WASHINGTON STATE
Department of
Children, Youth, and Families

CHILD FATALITY REVIEW REPORT

December 2018

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FAMILY MEMBERS

- J.B.

DATE OF CHILD'S BIRTH

- [redacted] 2012

DATE OF FATALITY

- April 09, 2018

DATE OF FATALITY REVIEW

- August 14, 2018

COMMITTEE MEMBERS

- Patrick Dowd, Director, Office of the Family & Children's Ombuds
- Stephanie Widhalm, MSW, LICSW, MHP, CMHS, Supervisor, Partners for Families and Children Spokane
- Jenna Kiser, MSW, Deputy Regional Administrator, Department of Children, Youth, and Families
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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).

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EXECUTIVE SUMMARY

On August 14, 2018, the Department of Children, Youth, and Families (DCYF)[1], convened a Child Fatality Review (CFR)[2] to assess DCYF's practice and service delivery to J.B. and [RCW 74.] family[3]. All of the information surrounding the circumstances of J.B.'s death was obtained by DCYF staff via publicly available television and online news sources. According to online newspaper articles located by this writer, the incident initiating this review occurred on April 09, 2018, when J.B. was brought to an out-of-state hospital unresponsive. Efforts to revive J.B. were unsuccessful and [RCW 74] was declared dead by hospital staff. The hospital contacted law enforcement concerning J.B.'s death because of the suspicious circumstances under which [RCW 74] died. According to a news article, "The detective found aspects of the [RCW 74.15.515] appearance disturbing, including marks that covered the [RCW 74.15] from head to toe, including sores, cuts and scratches. The child's hair was patchy, and it appeared parts had been pulled out or were just not growing. The detective also noticed a mark on the [RCW 74.15.515] upper body that was 2 to 3 inches wide and appeared consistent with a strap or some kind of restraint. The [RCW 74.15.515] face was scabbed over and scarred with multiple injuries that were in various stages of healing…." At the time of [RCW 74.] death, J.B. and [RCW 74.] twin sibling were in the care of a family friend, Bobbie Bishop[4], and her paramour, Walter Wynhoff[5]. J.B.'s legal custodian, [RCW 74] maternal grandmother, sent the twin siblings to live with Bishop in August 2017 and ultimately gave Bishop temporary custody. Bishop and Wynhoff were arrested and charged with second degree murder without intent, first-degree manslaughter, two counts of second-degree manslaughter, and malicious punishment of a child resulting in great bodily harm in connection with J.B.'s death. DCYF has limited information as to this matter as the child's death occurred and is being investigated out-of-state.

The CFR Committee (Committee) included members selected from diverse disciplines within the community with relevant expertise including the Office of the Family and Children's Ombuds, a DCYF Deputy Regional Administrator, law enforcement, a supervisor from a local child advocacy center, and a Regional Administrator from the Alliance for Child Welfare.

Excellence[6]. A DCYF Child Protective Services (CPS) supervisor was invited but was not able to attend the CFR. The Confederated [RCW 74.15.515] and [RCW 74.15.515] Tribes received notification of the CFR and a representative was invited to participate, however the representative was not present for the review. Additionally, a DCYF supervisor observed a portion of the review. Neither CA staff nor any other Committee members had previous direct involvement with this family. One Committee member had professional involvement with Wynhoff over a decade prior, but that Committee member did not have involvement or contact with this family or children in question. Additionally, the facilitator and writer of this report once staffed the case involving

[1] As of July 1, 2018, the work of the Department of Social and Health Services (DSHS) Children's Administration (CA) transferred to DCYF. However, because case events occurred before July 1, 2018, CA is referenced throughout this report.

[2]Given its limited purpose, a CFR should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of the child. The CFR Committee's review is generally limited to documents in the possession of or obtained by DSHS or its contracted service providers. The Committee has no subpoena power or authority to compel attendance and generally only hears from DSHS 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 Department employees or other individuals.

