanyl.[3]

R.G. and RCW 74. family had a prior Child Protective Services (CPS) case with DCYF in the last 12 months. A new CPS case was assigned to investigate the circumstances of R.G.'s death and assess the safety of RCW 74. surviving sibling.

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.G. or RCW 74. family. R.G.'s Tribe was invited to participate in this review but were not available to attend. 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

In January 2022, an out-of-state referrer reported to DCYF that R.G.'s father relapsed while participating in a substance use disorder (SUD) treatment program. It was reported the mother also had substance use history, but she was sober. The caller said the mother was pregnant but that they did not know the due date. There was no allegation of abuse or neglect, so a DCYF response was not required.

In July 2022, DCYF was notified of R.G.'s birth when the mother reported she actively used narcotics during her pregnancy and while participating in a Medication Assisted Treatment (MAT) program.[4] The mother said

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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)]." Given its limited purpose, a CFR should not be construed to be a final or comprehensive review of all 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 only hears from DCYF 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 to replace or supersede investigations by courts, law enforcement agencies, or other entities with legal responsibility to investigate or review some or all the circumstances of a child's fatal injury or near fatal injury. Nor is it the function or purpose of a CFR to recommend personnel action against DCYF employees or other individuals. "The restrictions [described in this paragraph, and the paragraph immediately above,] do not apply in a licensing or disciplinary proceeding arising from an agency's effort to revoke or suspend the license of any licensed professional based in whole or in part upon allegations of wrongdoing in connection with a minor's death or near-fatality reviewed by a child fatality or near-fatality review team." See RCW 74.13.640(4)(d). See: https://app.leg.wa.gov/RCW/default.aspx?cite=74.13.640.

[2]R.G.'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 Fentanyl, see: https://www.cdc.gov/opioids/basics/fentanyl.html. Last accessed on March 3, 2023.

her last Fentanyl use was two weeks prior to R.G.'s birth. R.G.'s toxicology was positive for methadone and Fentanyl. A CPS risk-only[5] case was assigned, and DCYF notified the Tribe.

On July 14, 2022, the CPS caseworker met with the mother, father, and R.G. at the hospital. The parents' older child was in the care of a relative. The parents denied a history of criminal activity and mental health needs. The parents told the caseworker that their drug of choice is Fentanyl. The mother told the caseworker she was participating in a methadone program but relapsed two weeks prior. The father said he was using Fentanyl to maintain until he could get involved with a methadone clinic. The parents reported that they store the Fentanyl in a lock box outside the house. The parents confirmed residing with a relative, who they said has been supportive but does not enable them. The caseworker discussed a safety plan to include the relative providing supervision. The mother and father agreed. The caseworker completed a Plan of Safe Care[6] with the family, outlining a plan for R.G.'s safety and well-being needs, and discussed Safe Sleep[7] and the Period of Purple Crying[8] with the family.

On July 15, 2022, the CPS caseworker completed a walkthrough of the relative's home. The relative agreed to be a safety plan participant and provide supervision for R.G. and RCW 74. older sibling. The relative said she would not allow the mother or father to leave the home with the children if they were under the influence. The relative also said that she had taken time off of work so she could be present in the home. The caseworker observed the home to have appropriate resources for R.G., including clothing, diapers, and a bassinet.

On August 12, 2022, the CPS caseworker and tribal social worker contacted the mother to check-in. The mother admitted to using four days prior and said she had not told anyone. The mother agreed to complete a urinalysis test for DCYF but denied the ride offered by the CPS caseworker. The mother also said the father missed his methadone appointment, so it had been rescheduled. The mother said the relative continues to consistently check on them.

On August 16, 2022, the CPS caseworker and tribal social worker completed a home visit with the mother and R.G. at the relative's home. R.G.'s older sibling was present, and it was documented that RCW 74. appeared developmentally on track for RCW 74. age. The CPS caseworker observed R.G.'s sleep environment and spoke to the mother about Safe Sleep again. The mother said she understood and said she had been complying. The mother confirmed that R.G.'s father's methadone clinic appointment was moved to the end of the month. No concerns were documented.

On September 8, 2022, the CPS caseworker and tribal social worker completed an unannounced visit at the relative's home. No concerns or unmet needs were documented for R.G. or RCW 74. sibling. The mother reported

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[4]For information about Medication Assisted Treatment (MAT), see: https://www.cdc.gov/opioids/Medication-Assisted-Treatment-Opioid-Use-Disorder-Study.html. Last accessed on March 3, 2023.

