CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

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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

- M.T.J.

Date of Child's Birth

- September [redacted] 2016

Date of Fatality

- April 16, 2024

Child Fatality Review Date

- July 11, 2024

Committee Members

- Kate Walden, Thrive Services Manager, Cocoon House
- Ashley Mangum, MSW, LICSW, Director, Kids Mental Health Pierce County
- Cristina Limpens, MSW, Senior Ombud, Office of Family and Children's Ombuds
- Alissa Copeland, MA, Statewide FAR and FVS Program Manager, Department of Children, Youth, and Families
- Amy Boswell, MSW, Region 6 QA/CQI Area Administrator

Facilitator

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

Executive Summary

On July 11, 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 M.T.J. and RCW 74. family. The child, M.T.J., will be referenced by RCW 74. initials throughout this report.[2]

On April 12, 2024, DCYF was notified that seven-year-old M.T.J. arrived at a hospital with life threatening, non-accidental trauma injuries. RCW 74.1 was brought to the emergency department by RCW 74. maternal uncle and his partner. Resuscitation efforts were made at the hospital and M.T.J. was transferred to Harborview Medical Center. This resulted in a law enforcement investigation and a Child Protective Services (CPS) investigation. On April 16, M.T.J. died as a result of RCW 74. injuries.

At the time of this intake the family did not have an open case with DCYF. However, a Family Assessment Response (FAR) assessment had closed on June 20, 2023, and there were seven screened in intakes between 2015 and 2023. FAR is an alternative pathway within CPS for lower-risk allegations of maltreatment that are screened in for assessment. Screened in intakes are ones where the allegations of abuse or neglect meet legal sufficiency to open a CPS investigation or FAR assessment.

There were 12 screened out intakes during that same time period as well. M.T.J. and RCW 74.13.515 were placed in out-of-home care in March 2018 after their baby RCW 74.13.51 passed away and while an investigation regarding domestic violence (DV) was ongoing. The dependency case was dismissed in May 2021.

A CFR Committee was assembled to review DCYF's involvement and service provision to M.T.J. and RCW 74. 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 M.T.J or RCW 74. family. Before the review, the Committee received relevant case history from DCYF. On the day of the review, the Committee had the opportunity to interview the area administrator and CPS supervisor for the 2023 assessment period. The FAR caseworker from the 2023 case is no longer employed by DCYF and therefore was not present at the review meeting.

Case Overview

DCYF received six intakes between October 2015 and the death of M.T.J.'s then seven-month-old RCW 74.13.51 in 2018. Allegations included in those intakes included neglect, physical abuse, and exposure to DV. An intake in 2017 included lethal violence to include strangulation of the mother by one of the fathers and M.T.J. being hit by a 30lb suitcase thrown by the child's father. The father was arrested. The mother was pregnant during this investigation.

[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 near 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] M.T.J.'s name is not used in this report because RCW name is subject to privacy laws. See RCW 74.13.500.

Nine months later an intake was received stating the family recently moved back to Washington from Georgia. M.T.J.'s father was arrested for violation of a DV protection order from 2017. The family was unhoused and living in a park. Concern for the children was heightened due to all the children being born prematurely and having respiratory struggles. M.T.J. had significant gastrointestinal problems previously requiring medical intervention. Since returning to Washington, the father continued to be violent towards the mother with the children present. A friend of the mother's had to intervene at one point. And it was reported that the mother has physically assaulted the four-year-old child.

During the investigation in March 2018, the mother's seven-month-old RCW 74.13.515 died. The medical examiner's report stated the cause of death was Sudden Unexplained Infant Death with an undetermined manner of death due to external factors. Those external factors were that the infant died while bed sharing with two adults and two other children. The father was recently released from custody due to the violation of the DV protection order and they were together at the time of the infant's death. The protection order was still in effect. Dependency petitions were filed as to M.T.J. and RCW 74.13.515 in March 2018. The case was dismissed and closed in May 2021.

During the dependency case, the children were in out-of-home care and during a visit the mother absconded out of state with the children. When they were located and returned to Washington, the mother complied with court ordered services. The children were returned in October 2020 to the mother. She did not have a significant other and the children's fathers were not participating in the dependency action.

In May 2023, DCYF received allegations of neglect related to M.T.J. The allegations were that M.T.J. was coming to school in urine-soaked clothing. And that RCW 74. had recently regressed to using pull ups. The pull ups were also soaked with urine. The school said that the mother has not provided pull ups when M.T.J. showed up with none, and the mother did not come to the school when requested to do so. The mother reportedly said M.T.J. was "lazy" when asked about the regression to using pull ups. M.T.J. told school staff that RCW 74. saw blood in RCW 74. pull up. The information screened in for a CPS FAR assessment.

