CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

July 2019

Washington State Department of
CHILDREN, YOUTH & FAMILIES

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

- M.C.

Date of Child's Birth

- [redacted] 2015

Date of Fatality

- April 2, 2019

Child Fatality Review Date

- July 15, 2019

Committee Members

- Cristina Limpens, M.S.W., Senior Ombuds, Office of the Family and Children's Ombuds
- Phoebe Mulligan, L.I.C.S.W., Therapist
- Tracey Czar, J.D., CASA Coordinator/GAL, Pierce County Juvenile Court
- Tarassa Froberg, Child Protective Services Program Manager, Department of Children, Youth, and Families
- Kristie Deese, Child Protective Services Supervisor, Department of Children, Youth, and Families

Facilitator

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

Executive Summary

On July 15, 2019, the Department of Children, Youth, and Families (DCYF)[1] convened a Child Fatality Review (CFR)[2] to assess DCYF's service delivery to M.C. and [redacted] family.[3] [redacted] will be referenced by [redacted] initials throughout this report.

On April 10, 2019, DCYF intake received a telephone call with information regarding the death of M.C. The caller initiated the call to report about a different family but also shared information about M.C.'s death. The intake worker found additional information online in news articles. The articles said M.C. was killed by McKenna Belcher. M.C.'s father, Everett Cawley, failed to intervene to stop Ms. Belcher. The article referred to Ms. Belcher as M.C.'s stepmother. M.C. lived out of state at the time of [redacted] death. The death occurred in Arkansas on April 2, 2019. It was unclear to DCYF at the time who had legal custody of M.C. and whether [redacted] was living with, or visiting, [redacted] father and Ms. Belcher.

The writer of this document learned from the [redacted] County Prosecuting Attorney's office that M.C.'s father and stepmother were formally charged with the circumstances pertaining to M.C.'s death. In particular, the father has been charged with Permitting the Abuse of a Child[4] Class B and D; and McKenna Belcher has been charged with Capital Murder[5] and second degree Battery.[6] 13.50.100 [redacted].

On August 6, 2018, DCYF closed a Child Protective Services (CPS) investigation regarding M.C.'s family. The investigation pertained to a June 5, 2018 intake. The intake alleged that M.C. and [redacted] brother's mother and father did not live together. The intake also alleged M.C. and [redacted] brother lived at both of their parents' homes at different times. The mother reported the children have come back from their father's care with various injuries and complaints of being hungry. On one occasion M.C.'s brother was returned to his mother's care with a 13.50.100. After being asked whether she sought medical treatment the mother said a family member looked at 13.50.100. The family member is a nurse. The mother expressed concerns that the father did not seek medical treatment before returning their son to the mother. The mother also said that Mr. Cawley fails to provide clear explanations for how the injuries occurred.

[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 respons ble for child welfare; and the Department of Early Learning for childcare and early learning programs.

[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)]." 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 only hears from DCYF 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]Criminal charges have been filed in [redacted] County Arkansas against M.C.'s father Everette Cawley, and stepmother McKenna Belcher. Accordingly, the child's father and stepmother are named in this report.

[4]See https://law.justia.com/codes/arkansas/2017/title-5/subtitle-3/chapter-27/subchapter-2/section-5-27-221/.

[5]"Capital murder is the most serious type of homicide in Arkansas and, as the name suggests, can be punished by death." See https://statelaws.findlaw.com/arkansas-law/arkansas-first-degree-murder.html.

[66]See https://law.justia.com/codes/arkansas/2017/title-5/subtitle-2/chapter-13/subchapter-2/section-5-13-202/.

The CPS worker made contact with the mother, father and children. The case was closed after a DCYF Medical Consultant (MedCon)[7] said the father's explanation was a plausible description of the cause of injury. The case was closed as unfounded for physical abuse and negligent treatment or maltreatment. Two more intakes were received before the April 10, 2019 intake. Those intakes were screened out. Intakes are screened out when the information provided does not meet the definition of child abuse or neglect in the Washington Administrative Code (WAC)[8].

