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No. 98940-1

SUPREME COURT
OF THE STATE OF WASHINGTON

KYLE P. KEELY, individually and as the natural father and guardian of M.K., a minor,

Petitioner,

v.

STATE OF WASHINGTON,

Respondent.

PETITION FOR REVIEW

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A. INTRODUCTION

This case is about the Department of Children, Youth, and Families ("DCYF")'s responsibility to protect children. DCYF received a credible report that a mother, who had been addicted to heroin, routinely left her young children unattended for days while going on drug binges. But DCYF declined to investigate or take any other action. Then, just a few months later, the mother gave birth to another child, whom she left as an infant alone at home with his siblings, all of whom were minors. DCYF knew she gave birth but still took no action. While the mother was gone on a drug spree, with no other adults present, the infant was permanently injured.

This case squarely presents an issue that has fomented in the Court of Appeals. Despite the Legislature's admonitions that children's health and safety is among the state's highest priorities, the State of Washington argues that DCYF has no duty—either under RCW 26.44.050 or the common law—to any child when DCYF receives a report about child abuse or neglect, unless that child is specifically named in the report. Petitioner contends that DCYF has a duty to *all* children in the home, including an unborn child, when DCYF knows that a parent has abused or neglected at least one child. The scope of DCYF's duty remains hotly contested.

Besides this duty question, Division II incorrectly applied causation principles to hold that DCYF has no liability as a matter of law to the

severely injured baby here. Division II's opinion effectively creates a dangerous new immunity for DCYF; state officials charged with protecting children may now ignore the dangers to children who are abandoned alone at home. This Court should review these important issues.

B. IDENTITY OF PETITIONER

The petitioner is Kyle P. Keely, the respondent below.

C. COURT OF APPEALS DECISION

Division II's unpublished opinion in *Keely v. State*, No. 51639-0-II, issued on November 24, 2020, is reproduced in the appendix ("App.") at 1–14. Division II's order denying reconsideration is at App. 15–16.

D. ISSUES PRESENTED FOR REVIEW

1. Whether DCYF[1] has a duty of care under RCW 26.44.050 or the common law to all the children in a home, including an unborn child whose birth is later reported to DCYF, when DCYF knows that a parent has abused or neglected at least one child.

2. Whether, when DCYF owes a duty to protect children from abuse or neglect, the field of danger requiring protective action includes an unsupervised child harming a younger child during a parent's absence.

E. STATEMENT OF THE CASE

Before the injuries to baby here, DCYF came to know the family. By April 2010, police had arrested the mother, R.R., more than 20 times for

[1] The Department of Social and Health Services ("DSHS")'s Children's Administration was transferred to the newly formed DCYF. RCW 43.216.906. DCYF now has the same legal responsibilities once assigned to DSHS under RCW 26.44. Accordingly, this petition will refer to DCYF, even though the responsible agency here was DSHS. When referring to court opinions on RCW 26.44, this petition will substitute "DCYF."

crimes related to drugs and prostitution. CP 168–79. Around that time, CPS received a report expressing concern that R.R. was neglecting her two children, C.J. and Ra.R. CP 180–81. Although CPS "screened out" that report, meaning no investigation, CPS received another report the next month. CP 182–88. A social worker reported that R.R., who was pregnant, had been hospitalized due to her then-boyfriend's abuse. C.J., 11 years old, and Ra.R., just 7, were home alone. *Id.* The social worker was "very concerned" the children were alone and "placed at risk of harm." CP 184.

CPS investigated and determined that R.R., while pregnant, had left her children unattended, had a history of using drugs, including crack, had track marks on her arms, and was dating a drug dealer. CP 189–98. CPS found a "pattern of neglect/incidents/injuries … escalating in severity." CP 222–23. R.R. had left her children alone with "inadequate supervision, thus posing a risk to their health, safety, and welfare." CP 197.

At the conclusion of CPS's investigation, a social worker met with R.R. and outlined an intensive six-months'-long outpatient treatment program. CP 200. The program called for individual counseling, group counseling, random urinalysis tests, and "total abstinence from alcohol and other addictive drugs." CP 200. CPS noted ongoing risks, as R.R. had just given birth to her third child, S.H., and Ra.R. was autistic. CP 197, 200. But CPS closed the case just three months later. CP 204. CPS should not have,

according to an expert, given R.R.'s history of drug abuse. CP 249.

Six months later, R.R.'s own sister reported R.R. to CPS. CP 282–83, 290. R.R.'s sister told CPS that R.R. had a history of heroin addiction and was slurring her words during a phone call—and also confessed that she was going on drug binges again and not parenting her children well. CP 283, 290. At the time, R.R. had become pregnant with her fourth child, M.K., although CPS did not know it yet. CP 284–87.

Frontline CPS workers were alarmed. CPS's intake specialist, A.S., decided to "screen in" R.R.'s sister's report for follow up. CP 288–92. CPS's intake supervisor agreed and upgraded the urgency level, designating the case for a 72-hour response. CP 291. The supervisor noted that baby S.H. was in the home, that R.R. struggled with drug abuse, and that CPS had made a "founded" finding for the other report just months earlier. *Id.*

Despite CPS staff's initial evaluation, CPS never followed up with R.R. because a CPS administrator overruled the frontline workers. CP 284–86. This administrator admitted later that "intake is not really my area of expertise." CP 141, 217–18. Yet the administrator completely "screened out" the case. CP 76. Barbara Stone, an expert, concluded that the administrator's override "placed these children and an unborn baby at continued increased risk." CP 249–50. R.R. acknowledged that CPS could have removed her children, but she says she would not have stood in the

way: “If my children had been removed, I would have taken advantage of all available services and gotten off drugs.” CP 284–86.

DCYF learned about M.K.’s birth when R.R. sought services for the baby. CP 293–94. R.R. was still going on drug binges and leaving her kids. CP 284–86. But after DCYF learned about M.K.’s birth, it did nothing.

When baby M.K. was nine months old, R.R. left M.K. alone with his siblings and went on a drug spree. CP 296–310. The oldest of R.R.’s four children, C.J., living amidst domestic violence and documented neglect, had developed difficulties managing his anger and had struck the younger children before. CP 296, 349–55. During R.R.’s absence, baby M.K. would not stop crying one day. C.J., without his mother or any other adult present, violently shook M.K., causing massive, permanent injuries. CP 296–348. Due to these injuries, M.K. will need lifelong care. CP 332–34. CPS then removed M.K. and initiated a dependency action. CP 349–55.

