CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

January 2020

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CHILDREN, YOUTH & FAMILIES

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January 2020

Full Report

Child

- Z.E.

Date of Child's Birth

- 74.13.515 2003

Date of Fatality

- September 7, 2019

Child Fatality Review Date

- January 30, 2020

Committee Members

- Mary Anderson Moskowitz, Ombuds, Office of Children and Family's Ombuds
- Mariah Fabiani, CFWS Supervisor, DCYF
- Ly Dinh, MSW, Quality Practice Specialist, DCYF
- MaShelle Hess, MSW, LICSW-A, CFWS & Guardianship Program Manager, DCYF
- Julio Serrano Jr, Guardian Ad Litem, Pierce County Juvenile Court
- Kris Sanborn, LICSW, Clinical Director, YMCA

Observer

- DeAnn Bauer, Social Service Specialist III, DCYF

Facilitator

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

Executive Summary

On January 30, 2020, the Department of Children, Youth, and Families (DCYF)[1] convened a Child Fatality Review (CFR)[2] to examine DCYF's practice and service delivery to Z.E. and 74.13.5 family.[3] 74.13.5 will be referenced by 74.13.5 initials throughout this report.

During the summer of 2019, Z.E. was periodically running away from 74.13.5 foster care placements. The Department made efforts to locate Z.E. by working with local law enforcement and the National Center for Missing and Exploited Children. During this same time period, the Department was working to identify an appropriate, long-term placement option. As a part of this effort the Department initiated an updated relative search to determine whether there was an appropriate relative placement. While missing from care in mid-August, law enforcement told the Department Z.E. had been RCW 13.50.100 and was then released to 74.13.5 guardian. Law enforcement gave the Department the guardian's contact information. The CFWS worker contacted the individual and they stated their intent to become a caregiver for Z.E. The CFWS worker immediately took the necessary steps to complete an emergent background check[4] and complete a walk-through of the caregiver's home. The Department determined the placement was a suitable other placement and authorized Z.E.'s placement with the caregiver.[5]

On September 7, 2019, DCYF learned from the Sheriff's Department that Z.E. killed 74.13.515 self. The 911 call reporting the shooting was made by Z.E.'s caregiver, who Z.E. had been residing with for approximately 3 weeks. Emergency services at the scene pronounced Z.E. dead. The cause of death appears to be accidental and was determined to be due to a perforating handgun wound to the head.

The CFR Committee includes members with relevant expertise selected from diverse disciplines within DCYF and the community. Committee members have not had any involvement or contact with Z.E. or 74.13.5 family. The Committee received relevant case history that includes CPS history, case notes and on-going case planning.

On the date of the CFR the Committee interviewed two prior CFWS workers[6] and the CFWS supervisor who oversaw the courtesy supervision workers. The on-going CFWS supervisor last supervising the case had moved to another office and did not participate in the review as initially anticipated.

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[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)].

[3]The names of the deceased child's parents are not used in this report because neither parent has been charged with a crime in connection with the fatality incident. The names of the siblings are also not used in this report because they are subject to privacy laws. See RCW 74.13.500.

[4]Under RCW 26.44.240 DCYF is authorized to conduct a federal name-based criminal history record (Purpose Code X) check of each adult residing in a home where a child may be placed during emergent situations. Purpose Code X checks are not conducted for non-emergent placements, planned placements changes, Child Protective Services (CPS) investigations, individuals who live out-of-state, or Child In Need of Services (CHINS) cases. An emergent placement refers to the limited circumstance involving the sudden unavailability of a child's primary caregiver. Under these circumstances the child may be placed in the home of an unlicensed individual under a Voluntary Placement Agreement (VPA), or pursuant to a protective custody determination. The unlicensed individual may be a neighbor, friend, or relative.

[5]A suitable person is defined as someone who has a pre-existing relationship with the child or child's family. See RCW 13.34.130(1)(b)(ii)(B); and DCYF Practice and Procedures Guide Section 45274 (Placements with Unlicensed Relatives or Suitable Persons).

