CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

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CONTENTS

Nondiscrimination Policy

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

- A.S.

Date of Child's Birth

- [redacted] 2015

Date of Fatality

- September 28, 2023

Child Fatality Review Date

- December 5, 2023

Committee Members

- Danna Runsabove, MBA Executive and Management, Indian Child Welfare Director for the Fort Peck Assiniboine and Sioux Tribes
- Heidi He Does It, Esq., Attorney for the Fort Peck Assiniboine and Sioux Tribes
- Deborah Lurie, JD, Ombuds, Office of the Family and Children's Ombuds
- Aushenae Matthews, Director of Housing Servies, Domestic Abuse Women's Network
- Lisa Ryan, MSW, LICSW, Director of the Pediatric Care Continuum, Mary Bridge Children's Hospital
- Lisa Lopez, Region 3 CPS and FAR caseworker, Department of Children, Youth, and Families
- Amy Boswell, MSW, Region 6 Quality Assurance and Regional Program Area Administrator, Department of Children, Youth, and Families

Facilitator

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

Executive Summary

On December 5, 2023, the Department of Children, Youth, and Families (DCYF) convened a Child Fatality Review (CFR)[1] to examine DCYF's practice and service delivery to A.S. and RCW 7 family. A.S. will be referenced by RCW 7 initials throughout this report.[2]

On September 29, 2023, A.S.'s paternal aunt called DCYF and stated that A.S., RCW 7 father, and RCW 7 siblings had been residing with the paternal great-grandmother for several weeks. The paternal great-grandmother told the aunt that on September 28, the children accessed a loaded firearm and the 10-year-old RCW 74.13.515 shot and killed RCW 7 eight-year-old RCW 74.13.515 A.S. Law enforcement was notified. The great-grandmother told the aunt that the father had hidden cameras in the house and heard his children plotting to kill him. RCW 13.50.100, RCW 74.13.515 RCW 13.50.100, RCW 74.13.515 There were other reports of the mother physically abusing the children. This information led to a Child Protective Services (CPS) investigation.

DCYF had an open Family Assessment Response (FAR)[3] case with the family at the time of A.S.'s death. That assessment included allegations of physical abuse by the children's father. The children were living with their father and their mother's whereabouts were unknown.

A 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, as well as the Fort Peck Assiniboine and Sioux Tribes. The Indian Child Welfare Director and Tribal attorney participated in the review.

Committee members did not have any contact or involvement with A.S. or RCW 7 family. RCW 74.13.515 RCW 74.13.515 Before the review began, a member from the Tribes sang and spoke a prayer. The Committee received relevant case history from DCYF. On the day of the review, the Committee had the opportunity to interview DCYF staff who worked the case during the two years prior to A.S.'s death.

Case Overview

There were three intakes regarding this family in May 2019, all of which alleged physical abuse and maltreatment RCW 13.50.100 These intakes were screened out. In August 2019,

[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 of other individuals associated with the child. A CFR is not intended to be a fact-finding or forensic inquiry or to replace or supersede investigations by courts, law enforcement agencies, or other entities with legal responsibility to investigate or review some or all of the circumstances of a child's fatal injury. Nor is it the function or purpose of a CFR to recommend personnel action against DCYF employees or other individuals.

[2] A.S..'s name is also not used in this report because RCW name is subject to privacy laws. See RCW 74.13.500.

[3] "FAR is a CPS alternative response to a screened-in allegation of abuse or neglect. FAR focuses on children and youth safety along with the integrity and preservation of families when lower risk allegations of maltreatment have been screened-in for intervention." For more information about FAR, see: https://www.dcyf.wa.gov/policies-and-procedures/2332-child-protective-services-family-assessment-response.

a Family Reconciliation Services[4] case was opened after the father requested assistance with his then-16-year-old RCW 13.50.100 A second intake was received in August 2019. RCW 13.50.100 This intake screened out, as the reports were historical and mental health counseling was being sought to help the situation.

In September 2019, RCW 13.50.100 the case closed at the father's request.

The family came to DCYF's attention again in January 2020, resulting in a new FRS case. RCW 13.50.100 RCW 13.50.100 The case once again closed.

In October 2020 the school called with concerns about A.S. coming to kindergarten in clothing that was not warm enough and that RCW 7 appeared tired. This information screened-out. In November 2020 another FRS case opened and then closed in July 2021.

In August 2021, a FAR case opened due to allegations of neglect and lack of supervision. The case closed in February 2022. RCW 13.50.100

Another FAR case opened in May 2022 after two intakes were received. The allegations were: (1) the children were living with their father and he was not allowing them to see their mother; (2) the home was dirty; (3) substance abuse by the father; and (4) physical abuse by the mother.

