WASHINGTON STATE
Department of
Children, Youth, and Families

CHILD FATALITY REVIEW

January 2019

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FULL REPORT

CHILD

- S.S.

DATE OF CHILD'S BIRTH

- RCW 74.15.515 2017

DATE OF FATALITY

- June 11, 2018

CHILD FATALITY REVIEW DATE

- October 12, 2018

COMMITTEE MEMBERS

- Patrick Dowd, Director, Office of the Family & Children's Ombuds
- Tiffany Kelly, Clinical Director, Lutheran Community Services Spokane
- Jennifer Cooper, MSW, Area Administrator, Department of Children, Youth, and Families
- Molly Rice, Safety Program Manager, Department of Children, Youth, and Families

FACILITATOR

- Cheryl Hotchkiss, Critical Incident Review Specialist, Department of Children, Youth, and Families

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EXECUTIVE SUMMARY

On October 12, 2018, the Department of Children, Youth, and Families (DCYF or CA)[1], convened a Child Fatality Review (CFR)[2] to conduct a review of the Department's practice and service delivery to S.S. and [redacted] family.[3] The incident initiating this review occurred on June 11, 2018, when the parents of S.S. took [redacted] to a local hospital. S.S. was unresponsive when [redacted] arrived at the hospital. The father was arrested at the hospital, but was later released. The mother (Skye Metcalf[4]) has been accused of causing S.S.'s death and has been charged with second degree murder.

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 Area Administrator, Mental Health Professional, and a DCYF safety program manager. Neither DCYF staff nor any other Committee members had previous direct involvement with S.S. or [redacted] family.

Prior to the CFR, each Committee member received a family genogram, a case chronology, a Department summary describing Department involvement with the family and un-redacted Department case documents. Supplemental sources of information and resource materials were available to the Committee at the time of the review. These included mental health records, relevant state laws, and Department policies.

During the course of this CFR, the Committee interviewed the Child Protective Services (CPS) supervisor and the CPS worker assigned to the case. The Committee discussed possible areas for practice improvement after the Committee reviewed the case file documents, completed department interviews, and discussed the department activities and decisions. The Committee made one finding and two recommendations. The finding and recommendations are included at the end of this report.

[1] On July 1, 2018 the Department of Social and Health Services (DSHS) Children Administration division was moved to DCYF. The fatality that is the subject of this CFR occurred before July 1, 2018. For purposes of this CFR and depending on the context, a reference to DCYF may be considered a reference to the Department of Social and Health Services or the Department of Children, Youth and Families.

[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)]

[3] The full name of Skye Metcalf is used in this report because she was charged with committing a crime related to this report of abuse. *See* RCW 74.13.500(1)(a).

[4] The full name of Skye Metcalf is used in this report because she was charged with committing a crime related to this report of abuse investigated by DSHS. *See* RCW 74.13.500(1)(a).

CASE OVERVIEW

On March 8, 2018, the Department opened an investigation regarding the mother and her RCW 74.15.515 S.S. The mother's mental health counselor (Counselor) reported concerns to the Department about the safety of the child and the mother due to the mother's mental health, her recent statements about harming S.S., her lack of desire to care for S.S., and about harming herself if she (the mother) could not be in a relationship with S.S.'s father, adding to the counselor's concerns for ongoing domestic violence (DV) in combination with the mother's mental health concerns.

The Department opened an investigation on March 9, 2018, and the assigned CPS worker met with the Counselor, the mother, and a medical crisis worker. Based on the mother's statements, the Counselor believed the mother needed to be assessed RCW 74.13.520 . The Counselor also disclosed that based on the father's domestic violence history against the mother, the father would not be a safe placement for S.S. At the time of the March 9 meeting, the mother was living with a friend (mother's roommate) who was assisting with the daily care of S.S. It was reported the father was not living with the mother or providing care to S.S. Department staff made collateral contacts with the mother's and father's friends and family. These contacts also reported concern about the father's ability to care for S.S. These concerns are based on a previous domestic violence incident between the father and the mother, and the father's unemployment status.

On March 9, 2018, the mother was willing to agree to a Voluntary Placement Agreement (VPA[5]). The mother's friend (also a roommate) requested placement of S.S, however, the Department advised that Department policy and state law prevented the Department from placing S.S. in the roommate's care[1]. S.S. was then placed in a temporary foster care placement until a further assessment of family could be completed. The mother's roommate advised the Department that she would seek third-party custody[6] of S.S. through family court.

