CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

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CONTENTS

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Full Report

Child

- R.M.

Date of Child's Birth

- [redacted] 2009

Date of Fatality

- May 6, 2021

Child Fatality Review Date

- July 15, 2021

Committee Members

- Mary A. Moskowitz, JD, Office of the Family and Children's Ombuds, Ombuds
- Aushenae Matthews, Domestic Abuse Women's Network, Shelter Program Lead
- Erin Summa, MPH, Mary Bridge Center for Childhood Safety, Health Promotion Coordinator
- Jennifer Gorder, MSW, Department of Children, Youth, and Families, QPS Region 6
- Billie Patterson, Department of Children, Youth, and Families, ICW Consultant, Tribal Liaison Region 2

Facilitator

- Libby Stewart, Department of Children, Youth, and Families, Critical Incident Review Specialist

Executive Summary

On July 15, 2021, the Department of Children, Youth, and Families (DCYF) convened a Child Fatality Review (CFR)[1] to examine DCYF's practice and service delivery to R.M. and RCW 74. family[2]. RCW 74.1 will be referenced by RCW 74. initials throughout this report.

On May 6, 2021, R.M. was taken by ambulance to a local hospital. RCW 74.1 was in critical condition. Hospital staff initially thought RCW 74. condition was related to choking on a small piece of candy. R.M.'s mother reported they were at home with RCW 74. mother's friend. R.M. was eating miniature Starburst candies and lying down in a chair. The adults thought RCW 74. had fallen asleep, but R.M.'s mother noticed R.M.'s lips were purple. She started CPR and called emergency services. The hospital reported that the responding emergency services personnel informed the hospital that they did not trust what the mother told them and that the "parents" did not seem concerned. It is unclear what was meant by "parents" since R.M.'s parents did not reside together and were not together during this incident. R.M. died at the hospital.

Law enforcement was contacted. The initial intake screened out because no information indicated this was more than an accidental choking incident. Law enforcement later shared new information, and based on those details, the intake screening decision was changed, and a Child Protective Services (CPS) investigation began.

A diverse Committee was assembled to review this case and to evaluate DCYF's service delivery to the family. The Committee included community partners and DCYF staff. Prior to the review, no Committee members had any direct knowledge of, or involvement with the family. Committee members received copies of the DCYF case history, including CPS intakes, case notes, hospital toxicology results, law enforcement reports, and DCYF risk assessment tools and assessments. A representative of the Confederated Tribes of RCW 74.13.515 was invited to participate as a Committee member. However, the representative did not attend the review. On the date of the review, the Committee interviewed two caseworkers and the area administrator. The majority of DCYF staff that worked on this case before the fatality were no longer employed by DCYF and were not available for this review.

[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] The names of R.M.'s parents are not used in this report because neither parent has been charged with a crime in connection with the fatality.

Case Overview

The first intake about this family was received on Feb. 10, 2017[3]. RCW 13.50.100 called and reported RCW 13 seven-year-old RCW 74.13.515 lived with the mother and her boyfriend. R.M. allegedly had RCW 74.13.520 "again" that had been recently RCW 74.13.520 . RCW 74.1 allegedly had a previous RCW 74.13.520 infection during the summer. The caller reported the mother obtained medication but was concerned that the house and living conditions must have been poor to create this condition. This intake was screened out due to a lack of meeting legal sufficiency for intervention.

On Sept. 12, 2017, a RCW 13.50.100 called and reported that R.M. was recently at the caller's home. R.M. told the caller that RCW 74. father's girlfriend puts duct tape on RCW 74. mouth because "I won't shut up." R.M. stated that this also happens to the girlfriend's daughter. The caller also reported that the parents were in a custody dispute involving R.M. This intake screened in for a CPS/Family Assessment Response (FAR) assessment. CPS intakes can be screened out and assigned for a CPS investigation or a CPS/FAR assessment. FAR is an alternative response for a screened-in CPS intake. FAR intakes contain lower-risk allegations.

The September 2017 assessment was completed and subsequently closed on Nov. 2, 2017. The mother was offered services but declined.