Stone, the expert, laid blame at CPS’s feet: “This case represents a failure by [DCYF] to appropriately assess and serve this family.” CP 251–52. According to Stone, DCYF was negligent at two junctures. First, CPS prematurely closed the case it had opened in response to the second report, thus failing to “follow[] through with assessments and services.” CP 251. Second, CPS should have followed up on the report from R.R.’s sister, violating DCYF policy and procedures by not doing so. *Id.*

Baby M.K.'s father, Kyle Keely, sued the State as M.K.'s guardian. CP 1–8. The State moved for summary judgment on two grounds. CP 17–34. First, the State insisted that DCYF owed no duty to baby M.K., despite DCYF knowing R.R.'s history and knowing M.K. was born. CP 7–13. Second, the State argued that any negligence was not the proximate cause of baby M.K.'s injuries. CP 14–17. Instead, the State blamed C.J., the older child who shook baby M.K. CP 15–17. The trial court denied the State's motion but certified the case for appellate review. CP 375–77.

Division II reversed, holding "that even if [DCYF] owed a duty to M.K., Keely cannot establish a question of fact as to whether [DCYF]'s actions and omission[s] were the proximate cause of M.K.'s injuries." App. 11. Division II reasoned that "C.J.'s anger issues and violent tendencies" were "the direct cause of M.K.'s injuries." App. 12. This petition followed.

F. ARGUMENT WHY REVIEW SHOULD BE GRANTED

(1) This Court Should Decide Whether DCYF Has a Duty to All Children Living in an Abusive or Neglectful Home

(a) This Court Should Reach the Issue Because It Affects the Safety of Countless Children Living in Abusive or Neglectful Homes

While Division II did not directly reach the State's arguments about DCYF's duty, both RAP 13.4(b)(4) and RAP 4.2(a)(4) confirm that this Court should grant review. Whether DCYF's duty under RCW 26.44.050 is limited in scope to only the children expressly referenced in a report has

been debated vigorously in the Court of Appeals,[2] including in a case with a now-pending petition for review, *M.E. & J.E. v. City of Tacoma*, No. 99068-9. This Court's guidance would settle the matter, bringing certainty.

Besides that, this issue concerns a state policy of the highest order. The Legislature has made clear that "[t]he children of the state of Washington are the state's greatest resource," and that "[g]overnmental authorities must give the prevention, treatment, and punishment of child abuse the highest priority." Laws of 1985, ch. 259 § 1. The Legislature guarantees to children a "right to conditions of minimal nurture, health, and safety"—a right so important that it overrides the rights of parents. RCW 26.44.010. The safety of children, the Legislature admonishes, "shall be [DCYF]'s paramount concern." *Id.* The urgency to protect children, always present, has only grown in intensity as the global pandemic has shuttered schools and led to layoffs, with domestic violence and child abuse increasing while fewer watchful eyes are able to detect instances of abuse and neglect. It will be more difficult to provide families with child welfare services and remove children from harmful homes if, as the State claims, DCYF may lawfully close its eyes to the danger to other children living an

[2] *E.g.*, *M.M.S. v. Dep't of Soc. & Health Servs., Child Protective Servs.*, 1 Wn. App. 2d 320, 404 P.3d 1163 (2017), *review denied*, 190 Wn.2d 1009 (2018); *Boone v. Dep't of Soc. & Health Servs.*, 200 Wn. App 723, 734, 403 P.3d 873 (2017); *Estate of Linnik v. State ex rel. Dep't of Corrections*, 174 Wn. App. 1027, 2013 WL 1342316 at *5, *review denied*, 178 Wn.2d 1014 (2013).

abusive or neglectful home. This urgent issue should be decided now.

Precedent also supports reviewing a duty question at the same time as a question about proximate causation, the issue decided by Division II. While duty and proximate causation are nominally distinct elements, they intertwine. Indeed, when a causation question turns on foreseeability, as it does here, foreseeability analysis is the same for duty and causation. *McLeod v. Grant County Sch. Dist. No. 128*, 42 Wn.2d 316, 324, 255 P.2d 360 (1953). And this Court has simultaneously addressed duty and causation in many cases, including in its flagship decision on RCW 26.44.050, *Tyner v. State Dep't of Soc. & Health Servs., Child Protective Servs.*, 141 Wn.2d 68, 82–89, 1 P.3d 1148 (2000), and more recently in *H.B.H. v. State*, 192 Wn.2d 154, 179–82, 429 P.3d 484 (2018). To properly review the causation issue, then, this Court should start by reviewing—and deciding—the nature of DCYF's duty to vulnerable children like baby M.K.

(b) <u>The State's Position Conflicts with the Statutory Duty of Care Imposed on DCYF by RCW 26.44.050</u>

The State argues that, no matter how much danger a child is in, and even if the child's sibling is named in a report submitted under RCW 26.44.050, DCYF's duty is limited to the children specifically named in a report. Br. of Appellant at 14–16. That argument conflicts with this Court's decisions, starting with *Bennett v. Hardy*, 113 Wn.2d 912, 784 P.2d 1258

(1990) and *Tyner*, 141 Wn.2d 68.

Bennett established the protocol for determining whether a statute implies a cause of action. *See, e.g., Swank v. Valley Christian Sch.*, 188 Wn.2d 663, 680, 398 P.3d 1108 (2017) (applying *Bennett*). Under *Bennett*, courts must ask "first, whether the plaintiff is within the class for whose 'especial' benefit the statute was enacted; second, whether legislative intent, explicitly or implicitly, supports creating or denying a remedy; and third, whether implying a remedy is consistent with the underlying purpose of the legislation." *Bennett,* 113 Wn.2d at 920–21.

Tyner confirms that the *Bennett* framework must guide the courts' determinations about how far DCYF's duty extends under RCW 26.44. In *Tyner*, the Court addressed a parent's claim that he had a cause of action under RCW 26.44.050; CPS had taken his children from him for four and a half months. 141 Wn.2d at 71. The State argued that DCYF's statutory duty (acting through CPS) "does not flow to the child's parents." *Id.* at 77. This Court rejected that argument. Looking to RCW 26.44.010 and .050 as well as RCW 13.34.020, the Court "conclude[d] that under RCW 26.44.050, CPS owes a duty of care to a child's parent." *Tyner*, 141 Wn.2d at 82. The same analysis, when applied here as it must be, overrides the State's view.

