Children's Administration
Executive Child Fatality Review
Isayah Casch

January 7, 2011

Committee Members

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Executive Summary

On September 19, 2010, Children's Administration (CA) accepted an intake from Harborview Medical Center reporting the death of seven-year-old Isayah Casch, following a roll-over accident of a car driven by his mother, Kortnie Casch. The caller reported that Ms. Casch appeared intoxicated and that two blood draws had been completed; one by Providence Hospital and one by Harborview at the request of the Snohomish County Sheriff. The caller reported further that Isayah's half-siblings, and had been in the car and were admitted for observation and treatment of minor injuries. The caller noted that hospital staff were concerned about the children's unsanitary and dirty appearance. and were placed with their paternal grandfather and his wife following their release from the hospital

After an investigation by Snohomish County Sheriff of the accident leading to Isayah's death, the case was referred to the Snohomish County prosecutor. Charges against Ms.Casch are pending.

The family's history with CA began in February 2003 and includes four previous investigations in 2003, 2006, 2007, and July 2010. The investigations were based on allegations against Ms. Casch of driving while under the influence with her children in the car, neglect of her children, and alcohol abuse. The investigations in 2003 and 2006 were closed on inconclusive findings. The investigation in 2007 was closed without a finding The investigation begun in July 2010 was ongoing at the time of Isayah's death and was subsequently closed as unfounded in October 2010.

On January 7, 2011, CA convened a multi-disciplinary committee to review the decisions, policy, practice, and service delivery in this family's case.[1] The committee, including CA staff who had no direct connection to the case, represented disciplines associated with this case. Documents available to the committee included: chronology of the case prepared for the review, Snohomish County Sheriff's investigation of the September 18, 2010 accident, CA case records, Ms. Casch's childhood records from Georgia, Isayah's autopsy report, the CA policy on child protective services (CPS) investigations, and RCW and WAC

[1] Given its limited purpose, a Child Fatality Review by Children's Administration should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. A review is generally limited to documents in the possession of or obtained by DSHS or its contracted service providers and the panel may be precluded from receiving some documents that may be relevant to the issues in a case because of federal or state confidentiality laws and regulations. A review panel has no subpoena power or authority to compel attendance and generally will only hear from DSHS employees and service providers. The panel may not hear the points of view of a child's parents and relatives, or those of other individuals associated with a deceased child's life or fatality. A Child Fatality Review is not intended to be a fact-finding or forensic inquiry or to replace or supersede investigations by courts, law enforcement agencies, medical examiners or other entities with legal responsibility to investigate or review some or all of the circumstances of a child's death. Nor is it the function or purpose of a Child Fatality Review to take personnel action or recommend such action against DSHS employees or other individuals.

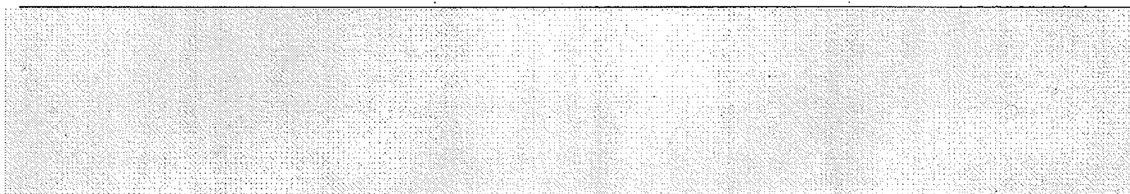
chapters on CPS activities including the definitions of child abuse and neglect. In addition, the supervisor on the case at the time of Isayah's death was interviewed by the committee. The social worker on the case was not available for interview.

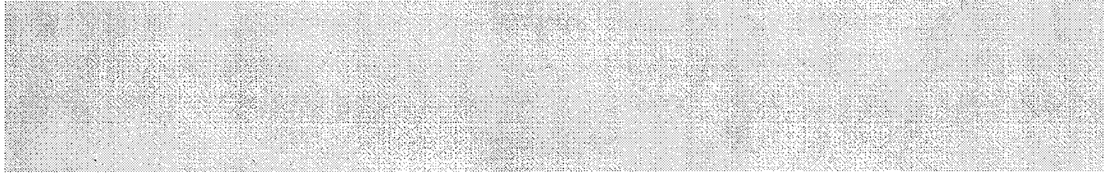
Given its limited purpose, a Child Fatality Review by CA should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. Review is generally limited to documents in the possession of or obtained by the Department of Social and Health Services (DSHS) or its contracted service providers and the committee may be precluded from receiving some documents that may be relevant to the issues in a case because of federal or state confidentiality laws and regulations. A review committee has no subpoena power or authority to compel attendance and generally will only hear from DSHS employees and service providers. The committee may not hear the points of view of a child's parents and relatives, or those of other individuals associated with a deceased child's life or fatality. A Child Fatality Review is not intended to be a fact-finding or forensic enquiry or to replace or supersede investigations by courts, law enforcement agencies, medical examiners or other entities with legal responsibility to investigate or review some or all of the circumstances of a child's death. Nor is it the function or purpose of a Child Fatality Review to take personnel action or recommend such action against DSHS employees or other individuals.

