CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

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Washington State Department of
CHILDREN, YOUTH & FAMILIES

Contents

Full Report

Child

- K.D-C.

Date of Child's Birth

- 74.13.515 2001

Date of Fatality

- December 2018

Child Fatality Review Date

- December 12, 2019

Committee Members

- Mary Moskowitz, JD, Office of the Family and Children's Ombuds, Ombud
- Julio Serrano, Pierce County Juvenile Court, Guardian ad Litem
- Amy Boswell, DCYF, Region 6 Quality Practice Specialist
- Derek Murphy, M-RAS, SUIDP, CSC, Gig Harbor Counseling, Director of Outpatient Services

Observer

- Leah Mattos, MSW, DCYF, Critical Incident Review Specialist

Facilitator

- Libby Stewart, DCYF, Critical Incident Review Specialist

Executive Summary

On Demeber 12, 2019, the Department of Children, Youth, and Families (DCYF)[1] convened a Child Fatality Review (CFR)[2] to assess DCYF's service delivery to K.D-C. and [redacted] family.[3] [redacted] will be referenced by [redacted] initials throughout this report.

On December 21, 2018, DCYF received a telephone call reporting that after going into cardiac arrest K.D-C. had been brought to the hospital by ambulance. The mother told hospital staff K.D-C. had difficulty breathing the night before, and she had been watching [redacted] The mother also said she was aware that earlier in the day 74.13.515 consumed 74.13.520 This intake was screened in for a Child Protective Services (CPS) investigation. K.D.C. was removed from life support and died the same day [redacted] was admitted to the hospital.

A CPS/Family Assessment Response (FAR)[4] case had closed in March of 2018 and there had been a screened out intake in May of 2018, However, at the time of K.D-C.'s December 21 hospitalization there was not an open DCYF case. While the December 21 case was open for investigation a second intake was received on January 3, 2019. For purposes of the January 3 intake, a caller reported that K.D-C. died by overdose, the parents are doing drugs, and someone should check on the 5 year old who is currently residing in the home. K.D-C. was seventeen years old at the time of [redacted] death.

The CFR Committee (Committee) includes members with relevant expertise selected from diverse disciplines within the community. Committee members have not had any involvement or contact with K.D-C., or [redacted] family. The Committee received relevant documents including intakes, case notes and other DCYF documents maintained in DCYF's electronic computer system.

The Committee interviewed the supervsiors who were involved in the cases prior to K.D-C.'s death. The CPS/FAR worker is no longer working for DCYF at the time of this review.

Case Overview

On 74.13.515 , 2001, the Department of Social and Health Services (DSHS) received an intake stating a baby [redacted] had been born 74.13.520 [redacted]. This intake was screened in for a CPS investigation. After the CPS investigation was completed DCYF 13.50.100 [redacted].

[1]Effective July 1, 2018 the Department of Children, Youth, and Families (DCYF) replaced the Department of Social and Health Services (DSHS) Children's Administration (CA) as the state agency responsible for child welfare; and the Department of Early Learning for childcare and early learning programs.

[2]"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 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 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 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.

[3]K.D-C's parents have not been named in this report because they have not been charged with a crime involving the circumstances descr bed in the reports maintained in DCYF's case and management information system.

[4] "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

On November 29, 2001, another intake was received stating the mother had been 13.50.100 ; was 13.50.100 ; and previously told the caller she 13.50.100 . This intake was screened in for a CPS investigation.

On December 6, 2016, DSHS received a telephone call reporting K.D-C. had been 13.50.100 . The caller reported that K.D-C. 13.50.100 and the 13.50.100 . The caller said K.D-C is volatile but does not have a history of violence. This intake was screened out and sent to law enforcement.

