CHILD NEAR FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

February 2022

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CONTENTS

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February 2022

Full Report

Child

- L.S.

Date of Child's Birth

- RCW 74.13.515 2015

Date of Fatality

- Aug. 12, 2021

Child Fatality Review Date

- Nov. 4, 2021

Committee Members

- Elizbeth Bokan, JD, Office of the Family and Children's Ombuds, Ombuds
- Lindsey Barcklay, MSW, LICSW, CMHS, SUPD, CCTP, Domestic Abuse Women's Network, Clinical Director
- Chris Kerns, MSW, Alliance for Child Welfare Excellence, Regional Education and Training Administrator
- Tracey Czar, JD, Pierce County Juvenile Department, Child Advocate Program Supervisor
- Beackie Colon Rivera, LICSW, SUDP, Consejo Counseling and Referral Service, East Pierce County Clinical Supervisor
- Paul Kallmann, MSW, Department of Children, Youth, and Family, Quality Practice Specialist Region 5

Consultant

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Facilitator

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

Executive Summary

On Nov. 4, 2021, 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 L.S. and [RCW 7] family[3]. [RCW 7] will be referenced by [RCW 7] initials throughout this report.

On Aug. 12, 2021, DCYF was notified that L.S. and [RCW 7] mother were killed in an automobile accident. L.S., [RCW 7] two sisters, and [RCW 7] mother were in the car at the time of the accident. The sisters survived the crash. L.S.'s three older brothers were not in the car. DCYF was also notified that the [RCW 74.13.515] Department of Human Services (DHS) had recently opened a Child Protective Services (CPS) investigation [RCW 13.50.100] [redacted]. The Aug. 12 DCYF intake screened in for a CPS Risk Only[4] case. DCYF [RCW 13.50.100] [redacted]. One of the children was living with his father and was safe. The children were with their maternal grandmother after the accident but prior to DCYF's legal intervention.

A diverse Committee was assembled to review this case and evaluate DCYF's service delivery to the family. The Committee included community partners and DCYF staff. An invitation to attend and participate in the review was extended to the [RCW 74.13.515] [redacted]. However, a representative did not attend the review. Before the review, none of the Committee members had any direct knowledge of or involvement with the family. Committee members received copies of the DCYF case history that included intakes, case notes, law enforcement reports, and DCYF risk assessment tools and assessments. A DCYF Indian Child Welfare Act (ICWA) regional consultant reviewed this case. She provided an email with her review of the

[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 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.

[3] The names of L.S.'s parents are not used in this report because neither parent has been charged with a crime in connection with the fatality.

[4] CPS Risk Only is an intake that alleges imminent risk of serious harm and there are no allegations of child abuse or neglect. See: https://www.dcyf.wa.gov/practices-and-procedures/2200-intake-process-and-response.

case. The email was provided to the Committee. On the day of the review, the Committee interviewed caseworkers, supervisors, a quality practice specialist, and two area administrators.

Case Overview

Between 2004 and 2018, DCYF received 21 intakes about this family. In September 2004, DCYF received the first intake. Intake allegations included physical abuse, neglect, substance use by the parents, and domestic violence (DV). Eight of the 21 intakes were screened in for a CPS response. The intakes received assessments or investigations; all the intakes were closed with no further action.

On Jan. 2, 2019, an intake was received and screened out. This intake alleged the family was living with the maternal grandparents. The allegations included that the parents were using marijuana and were suspected of using other substances, threats of physical harm by L.S.'s father to persons in the home, and turmoil between the parents and grandparents.

On Sept. 16, 2019, another intake was received. A family friend called in this intake. The caller alleged that on Sept. 15, law enforcement responded to a hotel where the family was living. The hotel was attempting to evict the family. Law enforcement told the parents the children would be placed in protective custody unless they found other places for the children to go. The parents dispersed the children amongst friends and family. One of the children had a broken arm. The caller reported being told three different stories about the cause. The caller also alleged that more than a month before the Sept. 16 intake, one of the children called law enforcement to report the stepfather was ingesting methamphetamine in the motel room bathroom. This intake screened in for a CPS investigation.

