Supreme Court No. 100433-8

SUPREME COURT
OF THE STATE OF WASHINGTON

No. 55007-5

DIVISION II
OF THE STATE OF WASHINGTON

W.M., a minor, by ERIN OLSON, his Litigation Guardian ad Litem and JAMES MANEY,

Petitioners,

v.

STATE OF WASHINGTON,

Respondent.

ON APPEAL FROM CLARK COUNTY SUPERIOR COURT
Honorable Bernard F. Veljacic

PETITION FOR REVIEW

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TABLE OF CONTENTS

Page

TABLE OF CONTENTS

Page

TABLE OF CONTENTS

Page

APPENDICES

Page(s)

TABLE OF AUTHORITIES

Page(s)

16Washington Cases

Constitutional Provisions, Statutes and Court Rules

I. IDENTITY OF PETITIONERS

Petitioners are W.M., a minor represented by his Litigation Guardian ad Litem Erin Olson, and James Maney.

II. COURT OF APPEALS DECISION

Petitioners seek review of the published majority decision[1] terminating review filed by the Washington Court of Appeals, Division Two on November 2, 2021. A copy is appended hereto. Appendix 1-22.

III. ISSUES PRESENTED FOR REVIEW

1. If, while conducting an ongoing child abuse investigation, the Department of Social and Health Services returns a child to live in the home of a documented child abuser and then that child is physically abused, is the decision to return the child to the abuser's home a "harmful placement decision" as defined in *M.W. v. Dep't of Soc. & Health Servs*., 149 Wn.2d 589 (2003)?

[1] The Court of Appeals panel was split 2-1, with Judges Lee and Sutton signing the majority, and Judge Maxa filing a dissent.

2. On review of summary judgment, is the Court of Appeals permitted to weigh and reject expert testimony that was presented by the non-moving party, view the evidence and inferences therefrom in the light most favorable to the moving party, and then rule on causation as a matter of law?

IV. STATEMENT OF THE CASE

This case arises from the brutal abuse of Petitioner W.M. in the home where he was living. When he was two years old, he was savagely beaten by his mother's boyfriend. At the time he was beaten, W.M. had a loving father who was going through court proceedings trying to get W.M. placed with him. At the time he was beaten, W.M. had a GAL who was concerned that his mother was deceptive, was not watching out for his welfare, and was trying to replace W.M.'s father with her new boyfriend. And the time he was beaten, the Department of Social and Health Services (the Department) was investigating abuse of W.M.: poisoning with a drug used by addicts.

A. March 2017: The family is living in Tennessee; Lawson takes W.M. away from Maney and brings him across the country.

W.M. was born in 2015. He is the child of Katelyn Lawson and Petitioner James Maney. In March 2017, Lawson absconded with W.M from the couple's home in Tennessee to Washington. CP 926. She filed to dissolve the marriage in Washington, seeking primary residential placement of W.M. *Id*. Lawson was granted temporary primary residential placement on August 28, 2017. CP 119. She told the court she and W.M. were living with her parents in Washington. However, they were actually living, at least part time, with her boyfriend in Gresham, Oregon. CP 138, 140, 941, 981.

Maney was also trying to get primary residential placement of W.M. CP 981. He travelled from Tennessee to Washington to visit W.M. in August and October 2017. CP 927. Maney was scheduled to have his first extended time with W.M. in Tennessee at the end of December 2017. *Id.*

The court appointed a Guardian ad Litem (GAL) for W.M. to investigate the custody issue. CP 168. In October 2017, the GAL wrote a report that was highly critical of Lawson and recommended that the court place W.M. with Maney. CP 117-141. The GAL was concerned that Lawson did not think that W.M. needed to have a relationship with Maney, and that her new boyfriend was a suitable replacement parent. CP 137-138. The GAL noted that Lawson was taking W.M. to her boyfriend's house "a significant amount of time, including overnights…". CP 138.

On October 23, 2017, less than two months before W.M. was abused and permanently injured by Lawson's boyfriend at his home, W.M.'s GAL wrote the following statement:

> It is concerning to this writer that [Lawson] would not disclose where her new boyfriend lives, only stating "near Portland." ***It is concerning because she and the child often stay with the boyfriend and that she plans on moving in with him.***

CP 140.

B. December 9, 2017: Lawson and W.M. are living with her new boyfriend, a documented child abuser. W.M. is poisoned by ingesting an opiate used by drug addicts. The Department opens an abuse investigation.

On Saturday, December 9, 2017 at about 1:00 p.m., Lawson brought W.M. to the emergency room at Legacy Mt. Hood Hospital in Gresham, Oregon. CP 980. W.M. was poisoned by Suboxone, which is prescribed for adults with opioid dependence. *Id*. Lawson's boyfriend was an opioid addict taking the Suboxone to "control his addiction." CP 688. W.M.'s Suboxone ingestion was indicative of lack of supervision and a substance abuser living with W.M. CP 196, 211.

At the Mt. Hood hospital, Lawson lied hospital personnel including social worker Antoinette Teixeira. She claimed W.M. was poisoned at her *parents'* house in Ridgefield. CP 216. Teixeira questioned why Lawson had brought W.M. all the way to the Oregon hospital, rather than one near Ridgefield. CP 980. Lawson became "defensive," and her explanation was

"confusing and incongruent." CP 217. A nurse wrote she was "having difficulty following [Lawson's] storyline." CP 219.

