CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

July 2021

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CHILDREN, YOUTH & FAMILIES

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July 2021

Full Report

Child

- K.W-F.

Date of Child's Birth

- [redacted] 2005

Date of Fatality

- November 2020

Child Fatality Review Date

- Feb. 4, 2021

Committee Members

- Mary Moskowitz, JD, Office of the Family and Children's Ombuds, Ombud
- Ashley Mangum, MSW, LICSW, Mary Bridge Children's Hospital and Health Center, Project Manager, Kids' Mental Health
- Brad Graham, Washington State Attorney General's Office, Senior Investigator/Analyst
- Terra Jacobson, Developmental Disabilities Administration, Field Services Administrator
- Yaquelin Rosas, Department of Children, Youth, and Families, Quality Practice Specialist Region 2
- Kelly Boyle, MA, Department of Children, Youth, and Families, Statewide Intake and Safety Program Manager

Facilitator

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

Executive Summary

On Feb. 4, 2021, the Washington State Department of Children, Youth, and Families (DCYF) convened a Child Fatality Review (CFR)[1] to assess DCYF's service delivery to K.W-F. and RCW 7 family.[2] RCW 7 will be referenced by RCW 7 initials throughout this report.

On Nov. 27, 2020, DCYF was notified that the mother took K.W-F. to the hospital. RCW 7 died while at the hospital. The family had an open Child Protective Services (CPS) investigation, which had been initiated on Nov. 20, 2020, and alleged severe malnourishment and food deprivation. When K.W-F.'s death was reported to DCYF, a new intake was created and assigned for an investigation. That investigation remains open and is waiting for a final determination of the cause of death from the medical examiner's office.

However, based on the condition K.W-F. was in, and an evaluation of RCW 7 two younger RCW 74.13.515 law enforcement placed the surviving siblings in protective custody. DCYF RCW 13.50.100, and the case remains open with DCYF.

The CFR Committee (Committee) included members with relevant expertise selected from diverse disciplines within the community. Committee members had not had any involvement or contact with K.W-F. or RCW 7 family. The Committee received relevant documents, including intakes, case notes, and other DCYF documents maintained in DCYF's electronic computer system.

The Committee interviewed the area administrator and deputy area administrator for central intake, the after-hours (AH) caseworker, AH supervisor, and AH area administrator. The Committee also interviewed the daytime CPS caseworker, the caseworker's supervisor, and the area administrator.

Case Overview

On April 21, 2017, DCYF received an intake alleging that a teenage child in the home was disciplined for lying by getting a "swat" or "loss of dinner." The child stated RCW 74. mother hit RCW 74. with whatever was available but did not provide examples. The caller did not observe any injuries on the child. The caller stated that when the child lost dinner, it was for no more than one day at a time. The intake referenced that the "RCW 74.13." received the same discipline. This intake was screened out.

On Oct. 17, 2017, DCYF received another intake from the same caller. The intake stated that the aunt, who was the adoptive mother, and her husband lived with their four adoptive children, ages 10, 11, 12, and 16. The caller had met with the 16-year-old the week prior. The child reported that RCW 74. and RCW 74.13.515 were punished by having dinner taken away one night. A child had taken extra grapes and a child had hidden some granola bars in their room. The mother was upset, and because no one admitted to the allegations, they all had dinner taken away. The children said this was the discipline in their home. The child RCW 74.13.520 . RCW 74.13.520 . The caller

[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 child fatality review (CFR) should not be construed to be a final or comprehensive review of all of 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 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 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]No one has been criminally charged related to K.W-F.'s death therefore no one is named in this report.

reported RCW 74.13.520, and that the mother had a lot of restrictions around food in their home. This intake was screened out because it did not meet the definition of neglect in statute, and there was no indication that the children's basic needs were not being met.

On Nov. 20, 2020, DCYF received an intake stating concerns for K.W-F. and RCW 74 two RCW 74.13.515 The caller reported the RCW 74.13 were adopted by their maternal aunt and uncle about 10 years ago in RCW 74.13.515 The family moved to Washington State three to four years ago. The caller stated the mother had been withholding food for years. The RCW 74.13 were stealing food when they could and hid the remains in drawers. The primary refrigerator and freezer were in the garage of the home, and the mother locked the door to the garage. The RCW 74.13 would eat expired food items from a smaller refrigerator in the kitchen, and when they did eat, they appeared "ravenous."

