CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

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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

- P.L.

Date of Child's Birth

- [redacted]2019

Date of Fatality

- Feb. 13, 2023

Child Fatality Review Date

- May 10, 2023

Committee Members

- Patrick Dowd, JD, Director, Office of the Family and Children's Ombuds
- Arden James, MBA, Substance Use Disorder Professional, Therapeutic Health Services
- Tarassa Froberg, CPS-FVS Program Manager, Department of Children, Youth, and Families
- Mon Ra Muse, MSW, Co-Director Graduation Success, Treehouse
- Olivia MacMaster, Permanency Outcomes Facilitator, Department of Children, Youth, and Families

Facilitator

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Finalized Date: Oct. 18, 2023
Approved for distribution by Paul Smith Critical Incident Practice Consultant

Executive Summary

On May 10, 2023, the Department of Children, Youth, and Families (DCYF) convened a Child Fatality Review (CFR)[1] to examine DCYF's practice and service delivery to P.L. and RCW 74 family. P.L. will be referenced by RCW 74 initials throughout this report.[2]

On Feb. 13, 2023, DCYF received a report that P.L. was found deceased in RCW 74 mother's home. Law enforcement called DCYF to report they had been called to the home by a friend of the mother after he found P.L. "cold to the touch." Law enforcement further reported that P.L. had multiple bruises in different stages of healing and there was concern of physical abuse. P.L.'s mother had been arrested for the murder of P.L. Law enforcement was requesting CPS respond to RCW 13.50.100 [redacted]

Additionally, the Medical Examiner's office shared information about P.L. with DCYF Intake. The Medical Examiner reported that P.L. had injuries to the left face, back of head, both shoulders, both arms, the right side of the abdomen, the back, buttocks, both legs, and the torso. The injuries included bruising and burns. The medical examiner also told DCYF Intake that in the room next to where P.L. was found there was duct tape in a circular shape, but he could not say for sure that it was used on P.L.

At the time of RCW 74 death, P.L. and RCW 74 mother had an open Child Family Welfare Services (CFWS)[3] case. There was an active dependency petition monitoring RCW 74 placement in RCW 74 mother's home. P.L. had been a dependent since he was 1 month old. He had been in a trial return home with RCW 74 mother for just over five months when he passed away. RCW 13.50.100 [redacted]

A CFR Committee (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 P.L. or RCW 74 family. Before the review, the Committee received relevant case history from DCYF. On the day of the review,

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

[3] Child and Family Welfare Services case workers assume responsibility of a child welfare case after the children have been removed from their caregivers and a dependency petition filed.

[4] "Family Voluntary Services (FVS) allows parents to voluntarily engage in services to increase their protective capacities and meet the child's safety, health, and well-being needs." See: https://www.dcyf.wa.gov/practices-and-procedures/3000-family-voluntary-services-fvs.

the Committee had the opportunity to speak with DCYF field staff who were involved with supporting the family.

Case Overview

P.L.'s family first came to the attention of DCYF in 2013 RCW 13.50.100 [redacted] This report was not investigated by CPS because the allegations did not meet legal criteria for child abuse or neglect. RCW 13.50.100 [redacted]

P.L.'s family did not become involved with DCYF again until 2019 when P.L. was born. DCYF received a report from the hospital that P.L. and RCW 74 mother were both positive for marijuana at the time of RCW 74 birth and that P.L.'s mother had tested positive for methamphetamine during her pregnancy RCW 74.13.520 [redacted] The hospital told DCYF that P.L.'s mother had not identified P.L.'s father; however, she had a boyfriend at the hospital with her and they were engaged in volatile fights at the hospital. Lastly, the hospital told DCYF that P.L.'s mother had reported that she did not have a car, a job, or a place to live and did not feel like she was ready to provide for P.L. She told the hospital she wanted to explore giving the child to another family. P.L.'s mother never identified a father for P.L. so paternity was never established for him.

DCYF opened a CPS investigation. DCYF held a family team decision making meeting (FTDM)[5] which the mother attended. At the meeting, P.L.'s mother agreed to participate in an FVS case and signed a voluntary placement agreement, placing P.L. in the care and custody of DCYF for a period of 45 days. DCYF placed P.L. with a maternal aunt. DCYF also attempted to engage P.L.'s mother in services such as visitation, random urinalysis, a drug and alcohol assessment, a mental health assessment, and a parenting education service. P.L.'s mother did not engage in any of the services. At the end of the voluntary placement agreement, she was not responding to DCYF and was not engaged in any services. P.L. and RCW 74 mother visited in June 2019 but would not see one another again until 2022. In July 2019, DCYF petitioned the court for care and custody of P.L., which was granted.

