CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

Washington State Department of
CHILDREN, YOUTH & FAMILIES

CONTENTS

Full Report

Child

- R.L.

Date of Child's Birth

- November 2023

Date of Fatality

- October 26, 2024

Child Fatality Review Date

- January 30, 2025

Committee Members

- Lori Eastep, MSW, LICSW, Therapist, Grassroots Therapy Group
- Addy Adwell, RN, BSN, AMB-BC, Doctor of Nursing Practice Student Intern, Department of Health
- Cristina Limpens, MSW, Senior Ombuds, Office of Family and Children's Ombuds
- Alissa Copeland, MA, FAR/FVS Program Manager, Department of Children, Youth, and Families
- Melinda Edmondson, Social Service Specialist 4 Region 6, Department of Children, Youth, and Families

Facilitator

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

Executive Summary

On January 30, 2025, the Department of Children, Youth, and Families (DCYF) conducted a Child Fatality Review (CFR)[1] to examine DCYF's practice and service delivery to R.L. and [redacted] family. The child, R.L., will be referenced by [redacted] initials throughout this report.[2]

On October 26, 2024, DCYF was notified by the medical examiner that R.L. died. R.L.'s mother found [redacted] earlier that day and called emergency services when she could not wake [redacted] Law enforcement opened a homicide investigation. This information resulted in a Child Protective Services (CPS) investigation. Allegations of abuse or neglect that meet legal sufficiency result in a screened-in intake to either investigation 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 investigation DCYF learned that R.L.'s cause of death was due to ingesting fentanyl. The DCYF investigation resulted in a founded finding for negligent treatment or maltreatment by R.L.'s mother.

Prior to R.L.'s death, DCYF received four intakes regarding [redacted] family. Of the four intakes only one was assigned for a CPS investigation. Prior to [redacted] death, R.L. lived with [redacted] mother. [redacted] father was incarcerated before [redacted] birth.

A CFR Committee was assembled to review DCYF's involvement and service provision to R.L. and [redacted] 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 R.L. or [redacted] family. 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 one of the contracted in home services providers and DCYF staff who were assigned to the case previous to the death.

Case Overview

The information documented in this section is not fully inclusive of all contacts and actions by DCYF staff.

On November 30, 2023, DCYF received a telephone call from a hospital. The hospital staff reported that at the time of [redacted] birth, R.L. tested positive for methadone and [redacted] mother tested positive for fentanyl. R.L's mother reported that she regularly used fentanyl during her pregnancy and that she started methadone treatment a month prior to giving birth. R.L.'s mother planned to continue with her methadone treatment. This screened in for a CPS investigation.

---

[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] R.L.'s name is not used in this report because [redacted] 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.

On December 1, 2023, the assigned CPS investigator met R.L. and RCW 7 mother at the hospital. R.L.'s mother denied using fentanyl since starting methadone treatment in November. She said this is her first child and that the child's father was incarcerated for the last few weeks. R.L.'s mother said that the paternal grandmother agreed to move in with R.L. and RCW 7 mother to help after discharge. R.L.'s mother agreed to sign a release of information and comply with random urinalysis. She also provided contact information for people she wanted to attend a Family Team Decision Meeting (FTDM)[4] that was to be held. FTDMs are held when there is a possibility of a child being placed in out-of-home care or a placement change is being considered.

On December 20, 2023, the caseworker requested records from the mother's methadone treatment facility. That same day the FTDM was held. Hospital staff and relatives were invited to the FTDM. The meeting resulted in a decision to keep R.L. with RCW 7 mother after RCW 7 was discharged from the hospital.

The next day the caseworker conducted a walk through of the mother's apartment prior to R.L.'s discharge. During the walk through the caseworker discussed multiple child safety related issues required by DCYF policy as well as the lethality of fentanyl and the need to wash hands and change clothes after using fentanyl. R.L.'s mother said the hospital gave her a bag full of Narcan, an opioid reversal medication, and showed the caseworker her lockbox. The mother and caseworker also completed a Plan of Safe Care (POSC)[5]. That same day the caseworker also referred R.L.'s mother for a random urinalyses and she also emailed the safety plan participants the Plan of Safe Care.

On December 21, 2023, the CPS caseworker received R.L.'s mother's substance use assessment. The document included a statement that R.L.'s mother was compliant with treatment and that all of her urine tests were positive for fentanyl.

