CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

December 2020

Washington State Department of
CHILDREN, YOUTH & FAMILIES

Contents

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Full Report

Child

- K.D.
- M.D.

Date of Child's Birth

- [redacted] 2013

Date of Fatality

- October 24, 2020

Child Fatality Review Date

- December 17, 2019

Committee Members

- Mary Anderson Moskowitz, JD, Ombuds, Office of the Family and Children's Ombuds
- Mara Campbell, MA, Region QA/CQI & Safety Administrator, DCYF
- Tarassa Froberg, Statewide CPS-FVS Program Manager, DCYF
- Jennifer King, MSW, LICSW, CCTP, Clinical Director, Connections Counseling NW
- Jerica Glover, Family Advocate, Domestic Violence Services of Snohomish County
- Robert Lee, MA, Family Law Guardian Ad Litem, Pierce County Superior Court

Facilitator

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

Executive Summary

On December 17, 2020, the Department of Children, Youth, and Families (DCYF) convened a Child Fatality Review (CFR)[1] to examine DCYF's practice and service delivery to K.D., M.D., and their family. They will be referenced by their initials throughout this report.[2]

On October 26, 2020, a DCYF supervisor formerly involved with K.D., M.D., and their mother received notification through a local news source of a murder-suicide involving the family. The news source reported that on October 24, 2020, law enforcement responded to a child welfare check at the home of K.D. and M.D. and found both children and their mother dead. Law enforcement determined the mother shot her twin RCW 74.13.515 while they were sleeping and then shot herself. Law enforcement identified an ongoing custody battle with the children's father as the motive. No further information was released pending a continued investigation and final autopsy report.

The intake of this critical incident did not screen in for a Child Protective Services (CPS) investigation. DCYF did not have an open case at the time of the critical incident, but had provided services to the family in the prior 12 months. The last DCYF case involving the family was closed in January 2020.

A 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 through community partnerships. Committee members had no prior involvement or knowledge of K.D. and M.D. or their family. The Committee received relevant case history from DCYF, including CPS history, case notes, provider records, and assessments. On the day of the review, the Committee had the opportunity to interview former DCYF caseworkers and supervisors who had involvement with the family.

Case Overview

K.D., M.D., and their family came to the attention of DCYF in spring 2017. On April 24, 2017, DCYF received a report that the father hit K.D. in the back of the head, but K.D. did not have an injury or complain about being injured. The father reportedly yelled at M.D. when RCW 74 would not stop crying. The reporter shared that the parents were going through a divorce. This intake screened out and was not investigated. On May 2, 2017, a report was called in reporting K.D. told RCW 74 nanny that RCW 74 father had hit RCW 74 in the face with an open hand. The caller reported no visible marks or injuries. The report mentioned the parents were in the middle of a divorce and there was domestic violence history, including both physical and verbal abuse. This report screened out and was not investigated.

On April 16, 2019, DCYF received a report with concerns about K.D. and M.D. being neglected and left to care for themselves, a lack of age-appropriate supervision, and the children being locked in the pantry.

[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)]." RCW 74.13.640(4)(a). Given its limited purpose, a child near fatality review (CNFR) should not be construed to be a final or comprehensive review of all of the circumstances surrounding the near death of a child. The CNFR Committee's review is generally limited to documents in the possession of or obtained by DCYF or its contracted service providers. A CNFR 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 near fatal injury. Nor is it the function or purpose of a CNFR to recommend personnel action against DCYF employees or other individuals.

[2] The names of K.D. and M.D.'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 K.D. and M.D. are also not used in this report because they are subject to privacy laws. See RCW 74.13.500.

Also reported was a concern that the mother may have depression and that she had been observed to be volatile in the neighborhood, yelling at neighbors. The referent made local law enforcement aware of these concerns. DCYF assigned the case for Family Assessment Response (FAR) .[3]

On April 19, 2019, the caseworker contacted the mother to review the allegations. The mother gave permission for the caseworker to complete a visit with K.D. and M.D. at their school. The caseworker's interview with K.D. and M.D. did not indicate any safety concerns as both children expressed they felt safe in their home and were supervised by adults at all times. They also reported having a lot of food to eat. M.D. reported their mother had been sick, then they got sick, and then M.D. gave the cold back to their mother, which is why they missed school.