P.L. moved from RCW 74 maternal aunt's home in January 2020 to licensed foster care. DCYF requested this move due to concerns that P.L.'s maternal aunt was utilizing relatives for child care who had not been approved with DCYF background checks. DCYF had worked with P.L.'s aunt for several months, offering her daycare options they would fund, but she had not followed through with those options. P.L. remained in the same licensed foster home he moved to in January 2020 for the remainder of RCW 74 time in foster care.

DCYF also had very little contact with P.L.'s mother between 2019 and 2022. In June 2020, P.L.'s mother attended a court hearing where P.L.'s permanency plan was changed from return home to adoption. In May 2021, P.L.'s case was set to go to court for termination of parental rights; however, P.L.'s mother had not been

[5] "Family Team Decision Making (FTDM) meetings follow the Shared Planning Meeting model of engaging the family and others who are involved with the family to participate in critical decisions regarding the removal of child(ren) from their home, placement stabilization and prevention and reunification or placement into a permanent home." See: https://www.dcyf.wa.gov/1700-case-staffings/1720-family-team-decision-making-meetings.

properly served notice of the termination petition, so the court date was struck and DCYF continued to work on locating her.

On March 22, 2022, the assigned caseworker received information that P.L.'s mother RCW 13.50.100 The caseworker attempted to see the mother RCW 13.50.100 but was unsuccessful. On March 29, 2022, RCW 13.50.100 called in a new CPS report about RCW 13.50.100 A Risk Only[6] CPS investigation was opened and assigned to the current CFWS caseworker.

On March 30, 2022, the assigned caseworker and a coworker made a visit to the mother's home and made contact with the mother, RCW 13.50.100. Initially they were allowed in the home, but RCW 13.50.100 became agitated and asked them to leave. They returned with law enforcement. They learned that RCW 13.50.100 had initially lied about his name. They assessed the safety in the home and the parents agreed to participate in services and a FTDM.

RCW 13.50.100 was connected to another case in Famlink[7] from 2021. Although RCW 13.50.100 in that case, there were allegations of child abuse and neglect made against RCW 13.50.100. The RCW 13.50.100 . Once it was determined RCW 13.50.100 . There were several indications in that case tha RCW 13.50.100 This information was in Famlink in 2022; however, there was no documentation indicating the case history had been searched by DCYF staff assigned to this case in 2022.

An FTDM was held in April 2022 as to RCW 13.50.100. The mother and RCW 13.50.100 attended. They agreed to participate in FVS. The mother agreed to complete random urinalysis testing, but RCW 13.50.100 only agreed to submit one random urinalysis sample. He was still somewhat resistant to engaging with DCYF. The mother also agreed to engage in a mental health assessment.

The CFWS caseworker and supervisor completed their assessment of the CPS Risk Only report as to RCW 74.13 They determined there were no active safety threats as to RCW 74.13. and the case was co-assigned to an FVS caseworker to work with the mother and RCW 13.50.1 The case remained open to the CFWS caseworker to reengage the mother with P.L., who remained in foster care. When the FVS caseworker began working with the mother RCW 13.50.100 they were living with the maternal grandparents and RCW 13.50.100 was reportedly living away from them. The FVS caseworker attempted to engage RCW 13.50.100 in services several times, but he repeatedly said he was too busy with work to participate in services. The mother agreed to an FVS case plan of random urinalysis testing, a mental health assessment, a drug and alcohol assessment, and a hands-on parenting education program.

On April 27, 2022, the CFWS caseworker facilitated a visit between P.L. and RCW 7 mother. This was their first visit since June 2019. P.L.'s foster parents were present for the first few of those visits as were some of RCW 7

[6] CPS Risk Only is an intake that alleges imminent risk of serious harm and there are no allegations of child abuse or neglect. See: https://www.dcyf.wa.gov/practices-and-procedures/2200-intake-process-and-response

[7] Famlink is case management system used by DCYF.

maternal relatives. The CFWS caseworker facilitated the visits for the first two months and then referred the case to a visit supervision contractor. The visits reportedly went well.

