CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

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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

- S.B.

Date of Child's Birth

- [redacted] 2019

Date of Fatality

- March 11, 2022

Child Fatality Review Date

- May 10, 2022 & May 19, 2022

Committee Members

- Cristina Limpens, MSW, Senior Ombuds, Office of Family and Children's Ombuds
- Annie Taylor, Area Administrator, DCYF
- Alex Fitzstrawn, QA/CQI Consultant, DCYF
- Margaret McCurdy, LICSW, Director of Programming, King County Prosecuting Attorney's Office
- Amy Bullard, DV/SA Grant & Training Coordinator, King County Prosecuting Attorney's Office
- Lydia Faitalia, Commissioner, WA State Commission on Asian Pacific American Affairs

Facilitator

- Leah Mattos, MSW, Critical Incident Review Specialist, DCYF

Executive Summary

On May 10 and May 19, 2022, the Department of Children, Youth, and Families (DCYF) convened a Child Fatality Review (CFR)[1] Committee (Committee) to examine DCYF's practice and service delivery to S.B. and RCW 74. family. S.B. will be referenced by RCW 74. initials throughout this report.[2]

On March 11, 2022, S.B. died. The family's Child Family Welfare Services (CFWS) caseworker attempted an unannounced health and safety visit at S.B.'s home and found emergency medical services (EMS) in the home attending to S.B., who was unresponsive. The mother told EMS that S.B. did not feel well the night before. The mother said she checked on S.B. at 5:30 a.m. and again at 8:00 a.m. when she found S.B. unresponsive. Initially, the cause of S.B.'s death was unknown to DCYF.

Law enforcement reported to DCYF that the medical examiner determined that S.B.'s cause of death was blunt force trauma to RCW 74. head. S.B. had a number of other injuries, including extensive bruising, lacerations, and scarring, that the medical examiner determined were not consistent with normal toddler activity and were indicative of physical abuse. S.B.'s death was ruled a homicide.

On March 11, 2022, the father of S.B.'s younger siblings was arrested and charged with second-degree murder, homicide by abuse, third-degree assault of a child, and felony violation of a domestic violence no-contact order. On March 13, 2022, S.B.'s mother was arrested and charged with second-degree murder. At the time of S.B.'s death, the family had an open CFWS case. A new Child Protective Services (CPS) case was assigned to investigate S.B.'s death.

A diverse 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. Committee members had no prior direct involvement with S.B. or RCW 74. family. Before the review, the Committee received relevant case history from DCYF. On the day of the review, the Committee had the opportunity to interview DCYF caseworkers, supervisors, and area administrators who were involved with the family.

Case Overview

In April 2021, S.B.'s family came to the attention of DCYF due to allegations of physical abuse. The caller reported concerns for the children, three-year-old RCW 7., two-year-old S.B., and one-year-old RCW 74.13.3, due to all three children having physical injuries and scarring. The caller reported that RCW 13.50.100 the mother left the home with S.B. A CPS investigation was assigned, and the children were placed

[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 CFR 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 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.

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

into protective custody. RCW 74. and RCW 74.13.5 were in the care of a relative and received medical attention. S.B. was located the following day, placed with the relative, and received medical attention.

DCYF received additional calls from RCW 74.13.520 team detailing each of the children's physical injuries. The information was also shared with law enforcement. All three children were observed to have hyperpigmentation, which can be seen during the healing process. The team noted that RCW 74. had numerous scars on his body, linear marks on his right thigh, and multiple "loop marks" that appeared to have come from a looped object, such as a belt or electrical cord. RCW 74. complained of arm pain, and his mother said he fell off his bed. The RCW 74.13.52 team recommended that RCW 74. have an x-ray of his shoulder. RCW 74.13.5 had a scabbed-over injury on his buttocks that appeared to be a bite mark, injuries to both ears (which included blood in his right ear canal), a dark mark covering his entire right cheek, and a scar on the back of his left thigh. S.B. had scars, a possible burn mark on RCW 74. left thigh, and possible bite marks. The RCW 74.13.52 team reported that the injuries were consistent with non-accidental injuries.

The CPS caseworker contacted the mother, who reported that she and RCW 74.13.515 father had been in a relationship for approximately two and a half years RCW 13.50.100. He was not the biological father of S.B. or RCW 74. The mother also shared RCW 74.13.520. She said he would use a belt to discipline the children physically, and when she told him not to, he began biting the children. She said she left the relationship approximately two or three weeks ago and would get a no-contact order if DCYF asked.

A Family Team Decision Making meeting (FTDM)[4] was held to discuss a plan for the family. After the FTDM, DCYF determined it would file a dependency petition and motion to place the children in shelter care, recommending the children remain in relative care. DCYF attempted to contact the fathers but was unsuccessful. DCYF also recommended services for the mother, RCW 74.13.515 father, and S.B. and RCW 74.13.5 father. The court entered a shelter care order for the three children.

