CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

January 2020

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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

- A.C.G.

Date of Child's Birth

- RCW 74.13 515 2016

Date of Fatality

- October 2019

Child Fatality Review Date

- January 9, 2020

Committee Members

- Patrick Dowd, JD, Office of the Family and Children's Ombuds, Director
- Loyal Higinbotham, Everett Police Department, Sergeant Sexual Assault Unit
- Jennifer McCarthy, MSW, DCYF, Quality Practice Specialist, Region 4
- Tarassa Froberg, DCYF, CPS/FVS Statewide Program Manager
- Maria Sherry, Olive Crest, Hispanic Community Outreach Fostering Together

Observer

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

Facilitator

Libby Stewart, DCYF, Critical Incident Review Specialist

Executive Summary

On January 9, 2020, the Department of Children, Youth, and Families (DCYF)[1] convened a Child Fatality Review (CFR)[2] to assess DCYF's service delivery to A.C.G. and RCW 74 family.[3] RCW 74 will be referenced by RCW 74 initials throughout this report.

On October 17, 2019, DCYF received a telephone call from the United States Consulate in Mexico. The caller reported two-year old A.C.G was found dead while in the care of RCW 74 father, Jose Caro Solis. A.C.G.'s sisters were removed from their father and placed in a temporary shelter in Mexico. With regard to A.C.G., Mr. Solis has been charged in Mexico with the crimes of aggravated rape and aggravated murder.

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 A.C.G. or RCW 74 family. The Committee received relevant documents including intakes, case notes and other DCYF documents maintained in DCYF's electronic computer system.

Before A.C.G.'s death there was a large number of DCYF staff who were assigned to RCW 74.1 case. The Committee interviewed the staff who had a significant role and are also currently employed by DCYF. The Committee interviewed nine staff in person and two staff by telephone.

Case Overview

A.C.G. has three older sisters, and in January 2017 the sisters ranged in age from two years to seven years. On January 13, 2017, RCW 74.13.515-old A.C.G. and RCW 74 family first came to DCYF's attention. On that date, DCYF received a telephone call reporting RCW 74.13.515 old A.C.G. had two broken ribs. The explanation for how RCW 74 broke RCW 74 ribs was inconsistent with RCW 74 injury. According to A.C.G.'s mother, she brought A.C.G. to the hospital's emergency department when the mother noticed RCW 74.13.515 back made a cracking sound. A.C.G. was then transferred to a higher level trauma hospital. This intake was screened in for an emergent Child Protective Services (CPS) investigation. Law enforcement conducted a criminal investigation that resulted in the arrest of A.C.G.'s father (Jose Caro Solis).

At the conclusion of the CPS investigation, DCYF entered a founded finding for physical abuse caused by the father and founded finding for negligent treatment caused by the mother.[4] A.C.G. and RCW 74 three older sisters were placed in protective custody.

On February 13, 2017, DCYF received a telephone call reporting that A.C.G.'s RCW 74.13.515 sister was brought to the medical clinic and found to have RCW 74.13.520. These were identified two weeks

[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.

[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]A.C.G.'s father has been charged with committing a crime related to ACG's death while in Mexico. Accordingly, he is identified by name in this document.

[4]At the conclusion of the appeal process the founded finding against the mother was overturned.

prior to the February 13 report but this was the first intake related to this concern. The mother reported she was not aware of any sexual abuse concerns. This intake was screened out. On February 23, 2017, an intake was screened in for a CPS investigation involving RCW 74.13.520 on A.C.G.'s RCW 74.13.515 sister and RCW 74.13.515 sister. A.C.G.'s RCW 74.13.515 sister had a RCW 74.13.520. This investigation was closed out as unfounded. The February 23 intake states that the children were to receive forensic interviews. DCYF did not have any records of any forensic interviews and the staff did not recall if they in fact occurred. Records and interviews with staff did not provide a clear explanation for the cause of the RCW 74.13.520. Without a clear explanation, it remains unknown if the RCW 74.13.520 were from sexual abuse, transmission from a parent or other unknown exposure.

Pursuant to a court order, on April 21, 2017, a family team decision meeting (FTDM) was held. The purpose of the FTDM was to discuss whether the children should be returned to their mother. On April 28, A.C.G.'s oldest sister was returned to her mother's care. On July 28, 2017, the next two oldest girls were also returned to their mother.