While the September intake remained open for investigation, another intake was received. On Dec. 2, 2019, RCW 13.50.100 alleged that one of L.S.'s brothers RCW 74.13.520 . That intake screened in for a CPS/Family Assessment Response (FAR)[5] assessment. On April 2, 2020, the investigative assessment for the earlier September 2019 intake was approved for closure. An unfounded finding was made with regard to this intake. An unfounded finding means that more likely than not child abuse or neglect did not occur or that there was not enough evidence to determine that it had occurred. L.S.'s parents provided a urinalysis. L.S.'s father's test result RCW 74.13.520 . The mother's test result RCW 74.1 .

On May 7, 2020, another intake was received. The family's case was still open for purposes of the December 2019 FAR intake. The May 2020 intake alleged the family was homeless but was staying in a one-bedroom "suite." There were six children and the mother staying in this one-bedroom suite. The night before the intake was received, the mother stole the landlord's car, left the children alone, and crashed the car. The caller alleged the mother was using drugs. The caller reported hearing a lot of screaming by the mother towards the children. However, the caller denied ever seeing any physical abuse. At the time of the May intake, there was a RCW 13.50.100 order issued against L.S.'s father. The order RCW 13.50.100 . The May 7 intake was screened out. The screening decision

[5] See: https://www.dcyf.wa.gov/practices-and-procedures/2332-child-protective-services-family-assessment-response.

stated that older siblings cared for the younger children. That same day the FAR Family Assessment Response (FARFA)[6] was approved for closure, and the case was completely closed with DCYF.

On June 11, 2020, another intake was received alleging neglect of the children by the mother, allegations of violence between the mother and her husband, which involved a firearm, and substance use by the mother. This intake screened in for a CPS/FAR assessment. While this assessment was pending, another intake was received on Aug. 26, 2020. The August intake alleged neglect and substance use. This intake was screened out because no specific child abuse or neglect allegations or an identified risk met statutory guidelines.

Another intake was received on Sept. 28, 2020. This intake alleged the mother was leaving the children with unsafe relatives, and RCW 13.50.100, she was having contact with her husband. One of the relatives had RCW 13.50.100 pending criminal charges RCW 13.50.100. This intake screened in for a CPS/FAR assessment. The June 2020 FAR assessment was approved for closure, and a new FAR caseworker was assigned to assess the September 2020 allegations.

On Oct. 14, 2020, an intake was received and screened out. The intake alleged L.S. was not attending school online. The school attempted to contact the family but was unsuccessful.

On Oct. 28, 2020, four intakes were generated. These intakes originated from law enforcement reports. The reports alleged domestic violence, RCW 13.50.100 order between L.S.'s parents. In one of the reports, L.S.'s father stated he and the mother were using RCW 74.13.520 together. L.S.'s father was arrested. None of the intakes were screened in for investigation or assessment.

On Dec. 30, 2020, the RCW 74.13.515 called DCYF. RCW 74.13.515 did not feel safe with his mother. He also said the mother and her husband RCW 13.50.100, and his father did not talk to him. The intake screener told RCW 74.13 515 that the intake would be screened in as a request for a Child In Need of Services (CHINS), and the purpose would be to improve family functioning. The intake was screened out for Family Reconciliation Services (FRS). The screening decision stated the case was currently open and could be dually assigned "as deemed necessary." On Jan. 4, 2021, another FRS intake was received and screened out. RCW 74.13.5 called in this intake. RCW 13.50.100 The screening decision was the same as the Dec. 30 intake.

A CPS supervisor requested a triage staffing. A triage is a staffing that includes a team of staff from the region. The purpose of a triage staffing is to assist a caseworker and supervisor with decision making. On Feb. 23, 2021, the case was staffed with a triage team. The team consisted of quality practice specialists, two CPS supervisors, a child health education tracker supervisor, and an early learning program manager. At the time of the staffing, the family had not been cooperative with any of the assessments or investigations, and the children were living with the maternal grandmother. The triage notes were documented in Famlink, the computer system used by DCYF. The notes indicated the team discussed Safety Threats 1 and 5. Safety Threat 1 is "The family/facility situation results in no adults in the home/facility performing parenting/child care duties and responsibilities that assure the child's safety." Safety Threat 5 is "Caregiver(s) will not or cannot control their behavior, and their behavior impacts child safety." There was no documentation about the Safety

[6] A FARFA is a comprehensive assessment of child safety and needs.

Thresholds. Safety Threats and the Safety Threshold are components within the Child Safety Framework used by DCYF to assess child safety throughout a case's life.

