CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

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Full Report

Child

- A.C.

Date of Child's Birth

- RCW 74.13.515 2018

Date of Fatality

- Feb. 22, 2022

Child Fatality Review Date

- April 28, 2022

Committee Members

- Cristina Limpens, MSW, Senior Ombuds, Office of Family and Children's Ombuds
- Tara Camp, Statewide CFWS Program Manager, DCYF
- Victoria Cantu, CPS-FVS Supervisor, DCYF
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- Lindsey Barcklay, MSW, LiCSW, CMHS, CCTP, Clinical Director, Domestic Abuse Women's Network

Observer

- Rylee McCauley, CPS Caseworker, DCYF

Facilitator

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

Executive Summary

On April 28, 2022, the Department of Children, Youth, and Families (DCYF)[1] convened a Child Fatality Review (CFR)[2] Committee (Committee) to examine DCYF's practice and service delivery to A.C. and RCW 74 family. A.C. will be referenced by RCW 74 initials throughout this report.[3]

On Feb. 22, 2022, law enforcement contacted DCYF to report that A.C. was found unresponsive in RCW 74 home and had been taken to the hospital. Medical professionals observed the following injuries: a brain bleed and bruising on RCW 74 neck, abdomen, back, arms, legs, and anus. A toxicology report revealed that A.C. tested positive for marijuana. A.C. was malnourished, evidenced in part by thinning hair. The hospital social worker reported the injuries were suspected non-accidental trauma.

On Feb. 23, 2022, A.C.'s mother and father were arrested. The mother was arrested and accused of first-degree assault of a child, third-degree assault of a child, first-degree criminal mistreatment, and tampering with a witness. The father was arrested and accused of first-degree criminal mistreatment. On Feb. 26, 2022, A.C. was pronounced brain dead.

At the time of A.C.'s death, there was no open DCYF case involving A.C. and RCW 74 family. However, there was a recent DCYF Child Family Welfare Services (CFWS) case and a Child Protective Services (CPS) case that were both closed in December 2021. A new CPS case was assigned to investigate the death of A.C.

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 A.C. 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 the area administrator who were all involved with the family.

Case Overview

A.C.'s mother first came to the agency's attention in 2010 and had an extensive DCYF involvement history. The mother has one adult child who reportedly grew up with a relative and one older child reportedly being raised by his father. RCW 74.13.515 (age 4), A.C. (age 3), and RCW 74.13 (age 2) are the children born to the mother and father.

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[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" or "department" 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 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.

[3] A.C.'s name is not used in this report because RCW name is subject to privacy laws. See RCW 74.13.500.

Before A.C.'s death, DCYF received 20 reports concerning the mother and her children. The reports alleged concerns about substance use, child neglect, and domestic violence (DV) between the parents. Eleven reports did not satisfy the criteria for a CPS investigation, and nine reports led to CPS investigations.

In late 2019, DCYF received a report of a DV incident between the mother and father. A CPS investigation was assigned. At the time of the report, RCW 74.13.515 and A.C. were in relative care pursuant to an agreed third-party custody order approved by the family court.

In RCW 74.13.515 2020 (before the 2019 CPS investigation was closed), DCYF was notified of the birth of RCW 74.1. It was reported that the mother tested positive for RCW 74.13.520 at RCW 74.13.515 birth and that the father appeared to be under the influence. The mother admitted to using marijuana, tobacco, and RCW 74.13.520. At the time of the call to DCYF, toxicology results for RCW 74.13 were pending. A CPS risk-only[4] investigation was assigned.

RCW 74.13 tested positive for RCW 74.13.520 at birth. The parents agreed to a voluntary placement agreement (VPA) and said they were willing to work with DCYF to address the concerns. Five days after the VPA was signed, the parents rescinded the VPA, requesting court involvement so they could have legal representation. In February 2020, DCYF filed a dependency action, and the court approved an interim shelter care order. RCW 74.13 was placed in licensed foster care.