On August 1, 2017, the court ordered DCYF to conduct another FTDM regarding the return of A.C.G. to RCW 74.1 mother. This meeting occurred on August 10, 2017; and on September 15, 2017, A.C.G. was returned to RCW 74.1 mother's care.

On February 5, 2018, the court dismissed the dependency case involving A.C.G.'s oldest sister; and on February 27, 2018, the court dismissed the cases for the next two oldest children. The dependency for A.C.G. was not dismissed.

On March 29, 2018, an intake was screened in for CPS investigation. The allegations were reported by the Children Family Welfare Services (CFWS) worker after the worker observed the girls during a health and safety visit.[5] The RCW 74.13 515 girls disclosed that their father was living in the home and hitting them with belts. The CFWS worker also reported that the girls said one of the children did not have a car seat and they are sleeping on the floor. The intake also indicates that the mother and children moved without the mother providing notice to DCYF.

During the CPS investigation of the March 29 intake, two of the girls confirmed their father had been living with them. One child said her mother pulled her ears because she disclosed this information to CPS. The child also said her dad no longer lives in their home. Another sister confirmed that their father hits them hard with a belt and "it really hurts." This child also said their father was in the home as recently as the night previous to the child's interview. During the RCW 74.13.515 child's interview the child denied their father lived in the home.

On April 6, 2018, the CFWS worker contacted the mother about the current CPS investigation. The CFWS caseworker also met with the children and learned that another family was sharing the residence. The CFWS caseworker told the mother the adults in the home must submit to a background check. The shared living area of the home was dirty and unkempt. The room that A.C.G.'s mother and sister shared was not as bad as the shared living area.

When the CFWS caseworker spoke with the children, one of the girls confirmed that her mother pulled the girl's ear because the mother was angry about the girl's disclosure that their father had been living

[5] Health and safety visits are required under DCYF Policy No. 4420. See: https://www.dcyf.wa.gov/4400-concurrent-tanf-benefits/4420-health-and-safety-visits-children-and-youth-and-monthly-visits.

in the same home as the girls. This child also said her disclosure to CPS caused her father to yell profanities at her. This child said she wanted to go to her grandfather's home and, "I want a different mom."

One of the other children disclosed she was injured after being hit by another unrelated child in the home. The child said their mother was aware of the situation, but did nothing to stop the hitting behavior. This child also confirmed that until the disclosure by the girls, their father was living with her, her sisters and mother. In an effort to work on keeping the home safe for the girls and prevent removal, the CFWS caseworker referred the family to the Homebuilders[6] program.

Before the investigation was completed, the assigned CPS caseworker ended her DCYF employment. The case was transferred to a different CPS caseworker. The newly assigned CPS caseworker completed the investigation and an unfounded finding for abuse or neglect was entered.

On July 20, 2018, another intake was received and assigned for a CPS investigation. This intake alleged that RCW 74.13.515 old A.C.G. was dirty with a severe diaper rash. The mother was instructed to take A.C.G. to the doctor but she failed to do so. The intake stated there was RCW 74.13.520 from the diaper rash. The CPS caseworker took a photograph of the RCW 74.13.520. The RCW 74.13.520 was attributed to ongoing severe diaper rashes. During the course of this investigation it was learned that the mother had again moved without providing notice to the assigned CFWS caseworker. For purposes of this CPS investigation, DCYF entered unfounded findings for abuse or neglect.

On November 6, 2018, A.C.G.'s dependency was dismissed. DCYF objected to the dismissal stating that pursuant to DCYF policy, the mother failed to cooperate with background check requirements. Because the court cases were dismissed the DCYF case was closed.

On May 20, 2019, DCYF received a telephone call reporting A.C.G.'s RCW 74.13.515 sister arrived at school upset. She reported her mother threatened to hit her hard enough to make her bleed. She also reported her mother previously hit her so hard with a belt that it left bruises, her mother hits her sister and she does not feel safe with her mother. This intake was assigned for a CPS investigation.