The triage team recommended that contact be made with the Native American Inquiry Referral team because one of the fathers was identified as having a tribal affiliation. The triage team also recommended that a Kinship Navigator contact the maternal grandmother to discuss the possibility of guardianship. It was noted that DCYF would file dependency petitions if, by March 5, the grandmother failed to establish guardianship for the children.

Because the mother refused to engage or communicate with DCYF, staff reviewed her RCW 13.50.100 [redacted] On March 22, the search results showed she was RCW 13.50.100 in Astoria and Clatskanie, Oregon. The assigned caseworker attempted communication with the mother and fathers through Facebook and checking jail rosters. One of the fathers responded to the caseworker. He said he did not know the mother and son's location, but he had recently texted him. He said he would try to determine their whereabouts and share that information with the caseworker.

The caseworker attempted numerous times to communicate with the maternal grandmother and parents. She also communicated with their schools on multiple occasions. Only one of the children was attending school. The caseworker met with him. He was unable to share any details about the location of his mother or siblings.

A review of the mother's Facebook page revealed she had a new boyfriend. This boyfriend RCW 13.50.100 [redacted].

On April 1, 2021, an intake was received stating the mother and six children were living in a two-bedroom hotel, and there were concerns the mother was using drugs and not feeding the children. The intake was screened out.

The grandmother failed to establish guardianship. At the beginning of March, the mother took all but her oldest child into her care. The mother or another family member hired a private attorney, and neither the attorney nor the family cooperated with DCYF. Multiple attempts were made to locate the mother and children, but none were successful. There was documentation that the case was staffed with the CPS caseworker, her supervisor, and the area administrator. The case was closed, stating DCYF was unable to complete the assessment because DCYF was unable to locate the family. At the time of case closure, the oldest child resided at the maternal grandmother's home and his best friend's parents' home.

On Aug. 12, 2021, DCYF was notified that L.S. and RCW 7 [redacted] mother were killed in an automobile accident. This intake screened in for a CPS Risk Only investigation. DCYF RCW 13.50.100 [redacted]. The one child RCW 13.50.100 [redacted] was living with his father and was deemed safe. The other children were allowed to remain with the maternal grandmother.

Committee Discussion

The Committee understands there were long-term vacancy and turnover issues at the office responsible for assisting this family. The Committee appreciates that staffing instability can create barriers and challenges to meeting policy expectations. The Committee was mindful of these facts during all aspects of the case.

The Committee perceived a lack of urgency by DCYF staff during the time DCYF was completing investigations and assessments. However, the Committee understands the parents and maternal grandparents were uncooperative, which made working with the family very difficult. Regardless, the chronicity of neglect and violence within the family was significant. The chronic neglect and violence justified stronger intervention and possible legal action.

While unclear if there was a primary aggressor, domestic violence was a consistent component within this family. It was discussed that the potential lethality was high. During an interview, one of the children was asked why he thought the caseworker was talking to him. In response, the child described in detail the way L.S.'s father RCW 13.50.100. The child spoke about RCW 13.50.100 On multiple occasions, that mother left the relationship. Leaving a domestic violence relationship increases the possibility of serious injury or death. There were multiple law enforcement reports RCW 13.50.100. L.S.'s mother RCW 13.50.100. Shortly before her death and while in RCW 74.13.515 she was RCW 13.50.100.

DCYF staff were aware of the mother's most recent boyfriend RCW 13.50.100. Before case closure, DCYF staff learned the mother was in RCW 74.13.515 The Committee discussed that DCYF should have called RCW 74.13.515 DHS during the open CPS case to notify them that the mother was in RCW 74.13 515 DCYF should have also shared DCYF's concerns about the mother's boyfriend. The Committee also discussed that DCYF should have attempted contact with the boyfriend at his last known address, or sought out other collaterals related to him in an attempt to find the mother and children.

The Committee expressed concerns that DCYF staff did not follow the documented triage team meeting recommendations. The Committee also expressed concerns that a majority of the individuals involved in the triage team meeting did not agree with the recommendations. The disagreement was documented by a supervisor who was not present at the triage staffing. Also concerning is the thought that DCYF created an informal placement with the maternal grandmother. If DCYF decides that children are unsafe and the identified safety threats meet the threshold requirements, DCYF must take action in an attempt to provide safety. By allowing a parent deemed unsafe to make a placement decision, such as leaving the children with the maternal grandmother, there is an implied approval of an informal placement.