[3] Family members are not named in this report because they have not been charged in an accusatory instrument with committing a crime related to a report maintained by the department in its case and management information system. [Source: 74.13.500(1)(a)]

[4] The family friend/caregiver is named in the report because she was charged with committing a crime related to this report of child abuse or neglect investigated by Children's Administration. RCW 74.13.500(1)(a). The names of the children are subject to privacy laws.

[5] The family friend/caregiver is named in the report because he was charged with committing a crime related to this report of child abuse or neglect investigated by Children's Administration. RCW 74.13.500(1)(a). The names of the children are subject to privacy laws.

[6] The Alliance for Child Welfare Excellence is a program through the University of Washington, in partnership with the Department, to provide regular training to Department staff. The Alliance provides the Regional Core Training (RCT) that all new Department case carrying employees must complete before they can be assigned cases.

J.B.'s biological mother in 2012 while in a supervisory role to assist a neighboring county investigating the biological mother's case, but neither the facilitator nor the writer of this report had direct contact with the involved children, family, or caregivers.

Prior to the CFR, each Committee member received a family genogram, a case chronology, a summary of Department involvement with the family and un-redacted Department case documents (*e.g.*, intakes[7], investigative assessments and case notes). Supplemental sources of information and resource materials were available to the Committee at the time of the review. These included medical reports, relevant state laws and Department policies.

During the course of this CFR, the Committee interviewed the Child and Family Welfare Service (CFWS) supervisor and worker assigned to the biological mother's case from 2013-2014 and to the maternal grandmother's case in 2015. The Committee additionally interviewed the supervisor (a newly transitioning and in-training supervisor) and the Family Assessment Response[8] (FAR) worker who were assigned to the maternal grandmother's case in 2016-17. Following the review of the case file documents, completion of interviews and discussion regarding department activities and decisions, the Committee discussed possible areas for practice improvement. The Committee made findings and recommendations related to the Department's response and systems that can be located at the end of this report.

[7] An "intake" is a report received by the Department in which a person or persons have reasonable cause to believe or suspect that a child has been abused or neglected. A decision to screen out an intake is based on the absence of allegations of child abuse or neglect as defined by Washington Administrative Code (WAC) 110-30-0030.

[8] FAR is a CPS alternative response to an investigation of a screened-in allegation of child abuse or neglect. FAR focuses on child safety along with the integrity and preservation of the family when lower risk allegations of child maltreatment have been reported. [Source: CA Practices and Procedures Guild 2332. Family Assessment Response]

FULL REPORT

SUMMARY OF FAMILY HISTORY

J.B.'s biological mother has a history with CPS dating back to 1999 including reported concerns for RCW 13.50.100, RCW 13.50.100, and RCW 13.50.100. In 2012, the biological mother left J.B. and twin, who were two months old, with Bishop and Wynhoff. At the time, CA determined that Bishop and Wynhoff were inappropriate and unsafe caregivers due to reported substance abuse, mental health issues, unsanitary condition of their living environment, and lack of appropriate supervision of J.B. and RCW 74 twin sibling. A dependency petition and motion to take the twins into protective custody were filed on May 25, 2012. The twins were placed in foster care until May 31, 2012, when they were moved to the care of a maternal relative. The twin's maternal grandmother, who at the time was residing in RCW 74.15.515, worked with her enrolled tribe to obtain custody of the twins. The Indian Child Welfare Act[9] (ICWA) applied to the dependency case, but the children's tribe did not request transferring the case to tribal jurisdiction. CA staff assigned to the case had been in communication with Tribal Social Services as well as RCW 74.15.515 State CPS in an effort to gain information on the maternal grandmother and address jurisdictional issues. The Tribe reportedly did not want to seek jurisdiction of the case as the children were not enrolled. However, the Tribe provided legal support to the grandmother who was enrolled and intervened, assisting her in court proceedings to obtain third party custody. Limited information was provided to CA by RCW 74.15 515 Tribal Social Services or RCW 74.15.515 State CPS regarding the maternal grandmother's caregiving capabilities or her home. The twins were transferred to their maternal grandmother's care and custody in RCW 74.15.515 after CA agreed to and entered into an order dismissing the dependencies in Washington state court on April 16, 2014. The CA's case as to J.B.'s biological mother was later closed.

