CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

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Nondiscrimination Policy

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

- M.E.

Date of Child's Birth

- [redacted] 2007

Date of Fatality

- May 6, 2022

Child Fatality Review Date

- Aug. 18, 2022

Committee Members

- Elizabeth Bokan, JD, Office of the Family and Children's Ombuds, Ombudsman
- Derek Murphy, M-RAS, SUDP, CSC, Olalla Recovery Centers, Director of Clinical Services
- Kate Bianchi, Domestic Abuse Women's Network, Shelter Advocate
- Holly Cristina, Department of Children, Youth, and Families, Child Protective Services Supervisor Region 5
- Paul Kallmann, MSW, Department of Children, Youth, and Families, Quality Practice Specialist Region 5

Observer

- Hailey Foster, Department of Children, Youth, and Families, Permanency Outcome Facilitator Region 5

Mapping Facilitator

- Tiffany Lindsey, EdD, PLC-MHSP, University of Kentucky, Assistant Professor

Facilitator

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

Executive Summary

On Aug. 18, 2022, 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 M.E. and [redacted] family. [redacted] will be referenced by [redacted] initials throughout this report.

On May 6, 2022, DCYF was notified that M.E., [redacted] mother, and a friend of M.E.'s were found deceased. Witnesses reported to law enforcement that M.E.'s mother had been driving her vehicle at high speeds and did not properly negotiate a corner. The mother's driving caused the car to land upside down in a body of water. All three passengers drowned. Law enforcement continues to investigate the incident and the medical examiner's office is waiting for toxicology reports.

DCYF had closed out a Child Protective Services (CPS) investigation in March of 2022.

A diverse CFR Committee (Committee) was assembled to review this case and to evaluate DCYF's service delivery to the family. The Committee included community partners and DCYF staff. Committee members received copies of the DCYF case history, including intakes, investigative assessments, assessment tools, and case notes. They also received historical police reports.

The Committee was joined by an assistant professor from the University of Kentucky who facilitated a conversation about systems mapping. The systems mapping process is new to DCYF. The goal is to look at root causes of identified areas the Committee believes can be improved upon. The Committee and staff involved in the case then discussed these improvement opportunities and how the root causes could be reduced or eliminated.

The Committee spoke with staff from two different offices who had contact with the family in 2022. The staff included two supervisors, two caseworkers, and the area administrator.

Case Overview

Between 2004 and the end of 2020, there were 20 intakes involving M.E.'s mother. The intakes involved allegations of neglect, domestic violence (DV), physical abuse, sexual assault, and parental substance use. Due to a concern from a sitting judicial officer, a dependency petition was filed with regard to M.E.'s oldest sibling.

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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. For purposes of this report, any reference to DCYF and events that occurred before July 1, 2018, shall be considered a reference to DSHS.

[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)]." RCW 74.13.640(4)(a). Given its limited purpose, a child fatality review (CFR) should not be construed to be a final or comprehensive review of all 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 DCYF or its contracted service providers.

The Committee has no subpoena power or authority to compel attendance and generally hears from only DCYF employees and service providers. It does not hear the points of view of the child's parents and relatives, or other individuals associated with the child. A CFR 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 CFR to recommend personnel action against DCYF employees or other individuals.

This child was placed with the maternal grandparents but eventually returned to her mother. In addition to M.E., M.E.'s mother has given birth to four children, M.E.'s older sister, two younger twin sisters, and a younger brother.

On May 4, 2021, DCYF received a telephone call from a community partner. The caller reported concerns for RCW 74.13.520 M.E. and that the mother was struggling with RCW 74.13.520. The mother left the children with the maternal grandparents. The mother did not say when she would return. This report screened out (did not meet requirements for a CPS investigation or assessment) because DCYF concluded the allegations did not meet the definition of child abuse or neglect.

In November 2021 and January 2022, two more intakes were screened out. Those intakes alleged neglect and identified concerns about the mother and her possible mental health issues. It was also reported that the mother and children were "kicked out" of the maternal grandparents home due to an argument between the mother and uncle.

