CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

August 2019

Washington State Department of
CHILDREN, YOUTH & FAMILIES

Contents

Nondiscrimination Policy

The Department of Children, Youth, and Families (DCYF) does not discriminate and does provide 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

- T.C.

Date of Child's Birth

- [redacted] 2005

Date of Fatality

- January 19, 2019

Child Fatality Review Date

- May 2, 2019

Committee Members

- Mary Moskowitz, JD, Ombuds, Office of the Family and Children's Ombuds
- Pam Hubbard, LMHC, CDP, Co-Occurring therapist and Outpatient Counselor Supervisor, Evergreen Recovery Centers
- Ida Keeley, Court Appointed Special Advocate Program Manager, Snohomish County
- Wendy Burchill, Child Death Review Coordinator and Injury Prevention Specialist, Snohomish Health District
- Kelly Boyle, Child Protective Services Program Manager, Department of Children, Youth, and Families
- Jennifer McCarthy, Quality Practice Specialist, Department of Children, Youth, and Families

Observer

- David Underwood, Child Protective Services worker, Department of Children, Youth, and Families

Facilitator

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

Executive Summary

On May 2, 2019, the Department of Children, Youth, and Families (DCYF)[1] convened a Child Fatality Review (CFR)[2] to assess the service delivery to T.C. and [74.13.5] family.[3] [74.13.5] will be referenced by [74.13.5] initials throughout this report.

On January 12, 2019, DCYF received a telephone call reporting that 13-year-old T.C. died by suicide. T.C. shot [74.13.515] self with a shotgun that was hanging on the wall at [74.13.5] home. Ammunition for the gun was stored in a different part of the house. At the time of the shooting T.C.'s parents were not home. However, T.C.'s paternal grandmother and [74.13.5] sister were in their respective bedrooms. Neither the grandmother nor T.C.'s sister, heard the gunshot. After returning home T.C.'s parents discovered their deceased [74.13.515] Earlier, on the same day as the shooting, T.C.'s parents told T.C. [74.13.5] must do extra chores because of [74.13.5] declining grades. This intake resulted in a Child Protective Services (CPS) Risk Only intake. However, on January 22, 2019, a subsequent intake was received providing more details about the family situation. That intake initially screened in for a CPS Family Assessment Response (FAR) assessment but was overridden by a CPS supervisor and assigned for a CPS investigation. With regard to T.C.'s death, DCYF issued a founded finding for negligent treatment or maltreatment against both of T.C.'s parents.

At the time of [74.13.5] death, T.C. lived with [74.13.5] mother, father, paternal grandmother and one of [74.13.5] two sisters. [74.13.515] 18-year-old sister did not live in the family home. During the death investigation, DCYF[13.50.100] as to T.C.'s sister, who remained in the family home. T.C.'s sister[13.50.100].

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 T.C. or [74.13.5] family. The Committee received relevant documents pertaining to this family including intakes, case notes, other DCYF documents maintained in DCYF's electronic computer system and a draft medical examiner's report. The Committee interviewed the original CPS worker for the January 2018 intake and the current CPS supervisor for the office that conducted the January 2019 investigation. The worker who completed the January 2018 intake no longer works for DCYF.

Case Overview

On January 31, 2018, DCYF received an intake reporting that T.C.'s parents have alcohol and drug problems. It was reported that the mother sells [13.50.100] and [13.50.100] and many people are in and out of the home. It was also reported the parents verbally abuse [74.13.515], [74.13.515] attempted suicide in October of 2017 and the parents will not buy any food that their 17-year-old daughter needs related to her[74.13.520] needs. The intake also reported that broken furniture is in the home due to the father and friend drinking and getting

[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 child care 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) or child near-fatality review (CNFR) 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 Department of Children, Youth, and Families (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 he child's parents and relatives, or of other individuals associated with the child. A CFR or CNFR is not intended to be a fact-finding or forensic inquiry or to replace or supersede investigations by courts, law enforcement agencies, or o her entities with legal responsibility to inves igate or review some or all of the circumstances of a child's fatal injury or near-fatal injury. Nor is it the function or purpose of a CFR or CNFR to recommend personnel action against DCYF employees or other individuals. "The restrictions set forth in [RCW 74.13.640] 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." RCW 74.13.640(4)(d).