When the CPS caseworker made contact with the RCW 74.13.515 sister the CPS caseworker did not observe any injuries. The CPS caseworker spoke with school officials who reported the family recently transferred to the school, and the school did not have any concerns. Likewise, the previous school also did not share any concerns. The RCW 74.13.515 child was interviewed. She said she feels safe with her mother when her mother is not mad. She also confirmed previous statements about injuries that were caused by being hit. The RCW 74.13.515 child was also interviewed. She talked about having to provide care for her RCW 74.13.515 sisters, including changing diapers. The RCW 74.13.515 child was interviewed at day care. She disclosed that their mother hits them with a belt. She also disclosed that sometimes the RCW 74.13.515 sister will hit her and it makes her sad. When the mother was interviewed, she denied the allegations. She said she did hit the girls before the dependencies were filed. However, during the dependency cases she learned alternatives to hitting the children as a result of attending the Homebuilders program and Triple P services. This investigation was closed as unfounded.

Two days after the investigation was closed another intake was received. On June 21, 2019, a neighbor called to report she saw a child waving a paper outside the window. The paper said, "We need water."

[6] Homebuilders is an intensive in-home service program focused on attempting to prevent the need for out-of-home placement.

The neighbor thought they were playing. However, when she returned an hour later she saw the child waving the sign again. She asked the child if she was playing or serious, and the child said they were very thirsty because they have not had a drink since the previous day. The neighbor saw that there was no furniture in the home, very little food and a stack of dishes in the sink. The girls had no way of calling anyone. The girls also told the neighbor that their mother was going to take them to Mexico to see their father when school ended for the year. This intake screened in for CPS investigation. Due to a scheduled vacation the CPS caseworker who closed the last investigation was unavailable to investigate these most recent allegations. On June 24, 2019, a different CPS caseworker unsuccessfully attempted to contact the family at the family home. However, at their school the CPS caseworker was able to make contact and interview the school aged girls. The RCW 74.13.515 child said they always have food and water and was not sure why she wrote the note and was waving it outside of their window. She also reported they were moving. The RCW 74.13.515 child said they do not always have food and when the neighbor gave them food, her RCW 74.13.5 sister told her to hide the food in a backpack and not tell their mother. The RCW 74.13.515 child reported that sometimes they are hungry and their mother doesn't have enough money to buy food. She also said they were going to visit their father in Mexico. The mother denied the allegations.

On July 23, 2019, the previously assigned CPS caseworker attempted to contact the mother. The mother told the CPS caseworker the girls were with a relative in Mexico and would not be returning to the area until August. The mother first said that her cousin had been watching the girls, during the period referenced in the CPS intake. When the CPS caseworker contacted the mother's cousin, the cousin first appeared confused but later agreed she sometimes watched the girls. The younger girls' day care said they were gone for the summer in Mexico but expected them to return for the school year. This intake was closed out as unfounded.

On October 17, 2019, DCYF received a telephone call reporting that A.C.G. was reportedly dead. At the time of RCW 74 death RCW 74 was living with RCW 74 sisters and father in Mexico.

Committee Discussion

The Committee spent significant time discussing the high DCYF staff caseloads for the staff involved in this case. When this case was first opened in January 2017, the assigned CPS caseworker was responsible for 33 open cases. This high caseload trend continued throughout the life of A.C.G.'s case. For example, by the end of January 2017, the CPS caseworker's caseload totaled 40 cases; and at the time the case was transferred to a CFWS worker, the CPS caseworker had 32 assigned cases. In June, 2018, the CPS caseworker who completed the March 2018 investigation was responsible for 59 open CPS cases.

With regard to the assigned CFWS caseworkers, the first CFWS caseworker was responsible for 34 assigned cases. When the case was transferred to a new CFWS caseworker in February 2018, the CFWS caseworker was responsible for 36 cases. At the time of case closure in November 2018, the CFWS caseworker was responsible for 41 cases. The Committee discussed that with such high caseloads there is a diminished ability for the assigned staff and supervisors to conduct thorough child safety assessments, and insufficient time to allow for critical thinking.

High caseloads along with internal turmoil was also discussed regarding two of the offices that were responsible for this case. Both offices suffered from high staff turnover, including area administrator turnover and a large workload for supervisors due to the number of staff they are supervising.

