Children's Administration

Executive Child Fatality Review

Jordyn Moses case

October 10, 2008

Committee Members

- Jessica Gurley, Community Services Supervisor, Snohomish County Superior Court
- Sherry Guzman, Senior Manager for Behavioral Services, Tulalip Tribes
- Cammy Hart-Anderson, Coordinator, Snohomish County Division of Alcohol and Other Drugs
- Sandra Kinney, Area Administrator, Division of Children and Family Services (DCFS) Region 3
- Linda Tosti-Lane, Supervisor, Division of Licensed Resources in Children's Administration, Region 5
- Betsy Tulee, Indian Child Welfare (ICW) Program Manager, Children's Administration Headquarters

Observer

Rachel Pigott, Office of the Family and Children's Ombudsman

Facilitator

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Case Overview

In October 2008, the Children's Administration (CA) convened an Executive Child Fatality Review[1] committee to review the practice and service delivery in the case involving six-month-old Jordyn Moses and his family.

RCW 74.13.500

On November 26, 2007 CA received a referral from the Tulalip Tribal Court reporting that the Tulalip Police had responded the day before to the Walmart on Tulalip lands. It was reported that there had been an incident of domestic violence involving , and , (both enrolled Tulalip members), that endangered , Jordyn Moses, then just seven weeks old.

RCW 74.13.500

was shopping with a female relative and had Jordyn and her three year old daughter with her. confronted in the parking lot. Arguing loudly and accusing g of going out with other men, it was alleged pulled Jordyn out of grocery cart in his baby carrier and "threw" him into his van, failing to belt him in. It was further alleged that he then "slammed" against the vehicle, causing bruising, and then left with Jordyn in the van. Police were called, and they later arrested him and returned Jordyn to The tribal court put a "no-contact" order in place, barring from having contact with either or their child Jordyn.

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[1] Given its limited purpose, a Child Fatality Review by Children's Administration should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. A review is generally limited to documents in the possession of or obtained by DSHS or its contracted service providers and the panel may be precluded from receiving some documents that may be relevant to the issues in a case because of federal or state confidentiality laws and regulations. A review panel has no subpoena power or authority to compel attendance and generally will only hear from DSHS employees and service providers. The panel may not hear the points of view of a child's parents and relatives, or those of other individuals associated with a deceased child's life or fatality. A Child Fatality Review is not intended to be a fact-finding or forensic inquiry or to replace or supersede investigations by courts, law enforcement agencies, medical examiners or other entities with legal responsibility to investigate or review some or all of the circumstances of a child's death. Nor is it the function or purpose of a Child Fatality Review to take personnel action or recommend such action against DSHS employees or other individuals.

The case was assigned to a Child Protective Services (CPS) worker and also to a worker in the Tulalip Tribal child welfare agency. There was a joint response that resulted in agreements with and to engage in a voluntary service plan. RCW 74.13.50

On November 27, 2007, entered into a service agreement with the social worker, in consultation with the assigned tribal worker, to participate in domestic violence awareness counseling and parenting classes. also agreed to abide by the restrictions of the restraining order. At that time, was living with Jordyn and her oldest child, then three-years-old, in the home of her father and stepmother on Tulalip Tribal lands. RCW 74.13.500

In December 2007, the case transferred to the Family Voluntary Services (FVS) unit. It was reported to the review committee that caseloads in that unit at that time were in the high 20s, and that a change in supervisor occurred in the unit in January, 2008. On January 3, 2008, the FVS worker went to the home and met with and her family. Together they completed the Family Assessment. RCW 74.13.500

The worker told the review committee that and her family discounted the incident and strongly advocated for the lifting of the restraining order prohibiting contact between and herself and child. did, however, agree to abide by it for as long as it was in force. RCW 74.13.500

The social worker then met with on January 11, 2008 and entered into a service agreement with him in which agreed to complete a domestic violence assessment and follow the recommendations of that assessment, as well as abide by the conditions of the order barring him from contact with Jordyn and . He requested that his services be completed through the Tulalip Tribe. At that time, said that he was living with his grandmother also on the Tulalip reservation. RCW 74.13.500

Over the course of the next several weeks, there were several phone conversations between the social worker and , as well as between the social worker and the Tulalip case manager, and attorney's office. It was clear from the documentation of these contacts that the primary activity of the family was in efforts to get the restraining order RCW 74.13.500

lifted. There was little in the way of progress on the service plans. [redacted] had some contact with a domestic violence service worker from the tribe. [redacted] had not engaged in any services. RCW 74.13.500

On February 28, 2008, the FVS social worker made another visit to the [redacted] home to check on the children. She reported to the review committee that she was told then by the maternal grandparents that [redacted] and the children had moved out. When she asked where they had moved, the family refused to tell her. The worker stated that she had suspicions at that time that the family may not be abiding by the court order, but did not have actual "proof."

