Washington State Department of Social & Health Services

CA Children's Administration

Child Fatality Review

T.K.

May 2007
Date of Child's Birth

Unknown
Date of Fatality

February 16, 2017
Child Fatality Review Date

Committee Members
Mary Moskowitz, J.D., Ombuds, Office of the Family and Children's Ombuds
Jessica Sullivan, Captain, King County Sheriff's Office
Cammy Hart-Anderson, Division Manager, Snohomish County Human Services
Jennifer Gaddis, M.S.W., Safety Administrator, Children's Administration
Jenna Kiser, M.S.W., Intake and Safety Program Manager, Children's Administration

Observer
Janet Pederson, Intake Supervisor, Children's Administration

Facilitator
Libby Stewart, Critical Incident Review Specialist, Children's Administration

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Executive Summary

On February 16, 2017, the Department of Social and Health Services (DSHS), Children's Administration (CA) convened a Child Fatality Review (CFR)[1] to assess the department's practice and service delivery to T.K. and her family.[2] The child will be referenced by her initials in this report.

On October 29, 2016, the Snohomish County Sheriff's Office placed two of T.K.'s siblings in protective custody. A third sibling was believed to be living out of the county. The children were placed in protective custody due to a law enforcement investigation regarding T.K.

The children were placed in protective custody after law enforcement requested the mother produce T.K. The mother provided a container to law enforcement indicating the remains in the container were that of T.K. Due to the condition in which the body was found, a date of death has not been determined. No other information has been shared with CA regarding a cause or manner of death as of the writing of this report.

The CFR Committee included members selected from diverse disciplines within the community with relevant expertise including the Office of the Family and Children's Ombuds, chemical dependency and mental health, law enforcement and child abuse and child safety. No Committee member had previous involvement with this family.

Prior to the review, each Committee member received a case chronology, a summary of CA involvement with the family and un-redacted CA case documents (e.g., intakes, investigative assessments and case notes). Supplemental sources of information and resource materials were available to the Committee at the time of the review. These included the most recent volumes of the case, relevant state laws, and CA policies.

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[1] 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 DSHS or its contracted service providers. The Committee has no subpoena power or authority to compel attendance and generally only hears from DSHS 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 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 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 Child Fatality Review to recommend personnel action against DSHS employees or other individuals.

[2] T.K.'s family members 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. [Source: RCW 74.13.500(1)(a)]

The Committee interviewed three staff who had direct involvement with the June 2016 investigation.

Family Case Summary

RCW 13.50.100

RCW 13.50.100

While the case notes indicate the case was to transfer to a voluntary services Indian Child Welfare unit, the case was closed after the CPS investigation.

While no father was listed on T.K.'s birth certificate, the mother identified two possible birth fathers that did not include the man to whom she was married. That man assumed care and custody of T.K. at varying times and paid child support through Division of Child Support, and thus for the purposes of this report is considered to be T.K.'s father.

RCW 13.50.100

In each intake, T.K. was listed as a participant as were the other siblings.[3] The inclusion of a child on the list of household participants would require the child to be included in a CPS investigation.

RCW 13.50.100

This intake was closed with a referral to an alternate intervention.[4] RCW 13.50.100

[3] Participant refers to a section of the CA intake listing all household members and the referent. All children in the household should be included in the CPS investigation.

[4] (Pre-Family Assessment and Response) Alternate Intervention—CA must respond within 10 calendar days to an alternate intervention intake. The CA social worker may send a letter, make a phone call to the caretakers(s), or make a brief home visit. CA may send the intake to an Early Family Support Service or other community agencies which are willing to accept the intake for services and/or monitoring. DLR/CPS may not use alternate intervention.

RCW 13.50.100 All of the children were listed on the intake under participants.

RCW 13.50.100

The intake was screened out.[5]

RCW 13.50.100

RCW 13.50.100

RCW 13.50.100

RCW 13.50.100

RCW 13.50.100

[5] An intake screens out if it does not meet the legal definition of child abuse or neglect under RCW 26.44.030.

[6] CA Practices and Procedures Guide Chapter 2541. Structured Decision Making Risk Assessment®

[7] Findings are determined when the investigation is complete and are based on a preponderance of the evidence standard. Unfounded means the determination that, following an investigation by CPS, based on available information: it is more likely than not that child abuse or neglect did not occur, or there is insufficient evidence for the department to determine whether the alleged child abuse did or did not occur. Founded means the determination that, following an investigation by CPS, based on available information: it is more likely than not that child abuse or neglect did occur. [Source: RCW 26.44.020]

RCW 13.50.100 .

The next intake CA received regarding the family was on June 6, 2016. RCW 13.50.100 The Snohomish County Sheriff's Office conducted a criminal investigation at the same time as CA's investigation regarding this allegation.