In March 2020, the CPS investigations were completed, and DCYF issued founded findings[5] against the parents for the negligent treatment or maltreatment[6] of RCW 74.13.515 and A.C. Pursuant to a family court order, RCW 74.13.515 and A.C. remained in relative care. The case involving RCW 74.13 was transferred to a CFWS caseworker for ongoing service provision and monitoring. The court entered another shelter care order and recommended the following services for both parents: substance use disorder (SUD) treatment (ongoing), random urinalysis testing, attendance at a DCYF-approved parenting class, mental health and domestic violence assessments. Both the mother and father were referred for DV assessments.

The CFWS caseworker frequently contacted the parents to give them the opportunity to engage in services and to provide case updates. Despite the CFWS caseworker's efforts, the caseworker received limited responses from the mother and father. The CFWS caseworker made collateral contacts with the parent's housing program (shelter staff) and attempted to obtain updates about the parents' services.

Despite DCYF's objection at a contested fact-finding hearing in January 2021, the court ordered that RCW 74.13 be returned to his mother's and father's care. The court ordered conditions for the return home and ordered both parents to engage in services. The mother and father were court-ordered to complete SUD treatment, random urinalysis, mental health evaluations, domestic violence assessments, and DCYF parenting classes.

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[4]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.

[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).

[6]"' Negligent treatment or maltreatment' means an act or a failure to act, or the cumulative effects of a pattern of conduct, behavior, or inaction, that evidences a serious disregard of consequences of such magnitude as to constitute a clear and present danger to a child's health, welfare, or safety…." RCW 26.44.020(19).

In February 2021, two health and safety home visits were conducted. No safety concerns were observed, and RCW 74.13.515 medical needs were being met. The CFWS caseworker discussed services with the parents, including providing the contact information for the local mental health agency and the number for the DV assessor to whom the parents were referred.

In March 2021, two health and safety home visits were conducted. The parents reported continuing the intake process for the DV assessment, and the mother said she contacted the mental health agency but had difficulties scheduling an appointment. The CFWS caseworker provided detailed information about how to access mental health services.

In April 2021, DCYF received a second-hand report about the father sharing concerns with a relative about the mother using RCW 74.13.520. This intake did not meet the CPS investigation criteria because there was no abuse or neglect allegation. The CFWS caseworker already assigned gathered information about this reported concern from her contacts with the parents, shelter staff, extended family, and attempted provider contacts.

In May 2021, an unannounced health and safety home visit was conducted. The father said he was alternating his living arrangement by residing at the family home and sometimes staying with a friend. No concerns were noted about RCW 74.1. In June 2021, it was reported that the father was back to residing full-time in the family home.

In July 2021, the case was transferred to a different CFWS caseworker. The July and August health and safety visit case notes did not indicate concerns about the home or care of RCW 74.1. In August 2021, a Family Preservation Services referral was submitted to provide in-home services to the family. The family did not engage with the service provider.

In September 2021, DCYF received a report that RCW 74.13.515 and A.C. had been spending increased time with their parents, hoping they may return to parental care. RCW 74.13.515 told her caregiver about a fight between the parents, which made her mother's nose bleed. The report also noted concerns about hygiene and the home's condition. This report did not screen-in for investigation because there was no abuse or neglect allegation. During the monthly health and safety visit, no concerns were documented. The parents said RCW 74.13 was adjusting well to having increased in-home sibling visits with RCW 74.13.515 and A.C. The family was referred to Project Safe Care services but did not follow through with the service provider.

In October 2021, DCYF received another report about concerns for RCW 74.13.515 and A.C. This report was received the day before RCW 74.13.515 and A.C. were to begin transitioning to their parent's care. The caller reported that RCW 74.13.515 had returned home from a visit saying the bathroom door had been locked and her parents were sleeping, and she could not wake them. The caller reported concerns that the children's hygiene needs were not being met. The caller said the parents do not let the caller in the home because they are angry about the calls to CPS. A CPS investigation was assigned.

While in the family home, a CPS investigator completed an initial face-to-face visit with RCW 74.1. No concerns were observed. A CPS courtesy caseworker conducted an initial face-to-face visit with RCW 74.13.515 and A.C. in the relative home. The CPS courtesy caseworker noted there were no observable concerns for either child. The CPS caseworker attempted to interview RCW 74.13.515 but noted she was difficult to understand. RCW 74.13.515 said the bathroom

door was locked and that she had an accident in her pants. RCW 74.13.515 could not tell the CPS caseworker anything else or how she got a bite mark. No additional details were documented.