Teixeira was instructed by the Oregon Child Abuse Hotline screener to call the Washington child abuse hotline, which she did. CP 491. Teixeira believed the Washington intake worker took minimal information; she was concerned the case would "fall through the cracks." CP 189.

W.M. was seriously ill and transferred to a children's hospital near Portland. CP 181. The case was screened by the Department under its policy for cases where the child is in "present or impending danger." CP 724. The Department's Child Protective Services (CPS) was required to have face-to-face contact with W.M. within 24 hours. CP 964. His case was assigned to investigator Kimberly Hartnagel. CP 212. Hartnagel's job was to investigate and make a safety plan for W.M. upon his release from the hospital. CP 213, 254. Hartnagel went to the hospital where W.M. was admitted. CP 255.

Contrary to what Lawson told Teixeira and other staff at Mt. Hood, Lawson admitted to Hartnagel that the poisoning occurred at her boyfriend's house in Oregon, and that the Suboxone was his. CP 256-257. Lawson also told Hartnagel she and her boyfriend had been dating about 6 months and there were baby gates for W.M. at his residence, indicating that (just as W.M.'s GAL had reported two months earlier, W.M. was spending significant time living there. CP 270.

Hartnagel documented the boyfriend's address but did not write down his name. CP 258. Despite becoming aware that the boyfriend had access to W.M., and W.M. was living at least part time at the boyfriend's residence, Hartnagel did not check the boyfriend's background. CP 264. Hartnagel also learned Lawson had drug issues: she had to provide urine samples "as well as nail follicles" to the court for drug testing purposes. CP 270.

Had Hartnagel called Oregon CPS or done a background check on Lawson's boyfriend, Samuel Rich, she would have

learned that Rich had a "founded" allegation of abusing his prior girlfriend's daughter. CP 311, 981.

Hartnagel also did not think it important to contact Maney, W.M.'s father. Lawson told Hartnagel that she was involved in a custody dispute with W.M.'s father. CP 270. However, Hartnagel did not even ask for Maney's name, let alone contact Maney, contravening CPS policy. CP 260-261. Hartnagel accepted Lawson's assurances that Lawson would let Maney know about W.M.'s hospitalization. *Id*.

Hartnagel also did not contact Teixeira, the Oregon hospital social worker who referred the case, despite this being standard procedure. CP 256. So Hartnagel did not learn from Teixeira that Lawson had given a vague, conflicting, and defensive story at Mt. Hood Hospital, and that her tale about the poisoning had changed materially, from occurring at Lawson's parents' house to occurring at her boyfriend's house. *Id.*

Hartnagel verified nothing in Lawson's account of the poisoning. CP 265. She did not check whether Lawson's

boyfriend Rich or Lawson's parents had any prior CPS history and did not do background checks on anyone involved.[2] CP 265.

Under the CPS Procedure for After Business Hours Responses, "After-hours workers are required to complete a Safety Assessment/Safety Plan in FamLink." CP 968. Hartnagel did not complete the assessment or plan. CP 980. W.M. was discharged from Randall on Sunday, December 10, and allowed to go home with Lawson with no safety plan in place. CP 678, 998.

Investigator Katie Palmquist continued Harnagel's investigation after W.M.'s release back to Lawson. But Palmquist did not uncover any of the critical facts Hartnagel initially missed. Despite the fact the poisoning occurred at Rich's house, and Lawson had indicated that W.M. was living at Rich's house at least part time, the investigator arranged to visit

[2] A background check would have revealed Rich's child abuse history and that Lawson's father was a Level 1 Registered Sex Offender. CP 688.

only Lawson's parents' house. CP 9-10, 495. She went to Lawson's parents' house three days after W.M. was poisoned. CP 317. Lawson was not there. CP 315, 495. Lawson's mother did not know the "full story" about Rich or the poisoning at Rich's house and told Palmquist that the story would "have to be gotten" from Lawson. CP 317. Palmquist took no further action to investigate the present and impending danger to W.M. CP 981.

C. Nine days after W.M. was poisoned and the CPS investigation was still ongoing, Lawson went to work while W.M. stayed home with abuser Rich. Rich beat W.M., causing him severe and permanent injuries.

On December 18, 2017, nine days after W.M.'s poisoning and eight days after the Department placed W.M. back with Lawson, Lawson went to work and left W.M. at home with Rich. CP 682, Appendix 11. Rich had savagely beat W.M., and did not take him to the hospital immediately. CP 981. When Lawson learned of the beating, she again brought W.M. to the emergency

department at Mt. Hood. *Id.* He was unresponsive, not breathing, and had no detectable pulse. *Id.*

W.M. was placed on life support and transferred to Randall Children's Hospital—the same hospital where he had been transferred nine days earlier. CP 679-682. He had abrasions on his back and shoulder blades. W.M. had a "skull abrasion," facial bruising, was red around his neck, and had bruising to the left side of his torso, as well as other bruising on his body. *Id.* He had bilateral brain bleeds and extensive brain swelling. *Id.* He was not expected to survive. *Id.*

As she had done with the poisoning just nine days earlier, Lawson tried to cover for Rich. She offered inconsistent accounts of the new injuries to W.M., including claiming that W.M. had fallen from a highchair or down the stairs. CP 680. Hospital staff immediately notified law enforcement. CP 981.

