Washington State Department of Social & Health Services

CA Children's Administration

Child Fatality Review

K.K.

RCW 74.13.515 **2016**
Date of Child's Birth

March 17, 2017
Date of Death

May 4, 2017
Child Fatality Review Date

Committee Members
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Executive Summary

On May 4, 2017, the Department of Social and Health Services (DSHS) Children's Administration (CA) convened a Child Fatality Review (CFR)[1] to examine the department's practice and service delivery to RCW 74.13.515-old K.K. and RCW 74.1 family. The incident initiating this review occurred on March 17, 2017 when K.K. passed away from medical complications stemming from critical injuries RCW 74.1 suffered on January 17, 2017 at the hands of RCW 74.1 father, Daniel Krempl.[2] A Child Protective Services (CPS) investigation had been active since RCW 74.13.515, 2016 in response to a Risk Only[3] intake regarding the birth of K.K. and RCW 74.1 twin sibling.

The CFR Committee included CA and community professionals with relevant experiences and expertise in child and family advocacy, child abuse and child safety, chemical dependency, and hospital social work. None of the Committee members had any direct involvement with the family.

In advance of the review, each Committee member received a chronology of the family's brief history of CPS involvement. Relevant un-redacted CA case file documents (e.g., intakes, case notes and assessments of safety and risk) were also provided, along with law enforcement reports regarding the criminal investigation of the initial serious injuries to K.K. and RCW 74.1 sibling. Supplemental sources of information (e.g., medical records) and resource materials (e.g., relevant CA policies) were available to the Committee at the time of the CFR.

During the course of the review, the Committee interviewed the CPS worker and her supervisor regarding their involvement with the family. Following review of the case file documents, completion of the interviews and discussion regarding department activities and decisions, the Committee made the findings and recommendations presented at the end of this report.

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[1] Given its limited purpose, a Child Fatality Review should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. The Child Fatality Review Committee's review is generally limited to documents in the possession of or obtained by DSHS or its contracted service providers. The Committee has no subpoena power or authority to compel attendance and generally will only hear from DSHS employees and service providers. It does 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 recommend personnel action against DSHS employees or other individuals.

[2] The full name of the father is used in this report because he is charged in an accusatory instrument with committing a crime related to this incident. Neither the mother nor K.K.'s twin sibling are identified in this report due to privacy laws. *See* RCW 74.13.500

[3] CA may investigate intakes that do not allege an actual incident of Child Abuse or Neglect (CA/N), but have risk factors that place a child at imminent risk of serious harm. [Source: CA Practices and Procedures Guide 2200]

Case Overview

On RCW 74.13.515 2016, CA was notified by a hospital social worker that the mother RCW 13.50.100 at delivery of K.K. and RCW 74.1 twin sibling. K.K. also RCW 13.50.100 . While RCW 13.50.100 was indicated, the initial assessment at the hospital did not suggest the newborns had been RCW 13.50.100 and no hospital/physician hold was initiated.[5] The information provided by the hospital lacked specific allegations of child abuse or neglect as defined in WAC 388-15-009. However, the intake screened in as a CPS Risk Only case due to concerns for RCW 13.50.100 and the fact that the father, Daniel Krempl, had previously been identified as having a history of RCW 13.50.100.

In-person contact was made at the hospital with the mother, the newborns and the maternal grandmother on RCW 74.13.515, 2016. The mother admitted having RCW 13.50.100 and was surprised when the doctor discovered the second baby during delivery as she did not realize she was pregnant with twins. She denied any substance abuse issues, reporting her RCW 13.50.100 . At the time of the initial contact with the mother, the CPS worker reportedly provided various informational packets for later discussion, including materials on infant safe sleep, Plan of Safe Care for Newborns,[6] and various available community resources.

The following day, the assigned CPS worker contacted the mother by phone in an attempt to arrange for a home visit to drop off some purchased baby items for the family, to meet with the twin's father, to discuss a plan for RCW 13.50.100 and to discuss the possibility of engaging the family in Family Voluntary Services

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[4] RCW 13.50.100 [Source: CA Practices and Procedures Guide Appendix A: Definitions]

[5] RCW 26.44.056; See also RCW 26.44.030(8)

[6] RCW 13.50.100 See: The Child Abuse Prevention and Treatment Act section 106(b)(2)(B)(iii)

(FVS).[7] The mother indicated she could not provide the address of her residence because she had just moved and could not remember the address. The worker discussed wanting to do a home visit as soon as the twins were discharged. The worker arranged for the grandmother to pick up the baby items at the local CA office, at which time the grandmother indicated having no concerns for her daughter's ability to parent.