The CFR Committee (Committee) includes members with relevant expertise selected from diverse disciplines within the community. Committee members have not had any involvement or contact with M.C. or [redacted] family. The Committee received relevant documents including intakes, case notes and other DCYF documents maintained in DCYF's electronic computer system.

Case Overview

On December 22, 2015, an intake was received with concerns for [redacted]-month-old M.C. and [redacted] 2-year-old sister. The concerns stemmed from M.C.'s father's mental health. Mr. Cawley was seeking mental health services due to a [redacted]. The referent reported that Mr. Cawley has a history of [redacted] and was in the military for three years but returned home in June 2015. The family was living in a recreational vehicle (RV) with limited food and no running water. Mr. Cawley disclosed that within the last week he had [redacted] commanding him to throw M.C. against the wall. Mr. Cawley reported he did not listen to the command and instead locked himself in a room. Mr. Cawley agreed to have a follow-up appointment and was not detained. M.C.'s mother was made aware of the [redacted] and agreed to keep a close eye on her husband. M.C. was to stay with a grandparent. The caller also reported that Mr. Cawley canceled a December 21, 2015 mental health appointment because he had to watch the children. This intake was assigned for a CPS investigation.

On December 22, 2015, at the maternal grandmother's residence, the CPS worker made contact with the parents and M.C. M.C.'s sister was not present. The CPS worker saw the living conditions and noted the parents and children were staying in a camper inside the maternal grandfather's shop. The CPS worker documented that the camper was messy with food and dirty clothes were strewn about. There were three portable heaters that had an automatic turn-off safety feature if the heater(s) tipped over. M.C. was reportedly sleeping on a couch that was being used as a bed. The mother put a "portable block" on the couch so that M.C. would not fall off. There was also a small mattress for added safety in case M.C. fell off the couch.

The family reported they go into the grandparent's home to use the bath, cook and use the water. The CPS worker observed food in the shop's refrigerator. The CPS worker documented that M.C. appeared to be happy and the parents interacted well with [redacted] The mother shared that she has two other children, a 2-year-old staying with a friend and an older child who lives with that child's father in [redacted].

[7] DCYF Medical Consultants (MedCons) are medical professionals with specific training pertaining to child abuse and neglect. These are contracted physicians with DCYF whose purpose is to assist with child abuse or neglect evaluations and assessments.

[8] " Child abuse or neglect means the injury, sexual abuse, or sexual exploitation of a child by any person under circumstances which indicate that the child's health, welfare, or safety is harmed, or the negligent treatment or maltreatment of a child by a person responsible for or providing care to the child., excluding conduct permitted under WAC 110-30-0030; or the negligent treatment or maltreatment of a child by a person responsible for or providing care to the child. An abused child is a child who has been subjected to child abuse or neglect as defined in this section." See https://apps.leg.wa.gov/wac/default.aspx?cite=110-30-0030

Mr. Cawley said he has 74.13.520 and 74.13.520 due to 13.50.100 He stated he has also been diagnosed with 74.13.520 74.13.520 ,74.13.520 and 74.13.520 . He has 74.13.520 . Mr. Cawley reported that 13.50.100 . He also shared that he cannot handle loud noises. He denied saying he had thoughts of throwing M.C. against the wall but did say he left the room because the neighbors were really loud and he needed to regain control. Mr. Cawley reported 74.13.520 . After 74.13.520, Mr. Cawley plans to take advantage of the GI bill to obtain an education. M.C.'s mother worked at 74.13.515. A safety plan was created that included no unsupervised contact between Mr. Cawley and the children. The maternal grandparents agreed to be safety plan participants.

As a part of the assessment, the CPS worker spoke with M.C.'s oldest sister's father and met with the family friend that was caring for M.C.'s other sister. The family friend reported that M.C.'s mother is "not a great mother" and that is why the family friend has cared for the child for almost her entire life. The family friend agreed to be a safety plan participant.