On February 1, 2018, DCYF received a telephone call from K.D-C.'s 13.50.100 reporting concerns about violence 13.50.100 . This occurred in the family home and was reported to the 13.50.100 by K.D-C.'s mother. The mother later recanted her statement. The intake included information about the stepfather having to 13.50.100 and 13.50.100 .. The stepfather also had to 13.50.100 during an incident between 74.13.515 . A family friend told the 13.50.100 that K.D.-C. is "out of control" and 13.50.100 . The family friend witnessed K.D-C. 13.50.100 . K.D-C also has a male friend living in the family home, but K.D-C's mother won't make the friend leave because she doesn't want to anger 74.13.515 . The 13.50.100 reported that in December 2017 the family successfully completed Functional Family Therapy (FFT)[5]. On February 1, 2018, the FFT therapist informed the 13.50.100 that the mother often 13.50.100 and believes she also sleeps a significant part of the day. This leaves the 4 year old child without supervision. K.D-C. told the 13.50.100 that 74.13.5 and 74.13.5 74.13.515 frequently smoke marijuana in the home and the mother and stepfather are aware. This intake was screened in for a CPS/FAR assessment.

On February 2, 2018, the assigned CPS worker made contact with the mother. The mother minimized the allegations. She did say K.D-C. needs anger management help. She said 74.13.5 has been 74.13.520 . She believes her son's anger stems from 13.50.100 . The mother said she is interested in receiving counseling for the family.

The CPS worker interviewed the 74.13.515 The interviews were first conducted in the presence of the mother and stepfather; she then spoke with the older 74.13.515 away from the adults. The 4 year old would not speak to the FAR worker. K.D-C. and 74.13.5 15 year old brother did not take the conversation seriously and joked and laughed throughout the interview. The mother reported she is not "afraid of 74.13.515 , but there comes a certain point where 74.13.5 blanks out" and the stepfather has to intervene. The stepfather said the 74.13.515 are "coming around a bit" and he feels things have positively progressed. He did say that when there are altercations he has had to physically restrain the 74.13.515 The mother said the 74.13.515 listen better when her husband is home. The mother and stepfather shared their criminal histories, which included drug-related charges.

The CPS worker spoke with K.D-C's 13.50.100 . The 13.50.100 said that except for FFT, the family doesn't follow through with services and referrals. She said K.D-C. does not cooperate 74.13.520 . Despite the fact the family has been provided with

[5]See https://www.fftllc.com/ for a description of Functional Family Therapy.

bus passes, the family always asserts there is a lack of transportation as the reason for why there are missed appointments. K.D-C. was [redacted]. There was also a [redacted] County warrant ordering the arrest of K.D-C [redacted]. This occurred when [redacted] was living with [redacted] father. The [redacted] also reported that K.D-C. has failed to provide a urinalyses the last two times she requested them.

The mother gave the CPS worker the names of two people to call for collateral information. Neither of the phone numbers the mother provided were working at the time telephone calls were attempted.

On March 14, 2018, DCYF Intake received a telephone call reporting historical concerns. K.D-C. disclosed that when [redacted] and [redacted] brother lived with their father beween 2013 and 2016, [redacted]. He also [redacted]. This intake was screened out.

On March 16, 2018 another telephone call was received from a provider working with K.D-C.'s family. The caller reported the mother called her earlier in the day reporting that K.D-C. was out of control, escalating and she needed help. The caller reported the mother has a history of [redacted]. When the caller arrived at the home K.D-C. was sleeping, but [redacted] woke up soon after she arrived. The mother and K.D-C. started yelling at each other and the situation escalated. The two younger boys witnessed this event. This went on for one hour. During this time the mother was holding a taser behind her back. The caller told the mother there was no reason to bring a weapon into the room and asked her to lock it up. The mother said she keeps it for her protection. This intake screened in for a CPS/FAR assessment.

The CPS worker contacted the mother three days later. The mother told the worker that she was getting a lock box and was going to put the taser in it. The taser had reportedly been removed from the home. The FAR worker then spoke with the referent. The referent stated she is concerned there is a lack of supervision in the home. The referent also told the FAR worker that she has gone to the home and marijuana was within plain view and easily accessible to the 4 year old brother. K.D-C. has stated [redacted] does not want to stop using marijuana. The mother also appears unmotivated to change her behavior.