On December 07, 2014, a relative contacted law enforcement regarding the twins after the maternal grandmother had left the twins in her care. The relative was concerned that the children had been neglected, possibly physically abused RCW 13.50.100. The relative RCW 13.50.100 reported unexplained bruising on both children. Law enforcement contacted CA, and the intake report was assigned to a CPS investigator. On December 08, 2014, law enforcement placed the twins into protective custody[10]. The assigned CPS worker completed a safety assessment,[11] determined the maternal grandmother was unsafe to care for the twins, and CA filed a dependency petition as to both children on December 10, 2014. The dependency petition outlined a number of safety threats[12] including that the maternal grandmother lacked parenting knowledge, skills, or motivation necessary to assure the children's safety. Further, the maternal

[9] The federal Indian Child Welfare Act (ICWA) of 1978 (USC 1901 et. Seq.) was the first federal legislation enacted to protect Indian children and families. This landmark law defines the rights of Tribes to assume jurisdiction over children who are members or eligible to be members in a Tribe. The Indian Child Welfare Act (ICWA), 25 U.S.C. 1901, et. seq., authorizes the state of Washington to enter into agreements concerning the care and custody of Indian children and jurisdiction over child custody proceedings involving Indian children. [Source: Children's Administration Indian Child Welfare manual.].

[10] RCW 26.44.050: "A law enforcement officer may take, or cause to be taken, a child into custody without a court order if there is probable cause to believe that the child is abused or neglected and that the child would be injured or could not be taken into custody if it were necessary to first obtain a court order pursuant to RCW 13.34.050."

[11] Safety Assessments are used throughout the life of a case to identify impending danger and determine whether a child is safe or unsafe. It is based on comprehensive information gathered about the family at the time the safety assessment is completed. [Source: DSHS CA Practices and Procedures Guide Chapter 1000]

[12] A threat of danger is a specific family situation or behavior, emotion, motive, perception or capacity of a family member that threatens child safety. The danger threshold is the point at which family functioning and associated caregiver performance becomes perilous enough to be perceived as a threat or produce a threat to child safety. The Safety threshold determines impending danger. Safety threats are essentially risk influences that are active at a heighten degree and greater level of intensity. Safety threats are risk influences that have crossed a threshold in terms of controllability that has implications for dangerousness. Therefore, the safety threshold includes only those family conditions that are judged to be out of a caregiver's control. Retrieved from: http://www.dshs.wa.gov/pdf/ca/SafetyThresholdHandout.pdf

grandmother could not explain the children's injuries or explain why she had given the children to another relative rather than caring for the children herself. On December 11, 2014, a contested Shelter Care hearing was held, and the court ruled that the children were at serious threat of substantial harm in the maternal grandmother's care and were to remain in foster care. The court listed seven findings at the shelter care related to the maternal grandmother's neglect of the children. On December 12, 2014, the children were seen by a local child advocacy center (CAC) and had a thorough medical evaluation. While it could not be determined whether the children had been RCW 13.50.100, the medical evaluation concluded that the twins were severely neglected and recommended they receive specialized placement and care to address their developmental and medical needs.

CA's investigation of the negligent treatment allegations resulted in a founded finding[13] as to the maternal grandmother. The dependency case was transferred to the CFWS unit on December 12, 2014. The CFWS worker completed home visitations, assisted in getting the children set up with medical and developmental services as well as monitored visitation outcomes between the children and maternal grandmother.

On January 28, 2015, a Family Team Decision-Making Meeting (FTDM)[14] was held, and the decision was made to return J.B. and RCW 74. sibling to the maternal grandmother's care. While there were concerns within CA about returning the children to the maternal grandmother, CA ultimately determined that doing so was in the children's best interests. After consultation with the Area Administrator and internal consultants, the assigned staff and supervisors concluded there was not sufficient evidence or safety threats to prevent the children from returning to the grandmother's care. The children were transported to their maternal grandmother in RCW 74.15.515, and Washington dismissed the dependencies in April 2015.