On May 12, 2023, the assigned caseworker went to the children's school and attempted to interview them. M.T.J.'s RCW 74.13.515 was not compliant with the interview. RCW 7 was unable to focus or sit still so RCW 7 interview did not last as long as the caseworker wanted it to. RCW 7 did say that RCW 7 liked RCW 7 teacher, RCW 7 was in third grade, RCW 7 likes living at home with RCW 7 mother and RCW 74.13.51 and RCW 7 shares a bedroom with RCW 74.13.515 RCW 7 said RCW 7 and RCW 7 RCW 74.13.51 have different fathers and RCW 7 does not speak with RCW 7 father because RCW 7 father stole $500 from their mother. RCW 7 said RCW 7 feels safe at home and enjoys eating noodles.

M.T.J. told the caseworker the blood in RCW 74. pull up was from a cut and that the cut still hurt. RCW 74.1 did not know how RCW 74. got the cut and that no one helps RCW 74. change RCW 74. "diaper." M.T.J. said RCW 74. uses pulls ups because RCW 74. does not try to use the toilet. RCW 74.1 said RCW 74. gets enough food at home, talked about RCW 74. parents and they discussed discipline. There were no concerning statements provided regarding RCW 74. parents or discipline.

The school told the caseworker that they did not have concerns with the children's attendance. No other details were documented regarding the interaction or discussion with school personnel.

The caseworker called the mother to discuss the allegations. The mother said she was not aware of the blood in RCW 74.13.515 pull up. The mother said they were moving from a shelter to a new home, it has been chaotic

and blamed the lack of changed pull ups, the mother uses the term diapers, on RCW 74.13.515 choosing not to change RCW 74.13.515

The mother explained that she did not arrive at the school in a timely manner because she worked an hour north of the school and by the time she got there RCW 74.13.515 would be at day care. The caseworker asked that M.T.J. have a medical evaluation as soon as possible. The mother agreed with the caseworker's request.

The caseworker provided the family with pull ups, storage totes, a set of bunkbeds, and gift cards to local stores for food and supplies.

Prior to the case closing the caseworker received text messages from the mother on May 26 and June 1, confirming that she received the items discussed above. The caseworker told the mother, via text, on June 1 that she was working to close the case. On June 2, the caseworker again texted the mother and asked about the medical appointment. The mother said it was on Monday June 5. On June 9 the caseworker texted the mother asking about the medical appointment. The mother said that on her next day off, she would ask the medical provider to send the information. The caseworker texted her again on June 12 and 13. On June 13, the mother said that the medical provider should have sent the information but that she will call them when she has a day off to facilitate the process again. The following day the caseworker asked for the medical provider's information. The mother said she would not provide that information because she does not want to disclose "all her information" and said that she signed a release of information. She said the caseworker needed to be patient and she was at work. The caseworker texted the mother again on June 16, but the mother did not respond.

The assessment was closed on June 20, 2023. At the time of the case closure the mother had not cooperated with providing information regarding any medical assessment for RCW 74.13.515

Committee Discussion

The Committee identified that the family may have benefited from more assessment and support regarding DV. They also discussed that DCYF child welfare staff would benefit from having a dedicated program manager for DV and that without that specialization it is difficult to provide specialized, detailed policies and updated trainings that are necessary for staff to conduct work in that area.

Related to this was the impact that DV had on the mother's ability to access services. The Committee member who specialized in DV discussed reading about, and experiencing in practice, that when the lethality indicators are extremely high (as they were in this case) many community service providers will not provide services for fear of the safety of other victims they are serving. The Committee also discussed that it takes time and patience to build relationships or even just establish enough rapport to help a survivor and understand the reasons why they may react in certain ways to differing circumstances. In this case the caseworker in 2023 documented the mother was angry but did not provide details as to what that looked like. The discussion between Committee members was around trauma informed contact knowing that this mother's trauma history was severe, she had a prior child welfare dependency, was struggling to provide basic needs, her children have significant developmental and behavioral needs, and that her anger may stem from all of those stressors and feeling overwhelmed.

The Committee acknowledged that in order to have the time to build those relationships child welfare units must be staffed. And that was not the case in 2023 when this case was open prior to the critical incident. They also discussed the nuances of safety planning on cases with survivors and what that can look like for child welfare caseworkers. Again, referencing that we need to have a program manager specific to DV to really drive that work.

