CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

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CONTENTS

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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.G.

Date of Child's Birth

- [redacted] 2019

Date of Fatality

- Febr. 14, 2022

Child Fatality Review Date

- April 14, 2022

Committee Members

- Patrick Dowd, JD, Office of the Family and Children's Ombuds, Director
- Lindsey Barcklay, MSW, LICSW, CMHS, CCTOP, Domestic Abuse Women's Network, Clinical Director
- Kate Bianchi, Domestic Abuse Women's Network, Shelter Advocate Supervisor
- Billie Reed-Lyyski, Department of Children, Youth, and Families, Child Protective Services Supervisor Region 5
- Jennifer McCarthy, MSW, Department of Children, Youth, and Families, Child Welfare Engagement Program Manager
- Chris Kerns, MSW, Alliance for Child Welfare Excellence, Regional Education and Training Administrator

Facilitator

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

Executive Summary

On April 14, 2022, the Department of Children, Youth, and Families (DCYF) convened a Child Fatality Review (CFR)[1] to examine DCYF's practice and service delivery to S.G. and [redacted] family.[2] [redacted] will be referenced by [redacted] initials throughout this report.

On Feb. 14, 2022, DCYF received a telephone call from the [redacted] County Deputy Medical Examiner. The Deputy Medical Examiner called to report that S.G. had died and requested information regarding DCYF's history with S.G. and [redacted] mother. S.G. was pronounced dead when [redacted] arrived at the hospital. The Deputy Medical Examiner reported that S.G.'s death was suspicious and stated law enforcement was investigating the death as a homicide. This intake was assigned for a Child Protective Services (CPS) investigation. Law enforcement (LE) directed DCYF staff not to communicate with S.G.'s mother, father, or the mother's boyfriend, Jonathan Torve. Law enforcement arrested Jonathan Torve; he was subsequently charged with Manslaughter in the first degree related to S.G.'s death. The CPS investigation resulted in founded findings of negligence and physical abuse by S.G.'s mother and physical abuse by Mr. Torve.

At the time of [redacted] death, S.G. lived with [redacted] mother, Mr. Torve, and other adults. DCYF closed a CPS investigation involving S.G. in August of 2021.

A diverse Committee (Committee) was assembled to review this case and to evaluate DCYF's service delivery to the family. The Committee included community partners and DCYF staff. Committee members received copies of the DCYF case history, including intakes, investigative assessments, assessment tools, and case notes. Committee members also received a 2021 law enforcement report, other documents, and information pertaining to persons S.G. lived with during [redacted] lifetime.

The Committee spoke with staff from two different offices, who each investigated separate intakes regarding S.G. prior to [redacted] death. The CPS caseworker assigned to the investigation from June 30, 2021, left his employment prior to the closure of that investigation. Therefore, he was not available to participate in this process. At the time of the June 30 intake, the caseworker's supervisor was on vacation. Two other supervisors in the [redacted] County office assisted until the supervisor returned.

Case Overview

On March 6, 2020, DCYF received a call regarding S.G. and [redacted] family. S.G.'s parents were in a polyamorous triad with another woman, and there were three children total in the home. A polyamorous triad is a

[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 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 from only 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.

[2] The names of S.G.'s parents are not used in this report because neither parent has been charged with a crime in connection with the fatality. However, Jonathan Torve has been charged with a crime related to S.G.'s death and is therefore named in this report.

relationship between three consenting adults. The caller reported the parents get "very high and drunk and neglect the children at times." The caller also reported that S.G.'s father RCW 13.50.100 in the home, and LE was investigating the allegation. The March 6, 2020 intake screened out. The written decision to screen out the intake stated the allegations of parental substance use and neglect occurred two months prior to the telephone call, and the caller did not provide details related to how long the children were left unattended. There was also no information regarding injuries or other "harm" to the children or that LE was investigating the RCW 13.50.1 allegation.

On June 30, 2021, DCYF received a telephone call from LE in RCW 74.13 County. LE placed three children in protective custody, two-year-old S.G. and two other children: a five-year-old female and a 20-month-old female. The three children's parents were the same ones mentioned in the March 6, 2020 intake. There were other adults living in the home, but they were not involved in the polyamorous relationship. Law enforcement initially directed DCYF not to speak with or interview anyone regarding the allegations.