The caller reported that K.W-F. was RCW 74.13.520, possibly on the RCW 74.13.520, and had RCW 74.13.520. She described RCW 74 as a "walking skeleton" and stated that RCW had fallen down because of malnourishment. The mother also removed the doorknob from the inside of the RCW 74.13.515' bedroom so they could not leave their room on their own. The father was described as "scared" of the mother and did not help the RCW 74.13.51

The caller also shared information that she wanted to remain confidential. She said that RCW 74 and RCW 74.13.515 were raised in a home where food was not readily available and that RCW 74.13.515 has been in chemical dependency recovery for many years. RCW 74.13.515 offered to take the RCW 74.13 for a weekend, but the mother did not allow it. This intake screened in for a 24-hour CPS investigation. This intake was received on a Friday evening and was assigned to an AH CPS caseworker who made contact the next day.

On Saturday, Nov. 21, an AH caseworker contacted the caller regarding the intake. The caller reported RCW 74 lived in the home and provided care for K.W-F. The AH caseworker went to the family home. The parents were not home, and the adult cousin/care provider asked her to wait outside while he called the parents back to the home. When the parents arrived, the caseworker made contact. The father told the caseworker he was told to "stay out of it." The mother and caseworker spoke outside before the caseworker was allowed to enter the home and meet with the RCW 74.13 individually. The mother stated that K.W-F. has RCW 74.13.520 syndrome, and there were many issues related to that syndrome. According to the National Institute of Health, "RCW 74.13.520." The mother stated K.W-F. was RCW 74.13.520, RCW 74.13.520, and had been diagnosed with RCW 74.13.520. She also stated RCW had issues with eating and RCW 74.13.520. They had tried a variety of ways to help RCW 74 consume RCW food and were trying to get RCW 74 protein through eggs and shakes. RCW took RCW 74.13.520[3] due to issues with RCW 74.13 520. The mother provided information about medical care and that they were attending school remotely. The mother stated she too was a social worker and worked with people with housing instability and who suffer from substance use issues in RCW 74.13 515, RCW 74.13.515.

The caseworker met with K.W-F.'s two younger RCW 74.13.515 individually. The first RCW 74.13.515 did not make any disclosures and did not appear to have any injuries on RCW exposed skin. The caseworker documented that RCW was very small for RCW age and seemed underweight.

[3]According to WebMD, RCW 74.13.520." See: **https://www.webmd.com/** RCW 74.13.520

The caseworker met with the other RCW 74.13.515 next. RCW 7 made disclosures about the other RCW 74.13.515 having injuries related to being spanked with objects on RCW 7 bare skin. After a paddle broke during an incident, the mother started using an extension cord. This cord was used on bare skin and caused broken skin that scabbed over. RCW 7 then shared that about a month prior, the mother and father started using a cane. The two other RCW 74.13 had been hit with the cane. K.W-F. was hit on Nov. 21, 2020, for RCW 74.13.520.

RCW 7 also shared that they were locked in their bedrooms because they used to steal things. Even though they stopped stealing, they continued to be locked in their bedroom each night. The caseworker observed the bedroom door handle had a lock on the outside. This child was very skinny but also very tall. RCW 7 did not have any observable injuries on RCW 7 exposed skin.

The caseworker encouraged the mother to look up the laws regarding acceptable discipline and said spanking with an object was not advised. She then left the home and documented that there was no present danger.

The next two case notes were entered on Tuesday, Nov. 24, by the daytime assigned CPS caseworker. He noted that he called the family home and left two messages requesting a call back to conduct a follow-up from the initial contact.

On Nov. 27, 2020, DCYF was notified by hospital staff that K.W-F. had died. RCW 7 mother drove RCW 74.1 to the emergency department. RCW 7 was not responsive. When RCW 7 arrived at the hospital, RCW 7 had a pulse, weighed 70 pounds, and was reported by the caller to be RCW 74.13.520, RCW 74.13.520, RCW 74.13.520, and RCW 74.1 - RCW 74.13.520. The mother reported to the caller that K.W-F. was RCW 74.13.520 RCW 7 also had scarring on RCW 7 neck that was light pink and white. The scarring was below the chin to the chest and in various stages of healing. The mother reported that due to RCW 7 "disorder," RCW 7 would "gouge RCW 7 throat RCW 74.1 self and make RCW 74.1 self regurgitate." This intake was screened in for a 24-hour CPS investigation.