Pursuant to a request from the mother's Counselor, crisis intervention community mental health professionals conducted an assessment. On March 11, 2018, the assessment was completed. The assessment concluded the mother was not a threat to herself or S.S. The mother's Counselor communicated this information to the Department, and on March 12, 2018, the mother asked that S.S. be returned to her care. The mother's roommate advised the CPS worker she filed a third party custody petition seeking the custody of S.S. and future hearings were scheduled.

On March 14, 2018, separate Family Team Decision-Making Meetings (FTDM)[7] were held for each parent.[8] During the mother's FTDM there were notable discrepancies between the

[5] A Voluntary Placement Agreement (VPA) safety supports a time-limited plan for a short-term removal and placement in out-of-home care for a child who cannot safely remain in the parent or legal guardian's home. [Source: CA Practice and Procedures Guide, Section 4307]

[6] Third party custody, or non-parental custody, is a legal mechanism whereby an individual who is not a child's parent may obtain physical and legal custody of a child through a court order. Chapter 26.10 RCW. An individual seeking a custody order must submit, along with his or her motion for custody, an affidavit declaring that the child is not in the physical custody of one of its parents or that neither parent is a suitable custodian and setting forth facts supporting the requested order. The party seeking custody shall give notice, along with a copy of the affidavit, to other parties to the proceedings, who may file opposing affidavits. [Source: RCW 26.10.034 (1)]

[7] 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 meetings are held to make critical decisions regarding the placement of children following the 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. Permanency planning starts the moment children are placed out of their homes and is discussed during a Family Team Decision-Making meeting. A FTDM will take place for all placement decisions in order to achieve the least restrictive and safest placement that is in the best interests of the

Counselor's concerns for the mother, versus the responding crisis mental health professional's final assessment.[9] Identified concerns about the mother included: RCW 74.13.520 , and the discrepancy between the community mental health responders and the Counselor's initial assessments. Department staff determined there was insufficient information establishing an active safety threat that would prohibit the return of S.S.to the mother's care. The father supported S.S.'s return to the mother. During the father's FTDM, he admitted to a domestic violence incident in April 2017 with the mother that resulted in a no-contact order between them. The father was reportedly RCW 13.50.100 as a result of the domestic violence incident. The Department did not receive substantial information from family and friends concerning the father's inability to care for the child that would prohibit him from visiting S.S. The majority of the reported concerns surrounded his lack of employment or involvement with S.S.

A court hearing on April 24, 2018, considered the roommate's third party custody petition. The Department was not involved in the hearing. Both parents opposed the motion and provided the court with information about the mother's mental health crisis assessment that determined she did not pose a threat of harm to herself or others at that time. The Court dismissed the third party petition. The court cited, "The court cannot compare the petitioner's home and the parents' homes. Burden of proof for adequate cause has not been met for unfitness or actual detriment."

Shortly after the custody hearing, the mother and S.S. moved out of the roommate's home. On May 1, 2018, the CPS worker contacted S.S.'s pediatrician and was told the child was current on exams and had a subsequent exam scheduled for later that month. No concerns were communicated to the CPS worker regarding the child or the mother. On June 6, 2018, the CPS worker conducted a health and safety[10] visit at the mother's home. The mother told the CPS worker that she was continuing with counseling and was RCW 13.50.100 . She also stated she was receiving support from her maternal and paternal grandparents. The father was not present during the meeting, and as described by the mother, he was not visiting or living at the mother's home. The CPS worker did not identify any obvious hazards in the home or have concerns for the mother's behavior or statements during this visit. Later, after the child's death, the Department learned the father had been in the mother's home within a week prior to S.S.'s death.

On June 11, 2018, the Medical Examiner's (ME) Office called the Department to report the death of RCW 74.15.515 -old S.S. The child was declared deceased at 1:25 p.m. The suspected manner of death was homicide. According to the ME's office, on June 11, 2018, the mother and the father arrived at the local hospital at 1:15 p.m. with S.S. who was non-responsive. Medical staff attempted to resuscitate S.S. without success and RCW 74.15 was declared deceased.

At the hospital the mother initially told authorities she accidentally fell while holding S.S. and this was the cause of the child's injuries. However, according to investigators the mother's story "changed many times" and the parents eventually became uncooperative with sheriff's deputies. The father was arrested at the hospital due to the no-contact order between the father and mother. The initial charge of violation of a no-contact order was later amended to second-degree criminal mistreatment.

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child. By utilizing this inclusive process, a network of support for the child(ren) and adults who care for them may be ensured. www.dshs.wa.gov/pdf/ca/FTDMPracticeGuide/pdf

[8] Separate FTDMs were necessary because of a no contact order between the parents.

[9] During the FTDM the mother's Counselor disclosed that crisis mental health assessment and response was out of her professional scope and expertise.