[3] T.C.'s parents are not named in this report because they have not been charged in an accusatory instrument with committing a crime related to a report maintained by the Department in its case and management information system. See RCW 74.13.500(1)(a).

into a fight. In addition, it was reported that a year ago the father punched 74.13.515 in the face and 74.13.515 went to school with a black eye. In October 2017, 74.13.515 stopped taking her 74.13.520 medication. However, on her own she recently went back to her physician to obtain the needed prescription. This intake was screened in for a CPS/FAR assessment.

On February 2, 2018, the assigned CPS/FAR worker contacted T.C.'s oldest sister at her school. The sister disclosed during the CPS worker's interview that on a daily basis the mother drinks two-fifths of alcohol and is addicted to 74.13.520 and 74.13.520 The sister denied the mother uses 13.50.100 or sells drugs. The child said she believes her mother is clinically depressed. In October 2017, after returning home from babysitting, T.C. and a cousin told T.C.'s sister that 74.13.515 had put a gun to 74.13.515 mouth and pulled the trigger. However, the gun did not go off. T.C.'s sister also said that in the summer of 2016 she saw their dad try to kill their mother by strangling her. T.C.'s sister tried to wake her paternal grandmother who lived in the home but the grandmother was passed out and could not be awakened. The sister said she began to scream for help because her dad was going to kill her mom. Neighbors called the police. T.C.'s sister said their mother lied to police and made the children lie at court to say nothing happened. According to the sister, the legal case did not go forward.

T.C.'s sister described other substance abuse incidents involving her parents. She also disclosed that their dad punched 74.13.51 in the face after their dad tried to attack T.C. 74.13.515 had a black eye and did not go to school for two weeks. The sister provided other allegations involving abuse and neglect against the children by their parents. T.C.'s sister said she is worried that if the children are removed from the home, their dad would kill their mother. She also said T.C. is the victim of most of the abuse inflicted by the parents. She said that because of the abuse inflicted on T.C., 74.13.5 has behavior issues. For example, last year T.C. 13.50.100 . Their other sister 13.50.100 .

T.C.'s sister said an aunt has tried to get their mother help. T.C.'s sister has told her doctor and youth pastor about what happens at home but nothing has helped. T.C.'s sister was asked if she had ever gone to counseling. T.C.'s sister said their dad said counseling is for "pussies."

On Friday, February 2, 2018, the CPS worker requested law enforcement go with her to the family home. When they arrived the parents and all three children were home. The parents denied all of the allegations. The dad admitted they occasionally "get their drink on" but denied the alcohol abuse allegations. The dad repeatedly said he works for a large private company in the area and makes $100,000 a year. The CPS worker observed that the home was cluttered with mattresses, furniture, boxes and other items strewn about the home. However, the worker did not identify any safety hazard to teenage children. The parents agreed to provide urine samples on Monday, February 4, 2019.

While still at the family home, the CPS worker spoke with T.C. and 74.13.5 youngest sister. The children did not disclose anything and were told there would be follow up conversations at school.

After this contact with the family, the originally assigned CPS worker was promoted to a CPS supervisor position. On March 15, 2018, the newly assigned CPS worker contacted T.C.'s oldest sister. T.C.'s sister expressed concerns about her parents drinking, cleanliness of the house and lack of appropriate food. The CPS worker informed the child that she and her siblings were old enough to clean the home and prepare their own meals. The CPS worker also

told the child that unless the parents' drinking caused harm to someone in the home, there was no safety threat or hazard.

The document recording the parents' results of the observed urine samples provides an incorrect date of birth for T.C.'s father. It also indicates that both parents observed urine samples were collected at 12:00 a.m. This is not possible because the provider is normally not open at that time. The document for T.C.'s father indicates the urine was collected on February 5, the Monday following the CPS worker's contact. The father's 13.50.100 was considered in the normal range but very close to the cutoff. An identified 13.50.100 is often associated with a diluted result. The mother's urinalysis was collected on February 8, not the date requested by the CPS worker. Both parent's urine samples were negative for the tested substances. However, neither parent was tested for Ethyl glucuronide (ETG).[4] The ETG test is a test that detects recent alcohol consumption.