An unsuccessful attempt by the CPS worker to reach the mother occurred on RCW 74.13.515, 2016. Medical records obtained post critical incident show that K.K. and [redacted] sibling were seen by their primary care physician for newborn well-child exams on RCW 74.13.515 and no concerns were noted by the medical provider at that time.

Another unsuccessful attempt by the CPS worker to reach the mother occurred two weeks later. The grandmother was contacted and she agreed to try to contact her daughter about calling the CPS worker. Information obtained post critical incident shows that maternal and paternal relatives had in-person contact with the parents and the children in late December and early January and reported having had no concerns about the care or condition of the babies during the times they had seen them.

On RCW 74.13.515, 2017, CA central intake was contacted by RCW 74.13.515 Children's Hospital regarding RCW 74.13.515-old twins who had been admitted for serious injuries. K.K. was in grave condition with devastating neurologic injuries, multiple fractures (including skull) and other compromising conditions for which risk of mortality was high. Additionally, there appeared to be genital trauma which was concerning for sexual abuse. K.K.'s twin sibling, RCW 13.50.100 [redacted]. The infants had been discovered in their mother's basement apartment by a neighbor after a 911 response regarding their mother, who had died outside of the apartment building. Cause of death regarding K.K.'s mother was later determined to be from a bacterial infection.[8]

Daniel Krempl was subsequently arrested, charged and jailed for suspicion of two counts of first degree child assault. A CPS investigation was founded as to Daniel Krempl for negligent treatment and physical abuse of both children and for sexual abuse of K.K.

[7] FVS is a child welfare services program for families not involved in dependency matters. Parents are offered services designed to reduce the safety threats while the children remain in the care and custody of their parent(s).

[8] In Washington state a death certificate is a public record and a legal statement of the cause and manner of death.

Dependency petitions were filed on both children. While K.K. remained hospitalized, RCW 74.1 sibling was RCW 13.50.100 . On January 26, 2017, Do Not Resuscitate (DNR) and Do Not Intubate (DNI) orders were signed in Pierce County Juvenile Court regarding K.K., largely based on the recommendations of the child's medical team. Eight days later, the presiding judge signed an order to allow for Comfort Care Measures.[9] On February 13, 2017, K.K. was placed in a facility for medically complex and fragile children. One month later, K.K. succumbed to a multitude of complications stemming from the injuries RCW 74.1 suffered in mid-January.

Committee Discussion

As part of the review process, the Committee explored and discussed a number of issues potentially relevant to CA's delivery of services to the family and system responses to the needs of the family. This included issues relating to investigative practices (e.g., information gathering), assessment, worker caseload, worker experience, etc. It should be noted that not all the issues discussed and documented in this Discussion Section resulted in tangible presumptions or conclusions by the Committee. Those issues that were determined by the Committee to have significant consideration for CA practice are noted in the Findings Section of this report.

The Committee briefly discussed the screening decision for the RCW 74.13.515 2016 intake. It was noted that hospitals in Washington are encouraged to report to CPS RCW 13.50.100 , but that such information, in and of itself, is not an allegation of abuse or neglect.[10] CA policy directs intake to screen in reports as Risk Only when there is no child abuse or neglect allegation but the newborn is RCW 13.50.100 and risk factors indicate imminent risk of serious harm.[11] While an argument was made that the risk factors identified at intake were not unequivocally indicative of imminent risk of serious harm, the Committee did not take issue with the intake screening decision.

[9] Comfort Care Measures refers to medical treatment of a dying person where the natural dying process is permitted to occur while assuring maximum comfort. It is in contrast to other levels of intervention such as removal of all support modalities and long-term full care (intensive care support, mechanical life-support, multiple surgeries).

