RCW 74.13.500

Children's Administration

Executive Child Fatality Review

Leo Mathis III Case

Date of Birth: 10[redacted]/2007
Date of Death: 06/22/2011
Date of Review: 11/16/2011

Committee Members
Jennie Lindberg, Chemical Dependency Professional, Evergreen Manor
Cleveland King, Child Protective Services Supervisor, DCFS, Region 2 South
Megan Sweeney, Domestic Violence Coordinator, Lynnwood Police Department
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Executive Summary

On June 22, 2011, Leo Mathis Jr. was carrying his then three-year-old son Leo Mathis III across the Prickly Pear Creek near Helena, Montana. Mr. Mathis tripped and fell, dropping Leo III into the creek. The child was swept downstream and was found about 18 minutes later. Leo III fell into the water at around 7:15 p.m. Witnesses saw him go into the water and immediately called 911. An aid crew with East Helena Fire Department found him about a half mile down the creek. Rescue workers found Leo III at 7:38 p.m. and immediately began administering CPR. He was taken by an ambulance to St. Peter's Hospital in Helena. He was pronounced dead at 8:56 p.m. The Lewis and Clark County Coroner reported that Leo III died from drowning.

On June 24, 2011, Leo Mathis Jr. was arrested on a charge of negligent homicide in connection with his son's death. Police officers reported Mr. Mathis was intoxicated when he attempted to carry his son across the creek eventually dropping him into the water.

Mr. Mathis has pleaded not guilty to negligent homicide. He was still in the Lewis and Clark County Detention facility awaiting trial when this report was written.

Police reported that Leo Mathis Jr. moved to Montana from Oak Harbor just days prior to Leo's death. L.D., Leo's mother, moved with Leo III to Montana in December 2010.

Children's Administration has history on this family from November 2010. At that time, Oak Harbor Police officers stopped Mr. Mathis after he was observed stumbling down the street in Oak Harbor with his young son Leo in his arms. Mr. Mathis was intoxicated at this time. A Child Protective Services (CPS) case was opened on the family. The investigation was completed and the case was closed in December 2010 shortly after L.D and Leo III moved to Helena, Montana.

Leo Mathis Jr. participated in drug/alcohol treatment in September 2010, prior to CPS involvement with this family. His participation in drug/alcohol treatment was a condition of his probation. Mr. Mathis was court ordered into substance abuse treatment because of two DUI arrests and convictions in 2009.

On November 16, 2011, CA convened a multi-disciplinary committee to review adherence to policy and the social work practice in this family's case.[1] The fatality review team was

[1] Given its limited purpose, a Child Fatality Review by Children's Administration should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. A review is generally limited to documents in the possession of or obtained by DSHS or its contracted service providers and the panel may be precluded from receiving some documents that may be relevant to the issues in a case because of federal or state confidentiality laws and regulations. A review panel has no subpoena power or authority to compel attendance and generally will only hear from DSHS employees and service providers. The panel may not hear the points of view of a child's parents and relatives, or those of other individuals associated with a deceased child's life or fatality. A Child Fatality Review is not intended to be a fact-finding or forensic inquiry or to replace or supersede investigations by courts, law enforcement agencies, medical examiners or other entities with

represented by disciplines associated with the case and had no involvement or limited involvement with this family. The fatality review team members included a community representative working with victims of domestic violence and a chemical dependency professional. The team also included CA staff who had no direct connection to the case. An invitation was sent to the Office of the Children and Family Ombudsman.

Relevant case documents were made available to the fatality review team. These documents included: law enforcement reports, family history including intake information, a chronology of the case upon assignment of the case on November 20, 2010 and media reports on the tragic death of Leo Mathis III.[2]

Following review of the case history, case records and law enforcement records, the review team discussed the case and any issues and recommendations. The issues and recommendations are detailed at the end of this report. The team also discussed intake screening criteria when cases allege domestic violence between parents.

Case Overview

The CPS history on this family, prior to Leo III's death, consists of one intake received on November 20, 2010. This intake was accepted for investigation by Child Protective Services.

On Saturday, November 20, 2010, the Oak Harbor Police Department called Central Intake looking for assistance in placing three-year-old Leo Mathis III in protective custody. Police officers had decided to place him into protective custody after receiving a call that Leo's father, Leo Mathis Jr., was observed walking down a street in Oak Harbor, very intoxicated and stumbling with his son in his arms. Police responded and made contact with Mr. Mathis. He was belligerent and combative with police officers. Officers initially planned to return Leo III to his mother's care, but Mr. Mathis refused to tell police officers where she was located.