The grandmother and the children later moved back to the RCW 74.15.515 area from RCW 74.15.515. On December 13, 2016, CA received an intake that initially screened out. The reviewing supervisor then staffed the report with five additional intake supervisors who deliberated and determined that the report should screen in[15] for a FAR response. The intake alleged the maternal grandmother allowed the biological mother to remain in the home RCW 13.50.100 . There were also concerns because the maternal grandmother knew that the biological mother was an inappropriate and unsafe person to have around the children, and there were other recent reports that the children had been outside of the home unsupervised. The intake report further documented allegations of the biological mother being verbally abusive towards the twins. The report included an historical summary of CA involvement with the family including case history involving Bobbie Bishop.

[13] CA findings are based on a preponderance of the evidence. "Child abuse or neglect" is defined in Chapter 26.44 RCW, WAC 110-30-0030and WAC 110-30-0040. Findings are determined when the investigation is complete. Founded means the determination, following an investigation by CPS and based on available information, that it is more likely than not child abuse or neglect did occur. Unfounded means the determination, following an investigation by CPS and based on available information that it is more likely than not child abuse or neglect did not occur, or there is insufficient evidence for DSHS to determine whether the alleged child abuse did or did not occur.

[14] An FTDM is a facilitated team process, which can include birth/adoptive parents, guardians, extended family members, youth (as appropriate), community members, service providers, child welfare staff and/or caregivers. These meeting are held to make critical decisions regarding the placement of children following and emergent removal of child(ren) from their home, changes in out-of-home placement, and reunification or placement into a permanent home. There may be instances when a FTDM can be held prior to placement if there is not an immediate safety threat such as a child who is on a hospital hold and a FTDM could provide placement options. Permanency planning starts the moment children are placed out of their homes and are discussed during a Family Team Decision-Making meeting. Am FTDM will take place in all placement decisions to achieve the least restrictive, safest placement in the best interests of the child. By utilizing this inclusive process, a network of support for the child(ren) and adults who care for them are assured. www.dshs.wa.gov/pdf/ca/FTDMPracticeGuide/pdf

[15] Intake social workers determine program response type and response times (emergent or non-emergent) for an investigation.CA intakes fall into three categories: CPS – Involves a child who is allegedly abused, neglected, or abandoned and includes child abuse allegations. CPS Risk Only – Involves a child whose circumstances places him or her at imminent risk of serious harm but does not include child abuse allegations. Non-CPS – Involves a request for services for a family or child.

The assigned FAR worker made contact with the maternal grandmother, biological mother and the twins on December 20, 2016. The FAR worker noted that the maternal grandmother lacked parenting skills and needed help managing the twins. The grandmother RCW 13.50.100 . The biological mother denied RCW 13.50.100 or using foul language in the home; however, the biological mother confirmed yelling in the home. The assigned FAR worker did not observe marks on the twins but noted that they were dressed without documenting observing their skin under the clothing. The FAR worker also identified a non-relative roommate that was living in the home. The FAR worker documented assessing the roommate and having conversations with the maternal grandmother regarding the roommates contact with the children. It was reported and documented that the roommate had no caregiving responsibilities. This roommate reportedly moved out in February 2017. Minimal case activity occurred between February and August 2017.

On August 02, 2017, the FAR worker completed a health and safety[16] visitation with the children and maternal grandmother. The maternal grandmother informed the FAR worker that she cannot care for the twins any longer and was sending them to live with her friend, Bobbie Bishop, who resided in another state. The maternal grandmother said she was then planning on returning to RCW 74.15.515. The FAR worker was also informed that Bishop was planning to obtain legal custody of the twins. The FAR worker was able to make telephonic contact with Bishop on August 11, 2017, and received verbal confirmation that the twins were with her and that Bishop planned on having the temporary custody paperwork filed on August 14, 2017. Bishop stated that the twins were doing great and that she looked forward to raising them. Bishop reported that the maternal grandmother was somewhere in RCW 74.15.515 and that she was not sure of the maternal grandmother's future plans regarding where she would be living or when she planned on caring for the twins again. The Department subsequently contacted RCW 74.15 515 CPS. The supervisors who approved the FAR worker's assessments and entered documentation on the case had historical background knowledge of Bishop and the family but did not contact CPS in the state where Bishop was residing. This case was closed by the supervisor and FAR worker in August 2017 after they documented no safety threats. In April 2018, CA staff became aware of J.B.'s death via various news reports, which resulted in the CFR.

