CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

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CONTENTS

Nondiscrimination Policy

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

- A.G.

Date of Child's Birth

- January 2020

Date of Fatality

- March 27, 2024

Child Fatality Review Date

- June 13, 2024

Committee Members

- Deborah Lurie, Children's Ombudsman, Office of the Family and Children's Ombuds
- Brad Turi, Sergeant Special Assault and Domestic Violence Unit, King County Sheriff's Office
- Jane Chavira, B.S., SUDP, Substance Use Dependency Professional, The Center for Alcohol and Drug Treatment
- Michelle Hetzel, MSW, Program Manager, Department of Children, Youth, and Families
- Juan Guerrero, MSW, Supervisor, Department of Children, Youth, and Families

Facilitator

- Michelle Erickson, MSW, Critical Incident Review Specialist, Department of Children, Youth, and Families

Executive Summary

On June 13, 2024, the Department of Children, Youth, and Families (DCYF) convened a Child Fatality Review (CFR)[1] to examine DCYF's practice and service delivery to A.G. and RCW 7 family. A.G. will be referenced by RCW 7 initials throughout this report.[2]

On March 28, 2024, DCYF was notified A.G. passed away and RCW 7 body was discovered on the side of a road wrapped in a blanket. A.G.'s mother was under arrest for RCW 7 murder. She was accused of stabbing A.G. over 40 times and discarding RCW 7 body on the side of a road.

DCYF had an open case with the family at the time of A.G.'s fatal incident. The case had been open for three days when A.G. passed away. This was DCYF's first involvement with A.G.'s family.

The day A.G. passed away RCW 7 maternal grandparents obtained court ordered guardianship of A.G. and RCW 7 older RCW 74.13.515 A.G.'s grandparents were actively looking for RCW 74.1 in order to take custody of RCW 74.1 when RCW 7 body was discovered. RCW 74.13.515

A 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 A.G. or RCW 7 family. Before the review, the Committee received relevant case history from DCYF. On the day of the review the Committee had the opportunity to speak with DCYF field staff who had contact with the family.

Case Overview

A.G.'s family first came to the attention of DCYF four days before the critical incident occurred. A.G., RCW 7 seven-year-old RCW 74.13.515 and RCW 7 mother were staying with A.G.'s maternal grandparents. RCW 74.13.515 RCW 74.13.515

On March 23, 2024, DCYF received a call from A.G.'s maternal grandmother expressing concern A.G.'s mother was using drugs and "acting crazy." The grandmother reported the mother was hitting A.G. RCW 74.13.515 RCW 74.13.515 The maternal grandmother also reported A.G.'s mother pulled the older RCW 74.13.515 off the bed by RCW 7 legs and took RCW 74.1 to a bar with no shoes or a jacket. A.G.'s grandmother reported she had court paperwork to attempt to obtain custody of the children. A.G.'s grandmother's primary language is Spanish so the DCYF intake worker taking her report utilized a Spanish language interpreter during their conversation. The

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

concerns reported by A.G.'s grandmother on March 23, 2024, did not meet screening criteria[3] to open a case as no allegation of child abuse or neglect was reported. The report was documented in Famlink[4].

The following day, on March 24, 2024, DCYF received a call from law enforcement reporting A.G.'s mother had called them and claimed RCW 74.13.520 The mother was instructed to take the children to the hospital and when she arrived there her story changed RCW 74.13.515 RCW 74.13.515 The mother was not able to give a reason why she believed the children RCW 74.13.515 other than the children were acting strange. The children were seen by a doctor and RCW 74.13.520 RCW 74.13.515 RCW 74.13.515 During the RCW 74.13.52 exam, A.G.'s older RCW 74.13.515 reported that the previous night RCW 74 mother dragged RCW 74.1 by RCW 74 neck down the stairs and RCW 7 had trouble breathing during the event. This report from law enforcement met screening criteria for a Family Assessment Response (FAR)[6] assessment case with a 72-hour response time. DCYF opened a case, and a FAR caseworker was assigned.

On the same date DCYF received a report from the RCW 74.13.52 exam nurse who reported further details of the incident where A.G.'s older RCW 74.13.515 was dragged by RCW 74 neck. The RCW 74.13.52 exam nurse also reported concerns about the mother's behavior. This report did not meet screening criteria for investigation or assessment as it contained duplicate information, but the report was documented in Famlink for information purposes.