On April 23, 2019, the caseworker met with the mother to complete a parent interview. The mother denied the reported allegations. The mother shared she had been ill RCW 74.13.520 , which was why she was in her bedroom. She also stated K.D. had been sick, leading to the children missing school. The mother reported the children missed school approximately six weeks prior when she had a bout of RCW 74.13.520 and could not drive. The mother shared about her separation from the children's father, and that a parenting plan was in the process of being finalized. She reported RCW 13.50.100 The mother disclosed RCW 74.13.520 . She reported RCW 74.13.520 She reported RCW 74.13.520 . The mother shared that both K.D. and M.D. were attending counseling services to help them process the separation. Additionally, M.D RCW 74.13.520 and was involved with RCW 13.50.100 services. There were no observed safety hazards in the home, no weapons in the home, and the caseworker confirmed the pantry did not have a locking mechanism. The caseworker observed the children to be interactive and bonded to their mother.

On June 12, 2019, the caseworker completed a telephone interview with the father. The father expressed concerns about the mother's mental health during the interview, but stated he did not believe the mother was neglecting the children. He also stated the mother had never shown that she would harm the children in the past. He expressed concerns about the communication he and the mother had, and that her moods could shift. He also expressed concern that she used her title and educational background to present in a certain manner. He denied the allegations related to domestic violence, RCW 13.50.100 . He stated he learned of the allegations about him hitting the children RCW 13.50.100 . He denied ever hitting the children. He said he tried to follow the parenting model that the mother utilized with the children when he cared for K.D. and M.D. The father shared a concern about M.D.'s RCW 74.13.520 . The father shared RCW 13.50.100 . The caseworker inquired about

[3]"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.

weapons in the home, and the father denied any weapons in his home. He reported carrying a weapon at his job, but that it remained locked at his workplace when he was off-duty.

On June 13, 2019, the caseworker and the supervisor contacted the mother to address the concerns presented by the father regarding the mother's mental health needs. The mother again stated [redacted]. She also reported attending a group for self care due to the work she does in the community [redacted]. She stated she was not afraid to ask for help. The FAR family assessment was completed on June 17, 2019. No safety threats were identified. The Structured Decision Making Risk Assessment (SDM-RA)[4] was assessed at moderate risk. No service recommendations were made as the mother and children were receiving community-based services. The case was recommended for closure. A supervisory review of the case was conducted on June 24, 2019, and approved for closure.

On August 26, 2019, DCYF received another report involving K.D. and M.D. The referent stated that the father called them on August 16, 2019, to report linear bruising on K.D. and M.D. The father also sent photographs. One child had a bruise on the back of their arm, and the other had a bruise on their lower back. When the father asked the children how they got the bruises, they said they did not know. The referent called the mother on August 21, 2019, to inquire about the bruising; she stated the bruising may have come from playing on the monkey bars. The referent believed this was a plausible explanation, but was not certain. K.D. and M.D. had been on summer vacation with their father. The referent reported they planned to meet with the children on August 27, 2019, and would further inquire about the bruises and call back with any additional information. This intake screened out and was not investigated. No additional information was reported.

On September 9, 2019, the mother of K.D. and M.D. contacted DCYF and reported concerns related to the children's personal boundaries not being respected by their father during visitation time at his home. The mother reported the children [redacted]. The mother reported asking the father to respect the children's wishes, but he would not do so and responded in anger, to which she threatened CPS involvement. The mother requested that CPS educate the father so that he would stop [redacted]. This intake screened out due to no allegations of child abuse or neglect. On the same day, the mother called back to add additional information to the earlier report. The mother reported the father [redacted] A FAR case was assigned.