S.G.'s mother and another unrelated woman who lived in the home called LE. They alleged that the five-year-old child's mother physically abused the child. When they spoke with LE, the women reported the five-year-old child's mother had RCW 13.50.100. They also disclosed domestic violence (DV) in the home. The DV included strangulation, which sometimes occurred in the children's presence. They also dreamt that S.G.'s father RCW 13.50.100. One of the children in the home was previously observed RCW 13.50.100, and another female child RCW 13.50.100. S.G.'s father allegedly RCW 13.50.100. This call resulted in three screened-in CPS intakes because three different mothers were involved.

Law enforcement allowed S.G., RCW 74 mother, and another mother and her daughter to leave the home. LE released S.G. from protective custody. The mother and the other woman fled with their children to RCW 74.13.515 County. The RCW 74.13 County office made a courtesy request for an initial face-to-face contact by RCW 74.13.515 County.

On June 1, the RCW 74.13.515 County caseworker who conducted the courtesy contact observed multiple bruises on S.G.'s torso, arm, and foot. S.G.'s mother did not know how RCW 7 received any of the injuries. The caseworker photographed S.G.'s bruises. She discussed the bruising and her concern about S.G.'s presentation and sent the photographs to a CPS supervisor in RCW 74.13 County. That CPS supervisor called DCYF intake regarding the injuries, and a new intake was created. The new CPS intake was assigned to a CPS caseworker in RCW 74.13.515 County. LE did not inform DCYF that S.G. had injuries.

During the June 30 investigation, RCW 74.13 County CPS and LE interviewed multiple adults who lived in the family's home in RCW 74.13 County. There were a total of two men, four women, and four children in the home. Only three of the adults, S.G.'s mother, S.G.'s father, and another woman were involved in the polyamorous relationship. Two of the women, S.G.'s mother and the other woman who fled with them, told the caseworker and LE that they were subjected to physical violence and power and control dynamics and were not allowed to make decisions regarding their own children. They also said they believed they were RCW 13.50.100 and possibly RCW 13.50.100. S.G.'s mother told LE that she and S.G.'s father were in a RCW 13.50.100 relationship. This acronym has multiple definitions, including RCW 13.50.100. Merriam-Webster defines

RCW 13.50.100 as a "RCW 13.50.100 ."

On July 1, 2021, S.G.'s mother spoke with the RCW 74.13 County CPS caseworker by telephone. The caseworker documented the discussion in a case note. S.G.'s mother said she was not allowed to obtain a driver's license, was confined to the home, and could not leave without permission. She reported she was RCW 74.13.520 , and agreed to consent to a urinalysis if asked to provide one. S.G.'s mother told the caseworker that she would RCW 13.50.100 and was concerned RCW 13.50.100 . She stated that RCW 74.13.515 mimicked bondage and believed that S.G.'s father RCW 13.50.100 .

That same day, as a courtesy to RCW 74.13 County, a caseworker from RCW 74.13.515 County made contact with S.G.'s mother and the other woman. The RCW 74.13.515 County caseworker contacted LE, who responded with four officers to help provide safety to the women. The women expressed extreme fear that S.G.'s father would find them. The women and their two children were staying in their friends' home. Their friends expressed concern for the women and stated their willingness to help them obtain community support.

S.G.'s mother said she still breastfed RCW 74.13.515 , and RCW 7 was struggling to gain weight. S.G. was about a year and a half old at the time. The caseworker documented S.G.'s appearance as thin and small, with several marks and bruises on RCW 7 body. S.G.'s mother permitted the caseworker to take photographs of the child and RCW 7 marks. RCW 7 had four upper teeth removed and crowns on RCW 7 lower molars. S.G.'s mother said RCW 7 had dental trauma and had a "genetic issue that runs through" her family. During an observed diaper change, the caseworker saw a red mark on S.G.'s RCW 74.13.520 . RCW 74 mother said it was a birthmark.

S.G.'s mother said she RCW 74.13.520 . She was not taking any medications and wanted employment.

The RCW 74.13.515 County courtesy worker also spoke with the other mother. That mother shared details about her own mental health struggles, her family, and her daughter's father. The caseworker observed a diaper change RCW 13.50.100 . No other marks were observed. The mother RCW 13.50.100 . The caseworker gave the women a community resource packet.

The caseworker from RCW 74.13.515 County told a RCW 74.13 County CPS supervisor about the bruises and other information gathered from the contact. The RCW 74.13 County CPS supervisor called in an intake regarding the bruising to S.G. That intake screened in and was assigned to RCW 74.13.515 County for a CPS investigation.