Both reports received on March 24, 2024, indicated that neither A.G. or RCW 74.13.515 disclosed RCW 74.13.515 RCW 74.13.515 nor did the RCW 74.13.52 exam result in any findings of concern RCW 74.13.515

On March 26, 2024, DCYF received the written law enforcement report from the mother's call to them on March 24, 2024. The written law enforcement report had further details about two incidents that had never been reported to DCYF. There was report of an incident a few days prior to March 24, 2024, when A.G.'s older RCW 74.13.515 was reportedly dragged out of bed by RCW 74 mother and hit RCW 7 head. During the incident 911 was called and the fire department responded to the home. The written law enforcement report received by DCYF on March 26, 2024, also mentioned an incident on March 22, 2024, when law enforcement responded to an incident in a bar because A.G.'s mother had A.G.'s older RCW 74.13.515 walk to the bar with her without shoes which caused RCW 74.1 to suffer blisters on RCW 7 feet. The new information contained in the written law enforcement report met screening criteria for another FAR assessment with a 72-hour response time.

On March 27, 2024, the assigned DCYF caseworker contacted A.G.'s older RCW 74.13.515 at school and interviewed RCW 74.13 A.G.'s older RCW 74.13.515 was asked rapport building questions to begin RCW 7 interview. RCW 7 shared who lived in RCW 7 home as RCW 7 mom, RCW 74.13.515 A.G., RCW 74 grandparents, and RCW 7 uncle. A.G.'s older RCW 74.13.515 reported feeling safe at school and at home and said nobody had hurt RCW 74.1 or RCW 74.13.515 When asked, RCW 7 said RCW 7 did not

[3] The DCYF screening decision policy may be accessed at https://www.dcyf.wa.gov/practices-and-procedures/2200-intake-process-and-response.

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

[5] High-quality, specially trained nurses in hospitals that provide sexual assault evidence kit collection and compassionate care for sexual assault survivors.

[6] "Family Assessment Response (FAR) is a Child Protective Services (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 screened in for intervention." See: https://www.dcyf.wa.gov/practices-and-procedures/2332-child-protective-services-family-assessment-response

know any reason why anyone would be worried about RCW 74.1 at RCW 7 home. RCW 7 said RCW 7 liked when RCW 7 mom still worked and could buy things for RCW 74.1 and RCW 74.13.515 and RCW 7 wished RCW 7 mom, and RCW 7 uncle didn't argue so much. The caseworker met with the school counselor before they left the school, and the school counselor reported they had not had any concerns about A.G.'s RCW 74.13.515 or the family. The caseworker attempted to contact the mother, but she did not respond. The caseworker reached the maternal grandmother via text message and learned A.G.'s older RCW 74.13.515 was staying with her, but A.G. was with RCW 7 mother. A.G.'s grandmother told the caseworker she expected A.G. to be back with her the following day.

That evening the caseworker took a call from law enforcement after work hours and learned A.G. had been reported as missing. Law enforcement informed the caseworker A.G., and RCW 7 mother had spent the previous night with the mother of A.G.'s mother's ex-boyfriend. When that woman returned home from work on March 27, 2024, she found a significant amount of blood in her apartment and A.G. and RCW 7 mother were gone. She called the police to report her concern for A.G.'s well-being.

On March 27, 2024, DCYF intake also received a call from law enforcement to report that A.G. was reported as a missing child and the mother was in an inpatient mental health hospital stay in another county with blood on her clothing and shoes. A.G.'s older RCW 74.13.515 was still with the maternal grandparents, but A.G.'s whereabouts were unknown. The mother was reporting A.G. had fallen, and she had taken RCW 74.1 to the hospital. This report met criteria for a risk only[7] CPS investigation and the case switched from the Family Assessment Response pathway to CPS investigation.

On March 28, 2024, the caseworker communicated with law enforcement who was working throughout the day to locate A.G. The caseworker also worked on identifying A.G.'s father and finding the father's location. The father was identified and located in jail in another county. The caseworker also attempted to see A.G.'s older RCW 74.13.515 at the maternal grandparents' home, however nobody was home.