RCW 13.50.100

The father refused to comply with requests for urine testing. The caseworker made collateral contacts with relatives, completed data base searches, and requested and read law enforcement reports. The caseworker also provided the family with a lock box and gas cards. Due to lack of disclosures by the children, lack of behaviors indicative of substance use, and lack of imminent danger to the children, the case was closed in June 2022.

On September 8, 2023, RCW 13.50.100

[4] Family Reconciliation Service cases are related to family conflict, at-risk youth, or when a youth may need services. For more information, see: https://www.dcyf.wa.gov/policies-and-procedures/3100-family-reconciliation-services.

[5] At-Risk-Youth refers to when a parent or guardian believes the child needs court intervention to help maintain control of the child and alternatives to court involvement have already been attempted. For more information See: https://app.leg.wa.gov/rcw/default.aspx?cite=13.32A.191.

RCW 13.50.100 also stated the family has to move and they don't know where they will go. This intake screened-in for a FAR assessment.

met with the assigned caseworker and school counselor. said that RCW 13.50.100 RCW 13.50.100 his father hasn't physically harmed younger siblings, and that father's girlfriend sometimes takes care of them. When asked, said did not feel safe at home RCW 13.50.100 RCW 13.50.100 also said that dad drinks alcohol often and that about a month ago saw a bag with white powder in it next to a mirror and playing cards. said dad takes these items into the bathroom and tells to stay out. The kid's uncle will also go into the bathroom with the father. The counselor shared that the father is not responsive to their continued telephone calls or emails.

On September 14, the youngest child's school called in an intake. RCW 13.50.100 That information screened out because the child did not state the injury was due to abuse.

The next day a caseworker met with the elementary school-aged children at school. A.S. told the caseworker was excited to move. The children and their father were going to live with the father's friend. A.S. did not feel safe at home because it was in a "scary" area. They had been chased by someone and dad's gun was stolen. However, father bought a new gun. RCW 13.50.100 talked about DV between dad and RCW 13.50.100 also said that the family is moving. RCW 13.50.100 RCW 13.50.100 also shared they are moving and that the current residence is not safe. None of the children were able to provide any clear information regarding where they were moving or whom they were moving in with.

On September 29, DCYF was notified by the paternal aunt that eight-year-old A.S. had been shot by 10-year-old RCW 13.50.100 The incident occurred the previous day and law enforcement responded. A CPS investigation was initiated.

Committee Discussion

The Committee's discussions pertained to specifics related to this case but also to generalized child welfare case practice within DCYF. This section reflects those discussions.

Committee members identified that this was a tragic event that DCYF staff could not have predicted. They were concerned about the surviving siblings and the impact this death will have on those children as well as the impact felt by the DCYF staff who were and had been involved with the family.

The Committee discussed differing systemic issues that impacted the staff who worked the family's cases during the last two years. Those issues included a continuous change in staff due to a changing number of Indian Child Welfare cases. DCYF weighs cases that are identified as Indian Child Welfare cases at a greater weight than non-Indian Child Welfare (ICW) cases. However, due to fluctuating numbers within screened-in cases, regions have the ability to redistribute staff as needed. This specifically impacted the unit assigned to

this family. This unit also covers a larger area compared to other CPS units because it provides specialized ICW services. Covering larger areas can add to travel times and overall can take more time to work a case. Also due to vacancies, the supervisor at one point was overseeing another unit and the caseworkers were helping cover for another office.

The staff discussed how being told they may be placed under a performance improvement plan due to having cases open over 90 days caused them significant stress. The staff shared that they believe this may have caused them to place more emphasis on closing cases that they had already identified as safe over the cases they were actively assessing at the time they were told about the potential for being placed under a performance improvement plan.

The CPS supervisor shared her concerns about the timeframes required for CPS and FAR cases, specifically how those timelines are too short when trying to establish trusting relationships with families. This is especially true when a family is part of a community that has faced oppression or trauma by the government, such as indigenous families.

The Committee did discuss that documenting the efforts made to contact the father at his residence and other attempted relative contacts would have helped a person reading the case file to better understand the efforts made to gather information about child safety. The father was evasive and uncooperative.

Incorporating questions about weapons, storage, access to weapons, and lethality (as it pertains to DV) while assessing for child safety was discussed. DCYF policy does not require staff to ask about weapons in the home, storage of weapons, nor accessibility to weapons. The Committee members discussed that it may be appropriate for the DCYF Safety Program Manager to consider adding these considerations to DCYF policies.

Recommendations

The Committee did not make any recommendations.