Unlike during the Department' prior investigation, CPS now made a phone call to the Oregon Child Abuse Hotline. *Id.*

It learned that Rich had a prior founded allegation for physical abuse of a previous girlfriend's two-year-old daughter. *Id.*

After this second, catastrophic abuse, CPS finally contacted W.M.'s father, Maney, on December 20. CP 928. He immediately flew from Tennessee to Portland to be at the hospital. *Id*. Maney's attorney moved for sole residential placement of W.M., which the court immediately granted. CP 345-347.

Rich was indicted for abusing W.M. CP 355-365.

D. In the suit against the Department, the trial court concludes that there is no issue of material fact and dismisses all claims as a matter of law.

W.M., through his litigation guardian ad litem Erin Olson, and Maney filed negligence and negligent investigation claims against the Department. CP 1-7. W.M. presented, *inter alia*, an expert who opined that had the Department's investigation not been negligent, the Department would have learned about Rich's prior abuse and, at the very least, imposed a safety plan to ensure that W.M. had no contact with Rich. Appendix 10-11. The

Department's own expert stated that safety plans are "voluntary," and that the idea that a non-negligent investigation would have prevented the beating was "pure speculation." *Id*. 11-12.

W.M. moved for partial summary judgment dismissal of the Department's affirmative defenses. CP 416. The Department moved for summary judgment on all of W.M.'s claims. CP 542. The trial court granted the Department's summary judgment motion. CP 1167.

W.M. timely appealed to Division Two. CP 1205. In a published opinion, the majority of a divided panel affirmed the trial court's ruling dismissing W.M.'s negligent investigation claim as a matter of law. Appendix 16, 18. First, the majority concluded that the Department had no duty to W.M., because it had not made a "harmful placement decision." Appendix 14-16. Second the majority concluded that as a matter of law, the Department did not proximately cause W.M.'s injuries because W.M.'s expert testimony on causation was "mere speculation." Appendix 16-18.

V. ARGUMENT WHY REVIEW SHOULD BE ACCEPTED

A. The Court of Appeals decision conflicts with this Court's decisions and other decisions from the Court of Appeals with respect to the duty analysis in negligent investigation claims.

1. Precedent holds that leaving a child in a home where the child is later abused is a harmful placement decision.

Twenty-one years ago, this Court recognized an implied cause of action against DSHS for negligent investigation of child abuse allegations under RCW 26.44.050. *Tyner v Dep't of Soc. & Health Servs.*, 141 Wn.2d 68, 79–81, 1 P.3d 1148 (2000).

Two years after *Tyner*, a plaintiff brought a negligent investigation claim alleging that during an abuse investigation, Department employees physically assaulted a child. *M.W. v. Dep't of Soc. & Health Servs.*, 110 Wn. App. 233, 39 P.3d 993 (2002), *rev'd*, 149 Wn.2d 589, 70 P.3d 954 (2003). The child allegedly suffered post-traumatic stress disorder after undergoing a vaginal examination by untrained DSHS workers investigating sexual abuse allegations. *Id.* at 235-236.

Our courts in *M.W.* were confronted with a negligent investigation claim alleging an unusual type of injury: assault *by* Department employees during a medical examination as opposed to abuse by a third party committed at home. The issue in *M.W.* was whether physical assault by Department staff the type of harm giving rise to a cause of action for negligent investigation?

The Court of Appeals in *M.W.* was divided. The dissent – the reasoning of which this Court adopted when it reversed the *M.W.* majority – surveyed prior case law and identified three categories of harm remediable by a negligent investigation claim:

> [N]egligently placing the child in a foster home in which the child is *later abused*; …failing to remove the child from a foster or parental home in which the child is *later abused*; and…negligently removing the child from a parental home in which the child properly belongs.

Id. at 247 (Morgan, J., dissenting) (emphasis added). Thus, according to Judge Morgan, a harmful placement decision in the context of the duty analysis is when the child is left in a home and is then "later" abused. *Id.*

On review, this Court agreed with Judge Morgan's analysis. *M.W. v. Dep't of Soc. & Health Servs.*, 149 Wn.2d 589, 594-597, 70 P.3d 954 (2003). It held the statutory duty in RCW 26.44.050 is to properly investigate suspected child abuse and neglect, and to prevent subsequent child abuse. *Id.*[3] Because a claim for negligent investigation arises from a statute specifically intended to protect children from injuries resulting from living with child abusers, the *M.W.* court held that negligent investigation claims were cognizable "only when DSHS conducts a biased or faulty investigation that leads to a harmful placement decision, such as placing the child in an abusive home, removing the child from a non-abusive home, or failing to remove a child from an abusive home." *Id.* at 591.

[3] Of course, Department employees are liable under the common law for assaults and other torts committed during investigations.

This Court's *M.W.* "harmful placement" analysis focused solely on deciding what *types of harms* are remediable in a suit for negligent investigation:

> Because a harmful placement decision is not the ***type of harm*** alleged … we hold [the child's] claim for negligent investigation fails and reverse the Court of Appeals.

Id. at 591 (emphasis added), 598, 602 (discussing "injuries" and "harms" the negligent investigation statute was meant to address).

Thus, under *M.W.*, physical child abuse at the home where the child is placed or returned during or after a negligent investigation is one of the "types of harm" that the negligent investigation cause of action was intended to remedy.