A supervisor from RCW 74.13 County called S.G.'s mother and told her that S.G. needed to be checked out medically. S.G.'s mother said she did not have the ability to travel anywhere and needed other items to care for RCW 74.13.515 . She said they fled so quickly they did not have the opportunity to bring many items with them. The supervisor contacted the RCW 74.13.515 County office and requested that supports be provided to the mothers. On July 2, 2021, the RCW 74.13.515 office provided the women vouchers for clothing and provided household items, and bus tickets.

The originally assigned caseworker in [redacted] County interviewed S.G.'s father and his other partner by telephone. The caseworker asked about S.G.'s medical care, development, discipline methods, etc. S.G.'s father said he would consent to a urinalysis if one was requested. S.G.'s father denied any concerns about his other partner and how she cared for the children but stated he was concerned about [redacted], S.G., because the home [redacted] was staying in with [redacted] mother was not safe due to firearms and substance use.

On July 2, 2021, a supervisor from the DCYF office in [redacted] provided the mothers with bus passes, pack-and-plays, strollers, diapers, clothing, wipes, and personal hygiene products. S.G.'s mother told the supervisor she needed a referral for a [redacted] examination and hair follicle test. The supervisor stated she would provide that information to the [redacted] County CPS caseworker.

While the CPS cases were underway, LE interviewed the adults, and the five-year-old child had a forensic interview. [redacted] That information was provided to LE. The women interviewed by LE made multiple statements regarding violence in the home.

The assigned caseworker in [redacted] County documented three more contacts before the case closed in August of 2021. On August 12, 2021, S.G.'s mother contacted the [redacted] caseworker regarding her friend, with whom she fled [redacted] County because the women were fighting. S.G.'s mother said the other woman would not allow her to leave with S.G. Law enforcement was called, and S.G. and [redacted] mother left and went to her boyfriend's home in [redacted]. The caseworker contacted the DCYF child welfare office in [redacted] County and asked that a caseworker make face-to-face contact with S.G. and [redacted] mother.

On August 12, 2021, a caseworker from the [redacted] County office made contact with S.G. and [redacted] mother at the mother's boyfriend's house. The mother identified that she was going to move into the home. Her boyfriend, Jonathan Torve, and four other adults lived in the residence. The caseworker obtained the names and dates of birth of all adults and documented the information in her case note. The caseworker identified and documented many concerns in the case note—those concerns related to the home's condition, the care of S.G., and possible substance use. The mother expressed the need for parenting classes, housing, and child care.

The [redacted] CPS caseworker documented in a case note that he called the mother on Aug. 26, 2021. She did not answer, and he left a voicemail message. The investigation was closed as unfounded and approved by the CPS supervisor for case closure on Aug. 31, 2021.

On Feb. 14, 2022, DCYF received a telephone call from the [redacted] County Deputy Medical Examiner regarding S.G.'s death.

Committee Discussion

The Committee discussed that this case highlighted incident-focused investigations and that DV was not properly assessed. Due to multiple factors, including strangulation, violence occurring in the presence of children, and multiple attempts to flee the violent home, the lethality level within this family was extremely high. DCYF policy requires staff to assess for DV; when DV is identified, DCYF policy requires a more in-depth,

specialized DV assessment. The Committee suggested that DCYF staff could have more actively assisted the women in seeking supportive services, such as a finding a DV advocate or discussing a protection order. However, on a couple of occasions, the women were given packets for local community resources. The Committee believed that calling supportive services with the women or helping them connect with supportive services could have been more beneficial to the women.

The CPS caseworker interviewed S.G.'s father and the partner who remained in RCW 74.13 County telephonically. The Committee discussed that interviewing the partner separately, or documenting the ways in which attempts were made to do so, was necessary. There was no indication in the case note that the caseworker attempted to ensure the woman was alone or separated from S.G.'s father during her interview.

S.G.'s parents and their other partner, who remained in RCW 74.13 County after the June 30, 2021 intake, were involved in a polyamorous triad. S.G.'s mother discussed this during her interview with LE. She told the officer that S.G.'s father broke the boundaries of their RCW 13.50.100 relationship. Two of the Committee members had experience working with people involved in RCW 13.50.100 relationships. They shared that the term breaking boundaries specifies that a person RCW 13.50.100. There was no follow-up by CPS or LE concerning how S.G.'s father broke the boundaries of his relationship with the mother.

