CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

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CONTENTS

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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.

Full Report

Child

- RCW 13.50.100

Date of Child's Birth

- RCW 74.13.515 2017

Date of Fatality

- June 2022

Child Fatality Review Date

- Sept. 8, 2022

Committee Members

- Patrick Dowd, JD, Director, Office of the Family and Children's Ombuds
- Lindsey Barcklay, MSW, LICSW, CMHS, SUDP, CCTP, Therapist and Clinical Director, Domestic Abuse Women's Network
- Jordan Tracy, MSN, RN, Public Health Nurse 1, Strengthening Families, Tacoma Pierce County Health Department
- Jimmy Vallembois, MSW, MAS, Statewide Substance Use Disorder Program Manager, Department of Children, Youth, and Families
- Jasmine Hodges, MSW, Statewide Safety Program Manager, Department of Children, Youth, and Families

Observer

- Amy Matchett-Wagner, LMSW, Quality Assurance/Improvement Analyst, Department of Children, Youth, and Families

Facilitator

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

Executive Summary

On Sept. 8, 2022, the Department of Children, Youth, and Families (DCYF)[1] convened a Child Fatality Review (CFR)[2] to examine DCYF's practice and service delivery to RCW 13.50.100 and his family. He will be referenced by his initials throughout this report.

On June 28, 2022, an intake was received from law enforcement. RCW 13.50.100 was found unclothed and deceased. Law enforcement reported that after receiving a call to respond to the mother's home, law enforcement knocked on the mother's door for ten minutes before she responded. Law enforcement observed unsafe living conditions and placed RCW 13.50.100.'s sister in protective custody. Law enforcement also stated the mother's boyfriend had multiple criminal warrants for his arrest. The neighbors told law enforcement that RCW 13.50.100 would often escape from his home. This intake was screened in for a Child Protective Services (CPS) investigation.

At the time of his death, there was an open CPS case involving RCW 13.50.100.'s family. That case (intake) originated from law enforcement and reported a lack of supervision. The officer observed the children to be "happy and were in healthy condition." However, there was a smell of rotten garbage emanating from the home, and garbage was stacked up by the front door. The mother did not allow law enforcement to enter her home. That intake screened-in for a CPS/Family Assessment Response (FAR) assessment.[3]

A diverse CFR Committee (Committee) was assembled to review this case and to evaluate DCYF's service delivery to the family. The Committee included community partners and DCYF staff. Committee members received copies of the DCYF case history, including intakes, investigative assessments, assessment tools, and case notes. They also received historical police reports.

The Committee spoke with an area administrator, two supervisors, and one caseworker. Other caseworkers who handled the case were no longer employed by DCYF and were not available to participate in this review process.

Case Overview

In August 2016, DCYF received allegations of neglect and alleged parental substance use. That intake did not meet DCYF's screen-in requirements. In September 2016, another intake was received alleging the mother and her boyfriend were "shooting up meth" in the presence of her then-six-year-old son. This intake screened in for a CPS/FAR assessment. The mother denied the allegations, citing retaliation by the child's father after she

[1] Effective July 1, 2018, the Department of Children, Youth, and Families (DCYF) replaced the Department of Social and Health Services (DSHS) Children's Administration (CA) as the state agency responsible for child welfare; and the Department of Early Learning for childcare and early learning programs. For purposes of this report, any reference to DCYF and events that occurred before July 1, 2018, shall be considered a reference to DSHS.

[2] "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 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 from only DCYF 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.

[3] For more information about FAR see: https://www.dcyf.wa.gov/practices-and-procedures/2332-child-protective-services-family-assessment-response.

filed a request for a protection order. She said she had been sober since 2005, and her roommate had been sober "for years."

After 2016, the next intake received by DCYF was not until Sept. 1, 2019. At that time, the mother gave birth to a female child. The hospital called DCYF because the mother only had three prenatal visits and no obstetrician. The intake was screened out.

The following day the hospital called in another intake. The hospital reportedly received toxicology results indicating the baby and mother tested positive for amphetamines. A confirmation test result was pending. The mother stated she had a prescription for RCW 70 02 020 but the hospital was unable to verify the prescription. The hospital reported the mother had sores on her face and legs, was "jumpy and antsy," and the hospital room was often "full of people." This intake screened in for a Risk Only. A Risk Only intake only alleges imminent risk of serious harm. It does not include allegations of child abuse or neglect.

The assigned caseworker met with both parents at the hospital. The caseworker requested that the mother's boyfriend provide a urinalysis. The caseworker then went to the family's home and observed the interior. The home was cluttered but did not present a safety threat. A collateral contact was made with the mother's primary care physician (PCP), who confirmed a RCW 70.02.020 prescription for RCW 70 02 020 and that she had not provided any refills beyond that initial prescription. The provider said she did not observe any indicators of improper substance use.

