CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

DECEMBER 2021

Washington State Department of
CHILDREN, YOUTH & FAMILIES

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.T-A.

Date of Child's Birth

- [redacted] 2017

Date of Fatality

- Feb. 27, 2021

Child Fatality Review Date

- March 23, 2021

Committee Members

- Damon Jansen, Richland Police Department, Sergeant Criminal Investigation Division
- Patricia Erdman, MSW, LICSW, Alliance for Child Welfare Excellence, Regional Education and Training Administrator
- Yaquelin Rosas, MSW, Department of Children, Youth, and Families, CPS Quality Assurance Program Manager
- Mary Anderson-Moskowitz, JD, Office of the Children and Families' Ombuds
- Jennifer Wiss, MSW, LICSW, MHP, Institute for Family Development, Supervisor
- Cristin Richartz, Rural Resources Victim Services, Client Services Program Manager
- Jennifer Gourley, MSW, Department of Children, Youth, and Families, Supervisor

Facilitator

- Cheryl Hotchkiss, Department of Children, Youth, and Families, Critical Incident Review Specialist

Executive Summary

On May 23, 2021, the Department of Children, Youth, and Families (Agency) convened a Child Fatality Review (CFR)[1] to assess the Agency's service delivery to J.T.-A. and [RCW 7] family.[2]

On March 1, 2021, an Agency supervisor learned of J.T.-A.'s death from a local newspaper article. The article stated that J.T.-A. had been shot in the head on Feb. 27 by [RCW 7] father, Felipe Tapiaon. J.T.-A.'s father told officials that he accidentally fired the gun, which struck J.T.-A. in the head. The parents drove J.T-A. to a local hospital, where [RCW 7] was then flown to RCW 74.13.515 Hospital in RCW 74.13.515 J.T.-A.'s father was charged with possession of a stolen firearm, alien in possession of a firearm, and manslaughter in the second degree. The Agency contacted local law enforcement, who confirmed the information in the article and added that a no-contact order had been issued due to a domestic violence incident that occurred in January 2021, prohibiting Felipe from contacting J.T.-A.'s mother. The Agency did not have an open case in January 2021 and did not learn of the no-contact order until after J.T.-A. was killed.

The CFR Committee (Committee) included members with relevant expertise selected from diverse disciplines within the community. Committee members did not have any involvement or contact with J.T.-A. or [RCW 7] family prior to the fatal incident. The Committee received a case chronology and other relevant documents, including intakes, case notes, medical records, and other Agency documents maintained in the Agency's electronic computer system.

The Committee interviewed a Child Protective Services (CPS) investigative caseworker, CPS supervisor, and FAR supervisor that were assigned to the case in 2020. The committee reviewed all case file information but focused on the 2020 interventions and how the Agency utilized historical information in their design.

Case Overview

In 2011, prior to the birth of J.T.-A., J.T.-A.'s [RCW 74.13.515] sibling was placed in state custody due to concerns about the mother's mental health and substance use. The dependency was dismissed in 2013. J.T.-A. was born one month early in [RCW 74.13.515] 2017 with RCW 74.13.520. The medical team diagnosed J.T.-A. with RCW 74.13.520. [RCW 74] is a rare disease involving RCW 74.13.520. At about nine months old, J.T.-A. had a RCW 74.13.520 to grow and thrive. J.T.-A. also had surgery to RCW 74.13.520.

[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 the Agency 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 Agency employees or other individuals.

[2] J.T.-A.'s father is named in this report because he has been charged with a crime in connection with the fatal injuries. The relatives and family who are not charged are not named in this report because they are subject to privacy laws. See RCW 74.13.500.

The Agency opened six interventions between October 2017 and January 2019 with J.T.-A.'s family. The primary reported concerns were medical neglect, physical abuse, domestic violence, and neglect allegations. Family Preservation Services (FPS) were offered. Additionally, J.T.-A.'s mother received a founded finding for abuse and neglect and was charged RCW 13.50.100 in 2019.

In January 2020, J.T.-A.'s RCW 74.13.520 was repaired. Medical records noted RCW 74.13.520 . J.T.-A made good progress with RCW 74 growth and development, RCW 74.13.520 . The medical team commented RCW 74.13.520 .

On March 13, the Agency opened an investigation for medical neglect. J.T.-A.'s local physicians were concerned that RCW 74 RCW 74.13.520 [3] was not being properly managed. If not properly managed, the RCW 74.13.520 could cause an infection that could become fatal.