There was also confusion about the actual safety threat. While there were documented safety threats, there was no clear description of the facts or circumstances that supported the safety threats. The Committee is also concerned about the lack of a clear direction with regard to which staff were responsible to follow up on and document the outcome of the recommendations.

Substance use was another large component within this family. The only urinalysis test results received by DCYF involved a RCW 74.13 520 result for L.S.'s father and a RCW 74.13.520 test result for the mother. The

Committee believes there should have been additional investigation and discussions with L.S.'s mother about her RCW 74.13.520 use. The discussions could have focused on the frequency and method of use and how the drugs were stored. The purpose of additional investigation and discussion would have been to assess parenting impacts and child safety issues. Information from law enforcement reports about the parents' substance use could have been used to further assess the parents' drug use issues. The mother signed a release of information with substance use treatment providers. However, she limited the amount of information that could be released or discussed, making it a useless tool for assessment purposes. While she has the right to limit the amount of information released, her avoidance and refusal to cooperate should have resulted in greater intervention or legal action.

The Committee discussed screened-out intakes. While the case was open, there were multiple times that intakes were received and screened out. The Committee discussed that DCYF staff are expected to incorporate those intakes into their work with the family. Some of the intakes contained detailed information about substance use and violence. The Committee believes that incorporating those details into the work and assessments may have been helpful to the assigned staff and supervisors.

The DCYF staff who met with the Committee discussed the challenges the local court system has imposed on DCYF. The Committee discussed that even though the prior judges have been difficult to work with, DCYF must continue to file appropriate dependency petitions consistently. The Committee understands the challenges to DCYF staff when DCYF believes there is an imminent risk of harm to a child, and despite this risk, the courts repeatedly dismiss the dependency petitions that have been filed. The Committee discussed that DCYF staff must continue to work with their legal counsel to make the dependency case as strong as possible. In this particular case, the Committee believes the triage staffing was appropriate but also believes staffing the case with legal counsel should have occurred.

Findings

Before the death of L.S. and RCW 7 mother, neither the mother nor father disclosed the fact that the father was a descendant of the RCW 74.13.515 Tribe. Despite the parents' failure to disclose the father's Native American heritage, there was information contained in Famlink (DCYF's computer system) describing his heritage. Based on the information contained in the intakes, DCYF should have reached out to notify the Tribe each time a new intake was screened in and at other key points during the case, such as during a Family Team Decision Making meeting (FTDM). This is addressed in DCYF's Indian Child Welfare Policies and Procedures.

The Committee believes the domestic violence history should have been more thoroughly assessed throughout the life of this case. There were many police reports, RCW 13.50.100 orders, and a child's statement from 2020 RCW 13.50.100 . Also, pursuant to DCYF policy No. 1170 Domestic Violence, "If DV is determined to be present in a case through universal screening, CA[7] staff must conduct a Specialized DV Assessment with an interview protocol, not a tool." The Specialized DV Assessment was not completed before the child fatality.

[7] Prior to the formation of DCYF, child welfare staff within the Department of Social and Health Services were referenced as "Children's Administration (CA) staff".

As a part of the CPS process, DCYF Policy No. 2331 directs that caseworkers should "Interview professionals and other individuals who may have knowledge of the children or youth, parents or guardians, or the allegations of CA/N[8]…." DCYF Policy No. 2331 contains a list of the individuals who should be interviewed during the Child Protective Services CPS Investigation. Consistent with Policy No. 2331, the Committee believes DCYF should have contacted the RCW 74.13 515 Tribe, relatives, fathers, and medical providers. There were some attempts made to contact the fathers. However, those attempts did not occur during each assessment or investigation. Also captured within Policy No. 2331 is a requirement that caseworkers must conduct monthly health and safety visits with children and parents when a case is opened longer than 60 calendar days. DCYF did not meet this requirement in two separate involvements with the family.

Recommendations

The Committee recommends that all DCYF field staff attend or should have taken the Domestic Violence in Child Welfare training within the last two years. The Alliance offers this training.

All RCW 74.13.51 field staff need to retake the DV in Child Welfare, regardless of when they last took the training. The Committee recommends the RCW 74.13.51 office receive a refresher training regarding policy requirements related to the ICWA, including when and how to contact Tribes and engagement with Tribes.

[8] CA/N means child abuse and/or neglect.