RCW 74.'s x-ray showed that he had a broken upper right humerus. RCW 74. was referred for an appointment with the orthopedics clinic. This additional report was added to the ongoing CPS investigation.

In May 2021, DCYF completed a child health and education tracking report for all three children outlining medical and wellbeing recommendations. S.B. was referred for Early Support for Infants and Toddlers. DCYF also held an early learning staffing to discuss recommendations for meeting the developmental, academic, and cultural needs of RCW 74.1 S.B., and RCW 74.13.5 The case transferred from the CPS program to the CFWS program.

In June 2021, the CPS investigations were completed, and DCYF issued founded findings against the parents. The mother received a founded finding[5] for negligent treatment, and RCW 74.13.515 father received a founded finding

RCW 74.13.520

[4]For information on Family Team Decision Making (FTDM) meetings, see: https://www.dcyf.wa.gov/1700-case-staffings/1720-family-team-decision-making-meetings.

[5]"'Founded' means the determination following an investigation by the department that, based on available information, it is more likely than not that child abuse or neglect did occur. "RCW 26.44.020(14). "'Unfounded' means the determination following an investigation by the department that available information indicates that, more likely than not, child abuse or neglect did not occur, or that there is insufficient evidence for the department to determine whether the alleged child abuse did or did not occur." RCW 26.44.020(29).

for physical abuse. A court entered a restraining order, which ordered that RCW 74.13.515 father have no contact with or attempt to contact the children.

The CFWS supervisor requested DCYF parent locator services assist in locating the fathers as neither responded nor made themselves available to DCYF. The CFWS supervisor worked with law enforcement, who had an open investigation related to physical abuse by RCW 74.13.515 father. Neither DCYF nor law enforcement located RCW 74.13.515 father.

DCYF completed a comprehensive family evaluation. The evaluation noted that the mother was willing to meet with the CFWS caseworker and was motivated to engage in services, but the evaluator wanted to see more progress before a trial return home was considered.

In July 2021, the mother secured housing through a family shelter in another county. She reported having access to services and said she planned to begin mental health counseling and domestic violence (DV) services. The mother agreed to participate in a DCYF evidence-based parenting program. She also denied having any contact with RCW 74.13.515 father. DCYF continued to work with law enforcement, who said they had concerns about the mother's failure to protect the children given the length of time the abuse had occurred.

In RCW 74.13.515 2021, DCYF received a call reporting that the mother gave birth to her fourth child, RCW 74.13.5 The mother told the hospital staff that she was residing in a shelter and was a past victim of DV. A CPS risk-only[6] investigation was assigned to a DCYF office in the county where the mother was residing, not the county where her case was currently open. RCW 74.13.5 was discharged from the hospital to the mother's care.

In September 2021, DCYF received a report stating that RCW 74. had what appeared to be a cigarette burn on his neck. The child said his uncle "did it." A CPS investigation was assigned to investigate the relative caregivers.

In October 2021, the CPS investigation of the relative caregivers concluded. RCW 74. and his siblings were assessed as safe in the relative's home, and the case closed with unfounded findings. The CPS risk-only investigation involving RCW 74.13.5 also concluded. RCW 74.13.5 was assessed as safe in his mother's care.

In November 2021, a shared planning meeting was held to discuss progress and the next steps. The mother and S.B.'s father attended the meeting. The mother had secured housing, was seeking employment and requested child care services for the children upon their return home. The mother continued to express that she was agreeable to participating in DCYF services and would follow recommendations. DCYF and the stakeholders developed a plan to expand visitation to include overnight visits. DCYF tentatively set a trial return home for the following month. S.B.'s father also agreed to participate in services.

The juvenile court entered a default order of dependency for S.B.'s father because he did not appear at the dependency fact-finding hearing. He was court-ordered to complete a parenting assessment and follow recommendations, complete a drug and alcohol evaluation and follow treatment recommendations, submit random urinalysis testing, and establish paternity as to RCW 74.

[6] A CPS Risk Only investigation should be screened in when there are "reports [that] a child is at imminent risk of serious harm and there are no child abuse or neglect allegations." See: https://www.dcyf.wa.gov/practices-and-procedures/2200-intake-process-and-response.

The juvenile court also entered a default order of dependency for RCW 74.13.515 father, who did not appear at the fact-finding hearing. The court noted the restraining order remained in effect and could be re-evaluated if the father engaged in services. He was court ordered to participate in DV batterer's treatment and follow recommendations, a psychological evaluation with a parenting component and follow recommendations, three random urinalysis tests, where DCYF could request up to six additional random tests upon suspicion of use, and an evidence-based parenting program upon reunification.