After meeting with the referent, the CPS worker went to the home. When she arrived the mother was not present but gave permission for the worker to meet with the [redacted] When the worker arrived K.D-C.'s [redacted] was sitting alone on the couch. The [redacted] got up and soon after the [redacted] came out of the back of the home. The CPS worker first spoke with K.D-C.. [redacted] said that was the first time their mother had brought out the taser. Next, the worker met with K.D-C's younger brother. Both [redacted] denied any injuries from their mother, and both [redacted] discussed smoking marijuana and cigarettes at home. When the mother arrived home she provided the worker with the neighbor's information as a collateral contact. The worker called the neighbor who said she would call the worker back. At the time of case closure the neighbor had not called the CPS worker back.

On March 27, 2018, the FAR Family Assessment (FARFA) was completed and approved for closure. The document states the case was closing and FAR was successfully completed. The mother had been provided community resources; and [redacted] so the family could afford to obtain the [redacted] social security cards and birth certificates. The mother needed the social security cards and birth certificates [redacted]

13.50.100 The closing summary indicates that K.D-C. is engaged in community services and is providing random urinalysis to 13.50.100 .

On May 16, 2018, the 13.50.100 called in an intake stating she learned from a service provider working with the family that K.D-C. 13.50.100 at 74.13.5 15 year old brother. 13.50.100 . A neighbor took the 74.13.515 to the hospital. It was reported the doctor said 13.50.100 . The fight was over marijuana and the 74.13.515 did not tell the doctor the true story. The mother was not home at the time of the fight and police were not contacted. This intake was screened out.

On December 21, 2018, DCYF was notified that K.D-C. had been taken to the hospital for cardiac arrest. This intake was screened in for a CPS investigation. While the case was open for investigation a second intake was received on January 3, 2019. The caller referenced K.D-C's death, reported , the parents are doing drugs and someone should check on the welfare of K.D-C's 5 year old brother. This second intake was screened out stating the allegation was documented in the previous intake.

On March 6, 2019, a 13.50.100 for the now 16 year old brother of K.D-C reported the 16 year old is now living out of state with relatives. He disclosed witnessing his 74.13.515 seizing during the overdose. The 16 year old brother said he tried to get the mother and stepfather to help and they said, "Let 74.13.515 sleep it off, 74.13.5 will be O.K." The child reported his 74.13.515 was using marijuana and it was laced with something. The relatives told the 13.50.100 the 5 year old, still living in the family home, found a gun. It is unknown when this occurred. This intake was screened in for a CPS/FAR assessment.

On August 23, 2019, the CPS investigation regarding K.D-C.'s death was concluded. Based on information gathered from the medical providers, and after consultation with a DCYF Medical Consultant (Medcon), a founded finding for negligent treatment was entered against the mother. Law enforcement was initially involved but did not make any arrests. The March 6, 2019 intake was changed to a CPS investigation. That investigation resulted in an unfounded finding. The investigative assessment reports the child refused to speak with the CPS worker. The CPS worker did not observe any injuries on the child. A walk through of the home was completed and no safety concerns were noted. The child appeared to be appropriately cared for and basic needs were being met.

Committee Discussion

Through the interviews with the DCYF supervisors, the Committee learned that on March 15, 2018 there had been a change in supervisors. Both supervisors talked about looking back at the work they performed, and how they would now approach it differently. As a part of a practicum for the Masters of Social Work program, the original CPS supervisor changed job positions with the final supervisor. The second supervisor received CPS training but did not have actual CPS experience. She had been a Child and Family Welfare Services (CFWS) worker and most recently a CFWS supervisor. This is a regular practice that occurs statewide within DCYF. This particular office also provided support to the supervisors in their new roles and they were able to consult with one-another when necessary.

The Committee also discussed barriers to conducting thorough casework. At the time she was assigned the February 2018 intake, the CPS worker was responsible for 26 other assigned

cases. The Council on Accreditation and Child Welfare League of America recommends CPS caseloads be between 12 and 15 cases per CPS worker. Also discussed was the difference between caseload and workload. Caseload is considered the number of cases assigned to a worker. According to the U.S. Department of Health and Human Services (Administration for Children and Family Services) workload takes into consideration all aspects that go into investigating or assessing cases such as travel, services and how complex or challenging a case may be. Both supervisors identified the CPS worker is a good and conscientious worker. However, despite the fact the CPS worker is a good and conscientious worker, the Committee struggled with how a worker is expected to conduct thorough and adequate assessments, or investigations, with such a high caseload.

