CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

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Full Report

Child

- K.F.

Date of Child's Birth

- RCW 74.13.515 2018

Date of Fatality

- December 11, 2022

Child Fatality Review Date

- February 15, 2023

Committee Members

- Deborah Lurie, JD, Ombuds, Office of the Family and Children's Ombuds
- Elizabeth Bokan, JD, Ombuds, Office of the Family and Children's Ombuds
- Victoria Cantu, CPS Supervisor, Department of Children, Youth, and Families
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Facilitator

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Approved for distribution by Paul Smith, Critical Incident Supervisor

Executive Summary

On February 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 K.F. and RCW 7 family. K.F. will be referenced by RCW 7 initials throughout this report.[2]

On December 13, 2022, the medical examiner's office contacted DCYF, reporting K.F. had died due to blunt force trauma to RCW 7 head. On December 11, K.F.'s mother called emergency services for assistance. Upon their arrival, K.F. was pronounced dead. K.F.'s mother said RCW 7 fell in the bathtub and hit the back of RCW 7 head, then fell forward and hit the front of RCW 7 head when she tried to pick RCW 74.1 up. The medical examiner reported this explanation is not consistent with K.F.'s injuries. On December 12, 2022, K.F.'s mother and her boyfriend were arrested. They have both been charged with murder in the second degree.

At the time of K.F.'s death, DCYF did not have an open case, but a Child Protective Services (CPS) case had been open in the prior 12 months. Following K.F.'s death, CPS opened a new case to investigate the circumstances surrounding RCW 7 death.

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 K.F. or RCW 7 family. Before the review, the Committee received relevant case history from DCYF. On the day of the review, the Committee had the opportunity to speak with DCYF field staff who were involved with supporting the family.

Case Overview

In September 2020, DCYF learned of K.F. and RCW 7 family due to reported concerns about RCW 7 welfare. The referrer, RCW 13.50.100(7)(c) called DCYF. RCW 74.13.515 was available and also contributed to the report. They reported K.F. had two scars on RCW 7 face, and the referrer was told it was due to RCW 74.1 falling off the toilet. The referrer said it did not seem like the cut could have happened that way and was concerned the mother was not watching RCW 74.13 K.F. was reported to have received medical care. A CPS investigation was assigned.

Two attempts were made by after-hours caseworkers to complete initial contact with the child and family, but they were not able to locate the family. The CPS caseworker contacted the referrer, who said K.F.'s injuries

[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 near 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] K.F.'s name is not used in this report because RCW name is subject to privacy laws. See RCW 74.13.500.

were healing and that they felt better about the mother's story. The referrer said the family was meeting at the park later that day. The CPS caseworker met with the mother, father, father's girlfriend, and K.F. at a local park. K.F. had stitches covered by a bandage above RCW 7 left eyebrow. The mother said the doctor instructed her not to remove the bandage, so the caseworker did not observe the injury. The parents reported they do not have a formal parenting plan but met at the park so they could watch K.F. play. The father stated he cares for K.F. from Friday through Sunday. The mother agreed to a visit by the caseworker at her home at a later date.

The caseworker met with the mother, maternal grandmother, and K.F. at the maternal grandmother's home. The mother told the caseworker the events that led up to K.F.'s injury. The mother reported she left the bathroom and returned to find RCW 74.1 crying. The mother said RCW 7 slipped and hit RCW 7 head on the toilet. The mother took K.F. to the emergency room following RCW 7 injury. The mother stated K.F. is her priority. She shared their daily routine and denied any substance use, criminal history, or domestic violence (DV) with K.F.'s father. The mother mentioned that she had RCW 13.50.100 The maternal grandmother did not report any concerns and said the mother and K.F. could stay in her home as long as needed.

The caseworker requested K.F.'s medical records and did not receive them, and made a second request. The caseworker reviewed copies of K.F.'s medical records, including the report from the emergency room visit. The caseworker documented that medical professionals did not report concerns regarding the mother's explanation for K.F.'s injury. The caseworker contacted the father and left a voicemail sharing no concerns were noted from medical providers regarding K.F.'s injury.

In October 2020, the investigative assessment was completed. The assessment identified that K.F. was safe in RCW 7 mother's care, and no additional services were offered. The case was submitted for closure.