The CPS caseworker attempted another visit with the parents, but they were not home. The CPS caseworker spoke with shelter staff, who said they had no concerns for the children. The mother sent a text to the CPS caseworker confirming that RCW 74.13.515 and A.C. were permanently home and asked the caseworker to resubmit the referral for urinalysis testing.

In November and December 2021, the CPS and CFWS caseworker completed four visits to the family home to observe the children and to drop off supplies. No safety threats were identified. The children were observed to be clean, healthy, and with no visible marks or bruises. It was noted the home was" cluttered" but not unsafe. The CPS caseworker spoke with shelter staff, who confirmed the parents were participating in parenting classes. The parents confirmed urinalysis testing completion. Both were positive for RCW 74.13.520 and THC.

In December 2021, after 11 months of monitoring, DCYF recommended the dismissal of the RCW 74.13 dependency matter. There were no active safety threats, and the parents were identified as adequately meeting RCW 74.13.515 needs. At the time of case dismissal, the parents were reportedly continuing with the RCW 74.13.520 treatment program but had not completed court-ordered services. The court granted the dismissal request. With regard to RCW 74.13, the CPS investigation concluded with unfounded findings and was submitted for case closure. The parents were encouraged to remain connected with community-based services.

On Feb. 22, 2022, DCYF was notified that A.C. was in critical condition due to suspected non-accidental trauma. In addition to a law enforcement investigation, a CPS investigation was assigned. The children were placed in protective custody. RCW 74.13.515 and RCW 74.13 were placed in licensed foster care.

On Feb. 23, 2022, the mother was accused and arrested for first-degree assault of a child, third-degree assault of a child, first-degree criminal mistreatment, and tampering with a witness. On the same date, the father was accused and arrested for first-degree criminal mistreatment.

On Feb. 26, 2022, following a second brain death examination, A.C. was pronounced brain dead.

On May 4, 2022, the CPS investigation was completed. DCYF issued founded findings against the parents for the negligent treatment or maltreatment of RCW 74.13.515 and RCW 74.1. DCYF also issued founded findings against the parents for the physical abuse of A.C.

COMMITTEE DISCUSSION

The Committee met and spoke with caseworkers, supervisors, and the area administrator who were all involved with this family. The Committee appreciated learning from direct conversations with the field office and felt it provided more context than simply reading the case documents. The Committee learned about some of the recent challenges facing this office, including increased CPS intakes and caseloads and turnover within the CFWS program that contributes to the high caseloads.

From the review process, the Committee highlighted some positive practice areas. First, the Committee believes there was a strength-based perspective about the parents; second, both parents were equally involved with the DCYF interventions; and third, both parents were court-ordered to complete similar services to address their identified needs. The Committee also appreciates the case notes' details about the parent and child bonding.

The Committee believes DCYF's ongoing involvement with the family assessment lacked curiosity. The Committee's discussion focused on how information gathering and increased communication may have improved DCYF's ongoing assessment of the family and their needs.

The Committee believes the caseworkers relied too heavily on parental self-reports about their service engagement and progress. The Committee believes that more DCYF requests for documents such as law enforcement reports, background checks, and medical records may have better informed the caseworkers about the family's progress and needs.

The Committee learned from the field office there are ongoing barriers to accessing treatment records from the local SUD provider. Given that, the Committee wondered if a professional DV and SUD consultation may have provided an avenue to gather more knowledge to apply to the ongoing assessment.

With regard to DCYF's concerns about the lack of compliance and the parents' limited services participation, the Committee would have liked to have seen more documentation and communication with the parents, legal parties, and dependency court. The Committee believes it would have been beneficial to more clearly document DCYF's attempts to engage the parents with services, outline compliance-related concerns in court reports, and return to court to share this information with the parties verbally. With regard to the family's housing program, the Committee believes it would have been helpful for the court to know more about the program's limitations.

The Committee wondered about the caseworkers' willingness to have difficult conversations with the parents. The Committee discussed the benefits of Family Team Decision Making (FTDM) meetings and identified FTDMs as an opportunity for direct yet collaborative communication. An FTDM at the time of RCW 74.13.515 return home may have provided an opportunity to address, in a transparent manner, the concerns associated with the parents' lack of compliance. This conversation could have included not only the parents but other stakeholders as well.