[5]A CPS Risk Only investigation should be screened in when there are "reports [that] a child is at imminent risk of serious harm and there are no [child abuse or neglect] allegations". For more information about CPS Risk Only Investigations, see https://www.dcyf.wa.gov/practices-and-procedures/2200-intake-process-and-response.

[6]For information about Plan of Safe Care, see: https://www.dcyf.wa.gov/safety/plan-safe-care.

[7]For information about Safe Sleep, see: https://safetosleep.nichd.nih.gov/safesleepbasics/about. Last accessed on March 3, 2023.

[8]For information about Period of Purple Crying, see: http://www.purplecrying.info/what-is-the-period-of-purple-crying.php. Last accessed on March 3, 2023.

the father completed his intake for the methadone clinic but had not provided a urinalysis because he struggles to provide a urine sample when observed. The caseworker suggested the family inquire if an oral swab could be utilized, and the mother agreed to ask about this. The mother agreed to complete another urinalysis test.

On September 9, 2022, the caseworker received notification that the mother did not complete her scheduled urinalysis test.

On September 13, 2022, the caseworker received and reviewed the medical records for R.G. and RCW 74. sibling. The caseworker also received and reviewed law enforcement records. The caseworker attempted to contact the mother regarding the missed urinalysis test and asked for a response. The caseworker contacted the mother's treatment provider requesting a callback. The caseworker consulted with the supervisor of the tribal social worker about the mother's missed urinalysis. The CPS caseworker and tribal social worker attempted to complete an unannounced visit at the home, but no one answered. The caseworker received a text from the mother with a picture of her urinalysis result, which was negative for all substances but methadone.

On September 14, 2022, the CPS caseworker spoke with the mother regarding a law enforcement report from an incident earlier in the month purportedly involving the mother. The mother denied this and stated it was her sister who was involved. The mother said she was unaware her name was in the law enforcement report. The caseworker also spoke with the law enforcement officer, who confirmed that the mother was not involved in the incident.

On September 15, 2022, a monthly supervisor review took place. No safety threats were identified through the assessment. No additional services were recommended, and the parents were both connected with community-based SUD treatment providers. It was documented that the Tribe agreed with case closure. The investigative assessment was completed, and the case was submitted for closure.

On October 28, 2022, law enforcement and the medical examiner notified DCYF that R.G. had died. It was reported the family was bed sharing with the mother, father, R.G., and RCW 74. older sibling at the time RCW 74. was found unresponsive. R.G.'s initial toxicology report was positive for Fentanyl. At the initial contact, the medical examiner said the manner of death was undetermined. The CPS investigation concluded with the mother and father being assigned founded findings[9] for negligent treatment of R.G.

Committee Discussion

The Committee identified a number of positive aspects of the work through the review process. The Committee appreciated the agency's efforts to collaborate with the Tribe from the initial intake continuing throughout the life of the case. The caseworker was in continual contact with the tribal child welfare social worker and supervisor through consultation and completed joint home visits with the tribal caseworker. The caseworker demonstrated good relationship-building with the mother throughout the case. The caseworker promptly offered a solution to address a barrier to the father participating in urinalysis testing. The Committee

[9]RCW 26.44.020(14) defines "founded" as follows: "the determination following an investigation by the department that, based on available information, it is more likely than not that child abuse or neglect did occur." RCW 26.44.020(29) defines "unfounded" as follows: "the determination following an investigation by the department that available information indicates that, more likely than not, child abuse or neglect did not occur, or that there is insufficient evidence for the department to determine whether the alleged child abuse did or did not occur."

commented that the case narrative clearly documented contacts with appropriate collaterals. Lastly, the Committee pointed out that the Plan of Safe Care was comprehensive in meeting R.G.'s needs.

The Committee also discussed a number of other aspects of the case, including education and information related to Fentanyl, assessment of safety, tribal collaboration, and workload challenges. The Committee discussed the urgency of responding to and planning for parents and families using Fentanyl or in recovery from Fentanyl use. The Committee talked about what DCYF training is currently available related to Fentanyl and opioid overdose and also discussed other identified areas that may need planning and development related to Fentanyl. For example, there is no agency protocol in place for how field staff should prepare and respond should they be exposed to Fentanyl when in the field.