On November 20, 2021, DCYF received a call from RCW 13.50.100(7)(c) RCW 13.50.100(7)(c) reported witnessing the mother hitting K.F., but did not provide a time frame on when this occurred. RCW 13.50.100(7)(c) did not know if this caused an injury to K.F. or left any marks. RCW 13.50.100(7)(c) reported the mother has hit him in the presence of K.F., but did not provide dates or times when this occurred. A CPS investigation was assigned.

On November 21, 2021, an after-hours caseworker went to the home of K.F. and RCW 7 mother to complete an initial face-to-face visit. The mother told the caseworker she knew RCW 13.50.100(7)(c) had called. The mother said she intended to file a parenting plan through the court. The mother denied using inappropriate discipline with K.F. She explained she spanks RCW 74.1 on the bottom with an open hand, not a closed fist. The caseworker observed K.F. having a diaper change; no bruises, marks, or injuries were noted. The mother reported the father had put his hands on K.F., causing bruises, but did not provide dates and times this occurred. RCW 13.50.100 RCW 13.50.100

The after-hours caseworker observed other adults and children in the home, and the mother reported these were roommates and friends. The caseworker spoke with one adult in the home but did not interact with the other individuals. The caseworker asked if the mother's roommates would be willing to complete background checks. The mother did not believe her roommates would be willing to speak with a CPS caseworker.

On November 22, 2021, a CPS caseworker was assigned to the case. The following day the mother contacted the caseworker requesting a home visit. The mother said the father and his family were threatening to take K.F. away. K.F.'s mother said she had never hurt K.F., and K.F.'s godmother could provide a reference for her.

On November 29, 2021, the caseworker attempted to contact the father and left him a message requesting a return phone call.

On Nov. 30, 2021, the caseworker met with K.F. and RCW 7 mother in their home. The caseworker observed K.F. and RCW 7 mother interacting. K.F. was able to speak in small sentences. The mother did not want to enroll RCW 74.1 in daycare at the time due to COVID-19 concerns. The mother described how she manages discipline for K.F. She admitted she had spanked RCW 74.13 but never with a closed fist, and it had never left a mark or injury. She also imposes timeouts, or sometimes K.F. will lose privileges. She said she does not allow others to discipline K.F. The mother told the caseworker that she and K.F.'s father were no longer in a relationship. The mother last saw the father approximately two weeks prior. The caseworker completed a universal domestic violence screening with the mother. The mother denied being in a current relationship. She told the caseworker that K.F.'s father had used physical force against her in the past and was controlling in their relationship. K.F.'s mother denied ever contacting the police. She denied mental health history and criminal history. The caseworker did not observe any present danger during the home walkthrough or in interactions with the family. The caseworker requested the mother's roommates complete background checks. The mother said she would talk with her roommates, but it was unlikely they would work with CPS.

The caseworker received a call from RCW 13.50.100(7)(c) who said K.F.'s father was living with her and temporarily using her phone. RCW 13.50.100(7)(c) reported concerns that the mother's boyfriend, who has a felony, hit K.F. and the mother. The caseworker spoke with the father and discussed the allegations with him. The father said he was concerned the mother and her friends were neglecting K.F. The father said he observed red marks on K.F.'s bottom around November 1 but no longer had the pictures he took. He said he saw the mother hit K.F. on the chest on November 12 when K.F. would not go to sleep. He said he observed the mother throw K.F. down on the bed and attempt to choke RCW 74.1 a few months ago but had difficulty explaining further details to the caseworker. K.F.'s father denied using physical discipline with RCW 74.13 The caseworker completed a DV screening with the father. The father reported the mother has used physical force against him and detailed multiple incidents. The father also said that she had been verbally abusive towards him. The father agreed to allow the caseworker to send him DV resources.

On December 2, 2021, a monthly supervisor review took place. Next steps included interviewing the mother's roommates, making collateral contacts, and completing an early learning staffing, the safety assessment, and the investigative assessment.

On December 6, 2021, the caseworker contacted K.F.'s pediatrician's office. K.F. was up to date on RCW 74 medical appointments. RCW 74 next well-child exam was set for December 9, 2021. The caseworker contacted a family friend, who provided information to the caseworker. The friend said she did not think the mother disciplines K.F. enough. The friend reported encouraging the mother to use physical discipline with K.F. by spanking RCW 74.1 on the bottom with an open hand. The friend said she believed that K.F.'s father was trying to get RCW 74.1 taken

away from [redacted] mother. The friend believed the father posted lies about the mother online. The friend said the mother is a good mother to K.F.