On September 11, 2019, the assigned caseworker met with the mother, K.D., and M.D. at the mother's place of business. During this visit, the caseworker spoke with the mother, who shared the children [redacted]. The mother reported that she was in a new relationship, but she did not provide additional details as the individual had not yet met the children. The girls were observed during the interview, but spent most of their time playing and were not interviewed directly about the allegations.

[4] "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.

On September 12, 2019, the caseworker completed a visit with K.D., M.D., and their father in his home. The father denied not listening to the children's requests for privacy and also stated they had not voiced any concerns. The father shared RCW 13.50.100 . He stated RCW 13.50.100 . During this home visit, the children were playing and were not interviewed by the caseworker.

On September 20, 2019, the caseworker contacted a close friend of the father, whose name was provided by the father as a collateral. No concerns were reported during this conversation. On October 1, 2019, medical records for K.D. and M.D. were reviewed to ensure they were up to date with medical care. The worker also received records from M.D.'s RCW 13.50.100. No significant concerns were noted. The FAR family assessment was completed on October 1, 2019, with a SDM-RA of moderately high. No services were recommended as the family was accessing community-based services and pro-social activities in the community. The case was recommended for closure. A supervisory review occurred on October 1, 2019; the supervisor approved case closure.

On December 5, 2019, DCYF was contacted with concerns for K.D. and M.D. The report alleged the father continued to not follow the prior plan for the children to have privacy RCW 13.50.100 . K.D. was RCW 74.13.520 . The mother reportedly RCW 74.13.520 . When K.D. was at the father's home, RCW 13.50.100 . The referrer noted conflicting statements shared by the father RCW 13.50.100 . It was also reported the father RCW 74.13.520 The father RCW 13.50.100 . The father also RCW 74.13.520 . The referrer RCW 13.50.100 . A FAR case was assigned.

On December 6, 2019, the caseworker attempted to complete a visit with K.D. and M.D. at their school, but they had just left for the day. On December 9, 2019, the caseworker met with K.D., M.D., and their mother at her office. The children were interviewed during this visit. Without prompting, K.D. told the caseworker that "RCW 13.50.100." When asked what this meant, K.D. said RCW 13.50.100 . The caseworker asked K.D. what this meant and K.D. responded by saying that "RCW 74 does not know, but RCW 74 mommy said that." During the interview with M.D., RCW 74 stated RCW 74 " RCW 13.50.100 ." When asked what that meant, RCW 74 said RCW 13.50.100 . The mother stated concerns that the father was attempting to groom the children. The caseworker set an additional appointment to interview the mother.

On December 12, 2019, the caseworker completed an interview with the father at his residence. The children were not present. He shared with the caseworker RCW 13.50.100 . He has RCW 13.50.100 . He stated the children had not asked him for privacy. The father was receptive to the caseworker's suggestions about how to increase privacy for the children RCW 13.50.100

RCW 13.50.100 . He discussed RCW 13.50.100 . He reported RCW 13.50.100 . The father reported not having a say in the medical or educational planning for the children and that the mother changed the doctor for M.D. following a disagreement with the doctor about the treatment recommendations. The father again denied a history of domestic violence concerns and denied current mental health concerns. Following this visit, a supervisory review determined there was no active safety threat.

On December 13, 2019, the mother's attorney for the family court proceedings contacted DCYF RCW 13.50.100 . The caseworker reported there was not an active safety threat. On December 14, 2019, the caseworker reviewed the therapeutic records for K.D. and M.D. On December 16, 2019, the caseworker received a voicemail from the children's therapist concerning correspondence with the parents RCW 13.50.100 . The caseworker reviewed the correspondence and noted discrepancies in the reporting surrounding this incident. On December 17, 2019, the caseworker communicated with the children's school; no safety concerns were noted. The following day, the father informed the caseworker that the children had been unenrolled from this school per email communication from the mother.

On December 18, 2019, the mother contacted the caseworker requesting to be informed of the allegations. The mother disputed the reported allegations and believed that RCW 13.50.100 should have been included in the original allegations. The mother sent lengthy communication to DCYF, which included her attorney and the children's psychologist, regarding her ongoing concerns about the father. The mother notified the caseworker she would follow up with her attorney and the caseworker's supervisor. On December 27, 2019, the caseworker reviewed the medical records for both children.