[10] *See* Washington State Department of Health Guidelines for Testing and Reporting Drug Exposed Newborns in Washington State

[11] "Imminent Risk of Serious Harm" as used in Risk Only Intakes and coordination with law enforcement: Imminent - Having the potential to occur at any moment, or there is substantial likelihood that harm will be experienced. Risk of Serious Harm - A high likelihood of a child being abused or experiencing negligent treatment or maltreatment that could result in death, life endangering illness, injury requiring medical attention, and/or substantial risk of injury to the physical, emotional, or cognitive development. [Source: CA Practices and Procedures Guide Appendix A: Definitions]

Committee members discussed the investigative and assessment activities occurring prior to the mid-January critical incident, as reflected in case file documentation and in the recollections of the worker during the Committee interview. The CPS worker appeared to have met or was the in process of meeting basic investigative practice requirements per policy, with the exception of case note entry (timeline) policy violations. While belated case note entries were of some concern, with the exception of one Committee member, these were not viewed as significant oversights in terms of case outcomes and as such were not specifically included in the Findings Section of this report.

The Committee primarily looked at activities involving information gathering and assessment, key components of both the Child Safety Framework[12] and the Structured Decision Making Risk Assessment (SDMRA)[13] tool used by CA. The Committee recognized the worker's initial efforts in RCW 74.13.515 2016 to try to connect with the family as well as the worker's intentions to do more in depth information gathering and have additional discussions with the parents. This included the worker's plan to discuss infant safe sleep[14] and to offer resources available in the community that might benefit the family. However, the information actually gathered by the worker appeared to be very limited.

The Committee noted that, excluding the initial contact shortly after the birth of the twins in RCW 74.13.515 the worker had no further observations of the infants until after the critical incident in mid-January. While it later became known that the infants had been seen by others during that span of time, the worker had essentially no updated information on K.K. and RCW 74. sibling. The worker had just one follow-up conversation with the mother (by phone) and was unable to reach the father despite multiple attempts to contact both parents.

The Committee looked at other sources of available information that were not tapped by the worker. These sources included exploring what options the worker had to locate the address of the family, such as using information from hospital

[12] CA's Child Safety Framework is built on key principles of gathering, assessing, analyzing, and planning for a child's safety through (1) collecting information about the family to assess child safety, (2) identifying and understanding present and impending danger threats, (3) evaluating parent/caregiver protective capacities, (4) determining if a child is safe or unsafe, and (5) taking necessary action to protect an unsafe child.

[13] The SDMRA® is an evidence-based actuarial tool from the Children's Research Center (CRC) implemented by Washington State Children's Administration in October 2007. It is one source of information for CPS workers and supervisors to consider when making the decision to provide ongoing services to families. The tool is a household-based assessment heavily influenced by family history. [Source: Structured Decision Making® Procedures Manual]

[14] Current CA policy requires CA staff to conduct a safe sleep assessment when placing a child in a new placement setting or when completing a CPS intervention involving a child aged birth to one year, even if the child is not identified as an alleged victim.

admission records and inquiring with apartment managers at the street intersection given by the mother. The Committee also looked at possible sources the worker could have pursued to confirm the mother's assertion that she had previously been [redacted] RCW 13.50.100 [redacted]. K.K.'s mother had revealed to the worker that Daniel Krempl had spent time incarcerated in a federal penal facility (unspecified) and was on parole/probation. The Committee discussed what reasonable options the worker had to hasten criminal background checks.[15] Even if additional and/or clarifying information been gathered, the Committee was unable to say how such information would have impacted child safety decisions. However, the Committee felt that a relatively swift gathering of such information could have impacted decisions as to service referrals, such as a Public Health Nurse (PHN), Maternity Support Services,[16] and possibly Birth to Three.[17]

The Committee deliberated on the SDMRA® tool currently used by CA, which is an actuarial instrument based on empirical evidence and primarily provides prescribed, structured guidelines for assessment and practice in child welfare. The Committee discussed the limitations of the SDMRA® which does not allow for clinical judgments, including consensus-derived (non-actuarial derived) risk factors that could be considered in terms of combinations and interactions of risks. Questions arose as to whether a more expansive clinical-based assessment tool would have been more beneficial in this case.[18] While the Committee appeared to be generally supportive of the idea of CA re-evaluating the use of the

[15] CA is authorized to access the National Crime Information Center (NCIC) database for subjects of CPS investigations and other adults related to the investigations. The Purpose Code C check allows the social worker to assess the safety of children in the home and the safety of CA staff conducting the investigation. Purpose Code C checks are based on name and date-of-birth information and are a point in time check. Purpose Code C checks are not required and are completed at the discretion of the investigating social worker. Information from NCIC Purpose Code C checks and summary forms may not be printed out, placed in case files, or shared with parties outside of DSHS. [Source: CA Operations Manual 5518 NCIC Checks for CPS Investigations - Purpose Code C]

[16] Maternity Support Services are preventive health and education services to help improve birth outcomes. Services can begin any time during the pregnancy, delivery or postpartum period.