The family had an unmet need regarding father engagement and assessment. The CPS supervisor acknowledged that after she read through the history, she identified this as an area that could be improved. She also mentioned that it may not have occurred because of the severity of violence historically and that contacting the fathers may have placed the mother and children in danger. Understanding the unique dynamics at play with serious lethality indicators in this case, it definitely puts that engagement and assessment at a more difficult level that would require assistance or guidance from a person with expertise within the DV field so that it does not place the mother and children at risk of harm.

The Committee asked the staff if they utilize Child Protection Teams (CPT)[3]. CPTs are a multi-disciplinary group of community professionals who provide services to abuse and neglected children or their families. They provide recommendations to DCYF child welfare staff to cases where there is a concern for the safety of children in their parent or guardian's care. The area administrator told the Committee that this specific region does not have a CPT.

As it pertains to this case, the Committee members discussed that prior to closure of the FAR case in 2023, it would have been appropriate to utilize a CPT. They believed that the risk of recurrence of maltreatment was incredibly high and the family dynamics were very challenging. Utilizing a forum such as a CPT affords DCYF staff differing perspectives from subject matter experts that may have been beneficial to the family. After the caseworker told the mother she was working to close the case, the mother did not effectively communicate with the caseworker. A large part of the assessment was not completed, the medical assessment, and the case was closed without that aspect. The pattern of neglect and risk of physical violence interacting with the high needs of the children created an increased level of risk at the time of case closure. The Committee understood why the case was closed but believes that utilizing CPTs would be a helpful process for both the families and DCYF staff.

The Committee and the DCYF staff discussed Safe Child Consultations (SCC). SCCs were created when HB 1227 was enacted.[4] SCCs occur when a DCYF caseworker has completed their safety assessment and there is imminent risk of physical harm that cannot be managed through a safety plan. The consultation is often internal DCYF staff, but some may include an Assistant Attorney General. The Committee discussed that there is not a policy specific to SCCs. They discussed that having a policy allows for DCYF staff and anyone in the community to access information about process. Having that access, or transparency, is beneficial to building trust and relationships.

When discussing the assessment of the 2023 intake, the Committee wanted there to be more urgency related to the medical care for this child. There were many flags for concern from prior involvement with this family, including significant violence. The case was closed without verification that the child received medical

[3] For information about Child Protection Teams, see: https://www.dcyf.wa.gov/1700-case-staffings/1740-child-protection-teams-cpt.

[4] For information about HB 1227, see: https://www.wacita.org/hb-1227-keeping-families-together-act/.

care/assessment and without discussing supports for the family surrounding the toileting and neglect identified in the referral. The Committee discussed that even though M.T.J. did not make a disclosure there were unanswered questions pertaining to origins of the blood in the pull up. They also considered whether there were barriers for the mother accessing medical care. Barriers such as transportation, insurance, fear of medical providers, etc. They discussed that having a conversation with the mother, especially knowing her history related to housing, transportation, economics struggles, may have been fruitful in rapport building and also getting the medical assessment completed.

The Committee was concerned that the history with DCYF was not fully appreciated during the 2023 case. Specifically, the mother's pattern of neglecting her children and concerns that were identified in the mother's psychological evaluation from the prior dependency case. The CPS supervisor said that regular practice for her staff would have been for the FAR caseworker to speak with the previous CFWS caseworker. If a conversation had occurred, it was not documented.

The Committee also discussed a case note prior to the 2023 FAR assessment. The case note identified that one of the children was two years of age during a contact. The caseworker identified that due to the child's age they could not be interviewed. The Committee discussed that a case note regarding assessment of that child should then include identifying development of the child, observations of the child and interactions with others in the home, collaterals to discuss the child such as medical or child care provider, etc. Also discussed was the access DCYF staff can have to tools such as Nursing Child Assessment Satellite Training and Parent-Child Interaction[5] can help caseworkers with assessing nonverbal children. The Committee discussed that this is an issue that has been seen statewide, not just specific to this case. This discussion caveat is that staff need to have workable caseloads and workloads, they need to have time to attend training which is a struggle for many offices.

The Committee appreciated the use of concrete goods to meet the mother and children's immediate needs. The Committee discussed providing concrete goods not only acknowledges that a caseworker has listened to or observed the needs of the family but is there to support the family as well conduct the investigation or assessment they are tasked with.

[5] For information about Nursing Child Assessment Satellite Training and Parent-Child Interaction services see: https://www.pcrprograms.org/our-story-continued/.