CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

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- Dave Thomson, Field Administrator, Department of Corrections
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Executive Summary

On October 17, 2024, the Department of Children, Youth, and Families (DCYF) conducted a Child Fatality Review (CFR)[1] to examine DCYF's practice and service delivery to F.A. and RCW 74. family. The child, F.A., will be referenced by RCW 74. initials throughout this report.[2]

On July 7, 2024, DCYF was notified that six-month-old F.A. was in critical condition. F.A.'s mother was driving a vehicle and F.A. was the only other occupant. F.A.'s mother was observed driving erratically before her vehicle crashed. It was believed that F.A.'s mother was under the influence of substances. Law enforcement (LE) found cannabis in the vehicle. Both the mother and F.A. were transported to the hospital. At the time of the crash there was an open Child Protective Services (CPS) investigation. This new information resulted in a new CPS investigation. Allegations of abuse or neglect that meet the legal sufficiency result in a screened-in intake to either CPS or Family Assessment Response (FAR).[3] FAR intakes are an alternative response to CPS investigations. The allegations in FAR intakes are lower risk than those in CPS investigations.

On July 14, 2024, F.A. died as a result of RCW 74. injuries from the July 7 crash. The DCYF investigation resulted in a founded finding for negligent treatment or maltreatment by F.A.'s mother. F.A.'s father was incarcerated at the time of RCW 74. injury and death.

Prior to F.A.'s death, DCYF received 12 intakes regarding RCW 74. family. Of the 12 intakes, 10 were received after F.A. was born and five of the 10 intakes were assigned for a CPS investigation or FAR assessment. In the 12 intakes there were allegations of parental lack of supervision, domestic violence (DV), sexual assault by a family friend, physical abuse, and parental substance use.

A CFR Committee was assembled to review DCYF's involvement and service provision to F.A. and RCW 74. family. The Committee included members with relevant expertise selected from diverse disciplines within DCYF and community partners. Committee members had no prior direct involvement with F.A. 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 some of the DCYF staff who were involved in the case in 2024.

Case Overview

The information documented in this section is not fully inclusive of all contacts and actions by DCYF staff.

In 2019 DCYF was told that there was a lack of supervision by the mother for her then two-year-old, four-year-old, and eight-year-old children. A neighbor found the four-year-old child hiding in the neighbor's bushes. The child said they were scared to go home at night. The neighbor returned the child home and was concerned because the mother did not react in a way that the neighbor expected (i.e. the mother was not alarmed). That

[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 near 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 only from Agency 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] F.A.'s name is not used in this report because RCW name is subject to privacy laws. See RCW 74.13.500.

[3] For information about DCYF intakes, see: https://www.dcyf.wa.gov/policies-and-procedures/2200-intake-process-and-response.

information was screened out. Then in 2021, LE investigated a case of sexual assault to the mother's RCW 74.13.515 RCW 74.13.515 child by a family friend. This information screened out.

On January 11, 2024, a hospital social worker called to report that F.A. had been born earlier that month and at the birth RCW 74. mother tested positive for cannabis. F.A.'s mother did not obtain prenatal care and did not bring F.A. back for follow up medical care as directed at discharge. The medical provider called the mother multiple times to try and get her to bring F.A. back for a medical evaluation. The social worker shared that she had known the mother since the mother was 16-years-old, now 33-years-old. The social worker described the mother as "disorganized." This information resulted in a CPS investigation.

The assigned caseworker attempted to contact F.A. and RCW 74. mother multiple times on January 11 and 12 by calling telephone numbers and going to addresses for the mother. It wasn't until January 14 that the caseworker was able to reach the mother by telephone. On January 15, 2024, an afterhours caseworker met with F.A., RCW 74. father, and F.A.'s mother at her soon-to-be ex-husband's home. F.A.'s mother was married at the time and the couple shared three children together. This man is not F.A.'s father. RCW 74.13.515 RCW 74.13.515

F.A., RCW 74. mother, and F.A.'s father all arrived at the address and the afterhours caseworker spoke with them in the parents' vehicle. The mother refused to provide the family's address. The caseworker discussed the importance of following through with F.A.'s medical appointments. F.A.'s mother said they had an appointment scheduled with a pediatrician the following day.

On January 16, the caseworker left a voicemail message for the pediatrician's office. On January 18, a different caseworker spoke with the pediatrician. The pediatrician said the mother does not regularly bring in her children. The doctor also said if the mother did not bring F.A. in for the appointment later that day, that he would call the caseworker to alert him.

On January 19, the assigned caseworker received a telephone call from the hospital where F.A. was born. F.A.'s umbilical cord test results were positive for methamphetamines and cannabis. That same day the assisting caseworker received a call from the pediatrician's office stating that F.A. had been brought in by RCW 74. mother and that the pediatrician's office received the medical records which included a positive test result for substances at F.A.'s birth. Also on January 19, the hospital social worker reported this information to DCYF intake which resulted in a screened-out intake.