In December 2021, the mother agreed to an order of dependency. The mother was court-ordered to: participate in a parenting assessment and follow the provider's recommendations, continue individual mental health counseling, complete a DCYF evidence-based parenting program, and complete parent-child interactive therapy (PCIT).[7]

DCYF conducted a walk-through of the mother's home. The juvenile court placed RCW 74.1 S.B., and RCW 74.13.5 in their mother's care with continued monitoring on a trial return home. The court order outlined the conditions of return home, requiring the mother to comply with previously court-ordered services, demonstrate that she was meeting the children's developmental needs and participating with their services, comply with DCYF home visits, ensure safety in her home, notify DCYF of changes to her housing or changes in individuals having unsupervised access to the children, and contact law enforcement if RCW 74.13.515 father came to her home or attempted to make contact with the children. The court's order also requested that the mother work on establishing a parenting plan through the family court and participate in DV support services.

In January 2022, the CFWS caseworker completed two health and safety visits in the mother's home. The children were sleeping during both health and safety visits. When the caseworker asked the mother about the children sleeping, the mother said the children were not feeling well and had trouble sleeping, so she gave them Benadryl and Motrin. The CFWS caseworker told the mother that Benadryl should be used only as recommended for allergy symptoms and not for sleeping. The mother confirmed the children's child care schedule, which would start later in the month. The mother reported she was continuing with mental health counseling but had challenges with scheduling conflicts. PCIT services had started and worked with the family in the home. The provider told the CFWS caseworker that the mother was doing well in the sessions.

In February 2022, the CFWS caseworker completed one health and safety visit and attempted one unannounced visit. RCW 74.1 S.B., and RCW 74.13.5 were present and awake during the first home visit. RCW 74.13.5 was sleeping. RCW 74 was observed to have minor scratches and bumps on his face. The mother reported that he had been jumping on the bed and had fallen. The CFWS caseworker spoke with RCW 74 individually, who said, "I jump on the bed and fall off and hit my face." The family was not home when the caseworker attempted the unannounced visit, but the caseworker was able to have a video call with the mother and children, who were visiting a family member.

In early March 2022, the CFWS caseworker stopped at the family's home to complete a health and safety visit. The caseworker observed damage to the mother's car; the trunk window had been broken out, the backlights were cracked, and the side mirror and windshield were damaged. The mother also had a scratch on her face. The CFWS caseworker inquired about the damage to the car, and the mother said it was a break-in. The CFWS

[7]For information on Parent Child Interactive Therapy (PCIT), see: http://www.pcit.org/. Last accessed on May 27, 2022.

caseworker inquired about the status of the parenting assessment, and the mother confirmed her next appointment date. [redacted], S.B., and [redacted] were not home and had been dropped off at child care. The CFWS caseworker scheduled a shared planning meeting for March 11 to discuss the mother's compliance and progress with the conditions of the trial return home.

On March 11, 2022, the CFWS caseworker stopped by the family's home to complete an unannounced health and safety visit. EMS was in the home due to a 911 call that S.B. was unresponsive. That same day, [redacted] father was arrested and charged with second-degree murder, homicide by abuse, third-degree assault of a child, and felony violation of a DV no-contact order. On March 13, 2022, the mother was arrested and charged with second-degree murder. DCYF concluded the CPS investigation into S.B.'s death, assigned the mother a founded finding of negligent treatment and maltreatment, and assigned [redacted] father a founded finding of physical abuse.

Committee Discussion

The Committee met and spoke with caseworkers, supervisors, and an area administrator who were involved with this family. The Committee recognized that the ongoing CFWS caseworker and supervisor worked diligently on this case and that system-related issues may have contributed to missed opportunities. The Committee discussion focused on ongoing assessment and systemic barriers.

The Committee discussed the nuanced work of assessing safety throughout the life of a case and emphasized the importance of continual assessment, family engagement, use of collateral contacts to verify information, and collaboration with stakeholders. The Committee believed that throughout the assessment, more emphasis was placed on the DV experienced by the mother rather than the physical abuse of the children and the mother's failure to protect the children from abuse.

Due to the children's young ages, one-on-one interviews were limited. The Committee learned that the oldest child may have had [redacted] and would have liked DCYF to have learned more about this need. The Committee believed additional information may have guided field staff on how to best communicate with [redacted]. one-on-one.

The Committee also discussed DCYF's assessment of the parents' compliance and progress. The Committee identified that the mother's successes may have been over-emphasized while her lack of service engagement was minimized; however, the Committee appreciated DCYF's efforts to be strength-based. The Committee would have liked to have seen more inquiries with collateral contacts and relatives of all parents to gather information in assessing the parents' compliance and progress. One Committee member identified that additional time for the mother to engage with services and demonstrate progress may have been beneficial. Additional efforts in locating the father by law enforcement and/or further investigating the physical abuse experienced by the children may have assisted in more comprehensive services for both the mother and father.