On Jan. 26, 2022, another intake was received reporting that M.E.'s sister told the school she did not have anywhere to live and that M.E. had overdosed. This intake screened in for a CPS/Family Assessment Response (FAR) assessment.[3] On Jan. 27, a CPS caseworker contacted the maternal grandmother. The grandmother said her daughter picked the children up the day before and they had not returned. The grandmother also said M.E. had taken a bunch of pills because RCW 74.13.515 broke up with RCW 74.1 Also on Jan. 27, the caseworker documented two more attempts to contact the mother. On Jan. 31, 2022, the CPS caseworker contacted M.E.'s sisters at school. One of the twins appeared to influence the other as she entered the office. The DCYF reports described this influence as a change in the child's demeanor. After the twin came into the room, the sister began to speak very quickly to the caseworker and did not provide much information.

On Jan. 28, 2022, the caseworker again attempted to contact the mother. The caseworker called the younger brother's school. However, the younger brother was absent. The caseworker called law enforcement searching for an address to find the mother. Law enforcement was unable to help.

On Jan. 31, 2022, a different caseworker was assigned to the case. The first caseworker was covering for the second caseworker because the second caseworker was unavailable. The second caseworker attempted contact with M.E. at RCW 74. school but RCW 74.1 was absent. The caseworker was able to connect with the mother and met her and the children later that day at the community library.

The caseworker gave bus passes to the mother and children because the mother's car was not working, and referred the family for wraparound mental health services.[4] The school resource liaison helped the mother

[3] "FAR is a CPS alternative response to a screened-in allegation of abuse or neglect. FAR focuses on children and youth safety along with the integrity and preservation of families when lower risk allegations of maltreatment have been screened-in for intervention." For more information, see: https://www.dcyf.wa.gov/policies-and-procedures/2332-child-protective-services-family-assessment-response.

[4] "Wraparound with Intensive Services, or WISe, is an approach to helping children, youth, and their families with intensive mental health care. Services are available in home and community settings and offer a system of care based on the individualized need of the child or youth. WISe is a voluntary service that takes a team approach to support you and your family in meeting your goals." For more information, see: https://www.hca.wa.gov/free-or-low-cost-health-care/i-need-behavioral-health-support/wraparound-intensive-services-wise

and children obtain needed services that were available in the community. The case was ready to be closed, but another intake was received.

On March 3, 2022, an intake was received alleging the maternal uncle became upset and, while holding a gas can and torch, threatened to burn the house. The twins were reportedly in the living room when this occurred. This intake screened-in for a CPS Risk Only investigation.[5]

Due to staffing challenges, the CPS supervisor handled the risk-only investigation. On March 4, he contacted the twins at school. One of the twins told the other not to talk about the incident, stating their grandmother told them not to talk. The supervisor then met with the younger brother at his school. He said the uncle's behavior scared him and that his uncle also previously started a fire while making fries. He talked about the uncle and grandfather fighting, that the uncle poured gas on the floor, and that his mom was crying. They discussed a plan to exit the house if there is ever a fire. The child said the plan was that everyone would meet in the front yard.

Also on March 4, the supervisor tried to meet with M.E. at RCW 74. school, but RCW 74. had been withdrawn from the district. On March 8, 2022, the case was assigned to the same CPS caseworker who completed the last assessment. The CPS caseworker called the mother and left a voicemail to arrange for an interview with M.E. Due to scheduling conflicts, the supervisor interviewed M.E. at RCW 74. maternal grandparents' home. The grandparents would not allow the supervisor on their property, so M.E. had to meet him on the road. M.E. denied any issues or safety concerns. RCW 74.1 denied the incident involving the uncle's threats to burn the house and alleged it never happened. The case was closed.

On May 6, 2022, the fatalities were reported to DCYF.

Committee Discussion

This review included a new process called systems mapping, where during the review, the Committee and office staff discussed two possible improvement opportunities. During this process, everyone discussed differing perspectives of each improvement opportunity in detail in an attempt to get at the root cause and a possible way to ameliorate the identified issue. This process is part of what DCYF is learning from the National Partnership for Child Safety.[6]

The Committee learned from staff about the efforts they made to develop relationships with the family. This was difficult due to the family's previous involvement with the agency and negative opinion of DCYF. The staff discussed the many DCYF supports and conversations that were not documented. These supports and conversations added depth to the work the staff already were doing and helped the Committee to understand the complexities presented by this family. The Committee is hopeful that similar supports and conversations will be documented in future cases.