The Committee spoke with multiple staff from both RCW 74.13 and RCW 74.13.515 counties. They were told that shortly after the June 30, 2021 intake, the assigned caseworker in RCW 74.13 County terminated his employment with DCYF. His entire caseload was then reassigned to another caseworker. The new caseworker did not make any contact with any of the adults involved in the investigation prior to closing the case. She did communicate with LE and documented, in case notes, records that were requested.

In August of 2021, the assigned caseworker in RCW 74.13.515 County was on a two-week vacation. During that time, his entire caseload was reassigned to his co-worker. In both circumstances, there were no transfer staffings, notes summarizing the status of the cases, or anything else to help the receiving caseworker with the cases. The Committee discussed that offices and/or supervisors should have a process in place for transfer staffings and possibly preparing case synopses, or even having the supervisor themselves engage in contacts and decision making—especially during the August 2021 time period when the assigned caseworker was on vacation.

The Committee also wanted more supervisory direction in supervisory review case notes. The Committee wanted supervisors to complete supervisory direction to the caseworkers prior to the supervisor approving a case for closure. Specific to the case, which was closed in August 2021, many aspects of an investigation were left unfinished prior to the case closure. The Committee discussed utilizing form 10-042, CPS Casework Checklist, which outlines what needs to be completed prior to case closure. While form 10-042 is not a required tool identified for supervisors to utilize, the Committee discussed that supervisors would benefit from looking at the form prior to approving a case for closure. Specifically, the form identified searching for information about the family in FamLink, searching databases, summarizing LE reports in a case note and obtaining a medical examination of children—all aspects identified in this review.

Structured Decision Making Risk Assessment (SDM) is a tool utilized by DCYF staff. The SDM has questions regarding the current family dynamics and historical information. The tool helps staff identify current and

future risk for maltreatment. The questions in the SDMs are to be answered regarding primary and secondary caregivers. The SDMs completed as to S.G. included only RCW 7 mother. The Committee identified that the SDMs needed to include S.G.'s father, the third adult in the parents' triad relationship, and the other adults who provided primary care for S.G. as identified by RCW 7 mother.

When S.G. and RCW 7 mother fled to RCW 74.13.515 County, the Committee felt that DCYF treated the family as though they were no longer a family. No one contacted S.G.'s father for the intake generated on July 2, 2021, and caseworkers did not have conversations regarding any visitation, relationship exploration, etc. The Committee attributed this to the staff's lack of understanding or experience interacting with polyamorous triads.

Both S.G.'s mother and the other woman who fled to RCW 74.13.515 County with them were very young mothers. Both women verbally and non-verbally expressed significant fear of S.G.'s father (who was much older than them) and asked for support. S.G.'s mother specifically talked about not knowing how to parent RCW 13.50.100. There were a couple of junctures where the women were given community resource materials. This is a regular practice in many cases. However, particular to this case, the women appeared so traumatized: at times were described by DCYF as acting younger than their chronological ages. The Committee believed it would have been appropriate to interact with them in a more engaging and hands-on manner. An example would be to have met with the women to help them connect with supportive services or sit with them while they contacted a DV advocate program or shelter.

A DCYF policy directs staff to obtain a child protection medical consultation in certain circumstances. This case met the specific qualifications (the child's age, bruises of unknown origin, and the child appeared underweight), but the child protection medical consultation process was not followed. On at least two occasions, S.G.'s mother was told to seek a medical assessment for RCW 74.13.515. S.G. was not seen by any medical provider prior to the case closing. The Committee discussed that S.G. should have been seen by a medical provider immediately after the caseworker observed bruises and at least before the case closure. The bruises were initially observed during a courtesy contact, they were photographed, and an intake was created due to the bruising. A CPS supervisor saw the photographed bruises and called S.G.'s mother. She directed S.G.'s mother to take RCW 74.1 to an urgent care or emergency department immediately. S.G.'s mother said she did not have the ability to do so, but that was resolved by receiving bus tickets. The RCW 74.13.515 caseworkers also made in-person contact that same day and observed the bruises on S.G. The mothers were advised to take their children for medical evaluations. The women went to a location but did not stay long enough to have the children evaluated.

The Committee discussed that a thorough CPS investigation or assessment includes critical thinking and curiosity. Specific to this case, S.G.'s mother and the other mother who fled with them disclosed mental health disorders. However, no further questions were posed about when they were diagnosed, whether they received treatment, or if they would complete a release of information to gather assessments or discharge summaries. Another aspect of a comprehensive investigation is assessing all adults in the home. S.G. lived at two locations after RCW 7 left RCW 74.13 County. At each location, there were other adults in the home. Courtesy caseworkers obtained the adults' names and dates of birth. However, no one utilized internal or external databases to assess those individuals. This included the mother's boyfriend, Jonathan Torve.