[6]Child and Family Welfare social workers assume respons bility of a child welfare case after the children have been removed from their caregivers and a dependency petition filed.

Case Overview

In 2006, Z.E.'s family first came to the Department's attention. From 2006 to 2015 there were four CPS investigations with concerns related to RCW 13.50.100 RCW 13.50.100 and RCW 13.50.100. These concerns led to a 2015 RCW 13.50.100 of Z.E.'s younger half-sibling. The basis for the RCW 13.50.100 was the arrest of the mother and there being no parent available to care for the child. When the RCW 13.50.100, relatives were caring for Z.E. and 74.13.5 older sibling, so a dependency was not filed for Z.E. In 2016, a CPS intake was made alleging there was no responsible adult available to care for Z.E. due to the arrest of 74.13.5 mother. Law enforcement placed Z.E. in protective custody and a dependency action was filed. This dependency action pertained to Z.E. RCW 13.50.100.

In May 2017, dependency was established RCW 13.50.100. Accordingly, the Department made efforts to contact both parents to offer the required court-ordered services. However, neither parent consistently maintained communication with the Department or participated in the services. Likewise, visitation and on-going contact between Z.E. and 74.13.5 parents did not occur. Z.E.'s father did contact the Department a few times to request visits but failed to follow through. While Z.E. had contact with 74.13.5 older sibling, 74.13. had less frequent contact with 74.13.5 younger half-sibling.

Upon entering the foster care system, Z.E. was assessed under the Child Health and Education Tracking program (CHET).[7] The program identified a need for mental health counseling and challenges within the educational setting to include RCW 13.50.100 and RCW 13.50.100. In early 2017, Z.E. was referred for a psychological evaluation. However, this evaluation never occurred largely due to placement instability and Z.E. being on the run. The Department made attempts to encourage Z.E.'s relative caregiver to enroll 74.13.515 in mental health services but the relative caregiver was unresponsive. The family was also referred for in-home counseling services, but the family failed to engage and the referral was closed. Future attempts to refer Z.E. for services were declined by the youth as well as 74.13.5 relative caregiver.

Due to the reported academic and behavioral needs identified within the school setting, Z.E. was referred to the 13.50.100 Educational Advocacy Program.[8] Throughout this dependency there were significant gaps in Z.E.'s education due to RCW 13.50.100, which was caused in part by 74.13.5 placement instability. The Department's CFWS worker reported that despite these gaps, Z.E. was motivated to graduate from high school, as had 74.13.5 older sibling.

In 2018, a CPS Risk-Only intake was generated for RCW 13.50.100) services. The basis for the intake involved an allegation that Z.E. committed the crime of RCW 13.50.100. However, because Z.E. was less than twelve years old 74.13. was presumed to have insufficient capacity to commit the crime (see RCW RCW 13.50.100). Under chapter RCW 13.50.100 RCW the case was transferred to Child Protective Services. The CFWS worker met with Z.E. and 74.13.5 family to discuss available 13.50.100 services. Because they were

[7] The Child Health and Education Tracking (CHET) program is responsible for identifying each child's long-term needs at initial out-of-home placement. The evaluation's results are used to develop an appropriate case plan and assist with placement decisions. See DCYF Practices and Procedures, No. 43092 (Child Health and Education Tracking).

[8] The Educational Advocacy Program provides direct advocacy, consultation, information, and referral services for youth in care. All youth with educational needs who are in out-of-home care are eligible. Educational Advocacy Coordinators (EACs) are located throughout the state. EACs provide information and referral services designed to help keep foster youth engaged in school, and progress toward graduation.

concerned about the implications associated with accepting RCW 13. services, the family and Z.E. declined RCW 13. services. Z.E. denied the allegations and the Department was not concerned about the RCW 13.50.100 allegation, as there had been no other incidents reported to the CFWS worker.