On January 28, 2016, a supervisory case note says the mother called the CPS worker and said the family moved into an apartment. The case note indicated the CPS worker was going out that same afternoon to create a new safety plan. The worker met the couple that rented the room to M.C. and 74.13.51 family. That couple said they would watch over the family. Mr. Cawley's 74.13.520 said Mr. Cawley was 74.13.52 and he was no longer a threat to M.C. M.C.'s older sisters remained out of the home. On February 9, 2016, the case was transferred to Family Voluntary Services (FVS). The mother also shared that she was pregnant.

It was decided during the February 12, 2016 health and safety visit with the parents and M.C., that DCYF would refer the family for Family Preservation Services (FPS)[9] instead of Project Safecare.[10] Regular bi-monthly health and safety visits were made with the family. On April 7, 2016, during a health and safety visit, Mr. Cawley shared that he 74.13.520 The FVS worker urged him to 74.13.520 . The FPS contractor said she is helping him with this task. On June 6, 2016, the family's FVS case was closed. On July 19, 2016, an intake was received alleging the family was living in an RV with no running water and no bathroom. This intake was screened out.

Another intake was received on June 5, 2018. The intake alleged that M.C. and 74.13.52 brother's mother and father did not live together. The intake also alleged M.C. and 74.13.51 brother lived at both of their parents' homes at different times. The mother reported the children have come back from their father's care with various injuries and complaints of being hungry. On one occasion M.C.'s brother was returned to his mother's care with a 13.50.100. After being asked whether she sought medical treatment the mother said a family member looked at 13.50.100. The family member is a nurse. The mother expressed concerns that the father did not seek medical treatment before returning their son to the mother. The mother also said that Mr. Cawley fails to provide clear explanations for how the injuries occurred.

[9] "Family preservation services" are short-term, family-focused services designed to assist families in crisis by improving parenting and family functioning while keeping children safe." See https://www.childwelfare.gov/topics/supporting/preservation/.

[10] "Project SafeCare is an evidence-based training curriculum for parents who are at-risk or have been reported for child maltreatment. Parents receive weekly home visits to improve skills in several areas, including home safety, health care, and parent-child interaction." See https://www.childwelfare.gov/topics/preventing/prevention-programs/homevisit/homevisitprog/safe-care/.

On June 6, 2018, the CPS worker made contact with the mother, she had just returned from court. The children were not with her. The mother reported that in May 2018, Mr. Cawley 13.50.100 [redacted]. The mother shared that law enforcement had been called many times about the neglect of M.C. and M.C.'s brother, while under the father's care. The mother also alleged that a neighbor had pictures of Mr. Cawley possibly using 13.50.100 in the home. The mother said that Mr. Cawley is dating a woman named McKenna Belcher and that they both used drugs and have admitted to using 13.50.100

The CPS worker asked the mother about her son's 13.50.100. She said she first observed 13.50.100 on May 11 and a family member, who is a nurse, took care of it. She provided the family member's name and phone number. M.C.'s mother shared that she felt 74.13.520 due to the divorce and custody proceedings. She was 74.13.520 and in a support class offered by 74.13.520. M.C.'s mother provided a contact name for that supportive service.

The CPS worker then called Mr. Cawley. Mr. Cawley said his son's 13.50.100 was caused 13.50.100 [redacted]. Mr. Cawley was watching television and his son got out of his toddler bed. The toddler bed had a railing. Mr. Cawley stated his son 13.50.100 [redacted]. Mr. Cawley did not feel that the injury required anything other than 13.50.100. He said he tried to tell the mother about the injury but she would not listen to him. Mr. Cawley said that he has previously struggled with mental health issues but currently does not have any problems. He reported 74.13.520 [redacted]. He said 13.50.100 [redacted]. The 13.50.100 [redacted]. Mr. Cawley disclosed that he 13.50.100 [redacted]. He said there has been 13.50.100 in his relationship with the children's' mother. He also said that M.C.'s mother is physically aggressive towards the children. As punishment, the mother uses cold showers and allows the children's maternal grandmother to hit them. Mr. Cawley said he lives with his girlfriend McKenna Belcher. Mr. Cawley agreed to provide a random urinalysis on the same day as the June 6, 2018 interview. The urinalysis tested 13.50.100.

