CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

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- K.G-C.

Date of Child's Birth

- June 2024

Date of Fatality

- December 25, 2024

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- March 6, 2025

Committee Members

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- Kelli Robinson, Executive Director, Our Sisters' House
- Amy Boswell, MSW, QA/CQI Area Administrator Region 6, Department of Children, Youth, and Families
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Executive Summary

On March 6, 2025, the Department of Children, Youth, and Families (DCYF) conducted a Child Fatality Review (CFR)[1] to examine DCYF's practice and service delivery to K.G-C. and [redacted] family. The child, K.G-C., will be referenced by [redacted] initials throughout this report.[2]

On December 26, 2024, DCYF was notified that on the previous evening K.G-C. was found cold and unresponsive by [redacted] mother. When she found [redacted] a blanket covered [redacted] face. K.G-C.'s mother called emergency services. At the time of [redacted] death, DCYF had an open case with K.G-C.'s family. DCYF opened a Child Protective Services (CPS) investigation. Allegations of abuse or neglect that meet the legal sufficiency result in a screened-in intake to either CPS or Family Assessment Response (FAR).[3] FAR intakes are an alternative response to CPS investigations. The allegations in FAR intakes are lower risk than those in CPS investigations.

At the time of K.G-C.'s death, the family had an open CPS case due to allegations of domestic violence and parental substance use. K.G-C. lived with [redacted] mother, older sibling, and twin sibling. All three children have the same father but he was not living with the family at the time of K.G-C.'s death.

Prior to K.G-C.'s death, DCYF received nine intakes regarding the family. Of the nine intakes, six met sufficiency for a CPS investigation or FAR assessment.

A CFR Committee was assembled to review DCYF's involvement and service provision to K.G-C. and [redacted] family. The Committee included members with relevant expertise selected from diverse disciplines within DCYF and community partners. Committee members had no prior direct involvement with K.G-C. or [redacted] 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 staff who were assigned to this case in 2023 and 2024.

Case Overview

The information documented in this section is not fully inclusive of all contacts and actions by DCYF staff.

In 2022, DCYF received two different intakes regarding K.G-C.'s mom and older sibling. The allegations did not meet the legal threshold for assignment and were screened out. [redacted]

On August 7, 2023, a third intake was received and screened in for a CPS investigation. This intake was created based on a law enforcement report. K.G-C.'s mother had crashed her vehicle with her 21-month-old [redacted] in the vehicle. Law enforcement found alcohol related items at the scene. The mother was cited but released at the

[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 fatality review (CFR) should not be construed to be a final or comprehensive review of all of the 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 hears only from Agency 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 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.

[2] D.M.'s name is not used in this report because [redacted] name is subject to privacy laws. See RCW 74.13.500.

[3] For information about DCYF intakes, see: https://www.dcyf.wa.gov/policies-and-procedures/2200-intake-process-and-response.

scene. The next day the assigned caseworker tried to reach the mother and left a voice mail message asking for a return call. Then on August 9, another intake was received and assigned. The allegations related to domestic violence. The caseworker went to the location where K.G-C.'s mother and sibling were staying. The mother denied the allegations of domestic violence but confirmed that a no-contact order was in effect and she denied the allegation of driving under the influence. During this intervention DCYF provided concrete goods to help support the family. The caseworker also went to the jail and spoke with the father. The father did not share any concerns for the care of RCW 74.13.515 while in the care of the mother. The caseworker made contact with the maternal and paternal grandmothers. The case then closed the end of September.

On March 4, 2024, another intake was received and screened in for a CPS/FAR assessment. The intake related to domestic violence and a violation of the no-contact order between the mother and father. The caseworker made contact that same day. K.G-C.'s mother denied the allegations, refused the offer of services but asked for concrete goods. Contact was also made with the maternal grandmother who did not have any concerns for RCW 74.13.515 care and safety. Days later the caseworker spoke with the paternal grandmother. The paternal grandmother provided examples of concerning events relating to the parents and child. She also shared that the mother was pregnant and smoking cannabis. The caseworker met with the father. Both parents refused the offer of services and denied the allegations. The case was closed the end of March.

On June RCW 74 2024, DCYF was notified that K.G-C. and RCW 74.13.515 were born. One of the twins was placed in the neonatal intensive care unit due to low birth weight. The mother obtained prenatal care and smoked cannabis throughout her pregnancy. The information did not meet the legal threshold and was screened out.

A month later DCYF received a law enforcement report regarding domestic violence and another violation of the no-contact order between the parents. This resulted in a CPS investigation.

The caseworker met with the mother and three children. The mother admitted to using cannabis but not to the point of intoxication. She admitted to breaking the no-contact order but denied being an aggressor in any violence. The caseworker discussed safe sleep[4] and Period of Purple Crying®[5]. The mother requested concrete goods (which were delivered at a later date).