That evening the caseworker took another call from law enforcement after work hours and learned A.G.'s body had been discovered in an area where RCW 7 mother's phone had pinged.

On March 29, 2024, the medical examiner reported that A.G.'s body was discovered on March 28, 2024. The mother was arrested and charged with Murder 1 of A.G. She was accused of stabbing RCW 74.1 over 40 times and discarding RCW 7 body on the side of the road, wrapped in a blanket, and thrown over a fence.

The caseworker was able to verify through a court electronic case management system the maternal grandparents were granted guardianship of A.G. and RCW 7 older RCW 74.13.515 on March 27, 2024, the day A.G. was reported missing. RCW 74.13.515

Committee Discussion

The Committee appreciated their time meeting with the team who worked with A.G. and RCW 7 family. The Committee learned from the field staff who worked with A.G.'s family that the Investigation and FAR units in the office were experiencing a high-volume workload at the time A.G.'s case came in. The field staff reported to the Committee that the average goal for an Investigation or FAR caseworker in their office was to be

[7] 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

assigned eight to ten new cases per month, however the caseworker assigned to A.G.'s case was assigned around 15 cases in the month prior to A.G.'s case and those cases were still lingering on their caseload. Also, the month A.G.'s case was assigned to them, the caseworker was assigned 12 new cases. DCYF's current recommendation is 5, not more than 8 new cases per month, with a maximum of 12 open cases at any one time. A.G.'s case came at the end of two high-volume months for the caseworker. Additionally, the Committee learned that on the day A.G.'s case was assigned to the caseworker as well as the next few days, the caseworker was managing another intense case that was requiring much of their attention and time to prepare and file court paperwork. The caseworker shared with the Committee that when they have several months in a row of high caseload assignments as well as high demand cases with court involvement, it is hard to find enough hours in the day to meet the demands of every case on their caseload.

The Committee believed that given the information known at the time, the caseworker responded appropriately and within policy timeframes to see A.G.'s older [redacted] who was initially the only identified victim in the case. Although A.G. was not an identified victim in the case initially, the caseworker made efforts to see [redacted] right away and the Committee believed that was good practice. The Committee appreciated the collateral contacts the caseworker made in the three days the case was open to them prior to the critical incident. The Committee commended the caseworker and the office leadership for their teamwork with law enforcement after business hours on this case.

The Committee engaged in much discussion about the initial report from the grandmother on March 24, 2024, that did not meet screening criteria for a case to open. The Committee was concerned there may have been a language barrier in the way of getting enough detail during that call. The Committee was curious if there had been a worker who spoke Spanish available, instead of utilizing an interpreter to take the report from the grandmother if better details could have been gathered about how the mother was "acting crazy" or what her drug use looked like. The Committee also discussed the cultural component present for A.G.'s family. A member of the Committee mentioned that members of A.G.'s culture will often wait to seek the help of government structures in society until things are very bad and often there isn't a lot of comfort in navigating and/or trusting government systems. The Committee member noted this should be considered when taking reports from and working with relatives and families of this culture. Finally, the Committee was curious if the DCYF intake worker taking the call from the grandmother could have provided her with some community-based resources to help the family during their time of need as it was apparent the grandmother was in distress and needed help.

There was not a DCYF intake report screening expert on the Committee however two were consulted after the review and the Committee's discussion points were shared with them. The DCYF intake screening experts recognized that using interpreters can be a barrier to both the intake worker and the caller however they said there is no way to ensure DCYF intake calls from people who speak languages other than English can be routed to workers who speak their language so utilizing language line interpreters is necessary. The DCYF intake screening experts shared that intake workers across the state receive monthly trainings in topics such as cultural sensitivity, learning about working with different cultures represented in Washington State and the various community-based resources available across the state they can refer callers to. The DCYF intake

screening experts indicated DCYF intake workers are encouraged to share community-based resources with callers and 211[8] is a common referral which the Committee had mentioned in their discussion.

[8] Washington 211 provides the most current and comprehensive database of community resources in the State of Washington (over 30,000 listings), which serves as a central access point for connecting Washington residents to community resources. By simply dialing the number 211 people can connect to help when they need it regardless of who provides the services or where the services are located.