CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

February 2019

Washington State Department of
CHILDREN, YOUTH & FAMILIES

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The Department of Children, Youth, and Families (DCYF) does not discriminate and provides equal access to its programs and services for all persons without regard to race, color, gender, religion, creed, marital status, national origin, sexual orientation, age, veteran's status, or the presence of any physical, sensory, or mental disability.

February 2019

Full Report

Child

- P.Y.
- L.Y.

Date of Child's Birth

- 74.13.515 2015
- 74.13.515 2016

Date of Fatality

- June 27, 2018 (estimated)

Child Fatality Review Date

- Feb. 6, 2019

Committee Members

- Brad Graham, Senior Investigator/Analyst, Criminal Justice Division Office of the Attorney General (Seattle)
- Jake Fawcett, DV Fatality Review/Public Policy, Washington State Coalition Against Domestic Violence (WSCADV)
- Patrick Dowd, JD, Director, Office of the Family and Children's Ombuds
- Lonna Bowers, Guardian ad Litem (GAL), Kitsap County Juvenile & Family Court Services
- Tarassa Froberg, Child and Family Welfare Services and Family Voluntary Services Program Manager, Department of Children, Youth, and Families

Facilitator

- Bob Palmer, Critical Incident Case Review Specialist, Department of Children, Youth, and Families

Executive Summary

On Feb. 6, 2019, the Department of Children, Youth, and Families (DCYF or Department) convened a Child Fatality Review (CFR)[1] to examine the Department's practice and service delivery to P.Y., L.Y. and their family. This review originated from an apparent familicide.[2] On June 27, 2018, a DCYF Child and Family Welfare Services (CFWS) worker became concerned when she was unable to contact the children's parents about a scheduled home visit. The CFWS worker asked law enforcement authorities to conduct a child welfare check at the family apartment. Law enforcement made repeated efforts to locate the family. When found, law enforcement discovered that all four family members were deceased. The time of death is estimated at one week before discovery of the bodies. With regard to the mother and children, the 74.13.515 County Medical Examiner determined the cause of death was blunt force trauma to the head. The authorities did not initially publically disclose the father's cause and manner of death. The authorities believe the father killed both children, his wife, and himself.[3]

The CFR Committee (Committee) includes a DCYF CFWS program manager, a representative from the Office of Family and Children's Ombuds, a criminal justice investigator/analyst, a domestic violence (DV) expert with experience in DV related fatality reviews and a Guardian ad Litem (GAL) with prior experience in public child welfare social work. None of the Committee members had any previous direct knowledge of or involvement with the family.

At the beginning of the review, each Committee member received un-redacted DCYF documents (e.g., intakes, assessments and case notes) and a chronology summarizing the public child welfare involvement with the family. Committee members also received copies of the following Dependency Court documents: the GAL report to the court and a verbatim court hearing transcript. The hearing transcript is the transcript of the hearing pertaining to the judge's decision to order the return of the children to the care of their parents. This hearing occurred approximately 2 months before the deaths of the children and their parents. Supplemental information sources were also available to the Committee, including the following: mental health assessments and case management information, various community and Department-contracted service provider reports, 74.13.515 County Sheriff's Department records and court documents from 74.13.515 describing prior DV incidents.

The CFWS supervisor provided additional information during the Committee's in-person interview process. The assigned CFWS worker was not available for an interview and the previous CFWS worker was on maternity leave. The Committee made findings and recommendations after the case documents

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[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) or child near fatality review (CNFR) should not be construed to be a final or comprehensive review of all circumstances surrounding the death or 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 or CNFR 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 respons bility to investigate or review some or all the circumstances of a child's fatal injury or near fatality. Nor is it the function or purpose of a CFR or CNFR 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." RCW 74.13.640(4)(d).

[2] **Familicide** is defined as one family member who murders other members of their family, commonly taking the lives of all. It is most often used to describe cases where a parent, usually the father, kills his wife and children and then himself.

[3] There are no known criminal charges filed relating to the incident. Although the names of the family members have been released to the public, none are identified by name in this report. The names of the children are subject to privacy laws. See RCW 74.13.500.

review, consideration of interview responses by the DCYF supervisor and discussion about Department activities and decisions. The Committee findings and recommendations are included at the end of this report.