During the investigation, law enforcement placed K.W-F.'s RCW 74.13 515 in protective custody. RCW 13.50.100 , and the case remains open for investigation.

Committee Discussion

The Committee discussed multiple aspects involving AH. Of concern was the span of supervision within AH. The discussion regarding a large span of supervision and the number of staff supervised by a supervisor raised concerns that clinical supervision may be diminished. Each region within DCYF (there are six regions) has its own system for AH responses. AH responds to cases that require immediate response or a response within a timeframe that daytime staff could not respond within. AH staff also handle placement requests after 5 p.m. before 8 a.m., and on weekends. These duties are often fluid in frequency. Therefore, staffing can be difficult. The region where this case occurred has 11 counties. Within those 11 counties, there are 14 field offices and nine area administrators covering the 14 field offices. In this region, there is one AH area administrator with two full-time AH supervisors and two other supervisors who have other duties but are also on call and work sporadically as needed for AH. There are five full-time staff under the supervisors, and there are 24 on-call staff for AH.

Specific discussion regarding this case included a medical assessment for K.W-F., which is discussed further later in this report. AH staff do not have access to the DCYF MedCons. MedCons are contracted medical consultants who specialize in identifying illness and injury caused by child abuse and neglect. They are not available to any DCYF staff for emergent needs in the field. The Committee also discussed that AH lack the comradery of being in a field office, which comes with the ability to staff cases with multiple peers or

supervisors. They are instead on their own in the field with telephonic access to their supervisor. The Committee discussed that this difference may leave AH staff feeling less supported.

The AH supervisor and caseworker identified that they were concerned about K.W-F.'s wellbeing. They considered directing the family to the emergency department, but due to COVID-19 concerns (contracting the virus and the mother having a recent surgery), they decided not to advise this. They discussed how to approach the family, contingency plans if the parents did not allow contact, and how to proceed after the face-to-face contact was completed. However, the Committee would have appreciated those conversations being captured in case notes. The Committee understood that not all conversations could be accounted for in case notes, but they believed that significant discussions about clinical direction should be documented. This was tempered by how busy the AH caseworker was with referrals that evening and with a large span of supervision for the AH supervisor. The Committee acknowledged that it would be challenging to document actions and discussions completely when faced with those issues.

Based on the case notes and interviews of staff, the Committee believed there was a focused emphasis regarding physical abuse. The Committee appreciated that the daytime supervisor expressed her concern regarding the malnutrition and the nuanced challenges that type of case can have. She provided direction to the daytime CPS caseworker and discussed a long-term plan on how to investigate the case. That discussion and planning came from experience with another malnourishment case she had worked in the past. However, it was also discussed that cases like this one are infrequent, and there are challenging nuances with malnutrition and food deprivation cases. The Committee discussed that infrequency of certain types of cases could lead to a caseworker or supervisor forgetting the specific nuances. This can be even more challenging when the case begins with an AH caseworker. Case transfers are oftentimes where details or concerns can be missed without good communication between the sender and receiver. This was addressed further in the recommendation made by the Committee. The nuanced nature of these types of cases was also addressed by the recommendation made by the Committee.

There were some good questions raised by the AH worker, but the follow-up and curiosity about the answers and details were not in case notes and not discussed by the caseworker during the discussion with the review committee. The mother's words were taken as truth, but verification was not immediately sought by AH or daytime staff. A collateral visit to the pediatrician's office and school (during business hours) would have been helpful to verify attendance and regular care. The AH caseworker discussed that looking back, she wished she had asked to see the medication prescribed to the family members and photograph the bottles. This would have been very helpful to utilize as part of the assessment of care in conjunction with the child's disabilities and health status.

The Committee also discussed that oftentimes, there is a lack of urgency when a case is initially investigated by AH. They discussed the idea that the urgency of follow-up contact is lessened when a caseworker has already completed the initial face-to-face contact for a child. The Committee was not faulting anyone in discussing this but merely acknowledged that it happens across the state. The Committee discussed that the daytime CPS caseworker was considering this when he received the case. This case came in on a weekend before the shortened Thanksgiving holiday week. There were three business days that week, and multiple staff had taken leave. This CPS caseworker was assigned three cases during the holiday week and was handling a difficult case that included court work from the previous week. The CPS caseworker discussed that he knew the AH caseworker and trusted her work. While the Committee appreciated that confidence, they also discussed that that reliance could lead to a lack of critical thinking.

