**Children's Administration**
**Executive Child Fatality Review**
**Isayah Casch**

**January 7, 2011**

**Committee Members**

- Craig Davis, Detective, Everett Police Department
- Frances T. Chalmers, M.D.
- Deborah Brown, Certified Chemical Dependency Professional, Snohomish County Human Services
- Mary Meinig, MSW, Director Ombudsman, Office of the Family and Children's Ombudsman
- Yen Lawlor, MEd, Deputy Regional Administrator, Region 3, Children's Administration
- Rhoda Ramirez, MSW, Child Protective Services Supervisor, Children's Administration
- Natalie Green, MSW, Area Administrator, Children's Administration

**Facilitator**

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**Observers**

- Cristina Limpens, MSW
- Kara Rozeboom, MSW

**Table of Contents**





2

**Executive Summary**

On September 19, 2010, Children's Administration (CA) accepted an intake from Harborview Medical Center reporting the death of seven-year-old Isayah Casch, following a roll-over accident of a car driven by his mother, Kortnie Casch. The caller reported that Ms. Casch appeared intoxicated and that two blood draws had been completed; one by Providence Hospital and one by Harborview at the request of the Snohomish County Sheriff. The caller reported further that Isayah's half-siblings, and had been in the car and were admitted for observation and treatment of minor injuries. The caller noted that hospital staff were concerned about the children's unsanitary and dirty appearance. and were placed with their paternal grandfather and his wife following their release from the hospital

After an investigation by Snohomish County Sheriff of the accident leading to Isayah's death, the case was referred to the Snohomish County prosecutor. Charges against Ms.Casch are pending.

The family's history with CA began in February 2003 and includes four previous investigations in 2003, 2006, 2007, and July 2010. The investigations were based on allegations against Ms. Casch of driving while under the influence with her children in the car, neglect of her children, and alcohol abuse. The investigations in 2003 and 2006 were closed on inconclusive findings. The investigation in 2007 was closed without a finding The investigation begun in July 2010 was ongoing at the time of Isayah's death and was subsequently closed as unfounded in October 2010.

On January 7, 2011, CA convened a multi-disciplinary committee to review the decisions, policy, practice, and service delivery in this family's case.[1] The committee, including CA staff who had no direct connection to the case, represented disciplines associated with this case. Documents available to the committee included: chronology of the case prepared for the review, Snohomish County Sheriff's investigation of the September 18, 2010 accident, CA case records, Ms. Casch's childhood records from Georgia, Isayah's autopsy report, the CA policy on child protective services (CPS) investigations, and RCW and WAC

[1] Given its limited purpose, a Child Fatality Review by Children's Administration should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. A review is generally limited to documents in the possession of or obtained by DSHS or its contracted service providers and the panel may be precluded from receiving some documents that may be relevant to the issues in a case because of federal or state confidentiality laws and regulations. A review panel has no subpoena power or authority to compel attendance and generally will only hear from DSHS employees and service providers. The panel may not hear the points of view of a child's parents and relatives, or those of other individuals associated with a deceased child's life or fatality. A Child Fatality Review is not intended to be a fact-finding or forensic inquiry or to replace or supersede investigations by courts, law enforcement agencies, medical examiners or other entities with legal responsibility to investigate or review some or all of the circumstances of a child's death. Nor is it the function or purpose of a Child Fatality Review to take personnel action or recommend such action against DSHS employees or other individuals.

chapters on CPS activities including the definitions of child abuse and neglect. In addition, the supervisor on the case at the time of Isayah's death was interviewed by the committee. The social worker on the case was not available for interview.

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During the course of the review, committee members discussed concerns regarding the possible impact social worker inexperience has on thorough risk assessment and service delivery. The committee members also discussed concerns regarding the impact of recent funding cuts which eliminated the regional placement of chemical dependency professionals in local offices to assist social workers with home visits, consultation, and intervention with families where substance abuse is alleged to have placed children at risk.

Though the committee found that the practice on the case, up and until Isayah's death, was reasonable per CA policy, RCW, and WAC, there were concerns related to the inexperience of the assigned social worker, unnecessary delay in staffing the case with a child protection team (CPT), and the unavailability of professional chemical dependency providers for case consultation. Further discussion of this case by the committee and findings and recommendations made by the committee are detailed at the end of the report.

**Case Overview**

In December 2002, when Ms. Casch was 17 years old, she moved to Washington state with her seven-week old son, Isayah;

Ms. Casch's history with the department began the following year in February 2003 with an anonymous caller reporting that Ms. Casch drove with children in her car while under the influence of alcohol and pain medication. The caller reported that Ms. Casch mixed alcohol and pain medications that were supplied by Mr. F. The caller reported that they had contacted law enforcement several times about Ms. Casch.

CA sent the intake report to law enforcement and a CPS case was opened for investigation. The finding was inconclusive and the case was closed in September 2003. No services were offered.

An anonymous caller contacted the department on July 27, 2010 to report that Ms. Casch was driving while intoxicated everyday with her children in the car. The caller reported that Ms. Casch began drinking early in the morning and drank throughout the day until she

passed out. The home was reported to be in poor condition with empty alcohol bottles in view. The children were reported to be "filthy" and that they frequently took care of themselves.