Over the next several months the CFWS caseworker conducted monthly health and safety visits with P.L. and RCW 7 foster parents in the foster home and communicated with the mother about some of her services. The FVS caseworker conducted monthly visits with the mother RCW 74.13 515 in their home with the maternal grandparents. The FVS caseworker also communicated with the mother about her services. Neither caseworker was able to reach the mother consistently.

The FVS caseworker assessed RCW 74.13 . to be safe in RCW 74 mother's care and closed the case following a final visit with RCW 74.13.5 and RCW 7 mother at her place of employment on Aug. 23, 2022. A supervisory note stated the mother had provided several urinalysis tests that were positive for only low levels of marijuana, so she was not asked to complete a drug and alcohol assessment. The case note further stated the mother had completed a mental health assessment arranged by her defense counsel. The mental health assessment did not result in any further recommendations. The mother still needed to engage in a parenting service; the CFWS caseworker had agreed to provide the referral for that service. The FVS caseworker reached out to the CFWS caseworker to ensure the CFWS caseworker was following up with the referral.

On Sept. 4, 2022, P.L. returned home to RCW 7 mother. All parties involved in RCW 7 dependency case agreed to RCW 7 return home. Nine days later, the CFWS caseworker completed a visit with P.L. and RCW 7 mother in the maternal grandparent's home where they were still living. The mother indicated that her name had come up on a housing list and she and the kids would be moving soon. The caseworker also asked the mother about the parenting services as she had not started them, and she indicated she wanted to wait until she moved. The caseworker saw P.L. twice per month in September and October. One visit each month was documented in the maternal grandparent's home and one visit was at the mother's place of employment. At the visit with P.L. and RCW 7 mother on Oct. 31, 2022, the mother said she was moving into her apartment with P.L. RCW 74.13.515 . on Nov. 2, 2022.

On Nov. 13, 2022, RCW 13.50.100 was arrested at the mother's new apartment for RCW 13.50.100 According to law enforcement records, P.L. and RCW 74.13 were present when RCW 13.50.100 . Law enforcement did not report it to DCYF. DCYF did not learn about this assault until after the critical incident.

The caseworker next visited the family on Nov. 28, 2022 at the mother's place of employment and then again at their new apartment on Nov. 30, 2022. When the caseworker visited the apartment, she documented that P.L. had RCW 7 own room with an air mattress for a bed and toys. The caseworker also documented that the mother described P.L. as "chill and not needing any real discipline other than redirecting and communicating what are acceptable behaviors." The caseworker told the mother she would assist with furniture and Christmas gifts.

On Nov. 30, 2022, DCYF held a meeting to discuss P.L.'s case and plan for permanency. The mother was invited but did not attend. Although parenting services had been part of the service plan for the mother since April 2022, there was no record that those services ever started. The CFWS caseworker completed referrals in Famlink several times, the last time being on Dec. 14, 2022; however, the next steps to start the services never

appeared to have been followed up on. The last time the caseworker documented speaking to the mother about parenting services was in October 2022.

In December 2022, the CFWS caseworker saw P.L. in RCW 7 mother's home for both visits. The visits were four days apart on Dec. 26, 2022, and Dec. 30, 2022. The caseworker documented the family had received furniture and Christmas gifts for the children. P.L. was enjoying RCW 7 Christmas gifts. At the second visit on December 30, 2022, the caseworker and the mother talked about daycare for P.L. The mother said she had found a preschool down the street that she was planning to tour but she had been working a lot. The mother also mentioned wanting to travel with the maternal grandparents to Idaho in February for a family function.

In January 2023 the CFWS caseworker saw P.L. in RCW 7 mother's home for both visits again. The visits were three days apart on Jan. 24, 2023, and Jan. 27, 2023. At the Jan. 24, 2023, visit to the home, the caseworker documented that P.L. appeared to be getting along well with RCW 7 mother, that he had good hygiene and was not in any distress. The caseworker also documented the mother was working a lot and utilizing her mother and sister to watch her children. The mother again asked the caseworker about going to Idaho with her parents in February. The caseworker encouraged the mother to wait until the case was dismissed at court. The caseworker told the mother dismissal could happen as soon as February.

The visit to the home on Jan. 27, 2023, was the last time the caseworker saw P.L. During this visit the mother told the caseworker that she was working a lot and sometimes had to take the kids to work with her or have her mom or sister watch them. The caseworker and the mother talked about two preschool programs and the mother shared that she had toured one already. The caseworker documented that P.L. seemed comfortable in RCW 7 setting. The caseworker documented that no marks or bruises were observed on P.L. or his brother RCW 74.13

On Feb. 8, 2023, the caseworker documented an attempted visit to the home. The note indicated that the caseworker knocked several times, and nobody answered. The caseworker also tried to call the mother and she did not answer. This case note indicated the mother had requested to travel to Idaho with her parents for a funeral Feb. 9-15, 2023.