A second intake was received 13 days later RCW 13.50.100 T.K. was listed on both intakes as a participant. The assigned social worker made repeated inquiries into T.K.'s whereabouts to arrange an interview. The mother provided numerous differing statements regarding the whereabouts of T.K. The CPS investigator asked the assigned detective to assist with locating T.K. but the case was closed prior to locating the child.

On October 29, 2016, the Snohomish County Sheriff's Office notified CA that they had placed T.K.'s siblings in protective custody. Law enforcement took possession of a container that the mother advised held the remains of T.K. Law enforcement provided the container to the medical examiner's office for investigation.

Committee Discussion

For purposes of this review, the Committee mainly focused on case activity from the time T.K. was born until the time CA was made aware that her body was provided to law enforcement.

RCW 13.50.100

RCW 13.50.100 [redacted][8]

RCW 13.50.100 [redacted]

The Child Protective Services investigator documented that he told the mother that if she did not produce T.K. for assessment purposes he would conduct a Family Team Decision Making[9] (FTDM) meeting and/or pursue legal intervention. The Committee discussed that, often times, child welfare work is supported by the utilization of shared staffings or multi-disciplinary team (MDT) staffings which can include other partnering agencies such as law enforcement. This case may have benefited from utilization of an MDT, child protection team staffing or Family Team Decision Making meeting before closing out the case in September of 2016. The Committee believes it would have been appropriate for the CPS investigator to have followed through with the stated options.

The Committee also acknowledged that in order to comply with best case practice standards as well as policies, CPS workers may have to utilize legal interventions if a parent is refusing to produce a child for assessment purposes. The hope is that less intrusive actions such as an FTDM would lead a family to produce the child but if this fails, then CA must make all efforts to locate that child and assess for safety. One of the CPS investigators told the mother that these two options may become necessary if she did not produce T.K.; however, neither were utilized prior to the closure of the case.

A brief discussion occurred surrounding the issue of adequate pay as it pertains to recruitment and maintenance of consistent and well-trained staff. Also shared during this conversation was the ongoing issue of vacancies and movement within the agency that impacts stability within the offices.

Lastly, the Committee noted a lack of consideration during each of the investigations as it pertained to the parent's history RCW 13.50.100 [redacted] Incident-focused investigations may lead to incomplete

[8] FamLink is the case management information system that Children's Administration implemented on February 1, 2009; it replaced CAMIS, which was the case management system CA had used since the early 1990s.

[9] Family Team Decision Making (FTDM) meetings bring people together who are involved with the family to make critical decisions regarding the removal of child(ren) from their home, changes in out-of-home placement, and reunification or placement into a permanent home. [Source: CA Practices and Procedures Guide Chapter 1720]

investigations, possibly leaving children in unsafe situations. The Committee understood that it can be challenging to find the time to read a family's history in FamLink or MODIS (CA's archived case file system). However, it is imperative that staff understand the history of a family is important in assessing its current functioning and ability to provide for the safety of the children. The Committee also struggled with the period between 2010 and 2016 when there were no referrals. The Committee believes it would have been appropriate to ask the family as to what was working well for the family or where the children were during that time period. This curiosity can aid staff in conducting a more fruitful investigation.

Findings

The Committee identified areas where alternative choices or case practice by CA may have benefited the family. While no critical errors were identified, the Committee identified the findings below as areas for improved practice.

The Committee believed that the intake from July 22, 2010 should have screened in for an investigation. The Committee discussed the appropriateness of calling the mother and utilizing her statements in the decision to close out the intake at screening. Prior notes entered under T.K.'s father's case indicated that the mother told the case worker the child was RCW 13.50.100 that she denied to the intake worker therefore providing conflicting information.

There was a lack of comprehensive assessment regarding the children's needs and safety throughout both the mother's and father's cases. The Committee believes the mother's lack of cooperation during the RCW 13.50.100 and refusal to produce T.K., should have caused more curiosity by CA. CA could have taken the legal steps available to it through the juvenile court to have T.K. produced and filed a missing child report with law enforcement.

The Structured Decision Making Risk Assessment tool used by CPS to assess future risk of harm to the children. The Committee noted that the SDMRA was completed without including T.K.

The case was closed prior to an assessment of or contact with T.K. Policy states that prior to the completion of the Safety Assessment, face-to-face contact is required for all children who are not identified as victims but are related to the household.[10]

[10] CA Practices and Procedures Guide Chapter 2310. Initial Face to Face Response Time

Recommendations

CA should consider having all case carrying staff attend training related to open source searching. These trainings aid investigators who are searching for people through free sources on the internet. While it is particularly pertinent in this case, it would be beneficial in other cases where children may be on the run or missing from care.

RCW 13.50.100 The Committee participants have identified that the loss of RCW 13.50.100 professionals stationed within DCFS offices may have decreased staff's engagement with families regarding RCW 13.50.100 issues. The Committee recommends that CA reconsider this partnership.