The Committee discussed a closing case note that appeared to rely on the community wrap around service as a mitigating reason for keeping the case open. The Committee however, felt reliance on this service was misguided and there remained areas within the assessment process that went unassessed. This community based wrap around service provider was also 13.50.100 [redacted]

The Committee also discussed the topic of access to and providing Narcan, a substance used to treat suspected opioid overdose. The Committee considered what future role DCYF may legally play in identifying locations where families may obtain Narcan, or the possibility of providing it to families, where allegations include substance use or abuse.

The Committee discussed obtaining the criminal history of persons living in the homes where DCYF is conducting assessments or investigations. The Committee also discussed the strict Nation Crime Information Center (NCIC) record access and utilization requirements placed on DCYF by the federal government. The Committee learned that FAR cases do not have access to the Code C[6] through NCIC. CPS investigators have access to NCIC but CPS/FAR does not. This is a tool that is utilized as a part of the assessment process but also can be beneficial when considering safety. It was also shared during the staff interviews that field staff are prohibited from obtaining the actual criminal convictions and are only given "categories" of convictions. The Committee struggled with how a category, instead of the actual criminal convictions, can be beneficial to field staff.

The Committee discussed concerns about how FAR is supposed to work, as compared to the Committee's experience and understanding of CPS investigations. The Committee believes that while there are differences between FAR and CPS investigations, there still needs to be an emphasis on fully assessing child safety for all children within a home and doing DCYF's best to understand the family's functioning. The Committee also discussed the policy requirements in effect at the time of this case that require closing FAR cases at 90 days. The staff shared that they currently have 120 days to close the case, but it can be a struggle to fully engage a family in change within such a short time period. FAR cases often have generational issues that require long term engagement to ameliorate the identified root causes of abuse or neglect. Understandably, many families are not willing to engage with DCYF staff and open up about their family until a rapport has been built and trust is earned. This can take a considerable amount of time.

[6]For a discussion about Code C, see https://www.dcyf.wa.gov/6000-operations/6800-background-checks.

The supervisor who approved the case for closure prior to the fatality discussed her opinions on how teenagers are often viewed by DCYF. She shared that teens are often overlooked or their safety needs are underestimated due to their age. The Committee appreciated and agreed with the supervisor's statements. An example discussed by the Committee for this family included the concept that because K.D-C.'s stepfather was able to physically intervene during violent episodes in the home, he was considered a stabilizing factor.

The Committee believes this case is an example of an incident focused case. They believed DCYF should have conducted or documented how they assessed the safety and well-being of the two younger children, and how the adults were functioning within the home.The Committee believes there was an overreliance on the fact that a community based wrap around service was involved, as well as 13.50.100 and those two services mitigated the need for continued assessment or DCYF involvement.

The Committee also disagreed with the May 16, 2018 intake screening decision. Despite the fact the intake information came from the13.50.100 and not a physician, the information was very concerning to the Committee members. They discussed the risk to the children, overall safety, and the ongoing violence within the home appeared to continue. Combined with the available historical information, the Committee believes the information within the May 16 intake should have risen to the level of a screened in CPS intake.

Despite the concerns expressed in this section, the Committee does not believe DCYF's actions or approach to this case played a role in K.D-C's death.

Findings

The Committee does not find that any critical errors were made by DCYF. However, there are areas where the assessment and investigative efforts could be improved.

The Committee believes more collateral contacts would have been appropriate. Those include the following: speak with the FFT therapist; request the FFT assessments; and contact law enforcement to possibly request the call log to the address and request any reports for the persons living in the home. There also should have been an attempt to contact K.D-C.'s father, and attempt to obtain records from the 74.13.515 and 74.13.515 CPS agencies. The Committee noted the out-of-state CPS records request is based on the fact that at one point the 74.13.515 lived with their father in 74.13.515 and the mom mentioned her last arrest was from 74.13.515 The CPS worker could have tried to speak with K.D-C.'s 74.13.515 who frequented the home13.50.100 as referenced in the intake from February 1, 2018. Reaching out to K.D-C.'s 74.13.520 provider, the 74.13.515 schools and the family friend mentioned in case notes would also have been appropriate. The three collateral contacts the mother gave to the worker did not either cooperate or have working telephones when we called. The contact the social workers had with the 13.50.100 and wrap around provider included 13.50.100 and the provider's own concerns about the chaos and lack of safety within the home.