The case was opened for investigation and assigned to a social worker. The social worker made two attempts to visit the home. The door was not answered on the first visit. On the second visit, the worker attempted to interview Isayah. Ms. Casch and the paternal grandfather were present during the interview. and were also at home. The home was cluttered, extremely dirty inside and outside, with clothes and dirty dishes lying around the home. The home was noted to have an unpleasant odor. When interviewed, both parents denied using substances and that Ms. Casch had driven the car with the children while intoxicated. Ms. Casch submitted to a urinalysis test and results were negative. Services were offered to Ms. Casch which she declined. On August 23, 2010, the social worker prepared the transfer/closing summary. The supervisor requested follow-up work prior to closure including obtaining medical records for the children, criminal history checks on the parents, and contact with Isayah's school. The case remained open pending a CPT staffing. In October 2010 the investigation was closed. The allegations of neglect were unfounded based on clean random urinalysis from Ms. Casch, Ms. Casch and Mr. F.s' denial of using alcohol while driving, and Isayah making no report that his mother had driven him while drinking.

In the early morning hours of September 19, 2010, Harborview Medical Center contacted the department to report the accident leading to Isayah's death. Later during the day, Ms. F. called the department to report she had heard about the car accident the night before and that she had been the person to call in the July 2010 report.

**Committee Discussion**

*Practice*

Given the facts of the case at the time of the accident, the committee concluded that the CPS investigation and actions of the social worker and supervisor were reasonable per CA policy and the laws and code governing CPS investigations. The committee noted that, despite the history on the case indicating Ms. Casch was a long-term user of drugs and alcohol, there were never any allegations of physical harm to the children. Concerns about the conditions in the home or neglect of the children were not raised until July 2010. Ms. Casch, Mr. F., and Ms. F appeared to have ongoing conflict. Mr. F.'s ex-wife made several of the reports to the department including reports about Ms. Casch's use of alcohol and driving with children in the car.

The committee noted that the supervisor provided the necessary oversight on the case when the social worker staffed the case for closure. The supervisor stated she and the worker were both concerned about the allegations of Ms. Casch's substance use. Rather than close the case, the supervisor requested that the case be staffed by a CPT and that the parents be invited to the staffing with the goal of engaging the parents in services. The supervisor also directed the social worker to gather additional information that would be considered standard in any investigation. This included:

- Checking with the children's pediatrician to assess their physical health and development.
- Completing a criminal history check.
- Contacting Isayah's school for information about interactions with the family, his attendance and academic status.

During her interview with the committee, the supervisor commented that solution-based strategies of engaging the family were used in practice and that the CPT staffing held some promise of having the family better understand the concerns and possibly agree to services. The office had a two-month backlog of cases to be staffed with the CPT, and this case was put on the waiting list for October 2010. While it may be more convenient to staff a case with the local office team, this delay was of concern to the committee. There is no policy in place requiring that a case be staffed with the local office CPT.

*Social Worker Experience*

The social worker assigned to the case had four plus months experience working in CPS and had no field experience prior. The worker had completed the required academy training. Despite the consensus that the supervisor acted as an appropriate safety net for the social worker's inexperience, the committee discussed the value of experience and knowledge of practice and how those factors influence the social worker's interaction with the family, their skills of engagement, recognition of risk factors, and assessment of safety. The casework appeared to focus on Ms. Casch as an individual rather than on the family as a whole. Reports of her mental health history did not appear to be considered. Mr. F was never fully assessed for substance abuse or for his participation and condoning of Ms. Casch's use of substances while parenting the children. The paternal grandfather, who lived next door, had frequent contact with the family, provided care for the children, likely had knowledge of the parents' use of substances and their parenting of the children. Conflict between [redacted] and Ms. Casch appear to have provided a distraction from the concerns about Ms. Casch and the impact of her substance abuse on the younger children. This focus on the dynamic of adolescent conflict with caregivers appeared to become the primary focus of the early reports that also alleged Ms. Casch was driving under the influence of substances.

Historically, the CPS program has the highest rate of staff turnover in CA and, likely the highest rate of new or inexperienced workers. The committee had a discussion of how CA

manages this difficult reality and how the department can compensate for the lack of knowledge and experience in CPS without relying completely on supervisors who may not have a great deal of practice and management experience. The committee made recommendations that provide possible strategies on overcoming high staff turnover and inexperience in CPS.

*Chemical Dependency*

Of the four reports received by the department regarding Ms. Casch between 2003 and 2010, three indicated that she drove vehicles under the influence of alcohol and drugs with her children in the car. Ms. Casch had no criminal record of driving under the influence. When the case was open in October 2006, a drug and alcohol evaluation may have been helpful in determining Ms. Casch's substance use. This case, like so many the department manages, alleged substance abuse, however, investigations resulted in no findings of abuse or neglect of the children.

Reports that allege serious substance abuse without accompanying direct impacts to children are challenging for the department. Options include testing the client who is alleged to have used substances, offering voluntary services to the caregiver and family, determination if the department has information sufficient for filing a dependency, or if the family refuses services, closing the case.