First, children like M.K.—a child not specifically named in a report about a parent but who lives in the abusive or neglectful home—are within

RCW 26.44's protected class. For the Court to determine for whose "'especial benefit" RCW 26.44 was enacted, *Bennett*, 113 Wn.2d at 920, *Tyner* directs the Court's focus more broadly than just RCW 26.44.050. Indeed, the Legislature was concerned not just about children named in reports; the Legislature enacted the statute for the protection of any "child [who] is deprived of his or her right to conditions of minimal nurture, health, and safety." RCW 26.44.010. Even when parents have legal rights at stake, the Legislature directed that "the rights and safety of the child should prevail." RCW 13.34.020. M.K., as a child who did not live in conditions of minimal nurture and safety, was within RCW 26.44's protected class. After all, if parents—who have fewer protections than children—are within the protected class, per *Tyner*, then so too must be their vulnerable children, whose safety is DCYF's "paramount concern." RCW 26.44.010

The State argues that M.K. did not enjoy protection under RCW 26.44 because, as an unborn child, he did not meet the statutory definition of "child." Reply Br. of Appellant at 3–5. The statute defines a "child" as "any person under the age of eighteen years of age." RCW 26.44.020(2). But it does not further define "person," raising an interesting and important question for this Court. Even so, the State's argument ignores an undisputed fact—DCYF learned about M.K.'s birth. CP 293–94. At that point, M.K. unambiguously was a "child" within the special protected class.

Indeed, DCYF's own self-reporting obligation under RCW 26.44 was enough to trigger the duty upon M.K.'s birth.[3] This self-reporting obligation arose because DCYF knew—or should have known—that M.K. was soon to be born and was neglected. DCYF had information from R.R.'s sister that R.R. had been using drugs during M.K.'s gestation and had been abandoning her children. CP 72, 284–86. Plus, if DCYF had responded as it should have when frontline CPS workers sounded the alarm, DCYF would have met with R.R. and provided services over several months, as it had before, or would have started a dependency action. During that time, DCYF would have learned about R.R.'s pregnancy. CP 251. And anyway, DCYF learned about M.K.'s birth while DYCF still possessed R.R.'s sister's report of R.R.'s neglectful behavior. CP 293–94. Thus, even under the State's statutory interpretation, DCYF's duty broadened to include M.K. upon his birth because DCYF had to self-report baby M.K.'s neglect.

Second, legislative intent supports creating a remedy. *Bennett*, 113 Wn.2d at 920. In *Tyner*, the Court found this *Bennett* prong was satisfied because of the Legislature's expression in RCW 26.44.010. Here too, that part of RCW 26.44 implicitly supports creating a remedy for children in M.K.'s position. Again, the Legislature did not limit its concern to abuse or

[3] RCW 26.44.030(1)(a) provides that "[w]hen any employee of [DCYF] … has reasonable cause to believe that a child has suffered abuse or neglect, he or she shall report such incident ... to the proper law enforcement agency or to [DCYF]."

neglect that had been reported. Rather, the Legislature intended to protect children when "neglect" or other maltreatment "have occurred." RCW 26.44.010. The chapter's mandatory reporting requirements, in tandem with DCYF's investigatory duty, were just the Legislature's chosen mechanism to uncover such abuse or maltreatment. Thus, a remedy here aligns with the Legislature's intent to protect children whose "physical or mental health is jeopardized." RCW 26.44.010.

Third, "implying a remedy is consistent with the underlying purpose of the legislation." *Bennett*, 113 Wn.2d at 921. The statue's main purposes, as summarized in *Tyner*, are "to protect children and maintain the integrity of the family." This Court has long recognized that "tort liability will encourage [DCYF] to avoid negligent conduct and leave open the possibility that those injured by [DCYF]'s negligence can recover." *Tyner*, 141 Wn.2d at 80 (quotation omitted). Any argument to the contrary is in direct conflict with this settled principle.

This Court has already held, in *Schooley v. Pinch's Deli Mkt., Inc.*, 134 Wn.2d 468, 951 P.2d 749 (1998), that a statute implying a cause of action should not be read as narrowly as the State urges here. *Schooley* concerned tort liability under RCW 66.44 for selling alcohol to minors. The defendant was a store; the plaintiff was a minor who received alcohol from another minor, who had purchased it from the store. The plaintiff claimed a

duty arose from RCW 66.44.320, which prohibited "sell[ing] any intoxicating liquor to any minor." The defendant disagreed. Paralleling the argument here, the defendant argued that the protected class was only minors who bought liquor, not other minors who later drank it. *Schooley*, 134 Wn.2d at 474–75.

But this Court sided with the plaintiff, refusing to construe a statute's protected class so narrowly. This Court recognized that RCW 66.44.320's prohibition on sales to minors was simply the mechanism for protecting a broader class and achieving a more sweeping purpose. As this Court explained, the Legislature intended "to protect minors' health and safety interests from their own inability to drink responsibly and to protect against the particular hazard of alcohol in the hands of minors." *Schooley*, 134 Wn.2d at 476 (quotation omitted). The protected class should not be read narrowly if doing so would undermine the legislative purpose. *Id.* The lesson of *Schooley* is clear: the means that the Legislature has chosen—in *Schooley*, prohibiting alcohol sales to minors—to achieve its purpose does not limit the class of persons that the Legislature wishes to protect.

The same logic controls here. The Legislature's purpose was not to create a circular statute. It did not mandate reports, RCW 26.44.030, and require investigations of reports, RCW 26.44.050, only for the benefit of children mentioned in reports. Rather, "the protected class," *Schooley*, 134

Wn.2d at 476, is much broader. The legislation aims to protect *all* children suffering abuse or neglect; reports and follow-up investigations are simply a mechanism for achieving that goal. In other words, a "report" under RCW 26.44.050 is simply what "triggers" DCYF's duty to investigate. *Wrigley v. State*, 195 Wn.2d 65, 71, 73, 77, 455 P.3d 1138 (2020). It is not the duty itself. As in *Schooley*, however, the mechanism for achieving the Legislature's goal does not shrink the especial class of protected persons.

The State's warnings about unlimited liability do not align with this Court's teachings. As *Tyner* explained, "all that is required is that the State act reasonably, not that it act in a flawless manner." 141 Wn.2d at 81. And the reasonableness standard is not the only limitation on DCYF's liability. Another curb, says *H.B.H.*, is "the concept of foreseeability." 192 Wn.2d at 176. The sky will not fall.