The caseworker spoke with the oldest child's father. He expressed concern for the condition of the home but did not suspect any child abuse or neglect occurring in the mother's home. Their son spent the majority of the time with his father.

The mother's boyfriend was unable to provide a urinalysis.

The family agreed to voluntary services through Project Safe Care. Project Safe Care is an evidence-based service that provides in-home services to address identified needs for the family. The service includes 18-22 weekly visits. The case was transferred to Family Voluntary Services (FVS).

On Sept. 18, 2019, a case note was entered by an intake caseworker. The hospital called to report that the newborn's meconium tested positive for methamphetamine. The mother's confirmation test was also positive for methamphetamine.

Concerns for the newborn's lack of weight gain were documented by the Project Safe Care provider. Contact was made with the PCP, who verified the newborn was receiving specialty care from a gastroenterologist. The mother was attending appointments, and the physicians were "not overly concerned." The Project Safe Care provider worked with the family to address the condition of the home. The issues were resolved.

The case closed in December 2019. At the time of closure, there were no toxicology samples provided by the mother or her boyfriend, and there were no documented discussions about the newborn's positive methamphetamine test results.

On Nov. 9, 2020, DCYF received an intake alleging an unsafe living environment and parental substance use. This intake was assigned for a CPS/FAR assessment.

On Nov. 10, the assigned caseworker attempted to contact the mother by calling her multiple times. There was no other documentation until a Nov. 30, 2020, case note that indicated the caseworker conducted initial face-to-face contacts with RCW 13.50.100 and his sister. RCW 13.50.100 was reportedly behind in speech, but the mother said he was making progress. He was not in daycare and did not have a PCP. The mother reported taking him to RCW 70.02.020 Urgent Care for medical attention when needed. The caseworker also learned that RCW 13.50.100 had not been to a dentist. RCW 13.50.100.'s sister also did not have a PCP. The mother did not allow the caseworker into the home, stating that due to COVID-19, she was uncomfortable with in-home visits. The caseworker could see into part of the home. The home was observed to be cluttered, but no visible safety hazards were identified. The mother said she lived there with her three children. She said her oldest child stays there Thursdays through Sundays.

The caseworker contacted the oldest child's father. He stated that under the parenting plan, he is the custodial parent. The mother was supposed to complete a substance use assessment and follow recommendations, but she failed to comply.

On Dec. 21, 2020, the Structured Decision Making Risk Assessment (SDM) tool was completed. The SDM showed there was a moderately high future maltreatment recurrence indicated. The SDM is required to be completed in connection with the safety assessment and during all CPS assessments and investigations. The tool assists caseworkers by identifying future risk to children and helps determine whether services are needed. On Dec. 31, 2020, the case was closed without gaining access to the home or conducting further collateral contacts.

On April 8, 2021, an intake was received. Law enforcement forwarded a report to DCYF that RCW 13.50.100 was naked and running around his neighborhood. Due to the clutter and garbage, the responding officer found the home to be concerning. A male at the home stated that on multiple occasions, the child "defeated the security measures" at the home. This intake screened in for a CPS/FAR assessment. A second intake with similar allegations was received the following day. It was screened out because the allegations were already reported.

On April 9, 2021, the assigned CPS caseworker called the mother. The mother said they were going to the beach and they could set up a time to meet the following week. After an agreed-upon date was scheduled, the caseworker called the mother three times, but the mother did not answer or respond to the caseworker's voicemails. On April 16, the caseworker went to the home unannounced. The mother's husband was leaving but spoke briefly with the caseworker. He said they were now divorced, and he lived in Yakima. The caseworker gave him a business card and left one for the mother in the home's front door jamb.

On April 20, the mother responded to a text from the caseworker. The mother said the children were in Yakima with their father. The mother and caseworker set an appointment for two days later. On April 22, the mother told the caseworker the children were staying longer with their father and would be home four days later. On April 26, the caseworker went to the mother's home at the agreed-upon time. The mother and children were not home. The mother later texted and apologized, and set another appointment for the next day.

On April 28, 2021, the caseworker met with the mother at her home. The children were present and were observed by the caseworker. The mother's now ex-husband was also present. He stated he was the father of

the two younger children. The mother stated RCW 13.50.100 rarely escapes now because she has three locks on the door, and when she showers, she makes him sit in the bathroom so she knows where he is.

The supervisor's case note indicated a decision to close the case. However, on May 22, 2021, another intake was received. That intake alleged a shooting occurred at the family home. The referent said the incident was described in a local newspaper. The article said the mother's ex-boyfriend broke into the home and threatened her current boyfriend, who then shot the intruder. The children were reportedly present but unharmed. Law enforcement did not inform DCYF of this shooting. This intake was screened in for a Risk Only assessment.

