CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

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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

- V.R.
- S.R.

Date of Child's Birth

- [redacted] 2023
- [redacted] 2016

Date of Fatality

- September 2, 2023

Child Fatality Review Date

- November 15, 2023

Committee Members

- Elizabeth Bokan, JD, Deputy Director, Office of the Family and Children's Ombuds
- Myranda Dixon, Quality Practice Specialist, Department of Children, Youth, and Families
- Margaret McCurdy, LICSW, Executive Director, Children's Justice Center of King County
- Nadia Van Atter, Assistant Director, Crystal Judson Family Justice Center
- Traci Krieg, MFT, LMHC, Executive Director of Adult Behavioral Health, Comprehensive Life Resources

Facilitator

- Leah Mattos, MSW, Critical Incident Review Specialist, Department of Children, Youth, and Families

Finalized Date: February 28, 2024
Approved for distribution by Paul Smith, Critical Incident Practice Consultant

Executive Summary

On November 15, 2023, the Department of Children, Youth, and Families (DCYF) convened a Child Fatality Review (CFR)[1] to examine DCYF's practice and service delivery to V.R., S.R., and their family. V.R. and S.R. are referenced by their initials throughout this report.[2]

On September 2, 2023, law enforcement called DCYF from a house fire to report that RCW 13[redacted] had climbed out a window to escape and would require placement with legal structure due to the circumstances. The officer said the rest of the family, including RCW 13.50.10[redacted] two siblings, mother, and father were inside and presumed dead. Law enforcement initially believed the father shot the mother, barricaded the home, and set it on fire. The medical examiner reported to DCYF the mother's cause of death was multiple sharp force injuries and ruled a homicide. The father's cause of death was asphyxia due to smoke inhalation and ruled a suicide. S.R. and V.R.'s cause of death was asphyxia due to smoke inhalation and ruled as homicide.

The family had an open Child Protective Services Family Assessment Response[3] (CPS-FAR) case at the time of this notification. The case had been opened the day prior.

A CFR Committee (Committee) was assembled to review DCYF's involvement and service provision to the family. The Committee included members with relevant expertise selected from diverse disciplines within DCYF and community partnerships. Committee members had no prior direct involvement with the family. Before the review, the Committee received relevant case history from DCYF. On the review day the DCYF mental health program manager who was a confirmed committee member had an unexpected conflict and was not able to participate.

Case Overview

From 2017 to 2022, DCYF received four intakes reporting concerns for the welfare of the children and family. Allegations included physical abuse, unmet academic needs, and concerns related to the father's mental illness and substance addiction. The four reports led to one CPS investigation, two CPS-FAR cases, and one intake screened out as the allegation had previously been reported. In all three cases the children were

[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)]." Given its limited purpose, a CFR should not be construed to be a final or comprehensive review of all 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 to replace or supersede investigations by courts, law enforcement agencies, or other entities with legal responsibility to investigate or review some or all the circumstances of a child's fatal injury or near fatal injury. Nor is it the function or purpose of a CFR to recommend personnel action against DCYF employees or other individuals. "The restrictions [described in this paragraph, and the paragraph immediately above,] 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." See RCW 74.13.640(4)(d). See: https://app.leg.wa.gov/RCW/default.aspx?cite=74.13.640.

[2]V.R. and S.R.'s names are not used in this report because their names are subject to privacy laws. See RCW 74.13.500.

[3]For information on CPS Family Assessment Response (CPS-FAR), see: https://www.dcyf.wa.gov/policies-and-procedures/2332-child-protective-services-family-assessment-response.

assessed as safe, and the cases were closed. Concrete goods were provided to meet the basic needs of the family, and no ongoing services were provided by the agency.

On September 1, 2023, DCYF assigned a CPS-FAR case when it received a report that the family had been to the hospital for follow-up care after a car accident the prior weekend. The referrer said the mother was described as "overwhelmed" and possibly experiencing RCW 70.02.020 The mother made statements to the referrer about the father's behaviors and expressed concern RCW 70.02.020 RCW 70.02.020 but could not explain the threats. The mother said the father had an appointment scheduled with his mental health provider and hoped he would follow through.

The assigned caseworker attempted to contact the family by phone but did not receive a phone call back. The caseworker went to the family's home unannounced. The mother agreed to meet with the caseworker. The caseworker attempted to interview S.R. and RCW 13.50 but both children declined. The caseworker documented that all three children did not appear to have bruises or injuries. The caseworker documented hearing the father asking the mother to tell the caseworker to leave the home. The caseworker spoke with the mother, who said the father is diagnosed with RCW 70.02.020 and is undermedicated. The mother said he attended a medication management appointment with his doctor, and they would be picking up his prescription tomorrow. The mother denied domestic violence in the home and said a previous incident, when the father attempted to barricade the home and set it on fire, was found to be accidental. The mother denied concerns about her or the children's safety and said she would call 911 and the designated crisis response line if the father was becoming a threat to himself or others. The caseworker provided the mother with another crisis line option should she feel overwhelmed caring for the children. The caseworker told the mother they would return next week to try and speak with the father and discuss services.