Because the State's arguments conflict with the principles set out in this Court's many decisions, review is warranted. RAP 13.4(b)(1).

(c) The State's Position Conflicts with Common Law Principles for When One Owes a Protective Duty

The State's argument about DCYF's lack of a duty to M.K. also conflicts with common law principles. To begin with, DCYF voluntarily undertook to provide services to R.R. for the benefit of her children. CP 199–204. It is black letter tort law that "if someone gratuitously undertakes

to perform a duty, they can be held liable for performing it negligently." *Burg v. Shannon & Wilson, Inc.*, 110 Wn. App. 808, 43 P.3d 526 (2002); *accord*, *Restatement (Second) of Torts* § 323. As expert Stone concluded, DCYF was negligent in providing those services. CP 249–50.

DCYF also formed a special relationship with R.R.'s children, triggering a duty to protect them from harm, even from each other as third parties. A special relationship between a defendant and a plaintiff supports a duty to prevent a third party from harming the plaintiff. *Niece v. Elmview Grp. Home*, 131 Wn.2d 39, 43, 929 P.2d 420 (1997). Examples of such special relationships include schools and students, *McLeod*, 42 Wn.2d at 320; a group home and their disabled residents, *Niece*, 131 Wn.2d at 46; and DCYF and foster children, *H.B.H.*, 192 Wn.2d at 178.

In the same vein, a special protective relationship arises between DCYF and abused or neglected children once DCYF's duty to investigate is triggered under RCW 26.44.050. Crucially, DCYF's duty to children becomes serial in nature, as recognized in both *Wrigley*, 195 Wn.2d at 77 and *Tyner*, 141 Wn.2d at 78–79. DCYF's duty to investigate under RCW 26.44.050 is linked to its duty to investigate under RCW 74.13.031 when aware of "'an imminent risk of serious harm'" to children. *Wrigley*, 195 Wn.2d at 77 (quoting RCW 74.13.031(3)). DCFY's duty is also chained its duty "to protect children" under RCW 13.34, such as by seeking shelter care

and starting a dependency action. *Wrigley*, 195 Wn.2d at 77; *Tyner*, 141 Wn.2d at 78–79. Upon investigating abuse or neglect as required by RCW 26.44.050 and RCW 74.13.031(3), DCYF then must "offer child welfare services" or "bring the situation to the attention of an appropriate court." RCW 74.13.031(3). RCW 26.44.050 echoes this provision, directing DCYF "where necessary to refer such report to the court"—an allusion to shelter care and dependency actions in RCW 13.34.

When DCYF navigates these connected duties, it has discretion, as long as it "act[s] reasonably in its determination" on whether to provide services, or to instead "initiate a dependency," or to do nothing at all. *Tyner*, 141 Wn.2d at 81. Thus, a child living with a parent under investigation is completely at the mercy of DCYF's discretion. The decision about how to protect the child is determined by DCYF alone, not the child. Thus, under these interrelated statutes, DCYF bears the "assumption of responsibility for the safety of another." *Niece*, 131 Wn.2d at 46. Any other conclusion conflicts with the forgoing principles. RAP 13.4(b)(1).

(2) This Court Should Decide Whether the Field of Danger to a Baby, When Abandoned Home Alone by a Drug Addicted Parent, Includes Harm from Another Unsupervised Child

Division II is the intermediate appellate court that decides most appeals involving DCYF, and so Division II's opinions serve as important guidance to DCYF. With Division II's decision here, DCYF need not

protect against the dangers to a baby who is home alone. While couched as a matter of causation, the court's opinion limits DCYF's duty too because the "pertinent inquiry"—foreseeability—is the same. *McLeod*, 42 Wn.2d at 321. Given this overlap, the decision narrows the field of danger that DCYF must anticipate and guard against. That limiting effect on DCYF's liability cries out for review under RAP 13.4(b)(4).

Division II's opinion also creates a rupture in the law of causation, meriting review under RAP 13.4(b)(1). Division II severed causation analysis from the strict rules for finding a superseding cause. Any intervening act that is reasonably foreseeable, or that was related to the situation created by the defendant's negligence, cannot be a superseding cause. *Campbell v. ITE Imperial Corp.*, 107 Wn.2d 807, 813, 733 P.2d 969 (1987). Thus, the intervening intentional acts of third parties, if within these criteria, are not a superseding cause. *Schooley*, 134 Wn.2d at 482; *McLeod*, 42 Wn.2d at 323. Division II overlooked these criteria for superseding cause, and its decision invites DCYF and other courts to do the same.

Division II also focused too narrowly on the specific mechanism of harm that resulted to baby M.K. App. 11–12. Under causation principles, "the pertinent inquiry is not whether the actual harm was of a particular kind which was expectable." *McLeod*, 42 Wn.2d at 321. Instead, causation turns on "whether the actual harm fell within a general field of danger which

should have been anticipated." *Id.* For decades, tort law has firmly held that the chain of causation does not break even if "[t]he manner in which the risk culminates in harm may be unusual, improbable and highly unexpectable." *Berglund v. Spokane Cty.*, 4 Wn.2d 309, 319–20, 103 P.2d 355 (1940). Thus, courts must consider the general field of danger, not the specific "sequence of events." *Id.* at 319.

These principles hold true even if, as before, the cause was "the intervening act of a third party." *Hendrickson v. Moses Lake Sch. Dist.*, 192 Wn.2d 269, 276, 428 P.3d 1197 (2018). When DCYF owes a protective duty to a vulnerable child, as it did under both RCW 26.44.050 and the common law, DCYF must protect the child from harm at the hands of third parties. And *H.B.H.* confirms that a third party's intentional acts—like C.J.'s here—may be unforeseeable only "if it is so highly extraordinary or improbable as to be wholly beyond the range of expectability." 192 Wn.2d at 177 (quotations omitted). C.J.'s conduct here did not reach that level.

Here, the general field of danger was not M.K.'s exposure to C.J. Instead, the general field of danger was the baby's mother abandoning him. It was the panoply of physical harm that can befall a baby left without suitable supervision—being dropped, tumbling down stairs, yanking on unsecured objects, eating harmful substances, experiencing a medical event, being shot by a sibling playing with an unlocked gun, and so on. In that

general field of danger is where M.K.'s injuries occurred. Anyone with experience carrying for babies knows that such helpless creatures cannot be left alone even when an adult is home. As DCYF tells the public, "children under 10 should not be left on their own,"[4] but R.R. was leaving *three* children under 10 alone—a baby, a toddler, and an autistic elementary schooler. Indeed, CPS knew about this general field of danger; that's why CPS initially designated the case for urgent follow up. CP 76, 288–92. *Berglund*, 4 Wn.2d at 319–20.