Case Overview

On Sept. 11, 2017, P.Y., L.Y. and their family were first brought to the Department's attention when a family relative contacted the Department seeking help to care for P.Y. and L.Y. At the time, the children's father was in jail due to criminal charges related to domestic violence and resisting arrest. The mother was in custody for an outstanding 74.13.515 bench warrant. The relative provided second-hand information to the Department indicating the father recently slapped 1-year old L.Y. in the head. Local law enforcement responded to the abuse allegations but did not take any further action. On Sept. 13, 2017, Child Protective Services (CPS) initiated a physical abuse and negligent treatment/maltreatment investigation. CPS issued an unfounded finding after the investigation was completed.[4]

On Sept. 14, 2017, the Department filed dependency petitions on behalf of both children. The petitions alleged the father was unavailable to care for the children because he was in jail and there was a No Contact Order prohibiting him from having contact with the children. The petition also alleged the mother was unavailable because she was extradited to 74.13.515 At the shelter care hearing, the children were placed in relative care.

In early November 2017, the mother returned to Washington State after a 74.13.515 court revoked the bench warrant. Also in early November and with regard to the father, the 74.13.515 County Juvenile Court entered a default order and dependency order. The dependency order required the father to complete a chemical dependency assessment, a domestic violence perpetrator evaluation and a psychological assessment with a parenting assessment component. The father's attorney requested his client be provided a neuropsychological evaluation due to possible previous 74.13.520.[5] On Dec. 12, 2017, the mother agreed that P.Y. and L.Y. were both dependent. Dependency orders involving the mother and children were entered on the same date. The court ordered the mother to participate in a parenting assessment, a parenting program such as Promoting First Relationships[6] and a chemical dependency assessment (pending any positive urine analysis results).

On Feb. 26, 2018, the Department filed a motion to change the children's placement from relative placement to licensed foster care due to disruption with the relative placement. The motion and supporting documents described the Department's concerns about the parents' ongoing parental deficiencies that were preventing, at that time, any consideration of reunification. On March 1, 2018, the court granted the motion to change placement.

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[4] The Department issues a "founded" or "unfounded" finding after the Department completes its abuse or neglect investigation. The preponderance of evidence standard applies to the Department's founded or unfounded determination. *Unfounded* means the "determination following an investigation [by CPS] that available information indicates that, more likely than not, child abuse or neglect did not occur, or that there is insufficient evidence for the Department to determine whether the alleged child abuse did or did not occur." RCW 26.44.020(28). **Founded** means the "determination following an investigation [by CPS] that based on available information, it is more l kely than not that child abuse or neglect did occur." RCW 26.44.020(13).

[5] A neuropsychological evaluation is a testing method through which a neuropsychologist can acquire data about a person's cognitive, motor, behavioral, linguistic, and executive functioning.

[6] *Promoting First Relationships® (PFR)* is a prevention curriculum program dedicated to promoting children's social-emotional development through responsive, nurturing caregiver-child relationships. Professionals who work with caregivers and young children often see the need to support and guide caregivers so the caregivers can build nurturing and responsive relationships with children. As PFR is a positive, strengths-based model, caregivers are open to the intervention and gain competence, and thus investment, in their caregiving.

On April 17, 2018, the father's attorney filed a motion to change placement. The father's motion raised concerns the new foster placement was failing to provide proper care to the children. The father's motion also asked that the parents be allowed to have weekend overnight visitation. On April 18, 2018, the children's GAL filed a declaration in support of the children being returned home. In the alternative, the GAL recommended that unsupervised weekend visitation should begin. The Department filed a declaration opposing any transition to parental care based on the parents' failure to complete their court-ordered services (e.g., DV assessments, parenting programs). On April 19, 2018, the court denied hearing the motion to transition the children to parental care.

A Family Team Decision Making (FTDM) meeting occurred on May 1, 2018. Meeting participants included the parents and their attorneys, the children's GAL, the foster parent and Department staff. At the conclusion of the FTDM meeting, the team made a transition to reunification recommendation.

At the May 3, 2018, Permanency Planning Review Hearing, the Department recommended the court find the mother in compliance and making progress. The Department reported the father's neuropsychological evaluation was complete, subject to completion of an 74.13.520 that had yet to be arranged due to 74.13.520. The Department also reported the father had not been consistent with urine analysis testing requests, did not complete a chemical dependency evaluation and did not complete the court-ordered domestic violence perpetrator evaluation. Because of his partial compliance with court-ordered services, the Department requested the court reserve a finding of progress on the father. After hearing the parties' arguments, the court ordered that on May 5, 2018, the children begin a trial return home.