On January 2, 2020, the FAR caseworker and supervisor met with the mother in person to review her concerns. The mother brought an advocate RCW 13.50.100 to this meeting. The mother continued to express her concerns related to boundaries and privacy for the children when at their father's home, and DCYF reiterated the concerns presented did not constitute RCW 13.50.100 or abuse. The supervisor reminded the mother that neither K.D. nor M.D. had made disclosures of RCW 13.50.100 or abuse. The supervisor also reiterated the respective role of DCYF in contrast with that of the family court proceedings and that DCYF did not involve itself in family court proceedings.

On January 15, 2020, the caseworker contacted the father to check in on how the plan for increasing privacy for the children was going. He reported it was going well RCW 13.50.100 . The father also confirmed the children were enrolled in a new learning co-op. On January 16, 2020, the caseworker interviewed the children again and met with each child separately. The caseworker explained they were there to speak about the privacy issues again. When K.D. was asked if anything was different RCW 13.50.100 . RCW 74. said that her father RCW 13.50.100 . When the caseworker tried to verify what K.D. meant, RCW 74. said RCW 74. did not know. K.D. was antsy and did not make a disclosure or express any new concerns during the interview. M.D. was also asked if RCW 13.50.100 was any different. RCW 74. said no, but the caseworker believed RCW 74. was confused. M.D. shared RCW 13.50.100 Following the child interviews, the caseworker called the father again.

She inquired why he was continuing RCW 13.50.100 when that was not the plan they had discussed the day prior. The caseworker again reiterated a plan for allowing the children more privacy RCW 13.50.100. Also discussed was a plan RCW 74.13.520 should the need arise, including having the father demonstrating RCW 74.13.520 and then allowing the children to do so independently. The father agreed to this plan. On January 17, 2020, the caseworker received and reviewed emails sent by the mother that included correspondence with the therapist and her attorney.

The FAR family assessment was completed on January 27, 2020, with a SDM-RA of moderate. No services were recommended. The case was recommended for closure. On January 28, 2020, a final supervisory review was conducted and the case was approved for closure.

On October 26, 2020, a DCYF supervisor formerly involved with the family received information from the local news reporting a murder-suicide involving K.D., M.D., and their mother. The incident took place on October 24, 2020, and was investigated by law enforcement. DCYF did not investigate.

Committee Discussion

The Committee had the opportunity to hear from the caseworker and supervisory staff that worked with the family throughout their involvement with DCYF. The Committee was also able to interview the area administrator from the local DCYF office and the administrator for the regional roving unit. The caseworker involved with the third FAR case is no longer employed with DCYF and was not available to interview. The Committee felt hearing directly from the workers and supervisors deepened their understanding of the case and the decision making processes.

The Committee did not believe DCYF could have predicted an outcome of this nature based on the prior involvement with the family, nor did the Committee believe DCYF oversight led to this incident. Overall, the Committee found the work done with the family to be thorough and addressed the identified safety concerns reported in the intakes. The Committee learned from the area administrator of the office that there were significant staff vacancies in 2019, leaving the office with half the necessary employees in the CPS program. The regional roving CPS unit provided assistance with CPS investigations from the office beginning in the summer of 2019 and was assigned to the second FAR case. The Committee further commended the work done on this case once they were aware of the staffing shortages. The Committee discussed areas where they felt practice could have been enhanced in this case. The discussion centered around the following topics: safety assessment, comprehensive evaluation, and trauma impacts on casework staff.