Information shared during the staff interviews regarding the change of area administrators appeared to have a significant impact on turnover within the two offices, which led to higher caseloads for the remaining workers and supervisors. The Committee was hoping to have observed more critical thinking, reflective supervision and less copying and pasting of prior supervisor case notes. However, the Committee believes this issue was caused by the workers' high caseloads, staff turnover and the large span of supervision for the supervisors. Under the circumstances, the Committee does not believe the high staff turnover caused or played a role in A.C.G.'s death.

Another discussion topic focused on Mr. Solis and the children's communication while in the presence of DCYF. For example, some staff shared there were times that the oldest child would stop a younger sibling from answering a question by speaking to her in Spanish. Some staff reported the father refused interpreters and appeared to be able to communicate in English.

The Committee was concerned about what appeared to be a lack of engagement initiated by DCYF with Mr. Solis. Even when considering that the case was in extended shelter care for a considerable amount of time, and there was significant conflict between DCYF staff, the parents and their attorneys. Despite this conflict, and the fact there was a criminal case filed against the father, the Committee would have liked to have seen more attempts to engage the father and to discuss his background.

Staff interviews provided the Committee with information regarding challenging working relationships between DCYF and all other parties, to include at times the Attorney General's Office (AGO) office. There were conflicting perspectives on reasons for these challenges. Regardless of the cause of the conflict, it was mentioned by numerous staff and identified by those staff, as a barrier to timely, best case practice. Based on staff interviews and the Committee's review of the documents provided, the Committee identified throughout this case a clear pattern of evasive, inconsistent and untruthful statements and/or behaviors by the mother. The Committee expressed hope that workers would have identified this if they had appropriate sized caseloads. The Committee recognizes the fact that the worker's inability to identify the mother's untruthful conduct did not play a role in A.C.G.'s death. The Committee also would like to have seen clear communication to the court about the mother's dishonesty, and more clearly described concerns that support why, at multiple points throughout the case, DCYF objected to dismissal of the dependency cases. During the staff interviews, and from information shared by the AGO's office, it was clear the court was made aware of the concerns as they occurred, but it was not documented in the case record.

The Committee did appreciate there were clear efforts to locate a Spanish speaking service provider for the father. The Committee discussed the observable impact this case had on some of the staff. The Committee appreciated the staff's presentation, honesty and openness.

Findings

The Committee found that while no critical error was made by DCYF, the caseloads were too high for the CPS investigators and CFWS caseworkers who handled the case from January 2017 through October 2019. The Committee believes the extremely high caseload assignments contributed to a diminished level of case work. The following are examples identified by the Committee, that supports this finding:

1. Forensic interviews should have been conducted regarding the January 2017 investigation. However, there is no documentation and no uploaded documents. When the staff were interviewed by the Committee, they were unable to recall if this occurred.

2. The law enforcement reports from the 2017 investigation were not contained within the electronic file. There is no documentation to indicate the reports were requested.

3. There is no documentation of subject interviews (interviews of the parents who were identified as subjects of the investigation or the verbal children).

4. There is a lack of documentation regarding DCYF's attempts to engage the father in the dependency case. There are no documents indicating attempts to reach him by phone to discuss the case or engagement in services.

The Committee also believes the DCYF policy for assessing domestic violence (DV) was not followed. This policy applies throughout the life of a case, and therefore the policy needs to be followed by both CPS and CFWS. More information regarding this policy can be found at: https://www.dcyf.wa.gov/1100-child-safety/1170-domestic-violence.

Recommendations

Even though the initial investigation started in 2017, the Committee identified gaps within that original investigation. Those gaps included documentation of forensic interviews, obtaining law enforcement reports and collaboration with law enforcement and the prosecutor's office. These types of interactions, information sharing and investigative steps are often outlined in a Child Abuse Center (CAC) protocol. It does not appear the Skagit County protocol has been updated and signed since 2014. The Committee believes it would benefit DCYF staff, and ultimately the community as a whole, for DCYF and the other multi-disciplinary team (MDT) members to revisit this protocol. As part of this meeting, there needs to be a clear understanding for DCYF staff regarding roles and requirements, specifically addressing who can request a forensic interview and how those are conducted. The local DCYF office involved should then receive a refresher training about the protocol.