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

On June 12, 2018, the mother was arrested and charged with second-degree murder for the death of S.S. After she was arrested, the mother admitted to causing S.S.'s death. She reported that the father had been in the home prior to S.S.'s death but had left due to an argument. The mother explained that after the argument she was frustrated with S.S and threw RCW 74.1 face first into the bottom of RCW 74.1 playpen. The mother admitted that she then struck S.S. multiple times with a closed fist on the back of RCW 74.1 head, which caused the skull fractures described in the autopsy. After the assault the mother noticed a soft spot on the back of S.S.'s head causing her to call the father and request a ride to the hospital.

COMMITTEE DISCUSSION

With regard to domestic violence, the Committee observed that a domestic violence assessment was initiated but does not believe it included a complete assessment of power and control issues. Further, it appeared to the Committee that the domestic violence screening overlooked the impacts of domestic violence on the mother's mental health, and S.S.'s safety and functioning. Instead of examining all domestic violence indicators it appears the CPS staff primarily focused on the April 2017 physical altercation between the mother and father.

With regard to services offered to the family, while the Structured Decision Making Assessment[11] (SDMRA) demonstrated a moderate risk tag which does not mandate the offering of services, the Committee believes such services should have been offered. The Committee notes that the SDMRA was completed just prior to S.S.'s death. The Committee believes the SDMRA should have been completed during the case activities. Despite this concern, the Committee believes this delay is not an area of practice that needs to be addressed in this particular case, and the offered SDMRA services would not have prevented the mother's impulsive behavior that resulted in S.S.'s death. Regardless, the Committee believes domestic violence victim support services and other home-based community infant support services should have been offered.

With regard to the timely collection and analysis of records, the Committee discussed the importance of gathering records to verify and analyze second-hand reports. The Committee believes this would have been especially helpful for purposes of the review and analysis of mental health records; in particular, and the crisis mental health assessment and results. Despite the fact the mental health records were not gathered before S.S.'s death, or that direct contact was not initiated with the crisis mental health staff, the mother's primary Counselor was in direct communication with the crisis team and communicating information to Department staff and FTDM participants. The delay in gathering the records or failure to initiate direct contact with the crisis mental health staff did not directly or indirectly cause S.S.'s death. The Committee believes the best practice is for the Department to timely obtain the necessary information directly from the information's source.

With regard to Department staff training, the Committee has concerns Department staff are sometimes expected to have expertise beyond their actual qualifications or what is described in their job description. For example, expectations related to a staff person's mental health training and/or expertise. The Committee recognizes that if this concern is valid, Department staff may be unable to properly understand mental health records to the extent necessary to gain a clear understanding of the diagnoses and recommendations. The Committee does not have sufficient information to determine whether the Department has the resources to make available, or

[11] The Structured Decision Making Risk Assessment ®(SDM-RA®) is an evidence-based actuarial tool from the Children's Research Center (CRC) that was implemented by Washington State CA in October, 2007. It is one source of information for CPS worker and supervisors to consider when making the decision to provide ongoing services to families.
[Source: DSHS CA Practices and Procedures Guide, Chapter 2541]

retain, expert mental health professional(s) for the purpose of analyzing information received from mental health providers.

The Committee understands that unlike Department staff who are responsible for assessing a situation for impending danger over a period of time, crisis mental health responders are tasked with assessing clients for just a moment in time. To assess child safety, the Committee believes Department staff must apply a global perspective considering all relevant factors including, but not limited to, the crisis team assessment.

FINDINGS

The Committee did not identify any critical errors made by CA that contributed to the death of S.S. However, while not directly or indirectly connected to the circumstances of the child's death, the Committee did identify practice areas that the Department may want to consider for possible improvement.

Although staff made initial domestic violence inquiries involving the parents, the Committee believes the patterns and statements related to domestic violence could have been more thoroughly evaluated and analyzed for a more accurate assessment. Specifically, the Committee believes that a more accurate safety assessment may have been developed if there had been a more in-depth analysis of the lethality indicators, family functioning, child safety, the cycle of violence, and the possible impacts domestic violence had on the mother's mental health issues.

Child welfare staff are often required to have expertise in a variety of professional services or vocations and often beyond their education and training, such as mental health assessment and domestic violence.

RECOMMENDATIONS

The local unit involved in this case might consider refreshing their domestic violence assessment skills with a Department program manager.

In an effort to enhance the workers' assessment and analysis of client mental health issues, Department leadership should make a statewide mental health consultant(s) available to staff. The purpose for the statewide mental health consultant(s) would be similar to the purpose of the statewide medical consultants.