The Committee discussed at length the various components of safety assessments as required by policy and how the components were applied in each of the three FAR cases. An area of focus was the child interviews. The Committee thought the child interviews in the initial FAR case were well conducted, thoughtful, and clearly documented. The Committee noted during the second FAR case that child interviews were not conducted. The children were observed during a home visit at the father's home and during a visit at the mother's office, but were not directly interviewed. The caseworker obtained information about the children directly from the parents rather than communicating directly with K.D. and M.D. to learn their perspectives. The caseworker noted concerns about RCW 13.50.100, but the Committee was aware that despite RCW 13.50.100, the children had been interviewed during the prior case. The third FAR caseworker completed an initial interview with the children and then completed a follow-up interview where the children were interviewed separately. The supervisor shared

the rationale and purpose with completing a follow-up interview. The second interview was conducted to address inconsistencies reported during the assessment and to ensure the plan developed between the caseworker and the father was being followed. The Committee identified this as positive practice in order to ensure child safety, but was also aware that child interviews for FAR cases typically do not occur individually and a parent is often present.

Domestic violence was an identified concern in the initial intake for this case, so the Committee spent time discussing the nuanced work of assessing for domestic violence. The caseworker for the initial FAR case completed a thorough specialized domestic violence assessment during their interviews with each of the parents. For the second and third FAR cases, the caseworkers inquired about domestic violence history, but did not complete a full assessment. The caseworker and supervisors explained they did not complete the full assessment because of the historical nature of the concerns and because the parents were not residing together during the assessment. The Committee wondered whether DCYF may have missed an opportunity to gather more information about possible patterns in behavior RCW 13.50.100 [redacted] The mother also identified a new relationship during the second FAR case, but this was not inquired about as the partner was not residing in the home. DCYF was aware the father completed RCW 13.50.100 [redacted] services, but DCYF did not request those records for review. The Committee wondered if this additional information could have provided more insight into the family dynamic and relationship patterns. The Committee members did not reach a consensus about whether a specialized domestic violence assessment should have been completed for each FAR case, so this was not identified as a finding.

DCYF utilizes the SDM-RA to assess risk and guide recommendations for service provision. The Committee reviewed and compared the completed SDM-RAs and found minor inaccuracies between the three assessments, but did not believe this had bearing on the case outcome. Typically, services are considered only for cases with a risk assessment of moderate high or higher. Although one risk assessment was calculated at a moderate high risk, DCYF did not provide services. The Committee ascertained from the caseworkers and supervisors more information surrounding the decison to not offer services. K.D. and M.D. were involved in therapeutic services, including counseling, RCW 13.50.100 [redacted] services (M.D.), specialty medical services (M.D.), and pro-social activities. The mother also reported she was connected with her own counseling services. DCYF believed the family was well connected to community-based resources and was also knowledgeable about how to identify additional services should a need arise. The Committee agreed with this logic and suspected that had services been offered, the mother likely would have declined. The Committee felt that counseling with a focus on co-parenting for divorced parents may have been beneficial for the family, but knew this was not a service available through the DCYF service array.

DCYF strives to complete comprehensive global assessments of children and families when assessing child safety. One method for evaluating the comprehensiveness of an assessment includes a review of the collateral contacts along with the collaboration that may have taken place. The Committee discussed the level of comprehensiveness with information gathering and assessment during DCYF's involvement with this family and identified that some aspects of the assessment were more narrowly focused, rather than global.

One particular area the Committee felt could have been explored further was the mother's mental health needs. The caseworkers all had dialogue with the mother regarding her mental health needs, RCW 74. [redacted]. She reported accessing counseling services and having current involvement with counseling. During the first and second FAR case, the caseworker did not ask for a release of information to verify the mother's involvement with mental health services. The caseworker for the third FAR case did ask the mother to sign a release of information, but she declined. The Committee appreciated this caseworker's attempts to verify the mother's mental health services. During interviews with the father in the initial FAR case, he expressed concerns regarding the mother's mental health, but clearly stated he did not believe she would harm their children. The caseworker and their supervisor then followed up with the mother to touch base about her mental health needs. During the Committee interviews, the caseworkers and supervisors shared that although mental health concerns were identified, they did not believe those needs were jeopardizing child safety based on their interactions and observations with the mother and children.