During the initial month of the trial return home, the Department conducted two Health and Safety Visits. The first visit was at the family residence and the second visit at the children's child care. Observations by the CFWS worker and providers reported the parents and children doing well. The Department continued to monitor services, including the following: parenting, in-home Family Preservation Services (FPS), the father's individual counseling and occasional UA testing. The CFWS worker continued to make efforts to seek referrals for the father for a DV perpetrator assessment and chemical dependency services.

On June 27, 2018, a CFWS worker became concerned when she was unable to contact the mother before a scheduled Health and Safety Visit. The worker shared her concerns with her supervisor and the GAL. The GAL reported she also had a home visit scheduled for June 27. The Department learned from the FPS provider that she saw the family a week prior to June 27 but was unsuccessful in her efforts to meet with the family earlier in the day. Based on all of this information the CFWS worker called law enforcement to request a welfare check. At approximately 5:00 p.m. law enforcement reported they were unable to contact the family at the apartment. A relative went to the family apartment but no one answered. At approximately 9:00 p.m. law enforcement told the CFWS worker that a criminal investigation had been initiated at the family residence. Law enforcement did not provide any other details at that time.

On June 28, 2018, DCYF learned the police found the deceased bodies of all four family members. Law enforcement authorities believe the father killed the children and mother and himself, about one week prior to June 28.

Committee Discussion

The CFR Committee initially looked at the circumstances that led to the dependency matter and the September 2017 decision to place the children in out-of-home placement. Those discussions did not result in any significant insights. The remaining discussions and deliberations focused on the reunification decision. There were three separate components to the Committee's reunification discussions: the reunification process, the compliance with court-ordered services and third, the procedures occurring at the Permanency Planning Hearing Review that led to the court's decision to order reunification.

For purposes of the first component, the Committee reviewed the case evolution from the first review hearing in January 2018 in which reunification was clearly not a consideration, to the Department eventually supporting reunification during the May 1, 2018 FTDM meeting. The Committee understands why case decisions change over time. With this in mind, however, the Committee struggled to understand the basis for which the CFWS worker supported reunification at the May 1, 2018 FTDM meeting. Twelve days earlier on April 19, 2018, at the change of placement hearing, the department opposed the parents' request to allow the children to transition to parental care based on the parents' failure to complete their court-ordered services. One plausible explanation for DCYF's May 1 recommendation may be that based on the facts presented at the May 3, 2018 permanency planning hearing, the mother was in compliance and making progress; and the father was in partial compliance. Another possible explanation may be that based on interview responses from the CFWS supervisor during the CFR, the Committee explored whether a confluence of system and individual biases may have contributed to a premature agreement to support transition and reunification efforts. Described another way, a function of "Groupthink".[7]

For instance, there was formidable pressure from the parents' attorneys who argued that due to incidents in disruption in out-of-home placements, the children would be better off in their parents' care. Similarly, based on GAL correspondence with the CFWS worker and a filed court declaration, the GAL strongly argued that frequent placement changes are severely traumatic to children and needed to be immediately addressed. There also appeared to be a worker bias in favor of early reunification, versus risking the parents' possible loss of housing resources if the children continued to remain in out-of-home placement. The Committee also considered the possibility that some DCYF workers believe Department legal representatives in 74.13.515 County Dependency Court tend to lean toward arguing for an agreement rather than risk an adverse court decision. This may result in worker staff capitulation. The Committee considered whether this impacted the decision to return home at the May 3 court hearing and discussed this with the assigned social worker and supervisor. The social worker and supervisor informed the Committee that this was not a factor in the decision to propose a trial return home.

[7] Groupthink is the psychological phenomenon that occurs within a group of people in which the desire for harmony or conformity in the group results in an irrational or dysfunctional decision-making outcome. Group members try to minimize conflict and reach a consensus decision without critical evaluation of alternative viewpoints by actively suppressing dissenting viewpoints, and by isolating themselves from outside influences

However, they agreed with the Committee's supposition that the appeal for compromise has been an issue in other dependency cases.

For purposes of the second component, the Committee discussion focused on compliance with the court-ordered services listed in the dependency orders, most notably, the case services ordered for the father in November 2017 and the case services ordered for the mother in December 2017. From January through March 2018, the parents demonstrated some efforts to engage in court-ordered services. However, such efforts were insufficient to remedy the parents' significant parental deficiencies or meet full compliance with the court-ordered services. For example, the father completed an initial mental health diagnostic evaluation that included the following diagnoses: 74.13.520 – 74.13.520 During the January 2018 to March 2018 timeframe, the father was only in the initial stages of the mental health management services. During the May 3, 2018 Permanency Planning Hearing the CFWS worker clearly described concerns about the father's failure to consistently submit to 74.13.520 urine analysis testing, complete a chemical dependency evaluation and complete a domestic violence perpetrator assessment. The CFWS worker also reported the father's neuropsychological evaluation was incomplete because he failed to submit to an 74.13.520 At the time of the Permanency Planning Hearing, there was uncertainty about the father's mental health status and his current mental health medications.