Division II's decision confuses the matter by holding that petitioner had to show that DCYF's intervention would have caused C.J., the eldest sibling, to become less of a danger to baby M.K. But again, Division II focuses too narrowly on the specific mechanism of harm. The general field of danger was the risk of physical harm to a helpless baby when a drug-addicted parent leaves home to go on drug binges. But for DCYF's negligence, R.R. would have brought her addiction under control: DCYF thought she had responded well before without outpatient services, and she attests she would have cooperated again. CP 204, 285. In fact, after DCYF took M.K. from her, she received services and sobered up. CP 285. So she would have not left M.K. home alone with C.J. Or, if she continued her

[4] DCYF, "Finding Care for Your Child During the COVID-19 Emergency," *Family Resources*, https://www.dcyf.wa.gov/coronavirus-covid-19/families.

addictive behavior, CPS would have removed M.K. from the home.

None of this is speculation. By holding otherwise, Division II's decision conflicts with the core of causation: the jury decides. "The foreseeability of an intervening act," this Court holds, "is ordinarily a question of fact for the jury." *Crowe v. Gaston*, 134 Wn.2d 509, 520, 951 P.2d 1118 (1998). Likewise, the "question of whether the harm is within the scope of the duty owed … is a question of fact for the jury." *McKown v. Simon Prop. Grp., Inc.*, 182 Wn.2d 752, 764, 344 P.3d 661 (2015). Causation necessarily requires a jury to find a counter-factual, "to reconstruct the causal chain." *H.B.H.*, 192 Wn.2d at 182. But like this Court did in *H.B.H.*, this Court should reject the view that the jury's task is "complete speculation." *Id.* It is easy to anticipate babies suffering serious harm if their parents abandon them to go on drug binges.

Review is warranted under RAP 13.4(b)(1) and (b)(4).

G. CONCLUSION

For the forgoing reasons, this Court should grant review.

DATED this 24th day of December 2020.

Respectfully submitted,

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APPENDIX

Filed
Washington State
Court of Appeals
Division Two

November 24, 2020

IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON

DIVISION II

KYLE P. KEELY, individually and as the natural father and guardian of M.K., a minor. Respondent, v. STATE OF WASHINGTON, Appellant.	No. 51639-0-II UNPUBLISHED OPINION

CRUSER, J. — Kyle P. Keely, individually and on behalf of his child, M.K., sued the State of Washington for allegedly failing to provide adequate services and failing to investigate the home of M.K.'s mother, Robin Ross. M.K. lived with Ross until Ross's older son assaulted and severely injured M.K. when he was 10 months old.

The State moved for summary judgment on the basis that Keely could not establish that the Department of Social and Health Services (DSHS)[1] owed M.K. a legal duty and that Keely could not establish causation. The trial court denied the State's motion.

We reverse the trial court's denial of summary judgment on the basis that Keely cannot establish factual causation on his claims.

[1] Starting July 1, 2018, the Department of Social and Health Services and the Children's Administration and Department of Early Learning ceased to exist and the Department of Children, Youth, and Families took over all functions of both agencies. LAWS OF 2017, ch. 6, § 101. Because the lawsuit in this case commenced before the name change, we refer to the agency as DSHS.

FACTS

I. REFERRALS

A. <u>APRIL 30, 2010 REFERRAL</u>

DSHS received a referral on April 30, 2010 concerning possible negligent treatment or maltreatment of C.J. and Ra.R. The referent was concerned because C.J. was falling asleep in class on a regular basis and his teacher struggled to wake him. C.J. told his teacher that his mother, Ross, wakes up him and his little brother, Ra.R., before she goes to work in the morning at 5:00 AM. At the time, C.J. was 11 years old and Ra.R. was 7 years old. DSHS "Screen[ed] Out"[2] the referral on the grounds that the referent did not make a specific allegation of child abuse or neglect. Clerk's Papers (CP) at 45.

B. <u>MAY 28, 2010 REFERRAL</u>

One month later, on May 28, 2010, DSHS received a second referral concerning possible negligent treatment or maltreatment of C.J. and Ra.R. The day before, Ross left C.J. and Ra.R. home alone while she and her boyfriend drove to Seattle to "[get] drunk." *Id.* at 63. That evening, Ross's boyfriend beat Ross by hitting her over 30 times, choking her, and dragging her by her hair down a city block. At the time, Ross was pregnant with her boyfriend's child and her boyfriend was living in Ross's home.

Ross was taken to the emergency room and treated for her injuries. The referent reported to DSHS that Ross was at the hospital and Ross stated that she was worried about her children.

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[2] "Screened-out" means "a report of alleged child abuse or neglect that [DSHS] has determined does not rise to the level of a credible report of abuse or neglect and is not referred for investigation." Former RCW 26.44.020(21) (2012).

The referent called C.J. and Ra.R., who told the referent they were "fearful" and home alone. *Id.* at 48. The referent was "very concerned about the children who were left alone and exposed and placed at risk of harm." *Id.* at 49. The referent was of the "opinion that the family desperately needs services and help." *Id.* The referent contacted Ross's estranged husband and Ra.R.'s biological father, and he picked up C.J. and Ra.R. from the home.

DSHS "Screen[ed] In" the referral for investigation on the basis that Ross left C.J. and Ra.R. alone for an extensive period of time and Ross allowed her "violent boyfriend" to stay in the home. *Id.* at 48-49. The report also listed additional "Risk Factors": Ross was six months pregnant, lost her house to foreclosure, and was in the middle of a divorce. *Id.* at 49. DSHS completed a "Safety Assessment" and determined that Ross's home indicated a "pattern of neglect/incidents/injuries" involving Ross's children, "which [was] escalating in severity." *Id.* at 222.

Interviews throughout DSHS's investigation revealed that Ross had been romantically involved with her boyfriend, an actively using drug dealer, since the fall of 2009 and moved him into her home. Ross admitted to using cocaine with her boyfriend in May 2010. Ross had a "history of severe drug use," including numerous criminal convictions related to drug use beginning in 1994. *Id.* at 64. Ross also suffered from mental illness and severe childhood trauma. Ross stated her only support was her mother, and "she [had] no one to count on." *Id.* at 66.