On May 23, 2021, the assigned caseworker made an unannounced home visit. No one answered the door. The condition of the property was described in the case note. The caseworker observed cannabis on the bench by the front door and could see into the home through a hole. She noted the room to be cluttered but could still see some of the floors. The caseworker called the mother. She was running errands and searching for her boyfriend's dog, who had escaped during the shooting. They agreed to meet the following Monday. The caseworker attempted contact on six different days.

On June 3, 2021, the supervisor created a case note for case closure.

On June 8, 2021, another intake was received. The information for this intake was contained in a police report and was about a burglary. The report indicated the home was unclean, there was a dead mouse in the bathtub, and the house smelled of urine. Other detectives observed live rodents in the mother's bedroom. This intake screened in for a CPS investigation, and it was noted the May 22 intake was still open and active.

On June 9, the assigned caseworker went to the mother's home. No one answered the door. The caseworker called the school attended by the mother's oldest son and eventually spoke with the child's father. The child's father stated his son lived with him full-time and that the mother was using methamphetamines and heroin. The court authorized the mother to only have supervised visitation with the oldest son. This order was from Dec. 2020. The father alleged the mother was dating the person who sells her substances. There was a guardian ad litem (GAL) involved in the family court case. In family law cases, GALs are appointed by a court to represent the best interests of the children involved in the case.

After June 9, multiple attempts were made to contact the mother, but actual contact did not occur until Aug. 11, 2021. The mother came into the DCYF office with her two youngest children. She said both children slept through the shooting and the mother reported the rooms do not smell like urine. Because the mother was wearing a tank top and shorts, the caseworker did not see any marks that would indicate she was injecting substances.

The Aug. 12, 2021, supervisor case note indicates the case was going to be closed.

On June 17, 2022, another intake was received from law enforcement. The report alleged lack of supervision, neglect, and concerns for the condition of the home and property. This intake screened in for a CPS/FAR assessment. On the day the intake was received, the caseworker called the mother's phone number multiple times and went to the home twice.

On June 19, 2022, an after-hours caseworker called three different telephone numbers to contact the mother. Two did not work, and there was no answer for the third. The after-hours caseworker went to the home. She walked around the property and looked inside the home through a window. The after-hours caseworker documented in her case notes that she did not believe the home was safe for young children and that it was a fire hazard with no clear pathways. Two exits from the home appeared to be blocked by large items. On Monday, June 20, at 8 a.m., the originally assigned caseworker arrived at work, checked the case, and did not see any updated information in the computer system. The after-hours worker did not enter her June 19 observations into a case note until 8:30 a.m. on June 21.

On June 21, 2022, the assigned caseworker arrived unannounced at the home. The mother was on the front porch with a male adult. The mother said she had been working out of town and did not arrive home until 5:30 a.m. that morning. She would not provide the name of her male friend. She said she lives alone with her two youngest children and occasionally sees her oldest son.

RCW 13.50.100.'s mother said her son is an "escape artist" and always looks for ways to get out of the home. She has door knob covers, but he recently got out through the garage. She has an alarm on the front door as well. The mother went inside the house and brought out her daughter and RCW 13.50.100 would not interact with the caseworker, but he was observed to be "clean" and "content." He became upset when his mother took him back inside the home. The mother told the caseworker she could come back the following day to see the inside of the home.

On June 22, 2022, the mother sent a text stating she forgot it was the last day of school for her oldest son, and she had promised him she would take him out to eat. They agreed to meet at the mother's home the following afternoon. On June 23, the mother texted the caseworker stating her employer called her into work. An appointment was set for 2:00 p.m. on June 28.

On June 28, 2022, law enforcement responded to a naked male child found deceased in a body of water. The child was later identified as RCW 13.50.100 An intake was created, and law enforcement placed the younger sister into protective custody.

Committee Discussion

The Committee discussed many challenging areas and improvement opportunities. The major discussion areas are covered in this section. The improvement opportunities discussion is not correlated to the death of RCW 13.50.100

The office that was assigned this case has experienced many vacancies and high caseload levels. The Committee discussed how these issues might impact the agency staff's ability to complete their duties. This was shared as an acknowledgment of the challenges faced by DCYF's child welfare staff and, in particular, the office that was assigned the RCW 13.50.100 case.

DCYF has a policy about universal domestic violence (DV) screening to determine what impact DV may have on child safety.[4] The Committee believes this case should have qualified for a specialized DV screening. The first

[4] For more information about DCYF's domestic violence universal screening policy, see: https://www.dcyf.wa.gov/1100-child-safety/1170-domestic-violence.

time DV was mentioned involved DV allegations between the mother and her oldest son's father. Fully assessing the children's fathers may have resulted in a more comprehensive child safety assessment.