2. Contrary to precedent, the majority's decision holds that leaving a child in a home where he is later beaten is not a harmful placement decision unless the child was also beaten pre-placement.

The majority here disregarded precedent defining child abuse as the type of harm that gives rise to a cause of action for negligent investigation. They ruled that the Department did not

make a "harmful placement decision" as a matter of law. Appendix 14. The majority argues that because there is no evidence that Rich, a documented child abuser, had already beaten W.M. at the time the Department returned the child to his home, the placement decision was not harmful. *Id.*

As Judge Maxa so succinctly put the matter in his dissent: "*Of course* the State's placement decision was harmful to WM. This fact is undisputed. The State's placement decision resulted in Rich savagely beating WM and causing him permanent disabilities." Appendix 19 (emphasis in original). The Department conducted a negligent investigation and W.M. was placed back in a home with a documented child abuser, wherein he was in fact abused. This is a harmful placement decision as a matter of law.

The majority here appears to replace the concept of a "harmful" placement decision with the concept of an "incorrect" placement decision. In other words, according to the majority decision, if the Department had no evidence that the child had

already been physically abused[4] then returning him to Lawson and Rich's home unprotected was not "harmful".

It is indisputable that the Department's placement decision was harmful according to M.W. If the evidentiary record supports it, the Department can argue to the jury that its investigation was not negligent, that the decision to release W.M. to Lawson unconditionally was correct, that it continued to properly investigate after his placement, and that Rich inevitably still would have beaten W.M.[5] But the Department made a "harmful placement decision" here as a matter of law, because it

[4] Apparently, the majority did not believe that leaving W.M. alone with a drug addict and child abuser and neglecting him to the point that he was poisoned with an opioid constituted "abuse." This error is discussed *infra*.

[5] The majority's sole focus on the decision to unconditionally release W.M. back to Lawson on December 20 is too narrow. The Department's investigation continued. It could have contacted Maney, Teixiera, W.M.'s GAL, or gathered other information that could have saved W.M. during the eight-day span between the release and the final abuse.

is undisputed that he was left in his mother's home by the Department and was then abused.

3. The Court of Appeals decision conflicts with decisions of this Court and the Court of Appeals because it concludes that negligent treatment or maltreatment of a child is not child abuse.

The majority's erroneous decision that there was no harmful placement decision here was based partly on an incorrect conclusion: that the Suboxone poisoning did not constitute abuse. Appendix 15. The decision states:

> At the time that W.M. left the hospital ***there was no evidence that any abuse had occurred in either Katelyn's or Rich's homes***.

Id. (emphasis added).

Negligent treatment or maltreatment, including child neglect that results in poisoning by an opiate, *is* child abuse. RCW 26.44.020(1); *Petcu v. State*, 121 Wn. App. 36, 58, 86 P.3d 1234 (2004). According to the Legislature, a child is "abused" when that child has suffered either intentional physical abuse *or* negligent treatment:

> ”Abuse or neglect” means…the negligent treatment or maltreatment of a child by a person responsible for or providing care to the child. ***An abused child is a child who has been subjected to child abuse or neglect as defined in this section.***

RCW 26.44.020(1) (emphasis added). This is essentially the same definition in effect in 2003, when *M.W.* was decided.[6]

In *Petcu*, the Court of Appeals acknowledged the Legislature's definition of "child abuse" that encompasses both abuse and neglect. Citing *M.W.*, this Court used the term "child abuse" to refer to allegations of abuse *and* neglect made to the Department under RCW 26.44.050. In footnote 4, the *Petcu* Court defined the term "child abuse" as "abuse or neglect" citing RCW 26.44.050. *Petcu*, 121 Wn. App. at 58 n.4. Because the Department has a duty to investigate both abuse *and* neglect, and because a child who has been subjected to neglect is an "abused child", then "an abusive home" encompasses both intentional physical abuse and negligent treatment or neglect.

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[6] See former RCW 26.44.020 (2000).

The majority is incorrect: W.M. was indisputably abused before the Department placed W.M. back with Lawson and Rich. The Department itself found that the Suboxone poisoning constituted negligent treatment or maltreatment of W.M., which is "abuse." CP 979, Appendix B1.

Also, the majority ignores that Larson also abused W.M. before the placement decision by allowing him to live with child abuser Rich, and by leaving him alone with Rich. WAC 388-15-009(5)(b) (negligent treatment or maltreatment includes "[a]ctions, failures to act, or omissions that result in injury to or which create a substantial risk of injury to the physical, emotional, and/or cognitive development of a child").

The majority grossly erred in concluding that W.M. was not abused prior to the Department's placement decision. It is indisputable that he was. In fact, the Department's mishandling of that very abuse investigation caused W.M. to be placed back in the home of a documented child abuser, where he was then horrifically beaten.

4. Contrary to this Court's precedent, the majority reached its "harmful placement" ruling by improperly viewing the facts in the light most favorable to the Department.

It is black letter law that courts considering summary judgment construe the facts in the light most favorable to the non-moving party. *Babcock v. State*, 116 Wn.2d 596, 599, 809 P.2d 143 (1991). In fact, in *Babcock*, this Court reversed its own prior opinion in the same matter after it recognized that it had erroneously viewed the facts in the moving party's (the Department's) favor:

> [T]he plurality's previous opinion erroneously construed at least one disputed fact in favor of the State as the moving party. …The plurality's previous opinion also erroneously presented the undisputed facts in the light most favorable to the State as moving party instead of in the light most favorable to the nonmoving party as required by our case law. …All of these errors are corrected in this opinion.