The investigation also revealed that Ross left her children home alone on a regular basis. Ross often left her children home alone in the evenings and through the night. C.J. did not "feel safe often because of" Ross's boyfriend. *Id.* at 64. C.J. had been diagnosed with attention deficit

hyperactivity disorder. Ra.R had severe asthma and was "Autistic/Asbergers." *Id.* at 63. Ra.R. had "breathing treatments daily and [had] to be monitored well because of his Autism." *Id.*

The record does not indicate when C.J. and Ra.R. returned to Ross's care. A case note indicates that C.J. returned to Ross's care on or before July 9, 2010, but Ra.R. was still living with his biological father. On August 4, 2010, Ross gave birth to S.H.[3] DSHS received a separate referral and a social worker noted S.H.'s birth in Ross's case file. By August 20, 2010, all three of Ross's children were living in Ross's home.

As a result of the investigation, DSHS recommended Ross complete a drug and alcohol program, a mental health assessment, and participate in domestic violence services. On August 20, Ross met with a social worker to discuss DSHS's recommendation that Ross complete an "Intensive outpatient" drug and alcohol program. *Id.* at 200. The program included six months of "[c]ontinuing [c]are" counseling sessions, individual counseling, and participation in support groups. *Id*. Ross told the social worker that she was "not too happy" about the recommendations. *Id*. The case note from August 20 indicates that Ross was not engaged in any domestic violence services and had not completed a mental health assessment.

On September 22, a social worker noted that Ross was "linked" to domestic violence and mental health services. *Id.* at 201. On October 15, a social worker noted that Ross's case was "getting close to closing." *Id.* at 202. The social worker reported that Ross was involved with drug and alcohol services, but Ross still needed "to get involved with [domestic violence] services and support groups." *Id*. Ten days later, a social worker reported that Ross was "following through

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[3] Appellant's brief refers to S.H. as S.R. However, the record refers to this child as only S.H. Therefore, we use S.H.

with [drug and alcohol] outpatient treatment, [domestic violence] support group, and her one on one mental health counseling." *Id*.

There is no further reporting by DSHS regarding Ross's compliance with DSHS recommended services. On November 23, a social worker reported that Ross's case was "staffed for closure back in Oct., however [Ross] called for some assistance due to her leaving her job to become a stay at home mom." *Id.* at 204.

DSHS "completed" its investigation and closed Ross's case on or around December 10. *Id.* at 59. DSHS determined that the allegations were "founded for negligent treatment/maltreatment" and the risk of child abuse and neglect of Ross's children was "high." *Id*. The case was closed because Ross "followed through [with] all services, namely [domestic violence] services as well as [drug and alcohol] treatment." *Id.* at 67.

C. JUNE 10, 2011 REFERRAL

DSHS received a referral on June 10, 2011 concerning possible negligent treatment or maltreatment of C.J., Ra.R., and S.H. At the time, C.J. was 12 years old, Ra.R. was 8 years old, and S.H. was 10 months old.[4] Ross's sister called Child Protective Services[5] (CPS) to report that she had spoken to Ross on the phone and Ross was slurring her words. Ross also told her sister that she was going on drug "binges" and that she was not a good mother. *Id.* at 283. Ross's sister contacted CPS out of concern for Ross's children. The intake report states,

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[4] The second page of the intake report mistakenly states that C.J was 14 years old and S.H. was 2 years old at the time of the referral.

[5] "Child Protective Services" means those services provided by DSHS. Former RCW 26.44.020(3).

> Mother has a history of heroin addiction. Today . . . mother was slurring her words during a phone conversation. Mother said she is not a good mother. She also reported being on a binge. No information about how mother's drug use is affecting the children.

Id. at 72. Ross's sister gave CPS her name and phone number.

The intake worker "Screened In" the allegation for investigation and assigned a response time of 10 days. *Id.* at 73. The intake supervisor changed the response time to 72 hours "due to baby being in home; [Ross] has FOUNDED intake . . . for older sons; [Ross] may have substance abuse issues." *Id*. Three days later, an area administrator at DSHS's regional headquarters overrode the intake supervisor's decision. The area administrator "Screen[ed]-Out" the referral because "there is no allegation of how this is affecting the children, caller doesn't know mother is using again." *Id.* at 76. The investigation assessment states, "Unable to complete invest[igation] – No Finding." *Id.* at 75.

In a subsequent statement, Ross explained,

> Sometime between May 2011 and June 10, 2011 I conversed with my sister, A.S. I informed her that I had relapsed and was again binging on drugs. I informed her I was not a good mother. This was a cry for help as I was very deep into drug abuse and desperately wanted treatment but felt it was impossible given my status as a single, working mother.

Id. at 284.

DSHS did not contact Ross or her sister in response to the June referral. Ross stated that had she been contacted, she would have accepted services as she did following the May 2010 referral. When Ross's sister made the referral, Ross was pregnant with M.K. Ross was unaware of her pregnancy.

II. Events Relating to M.K.

M.K. was born on February 22, 2012. M.K was born healthy and was generally a healthy child for the first nine months of life. DSHS was informed of M.K.'s birth on February 28 because Ross sought services for M.K.

On December 1, Ross left her children unattended to go on a drug binge. At the time, C.J. was 14 years old, Ra.R. was 10 years old, and S.H. was 2 years old. While the children were unattended, C.J. became upset when M.K. spit up his milk. C.J. hit M.K. in the head with a rubber ball, shook M.K., and threw him onto a bed. Ross did not come home that night. It is unclear when Ross returned home, but M.K. did not receive medical care until approximately 18 hours after his injuries. M.K. suffered permanent brain damage.

DSHS investigated this incident. During the investigation, Ross stated that C.J. had anger issues and violent tendencies. C.J. was violent toward Ra.R., S.H., and Ross. On several occasions, C.J. hit Ra.R. in the head, pulled a knife on Ra.R., and choked Ra.R. until he couldn't breathe. C.J. also hit S.H. and had attempted to hit Ross on several occasions. C.J.'s violent tendencies surfaced about a year before the incident. C.J. often yelled at M.K. and asked Ross to keep M.K. in his crib all day. About two weeks before the incident, C.J. told Ross that he hated M.K. and wanted him dead. Following the incident, C.J. was charged with first degree assault of M.K. and Ross was charged with first degree criminal mistreatment.