The caseworker also contacted the public health nurse (PHN), who formerly worked with the mother and K.F. through the Nurse-Family Partnership[3] program. The PHN said she had known the mother for approximately two and a half years and that the mother was nearing graduation from the program when they lost contact. The PHN said the mother participated in the appointments and appeared interested in what was shared. The PHN taught the mother about discipline, not punishment, and to her knowledge, the mother did not utilize force with K.F. The PHN did have knowledge of past DV between K.F.'s mother and father but did not believe it was ongoing and had not referred the mother for services. The caseworker contacted the maternal grandmother and left a message but did not receive a response.

On December 14, 2021, a monthly supervisor review took place. The caseworker participated with an early learning staffing hosted by a Child Welfare Early Learning Navigator[4] (CWELN). The CWELN recommended enrolling K.F. in an early learning program and provided suggestions for local resources for the mother.

On December 15, 2021, the caseworker attempted to contact the mother, but her phone was disconnected. The caseworker attempted to contact the maternal grandmother and left a message.

On January 3, 2022, the caseworker contacted the mother and left a message providing information from the early learning staffing and offered to submit a referral if the mother was interested. The caseworker asked the mother to return their call.

On January 6, 2022, the investigative assessment was completed. The investigation assessed K.F. as safe in the care of [redacted] mother and said there were no additional unmet needs for the family. Both parents received DV resources and community resources for completing a parenting plan. The mother received concrete goods including a clothing voucher, diapers, and baby wipes for K.F. The mother also received information about early learning programs. No additional services were offered and the case was submitted for closure.

On February 23, 2022, DCYF received a report from the father that during his visitation with K.F. he observed a small purple bruise on K.F.'s lower stomach and an inch-long scratch on [redacted] shin. He said the mother would not tell him how K.F. obtained these injuries. The father told DCYF he was not going to return K.F. to the mother and intended to get a restraining order against the mother. The father reported an incident of DV between the mother and father that K.F. had witnessed and said the mother threatened to kill him. The father denied involving law enforcement. DCYF provided the father with contact information for an attorney clinic in his area. Following the report, the intake caseworker contacted the father to obtain more information about the reported DV incident. The father could not provide additional information or the exact date but said it occurred "a week ago." A CPS case was assigned.

[3]For information on the Nurse Family Partnership program, see: https://www.nursefamilypartnership.org/locations/washington/. Last accessed on February 23, 2023.

[4]For information on Child Welfare Early Learning Navigators (CWELN), see: https://www.dcyf.wa.gov/news/child-welfare-early-learning-navigators.

The area administrator, whose office was assigned to the intake, consulted with the regional safety administrator and deputy regional administrator per protocol in this county. A determination was made to screen out the intake and not complete an investigation. The case was closed.

On December 13, 2022, the medical examiner reported K.F. had died. DCYF learned that K.F.'s mother and her boyfriend were arrested on December 12, 2022, and held pending charges of murder in the second degree.

Committee Discussion

The Committee discussed the positive aspects of the casework in the two CPS investigations. In the first case, it was noted that the caseworker was creative in how they engaged with the family by meeting them at the park for the initial visit. The caseworker was also diligent in requesting K.F.'s medical records and re-requesting the records when they were not immediately received.

In the second CPS investigation, the Committee observed that the after-hours caseworker who made initial contact with the family was very detailed in their assessment of present danger and the corresponding documentation. The Committee also thought it was a strength that the after-hours caseworker helped RCW 13. RCW 13.50.100(7)(c) call the intake hotline to report her concerns. The Committee observed that the ongoing CPS caseworker was quick to follow up with the family, was comprehensive in the manner in which they assessed the capacity of the mother and the child, and detailed their observations in the documentation. The Committee also pointed out the good use of collateral contacts, review of the law enforcement records, and the early learning staffing that was held to discuss possible services for K.F. The Committee felt the caseworker made efforts to build a trusting relationship with the mother throughout the intervention.