Babcock, 116 Wn.2d at 599 (internal citations omitted).

However, the majority violated this precept here. Part of the majority's rationale here for ruling in the Department's favor

was the factual finding: that the Department did not "place" W.M. in Rich's home. Appendix 15. The decision states that the Department placed W.M. at Lawson's parents' home. *Id.* This finding is an improper factual inference drawn in the Department's favor, rather than W.M.'s favor as summary judgment review demands.

In fact, viewing the facts in the light most favorable to W.M, the Department did not place him at Lawson's parents' home. The Department allowed Lawson to take W.M. away from the hospital, and took Lawson at her word that she was living with her parents. The Department's negligent investigation did not pursue significant evidence that Lawson was lying about living with her parents, and was actually living

with Rich.[7] Given Lawson's established history of deception about whether she was living with Rich and the many other indications regarding their living arrangements, by placing W.M. with Lawson, the Department placed W.M. in Rich's home.

Viewing the facts in the light most favorable to W.M., the Department placed W.M. with Rich as a result of its negligent investigation.

B. Contrary to precedent, the majority's decision weighed and discarded expert testimony on causation, and impermissibly resolved a factual dispute in favor of the Department on summary judgment.

1. Appellate courts do not weigh evidence. The majority did so here.

A close corollary to the rule that the facts must be viewed in the light most favorable to the non-moving party is the rule

[7] Among those clues included: (1) W.M. was poisoned at Rich's home; (2) Lawson repeatedly lied about her living circumstances, including initially lying that the poisoning occurred at her parents' house; (3) W.M.'s GAL concluded two months prior that Lawson was lying about her living circumstances because she did not want the courts or Maney to know she was moving in with Rich; (4) Lawson told the Department that Rich's house had baby gates for W.M.

that our appellate courts do not weigh evidence and do not find facts. *Thorndike v. Hesperian Orchards, Inc*., 54 Wn.2d 570, 575, 343 P.2d 183 (1959); *Quinn v. Cherry Lane Auto Plaza, Inc*., 153 Wn. App. 710, 717, 225 P.3d 266 (2009). They do not substitute their judgment for that of the trier of fact. *Hesperian,* 54 Wn.2d at 575.

Here, in its section ruling on proximate cause as a matter of law, the majority weighed evidence. Appendix 16-17. It rejected W.M.'s expert opinion on causation and accepted the Department's expert opinion. *Id.* In particular, the majority agreed with the Department's expert who stated that W.M.'s expert causation opinion was "speculation." *Id.*

Judge Maxa's dissent explains the difference between mere speculation and a reasonable inference that can be drawn from the evidence:

> The majority states that even if the State had directed WM's mother not to allow Rich to have contact with WM, she would have ignored that directive. But this is an inference – no evidence supports that statement. And the majority is viewing

> that inference in favor of the State. *Viewed in the light most favorable to WM*, a reasonable inference is that WM's mother would have followed such a directive and WM would not have been injured.

Appendix 19.

The majority goes astray by criticizing as merely "hypothetical" W.M.'s expert opinion that a non-negligent investigation could have prevented W.M.'s injures. Appendix 17. This ignores reality: *every* negligent investigation causation inquiry, by its very nature, requires the factfinder to hypothesize about a counter-factual: what would have happened had the investigation been non-negligent? Would the plaintiff have been injured, or not?

By the majority's logic, both experts asserted a "hypothetical". The Department's expert "hypothesized" that even if the Department had properly investigated, nothing would have changed, and Rich still would have beaten W.M. W.M's expert "hypothesized" that he would not have. This is a fact issue for a jury, not an appellate court.

2. The majority's decision here directly conflicts with the Court of Appeals decision in *Albertson v. State*[8].

Only six years ago, the Court of Appeals issued an opinion that is completely contrary to the majority's proximate cause ruling here. *Albertson v. State*, 191 Wn. App. 284, 302-303, 361 P.3d 808 (2015). It held expert testimony opining that a safety plan would have prevented catastrophic physical child abuse created a fact issue for the jury:

> Catherine Cruikshank testified on behalf of ARB that DSHS's *failure to complete an adequate safety plan and to follow up with the family caused ARB's injuries*. Barbara Bailey testified on behalf of DSHS and stated that even if Lofgren had sought additional information that ARB argued Lofgren should have sought in her investigation, that additional information would not have been sufficient for DSHS to file a dependency action.
>
> Taken in the light most favorable to ARB, the nonmoving party, Cruikshank's and Bailey's conflicting testimony created an issue of fact on causation for the jury.

Id.

[8] *Albertson v. State*, 191 Wn. App. 284, 361 P.3d 808 (2015).

There is absolutely no daylight between the facts on this point in *Albertson* and here. The majority's proximate cause ruling directly conflicts with that decision.