During the course of the review, committee members discussed concerns regarding the possible impact social worker inexperience has on thorough risk assessment and service delivery. The committee members also discussed concerns regarding the impact of recent funding cuts which eliminated the regional placement of chemical dependency professionals in local offices to assist social workers with home visits, consultation, and intervention with families where substance abuse is alleged to have placed children at risk.

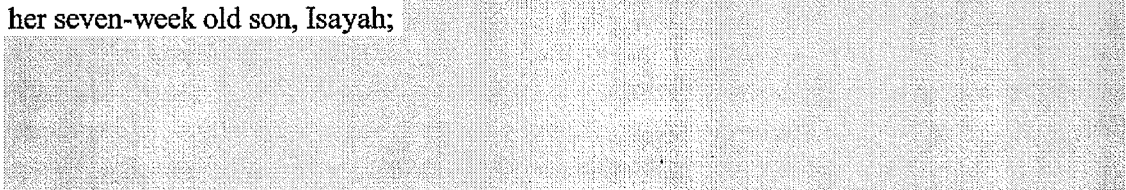
Though the committee found that the practice on the case, up and until Isayah's death, was reasonable per CA policy, RCW, and WAC, there were concerns related to the inexperience of the assigned social worker, unnecessary delay in staffing the case with a child protection team (CPT), and the unavailability of professional chemical dependency providers for case consultation. Further discussion of this case by the committee and findings and recommendations made by the committee are detailed at the end of the report.

Case Overview

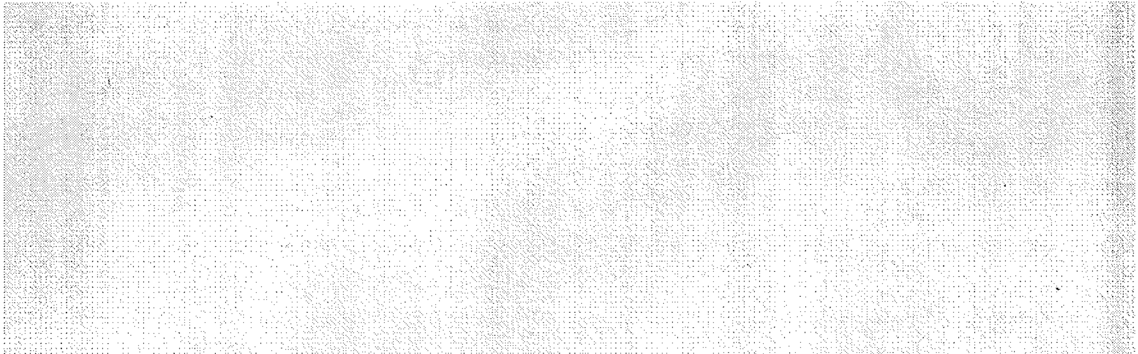


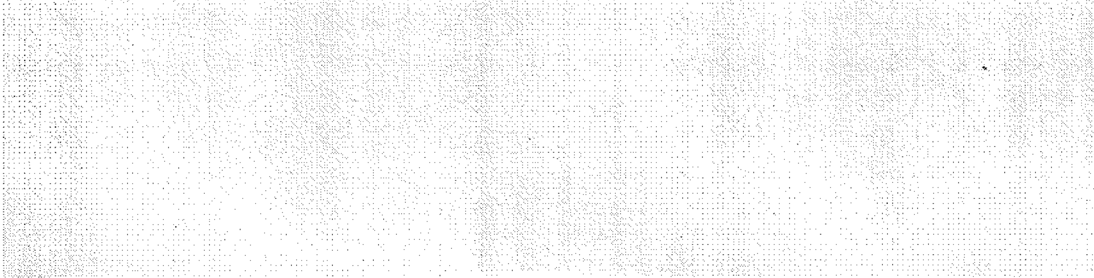


In December 2002, when Ms. Casch was 17 years old, she moved to Washington state with her seven-week old son, Isayah;



Ms. Casch's history with the department began the following year in February 2003 with an anonymous caller reporting that Ms. Casch drove with children in her car while under the influence of alcohol and pain medication. The caller reported that Ms. Casch mixed alcohol and pain medications that were supplied by Mr. F. The caller reported that they had contacted law enforcement several times about Ms. Casch. CA sent the intake report to law enforcement and a CPS case was opened for investigation. The finding was inconclusive and the case was closed in September 2003. No services were offered.