The Committee also discussed needs related to parents in active use or recovery from Fentanyl and identified that there is not a current protocol about how to case and safety plan for individuals using Fentanyl. The Committee pointed this out as a concern because of the increased risk Fentanyl presents due to the lethality of this substance compared to other illicit and harmful substances. The Committee highlighted the importance of field caseworkers and supervisors having the necessary tools and information to effectively assess safety. One suggestion was that field staff may benefit from a medical consultation to help better understand the potential risk to the child(ren) if the parent(s) is actively using Fentanyl. A Committee member pointed out that the Revised Code of Washington (RCW) 26.44.020(19) states, "When considering whether clear and present danger exists, evidence of a parent's substance abuse as a contributing factor to negligent treatment or maltreatment shall be given great weight."[10] The Committee wondered how or if the Assistant Attorney General's office may be able to offer support and education to the agency related to this RCW, such as by providing training on how to best articulate that substance use is impacting child safety to the court.

Through the discussion about the Fentanyl crisis in Washington State[11], the Committee discussed SUD treatment services. The Committee discussed MAT as one form of treatment for opioid recovery. The Committee wondered about the success rates related to MAT and Fentanyl use and hoped that in the future, there would be data compiled about the effectiveness of this treatment modality. The Committee SUD expert pointed out that therapy is not always a required component of MAT. The Committee members expressed value in participating in therapy, such as individual outpatient or group therapy, and identified this as an important component of recovery.

The Committee discussed the ongoing assessment of safety throughout the life of the case. Initially, R.G. was assessed as unsafe, and a safety plan was developed to support [RCW 74.] remaining in [RCW 74.] parent's care. The plan required a relative to act as a safety plan participant by providing monitoring and supervision of the parents and the children. The Committee asked the field staff about what was expected of the relative caregiver as the safety plan did not identify specific details other than that the relative would provide supervision for the family. The Committee learned from the field staff about the conversations with the relative and about how

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[10] For Revised Code of Washington (RCW) 26.44.020 (19), see: https://app.leg.wa.gov/rcw/default.aspx?cite=26.44.020. Last accessed on March 3, 2023.

[11] For information about opioid trends in Washington State, see: https://adai.washington.edu/WAdata/deaths.htm#:~:text=Deaths%20attributed%20to%20any%20opioid%3A%20More%20than%20doubled&text=Almost%20all%20counties%20saw%20increasing,has%20accelerated%20in%20recent%20years. Last accessed on March 3, 2023.

the relative offered support and supervision. The Committee appreciated that the relative support was included in conversations about Safe Sleep, Period of Purple Crying, and the Plan of Safe Care. However, the Committee felt it would have been beneficial for the safety plan to lay out more detailed behavioral expectations of the relative support who was providing supervision to the family.

The Committee and field staff discussed the fluidity needed for completing a thorough assessment of safety and risk, as situations may be changing throughout the duration of a case. The Committee identified an opportunity to re-evaluate the safety plan when the mother disclosed that she had a relapse. The Committee would have liked to see additional case documentation about how the safety assessment went from unsafe to safe prior to the case closure. The Committee suggested that it may have been beneficial to utilize an internal DCYF staffing to request additional consultation about the ongoing assessment and safety plan.

As mentioned above, the Committee commended the field staff on their collaboration with the tribal child welfare team. From the discussion with the field staff they learned about the extensive teamwork that took place between DCYF and the Tribe but felt this could have been better reflected in the case documentation to demonstrate the extensive efforts made to collaborate. However, the Committee did acknowledge that workload can impact case documentation, but wanted to ensure the field staff were credited for all of the efforts they made.

Lastly, the Committee discussed the workload challenges that were reported by this field office. For example, the Committee learned that this particular CPS unit had had a vacant CPS investigator position for a year that the office has not been able to fill. Also, there have been supervisory coverage needs in this office that have led to one supervisor covering two CPS units for periods of time. The field staff shared that this has caused hardship and increased caseload size. The field staff also shared their perspective that a reevaluation of the workload for Indian Child Welfare (ICW) cases is needed. ICW cases are currently weighted higher than non-ICW cases, but the field staff did not feel the current weight accurately reflects the work done through active efforts and collaboration with tribal child welfare social workers. The Committee spoke about the potential impacts of workload challenges and acknowledged that they did not have a solution to address these concerns.

Recommendations

The Committee did not develop any recommendations.