C. The majority's decision raises issues of substantial public interest under RAP 13.4(b)(4).

The protection of children from abuse is of paramount importance to the citizens of Washington. The Department's Child Protective Services agency exists for *no other purpose* than to protect children like W.M., who was two years old when he was beaten, from abuse and neglect. It cannot fulfill its duty to protect children unless it *carefully* investigates reports of potential abuse and neglect. RCW 26.44.050. The Legislature has proclaimed the Department's vital role in no uncertain terms:

> [I]n the instance where a child is deprived of his or her right to conditions of minimal nurture, health, and safety, the state is justified in emergency intervention based upon verified information; and therefore the Washington state legislature hereby provides for the reporting of such cases to the appropriate public authorities. *It is the intent of the legislature that, as a result of such reports, protective services shall be made available in an*

> *effort to prevent further abuses, and to safeguard the general welfare of such children*.

RCW 26.44.010 (emphasis added).

The Department is charged with protecting the most vulnerable population in this state: abused and neglected children. It must carry out those duties non-negligently in accordance with its statutory mandates. When it fails to do so, and children are injured or killed, accountability is of intense public interest to all in Washington State.

The Court of Appeals decision undermines this important public policy and protects the Department from accountability for its own inadequate investigations. If an initial abuse investigation substantiates negligent treatment, but negligently fails to uncover an immediate threat of further abuse to the child, then under the majority's decision when the child is harmed the Department has not made a "harmful placement decision" as a matter of law.

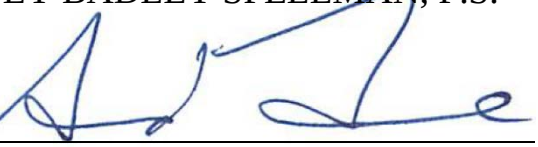
VI. CONCLUSION

The majority's decision represents a departure from established precedent and threat to the safety of children whom the Department is mandated to protect. This Court should take review.

This document contains 4988 words, excluding the parts of the document exempted from the word count by RAP 18.17.

Respectfully submitted this 2nd day of December, 2021.

CARNEY BADLEY SPELLMAN, P.S.

B y */s/* 
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CERTIFICATE OF SERVICE

The undersigned certifies under penalty of perjury under the laws of the State of Washington that I am an employee at Carney Badley Spellman, P.S., over the age of 18 years, not a party to nor interested in the above-entitled action, and competent to be a witness herein. On the date stated below, I caused to be served a true and correct copy of the foregoing document on the below-listed attorney(s) of record by the method(s) noted:

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DATED this 2nd day of December, 2021.

S:/ Patti Saiden
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Filed
Washington State
Court of Appeals
Division Two

November 2, 2021

IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON

DIVISION II

W.M., a minor, by ERIN OLSON, his Litigation Guardian ad Litem and JAMES MANEY, Appellants, v. STATE OF WASHINGTON, Respondent.	No. 55007-5-II PUBLISHED OPINION

LEE, C.J.—W.M.,[1] through his litigation guardian ad litem (GAL) Erin Olson, and his father James[2] sued the State for the negligent investigation of a child abuse report involving two-year-old W.M. Olson appeals the trial court's grant of summary judgment in favor of the State. We hold that the superior court properly granted summary judgment in favor of the State and affirm.

FACTS

A. INCIDENT BACKGROUND

James and Katelyn, W.M.'s mother, were married from 2015 to 2017. W.M. was born in July 2015 in Longview. James and Katelyn moved to Tennessee in 2016. In 2017, Katelyn left James and returned to Washington with W.M. Katelyn then filed a dissolution action in

[1] We use W.M.'s initials to protect his privacy. Because identification of close family members could lead to the identity of W.M., we also refer to those adults by their first names. We intend no disrespect.

[2] For ease of reference, we refer to the appellants collectively as Olson. We will use W.M. and James when we refer to them in their individual capacities.

Washington. The Cowlitz County superior court entered a temporary parenting plan giving Katelyn primary residential custody of W.M. The temporary parenting plan allowed James visitation with W.M. when James was in the local area.

On December 9, 2017, Katelyn brought W.M. to the emergency room at Legacy Mount Hood Medical Center (LMHMC) in Gresham, Oregon because he had ingested Suboxone.[3] Antoinette Teixeira, a hospital social worker, contacted Oregon Child Protective Services to report the Suboxone ingestion. Because Katelyn claimed that the ingestion occurred at her parents' home in Washington, Teixeira also called Washington Child Protective Services (CPS)[4] to report the Suboxone ingestion.

W.M. was transferred to Legacy Randall Children's Hospital in Portland, Oregon. On December 9, Kimberly Hartnagel, a CPS after-hours investigator, met with Katelyn and W.M. at Randall Children's Hospital. Hartnagel did not document any concerns about Katelyn's appropriateness with or attentiveness towards W.M. W.M. was scheduled to be discharged from the hospital on December 10.

Eight days later, on December 18, Katelyn and her boyfriend, Samuel Rich, brought W.M. to the emergency department at LMHMC again. W.M. was unresponsive, was not breathing, had no pulse, and was cold to the touch. W.M. had multiple abrasions, contusions and bruises; doctors also determined that W.M. had bleeding and swelling in his brain. Katelyn gave different explanations for how W.M.'s injuries occurred.

[3] Suboxone is a prescription drug used to treat pain as well as drug addiction.

[4] At the time of CPS's investigation, CPS was a subdivision of the Department of Social and Health Services (DSHS).

W.M. was transferred from LMHMC to Emanuel Hospital in Portland, Oregon. A law enforcement officer from Gresham Police Department met with Katelyn at Emanuel Hospital.