The Committee discussed the CPS risk-only case assignment at length when baby [redacted] was born. The Committee identified a missed opportunity for collaboration between the CFWS team and CPS team to assess the safety and utilize shared decision-making jointly. The Committee perceived the CPS team had a narrow focus rather than a global assessment and may have benefited from gathering additional information from

relatives and collateral contacts. The Committee pointed out that the mother was assessed as safe to parent the newborn while residing in a shelter but believed more information was needed to identify how the newborn was safe once the mother transitioned to independent housing with fewer supports and less oversight.

The Committee discussed what they perceived to be a complete system overwhelm for DCYF and agency partners, such as law enforcement. The Committee acknowledged the importance of ongoing collaboration with external agencies, like law enforcement and DV support providers, and how important it is to include their perspectives when assessing families, but the Committee also understood that each agency faces its own limitations.

Another system aspect discussed was the loss of collective knowledge and expertise within DCYF due to recent staff turnover and vacancy rates. The Committee learned from the field staff that turnover in this office led to multiple case transfers and oversight by different supervisors during the course of the CFWS case. The Committee identified the importance of new field staff having the opportunity to learn through the transfer of knowledge from veteran field staff and supervisors.

The Committee also discussed the knowledge base of field staff regarding DV and physical abuse cases. A DCYF subject matter expert on the committee acknowledged that DCYF offers good training about DV. The Committee also discussed DCYF training offered related to physical abuse. The Committee believed that DCYF cases involving severe physical abuse are much less common than cases involving neglect. The Committee highlighted the importance of internal collaboration to seek additional guidance on complex cases. The Committee identified a potential service gap because no current services are explicitly offered for physical abuse cases or cases involving a parental failure to protect from physical abuse.

The Committee pointed out barriers to engagement that exist within the child welfare system. For example, focusing on mothers over fathers may lead to a lack of efforts to locate and engage fathers. The Committee wondered if historical racism impacted the mother's willingness to engage with a government agency. The Committee also discussed the importance of DCYF building connections with culturally relevant communities and service providers as a mechanism to reduce barriers for parents accessing services.

The Committee believed that despite identifying opportunities for improvement within the system, the DCYF field staff did what they could with the available resources.

Findings

The Committee identified improvement opportunities in the following areas related to collaboration:

- The family needed collaboration between the DCYF programs, service providers, and relatives to help with the initial and ongoing assessment. Additionally, the family may have benefited from DCYF building connections with culturally relevant providers.
- Internal collaborative staffing between the CFWS and CPS team assigned to the intake of the newborn baby did not occur. This may have led to an opportunity for shared decision-making and a more thorough safety assessment.

- A more investigative approach to verifying information the mother reported through contacting relatives and collaterals may have been beneficial in accurately assessing the mother's compliance and progress.
- Initial efforts were made to locate and engage the fathers with the case, but they did not occur consistently throughout the life of the case.

Recommendations

The Committee respectfully asks that DCYF consider the following recommendations as a way to continue improving opportunities for ongoing case collaboration and transfer of knowledge among field workers:

- It is recommended that DCYF hire an internal DV expert that can provide direct support and consultation to field caseworkers. This would include, but is not limited to, the following supports:
    - Assist field workers in learning how to formulate questions related to DV and how to begin difficult conversations with parents.
    - Provide consultation on the development of safety plans where behavioral expectations are outlined for the family to follow.
    - Model engagement and interviewing with the offending parent.
    - Accompany field workers to assist with assessment and engagement during their interactions with families.

- It is recommended that DCYF consider modifying Policy 4122 Case Transfer[8] to include language that both the sending and receiving supervisor will participate with case transfers, along with the sending and receiving caseworkers.

- It is recommended that DCYF develop a policy requiring internal, collaborative staffing for ongoing CFWS cases when a new intake leads to a CPS investigation. This policy should include cases where the CFWS and CPS are housed in the same office and when there may be a case assignment to multiple offices.

- It is recommended that DCYF identify field staff in each region to develop a list of community-based resources within the Asian, Pacific Islander, and Native Hawaiian (APINH) communities that could be shared regionally with all field staff. The Committee also recommended DCYF staff build collaborative connections within the APINH communities to help educate about DCYF's role and function and build culturally relevant connections for the families served by DCYF.

[8]For information about DCYF Policy 4122 (Case Transfer), see: https://www.dcyf.wa.gov/4000-child-welfare-services/4122-case-transfer. Last accessed on June 14, 2022.