The Committee discussed that it may have been more helpful if the assessments and investigations had been more comprehensive. Collateral contacts such as law enforcement and family court may have assisted DCYF in understanding the mother's substance use issues and the activity that was occurring within the home. Related to this, further assessment and curiosity about RCW 13.50.100.'s behavioral challenges and needs and discussions of parental supervision while in the home may have improved the understanding of the safety issues.

Specific to substance use issues, in 2019, at RCW 13.50.100.'s sister's birth, the screened-in intake identified possible concerns for substance use by the mother. Both the mother and sister had positive toxicology results for amphetamines. The mother denied using anything other than RCW 70 02 020 However, confirmation testing showed both the mother and sister had methamphetamine in their systems at the time of the sister's birth. This result was provided to DCYF after the case was transferred to FVS. This information was not incorporated into the case plan or discussed with the parents or service provider. The parents were asked to complete further urinalysis testing, but they did not follow through.

As a part of the substance use discussion, the DCYF Substance Use Program Manager said that all offices have access to oral swabs. Compared to observed urinalysis testing, oral swab testing was discussed as a cheaper, easier, and barrier-free alternative. The staff discussed that they do have other alternatives to urinalysis testing, including hair follicle testing. However, there are no hair follicle testing sites in the county where this particular office is located. Therefore, to complete the testing, the caseworkers have to refer families to another county which adds additional barriers, including transportation. After the Committee met, the author of this report learned that while the regions and offices have access to oral swabs for substance testing, not all the regions and offices are using them. The regions and offices are currently creating the necessary training and procedural guidance for staff to utilize this tool.

From two of the Committee members, the Committee learned about the relationship between early childhood sexual assault and the inability to produce urine. There is a history of childhood sexual assault in this case. On more than one occasion during observed urinalysis testing, the alleged victim of the childhood sexual assault unsuccessfully attempted to provide urine samples. This topic is further addressed in the Recommendation section below.

There are DCYF staff assigned to work outside of regular DCYF business hours. These staff are referred to as after-hours workers or staff. DCYF offices are normally closed on weekdays between 5 p.m. and 8 a.m., weekends and holidays. On June 19, 2022, an after-hours caseworker attempted to contact the family. The case note was not entered until two days later, on June 21. On Monday, June 20, the regularly assigned caseworker arrived at the office at 8 a.m. and checked for updated information about the case before attempting contact with the family. The assigned caseworker said that had she known about the case note prepared by the after-hours caseworker, the assigned caseworker may have pushed harder to convince the mother to allow her to enter and observe the home. The timely completion of a case note was discussed as a missed opportunity to help inform the assigned caseworker about the case.

The Committee discussed that supervisor support and direction is very important. This case may have benefited from further documentation and direction provided by the supervisor to complete the areas identified by the Committee as improvement opportunities.

Recommendations

The Committee members agree that DCYF's clients can benefit as a whole from the Committee's efforts to provide comprehensive discussion and analysis of the case. While recommendations are made about the many aspects of this case, there is no correlation between the death of [redacted] and the recommendations. The purpose of the recommendations is to help DCYF improve its case procedures and practices.

1. DCYF staff have multiple tools to assess child safety and alleged parental substance use. One tool that was recently added is oral swabs for substance use testing. The Committee recommends that DCYF use oral swabs as the primary parental substance use testing source. The advantages of oral swabs over the use of urinalysis testing include: oral swabs do not require a person to travel to a testing site, are less invasive, are easier to administer, and are less costly. Oral swabs are also more difficult to tamper with during the sample collection process because the collection takes place under direct supervision.
2. The cost of a substance use assessment should not be a barrier for an uninsured parent to complete an assessment. DCYF should provide the necessary funding if the parent is uninsured or insurance does not cover the cost of an assessment. Additionally, a substance use assessment must be based on more than just self-reported information. The assessment must also be based on collateral information collected by the agency. The DCYF substance use Program Manager should discuss this issue with all six regional leads.
3. DCYF should provide staff education about the correlation between early childhood sexual abuse and the victim's inability to provide a urine sample during observed urinalysis testing. This knowledge will allow DCYF staff to have a more trauma-informed approach to interactions with parents who suffered childhood sexual abuse and are also experiencing substance use issues.
4. DCYF should provide staff education about the warning signs and risk factors when assessing child safety in an environment where substance use may be present. The DCYF Substance Use Program Manager is currently working on monthly child safety warning signs training and risk factors training and plans to do so. Information from this review, along with this identified need, should be incorporated into these trainings.