On December 22, and continuing for several weeks, the caseworker received text messages and emails from the mother and paternal grandmother about their challenges living together. A different paternal relative called DCYF on December 23 alleging that the mother was not following the safety plan. The relative reported that R.L.'s mother was trying to kick the grandmother out of the home and that she has been engaging in unsafe sleep practices. The paternal relative called again that same day with the same concerns and added that law enforcement responded to the home but did not change the circumstances. The paternal grandmother also called DCYF intake and reported that the mother is engaging in unsafe sleep practices and is yelling at the grandmother. All three intakes were screened out. The CPS caseworker received text messages from R.L.'s mother about the issues as well but there is no documentation that the caseworker responded to those messages. Intake called one of the callers back later that day and he said that R.L. and RCW 7 mother went to stay at another paternal relative's home. The uncle asked that the caseworker contact the paternal grandmother. All of the paternal relatives referenced are part of the DCYF safety plan.

The caseworker called R.L's mother back on December 26. R.L.'s mother discussed what occurred and said that things were calm and she would stick with the safety plan and with the paternal grandmother remaining in the home. On December 29, the caseworker met with the mother and other relatives to complete a new safety plan. The caseworker again provided the mother with concrete goods including a second bassinet,

[4] For information about Family Team Decision Making meetings, see: https://dcyf.wa.gov/1700-case-staffings/1720-family-team-decision-making-meetings.

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

lockbox and Narcan. Also on this day, the mother provided a urine sample. The sample tested positive for fentanyl and methadone.

On January 8, 2024, the caseworker submitted a referral for Homebuilders[6]. Homebuilders is a service delivered by contracted providers that offer families in-home counseling and support. In this case Homebuilders provided its services to aid in preventing R.L. from being placed in out-of-home care.

On January 9, 2024, the caseworker called the mother's substance use treatment provider. She left a voice mail message. On January 11, the caseworker and coworker made an unannounced home visit. The mother, R.L. and relatives were home. No concerns were observed or noted by the relatives. The caseworker asked R.L.'s mother about a positive urinalysis and fentanyl use. R.L.'s mother denied using any drugs. On January 12, R.L.'s mother's treatment provider called the caseworker back. The treatment provider left a voicemail message stating the mother is in compliance with her treatment. On January 15, the caseworker documented an email raising concerns about R.L.'s mother not allowing others to help care for the baby and saying that she is not following the safety plan. The email also stated that the baby had been dropped or fallen to the floor when the mother fell asleep while holding [redacted] The case note does not state who wrote the email and the email was not uploaded in Famlink (the DCYF computer system) to identify the writer.

On January 11, 2024, R.L.'s mother provided a urine sample. This test was positive for fentanyl.

On January 16, the caseworker texted the mother and asked her if she was still engaging in unsafe sleep practices and not allowing others to help her. The caseworker also asked if R.L. had been dropped or fell. The mother denied all of the allegations and stated that the paternal grandmother was trying to cause problems by making false allegations. The caseworker case noted an email from a paternal aunt stating the allegations were not true.

On January 22, the caseworker again asked the mother about continued fentanyl positive urinalyses. This conversation was through text. The mother continued to deny using fentanyl. The paternal aunt emailed the caseworker two days later stating she has not observed the mother using drugs.

On January 24 and 30, R.L.'s mother provided urine samples. Both samples tested positive for fentanyl and methadone.

On January 31, the Homebuilders therapist emailed the caseworker and supervisor. She stated the sessions were going well and that she discussed the positive urine results with the mother. The email indicated that the referral was closing that same day and the mother successfully completed the service.

On February 1, the caseworker entered a case note regarding an email received from a relative. The email stated that the relative tried calling the caseworker a couple times but was unable to leave a voice mail message. The relative asked that the caseworker call her back to discuss the safety plan. The caseworker documented that she emailed the relative asking how she could help and what questions the relative had. There was no other follow up documented.

On February 8 the caseworker entered a case note that the mother sent the weekly list of who was going to check on her and R.L. The information included the relatives' names, telephone numbers and addresses. The

[6] For more information about Homebuilders, see: https://dcyf.wa.gov/services/child-welfare-providers/evidence-based-practices.

caseworker also documented that while the mother continued to test positive for fentanyl the levels were greatly improved.

On February 9, R.L.'s mother provided a urine sample. The sample tested positive for fentanyl and methadone.

A Family Voluntary Services (FVS) caseworker was assigned to the case. The new caseworker met with the mother and R.L. on March 7. The mother shared that she was working with another in home provider from Project Safe Care[7] but it was later documented that the service changed to Promoting First Relationships[8]. They also discussed R.L.'s needs, RCW 7 well-being, and the mother's substance use treatment. The caseworker did not observe any concerns. The mother did ask for diapers, help with formula, a baby care kit, and bus tickets. The caseworker conducted another visit the following day.