[17] Birth to Three services are intended to help families build knowledge and skills to meet the developmental and health needs of a child, birth to three years old, with special needs. Most of the infants and toddlers served by Birth to Three Developmental Center qualify for services under the Individuals with Disabilities Education Act (IDEA).

[18] In an effort to improve decision-making in child protective services (CPS), most states have implemented one of two types of risk assessment – either a theoretical-empirical (consensus/ecological) based or an actuarial based model. The Theoretical-Empirically Guided Approach is based on an established set of theoretical and empirically based risk factors and the "clinician" formulates an overall assessment of risk based on observed combinations of risk factors. A key is the interaction of risk factors associated with the child, caregiver, caregiver/child interaction, family factors and factors related to the larger social context within which the family lives. [Child Welfare League of America: *A Comparison of Approaches to Risk Assessment in Child Protection and A Brief Summary of Issues Identified from Research on Assessment in Related Fields*]

SDMRA®, the Committee did not reach consensus about a better screening method and therefore no specific recommendation was included in the Recommendation Section of this report.

At the time of first contact with K.K. and [redacted] family in [redacted] 2016, the assigned CPS worker had a caseload of approximately 15 active investigative assignments.[19] The Committee was made aware that the worker was assigned 12 new intakes in the month of [redacted] At the time of the second intake on this family in [redacted] the worker had 20 total cases assigned. The caseload did not appear dramatically outside the standards for CPS as recommended by national associations or as statistically indicated for Washington state.[20] However, the Committee also considered the limited number of work days available for the worker to cover all the families on her caseload during this period of time. While this span of time equated to 41 calendar days, the Committee was aware that, accounting for non-work days (i.e., weekends, 3-day holidays and several days of worker leave time), the actual amount of available work days was about 20. CA documentation shows casework activities on this case occurred on four of those available days.

The Committee also spent time discussing the worker's length of CPS experience for the worker and the supervisor's length of supervisory experience. The Committee acknowledged the challenges faced by CA to maintain a high level of practice during a time of significant workload, staff turnover and reliance on workers with relatively limited experiences in child protection.[21] While both the worker and supervisor had advanced degrees in social work, the Committee pondered how the limited CPS experience by the worker (1½ years), and the limited supervisory experience by the supervisor (less than 2 years), may have been a barrier to understanding the connections and interactions of risk factors in this case, particularly those risk factors not accounted for within the SDMRA®.

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[19] Caseload and workload are not synonymous. While a worker's caseload generally equates to the number of assigned cases, workload involves the complexity of cases requiring intensive intervention and additional administrative requirements. [Source: U.S. Department of Health & Human Services, Administration for Children & Families, Child Welfare Information Gateway]

[20] For investigative workers in child protective services, the Council on Accreditation recommends that caseloads do not exceed 15 investigations or 15-30 open cases. The Child Welfare League of America (CWLA) recommends a caseload size of 12 intake reports per month per worker. In Washington state, the average caseload size for investigation caseworkers ranged from 16.4 to 19.3 intakes per month in calendar year 2015 [CA/CPS 2016 Supplemental Budget report]

[21] DSHS Strategic Plan Metrics – Children's Administration (April 2014): "It takes an average of two years for an investigator to become proficient. It takes an average of 3 months to hire a new CPS investigator. The high turnover rate also impacts staff that remain. They are burdened with higher caseloads and mentoring new staff."

The Committee briefly discussed current mentoring, training and supervision within CA. This discussion was in the context of looking at whether the worker was given the tools necessary to do the work and the supervisor given the training to provide sufficient supervision. During the interview with the supervisor, the Committee learned of several changes to practice initiated by the local office following the critical incident under review. An FVS position was developed to help deal with the increased number of RCW 13.50.100 infants coming into the system through Risk Only intakes. Routine use of a Plan of Care for newborns who are RCW 13.50.100 was put into practice. Extra emphasis was given to focusing on home visits for infants, preferably prior to release from hospitals. Specific database training was provided so workers could better access and locate missing parents. Training from RCW 13.50.100 and RCW 13.50.100 programs was provided to reinforce practice regarding RCW 13.50.100 by parents. CPS supervisors in the office are now scheduled twice a month with the Area Administrator to address CPS-specific needs.[22] While such training and practice changes were viewed positively, the Committee could only speculate as to what difference these activities would have made in this case had they been initiated prior to the case being opened with CPS.