The Committee desired more curiosity regarding the women feeling RCW 13.50.100 and stating they believed they might have been RCW 13.50.100. There was also a statement made that the children were given melatonin drops. The Committee identified that asking to see the bottle and verifying what the children were given was necessary. The Committee understood there were no allegations of substance abuse, but the multiple allegations of adults feeling RCW 13.50.100 led the Committee to discuss that blood or urine testing may have been beneficial.

As part of the June 30, 2021 investigation, the five-year-old female child had a forensic interview. RCW 13.50.100 That statement was made while she was being transported by DCYF staff to a foster home. While LE could not proceed with a criminal investigation, DCYF staff could have inquired further into the RCW 13.50.100 allegations. There were statements RCW 13.50.100 , and CPS investigators could have interviewed the other adults living in the home.

In August of 2021, S.G. and RCW 7 mother moved to the RCW 74.13 515, Washington area. They moved in with Mr. Torve. Other adults also resided in that home. When the assigned CPS investigator returned from vacation, he called S.G.'s mother to discuss ongoing services, intending to request to open a voluntary services case out of the RCW 74.13.515 DCYF office. The caseworker told the Committee that he left voicemail messages for the mother, but she did not return his messages. The Committee discussed that more action should have been taken to engage S.G.'s mother prior to closing out the case.

The Committee discussed that DCYF staff utilize Child Safety Framework when assessing for child safety throughout the life of a case. That framework helps guide staff through multiple points of assessment, including family functioning, roles people play within a family, DV, child development, etc. Had the framework tool been utilized as intended, the Committee opined that it would have helped guide the CPS caseworkers and supervisors to complete a thorough assessment of child safety.

The Committee also discussed that two DCYF staff wrote very clear, thorough, detailed case notes. They appreciated that the notes included details about the names and birth dates of other adults in the home, the presentation, injuries to S.G., the residences where S.G. was staying, etc.

Recommendations

1. DCYF should alter the Present Danger Assessment tool to include the term 'torso' in the "Injuries to Face/Head" line under the Maltreatment heading. Torso is included further in the document in the Face/Head section. This is specifically brought up in this review due to the fact that the victim was observed to have sentinel injuries on RCW 7 torso. There was no medical evaluation conducted prior to closing out the case.
2. Within the definitions in the Present Danger Assessment tool, DCYF HQ program managers should review the definition of "serious bodily injury" to include the term 'sentinel injury.' While the injury itself may not appear to be serious, the seriousness of a sentinel injury is often related to fatal or near-fatal events to come. The tool is adapted from the National Resource Center for Child Protective Services and was edited by DCYF in May 2021.

3. DCYF should collaborate with the Alliance to incorporate more "wheels"[3] at Regional Core Training, place laminated Power and Control[4] and Post-Separation[5] wheels in DCYF offices, and work on communicating the different "wheels" to the fields. Possible ways to do that include discussing the "wheels" at all-staff meetings or Leads meetings and placing them in the Digest email (DCYF's internal weekly communication email). This link provides various wheels: http://www.ncdsv.org/publications_wheel.html.
4. DCYF should create a DV Best Practices group for each of the six regions. This is based on the group that is established in Region 4.
5. DCYF HQ staff should review form 10-042, CPS Casework Checklist, for case closure to discuss ways to remind staff about the form and communicate how useful it can be. DCYF HQ staff should also remind supervisors that the checklist may be a helpful roadmap when closing a case. In this case, multiple areas were identified on the checklist that were not completed prior to case closure. DCYF HQ staff can remind staff that when the checklist is utilized, the completed form should be uploaded into Famlink. Communication regarding this recommendation could be through all-staffs, Leads meetings, etc.
6. DCYF should work with the Alliance to create a Facilitated Cohort Learning Session to Support DV practices. This is a current proposal in at least one region (Region 5) and was discussed at the review.

[3] For information about "wheels," see: https://www.theduluthmodel.org/wheels/.
[4] For information about the Domestic Abuse Intervention Programs' Power and Control Wheel, see: https://www.theduluthmodel.org/wp-content/uploads/2017/03/PowerandControl.pdf.
[5] For information about the Domestic Abuse Intervention Programs' Post-Separation Wheel, see: https://www.theduluthmodel.org/wp-content/uploads/2021/10/Post-Separation-Power-and-Control.pdf.