As a result of the substance use, and substance abuse, the Committee believes there should have been an assessment of such use and the current impact to the children residing in the home. This is based on the 74.13 515 substance use, the mother's and stepfather's statements, the FFT therapist's statements, and the information within DCYF's records about the mother's substance use history. The mother has a significant substance use history, and admits she 13.50.100 . The stepfather has a significant criminal history and

admits to substantial historical substance abuse. The wrap around staff member reported she has observed marijuana in plain view in the family home that was accessible to the 4 year old child. Based on the totality of the information known to the department, the Committee believes it would have been appropriate to request that the mother and stepfather provide a random urinalysis, and possibly substance use assessments.

The CPS worker did speak with the stepfather, but did not do any further gathering of information or assess his role and functioning within the home. The Committee believes the social worker should have made more efforts to assess him as a care provider within the home. The Committee also identified that a complete assessment of the 4 year old was not conducted. The 4 year old was at home full-time with his mother, he was not engaged in any services or activities in the community, it was alleged the mother was drinking or sleeping most of the day and when the incidents of violence occurred, the 4 year old was often present.

The Committee did not agree with the assessment that the home was safe and there were no active safety threats. The mother possessed a taser and displayed it during an altercation in which the older 74.13.515 were fighting over marijuana. There was ongoing violence within the home, a lack of engagement by the mother and step-father and a failure by the parent and step-parent to acknowledge and collaborate with efforts to combat the children's open substance use. It appears to the Committee that at best the home was chaotic, if not unsafe (especially for the 4 year old). The Committee understands wrap around services are intense; and it can be a relief to DCYF when DCYF is exiting a case. However, the Committee would have liked to have seen either a shared planning meeting or other type of meeting documenting that all parties met and discussed the following: safety issues for all the children; a plan for how to move forward with K.D-C.'s 13.50.100 needs (to include mental health and substance use); and if necessary, when to call DCYF in the future. The Committee appreciates the fact the supervisors retrospectively looked at the case and discussed safety threats that they now identify but did not identify when the case was opened.

The Committee believes there should have been a full domestic violence (DV) assessment. The policy does not differentiate between intimate partner violence and violence within a household. However, staff training materials do recognize the difference by only discussing DV within intimate partners.

The Structured Decision Making Risk Assessment (SDM)[7] was inaccurately completed. The Committee understands the SDM is a tool that is to be used to help guide workers through the assessment/investigation process. However, the inaccurate information in the SDM is concerning to the Committee. This concern is focused on key components of the case or situation that may not have been fully understood or assessed by the worker. This may have impacted the decision to close the case.

Despite the concerns expressed in this section (Findings), the Committee does not believe DCYF's actions or approach to this case played a role in K.D-C's death.

[7] The 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

Recommendations

The Committee recommends that DCYF provide statewide mandatory training to all field staff statewide regarding substance use/abuse. This training must be provided by a qualified person within the substance abuse field who has current subject-matter knowledge. The training should focus on the following:

1. Training about the substances most commonly known to the community that are being abused;
2. Training about the interactions of the abused substances with other substances; and
3. Training about the factors DCYF field staff should consider when deciding whether it is appropriate to ask that a subject matter expert (for example, a Substance Use Disorder Professional[8]) work with a client, or provide consultation services about an issue specific to a particular client.

The Committee does not believe there are any current training opportunities specific to this recommendation. If there is a current training consistent with this recommendation, the Committee recommends DCYF inform all field staff about the specific training.

The Committee also recommends that FAR case be given access to the Code C through the NCIC checks. The Committee believes this tool could have aided the CPS worker by allowing her to confirm the mother's and stepfather's drug related criminal charges and hopefully aided in a further assessment of possible current substance abuse. With regard to this particular family, this is especially concerning because there was violence in the home between the two older [redacted] that was associated with drug use and K.D-C. died after using drugs and not receiving timely medical care.

[8] A "substance use disorder professional" was formerly known as a "chemical dependency professional".