On Feb. 13, 2023, DCYF received a report that P.L. was found deceased in RCW 7 mother's home.

Committee Discussion

The Committee discussed P.L.'s initial removal from RCW 7 mother's care. Following review of the case and discussion with field staff, the Committee felt would have been helpful for DCYF to explore other relative placement options more thoroughly at the onset of the case when PL was placed in foster care after he was removed from RCW 7 aunt's home. The Committee also stated that relative search should have continued to occur while P.L. resided in foster care.

The Committee discussed the legal path to permanency on RCW 74.1 case as P.L. was dependent for almost three years and there were no parents visiting him or engaged with DCYF. The field staff spoke with the Committee about several factors they thought prolonged P.L.'s path to permanency. The Committee ultimately maintained their opinion that timely permanency for P.L. would have better met RCW 7 needs.

The Committee discussed initial visits between P.L. and RCW 7 mother. They appreciated that the mother was offered visits right away in April 2022 when she re-engaged in the case. The Committee felt it was good

practice that the caseworker supervised the first several visits between P.L. and [redacted] mother. They also appreciated that P.L.'s foster parents were in those visits initially. The Committee wondered if having relatives present at so many of the visits was a good choice or not. Their concern was that it may have distracted from P.L. and [redacted] mother's ability to build relationship. The Committee suggested that an additional assessment of attachment and bond between P.L. and [redacted] mother would have been helpful in this case to guide case planning.

The Committee noted it was a strength that the FVS caseworker completed a written case plan with the family. The Committee also appreciated the attempts made by the caseworkers to complete a DV screening with the mother. The Committee inquired with field staff as to how they assessed [redacted] father. The field staff available to meet with the Committee had not viewed the father's Famlink history, but they were aware he had some history in Famlink. There had also been some collateral conversations with relatives as to the relationship between the mother and [redacted] father. Following their review of the case documents and meeting with field staff, the Committee was concerned the case became siloed between CFWS and FVS programs at the time mom reengaged with DCYF. It appeared to the Committee that the CFWS team felt P.L. was their responsibility and the FVS team felt [redacted] was their responsibility. The Committee felt that increased communication between the two programs could have been helpful in managing this case during the important time period when P.L. and [redacted] mother were reuniting after a long period of no contact and she was parenting an infant for the first time.

The Committee inquired with field staff about the mother's mental health assessment. Field staff elaborated that the mother was hard to communicate and coordinate services with. According to field staff, the mother's defense attorney eventually offered to have the Office of Public Defense social worker arrange mental health services. The Committee was concerned that when DCYF acquiesced and allowed the public defense social worker to arrange the mental health assessment, they additionally did not provide collateral information to assist in the assessment of the mother. The Committee felt that the mother was not provided an objective assessment that could have identified her mental health needs.

The substance use disorder expert on the Committee discussed concern that the use of marijuana should still be assessed as a risk with a parent who has addiction history. The Committee inquired with field staff about their practice with parents who use marijuana. Field staff shared they had the mother provide her medical card for marijuana. Field staff shared there had been a discussion with the mother about safe storage of marijuana and a lock box provided to her. Finally, the field staff said their court Commissioners typically overlook marijuana positive urinalysis results unless there are several other concerns, which there were not in this case at the time.

Recommendations

The Committee's recommendations come from a comprehensive review and discussion of the many aspects of the case. The recommendations and corresponding discussion were unrelated to P.L.'s fatality. The Committee respectfully recommended DCYF consider the following recommendations to help DCYF and their staff comprehensively improve practice.

- DCYF should amend its policy to say that the assigned caseworker will make all efforts to provide collateral information as to the purpose and scope of the following types of assessments:
    - Substance use
    - Psychological
    - Mental health
    - Domestic violence
    - Parenting
- DCYF should require joint supervisory meetings on cases carried simultaneously by more than one caseworker.
- DCYF should consider changing its policy to allow for case-specific direction around health and safety visit frequency, health and safety visit timeframes, and whether or not health and safety visits are unannounced. The decision making around these health and safety visit factors should take place during clinical supervisory meetings between the caseworker and supervisor.