On Jan. 25, 2018, a RCW 13.50.100 called to report that R.M.'s father's girlfriend told her that there were feces in the mother's home and that R.M. previously had RCW 74.13.520 The girlfriend told the RCW 13 50.100 she spoke with the mother earlier about this, and the situation was resolved. This intake was screened out.

On June 20, 2019, RCW 13.50.100 called and reported that R.M. had dreams about RCW 74. mother's boyfriend inappropriately touching RCW 74.1 R.M. was previously in counseling, but RCW 74. mother ended the therapy. The father was going to attempt to restart the counseling. RCW 13.50.100 also reported that R.M. missed 18 days of school, RCW 13.50.100 . This intake was screened out because R.M. did not make any actual disclosures of inappropriate touching. However, on June 21, 2019, DCYF received a law enforcement report regarding the same allegations. New information included R.M. waking up on several occasions under concerning circumstances. The report was forwarded to detectives. This intake was screened in for a CPS investigation. A third report with similar information was received and screened out.

During the June 2019 CPS investigation, R.M. participated in a forensic interview but did not make clear disclosures. The mother denied the allegations. Both R.M.'s father and his girlfriend shared their past RCW 13.50.100 histories and discussed the continued custody struggles. The caseworker discussed with the father and his girlfriend on more than one occasion that they should not make disparaging or inappropriate statements about R.M.'s mother in R.M.'s presence. The caseworker had numerous contacts with all parties involved in this investigation. Ultimately, R.M. stated RCW 74. made up the allegations. The law enforcement and CPS investigations were both closed.

[3] 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.

During the investigation, another intake was received. The intake made similar allegations to the current investigation but also reported a no-contact order had been served on the mother. The no-contact order prohibited the mother from having contact with R.M. until the CPS investigation was completed. A Native American Identification Referral was made to the Native American Inquiry unit during the investigation. The father reported he was enrolled with the [redacted] Tribe located in [redacted] Contact was attempted with the tribe, but DCYF received no responses.

On Dec. 4, 2019, an [redacted] called DCYF and reported that R.M.'s mother put R.M. in a "chokehold." The caller reported that R.M. told her about this incident. R.M. also reported that [redacted] mother hurt R.M.'s neck by doing this, and the mother's boyfriend had to tell her to stop. The mother reportedly said, "I'm just trying to toughen [redacted] up." According to the caller, R.M.'s mother also did this to another younger, unrelated child who was in the mother's home, and the mother was "drunk" when this occurred. This intake screened out because there was a lack of clarity of strangulation, the child denied that her breathing was impacted, and the pain was transient. This intake was received prior to the closure of the June 2019 investigation.

On Feb. 19, 2020, an [redacted] called DCYF and reported that R.M. was worried about [redacted] mom and [redacted] mother's possible [redacted]. R.M. told the caller that [redacted] mother also brings different men to the home at night and [redacted] does not like this. R.M. also told the caller that [redacted] mother left [redacted] at home alone all night. R.M. told the school [redacted] did not want to go home and did not feel safe, so the principal called [redacted] father to pick [redacted] up. R.M. also reported there was domestic violence between the mother and her ex-husband and that the mother drinks too much and calls [redacted] obscene names. This intake was screened out. The screening decision stated, "At this time, there is not enough to support an allegation of CA/N nor imminent risk of serious harm." The term CA/N means child abuse and/or neglect.

On Feb. 20, 2020, [redacted] called and reported that on the previous day, [redacted] called by the school to pick [redacted] up because [redacted] did not feel safe. R.M. said [redacted] mother wanted to [redacted]. [redacted] believed there were three guns in the home. R.M. also told him there was a hatchet or ax in [redacted] room and multiple cases of beer. The school told [redacted] that R.M. was often upset, tired, crying, and appeared unable to focus. This intake was screened in for a CPS investigation.

The caseworker contacted the father, the father's girlfriend, and the responding law enforcement officer. The father reported that the police officer went to the home and found air-soft guns and unopened alcohol in R.M.'s room. The caseworker met with R.M.'s principal, who reported that R.M. was scared to go home three weeks ago. [redacted] mother had been at a bar, and the stepfather was with R.M. At some point, the stepfather wanted to find the mother, located her, and eventually, there was pushing between the mother and stepfather. The stepfather was arrested for [redacted]. On May 1, 2020, this investigation was closed as unfounded.