DISCUSSION

The Committee first discussed the CFWS case that closed in April 2014. The Committee questioned why CA agreed to dismiss the dependency petition without requesting a home study or submitting an Interstate Compact Placement of Children (ICPC) request to RCW 74.15.515[17]. The Committee heard from the supervisor and assigned CFWS worker that the tribe intervened in the dependency when the maternal grandmother, who was an enrolled tribal member, requested custody of J.B. and RCW 74. sibling, resulting in the tribe assigning an attorney to assist the grandmother. However, the tribe did not assume legal jurisdiction but instead intervened and pursued a third party custody agreement on behalf of the maternal grandmother. CA staff reported that the children may have been considered domiciled on the reservation since they were in the custody of the grandmother who resided there and was enrolled. The third party custody was reported by staff to have been entered in RCW 74.15.515 County; however, a copy was not found by the facilitator or previously assigned staff in the case file. The court entered the agreement for dismissal with the support of all parties. Reflecting back, the supervisor stated that they possibly should have consulted further with management or requested a home study in

[16] Investigators must conduct monthly health and safety visits with children and parents if the case is open longer than 60 calendar days according to Department policy.

[17] ICPC is a uniform reciprocal compact enacted in every state that governs the interstate placement of foster children. The Compact prohibits states from sending a dependent child to live with an out-of-state caregiver without first obtaining approval from the receiving state's child welfare agency following a home study and other assessments of the caregiver. Chapter 26.34 RCW.

RCW 74.15 515 on the grandmothers' home prior to agreeing to the dismissal of the case. The supervisor noted that her understanding of court procedures in such situations was very limited as she was new to her supervisory position. The Committee appreciated the CFWS supervisor's presentation of case information as she was clear, concise, and candid but wondered about the levels of guidance from her superiors and consultants during that time. Some members of the Committee also questioned the authority of the tribe in such circumstances where ICWA applied but the tribe did not take jurisdiction and if CA staff were uncomfortable challenging tribal preferences and case planning. After hearing from the CFWS supervisor and DCYF Deputy Regional Administrator Committee member, the Committee better understood Indian Child Welfare processes and laws and what occurred during this time on the case.

The Committee briefly discussed law enforcement involvement in neglect and FAR responses generally across the state. Some Committee members wondered why law enforcement was not involved more often during the home visitation and specifically during the FAR responses in 2016-17 and speculated about whether law enforcement involvement would have impacted the case. The Committee discussed differences between counties and jurisdictions as well as varied community protocols for response.

The Committee noted the importance of CA staff and supervisors addressing each concern with caregivers and verifying information that is gathered or supplied for accuracy of the Department's risk and safety assessments. After hearing from the assigned CA staff regarding the decision to return the children to the maternal grandmother, the Committee discussed that it was unclear how CA came to determine the maternal grandmother was a safe caregiver in 2014 and 2015, in particular after the maternal grandmother's founded finding for neglect in 2015. The Committee did not locate a documented safety assessment in FAMLINK[18] related to the 2015 CFWS case but did receive a verbal report from the assigned worker that CA determined there was not an active safety threat preventing the children from being returned to their grandmother. The worker's recollection and reasoning behind the safety assessment determination was limited and did not provide the Committee with a clear understanding as to how staff arrived at the determination it was safe to place the children with the grandmother. The Committee wondered if bias might have swayed the assessment of the assigned worker in the 2014 and 2015 decisions in returning the children to their grandmother. The Committee based this speculation on a brief admission by the worker that she was Native American and had a personal desire to place with the maternal grandmother to maintain the children's connection to their Native heritage even though the court had strong findings about the maternal grandmother's inability to care for the children at the shelter care hearings. The Committee discussed the findings made by the court at the 2015 shelter care hearing and believed it should have been given greater weight in the assessment of safety.