On March 14, 2008, the social worker attempted to visit [redacted] and the children at the address where she found her listed as receiving [redacted]). The worker documented in the RCW 74.13.500 record that she was unable to locate that specific address and returned to the office. It was only after the death of this child that this address was identified as the home of [redacted] and his grandmother. There is no indication that the grandmother or aunt provided any significant care of the deceased child while this family lived in their home. There is also no information the aunt and grandmother had any connection to the death of Jordyn Moses. However, law enforcement continues to investigate this fatality and has not shared any information with department or tribal social workers. The full extent of grandmother or aunt's knowledge of the fatality or their roles as caretakers is still unknown.

On this same day, March 14, 2008, the social worker attended the regularly scheduled twice-monthly staffing with the Tulalip Family Services staff. At that staffing, the possibility of closure of the state's case was discussed, as the family had identified that they wanted their services to come through the Tulalip Tribe. The worker reported to this review committee that she learned at this staffing that the tribe did not have the ability to conduct domestic violence assessments, and would need to keep the state case open until that contracted service could be paid for, and then the tribe could provide the treatment, if indeed that was recommended by the assessment.

There had been some discussion during February and March, 2008 between the Tulalip case manager and the state social worker regarding the possibility of Tulalip Family Services closing their case. However, on April 1, 2008, the assigned Tulalip Family Services case manager left a voice mail

for the state social worker saying that Tulalip had staffed this case the day prior, and decided to take over the case from that point on, and the state could close their case, as the parents were following the court order. There were voice mail exchanges only on this issue, and not a full discussion of the case.

The social worker stated to the review committee that she did not have a copy of the restraining order from the Tulalip Court, and there appeared to be some lack of clarity about the content of the order and whether or not it remained in effect.

On April 10, 2008, CPS received a referral from Children's Hospital saying that Jordyn was on life support, having suffered a cardiac arrest. He was non-responsive.

It was reported that early in the morning of April 10, 2008 emergency aid was called to the home of . told the first responders that she and the children had been living in the house with , and that she had come home in the early morning hours after taking a relative to the hospital and found and her three year old asleep. She reported that she saw Jordyn, not breathing and non-responsive, suspended by his neck from an "exer-saucer" with his feet not touching the floor. She said that he had evidently fallen between the bed and the wall, and immediately called 911. RCW 74.13.500

The detectives interviewed both parents and reportedly expressed some doubt at that time, believing that the physical and medical evidence did not support s version of the events. Jordyn remained in the hospital until April 23, 2008 and after it was clear he had suffered brain death, he was taken off life support and was officially declared dead. RCW 74.13.500

An autopsy was performed. The conclusion of the autopsy was that the circumstances of the injury as reported to medical personnel and the investigating police agency were not consistent with Jordyn's injuries. He had blunt force injury of the head and the manner of death was classified as homicide.

RCW 74.13.500

Although this referral was

assigned for a CPS investigation, it was reported to the review committee that the Federal Bureau of Investigation (FBI), which had jurisdiction in the case, directed the department social worker not to interview [redacted], [redacted], or [redacted]'s three year old child until cleared to do so. RCW 74.13.500

As of the date of this report, the investigation is ongoing and no arrests have been made. The department has not conducted interviews on this matter with the family. It was reported to this committee that several subsequent attempts by the assigned CPS worker to contact the assigned FBI agent and tribal law enforcement to discuss this case were not successful.

RCW 74.13.500

It was later determined that the home in which Jordyn was injured was a licensed foster home. [redacted] and her adult daughter, [redacted] (the grandmother and paternal aunt, respectively, of [redacted]) were licensed by a private agency as a foster home. Three of [redacted] grandchildren were placed in that home in a tribal guardianship. The [redacted] foster home had previously (2007) had a referral alleging that they had allowed a relative to temporarily reside in the home without notifying licensing. They subsequently signed a compliance agreement in which they agreed to notify licensing if a relative were to be in the home for more than two weeks.

Findings and Recommendations

The committee met on September 29, 2008 and on October 6, 2008 and made the following findings and recommendations based on interviews, review of the case records, and department policy and procedures.

Findings

- Personnel transitions and workload issues may have affected the worker's ability to closely follow and monitor this family's activities. (The Children's Administration has, since this incident, implemented a policy requiring face to face contact with children every thirty days in voluntary service cases.)
- The standard format currently used for the writing of voluntary service plans does not lend itself to identification and documentation of specific timeframes for completion of service activities. The newer information system for documentation of case activities (FAMLINK), which is to be implemented in

December 2008, has a complete Family Assessment section that will require specific timeframes to be included in service plans.

- Communication issues among the FBI, CPS, and the tribe impeded the timely identification of the home in which this child was injured as a licensed foster home.

Recommendations

- It is recommended that the Smokey Point Office management make outreach to Tulalip Tribes to begin discussions on the possibility of developing a joint working protocol that would more clearly delineate roles and responsibilities in shared cases.

- It is recommended that Children's Administration continue work on the development of a practice guide for domestic violence and that the training on this practice guide be offered to tribal child welfare workers as well as state social workers.

It is recommended that the Division of Licensed Resources (DLR) explore the possibility of establishing a standardized format for the Licensing Health and Safety Checklist, to include questions about significant changes of circumstances in the home, particularly the composition of the household.