One aspect the Committee discussed was related to bias that field workers may experience. The Committee identified that cases involving conflict between parents who are co-parenting in separate households or parents who are engaged in child custody proceedings can present unique challenges. The Committee asked the field staff how this may have impacted their case decision-making. One field staff explained that based on their assessment of the mother, they did not have concerns about her parenting, but this left the Committee with additional questions, given the father was the individual who shared his concerns about the mother over the course of DCYF involvement.

Another similar aspect discussed was related to bias that may exist about domestic violence. Both the mother and father reported a DV incident where the other parent was the aggressor. Through a collateral contact the caseworker was able to learn the mother was likely the aggressor. Both parents denied involving law enforcement. The Committee discussed that it is less common for a female to abuse a male and wondered how this may have impacted the field staff's thinking about the DV history between the parents.[5] The Committee discussed how all field staff could fall guilty to bias when completing assessments.

The Committee noted that the focus of the case seemed to emphasize the mother over the father. It was identified based on DCYF's interactions that the mother was meeting K.F.'s needs and that there were no safety concerns. The Committee wondered why a stand-alone Structured Decision Making Risk Assessment®[6]

[5]For additional information on intimate partner violence statistics, see: https://www.cdc.gov/violenceprevention/intimatepartnerviolence/fastfact.html. Last accessed on February 23, 2023.

(SDMRA) was not completed for the father's household. The Committee discussed different points related to use of the SDMRA in the field, such as the most updated information gathered is not always updated in the SDMRA if it has already been completed. However, the Committee discussed that the SDMRA guide has limitations in offering guidance, which may leave room for individual interpretation. The Committee suggested it may be beneficial if SDMRA require supervisory approval.

The Committee discussed the closure of the second CPS investigation. The Committee pointed out that the mother had been fairly engaged with the caseworker but that prior to case closure, there was no response by the mother when the caseworker attempted to share information about early learning programs with her. The Committee speculated, with hindsight, that perhaps the mother's lack of response may have been cause for concern. Given the mother's age and lack of family support, the Committee felt the mother may have benefited from the agency providing more hands-on assistance related to connecting the family with early learning resources. The Committee appreciated that the agency provided community-based resources to both parents. The Committee acknowledged that workload factors might limit field staff's ability to provide hands-on support to parents.

The Committee also discussed interviewing young children during an assessment of suspected physical abuse. The Committee discussed the challenges in obtaining information from pre-verbal children or children with developing verbal skills. The Committee discussed the importance of identifying an individual child's developmental level as it may vary widely from child to child. The Committee believed that for young children developing verbal skills, it could be helpful to try to complete an interview, understanding there may be limitations to what is gained dependent upon the child's abilities and cognition.

The Committee reviewed the current training catalog offered for DCYF child welfare staff related to physical abuse and injuries. The Committee discussed the importance of all DCYF staff, at all levels being well-informed about assessment of child abuse, specifically related to physical injuries. The Committee developed a recommendation for DCYF's consideration related to requiring an annual mandatory training about physical abuse. The Committee wished to mention that they understand time constraints for agency staff around additional training requirements but conveyed there may be value for all agency staff, including tenured staff, in completing a refresher training as assessment of abuse and neglect is central to keeping children safe.

The Committee discussed the agency's decision to screen out the intake received in February 2022. Based on the conversation with the field staff, the Committee wondered if bias related to workload challenges may have impacted the decision-making. The Committee learned from the field staff about how this region has redesigned the protocol they utilize for consideration of screening out intakes that have been assigned to a local office. The redesign includes increased shared decision-making when evaluating if an intake may be screened out. The Committee felt this was a positive practice change that may reduce subjectivity and bias when making screening decisions. The Committee appreciated learning about this change from the field staff.

[6]For information on Structured Decision Making Risk Assessment® (SDMRA), see: https://www.dcyf.wa.gov/policies-and-procedures/2541-structured-decision-making-risk-assessmentrsdmra.

Recommendations

The Committee recommendations come from a comprehensive review and discussion of the many aspects of the case. The recommendations and corresponding discussion were unrelated to the death of K.F. The Committee respectfully recommended DCYF consider the following to comprehensively improve practice:

- DCYF should consider an annual training requirement for all agency staff across all programs related to the assessment of physical child abuse and injuries.
- DCYF should consider a requirement that active efforts are made to connect families with resources when an early learning staffing or other consultation occurs and recommends resources for the family.