During the July 2010 home visit, when the social worker was attempting to interview Isayah, Ms. Casch and the paternal grandfather were present. Ms. Casch was disruptive, interfering with the interview. The paternal grandfather appeared to condone Ms. Casch's behavior and did not intervene. The committee recognizes that interacting with a person who is using or addicted to drugs or alcohol can be an intimidating and frightening encounter. For those social workers who do not have experience with substance using or addicted clients, this type of behavior may result in backing off or avoiding continued contact with those clients. The social worker understood there were underlying concerns about substance abuse but may not have known how best to respond to Ms. Casch's behavior.

Having certified chemical dependency professionals (CDPs) available for home visits, consultation, and intervention provides the expertise that can support child welfare social workers in their investigations and case management responsibilities. The value of these CDPs was recognized when the department, in partnership with the Division of Alcohol and Substance Abuse (DASA), placed CDPs in CA offices within each region to assist

social workers when working with clients impacted by substance abuse or addictions. As a result of budget reductions the CDP program was reduced. In 2008 in Region 3, the CDPs were reduced to one to cover the entire region. This CDP placement was cut in December 2010.

The committee questioned whether or not alcohol use is regarded differently by the department than abuse of illegal drugs or prescription medications. The CDP on the committee noted that there has been a significant increase in heroin and prescription drug abuse in the last five years. The absence of chemical dependency experts in an agency that sees the majority of its caregivers using substances to some degree creates a void of educated and experienced professionals who can assist CA social workers in understanding and assessing chemical dependency.

In this case, the urinalysis run on Ms. Casch did not include analysis of ethyl glucuronide (ETG) in the urine.[3] ETG analysis is a more expensive test but is more accurate in determining alcohol consumption. While ETG analysis continues to be requested by CA social workers, budget considerations are resulting in fewer tests of this type. Consultation with CDPs can result in recommendations about drug and alcohol testing and may provide CA social workers with better opportunities for information gathering, intervention, and engagement with those clients who have a lengthy substance abuse history.

**Findings and Recommendations**

*Findings*

1. The committee found that the delay in staffing the case with a CPT was unnecessary as CPTs exist in other offices and the case could have been staffed by another team.

2. The committee found that the practice on the case, up and until Isayah's death, was reasonable per CA policy, RCW, and WAC. Given her four month's on the job, the social worker did an adequate job. The social worker did not see the whole picture and focused primarily on Ms. Casch. She did not appear to consider the need for additional work on this case and was prepared to close the case after the home visit. The supervisor addressed the direction the case was headed and requested additional information be gathered and further consideration given to address the substance abuse of the parents.

3. The lack of available CDPs to social worker for consultation, intervention, and planning on cases involving substance abusing clients presents a significant void in expertise that CA must find ways to fill. Having CDPs out-stationed in local offices is best; one CDP for an entire region is not practical or realistic.

[3] An ETG urinalysis provides a definitive indicator that alcohol has been ingested about 80 hours prior to the test. A urinalysis that does not include ETG analysis may show alcohol consumption only within a few hours prior to the test, depending on the amount of alcohol consumed.

4. Department policy does not require regular visits to a home when the case is open for CPS investigation. This case was open for two and a half months. One attempted visit and one achieved visit was made in an effort to complete face-to-face contact with the children.

*Recommendations*

1. Region 3 should ensure that social workers and supervisors are aware that cases can be staffed with CPTs in any office and do not have to wait for an opening in their own office.

2. CA should consider new social workers as "in training status" for up to 90 days minimum and should consider implementing the following training and mentoring strategies:
   - Partner "in training" social workers with experienced, mentor social workers.
   - "In training" social workers will not be assigned cases for 45 days. If assigned cases prior, the "in training" social worker should be assigned as a secondary with the mentor social worker as the primary social worker assigned to the case.
   - If staffing resources do not allow for partnering, "in training" social worker has daily supervision with assigned supervisor.
   - CA should develop a checklist of case "types" to ensure "in training" social worker has exposure to and experience with a variety of cases while in training, to include:
     - Newborn victim cases
     - Non-verbal victim cases
     - Adolescent victim cases
     - Substance abusing and addicted caregivers
     - Mentally ill caregivers
     - Physical abuse
     - Sexual abuse
     - Negligent treatment or maltreatment
     - Chronic maltreatment

3. Snohomish County providers of services for chemically dependent clients have begun monthly meetings to address budget cuts, reduction in resources, and how to maximize existing resources. This meeting has recently been joined by Region 3, Everett office management. The additional goal is to improve and increase communication about working with chemically dependent clients.
   - The department should consider working with local county providers and setting up similar network meetings around the state.
   - The department should conduct a survey to identify social workers currently employed by the department who are also CDPs. These staff could be utilized as local "experts" and assist social workers, particularly those less experienced, with cases involving chemically dependent clients.

4. The department should implement a visitation requirement for families who have open CPS cases longer than 30 days. Similar to dependent children, children who are open to CPS should be seen every 30 days.



11