Katelyn initially told law enforcement officer that she was walking with W.M. at the time of the incident, but Katelyn's mother, Sally, interrupted Katelyn and told her to tell the truth. Katelyn then told the officer that she was at work when Rich called her to tell her that W.M. had fallen out of his high chair. When the officer asked Katelyn why she did not call 911, she explained that the hospital was right around the corner. When the officer asked Katelyn why Rich did not call 911, she stated that he did not know to do that because he did not have kids.

The officer then interviewed Rich. Rich told the officer that WM was playing with the dog on the stairs, fell four to five steps, and landed on tile. Multnomah County Sheriff's Office detectives then took over the investigation because of where the injury occurred.

On December 19, Detective Kate Lazzini of the Multnomah County Sheriff's Office conducted a recorded interview with Katelyn regarding W.M.'s injuries. Katelyn stated that she got off work around 5:00 PM and was driving to Rich's when he called her to tell her that she needed to get home right away because W.M. had fallen and was unconscious. Katelyn said that she asked Rich how severe W.M.'s injuries were and whether they needed to call 911. Rich told Katelyn that he was not sure about the extent of W.M.'s injuries and that he was trying to wake WM up by splashing water on him. When Katelyn arrived at Rich's house, she explained that she took a couple of minutes to assess the situation to decide if they needed to take W.M. to the hospital.[5]

[5] As a result of the incident involving W.M., an Oregon grand jury indicted Rich with first degree assault and multiple counts of first degree criminal mistreatment and third degree assault.

As a result of the assault, W.M. suffered severe, permanent brain damage. W.M. requires constant care for all daily activities.

B. WA CPS INVESTIGATION

1. Initial CPS Investigation into Suboxone Ingestion

The initial report of W.M.'s Suboxone ingestion came into CPS intake on a Saturday, which was after normal business hours. An intake report was created based on Teixeira's report to CPS on December 9, 2017. The intake report included Katelyn's original report that the Suboxone ingestion occurred at her home in Washington and she did not know how W.M. ingested the Suboxone. The intake also noted that there was no prior history in the CPS "Famlink" system.

Intake contacted the after-hours supervisor to staff the intake because W.M. had ingested Suboxone, which placed him in present or impending danger. The after-hours supervisor assigned the intake to Hartnagel.

Suboxone ingestion raises concerns for lack of supervision as well as concerns about potential drug abuse. Therefore, under CPS policy, Hartnagel was required to make an attempt to see the child within 24 hours.

When Hartnagel received the intake for W.M., she went to the hospital and spoke with the registered nurse who was caring for W.M. Hartnagel also interviewed Katelyn at the hospital.

Katelyn told Hartnagel that W.M. ingested the Suboxone while they were at her boyfriend's house. Hartnagel could not recall if she specifically asked Katelyn for her boyfriend's name. In her deposition, Hartnagel explained that the information would be important if CPS determined a background check was necessary. She said the agency might request a background check if the

boyfriend lived in the home, was present during the reported incident, or had a lot of access to the child.

Hartnagel stated that it would be her normal response to try to contact the biological father and tell him the child was in the hospital. Hartnagel did not follow up on contacting James because she believed it was appropriate for the assigned social worker to do that as part of the follow-up investigation.

Hartnagel's report states medical staff did not report any concerns regarding Katelyn and she has been appropriate with the child. Medical staff also reported that the child was doing well and would likely be discharged the next day, December 10. Hartnagel observed Katelyn interact with W.M., and Katelyn was appropriately concerned and attentive.

Katelyn explained to Hartnagel that W.M. ingested the Suboxone while they were at her boyfriend's house, where Katelyn had been intending to surprise her boyfriend by putting up Christmas decorations while her boyfriend was at work. Katelyn said her boyfriend was not at the home when the Suboxone ingestion occurred. Katelyn reported that there were baby gates at her house and at her boyfriend's house. Katelyn also told Hartnagel that she did not have contact information for James, but she would have her attorney inform his attorney about the Suboxone ingestion on Monday. Hartnagel informed Katelyn that another social worker would be assigned to conduct a follow-up investigation, and Katelyn provided her contact information. After Hartnagel's interview with Katelyn, the hospital discharged W.M. to Katelyn's care.

Katie Palmquist was assigned to continue the CPS investigation. On December 11, Palmquist contacted Katelyn to arrange to visit W.M. in the home. Katelyn told Palmquist that Sally watched W.M. during the day while she was at work and provided Sally's contact

information for Palmquist to arrange the home visit. Palmquist arranged to visit Sally at her home on December 13.

During the home visit, Palmquist observed that W.M. acted as a typical two year old. The home was clean and had several baby gates and safety locks. Sally told Palmquist that she did not have any concerns regarding Katelyn's care of W.M. Sally identified Rich as Katelyn's boyfriend and stated she had been to his house and did not think that it was unsafe. Sally believed the Suboxone ingestion was a one-time incident, and she did not believe anything like it would happen again. Sally agreed to call CPS if she had any concerns about Katelyn caring for W.M.

In her deposition, Palmquist explained that initial face-to-face contact with the child was required to occur within 24 or 72 hours, depending on the type of referral. CPS had 60 days to complete remaining aspects of the investigation.