The caseworker made contact with the paternal grandmother and the children's father who was incarcerated at that time. The father denied having any concerns about the children's well-being and denied that there was any violence between him and the children's mother.

While this investigation was ongoing DCYF received another intake. The mother was arrested for driving under the influence while she had all three children in the vehicle. The children were released to an aunt. The intake screened in for a CPS/FAR assessment but was changed to an investigation due to the family already working with DCYF in a previous investigation.

The caseworker and supervisor gathered information from law enforcement and the courts regarding the incident as well as previous contacts with law enforcement for both of the parents.

[4] For information about DCYF policy related to safe sleep, see: https://dcyf.wa.gov/policies-and-procedures/1135-infant-safety-education-and-intervention.

[5] Period of Purple Crying® for information see: https://dontshake.org/purple-crying.

On October 15, 2024, DCYF received a call reporting that the mother was living in her vehicle outside of a relative's home. She could hear the children screaming and she was concerned about neglect of the children by their mother. This information resulted in another CPS investigation being opened.

When the caseworker met with the mother, the mother admitted to drinking alcohol while driving her children. She said she was starting substance use treatment. K.G-C.'s mother initially denied the allegations of living in her car with the children. The caseworker tried to work with the mother to resolve the housing instability. K.G-C.'s mother was not willing to consider utilizing the paternal grandmother due to conflict between herself and the grandmother. The mother eventually was able to have her mother, the maternal grandmother, take the children in so they were not sleeping in the car for a couple nights. The DCYF caseworker was able to obtain funding for a hotel room after those couple of nights at the grandmother's home.

An after hours caseworker visited the mother and children at the hotel room. The caseworker observed that the twins were lying on one of the two beds in the room. When asked about where the babies would sleep the mother said they would sleep on the bed. The caseworker asked if the mother had access to a portable sleep environment and the mother said it was in her car but she didn't want to get it. The grandmother, who was also present, said she would help to get the portable crib. The caseworker discussed safe sleep again with the mother and grandmother. They also briefly discussed that the mother was going to work with a voluntary in-home service provider through DCYF.

The assigned caseworker also referred the mother for a mental health evaluation. On October 24, the CPS supervisor went to the hotel to see the mother and children. Safe sleep was again addressed because the twins were observed to be propped on a bed with a pillow and their mother confirmed that she was not utilizing the portable cribs. The supervisor insisted on having the mother retrieve the crib and utilize it in the hotel room. The crib appeared broken so the supervisor stated she would issue two new ones for the mother to use.

The mother engaged in a couple sessions with the in-home provider and then ended the service. She told the provider that she also wanted to end her CPS involvement. On October 28, the case transferred to Family Voluntary Services (FVS). The next day the FVS caseworker reached out to the mother. The mother expressed a desire to stop working with DCYF but the FVS caseworker discussed how other services would not be as intense as the previous service.

On October 31, 2024, the case was staffed at a Safe Children Consultation (SCC)[6]. The recommendations from the staffing were to offer financial assistance to maintain a hotel room for the mother and children and to continue to try and engage her in services. DCYF was notified five days later that the mother was banned from the hotel because she was letting people frequent the hotel room, drinking and roaming the property.

On November 6, 2024, the CPS caseworker spoke with the primary medical provider for the children. The clinic said that the oldest child was seen in October but that the twins have never been seen and they had seven

[6] "Safe Child Consultations occur prior to filing a petition with the Juvenile Court to removal a child. A child welfare caseworker first completes a safety assessment. If the assessment indicates an imminent risk of physical harm that cannot be managed through a safety plan, then a Safe Child Consultation is scheduled. These consultations offer support for the caseworker to determine if there are additional measures that can be taken in the safety plan for the family to prevent the need to remove the child from the home." For more information about Safe Child Consultations, see: https://dcyf.wa.gov/practice/practice-improvement/HB-1227.

missed appointments. Another case note indicated that the twins were seen and weighed during a well-child check but it is not clear what provider that was with.

On November 7, DCYF held a Family Team Decision Making meeting (FTDM) due to ongoing concerns about the mother's substance use and the mother wanting to end engagement with the agency. The meeting resulted in the mother agreeing to maintain voluntary services with DCYF.

On November 18, the FVS caseworker saw the mother and children at the hotel room. The babies were observed to be laying on a bed with their older [redacted] The caseworker discussed safe sleep again with the mother. On December 3, another incident of unsafe sleep was observed and the caseworker intervened.

