CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

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Full Report

Child

- J.F.A.

Date of Child's Birth

- RCW 74.13.515 2019

Date of Fatality

- May 23, 2022

Child Fatality Review Date

- August 15, 2022

Committee Members

- Mary Anderson Moskowitz, JD, Ombuds, Office of the Family and Children's Ombuds
- Alissa Copeland, MA, Statewide Intake and Early Learning Program Manager, Department of Children, Youth, and Families
- Vanessa Lea, CPS-FAR Supervisor, Department of Children, Youth, and Families
- Lindsey Barcklay, MSW, LICSW, CMHS, CDP, CCTP, Clinical Director, Domestic Abuse Women's Network
- Lori Vanderburg, LMFT, Executive Director, Dawson Place Child Advocacy Center

Facilitator

- Leah Mattos, MSW, Critical Incident Review Specialist, Department of Children, Youth, and Families

Executive Summary

On August 15, 2022, the Department of Children, Youth, and Families (DCYF) convened a Child Fatality Review (CFR)[1] Committee to examine DCYF's practice and service delivery to J.F.A. and RCW 74 family. J.F.A. will be referenced by RCW 74 initials throughout this report.[2]

On May 23, 2022, J.F.A. died. The medical examiner called DCYF to report that J.F.A. was found unresponsive by the mother's partner, who had been caring for J.F.A. while the mother was at work. J.F.A. was pronounced dead after the arrival of emergency services at the home. The medical examiner's report identified J.F.A.'s cause of death as multiple blunt force injuries. The manner of death is homicide. On July 28, 2022, J.F.A.'s mother was arrested and is awaiting trial for second-degree murder.

J.F.A. and RCW 74 family had prior involvement with DCYF. A Child Protective Services (CPS) case was closed five days before J.F.A.'s death. A new CPS investigation was assigned after receiving notification of J.F.A.'s death.

A diverse CFR Committee (Committee) was assembled to review DCYF's involvement and service provision to the family. The Committee included members with relevant expertise selected from diverse disciplines within DCYF and community partnerships. Committee members had no prior direct involvement with J.F.A. or RCW 74 family. Before the review, the Committee received relevant case history from DCYF. On the day of the review, the Committee had the opportunity to speak with DCYF field staff, who provided case oversight. The caseworkers who had direct interactions with the family were not available to participate on the day of the review for various reasons.

Case Overview

In November 2021, DCYF received a call reporting that J.F.A. and RCW 74 mother were homeless due to an alleged conflict between the mother and her family. The caller said the mother was staying with a partner who the caller did not know. A CPS investigation was not assigned because no allegation of abuse or neglect was reported.

On February 19, 2022, DCYF received a call alleging that the mother's partner was physically abusing J.F.A. and RCW 74 mother. It was reported that the mother's partner kicked and strangled the mother. It was also reported that J.F.A. often has bruises on RCW 74 arms, legs, back, and sometimes RCW 74 face. The caller said the mother's partner spanks J.F.A. and puts RCW 74.1 in a cold shower. DCYF opened a CPS investigation.

On February 20, 2022, an after-hours caseworker completed the initial face-to-face visit with J.F.A. and RCW 74 mother. The mother denied that her partner is physically violent with her and J.F.A. Because of RCW 74 age, J.F.A. was not interviewed. The caseworker did observe a large bruise on RCW 74 hand and a fading bruise on RCW 74 back.

[1] "A child fatality or near fatality review completed pursuant to [RCW 74.13.640] is subject to discovery in a civil or administrative proceeding, but may not be admitted into evidence or otherwise used in a civil or administrative proceeding except pursuant to [RCW 74.13.640(4)]." RCW 74.13.640(4)(a). Given its limited purpose, a child fatality review (CFR) should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. The CFR Committee's review is generally limited to documents in the possession of or obtained by DCYF or its contracted service providers.

The Committee has no subpoena power or authority to compel attendance and generally hears only from Agency employees and service providers. It does not hear the points of view of the child's parents and relatives, or 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 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] J.F.A.'s name is not used in this report because RCW name is subject to privacy laws. See RCW 74.13.500.

The mother said [redacted] got the bruise on [redacted] hand when [redacted] ran into the refrigerator. The mother did not know the cause of the bruise on [redacted] back. She said that everyone in her family bruises easily.