On September 2, 2023, DCYF was notified about the event leading to the death of the mother, father, V.R., and S.R. RCW 13.50.100

Committee Discussion

The Committee spoke with the area administrator from the field office where the case was assigned. This discussion provided an opportunity for the Committee to learn about typical office practice, training opportunities, and system barriers.

The Committee identified positive aspects of the casework practice in addition to improvement opportunities, which are areas where a family may have had a need that was unmet by the system. The Committee also discussed barriers to DCYF's capacity to provide services and suggestions on how DCYF may be able to build increased capacity through enhancing skill building opportunities and development of resources for field staff.

The Committee heard from the area administrator that in the last two years the office has experienced significant turnover and ongoing vacancies that have been difficult to fill, leading to increased caseload sizes. The Committee discussed how DCYF's focus on timelines and closing cases within timeframes may compete with field workers' ability to complete thorough assessments of a family's needs. The Committee emphasized the importance of offering support, especially to new field workers, who may have high caseloads to help them prioritize and create a system to close out cases timely but after a family's needs have been addressed.

Another barrier the Committee discussed was related to cross-system collaboration. The Committee acknowledged that systems are not set up well to manage cross-system collaboration and discussed whether something could have been done differently to support the father's mental health needs. The Committee did not identify anything that could have been done differently but discussed a suggestion that DCYF provide learning opportunities for field staff on working with individuals diagnosed with mental illness. The Committee felt field staff would benefit from having a basic understanding about diagnoses, how to identify an escalation in dangerous behaviors, and how to respond. The Committee felt this type of training opportunity would provide information for field staff on how to more effectively engage with individuals diagnosed with mental illness and how to respond. DCYF headquarters has a mental health program manager, and the Committee thought it may be beneficial to provide information to field staff on this role and what supports they may be able to offer.

Another aspect discussed was that child welfare field staff cannot be experts in all cross-systems or domains such as mental illness or domestic violence. For example, the Committee discussed how conversations with domestic violence survivors are nuanced and individual's responses may vary. The Committee identified that domestic violence was present in this case and believed the mother may have benefited from being provided with domestic violence resources. Based on the Committee's discussion about cross-system collaboration challenges they developed a recommendation that would provide multi-disciplinary services to families without relying on individual caseworkers to be subject matter experts in all areas. The Committee discussed the benefits of the agency utilizing a multi-disciplinary approach including experts in the field of domestic violence, substance use disorder, and mental health to partner with caseworkers to help inform case decision making and provide resources and support to families.

The Committee discussed various aspects of information gathering done throughout an assessment. The Committee felt that attempts to gather additional information related to the children's needs may have been beneficial to providing a more thorough overview of the family's needs. For example, the Committee understood that limited information was provided by the family to the caseworkers about relatives or other collateral contacts and wondered if additional contacts with the children's schools may have provided further insight. The Committee also wondered if more resources and training would be beneficial to field staff related to identifying and engaging with collateral contacts.

Throughout the Committee's discussion, they underlined the importance in using critical thinking when assessing child safety. One area they stressed is monthly clinical supervision, which should be an opportunity for utilizing critical thinking skills. A Committee member shared the agency's requirements for monthly supervision but pointed out that CPS supervisors may benefit from further guidance on providing clinical supervision. The Committee developed a recommendation for the agency to provide supplemental guidance for CPS monthly clinical supervision to assist field supervisors in fostering conversations that encourage critical thinking.

The Committee considered additional ways for DCYF to build capacity to support field caseworkers in their work. The Committee identified value in spending time supporting field workers who may be experiencing vicarious trauma from their work. There was also discussion about creating more access to ongoing and specialized training, such as vicarious trauma training, and making this available to field workers at all levels

including those in leadership roles. The Committee noted that while field workers may have time limitations related to participating with training and wellbeing supports, such as DCYF's Peer Support, DCYF may help field workers to build their capacity for the work by prioritizing these opportunities.

Recommendations

The Committee's recommendations come from a comprehensive review and discussion of the many aspects of the case. The recommendations and corresponding discussion were unrelated to the deaths of V.R. and S.R.

The Committee respectfully recommends that DCYF develop a multi-disciplinary team response for families by providing internal mental health and domestic violence experts regionally. The mental health and domestic violence experts would be able to provide the following, but not limited to:

- Provide case consultation to field staff related to their area of expertise.
- Provide education to field workers about safety when assessing individuals with mental illness or domestic violence history. This may include but would not be limited to providing suggestions on engagement, identifying patterns of escalating behaviors, identifying danger, and developing a plan for response.
- Be available to partner with field staff to meet families in the field, participate with shared planning meetings, and internal consultations.
- Connect families with local resources to meet identified needs.

The Committee respectfully recommends that DCYF develop CPS program specific guidelines for providing monthly clinical supervision to encourage critical thinking.