On Jan. 15, 2021, a [redacted] reported that R.M. had [redacted]. R.M. filled out an online school form stating [redacted] had [redacted]. The [redacted] tried to call the home but did not connect with R.M. or [redacted] mother. The [redacted] contacted R.M. online during school. They spoke privately in a breakout room. R.M. did not have a [redacted] but indicated that the [redacted] were becoming worse and more frequent. R.M. said [redacted] made a [redacted] that morning by using [redacted].

The RCW 13.50.100 could not see the RCW 74.13.520 that R.M. was referring to. R.M. also said RCW 74.1 was "possibly RCW 13.50.100 about one year ago" and that RCW 74. mother said RCW 74.1 made it all up. The RCW 13.50.100 called R.M.'s father. He told the RCW 13.50.100 he was at his "wit's end" and was worried about his RCW 74.13.515 The RCW 13.50.100 said she would request a law enforcement child welfare check. This intake was screened out, stating that the allegations were documented in a previous intake.

On Feb. 1, 2021, the RCW 13.50.100 called again to report that R.M.'s mother was not obtaining the mental health counseling for R.M. that RCW 74.1 needed. R.M. told the caller RCW 74.1 had RCW 74.13.520 . The RCW 13.50.100 worried that the mother was ignoring the RCW 13.50.100 expressed concerns. The mother said RCW 74.13.520 were related to puberty. The RCW 13.50.100 also spoke to R.M.'s father, who shared the same concerns but was not the custodial parent and reported that he could not get his RCW 74.13.515 into counseling. The mother also screamed at her RCW 74.13 515 for the RCW 74.13.520 behavior. This intake was screened in for a CPS investigation.

On Feb. 2, 2021, the assigned CPS caseworker met with R.M. and RCW 74. mother. The caseworker also completed a walk-through of the family home. The home was observed to be safe. A male at the home was also identified as the mother's friend.

The mother discussed her mental health history, mental and medical diagnosis, history with DCYF, DV history, and other details about the current situation. R.M.'s mother discussed her thoughts about R.M.'s RCW 74.13.520 statements and RCW 74.13.520, as well as her plans to pursue mental health supports for her RCW 74.13 515

The caseworker reached out to the Confederated Tribes of RCW 74.13.515 and left a voicemail requesting a return telephone call. Later, the caseworker also followed up with a referral to the Native American Inquiry unit due to the father's statements that he is an enrolled member of the tribe.

The caseworker also interviewed R.M.'s father. He discussed an arrest in 2008 for a RCW 13.50 who lives in his home, weapons and how they are stored in his home, and other pertinent topics related to assessing R.M.'s safety and well-being.

The caseworker made collateral contacts with the initial referent of this intake and R.M.'s medical and dental providers. The case was closed out with an unfounded finding for neglect. The Structured Decision Marking Risk Assessment tools (SDM) for the mother's home were moderately high, and the father's SDM was low. The caseworker and supervisor determined there were no active safety threats and that R.M.'s mother was aware and accessing appropriate services to address R.M.'s mental health.

On May 6, 2021, the critical incident occurred.

Law enforcement was contacted. This initial intake screened out because there was no information indicating this was more than an accidental choking incident. However, law enforcement shared new information, and based on those details, the intake screening decision was changed, and a CPS investigation began. Neither the law enforcement nor DCYF investigations have been completed as of the writing of this report. The law enforcement investigating agency is waiting for the completed medical examiner's report with toxicology results.

Committee Discussion

The Committee discussed areas of missed opportunities which are addressed in the Findings section. They also discussed how it would have been incredibly difficult to complete all the required work due to the amount of turnover and lack of adequate staffing in the local office where this case was handled.

There was also a discussion about law enforcement's failure to cross-report incidents to DCYF. In particular, there was a specific DV incident, and while DCYF was made aware of it during an open CPS investigation, DCYF did not receive the report from the law enforcement agency, nor did DCYF request it. For purposes of determining whether another intake should have been created, the Committee believes it would have been beneficial for the caseworker to request the report and share it with intake.

While there were medical and dental collateral contacts, the Committee discussed a lack of personal collateral contacts. This is also addressed in the Findings section below. Other relatives, friends, or significant others may have provided more details about the family.