On April 12, 2018, the CPS worker conducted a health and safety visit with T.C. and the sister who was not interviewed on March 15, 2018. Both children talked about their parents' drinking habits. They both said their mother drinks more than their father and described the mother's drunken behaviors. T.C. said 74.13.5 did not have anything 74.13.5 liked about 74.13.5 mom because 74.13.5 doesn't really know her. 74.13.5 likes the fact that 74.13.5 father will play video games with 74.13.515 Both children said they go to friends' houses over the weekend to get away from their parents' drinking and yelling. Both children said they felt safe in their home and had adults they could go to for help if they needed it. On April 19, 2018, the case was closed with no further intervention or referrals for services.

On January 12, 2019, DCYF received a telephone call reporting that 13-year-old T.C. died by suicide. T.C. shot 74.13.515 self with a shotgun that was hanging on the wall at 74.13.5 home. Ammunition for the gun was stored in a different part of the house. At the time of the shooting T.C.'s parents were not home. However, T.C.'s paternal grandmother and 74.13.5 sister were in their respective bedrooms. Neither the grandmother, nor T.C.'s sister, heard the gunshot. After returning home T.C.'s parents discovered their deceased 74.13.515 Earlier, on the same day as the shooting, T.C.'s parents told T.C. 74.13.5 must do extra chores because of 74.13.5 declining grades. This intake resulted in a Child Protective Services (CPS) Risk Only intake. However, a subsequent intake received on January 22, 2019 provided more details about the family situation. That intake initially screened-in for a CPS Family Assessment Response (FAR) assessment but was overridden by a CPS supervisor and assigned for a CPS investigation. With regard to T.C.'s death, DCYF issued a founded finding for negligent treatment or maltreatment against both of T.C.'s parents.

Committee Discussion

The Committee discussed many aspects of this case and the general practice within DCYF. The Committee spent significant time discussing the need for training and guidance for all field staff, versus challenges related to high staff turnover and high caseloads. High caseloads often prohibit staff from attending trainings, the mentoring of new staff and many other areas that support strong social work practice. The Committee discussed that the current infrastructure does not fully support best practice.

The Committee believes DCYF could bolster suicide and weapons training. The Committee discussed the rising numbers of death by suicide, the decreasing age of children attempting

[4] See http://cordantsolutions.com/wp-content/uploads/2015/09/etG.pdf.

suicide and dying by suicide and the immediate need to address this issue. The Committee is mindful of the fact that this case included the use of a gun in a suicide attempt by 74.13.515 and T.C. died by suicide with an unsecured gun in the home. This topic is addressed in the recommendation section below.

The Committee also discussed DCYF's initial contact with T.C.'s oldest sister. The interview was thorough and well documented. However, that same level of questioning and detail did not continue during other contacts with the parents, T.C., 74.13.5 sister and the paternal grandmother. The Committee also discussed that DCYF historically holds a higher legal intervention threshold. The Committee discussed that it is important for DCYF to only become legally involved when it is absolutely necessary. However, when a case involves a teenager there may be too much emphasis placed on the teen's ability to protect him or herself.

For purposes of assessing substance use and dependency allegations, the Committee also discussed whether there was an over-reliance on urinalyses results. The children made clear and consistent statements about their parents' alcohol abuse. Despite these statements there appeared to be an over-reliance on the "negative" urinalyses provided by each parent. In addition, the Committee discussed the issue with regard to when the tests were completed, versus when they were requested to be completed; and concerns related to how close the 13.50.100 were to a finding consistent with dilution findings. The Committee considered whether these factors support a finding of possible substance abuse. If so, consideration should have been directed towards appropriate next steps, including asking both parents to provide an assessment completed by a substance use disorder specialist.

The Committee also discussed the fact that the particular office that handled this case consistently struggles with significant staff turnover, from the area administrator down to all staff positions. The Committee discussed the need for this particular office to receive stronger support and stabilization from DCYF. The Committee was told this office consistently receives approximately 20 intakes per CPS worker per month. This number is significantly above the identified goal of 8 intakes per month.