Also on June 6, 2018, M.C.'s mother brought M.C., M.C.'s brother and one of M.C.'s sisters to the CPS office. The CPS worker observed M.C.'s brother's 13.50.100. The injury was the 13.50.100 [redacted]. The CPS worker photographed the injury.

On June 14, 2018, another intake was received. This intake alleged concerns about M.C.'s 4-year-old sister. The caller said he has previously had no concerns for 13.50.100 care. However, he was getting worried because when 13.50.100 visited her mother, she seemed to be cared for by different people with no consistent residence. He is also concerned because the mother told him he may receive a call from CPS.

On July 10, 2018, the CPS worker called the mother. The mother said she observed McKenna Belcher hitting the father as they left court. Ms. Belcher was reportedly upset because Mr. Cawley was ordered to pay child support. The court-appointed a guardian ad litem and ordered supervised visits between the children and Mr. Cawley.

On August 2, 2018, the CPS worker documented that he received a MedCon assessment about the 13.50.100 injuries to M.C.'s brother. The MedCon assessment said the photographs and explanation are consistent with the explanation provided by Mr. Cawley and this type of 13.50.100 injury is frequently treated with first

aid that does not require additional treatment. On August 6, 2018, this CPS investigation was closed as an unfounded for physical abuse and negligent treatment or maltreatment.

On October 20, 2018, intake received a telephone call from a nurse reporting that M.C.'s 2-year-old brother was seen in the hospital's emergency department. The brother had a 13.50.100 . The mother reported that when the child was returned to the mother, the father told her the child 13.50.19 . The mother told the nurse the father's girlfriend, Mckenna Belcher, could have inflicted the injury because she is short-tempered 13.50.100 . The nurse reported the child was seen by an emergency department physician who stated the explanation was consistent with the injury. The caller said the physician concluded there was "no pattern or linear bruises consistent with being slapped, hit or intentionally being struck in any manner." This intake was screened out due to the physician stating the explanation was consistent with the injury.

On February 22, 2019, another intake was received from 13.50.100 . He reported that in January 2019, the mother moved to 74.13.515 . He was told by the mother that it was a temporary move but has now learned she plans to permanently live there. The mother did not provide any information as to who was caring for 13.50.100 and he is worried 13.50.100 .

This intake was screened out due to no specific allegations of abuse or neglect.

On April 10, 2019, DCYF received a telephone call with information regarding the death of M.C. The caller initiated the call to report about a different family but also shared information about M.C.'s death. The intake worker found information online in news articles. The articles said M.C. was killed by McKenna Belcher. M.C.'s father, Everett Cawley, failed to intervene to stop Ms. Belcher. The article referred to Ms. Belcher as M.C.'s stepmother. M.C. lived out of state at the time of 74.13.51 death. The death occurred in Arkansas on April 2, 2019. It was unclear to DCYF at the time who had legal custody of M.C., and whether 74.13.51 was living with, or visiting, 74.13.51 father and Ms. Belcher.

Committee Discussion

The Committee discussed the first investigation in 2015 and the offered voluntary services. The Committee noted the work conducted was appropriate. The Committee appreciates the information provided by DCYF describing the areas where current case practice is different from what occurred in 2015 and 2016. The Committee believes it may have been appropriate, before the case was closed, for a follow-up contact with the mental health provider.