Regarding the 2017 FAR response, the Committee agreed with the intake supervisor's decision in 2017 to overrule the intake SW's initial decision to screen out the intake. The Committee found that this was an appropriate screening decision. The Committee determined that there was readily available information regarding Bishop that the assigned staff or supervisor should have responded to either immediately with a request for a VPA, law enforcement involvement or with a call to the CPS jurisdiction where Bishop was residing once the Department learned that the children were no longer in Washington State. The Committee was pleased to see that the intake supervisors who screened this in documented that they had assessed the biological mother as a risk to the children. The Committee felt that Bishop's history with CA and the grandmother's notable and consistent inability to provide care for the twins should have been acted on more aggressively by the assigned staff. Further, the Committee wondered why the biological mother's presence in the home was minimized during this intervention. The assigned

[18] FamLink is the case management information system that CA implemented on February 1, 2009, and it replaced CAMIS, which was the case management system used by the agency since the 1990's.

worker informed the Committee that they had unintentionally failed to review the historical record for either Bishop or the biological mother. The Committee believed this led to an inaccurate safety assessment.

The Committee heard from the assigned workers and supervisors of the historical workload issues and vacancies in their unit between 2012 and 2017 that significantly impacted their ability to do thorough assessments and supervision. The Committee heard that often a supervisor was left to oversee multiple units as well as having case carrying responsibilities or that workers would have to assume multiple caseloads. While recognizing workload constraints, systemic issues surrounding turnover, and insufficient staffing levels related to the workload, the Committee noted that the 2017 FAR response had not been completed in the required timeframes. The Committee questioned whether global assessments of child safety and family functioning were adequate in this case given the difficulties mentioned above.

The Committee discussed both the CFWS worker and FAR workers' verbal reports regarding the maternal grandmother and the children. The Committee felt there was a discrepancy in the workers' verbal report during the review in comparison to what was documented regarding the maternal grandmother's abilities to care for J.B. and [redacted] sibling at the time of the Department's prior involvement with the family. The Committee discussed the evidence pointing to the maternal grandmother's inability to care for the children in 2015. Specifically, there was a recommendation in 2015 by the local CAC that the children should be in a medical placement to address their developmental needs. The Committee discussed how the workers may have had sympathy for the maternal grandmother an elderly woman caring for her active grandchildren and did not fully acknowledge the risk of leaving the children in her care. In addition, it seemed to the Committee that the assigned workers may have not understood how to fully identify and assess information relevant to children who have experienced chronic trauma and child safety. The Committee felt that the assigned workers had minimized the children's behavioral and medical needs as well as the grandmother's inability to care for the children.

FINDINGS

Based on a review of the case documents and interviews with staff, the Committee found one critical error made by Department staff. The Committee found that the Department did not utilize or respond sufficiently to readily available information on Bishop during the 2017 FAR intervention.

ADDITIONAL FINDINGS

Understanding that workload, medical leave, and staff turnover impact a worker's ability to carry out their job responsibilities fully and completely, the Committee found that readily available information was not utilized to assess the maternal grandmother's suitability and capability to provide care to J.B. and [redacted] sibling and such information was not utilized accurately in the safety assessments during CA's 2015 and 2017 involvement with J.B. Further, the Committee believed that there may have been an active safety threat when the children were returned to their grandmother in 2015 as well as present danger during the FAR intervention in 2017.

RECOMMENDATIONS

DCYF management should develop alternatives to current practices to address high workload and staffing vacancies in an effort to reduce overloading employees and improve safety assessment and case planning. The Committee provided one suggestion, which is for the Department to consider using program managers with supervisory and field experience to fill in across the state where staffing levels are low and caseloads are over the recommended levels.

DCYF should consider clarifying CPS safety assessment policy so workers better understand how to utilize all available information about all individuals who have frequent contact with a child(ren) or are who are seeking custody of a child(ren).