April 27, the CPS caseworker requested J.T.-A.'s medical records and spoke with a nurse who was concerned with RCW 74 appearance and potential complications with the RCW 74.13.520.

April 29, the CPS caseworker contacted the parents telephonically for interviews. The CPS caseworker also requested records from local law enforcement regarding the mother's RCW 13.50.100 charge and several of the father's RCW 13.50.100 charges. The allegations were determined to be unfounded.

The caseworker completed a safety assessment, and the children were determined to be safe. The caseworker also completed a Structured Decision-Making Risk Assessment (SDMRA)[4] and identified a moderately high risk. CPS transferred the case to Family Voluntary Services (FVS)[5] and requested in-home services.

On May 5, the caseworker contacted a local medical provider who stated that J.T.-A. had not been seen since a December 2019 visit related to RCW 74 RCW 74.13.520 and that the older siblings had well-child exams in September 2019 and January 2020. Later, on May 20, the in-home service provider contacted the mother and offered twice-weekly meetings; the mother declined, saying she needed to reschedule. At the end of May, a family member tested positive for COVID-19. The in-home service was rescheduled to accommodate the health needs of the family.

On June 11, the in-home service provider notified the Agency caseworker that the mother requested to end services stating she did not have the time to participate. The case was closed.

On June 18, the Agency opened a CPS Family Assessment Response (FAR)[6] intervention after J.T.-A. was found unsupervised about a block from RCW 74 home. Between June 18 and Aug. 11, the assigned FAR caseworker made one in-person contact with the family. The FAR supervisor completed the safety,[7] risk, and FAR assessments.

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[3] For a description of RCW 74.13.520 , see: https://www.seattlechildrens.org/ RCW 74.13.520

[4] "Structured Decision Making Risk Assessment (SDMRA) is a household-based assessment focused on the characteristics of the caregivers and children living in that household. By completing the SDMRA following the Safety Assessment, the worker obtains an objective appraisal of the risk to a child. The SDMRA informs when services may or must be offered." See: https://www.dcyf.wa.gov/practices-and-procedures/2541-structured-decision-making-risk-assessmentrsdmra

[5] "Family Voluntary Services (FVS) allows parents to voluntarily engage in services to increase their protective capacities and meet the child's safety, health, and well-being needs." See: https://www.dcyf.wa.gov/practices-and-procedures/3000-family-voluntary-services-fvs.

[6] "Family Assessment Response (FAR) is a Child Protective Services (CPS) alternative response to an investigation of a screened-in allegation of child abuse or neglect. FAR focuses on child safety along with the integrity and preservation of the family when lower risk allegations of child maltreatment have been screened in for intervention." See: https://www.dcyf.wa.gov/practices-and-procedures/2332-child-protective-services-family-assessment-response.

[7] For more information on Agency safety assessment policy, see https://www.dcyf.wa.gov/1100-child-safety/1120-safety-assessment.

The assessments included a notation that adhesive locks for the doors were ordered for the family prior to case closure on Aug. 11.

The fatal incident occurred on Feb. 27, 2021. The Agency discovered J.T.A.'s death from a local news article.

Committee Discussion

The Committee identified information in the Agency case history about the parents' mental health, substance use, legal matters, and ongoing domestic violence that was not accurately analyzed and applied to the SDMRA and safety assessment. The Committee believed that these 2020 assessments and interventions lacked critical thinking by the assigned caseworkers and supervisors. The Committee also believed the 2020 interventions lacked effective supervisory oversight. The Committee found that the supervisors relied solely on the information provided by the assigned worker and did not personally review the information more formally to provide direction in assessing the safety and risk to the children in the home. The Committee believed the caseworkers should have been advised to seek additional information, analyze gathered information, amend inaccurate assessments, and request a shared planning meeting[8] or family team decision-making meeting (FTDM)[9].

The Committee opined that had there been a shared planning meeting or FTDM that included more participants; the Agency could have gathered enough information for more accurate assessments. Suggested participants in this meeting include both parents, past and current in-home service providers, previous referents and caseworkers, relatives identified by the school and family, medical providers, mental health providers, and substance use providers. The Committee discussed the importance of collaboration and communication to better assess the parents' individual functioning as well as household function in correlation with their protective capacities for their children.