III. Procedural History

Keely, individually and on behalf of his child, M.K., sued the State for negligence. Keely alleged that the State owed M.K. a statutory and a common law duty of protection from abuse and neglect, and the State breached its duties when it failed to fully investigate allegations of child

abuse and neglect following the May 28, 2010 referral and failed to perform any investigation into allegations of child abuse and neglect following the June 10, 2011 referral. Keely alleged that these failures resulted in DSHS's failure to take steps to protect M.K., which directly and proximately resulted in the injuries M.K. sustained on December 1, 2012.

The State moved for summary judgment, arguing that the State did not owe M.K. a duty of protection under statutory law or a duty based on common law, and Keely cannot establish factual or legal causation. The trial court denied the State's motion for summary judgment.

The State moved to certify the matter for appeal pursuant to CR 54(b). The trial court agreed and certified the matter for appeal.

DISCUSSION

The State argues that the trial court erred when it denied its motion for summary judgment because it did not owe M.K. a statutory duty of protection under former RCW 26.44.050 (2012) or a duty of protection based on common law. The State further argues that even if it owed M.K. a duty of protection, Keely cannot establish proximate cause under the facts of this case. Keely argues that the trial court did not err when it denied the State's motion for summary judgment because the State owed M.K a duty as an immediate member of Ross's family. Keely also argues that the State breached its duty when DSHS failed to provide adequate services after the May 2010 referral and failed to investigate the June 2011 referral, and that M.K.'s injuries are a direct and proximate result of DSHS's failures.

We hold that even assuming the State owed M.K. a duty of protection and it breached its duty by failing to provide adequate services and failing to investigate, the trial court erred in denying summary judgment because Keely cannot establish factual causation.

I. Standard of Review

We review an order for summary judgment de novo, performing the same inquiry as the trial court. *Aba Sheikh v. Choe*, 156 Wn.2d 441, 447, 128 P.3d 574 (2006). We view the evidence in the light most favorable to the nonmoving party and draw all reasonable inferences from the evidence in that party's favor. *Boone v. Dep't of Soc. & Health Servs.*, 200 Wn. App. 723, 731, 403 P.3d 873 (2017). "Summary judgment is proper when the record demonstrates there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law." *Munich v. Skagit Emergency Commc'ns Ctr.*, 175 Wn.2d 871, 877, 288 P.3d 328 (2012). If a genuine issue of fact exists as to any material fact, a trial is necessary. *Lish v. Dickey*, 1 Wn. App. 112, 113, 459 P.2d 810 (1969).

A claim for liability cannot rest on a speculative theory or an argumentative assertion of possible counterfactual events. *Martini v. Post*, 178 Wn. App. 153, 165, 313 P.3d 473 (2013); *H.B.H. v. State*, 197 Wn. App. 77, 93, 387 P.3d 1093 (2016), *aff'd*, 192 Wn.2d 154, 429 P.3d 484 (2018). To survive summary judgment, a plaintiff must present "'some competent evidence of factual causation' that precludes jury speculation." *Behla v. R.J. Jung, LLC*, 11 Wn. App. 2d 329, 347, 453 P.3d 729 (alteration in original) (quoting *Estate of Bordon ex rel. Anderson v. Dep't of Corr.*, 122 Wn. App. 227, 242, 95 P.3d 764 (2004)), *review denied*, 195 Wn.2d 1012 (2020). The evidence may be circumstantial, so long as the evidence "'allow[s] a reasonable person to conclude that the harm more probably than not happened in such a way that the moving party should be held liable.'" *Martini*, 178 Wn. App. at 165 (alteration in original) (quoting *Little v. Countrywood Homes, Inc.*, 132 Wn. App. 777, 781, 133 P.3d 944 (2006)).

II. CAUSATION

A. <u>LEGAL PRINCIPLES</u>

The State of Washington, through DSHS, has a mandatory duty to investigate child abuse. Former RCW 26.44.050. The duty to investigate under former RCW 26.44.050 "derives from the paramount importance that is placed on the welfare of the child." *Rodriguez v. Perez*, 99 Wn. App. 439, 444, 994 P.2d 874 (2000). Former RCW 26.44.050 states in relevant part,

> [U]pon the receipt of a report concerning the possible occurrence of abuse or neglect, the law enforcement agency or the department must investigate and provide the protective services section with a report.

DSHS's statutory duty implies a cause of action for children when DSHS fails to adequately investigate a child's living situation before making a placement decision, lets a child remain in an abusive home, or places a child in an abusive home. *M.W. v. Dep't of Soc. & Health Servs.*, 149 Wn.2d 589, 595, 70 P.3d 954 (2003). The duty requires DSHS to act reasonably while investigating, which includes protecting children from potential abuse. *Tyner v. Dep't of Soc. & Health Servs.*, 141 Wn.2d 68, 79, 1 P.3d 1148 (2000).

To prevail on a negligent investigation claim, a plaintiff must establish that the State owed a legal duty to the plaintiff. *Yonker v. Dep't of Soc. & Health Servs.*, 85 Wn. App. 71, 77, 930 P.2d 958 (1997). Once a duty is established, the plaintiff must show that the State breached its duty when it failed to conduct an adequate investigation and the investigation's deficiencies proximately caused a harmful placement decision by DSHS. *M.W.*, 149 Wn.2d at 602.

B. CAUSE IN FACT

The State argues that even if DSHS owed a duty to M.K., Keely cannot establish a question of fact as to whether DSHS's actions and omission were the proximate cause of M.K.'s injuries. We agree.

Even assuming the State owed M.K. a duty of protection and it breached its duty by failing to provide adequate services following the May 2010 referral and failing to investigate the June 2011 referral, the trial court erred in denying summary judgment because Keely cannot establish factual causation. *H.B.H.*, 197 Wn. App. at 93.

Proximate cause has two elements: cause in fact and legal causation. *Tyner*, 141 Wn.2d at 82. Cause in fact exists when "but for" the defendant's actions, the claimant would not have been injured. *Id*. In most instances, cause in fact is a question for the trier of fact and not susceptible to summary judgment. *Martini*, 178 Wn. App. at 164. Cause in fact may be resolved as a matter law where a reasonable jury could reach only one conclusion based on the evidence presented. *H.B.H.*, 197 Wn. App. at 93.