The next documented contact between the assigned caseworker and the mother was on February 27. The caseworker texted the mother and set up an appointment to see her. The caseworker then tried to reach F.A.'s father but his telephone number was no longer in service.

On March 1, 2024, DCYF was informed that one of F.A.'s older siblings told an employee at the Boys and Girls Club that their mother and F.A. were hit by F.A.'s father while the mother was holding F.A. This information was assigned to the current caseworker for a new CPS investigation.

On March 2, an afterhours caseworker called F.A.'s mother. They agreed to meet at a laundromat where the mother was doing laundry. F.A.'s mother denied the allegations. The caseworker conducted a check of F.A.'s

body and did not observe any injuries. On March 8, the investigative assessment for the January investigation was closed as unable to complete due to the parent's lack of cooperation with the investigation.

On April 23, 2024, the CPS caseworker called the pediatrician's office. The case note said that the office staff were not available. The caseworker requested LE records from a local police department and they responded stating they did not have any records for F.A.'s mother or father. The caseworker then called the referral source from the March 1 intake. The caseworker also tried to speak with the mother's soon-to-be ex-husband but his voice mailbox was not set up. Then the caseworker emailed the mother.

On April 24, the caseworker called the mother and the pediatrician's office but was unable to speak to anyone at either number. The caseworker then requested a DCYF parent locator to assist with contacting F.A.'s parents. On April 26, the caseworker spoke with the pediatrician's office who indicated that F.A.'s next appointment was scheduled for May 6 and there were no current health concerns. At some point between April 26 and May 6 the caseworker left her employment with DCYF and the case transferred to a new CPS caseworker.

On May 6, the newly assigned caseworker received a call from F.A.'s mother. The mother was angry. She said she scheduled multiple home visits with the previously assigned caseworker but the caseworker never showed up. The newly assigned caseworker scheduled a time to meet later that day.

F.A. and RCW 74. parents lived in a trailer on the paternal great-grandmother's property. The paternal great-grandmother and paternal grandmother lived together in a separate dwelling on the property. F.A.'s mother denied the domestic violence allegations. RCW 13.50.100 F.A.'s mother discussed F.A.'s paternal grandmother and great-grandmother's health issues as well as their frustrations with "CPS" involvement. F.A.'s mother refused to comply with the requested oral swab to test for substance use.

The caseworker requested records from multiple LE agencies and the supervisor assisted by seeking information in data bases available to DCYF. The supervisor noted that F.A.'s father had been released from jail on May 3, 2024.

On May 9, 2024, the caseworker conducted a walkthrough of the paternal great-grandmother's home. When discussing supportive community-based services, F.A.'s mother stated she would not cooperate with services that come to the family's home. She refused an offer for a referral to Parent-Child Assistance Program (PCAP).[4] F.A.'s mother provided an oral swab during this visit. The result was negative for all tested substances.

On May 13, 2024, RCW 13.50.100(7)(c) called DCYF. She reported she was concerned about the children's safety when they visited their mother. RCW 13.50.100(7)(c) who identified as a mental health professional, said one of the children told her that the mother's boyfriend (F.A.'s father) is violent with the mother. This included smashing her windshield (the caseworker observed a broken windshield during the May 9 home visit but the family gave a different explanation) and an incident where the mother was holding F.A., feeding RCW 74. and F.A.'s father slapped the mother on the face while she was breast feeding the baby. He then dragged the

[4] For information about Parent-Child Assistance Program, see: https://pcap.psychiatry.uw.edu/.

mother out of the trailer by her hair. The children were present and observed this assault. This intake was assigned for a FAR assessment.

On May 14, the assigned caseworker called the Department of Corrections (DOC). F.A.'s father had an active arrest warrant, issued on May 13, because he did not report to his probation officer. The DOC officer said that they tried to speak with the mother a few weeks ago because they had heard that the father was beating the mother in front of her children. The mother denied the allegations. The DOC officer warned the caseworker not to go to the home alone and stated the father has been known to carry many weapons. The father has been aggressive with the DOC officers in the past and he has been known to engage in racially motivated assaults.

Then the caseworker, along with another caseworker, went to F.A.'s residence to conduct the FAR assessment. F.A. and RCW 74. parents were present. The caseworker documented the actions by the father and later shared with the Committee that she believed he was under the influence of substances while they were there. She also shared her concerns about her and her co-worker's safety while at the home, and how it impacted their ability to discuss the allegations of violence.

On May 15, a DOC supervisor called to speak with the caseworker about why DCYF went to the family's home. The DOC supervisor discussed her observations relating to the physical changes she has seen for F.A.'s mother since the father was released from prison. The DOC supervisor was concerned that the mother is using substances. The DOC supervisor again warned the caseworker that the father was very violent and that she was concerned about the caseworker's safety when having contact with the father. The DOC supervisor also said they were planning to arrest the father for his current warrant.