The Committee discussed the differences between family court and dependency court. The Committee believes there may be a systemic gap between these two court structures. The Committee speculated whether information sharing between the two court systems may have been beneficial.

The Committee noted that an updated safety assessment was not completed when the two older children were returned home. The Committee believes an updated assessment, as required by policy, may have provided additional information about the two older children's needs (i.e., developmental and medical). It may have also addressed any unmet needs of the parents. The Committee discussed additional community-based services that may have mitigated risk and benefited the family. However, the Committee understands the parents may have declined to participate.

The Committee did not develop recommendations from this CFR but discussed some ideas and suggestions that may benefit the field office. The Committee recognizes the potential decision-making impacts associated with the contentious relationships with some court partners, as reported by the field office. The Committee speculated that based on the court returning RCW 74.13 home over DCYF's objection, the caseworkers might have felt somewhat immobilized in their roles. The Committee discussed the importance of caseworkers feeling empowered to be a strong voice for child safety in the courtroom.

The Committee suggested the use of an internal case consultation process may have been beneficial to the ongoing safety assessment and in addressing the parents' lack of compliance. To seek guidance from a professional, a Committee member who is a subject matter expert suggested using the DV hotline or local DV providers to provide case consultation for caseworkers. This may be accomplished through the DV hotline without providing the family's name. The Committee also discussed an aspect of the Child Safety Framework[7] and outlined the benefits of caseworkers completing all five threshold questions. The Committee member discussed the potential benefits of taking the time to do this and how it can enhance safety assessment critical thinking.

Findings

The Committee identified the following improvement opportunities from this review process:

1. The Committee found there was a lack of curiosity demonstrated throughout DCYF's ongoing assessment of the family. Although DCYF staff made collateral contacts, DCYF heavily relied upon the self-reports provided by the parents. In addition to challenging the parents when discrepancies arose between information reported to DCYF and what the parents reported, the Committee believes additional independent verification was needed.

2. The Committee believes it may have been beneficial for DCYF to more clearly articulate and share with the court the ongoing concerns about the parent's lack of compliance and progress with court-ordered services.

3. The Committee identified the following DCYF policy-related areas that needed attention:
    - With regard to RCW 74.13.515 birth, a Plan of Safe Care was not completed during the CPS investigation. [Policy 1135 (Infant Safety Education and Intervention)].[8]
    - Safe Sleep and Period of Purple Crying discussions with the parents were not clearly or consistently documented in case notes. [Policy 1135 (Infant Safety Education and Intervention)].

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[7] For information about DCYF Policy 1120 Safety Assessment, see: https://www.dcyf.wa.gov/1100-child-safety/1120-safety-assessment. Last accessed Last accessed on May 24, 2022.

[8] For information about DCYF Policy 1135 (Infant Safety Education and Intervention), see: https://www.dcyf.wa.gov/1100-child-safety/1135-infant-safety-education-and-intervention#:~:text=Purpose,of%20child%20abuse%20and%20neglect. Last accessed on May 2, 2022.

- A Family Team Decision Meeting (FTDM) or shared planning meeting was not held at the time of RCW 74.13.515 return home. [Policy 1720 (Family Team Decision Making Meetings)].[9]
- An updated safety assessment was not completed when there was a change in household structure due to RCW 74.13.515 older siblings' move back home. [Policy 1120 (Safety Assessment)].[10]
- Background checks were not completed for the parents at any point during the case. [Policy 6800 (Background Checks)].[11]

Recommendations

The Committee did not develop any recommendations.

[9] For information about DCYF policy 1720 (Family Team Decision Making Meetings), see: https://www.dcyf.wa.gov/1700-case-staffings/1720-family-team-decision-making-meetings. Last accessed on May 2, 2022.

[10] For information about DYCF policy 1120 (Safety Assessment), see: https://www.dcyf.wa.gov/1100-child-safety/1120-safety-assessment. Last accessed on May 2, 2022.

[11] For information about DCYF policy 6800 (Background Checks), see: https://www.dcyf.wa.gov/6000-operations/6800-background-checks.