An anonymous caller contacted the department on July 27, 2010 to report that Ms. Casch was driving while intoxicated everyday with her children in the car. The caller reported that Ms. Casch began drinking early in the morning and drank throughout the day until she

passed out. The home was reported to be in poor condition with empty alcohol bottles in view. The children were reported to be "filthy" and that they frequently took care of themselves.

The case was opened for investigation and assigned to a social worker. The social worker made two attempts to visit the home. The door was not answered on the first visit. On the second visit, the worker attempted to interview Isayah. Ms. Casch and the paternal grandfather were present during the interview. and were also at home. The home was cluttered, extremely dirty inside and outside, with clothes and dirty dishes lying around the home. The home was noted to have an unpleasant odor. When interviewed, both parents denied using substances and that Ms. Casch had driven the car with the children while intoxicated. Ms. Casch submitted to a urinalysis test and results were negative. Services were offered to Ms. Casch which she declined. On August 23, 2010, the social worker prepared the transfer/closing summary. The supervisor requested follow-up work prior to closure including obtaining medical records for the children, criminal history checks on the parents, and contact with Isayah's school. The case remained open pending a CPT staffing. In October 2010 the investigation was closed. The allegations of neglect were unfounded based on clean random urinalysis from Ms. Casch, Ms. Casch and Mr. F.s' denial of using alcohol while driving, and Isayah making no report that his mother had driven him while drinking.

In the early morning hours of September 19, 2010, Harborview Medical Center contacted the department to report the accident leading to Isayah's death. Later during the day, Ms. F. called the department to report she had heard about the car accident the night before and that she had been the person to call in the July 2010 report.

Committee Discussion

Practice

Given the facts of the case at the time of the accident, the committee concluded that the CPS investigation and actions of the social worker and supervisor were reasonable per CA policy and the laws and code governing CPS investigations. The committee noted that, despite the history on the case indicating Ms. Casch was a long-term user of drugs and alcohol, there were never any allegations of physical harm to the children. Concerns about the conditions in the home or neglect of the children were not raised until July 2010. Ms. Casch, Mr. F., and Ms. F appeared to have ongoing conflict. Mr. F.'s ex-wife made several of the reports to the department including reports about Ms. Casch's use of alcohol and driving with children in the car.

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The committee noted that the supervisor provided the necessary oversight on the case when the social worker staffed the case for closure. The supervisor stated she and the worker were both concerned about the allegations of Ms. Casch's substance use. Rather than close the case, the supervisor requested that the case be staffed by a CPT and that the parents be invited to the staffing with the goal of engaging the parents in services. The supervisor also directed the social worker to gather additional information that would be considered standard in any investigation. This included:

- Checking with the children's pediatrician to assess their physical health and development.
- Completing a criminal history check.
- Contacting Isayah's school for information about interactions with the family, his attendance and academic status.

During her interview with the committee, the supervisor commented that solution-based strategies of engaging the family were used in practice and that the CPT staffing held some promise of having the family better understand the concerns and possibly agree to services. The office had a two-month backlog of cases to be staffed with the CPT, and this case was put on the waiting list for October 2010. While it may be more convenient to staff a case with the local office team, this delay was of concern to the committee. There is no policy in place requiring that a case be staffed with the local office CPT.

Social Worker Experience

The social worker assigned to the case had four plus months experience working in CPS and had no field experience prior. The worker had completed the required academy training. Despite the consensus that the supervisor acted as an appropriate safety net for the social worker's inexperience, the committee discussed the value of experience and knowledge of practice and how those factors influence the social worker's interaction with the family, their skills of engagement, recognition of risk factors, and assessment of safety. The casework appeared to focus on Ms. Casch as an individual rather than on the family as a whole. Reports of her mental health history did not appear to be considered. Mr. F was never fully assessed for substance abuse or for his participation and condoning of Ms. Casch's use of substances while parenting the children. The paternal grandfather, who lived next door, had frequent contact with the family, provided care for the children, likely had knowledge of the parents' use of substances and their parenting of the children. Conflict between [redacted] and Ms. Casch appear to have provided a distraction from the concerns about Ms. Casch and the impact of her substance abuse on the younger children. This focus on the dynamic of adolescent conflict with caregivers appeared to become the primary focus of the early reports that also alleged Ms. Casch was driving under the influence of substances.

Historically, the CPS program has the highest rate of staff turnover in CA and, likely the highest rate of new or inexperienced workers. The committee had a discussion of how CA