[5] CPS Risk Only is an intake that alleges imminent risk of serious harm and there are no allegations of child abuse or neglect. For more information about CPS Risk Only, see: https://www.dcyf.wa.gov/practices-and-procedures/2200-intake-process-and-response.

[6] To access information about the National Partnership for Child Safety, see: https://www.dcyf.wa.gov/news/dcyf-joins-child-welfare-leaders-across-country-form-national-partnership-child-safety.

The primary caseworker who handled the cases in 2022 was also completing work for another office that was struggling due to workload issues. This burden was significant and impacted the caseworker's ability to document as much as she would have wanted to, or had documented in the past. This case was handled by staff from two very small offices. An issue unique to DCYF client families who reside in a small town is that there are few available local service providers or services. An issue unique to caseworkers who work and reside in a small town is the fact that the caseworker will often unintentionally encounter DCYF client families outside of work.

The Committee discussed the 2022 risk-only assessment. The Committee believes the family could have possibly benefited from the completion of an additional safety assessment of the grandparents' home, particularly an assessment focused on violence. The uncle's threat to set the house on fire was severe and corroborated the fact that this family's underlying issue was ongoing violence in the presence of the children. The supervisor discussed his unsuccessful attempts to gather information from the responding law enforcement agency. According to DCYF staff, that particular law enforcement agency has consistently lacked a willingness to collaborate with DCYF.

The Committee appreciates the fact that the supervisor discussed an evacuation plan with M.E.'s brother. The Committee also appreciates the supervisor's creative approach to the grandparent's refusal to allow him on the property. The Committee believes the attempts to gather information should have been more clearly documented in the case notes and investigative assessment. The Committee also believes that contacting the wraparound mental health service that had previously been referred to the family may have also provided another substantial collateral resource.

The staff discussed their consistent efforts to conduct walk-throughs of the homes where the children and their mother resided. The mother and her son were living with friends who had a CPS history and who did not want to allow the caseworkers or supervisors in their home. The girls often stayed at the maternal grandparents' home, however, the grandparents refused to allow staff to conduct a walk-through or allow staff to enter the property. While multiple attempts were made by staff to conduct walk-throughs of the grandparents' home, not all of the attempts were documented. The Committee discussed that other approaches to learning about the safety of the homes could have been pursued. Alternative approaches may have included asking law enforcement about the condition of the homes they observed, obtaining law enforcement reports, or speaking with the wraparound provider or the school resource liaison.

Consistent with the second recommendation in the next section below, the Committee believes that staff should take specific training about how to engage in difficult client conversations. Difficult client conversations and engaging a hostile person are incredibly challenging and often take not only time and repeated encounters, but also effective training and supervisory supports. Sometimes, when staff have had numerous contacts or "know" of a family due to the frequency of DCYF engagement, staff will resign themselves to what they previously learned about the family. Under these circumstances, it is sometimes a matter of staff feeling overwhelmed, overworked, or frustrated that can lead to not aggressively pursuing the case. Regardless of the reason, the training may provide staff with other approaches for how to interact with difficult clients.

There was significant discussion about how living and working in a very small community can easily lead a person to unknowingly become biased against a person or family. The Committee discussed a recommendation (listed below) that is an attempt to help support staff with this challenge. This family has been known to DCYF for generations, and the staff and family were long-time residents of the same small community. These factors may have made it very challenging to work with this family.

Recommendations

1. The Committee recommends that DCYF assess the current bias and critical thinking trainings provided by the Alliance, specifically reviewing content related to living and working in small communities and how to handle that in a professional and unbiased manner.

2. The Committee recommends that the two offices involved in this case should complete Advanced Guidelines for Difficult Conversations training.

3. DCYF should create a system that requires staff to take DV and substance use training every two years. This is necessary due to changes in language, treatments, ideology, current understanding, and other factors. The Committee discussed that this is a requirement for many other social service and professional services providers and is a positive process for maintaining current standards of practice as it relates to the work conducted by DCYF.