Findings

With the exception of one member, the Committee found no critical errors in terms of decisions and actions taken by CA, particularly given the fact that the initial investigation was still in progress at the time of the critical incident. Based on the information known at the time, the critical incident did not appear to be predictable. Even had information gathered post critical incident been known earlier, the majority of the Committee concluded that it would likely not have resulted in a decision by CA to legally intervene prior to the critical incident.

The Committee did identify instances where additional or alternative social work activity may have been beneficial to the assessment of the family situation. The majority of the Committee members struggled with assigning particular value to missed practice opportunities in terms of singular or collective significance to the subsequent critical incident and possible prevention of such an event. The Committee collectively viewed the below issues as sufficiently noteworthy in terms of identifying areas where practice could have been better in this case.

[22] Note: Subsequent to this review, the Region 3 Administrator implemented additional supports for new staff that had been in development for about a year. This included New Employee Support Training (NEST) that provides additional one-on-one practice supports to staff (individuals, units, offices) and the development of a new employee desk guide. This desk guide is a quick reference source for resources and tools designed to support practice. A similar source for Region 3 new supervisors is also in development at this time.

- The information actually gathered by the worker prior to the critical incident appeared to be very limited. The worker missed opportunities to more actively probe in terms of seeking and verifying information (particularly as to the father's criminal history) and more aggressive in locating and meeting with the parents at the residence and having follow-up contact with the twins.
- The Committee questioned whether or not the SDMRA® was accurately scored, with one Committee member arguing that it clearly had underestimated risk. The SDMRA® was completed within the 60-day timeline required by CA policy but completed after the critical incident and may have been moderated due to a lack of information in a number of areas utilized by the tool. If the SDMRA® had been done earlier in the investigation and included more corroboration of information, the worker likely would have had a better comprehension of the family service needs and expedited appropriate community referrals such as PHN, Maternity Support Services and/or Birth to Three.

Recommendations

- CA should consider requiring a home visit to be conducted within some short period of time after an accepted intake involving a newborn. The Committee discussed various time periods including three days of the intake, within one day of discharge from a hospital or within a week. This requirement would be separate from current policy requirements for initial face-to-face contact that may occur outside the home (e.g., hospital). This recommendation would require an immediate assessment of the home and infant sleep environment within a specified time frame not currently set in policy.
- The Committee recommends that CA evaluate the potential of using shared planning meetings, such as an FTDM or CPT,[23] on cases involving Plans of Safe Care for newborns. While the Plan of Safe Care form (DSHS 15-491/December 2016) includes a section documenting any referrals to resources such as Public Health Nurse and Maternity Support Services, shared planning around such resources may beneficially expedite and streamline the process.

[23] A Family Team Decision-Making meeting (FTDM) is a facilitated team process, which can include birth/adoptive parents, guardians, extended family members, youth (as appropriate), community members, service providers, child welfare staff and/or caregivers. These meeting are held to make critical decisions regarding the placement of children. A Child Protection Team (CPT) provides confidential, multi-disciplinary consultation and recommendations to the department on cases where a Family Team Decision Making (FTDM) meeting will not or cannot be held, there is a risk of serious or imminent harm to a young child, or when there is dispute as to the appropriateness of an out-of-home placement.

- The Committee recommends that CA explore the possibility of re-initiating the Chemical Dependency Professional (CDP) liaison program, which provided CA field offices with "in-house CDPs" that were available for substance abuse related consultation, informational resources, guidance for client engagement and community resources. The Committee is aware that current state budget constraints may pose a barrier to this recommendation.
- CA should consider expanding current substance abuse training to include information and discussion regarding typical behavior patterns displayed by users of specific types of drugs (e.g., heroin, methamphetamine, heavy marijuana use). This training would provide workers with the potential to better assess the caregiver's situation as it relates to child safety.
- CA is encouraged to continue ongoing evaluation of formal mentoring of new child welfare workers beyond Regional Core Training (RCT).[24] This would include looking to replicate formalized mentoring programs from other disciplines (such as law enforcement) that have sought to increase in-field competency.

[24] Regional Core Training (RCT) is a structured learning program developed for new employees to gain knowledge and skills identified as foundation level competencies. RCT is the initial, intensive, task-oriented training that prepares newly hired Social Service Specialists to assume job responsibilities.