On April 17, R.L.'s mother provided a urine sample. The sample tested positive for fentanyl and methadone. R.L. and RCW 7 mother met with the in-home provider three times in the month of April. The DCYF caseworker did not have any documented contact with the family during that period.

On May 17, the caseworker spoke with the mother's substance use treatment provider. The provider shared that R.L.'s mother attends dosing appointments and treatment meetings and that her urine tests continued to be positive for fentanyl. The treatment provider told the caseworker that the amount of fentanyl was not high and that she was not concerned. No documents were requested by the caseworker from the treatment provider. The caseworker then went to the mother's home to discuss that information. R.L.'s mother continued to deny using fentanyl.

On June 3, 2024, the caseworker documented that the in home service provider conducted her last session with R.L. and RCW 7 mother at their new residence. The provider did not have any concerns. The caseworker met with the mother on June 27 to discuss the case closing. The caseworker did not observe any concerns during that visit. The supervisor closed the FVS case on July 2, 2024.

On October 26, 2024, DCYF was notified that R.L. died.

Committee Discussion

The Committee was very impressed with much of the work conducted on this case. Specifically, the Committee identified good use of collaterals contacts, service referrals and use of concrete goods. The Committee also identified that the CPS caseworker was diligent and thorough in discussions about substance use harm reduction and support to the mother when she identified unmet needs related to her substance use treatment. The Committee appreciated the diligence regarding the CPS caseworker's use of the POSC and that she updated the document and shared it with everyone involved in the safety plan. There were multiple FTDM's held which showed that the caseworker was listening to concerns and was seeking strong communication and collaboration to safely maintain R.L. in RCW 7 mother's care. The CPS caseworker also documented multiple discussions about safe sleep and the Period of Purple Crying was well addressed.

[7] For more information about Safe Care (AKA Project Safe Care), see: https://safecare.publichealth.gsu.edu/.

[8] For more information about Promoting First Relationships, see: https://pfrprogram.org/.

The Committee did identify some improvement opportunities. Those included making the referral to Early Support for Infants & Toddlers (ESIT)[9] as part of the POSC and following up on the hospital's referral to Parent-Child Assistance Program[10]. The Committee also discussed that R.L.'s mother had experienced trauma and had been diagnosed with RCW 74.13.520 and that she may have benefited from supportive mental health services or a co-occurring treatment provider to address both the mental health issue and substance use issues at the same time.

The Committee wondered about the support or training provided to DCYF staff about how to discuss a parent's progress in substance use treatment, how to have the conversations about compliance and progress, and where those intersect with child safety. Many substance use treatment providers do not require abstinence for a client to be considered making progress or identified as compliant with services but not all DCYF staff are aware of this practice. Understanding how to have the conversations about utilizing the collateral information obtained from a substance use treatment provider within child welfare can be challenging. R.L.'s mother did not have a negative urinalysis during the time that DCYF worked with her.

Specific to fentanyl use, the Committee discussed that the impacts of fentanyl use on the person using and the impact to child safety seem to be ever-changing. There was a training regarding High Potency Synthetic Opioids (HPSO) provided by DCYF headquarters staff, after this case closed in July 2024. The Committee wondered whether a second, higher level HPSO training that integrates concepts related to having an open case with DCYF while a parent may struggle with HPSO use, would benefit FVS staff specifically. The Committee also discussed the need for DCYF to provide updated training to staff regarding how long fentanyl can be stored in a person's body and how that information should be considered when using tools such as substance use testing tools.

R.L.'s father was incarcerated during the entire CPS and FVS case. The Committee discussed that it may have been helpful for a more comprehensive family assessment to have attempted to meet with R.L.'s father, correspond in some capacity, and utilize his family members as part of the assessment related to understanding the relationship dynamics between R.L.'s parents.

The Committee heard from one of the in-home providers who worked with R.L. and RCW 7 mother. This contract provider discussed the need for DCYF contracted providers to receive more education regarding how DCYF assesses child safety including an explanation and training on the safety threats and other tools utilized by DCYF staff. This may help in shared language when discussing child safety.

[9] For information about Early Support for Infants & Toddlers, see: https://dcyf.wa.gov/services/child-development-supports/esit.

[10] For information about the Parent-Child Assistance Program, see: https://pcap.psychiatry.uw.edu/.