With regard to the 2018 investigation, the Committee identified multiple missed opportunities for a more comprehensive assessment of the allegations and child safety. Those missed opportunities are described in the findings section below. Despite the missed opportunities, the Committee also discussed the fact that child welfare is difficult work. This difficult work is made even more difficult when caseloads are high and there is significant staff turnover. The Committee believes high staff turnover and vacancies cause new workers, with little training, to be assigned challenging cases involving complicated issues. The staff who met with the Committee described the historically high turnover in this particular office that dates before the first intake in 2015 through the 2018 intake.

The Committee was told that the CPS worker for the 2018 intake was new to CPS. At the time of the case assignment, he had 39 other assigned cases. The CPS worker described areas in which he could have done better, his current practice and improvements to how he now approaches his casework. The

CPS supervisor who closed the 2018 intake was new to supervision and was not interviewed by the Committee. The Committee noted that all of these challenges may have contributed to an incomplete assessment of the allegations.

The Committee also discussed the October 20, 2018 intake. The Committee struggled with many parts of this intake. They questioned why a call was even made if there were no abuse concerns. They also observed this often occurs and intake workers frequently receive calls from mandatory reporters who are calling about a family but state they do not believe abuse or neglect is present. The Committee also discussed specific medical professional child abuse training issues and the purpose of MedCons. The Committee's concerns are addressed in the recommendation section below.

Findings

The Committee did not identify any critical errors. The Committee did identify areas for possible practice improvement. Those areas are noted below.

The Committee found that the June 6, 2018 CPS investigation could have been more comprehensive. The Committee noted that increased collateral contacts could have assisted with a more comprehensive assessment. Some suggested collateral contacts include law enforcement, the assigned family court guardian ad litem, the family member who treated the 13.50.100 and other relatives. Siblings are often utilized as collateral contacts and that would have also been appropriate. There was no documentation about any attempts to speak with M.C. regarding 74.13.51 brother's 13.50.100 and while 74.13.51 may have not had the verbal ability to respond to a forensic interview, documentation of an attempted interview would have been prudent. The Committee also believes an additional assessment of Mr. Cawley's mental health stability would have been appropriate. The additional assessment may have included a determination as to whether the father successfully complied with and completed treatment recommendations.

Conducting a face-to-face interview with Mr. Cawley and Ms. Belcher, as well as seeing the residence where the 13.50.100 occurred, may have been appropriate. Taking pictures of the room 13.50.100 that Mr. Cawley alleged to have caused the 13.50.100 may have also been appropriate. These types of photographs can be helpful to MedCons during their case assessment.

The last documented supervisory review case note was June 27, 2018. On August 6, 2018, the case was closed. There was a change in supervisors between June 27 and August 6. Before closing out the investigation it would have been appropriate for the new supervisor to conduct and document a supervisory review with the CPS worker.

Recommendations

The Committee recommends DCYF Intake Area Administrators, the Intake Program Manager and CPS program Manager review screened out intakes received from medical providers. The review is to specifically evaluate cases that pertain to medical providers who call to report an injury involving a child that is less than four years of age in which the medical provider concludes the injury is consistent with the explanation given. The Committee also recommends the above identified DCYF staff review Practices and Procedures Policy No. 2200 (Intake Process and Response).[11] In particular, the Committee recommends the identified staff consider whether section 1.c.ii.A.I.iv. ("*Abuse or neglect reported by a*

[11] See https://www.dcyf.wa.gov/practices-and-procedures/2200-intake-process-and-response.

physician, or a medical professional on a physician's behalf, regarding a child under age five") should be revised.

The Committee is concerned that many medical personnel has limited training associated with child abuse or neglect. This concern causes the Committee to question whether the lack of sufficient child abuse or neglect training impacts the ability of some medical professionals to recognize whether certain injuries are caused by abuse or neglect. If there is a failure to recognize child abuse or neglect in certain cases, such cases are unfortunately not subject to a child safety assessment.

The Committee understands the recommendation would create a workload and staffing resource issue. However, the Committee believes the birth to four age group is the most vulnerable age group. Despite this recommendation, the Committee is not suggesting the department's intake screening decisions have been incorrect.