On December 13, the FVS caseworker conducted an unannounced visit to the home, after receiving multiple calls reporting the mother was believed to be overwhelmed, yelling at the children, and ignoring the children. During the unannounced home visit, the caseworker observed multiple other people sleeping in the home, a strong smell of cannabis and that one twin was sleeping on a bed while the other was in a portable crib. Both twins were covered with a blanket. The caseworker identified the unsafe conditions and intervened by once again explaining what safe sleep was and why it was so important. The children's mother said it was cold in their home the heater did not work often and she didn't want to put them in warmer clothes and chose to use a blanket for warmth instead. The older child was showering and the mother asked that they return later to see that child. When the caseworker arrived later that day to meet with the older child, she observed that the twins were again covered with blankets and a strong smell of cannabis. The mother was asked to provide an oral swab for testing for substances. The caseworker once again discussed safe sleep and the necessity to comply each time the children are laid down.

On December 26, 2024, DCYF was notified that K.G-C. died. A CPS investigation was initiated and law enforcement was also investigating.

Committee Discussion

The Committee identified that it was clear that the children's mother did not want to engage in ongoing contact with DCYF. The Committee discussed that the mother was a very young mother and experienced trauma prior to becoming a mother and then violence since having her first child. Those past traumas may have impacted her willingness to engage with a governmental entity such as DCYF. The Committee also appreciated that taking the time to develop relationships can be incredibly time consuming and often DCYF staff have workloads that may inhibit this. However, it may have benefited the family if the DCYF staff, or another community service provider, had been able to take the time to establish a stronger relationship with the mother.

The Committee discussed culturally appropriate services in this community. The current Deputy Regional Administrator (DRA), who was previous the area administrator for the office handling this case, shared that there is a lack of services specifically for African American or Black identifying individuals. The Committee considered that this may have impacted the mother's willingness to engage with service providers in the community. The community also does not have any programs specific for teen mothers which may have also benefited K.G-C.'s mother.

The Committee appreciated hearing from the DRA about the hindsight evaluation related to this case and how practices have changed since K.G-C.'s death. Some of those highlights include more conversations with and more advocating for in-home dependency actions. The DRA discussed that they are working with their assistant attorneys general regarding this specifically because the DCYF staff believe this could be a helpful tool especially in certain circumstances. The DRA also discussed that more discussions have occurred about remaining curious during open cases, engaging relatives throughout a case, and taking the time to really understand historical information pertaining to the family. In this specific case that related to not only the intakes pertaining to K.G-C.'s mother as a mother but also pertaining to her childhood prior to becoming a mother.

There was also discussion about how DCYF could improve and emphasize assessing the child parent relationship as part of all interactions by child welfare staff. Specifically related to this case it would have possibly aided in addressing any post-partum needs of the mother with such a high-needs situation with vulnerable children. One Committee member with expertise in relation to the parent child relationship asked the DRA if further trainings related to that topic would be beneficial. Some trainings had occurred but were disrupted by competing priorities. The DRA agreed that it would be beneficial for DCYF staff.

This family consisted of young parents with housing and income instability. There was ongoing violence between the parents and the mother struggled with substance misuse. The mother was 18-years-old with twin infants and a toddler. She also had conflict within her own family and did not have a positive relationship with the paternal grandmother. The children's mother and father denied the violence a majority of the time and did not engage in any services related to domestic violence. The Committee discussed that DCYF staff would benefit from a statewide program manager specific to this topic. That position has been funded and is in process of hiring.

The Committee was hopeful that progress will be made between the assistant attorneys generals for this area and DCYF staff moving forward with utilizing in-home dependency actions. Staff shared their struggles with moving forward with in-home dependencies and how they felt it may have been helpful in this specific case. The Committee identified that the DCYF staff were clearly concerned about the well-being of the children and they identified and intervened multiple times with unsafe sleep incidents but the mother was not willing to change her parenting choices. The Committee was also curious as to how the newly created role of legal liaisons for DCYF office could help facilitate this discussion.

The Committee also discussed the findings of the fatality investigation and the investigation from October 5, 2024 DUI incident. The Committee asked the staff why they made an unfounded finding in 2024. The staff discuss their awareness and concerns for how bias and racism can play a role in decision making by all persons involved (law enforcement and DCYF staff) and they also stated that because the children were not physically harmed they did not believe it met a founded finding threshold. The Committee appreciated the acknowledgement of racism that may play a part in decision making but believed there was adequate information to determine that the allegations were in fact founded. There was also robust discussion about the finding related to K.G-C.'s death. The discussion included the numerous times that safe sleep was discussed with the mother and interventions occurred by the staff who observed each event. They also discussed that during the investigation of the death, the mother admitted that she had been counseled

numerous times about the need to provide a safe sleeping environment and how she regretted not taking those actions. This discussion only pertained to the DCYF finding not to any criminal charges the mother faced.