Police reported they transported Mr. Mathis to the police station, but when they arrived, he jumped out of the car and ran.

A police officer contacted an after hours social worker to arrange for a transfer of custody to place Leo III in out of home care. The after hours social worker was dispatched from Bellingham but was unable to respond in a timely manner due to treacherous road conditions.[3]

Police were later called to the home of a friend of L.D. L.D. and Leo III were staying at this friend's home. After fleeing from the police, Mr. Mathis went to the home of L.D's friend. Oak Harbor Police responded to a call by the mother's friend when Mr. Mathis arrived at her

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legal responsibility to investigate or review some or all of the circumstances of a child's death. Nor is it the function or purpose of a Child Fatality Review to take personnel action or recommend such action against DSHS employees or other individuals.

[2] The criminal case was pending at this time of the fatality review; therefore limited information regarding the criminal investigation is contained in this report to preserve the criminal proceedings of this case. A request for records was made to law enforcement in Montana, but no records were produced. A request was also made for records from Montana Child & Family Services Division. Again, no records were produced as the case was open at the time of the review.

[3] A winter storm resulted in snow and compacted ice on roads.

apartment still intoxicated, verbally abusive, and was refusing to leave the apartment. Oak Harbor Police found Leo's mother there and explained that her son was in protective custody. L.D. had a warrant for her arrest for a misdemeanor domestic violence assault. The victim of the assault was not Mr. Mathis or her son. There were no other suitable relatives in the area available to take Leo; Oak Harbor Police agreed to release Leo III to his mother if she agreed to appear in court the following Monday to have the warrant quashed.

Mr. Mathis was unable to walk and due to his state of intoxication, an ambulance was called and he was transported to Whidbey General Hospital. He spent the night at the hospital and had to be physically restrained due to his behavior that included verbally threatening hospital staff and threats of harm. Mr. Mathis was discharged the next morning.

L.D. reported Leo was with his father on a visit during the day. She spoke to Mr. Mathis around 3:00 p.m. and he did not appear intoxicated. L.D. acknowledged there was a No Contact Order barring Leo Mathis Jr. from seeing his son following a domestic violence (DV) dispute. L.D. told the assigned social worker that she had moved in with her friend after Mr. Mathis broke her rib about three weeks prior. She said she did not call the police after Mr. Mathis assaulted her.

L.D. said she planned to move to Helena, Montana where her father, brother, and several aunts and uncles lived.

L.D. went to court and had the warrant quashed. She and Leo III moved in with Leo's paternal grandmother in Marysville. The grandmother had arranged to drive them to Montana just prior to the Christmas holiday where the mother planned to relocate. This occurred around December 17, 2010.

The CPS investigation was closed with a founded finding for negligent treatment or maltreatment against Leo Mathis Jr. The CPS investigation was closed with an unfounded finding for negligent treatment or maltreatment against Leo III's mother, L.D.

There had been considerable domestic violence in the relationship between Leo Mathis Jr. and L.D. There were five different No Contact Orders in place during the course of their relationship. A No Contact Order was in place in November 2010 when the CPS investigation was conducted. This information had not been forwarded to Children's Administration staff. L.D. informed the assigned social worker of the No Contact Order during the course of the CPS investigation.

Issues Identified by the Review Team

The review team discussed actions taken by law enforcement and Children's Administration's after hours staff regarding the November 20, 2010 intake. The team acknowledged the excellent social work practice evidenced in the case file after the case was assigned to a local CPS social worker. The findings include the following:

- The team discussed law enforcement's initial contact with Leo Mathis Jr. and questioned why he was not arrested when he was stopped by police.

- Police were aware of Leo Mathis' extensive criminal history and the history of domestic violence and No Contact Orders between Mr. Mathis and L.D. No reports were made to CPS intake.
- According to L.D., there was a No Contact Order barring Leo Mathis Jr. from having contact with his son.
- The review team felt that Leo III should have been placed in care to give the assigned CPS social worker more time to assess his safety with both parents.

Recommendation

- The review team recommended that contact be made with Oak Harbor Police Department by CA staff and offer to provide training regarding Mandated Reporting and provide them with phone numbers to call when a No Contact Order is violated and there is a child in the home.