The State argues that Keely cannot establish a question of fact as to whether DSHS's decision to close its investigation in December 2010 following the May 2010 referral or its decision not to investigate the June 2011 referral proximately caused M.K.'s injuries. The State argues that even if DSHS had acted differently, the trier of fact would still need to speculate that (1) Ross would have engaged in services and those services would have equipped Ross with the necessary tools to prevent C.J. from assaulting M.K., or (2) either M.K. or C.J. would have been removed from Ross's home. The State further argues that whether Ross engaged in services is irrelevant to

cause in fact; the question is whether DSHS would have provided Ross services that would have enabled Ross to prevent C.J. from assaulting M.K.[6]

A reasonable person could conclude that but for Ross's negligent treatment of leaving M.K. unattended by an adult, M.K. would not have been at risk in general for injury. Keely presented evidence that Ross left M.K., an infant, and the rest of her children unattended by an adult to use drugs. CP at 285, 297. While unattended, M.K. was assaulted by C.J., his older brother, who Ross knew had violent tendencies and did not like M.K. CP at 297. However, although Ross's neglect presented an opportunity for C.J. to harm M.K., ultimately, it was C.J.'s anger issues and violent tendencies that caused of M.K.'s injuries. Therefore, the question here is if DSHS had provided Ross with adequate services following the May 2010 referral, and if DSHS had accepted the June 2011 referral and conducted an investigation, would DSHS have discovered C.J.'s violent tendencies towards other children in the home and would such discovery have enabled DSHS to prevent M.K.'s injury in December 2012.

Viewing the evidence in the light most favorable to Keely, there is still a missing link in the chain of causation. Keely presented no evidence of C.J.'s violent tendencies or anger issues at the time of the May 2010 referral or at the closure of Ross's case in December 2010. Rather,

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[6] The State raises a new argument on appeal regarding causation. The State argues that Keely cannot establish causation because Keely failed to present evidence that DSHS had authority to remove M.K. from Ross's care because Washington's dependency statutes limit DSHS's ability to remove children from their home or from their parents' care. As this argument was raised for the first time on appeal, we do not consider or address it.

the record indicates that C.J.'s violent tendencies surfaced in 2011.[7] Therefore, even if DSHS provided additional services following the May 2010 referral, it is far too speculative to assume that DSHS would have discovered C.J.'s violent tendencies because the record indicates that they surfaced a year later.

Even if we assume that C.J.'s anger issues and violent tendencies would have been revealed during an investigation in June 2011, it is far too tenuous to infer from the evidence that the harm to M.K. would have been prevented. In order to come to this conclusion, we would need to either adopt the possible theory that as part of the services provided to Ross, DSHS would have also provided services to C.J., C.J. would have participated in services, and the services would have fully addressed his anger to prevent M.K.'s injuries, or the possible theory that C.J. would have been permanently removed from the home. Keely does not present any evidence supporting these theories. Without evidence supporting a reasonable inference of either theory, both are speculative as to proximate cause. While Keely speculates that DSHS could have taken a number of steps that might have contributed to the prevention of M.K.'s harm, this type of speculation is insufficient to create a genuine issue of material fact as to whether M.K.'s injuries would have been prevented had DSHS intervened.

Therefore, viewing the evidence in the light most reasonable to Keely, we hold that a reasonable jury could not find a genuine issue of material fact as to whether DSHS's failure to provide adequate services and failure to investigate caused M.K.'s injury.

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[7] Ra.R. stated that C.J. became violent towards him when he was nine years old. Ra.R. was nine years old in 2011. Ra.R. also told his biological father that C.J. was "mean" to him and had choked him around six to eight months before the incident involving M.K., which would have been in the spring of 2012.

CONCLUSION

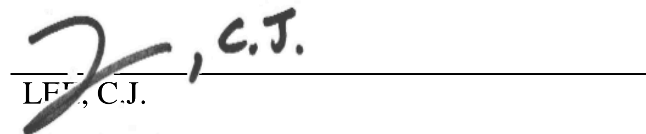
Even assuming that the State owed a duty to M.K. and the duty was breached, Keely cannot establish a genuine issue of material fact as to whether DSHS's breach was the proximate cause of M.K.'s injuries. Therefore, we hold that the trial court erred when it denied the State's motion for summary judgment. We reverse.

A majority of the panel having determined that this opinion will not be printed in the Washington Appellate Reports, but will be filed for public record in accordance with RCW 2.06.040, it is so ordered.

CRUSER, J.

We concur:

WORSWICK, J.



LEE, C.J.

Filed
Washington State
Court of Appeals
Division Two

August 11, 2020

IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON

DIVISION II

KYLE P. KEELY, individually and as the natural father and guardian of M.K., a minor. Respondent, v. STATE OF WASHINGTON, Appellant.	No. 51639-0-II ORDER DENYING MOTION FOR RECONSIDERATION AND WITHDRAWING OPINION

The Respondent, Kyle P. Keely, filed a motion for reconsideration of the unpublished opinion filed on November 13, 2019. The Appellant, State of Washington, filed a response. The court has considered this motion and the response and determined that the motion for reconsideration should be denied, but that the opinion should be withdrawn and a new opinion filed in due course.

Now, therefore, it is hereby

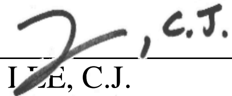
ORDERED that the Respondent's motion for reconsideration is hereby denied, and the opinion previously filed on November 13, 2019 is withdrawn. A new opinion will be filed in due course.

IT IS SO ORDERED.

CRUSER, J.

We concur:

WORSWICK, J.



LEE, C.J.

DECLARATION OF SERVICE

On said day below, I electronically served a true and accurate copy of the ***Petition for Review*** in Supreme Court Case No.98940-1 (Court of Appeals, Division II Cause No. 51639-0-II) to the following parties:

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Original E-filed with:
Supreme Court
Clerk's Office

I declare under penalty of perjury under the laws of the State of Washington and the United States that the foregoing is true and correct.

DATED, December 24, 2020 at Seattle, Washington.

/s/ Frankie Wylde, Legal Assistant
Frankie Wylde, Legal Assistant
Talmadge/Fitzpatrick

TALMADGE/FITZPATRICK

December 24, 2020 - 10:59 AM

Transmittal Information

Filed with Court:	Supreme Court
Appellate Court Case Number:	98940-1
Appellate Court Case Title:	Kyle P. Keely v. State of Washington
Superior Court Case Number:	16-2-05028-5

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