The mental health of R.M. and RCW 74. mother was also discussed. There were indicators that both may have been struggling with mental health-related issues. R.M. was not attending an online school, and RCW 74. mother, who was available to assist RCW 74.1 was not making sure this occurred. There was also non-compliance with R.M.'s Individual Education Plan (IEP). R.M. also shared bullying and relationship issues with RCW 74. girlfriend and friends, which were not more closely examined or considered. R.M. shared that RCW 74. wished RCW 74. mother had better hygiene. It is unclear if these issues were contributing factors or related to any mental health issues for the youth or RCW 74. mother. The Committee discussed whether additional assessments may have been beneficial.

Findings

The Committee discussed areas where practice could have been improved but did not find that these areas contributed to the fatality.

The Committee believes that DCYF should have conducted and documented a more thorough DV assessment. This case involved many incidents of violence that all included elements of substance abuse. Some of the DV incidents resulted in significant injuries, and one included a family pet. DCYF Domestic Violence Policy No. 1170 states that staff must "interview and review records and available databases." DCYF was aware of law enforcement involvement and a no-contact order (NCO) but did not request those records until after the fatality. A DV incident did occur during an open CPS investigation in 2019 which should have prompted a specialized DV assessment. The CPS caseworker shared with the Committee that he believed he reviewed the NCO electronically before the fatality. Also, for purposes of promoting safety in the home and because substance abuse was mentioned throughout the case, the Committee believes a more thorough assessment could have been completed if there had been a better understanding of the role that DV and substance use played in the safety of the home.

The Committee also identified that more collateral contacts may have been beneficial. The Committee understands DCYF has previously experienced RCW 74.13.520 refusal to cooperate with requests for records or communication (see recommendations for further information on this). With this in mind, the Committee appreciates the effort by the last CPS caseworker to obtain RCW 74.13.5 records. Also, as stated

in the first finding, law enforcement reports may have been beneficial in this case. Another possible helpful collateral would have been R.M.'s step-siblings. RCW 74.1 shared a bedroom with one when RCW 74.1 visited RCW 74.1 father. Neighbors and friends were also mentioned in case notes, as well as the mother's ex-husband (they were married during a portion of the case) and mother's boyfriends, and various individuals named in the screened-out intakes.

There were inaccurate answers within the Structured Decision Marking Risk Assessment tools (SDM). The SDM is a tool staff utilize to assess the level of risk posed to children. It is a tool that must be completed prior to the closure of a CPS investigation or assessment. The Committee discussed that accurate completion and appropriate utilization of this tool is a statewide struggle. This is addressed in the recommendation section.

The Committee also believes that additional substance use and abuse assessments may have been beneficial. According to R.M., RCW 74.1 father reportedly decreased his alcohol intake at some point. RCW 74.1 was happy with this change. However, R.M. also shared that at one point in RCW 74.1 life, he was drinking excessively and threw the family dog during one violent incident. The mother and her partners (boyfriends and ex-husband, not the victim's father) had a history of multiple substance abuse allegations, specifically alcohol abuse. Substance abuse was also mentioned in the DV incidents. At one point, the mother was taking medications for pain and mental health issues. There might have been adverse side effects if the mother was using alcohol while taking the prescribed medications. DCYF did not request any urine tests or substance use assessments.

Recommendations

The first recommendation is that the DCYF Region 5 management, including the area administrator and/or the Deputy Regional Administrator or Regional Administrator, attempt another meeting with RCW 74.13.520 . The information shared during the review was that RCW 74.13.5 refuses to release information pursuant to records requests made by DCYF, even when clients and DCYF utilize the form provided by RCW 74.13.52 The Committee understands the RCW 74.13.515 County Area Administrator has attempted numerous times to engage RCW 74.13.5 during her 10 years in her current role. However, one Committee member shared that there has been a change in staff and management, and they may be more open to collaboration.

The second recommendation is that DCYF program staff should assess ways to achieve accuracy in staff completion of the SDMs and the supervisor reviews. This includes how to utilize critical thinking during the assessment process. Once an assessment has been completed, DCYF should implement necessary changes to improve staff completion of the SDM and enhance the critical thinking necessary to appropriately utilize the tool to assess the risk to children.