Z.E. had over 25 placement changes that included foster homes, group homes, relative placement, and hotel stays when no placement was available to meet 74.13.5 needs. Z.E.'s runaway history includes lengthy time periods when 74.13. was missing from 74.13.5 foster care placement for more than 90 days. During those times the Department made search efforts to locate 74.13.515 including working with local law enforcement, and the National Center for Missing and Exploited Children. Both 74.13.5 grandmother and aunt struggled to maintain the placement of Z.E. for a variety of reasons including their inability to maintain safe and stable housing, a lack of follow through with educational, medical, and therapeutic needs; and an inability to manage Z.E.'s behavioral challenges. Also, contrary to department policy, neither family member completed a home study. The Department had on-going concerns about the relative placements and requested placement be changed due to the family's failure to adhere to the DCYF home-study policy. Permanency was not achieved through the foster care system.

Committee Discussion

The Committee had an engaging discussion about the DCYF work associated with Z.E. and the Committee recognizes the efforts made by the CFWS workers. The case workers' efforts were made despite the challenges facing the CFWS workers including high caseloads, supervisor and staff turnover and complexities associated with learning how to navigate through the child welfare system. The Committee believes it is difficult to hold case worker staff accountable without the proper training, clinical supervision and leadership guidance.

One CFWS worker said for the first nine months of employment he did not have a consistent supervisor. This caused the worker to rely on co-workers. Also discussed was the concept of clinical supervision. For purposes of case planning, under the current approach there appears to be a lack of supervision documentation that shows how critical thinking was used. Instead, the current process is more task-oriented in nature.

The Committee discussed the current practice DCYF uses to determine the appropriate services for youth in foster care, the appropriate placement type and the use of appropriate screening tools. The current tool used by the department is the CHET screening, which is completed at the beginning of a case. This tool makes recommendations about a child's medical, mental health and educational needs, as well as placement. It was discussed how important it is that when a case transfers, the new worker is made aware of what was previously recommended and whether the need has been met, or is still outstanding. The Committee also discussed community-based screenings through mental health and private agencies, which may be beneficial in development of youth service and placement plans. This included a discussion about Wraparound with Intensive Services (WISe) screenings[9] through county-based mental health agencies.

[9] WISe/"Wraparound is a team based planning process for youth with complex needs and their families designed to help produce better outcomes for youth so that they can live in their homes and communities and realize their hopes and dreams." Wraparound with Intensive Services (WISe), are Medicaid Elig ble; have a qualifying mental health diagnosis; and have concerning behaviors at home, school, and in the community that meet clinical criteria for the program. See https://www.kingcounty.gov/depts/community-human-services/mental-health-substance-abuse/services/Youth/wraparound.aspx]. DCYF Practice and Procedures Guide Section 4542 (Wraparound Instensive with Intensive Services).

Another component discussed on this case was the use of courtesy supervision case workers in addition to the ongoing CFWS worker. The youth was frequently placed out of county, so the CFWS worker utilized courtesy supervision case workers to assist with completing monthly health and safety visits. The Committee had the opportunity to interview one CFWS supervisor who oversaw courtesy supervision case workers that interacted with Z.E. The Committee highlighted the importance of communication between the on-going case worker and the courtesy supervision case worker. Also, the Committee felt it was important that on-going case workers understand their role and that they are responsible for the ongoing case planning.

Despite the fact that efforts were made to re-engage Z.E. with 74.13.5 educational plan, the Committee felt this was a missed opportunity. While Z.E. was referred to a RCW 13.50.100 educational advocate to help navigate 74.13.5 academic needs, there was limited direct correspondence from the CFWS workers to the schools. A courtesy supervision case worker did have contact with the school and the Committee discussed the importance of the case worker who is assigned as the primary worker taking the lead in this type of correspondence. While one CFWS worker did not agree with Z.E. being moved to the next grade RCW 13.50.100, the CFWS worker did not know how to advocate for Z.E. within this system.