On May 16, DOC arrested F.A.'s father. When they arrested him they found methamphetamine throughout the family's trailer and on the father's body. DOC and LE observed methamphetamine residue on furniture and next to the crib as well as a meth pipe next to the crib. They did not place F.A. in protective custody. DOC asked DCYF to respond to the family's home. DOC, Department of Justice, and the U.S. Marshall's Service left the property and the caseworker stayed to discuss F.A.'s safety with RCW 74. mother and paternal relatives. A plan was created to contract a cleaning service to clean the trailer where F.A. and RCW 74. parents lived, so that F.A. could safely return inside.

On May 17, 2024, RCW 13.50.100(7)(c) called DCYF and reported historical DV. She said she was recently at the house and windows in the trailer and car were broken as a result of violence. She also said the mother let the father drive intoxicated and that drugs were consumed by the parents. Due to the fact that no new information was reported the intake was screened out. Then on May 20, one of F.A.'s RCW 74.13.515 reported historical DV again. This information was screened out.

On May 21, 2024, DCYF held a Safe Child Consultation. An Assistant Attorneys General was present during the staffing. Multiple tasks were identified by the team for follow up. Including holding a Family Team Decision Making Meeting (FTDM) as well as if and when court intervention would be necessary. FTDMs are meetings that include family's and other supports to the family to discuss child safety when there is imminent risk of removal of the children from their parent or guardian's care.

On May 22, DCYF held an FTDM. Multiple relatives, maternal and paternal, were present and agreed to participate and support a safety plan.

The caseworker received notification that the mother's oral swab from May 16 was positive for methamphetamines. When this was discussed, F.A.'s mother again denied using substances other than cannabis.

On May 29, 2024, the caseworker visited F.A.'s father in jail. F.A.'s father told the caseworker that he wanted to attend substance use treatment. He refused to sign the safety plan but said he would follow the safety plan. F.A.'s father denied that any violence occurred during his relationship with F.A.'s mother. On May 30, DCYF was notified that F.A.'s father could be bailed out of jail at any time his bond was posted. DCYF made an unannounced home visit to see F.A. and RCW 74. mother. The caseworker discussed the positive oral swab result from May 16. F.A.'s mother continues to deny substance use other than cannabis. The caseworker also prepared referrals for substance use assessments for both parents. A contracted service provider had been working with the mother. The service provider discussed steps to get the mother in for an assessment.

On June 13, F.A.'s father was released from jail. The contracted service provider took both the mother and father for substance use assessments. On June 16, F.A.'s father returned to custody for failing to adhere to his conditions of release. F.A.'s father smoked cannabis and drank alcohol the previous day during his father's funeral.

On June 26, the caseworker was notified by F.A's father's DOC officer that he assaulted his cell mate and was subsequently criminally charged with assault. On June 27, F.A. and RCW 74. mother went to the DCYF office for a fuel voucher. She refused to provide an oral swab and said she wasn't using substances.

On July 3, a relative called DCYF to report that F.A. was unsafe because the mother is using drugs and the mother said her DCYF case was closing. The relative was worried about F.A.'s safety. The intake was closed at screening because it did not contain any new allegations of abuse or neglect.

On July 7, 2024, LE notified DCYF that F.A. and RCW 74. mother were in a collision. F.A. was found in critical condition. The mother was suspected of driving under the influence of substances and cannabis was found in her vehicle. On July 14, 2024, F.A. died.

Committee Discussion

The Committee spoke with some of the staff who were assigned, or supervised staff who were assigned, to the case in 2024. Those discussion topics included DCYF staff vacancies, lack of services and service providers in the area where this family lives, and other systemic challenges. The Committee identified that the case was complex due to familial relationships, the level of violence, and substance use. The Committee appreciated the urgency that was documented in case notes and expressed by the staff who met with Committee members.

The Committee expressed concern about the physical safety and mental well-being of staff when they are working cases with people who are known to be dangerous. Specifically related to this case was the ongoing danger that staff faced when they went to the family's home due to significant violence and substance use issues. Some Committee members questioned why DCYF staff aren't allowed to carry weapons. They also discussed and questioned why staff aren't treated like LE when a critical incident occurs (i.e. DCYF staff are still

assigned new cases and are not required to obtain well-being supports). F.A.'s father posed enough of a threat to LE and probation officers that those agencies required more than one person to respond at all times and at one point a drone was used (not by DCYF) prior to physical contact.

The Committee heard from the DCYF staff that there was no urinalysis collection sites in the Mt. Vernon catchment area. This required any substance use testing to occur either through oral swabs or required an adult to travel a long distance to provide a urine sample. After the review occurred, this writer reached out to the service array consultant for this region. A very recent contract was approved for one site to collect urinalyses for DCYF involved families. The service array consultant shared that she has diligently tried to work with other providers but she has not received any responses.

The Committee discussed their concerns and thoughts about the turnover and vacancies that DCYF child welfare field offices experience. There were some questions posed but unanswered about what DCYF leadership's role and responsibility is regarding these issues. There was also discussion about the fact that even though this office was experiencing those challenges, the caseworker and staff who were working on the case at the time of the fatality did very good work. The Committee identified clear, detailed case notes, a sense of urgency, concern, and perseverance.