On February 22, 2022, the area administrator conducted a monthly supervisor review. The review noted that a child abuse medical consultation would be requested to seek input about J.F.A.'s bruising. The review also noted a referral would be sent to law enforcement. The next steps for the assigned caseworker included gathering information about the child's father and the mother's partner and assessing for domestic violence (DV) and services. The caseworker completed the medical consultation referral and sent a referral to law enforcement.

On February 27, 2022, DCYF received the medical consultation findings. Based on the information provided, the doctor stated that "abuse cannot be ruled out, but I see nothing specifically concerning about these two injuries." The consultation recommended that a medical provider see J.F.A. if additional injuries are observed or reported.

On March 1, 2022, a CPS caseworker assigned to assist the primary caseworker contacted law enforcement. The caseworker left a message asking if a detective had been assigned and requested permission to contact the family.

On March 21, 2022, the CPS caseworker documented a third attempt to communicate with law enforcement and requested a response about contacting the family. The caseworker attempted to contact the mother the following day and left a message asking for a return call.

On April 21, 2022, an unannounced health and safety visit was conducted by an after-hours caseworker. The caseworker met with the mother and J.F.A. outside their apartment. The mother said she felt safe with her partner. The caseworker observed a diaper change and reported that J.F.A. did not appear to have any marks or bruises. The mother said she would need to apply for daycare for J.F.A. because her partner was beginning work in two weeks.

On May 3, 2022, the CPS investigation was transferred to another caseworker. On May 11, 2022, the caseworker interviewed the mother. The mother reported she and her partner had an argument outside her apartment, and other people witnessed it. She said the argument was verbal and did not include physical violence. The mother denied using physical discipline, saying she received physical discipline as a child and wanted to stop this cycle. She said J.F.A. is a "rowdy [redacted]" and often has bruises on [redacted] knees. The mother provided her partner's contact information and said prior CPS caseworkers had not contacted him.

On May 16, 2022, the CPS caseworker interviewed the mother's partner by telephone. He denied the allegations discussed with the mother on May 11 and said the mother's co-worker did not like him and made things up. He said that he and the mother agreed they would not use physical discipline with J.F.A. because they both experienced this as children and did not like it. The mother's partner described their daily schedule and said he was the primary caregiver during the day while J.F.A.'s mother was at work.

On May 17, 2022, a CPS caseworker spoke with local law enforcement. The detective told the caseworker they completed a welfare check with J.F.A. and the mother's partner. The detective said he saw no evidence of marks or injuries on J.F.A. and did not have any concerns. The detective said he would be closing the case.

On May 18, 2022, the CPS investigative assessment was completed. DCYF did not recommend services for the family. The case was submitted for closure.

On May 23, 2022, the medical examiner notified DCYF of J.F.A.'s death. The medical examiner's report found that J.F.A.'s death was due to multiple blunt force injuries and described the death as a homicide. On July 28, 2022, J.F.A.'s mother was arrested and is awaiting trial for second-degree murder. The CPS investigation concluded, and DCYF issued the mother and her partner negligent treatment and physical abuse founded findings.[3]

Committee Discussion

The Committee met with the supervisors and area administrator, who provided case oversight. A DCYF regional administrator also participated in the meeting. The Committee found that this meeting was informative. The Committee learned that during the nine months prior to May 2022, the DCYF office that was assigned; this particular case experienced a staffing crisis that caused staff shortages across programs and required supervisors to maintain their own caseloads. The Committee also learned that the majority of the workforce in this particular office had less than 12 months of experience. A regional administrator described how supports have been provided to the office. This information provided context for why multiple caseworkers had contact with the family during the investigation.

The Committee's discussion emphasized the importance of relationship building. The discussion included relationships DCYF builds with the families served and internal relationships within the agency. For example, the Committee discussed how continuity of care and relationship building might be impacted when multiple caseworkers are assigned to a case in a short time. The Committee wondered whether additional relationship building with the mother could have resulted in a more thorough needs assessment and a greater ability to assess the potential lethality of the reported DV accurately. The Committee also discussed the mother's relationship with her family and believes it may have been beneficial for DCYF to contact the maternal relatives to gather additional information.