The Committee also discussed the Department's May 3, 2018 permanency planning recommendations. At that time, the Department told the court the mother complied with the court's order and was making progress. The mother appeared to have completed a CD evaluation, participated in counseling, was engaged in a variety of parenting education and skills classes and was submitting to urine analysis testing. However, the documents also show the mother frequently failed to appear for such testing. Documents also indicated some minor concerns about the mother's possible minimalizing behavior toward her DV relationship with her husband. The Department's permanency planning hearing documents also suggest the mother could benefit from strengthening her general child safety skills. With regard to the father, the Department recommended that he be found in compliance with court services but reserved judgment on his progress with services. However, the court reserved judgment on the father's progress. The court adopted the recommendation for trial return home. The Committee is concerned the reunification recommendation was based on an uncertain favorable assessment that concluded the parents were in compliance with court-ordered services.

For purposes of the third component, the Committee's discussion focused on the May 3, 2018 Permanency Planning Hearing. The Committee considered the arguments and positions offered at the hearing by reviewing the original transcript (Verbatim Report of Proceedings). This included arguments by the parents' attorneys, the GAL's testimony and the recommendations of the CFWS worker and supervisor. All parties gave testimony that the parents had made significant improvements and were ready to begin transition and reunification. Following all hearing arguments, the presiding judge ordered the return of the children to their parents effective May 5, 2018.

Findings

The Committee did not reach consensus as to any definitive catastrophic errors or substantive policy violations by DCYF that directly contributed to the children's deaths. Similarly, the Committee did not

reach consensus as to definitive system improvements that would prevent a significant likelihood of a similar future incident (i.e., root cause analysis). For purposes of this CFR, a part of the challenge involved the lack of any information about the specific circumstances leading to the deaths. This lack of information caused Committee members to speculate what the assumed facts are and what did or did not happen. It is unknown if a major mental illness episode, a direct DV incident or some other situation triggered the event. For those reasons, it is difficult to know with certainty whether the events that caused the children's deaths were predictable.

The Committee did agree that the following aspects of the case raised practice-related concerns.

- The Committee believes the CFWS staff assigned to the dependency matter did not adequately understand the history, nature, frequency and extent of the parents' DV (intimate partner violence) issues. The Committee found workers did not have a reasonably sufficient working knowledge of DV policy and practice guidelines. Instead, the workers appeared to have only a peripheral understanding of DV dynamics. Although the intimate partner violence history may not have been extreme in terms of a history of physical violence or weapons, there was no effort to assess lethality as recommended by the Department's DV policy and published practice guidelines.
- With regard to the May 3, 2019 Permanency Planning Review Hearing, the Committee believes there were significant reasons why the Department should have argued that the father failed to adequately complete court-ordered services sufficient for the Department to support reunification. The Committee found multiple uncertainties related to incomplete efforts to improve mental health issues, the status of 74.13.520 use, the lack of a thorough chemical dependency evaluation and the lack of a substantive domestic violence assessment. While the Committee agrees the mother did appear to be making progress and complied with the court's orders, the Committee believes the Department's support for both parents to resume caring for their children was questionable. However, under the circumstances, the Committee understands the court would have likely ordered the children returned home even if the Department had disagreed with the reunification recommendation.
- For almost two months after the children's placement with their parents, there were no reports of serious issues or safety risks. However, there were reports the father had become less engaged and somewhat more remote. In hindsight, these reports may have been a red flag but not necessarily a clear indication of imminent danger issues.

Recommendations

The Department should explore the feasibility of requiring mandatory DV training every 1 or 2 years for all child welfare workers. This could be in-service training or on-going electronic training. The training should include subject matter pertaining to lethality assessments as a part of child safety assessments.

DCYF should consider using this case for a statewide Child Fatality Lessons Learned training. This is not due to any definite critical errors but instead due to the number of issues the case would facilitate for case discussions.

The Committee suggests DCYF explore ways to develop a more formal integrated team case approach. This should encourage information sharing with professionals who are working with family members (e.g., medical providers, educators, mental health providers and those providing assessments). The information-sharing should reduce the likelihood the worker accumulates information without the benefit of multiple professional perspectives having the opportunity to discuss the family's issues.