The Committee noted that when questioned, the 2020 CPS investigator was unclear on what specific service needs were assessed for the family. To further assess general parenting, the assigned CPS caseworker made an in-home service referral to assist with the family's transportation difficulties. The Committee did not believe the information gathered and assessed led to an accurate assessment of service needs. The Committee noted that the Agency primarily focused on J.T.-A.'s mother for service engagement and case-related communication. The Committee noted minimal engagement by the Agency with J.T.-A.'s father in assessments, service delivery, and case planning. The Committee believed the supervisor should have directed the assigned CPS caseworker to hold a shared planning meeting or FTDM once in-home services were declined based on the documented CPS history or interventions, reports, and risk to the children.

The Committee considered the effectiveness of virtual in-home provider services and believed it was important to note that due to COVID-19 precautions, in-person services were limited during 2020. The Committee speculated that clients with limited resources might find virtual services difficult to manage or foster engagement if internet or cellular service accessibility is a barrier. The Committee heard from the interviewed staff that in-home service availability in their area was further limited and often unavailable. The Committee was told that providers or clients needed to travel two or more hours to participate in a relevant

[8] For a description of the shared planning meeting process, see https://www.dcyf.wa.gov/1700-case-staffings/1710-shared-planning-meetings.

[9] For a description of the family team decision making meetings process, see https://www.dcyf.wa.gov/1700-case-staffings/1720-family-team-decision-making-meetings.

service to assess their needs. The Committee believed this was a barrier to service delivery and addressing immediate safety and risk issues. Bilingual services were also identified as lacking in this community. The Committee heard from the workers that due to a lack of bilingual and local in-home service resources, the Agency often resorted to in-home service providers that may not offer the necessary evidence-based practices requested or needed. The 2020 CPS investigator told the Committee that putting any service in the home was thought to be more effective in reducing risk than having no service providers working with the family. The Committee disagreed with the CPS investigator and emphasized the need for comprehensive information-gathering and accurate application of information to safety and risk assessments. The Committee noted that the SDMRA should drive service delivery, but an SDMRA did not occur in this case.

The Committee heard from the FAR supervisor that the 2020 FAR intervention relied on the information provided in the 2020 CPS assessments and verbal communication from the previously assigned CPS investigator. The Committee considered the Agency's response to be incident-focused and did not believe that it met the minimum policy requirements for assessments. The Committee believed the family's historical information should have been further considered in the overall assessment of the children's safety and functioning in the home. The Committee opined the case may have benefitted from a formal internal case consultation with program managers to assist with clinical direction, critical thinking, and comprehensive historical analysis of the case file.

Some Committee members strongly opined that there was a clear and documented pattern of domestic violence in the home that was not effectively screened or assessed. The Committee was told that the local office used a screening tool that was not an Agency-authorized tool. The Committee believed that this informal tool led to minimal assessment and inquiry as to the actualities of ongoing domestic violence in the home and that it did not meet the domestic violence screening policy[10] requirements. The Committee further believed that the Agency had limited knowledge of the father's daily impact on the household and could have further engaged or involved the father in the interventions. Some Committee members believed additional screening and assessment of available information would not have improved the outcome in this case. These Committee members believed that regardless of possible missed assessment opportunities, the Agency was not responsible for the incident nor had the capacity to prevent J.T-A's death.

Findings

The local office utilized an unofficial checklist to screen for domestic violence. The Committee believed this particular form led to ineffective screening for domestic violence and domestic violence assessments. The Committee found that the unofficial form contributed to inaccurate domestic violence assessments and screening on this case between the 2018 and the 2020 interventions.

In 2020, a lack of clinical supervision may have contributed to incident-focused interventions and assessments. The Committee found that the SDMRA and safety and domestic violence assessments were inaccurate, and there was insufficient information gathered for a comprehensive assessment. The Committee believed that the supervisors lacked critical thinking with the information the caseworkers gathered and shared. The

[10] See: https://www.dcyf.wa.gov/1100-child-safety/1170-domestic-violence.

Committee found there was opposing information available compared to what the caseworkers documented and shared with their supervisors, specifically a pattern of domestic violence and missing information on the parents' mental health and substance use and the day-to-day functioning in the home. The Committee additionally believed that a lack of critical thinking included failure to hold a shared planning meeting or case consultation.

Recommendations

The Committee heard from Agency program staff that the Agency is addressing clinical supervision, supervision of assessments, and improvement in the accuracy and efficacy of assessments through training, procedure, and policy improvements. The Committee believes supervisors statewide, especially the supervisors located in this office, might benefit from supervisor-specific training to enhance accuracy and critical thinking in SDMRA and domestic violence and safety assessments.

The Committee recommends that the local office cease use of any unofficial or unauthorized forms while screening and assessing for domestic violence. At the writing of this report, the local office and regional administration discontinued use of unofficial and unauthorized forms.