There was a lengthy discussion about the specific issues facing the adolescent foster care population that not only addresses their service needs, but also their safety needs. The Committee believes adolescents are often viewed as being less vulnerable and able to self-protect, placing too much responsibility on the youth for protecting his or her safety. The Committee also discussed specific training opportunities to better educate the work force about adolescent-related needs, including the need to shift thinking in a direction that is more aligned with how DCYF works with and assesses safety of an older population. In this particular case there were significant challenges associated with Z.E., who demonstrated risky behaviors throughout the life of this case. The Committee does recognize the challenges the Department faced in trying to mitigate those concerns, including Z.E. and 74.13.5 family's refusal to engage in therapeutic services. Another difficulty with this case identified by both CFWS workers included the lack of placement resources. Despite this difficulty the Committee strongly believes the Department has an obligation to assess the caregiver's safety and suitability to ensure the caregiver can meet the youth's needs.

Findings

In this case the Committee believes DCYF did not make any critical errors. The Committee does find that the Department did not complete, as required by policy, a Family Team Decision Meeting[10] after Z.E.'s placement was changed to an "other suitable person." Neither a Family Team Decision meeting, nor a shared planning meeting was held or scheduled. This would have been an opportunity to share information about Z.E.'s ongoing emotional and behavioral needs, and 74.13.5 academic support needs. It would have also been an opportunity to ensure continuity of care in the new placement setting.

The Committee also believes the Department did not assess the safety and suitability of the suitable person caregiver to ensure the caregiver could provide a safe, appropriate home that would meet Z.E.'s

[10] Family Team Decision Making (FTDM) meetings follow the Shared Planning Meeting model of engaging the family and others who are involved with the family to participate in critical decisions about the removal of child(ren) from their home, placement stabilization and prevention, and reunification or placement into a permanent home. See DCYF Practices and Procedures Policy No. 1720, Family Team Decision Making Meetings.

long-term needs. The Department did complete an emergent background check, which conditionally cleared the caregiver but did not complete the next steps for the background check process. Before authorizing the placement of Z.E. in the caregiver's home, the CFWS worker did review the caregiver's CPS history and consulted with her supervisor. The Committee believes the Department was focused on the fact that the caregiver's CPS history did not include any founded findings.[11] The Committee believes the Department should pay closer attention to reviewing the content and concerns identified within the CPS history. A home study referral was not submitted, which would have further explored the suitability and sustainability of this placement.

Recommendations

The Committee recommends that for DCYF programs experiencing significant turnover, the area administrator should develop a plan with the unit supervisor to address the turnover and a plan to improve retention. For the staff to do their jobs effectively these plans should ensure the staff have the necessary training and support from their area administrator, immediate supervisor and DCYF management. This plan should include utilizing the training and coaching supports that are available through the UW Alliance, Regional Quality Practice Specialists and Program Managers.

The Committee recognizes that because of time limitations the staff may not always know about relevant training opportunities. This is the case, despite the fact the Department has access to a wide variety of UW Alliance classroom and online trainings. With this in mind the Committee recommends the local office leadership, including the area administrator and supervisors, disseminate upcoming training opportunities to staff at All-Staff Meetings and Unit Meetings.

To establish a strong continuity of care when a CFWS case is transferred from one worker to another, the Committee recommends the receiving CFWS worker incorporate into his or her practice a review of any previous CHET Screening reviews. If the new CFWS worker conducts this review, the new case CFWS worker should have a better understanding of prior recommendations designed to address the child's health needs, mental health needs and education needs. For referrals previously recommended by the CHET Screening that have not been made, the new CFWS worker should be able to make such referrals after assuming responsibility for the case. This recommendation was developed specifically for this office due to frequent case transfers within CFWS, but should be considered a statewide best practice.

Department CFWS workers assigned as the primary caseworker, in addition to having a courtesy supervision caseworker for monthly health and safety visits, should adhere to the expectations in the courtesy supervision policy. The primary assignment CFWS worker has responsibility for service referrals, decision making and payment authorization.

The Wraparound Intensive Services (WISe) screenings should be implemented in cases involving a child or youth who is experiencing placement instability, or emotional, behavioral or academic challenges. WISe access is based on Medicaid eligibility for mental health services and can provide intensive

[11] "'Founded' means the determination following an investigation by CPS that based on available information it is more likely than not that child abuse or neglect did occur." WAC 388-15-005.

supports to children and youth statewide. The Committee understands that youth have the right to refuse services that are based on WISe screenings.