The Committee also discussed concerns for how information was shared by the AH staff with the daytime staff who completed child safety assessments. Specifically, the Committee would like to have seen the concern from AH expressed to the daytime staff in the email updates provided by AH supervisors to daytime supervisors. This was discussed as a possible contributing factor to the Committee's interpretation of a lack of urgency.

There was discussion about how there may have been a bias regarding the RCW 74.13.[redacted]' ages. Often, people believe that older children and youth are less vulnerable. While that can be true in some aspects, circumstances such as communication challenges or disabilities can make them just as vulnerable as an infant. This was not a large discussion piece but was discussed as a potential impact in this case.

The Committee discussed their perception that physical abuse was the main focus by the AH caseworker. They also discussed that such allegations could be even more difficult to assess given K.W-F.'s communication and intellectual challenges. DCYF was told that K.W-F. was RCW 74.13.520, had challenging medical issues, and had been hit with a cane by a parent that same day. The Committee believed that this information warranted a more in-depth conversation with the mother, father, and in-home care provider about this maltreatment, as well as consideration that law enforcement should have been contacted that same evening.

The majority of the Committee agreed with the decision to screen out the October 2017 intake based on intake screening criteria from 2017. They appreciated hearing from the Central Intake (CI) area administrator and deputy area administrator about their efforts to help educate the CI staff regarding abuse and neglect. They shared their efforts not only to support education by providing trainings, but also their work to more closely examine documentation and their work with staff on curiosity in gathering more details regarding each intake. They have requested and received regular Safety Boot Camp trainings for their staff. Safety Boot Camp is a multi-day training provided to staff where they learn about differing types of abuse, how to investigate them, consultation, and collaboration. The CI area administrators have also regularly shared lessons learned from reviews with their staff as they pertain to intakes. They have provided their own "lessons learned" training as well. They discussed with the Committee that screening criteria has changed since 2017, and this intake would likely have screened-in, if received in 2021.

Findings

After discussing the case and taking into consideration the very short timeframe, this case was open before K.W-F. passed away (six calendar days), the Committee identified one finding where they believed a different action could have been taken.

The intake was received on Nov. 20, 2020, and the Committee believed that K.W-F. should have been seen by a medical professional no later than Monday, Nov. 23. The Committee understood concerns expressed by the AH staff regarding COVID-19, but they also asserted that malnutrition was difficult to evaluate and was even more difficult given the inability of the AH caseworker to communicate with the victim. The Committee discussed that the father could have taken K.W-F. to a doctor to possibly diminish COVID-19 exposure to the mother. According to the AH caseworker, K.W-F. looked very thin and had reportedly fallen because RCW 7[redacted] was so weak from malnutrition. Those allegations were the same as what had been reported in 2017. The AH worker stated she did not see RCW 74.1[redacted] struggle with breathing, RCW 7[redacted] was awake, sitting up, and did not respond to RCW 7[redacted] name – all good details shared with the Committee. However, they still believed a medical evaluation was necessary. The Committee discussed that malnutrition can impact many organs within the body and those impacts cannot often be observed. Malnutrition can also impact the body's ability to fight off other ailments. Due to

RCW 7 inability to communicate, RCW 7 was RCW 74.13 and RCW 74.13.520 the caseworkers could not ask RCW 74.1 questions. An alternative option to a trip to the emergency department or a doctor's office would be requesting an onsite medical evaluation. This was brought up as a suggestion by the Committee member from the Developmental Disabilities Administration. She shared that medics can arrive to check vitals and assess for imminent medical needs.

Recommendations

The Committee recommended that DCYF create a field guide for staff regarding malnutrition. While this topic is discussed at DCYF Safety Boot Camp trainings, the Committee discussed that infrequent occurrences of these cases can lead to a loss of learned information and that staff would benefit from a guide that could be accessed online, and therefore be available to all staff regardless of the time of day or whether they are working in the field. The guide should be somewhat short and discuss what to look for (i.e., observe the chest or spine area, look at nails, hair, etc.), questions to ask (i.e., food restrictions, details of all food and drink consumed within the last 24 hours, etc.), and briefly discuss intersectionality with disabilities, food deprivation as discipline, as well as next steps (immediate medical assessment, law enforcement, etc.).