The Committee learned that DCYF offered community-based supports to the mother but did not document what services or providers were recommended. A field supervisor told the Committee the mother said she did not have time but was interested in mental health services. The Committee wondered if this may have been an opportunity for DCYF to help the mother prioritize her own needs and strategize how to access services. A Committee member described a local resource providing trauma-informed mental health and domestic violence services that the Committee member felt may have helped the mother. The Committee member also believes this resource may have created a culturally relevant connection for the mother. Although outside the scope of this review, a Committee member pointed out that the mother was young and wondered if, after J.F.A.'s birth, any early intervention services were offered to her.

[3] RCW 26.44.020(14) defines "founded" as follows: "the determination following an investigation by the department that, based on available information, it is more likely than not that child abuse or neglect did occur." RCW 26.44.020(29) defines "unfounded" as follows: "the determination following an investigation by the department 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."

The Committee had questions about J.F.A.'s biological father and discussed the importance of building relationships with fathers during the assessment process. The Committee believes DCYF should have made more effort to locate and engage J.F.A.'s father.

The Committee also discussed the parent-child relationship between J.F.A., RCW 7 mother, and her partner. The Committee believes additional information gathering and assessment may have helped DCYF gain a better understanding of the family. The Committee wondered if biases about non-parent partners being the cause of child harm may have played a role in DCYF's assessment of the family relationship. A DCYF Committee member pointed out that DCYF assessments may benefit from the utilization of tools designed to help assess parental relationships with young children, such as the Parent-Child Interaction (PCI) Feeding and Teaching Scales.[4] The Committee member suggested there may be a benefit to DCYF field staff being educated about PCI. For example, who conducts these assessments and how to utilize the information when making service provision decisions.

The Committee also discussed J.F.A.'s needs assessment. The Committee believes that due to J.F.A.'s age, it would have been a best practice for J.F.A. to have been seen by a primary care physician before the case was closed. However, the Committee understands the decision to close the case following the medical consultation, multiple contacts with J.F.A., and a child welfare check conducted by law enforcement.

The Committee discussed available supports to field staff, including DCYF's Peer Support Program. The Committee recognizes how important it is to share with all DCYF staff information about the availability of DCYF's Peer Support program. The Committee suggested additional efforts be made to consistently message information about the DCYF Peer Support program to all staff on a regular basis. The Committee also wondered about what supports may be needed beyond this program's scope.

The Committee also focused on the critical role supervisors play with regard to guiding the workforce and helping with their needs for ongoing support, mentoring, and training. The Committee recognized that when supervisors maintain their own caseloads, this may detract from their ability to provide clinical supervision to their staff. For purposes of providing a supportive network between DCYF's programs, the Committee discussed the value of information sharing and relationship building between supervisors. A Committee member suggested that a supervisory mentorship program may benefit supervisors and reduce the tendency to sometimes work in "silos."

The Committee recognizes the limitations a staffing crisis creates and how this may impact the field staff. However, the Committee strongly believes DCYF should not allow this to create new norms in their work that is contrary to the best interests of DCYF's clients. The Committee understands the need to prioritize workload duties and suggests that leadership provide additional prioritization guidance and training. It was mentioned that to address the causes of high staff turnover, it is important to first accurately determine why the turnover rate is high. A Committee member mentioned a perceived disconnect between what field staff need and how leadership provides field staff support. While the Committee recognizes the impacts of the current staffing

[4]For information about Parent-Child Interaction (PCI) Feeding and Teaching Scales , see: https://www.pcrprograms.org/parent-child-interaction-pci-feeding-teaching-scales/. Last accessed on September 8, 2022.

challenges at this particular office, they believe this case may have benefited from a higher degree of prioritization and a more thorough assessment.

Recommendations

The Committee recommendations come from a comprehensive review and discussion of the many aspects of the case. The recommendations and corresponding discussion are unrelated to the death of J.F.A. The purpose of the recommendations is to help DCYF and its staff improve their clinical supervision.

The Committee respectfully recommends that DCYF discontinue the practice of supervisors being assigned to case-carrying activities. This recommendation is made with the goal of supervisors having sufficient time to provide support and clinical supervision to their staff teams properly.

The Committee also recommends that DCYF develop a statewide supervisor mentorship program. The purpose of the mentorship program would be to create access for new supervisors and allow them greater opportunities to communicate, collaborate, and receive support from experienced supervisors from all programs.