To reduce staff turnover the Committee discussed concerns about necessary staff support during challenging cases, critical incidents, struggles with completing daily tasks and staff feeling unsafe to be vulnerable. The Committee received information about DCYF's Peer Support team. The Committee believes the Peer Support team is not designed to provide the type of support necessary to address the trauma and secondary trauma experienced firsthand by field offices and all levels of the staff within those offices. The Committee believes there is a high likelihood of continued turnover when there is such a significant gap in staff support. The Committee believes staff may feel more valued and secure if they are given the opportunity to have a support/triage team, as well as mentoring and robust onboarding for new and promoted staff. Hopefully, this would lead to stabilization within the workforce. The Committee believes that within the field offices, at the supervisor level and above, DCYF lacks consistent onboarding and continuing staff support. There was also a discussion about area administrator training and supervisor core training. The ongoing mentoring and support for day-to-day tasks were identified as an unmet need.

The Committee also talked about the fact that the community surrounding this specific office has strong supports from local tribes and other organizations. The discussion included recognition of the fact that local tribes have previously offered healing circles. The Committee also understands that therapy dogs have been brought into offices and other therapeutic supports have been made accessible to staff from within the local community. The Committee discussed

it would be helpful to the office if local connections with the various organizations were strengthened so that there is support for each other when a crisis (such as the suicide death of a child) occurs.

Findings

The Committee did not reach a full agreement as to whether there was a critical error. However, the Committee identified missed opportunities to improve practice areas.

The Committee noted that DCYF did not comply with the DCYF policy regarding domestic violence (DV).[5] The policy includes a directive to conduct universal DV screening through individual and separate interviews with all parents, caregivers, adults and children in the home.

The Committee also talked about whether DCYF missed an opportunity to assess the risk of weapons in the home. In particular, firearms. There was a documented gun-related suicide attempt by 74.13.515. When conducting their assessments and contact in the home, it would have been appropriate for the CPS workers to ask specific questions about firearms, including the storage of the weapon and ammunition.

The Committee believes DCYF did not fully assess the allegations during the two younger children's interviews. The interview of the oldest child was thorough, but contact with T.C. and the other sister did not include an adequate assessment.

Recommendations

The Committee recommends DCYF provide to all field staff mandatory suicide awareness training. This training should include what questions to ask, provide information on risk factors, provide suicide resources within the family's community including prevention, intervention, support and provide instruction about what next steps should be if suicidal ideation or attempts are identified. The Committee understands it is difficult to schedule trainings due to the high turnover experienced by DCYF. With that in mind, the intent for this recommendation is for an approximately 90-minute training for groups no larger than 30 individuals. This training should occur within the next 12 months for all current DCYF staff and be required ongoing training for all new staff.

The Committee believes that immediately after the implementation of the training recommendation described above, DCYF should add a question to the gathering questions[6], specifically identifying suicide as a topic. The question should be asked of children 10 years of age or older and ask the following: has the child considered and/or attempted suicide, or considered and/or attempted to kill himself or herself. If a child answers "Yes", then there should be documented follow-up regarding what next steps the worker took to address the issue. Next steps may include, but not be limited to, provide a crisis help number, contact a crisis mental

[5] See https://www.dcyf.wa.gov/1100-child-safety/1170-domestic-violence.
[6] Gathering questions are six questions required to be completed by DCYF staff during a CPS assessment or investigation.

health professional, discussion of weapons or access to other means related to their suicidal ideation or plan and engaging the child's parent or caregiver.

The Committee believes DCYF should submit a request to the legislature to fund a critical incident protocol. The Committee recognizes the emotional toll that it takes on DCYF staff when a critical incident occurs. This is especially the case if the Department does not have a staff support protocol. The Committee discussed that a protocol similar to the law enforcement protocols would be appropriate. The Committee believes a funded protocol should be created that supports a triage response from a group specifically trained to respond. The protocol should include directives that relieve the assigned staff from new responsibilities. This triage team would provide protected time for the worker and supervisor to address their secondary trauma needs. This would not take the place of any Peer Support or other emotional support programs.

The Committee recommends DCYF work with substance use disorder and mental health agencies to co-locate staff within each DCYF office. Ideally, a co-occurring provider could provide for both identified areas of need.