Another area the Committee felt required further collaboration and communication surrounded the family court component of this case. During Committee interviews, the caseworkers and supervisors expressed hesitancy to blur the lines between DCYF's role and that of the family court proceedings. A supervisor also mentioned they did not believe the family court matter related to child safety and did not warrant further exploration. There was an opportunity during the second FAR case when the father brought up his RCW 13.50.100 services and briefly showed the caseworker paperwork from court, but the caseworker did not ask additional questions or ask for copies of the records. Although the Committee recognized the challenges that can occur when both DCYF and family court are involved, the Committee still would liked to have seen more collaboration with the family court to ensure all relevant information had been gathered to complete a thorough assessment.

The Committee also felt additional collateral contacts may have been beneficial in compiling a well-rounded view of the family. With the initial FAR case, the caseworker did speak with the referent, who was a neighbor, but did not delve deeper despite other potential collaterals being identified, including a nanny, housekeeper, and the mother's former partner. The caseworker believed the information gathered would likely be neighborhood gossip rather than factual information. A Committee member believed this may have been biased thinking and discussed how information gathered should always be weighed and evaluated within an investigation or assessment. The Committee also commented on the limited collateral contacts made regarding the father. The father provided a reference and DCYF did make contact, but did not identify additional contacts. The mother provided contacts for the children's school, as well as medical and therapeutic professionals, all of whom were contacted. The Committee wondered if there were other individuals to contact that may have provided a different perspective than those collateral contacts believed to be within the mother's sphere of influence. During caseworker interviews, staff shared it is common for a parent to suggest and provide information for collateral contacts and since no additional concerns came to light during those conversations, they did not explore other collateral contacts. The supervisor for the initial FAR case also reminded the Committee the children were involved with many individuals considered mandated reporters, and the supervisor believed if there were additional child safety concerns they would be reported by community members and providers.

The Committee recognized that working in the field of child welfare can have profound impacts on individuals due to the traumatic events they may experience on their caseload. The Committee

expressed concern for the caseworkers involved with this case due to the tragic outcome and wondered how this may have affected them. Some Committee members reflected on cases they have been involved with that had tragic outcomes and how they have been personally affected in their respective professional roles. The Committee discussed the support options available to DCYF staff, including Employee Assistance Program (EAP) and DCYF Peer Support, but felt that more could be done to assist staff with difficult situations and critical incidents such as this.

One particular area that stood out to the Committee was during the interview with the supervisor who was assigned to the third FAR case. The supervisor shared the caseworker left the agency in October 2020 after less than a year of employment. Although the Committee only speculated as to why this individual chose to exit state service, they felt it was important to offer supports to casework staff, including staff who exit state service and no longer have access to services available to employees. The Committee suggested the agency work toward providing community-based resources to staff during exit interviews.

Findings

The Committee strongly felt that DCYF could not have anticipated a critical incident of this nature.

The Committee did, however, identify that during the FAR case in September 2019, the children were not interviewed per DCYF policy [DCYF Policies and Procedures: 2333. Interviewing a Victim or Identified Child]. The interactions with the children were observational. All information regarding the children was provided by the parents and not through direct interviews of the children.

Recommendations

The Committee suggested the following recommendations to provide continued support to casework staff completing assessments and investigations in the field:

1. The Committee acknowledged the challenges caseworkers may face in gathering all pertinent information to complete a thorough assessment. With that in mind, the Committee suggested that DCYF focus on individualized skill building for caseworkers to help them learn how to effectively gather pertinent information and evaluate the information gathered to assess child safety. The Committee suggested providing this technical support and guidance through individualized clinical supervision and coaching.

2. The Committee recommended this DCYF office identify a point of contact at the family court to enhance future collaboration on cases shared between DCYF and family court.

3. Finally, the Committee recognized the importance of casework staff receiving supports to address the trauma impacts that may occur due to working in child welfare. The Committee wanted to ensure that staff who exit state service, and no longer have access to DCYF Peer Support and EAP, are made aware of alternative resources. The Committee suggested that during staff exit interviews, individuals are provided with a list of community-based therapeutic resources.