2. Investigation Following December 18 Hospitalization

When CPS was informed of W.M.'s December 18 hospitalization, and the possibility that he was seriously harmed by Rich, Jennifer Gorder of CPS contacted Oregon Child Welfare. Oregon Child Welfare confirmed that they had an open intake regarding W.M. Oregon Child Welfare also informed Gorder that Rich had a founded investigation for harming his ex-girlfriend's toddler about six years ago. Gorder recorded the contact with Oregon CPS:

> Samuel Rich has a prior FOUNDED for physical abuse against his former girlfriend's child. Girlfriend is [redacted]. Child was too young to disclose but presented with injuries to the child's face and legs that were consistent with physical abuse. An older child, sibling, disclosed seeing the abuse.

Clerk's Papers (CP) at 343. Gorder stated that if CPS had known of the Oregon founded determination, they would have been concerned and addressed that with Katelyn. Initially, they

would have had a conversation about it with Katelyn and then decided how to proceed based on her response.

On December 20, Palmquist contacted James. James told Palmquist that he had been in contact with Katelyn's father, who said that W.M. fell down the stairs but was doing better. Palmquist informed James that CPS believed W.M.'s injuries were caused by abuse and recommended James come to the hospital as soon as possible.

James also told Palmquist about his concerns about Katelyn. James told Palmquist that there was an ongoing custody case regarding W.M. and that the GAL in the dissolution proceeding had recommended that he have full custody of W.M. He also told Palmquist that the dissolution GAL did not know about Rich until Rich dropped W.M. off at a custody exchange.

Katelyn continued to defend Rich after W.M. was hospitalized. Notes from W.M.'s medical records show that Katelyn did not believe Rich intentionally harmed W.M. Palmquist received a report from the hospital team which she recorded as follows:

> Investigator Palmquist rtcf Amanda from CARES team. She said that she and Dr. McCraig talked with [Katelyn] and [Maternal Grandmother (MGM)] Sally and presented all of the medical information and concerns that they had about [W.M.'s] injuries being caused by abuse. [Katelyn] became very defensive and angry and said that no one knows [Rich] like she does and why isn't anyone concerned about how he is feeling guilty about being home when [W.M.] fell? MGM Sally stepped in and told [Katelyn] that they are trying to tell her that someone hurt [W.M.] and that his medical care was postponed which most likely caused more injury to him, and [Katelyn] started yelling at MGM Sally. MGM shut down and did not talk anymore. Amanda let this investigator know that she talked to the detectives after this and [Katelyn] had already texted Mr. Rich to let him know that [Law Enforcement (LE)] thought he did this while LE was there questioning him.

CP at 339. Katelyn refused to further cooperate with CPS's investigation.

C. INFORMATION FROM DISSOLUTION PROCEEDINGS

Katelyn had filed a petition for dissolution of her marriage with James in March 2017. Katelyn included a request for a restraining order against James in her petition for dissolution. The temporary parenting plan restricted both parents from using marijuana and required them to submit to drug testing. The Cowlitz County Superior Court appointed a GAL in the dissolution.

The GAL submitted her report on October 23, 2017. The GAL recommended that James become W.M.'s primary parent and be granted sole decision-making authority for W.M. Both Katelyn and James made accusations of domestic violence against the other. Based on the investigation, the GAL opined that Katelyn had perpetrated domestic violence against James.

The GAL expressed concerns about Katelyn's stability and W.M.'s well-being. The GAL noted that Katelyn had just moved W.M. from Tennessee to Washington and planned to move to her boyfriend's home as soon as "she 'figures out' how she can do this through the courts." CP at 138. The GAL stated, "None of the mother's moves are geared toward the child, her independence or long-term stability for either of them." CP at 135. In addition, the GAL determined that Katelyn had "little regard to the emotional needs and developmental level of" W.M. because she saw no reason for W.M. to continue a relationship with James, her interference in James' relationship with W.M., and the sudden introduction of her boyfriend as a replacement parental figure for W.M. CP at 136.

The GAL further expressed concerns about Katelyn's dishonesty, especially regarding her living situation. The GAL noted that Katelyn and W.M. spent overnights at her boyfriend's house and that W.M. had his own bedroom there. The GAL concluded, "It appears that even though she professes to be living in Washington, and just hoping to move to Oregon, that she spends a

significant amount of time in Oregon." CP at 138. Further, Katelyn refused to disclose where her boyfriend lived, only telling the GAL that he lived near Portland. The GAL also noted difficulty in following Katelyn's time line of specific events in the case.

D. SUMMARY JUDGMENT

Olson filed a complaint against the State[6] for W.M.'s injuries, claiming CPS was negligent and conducted a negligent investigation.[7] The State filed a motion for summary judgment on Olson's claims.

In addition to pleadings establishing the facts as stated above, Olson presented depositions and declarations from expert witness, Barbara Stone. Stone opined that CPS did not meet the standard of care during the investigation into the Suboxone ingestion. Stone's deposition included the following exchange,

> Q. . . . Do you have an opinion on whether or not [W.M.] should have been removed from Katelyn . . . at the point of the December 9th, 2017 intake?
> **A. No. My opinion is, based on—that they needed to do the safety plan which was involved in an assessment of all the adults that was around [W.M.] and then make that decision based on the best information that they had.**

CP at 456. Stone recognized that the investigation remained open after Palmquist's home visit was completed.

[6] The complaint lists DSHS as an agency of the State.

[7] Although Olson filed a general negligence claim, the record shows that Olson conflated the general negligence claim with the negligent investigation claim and only pursued a negligent investigation claim.

In a declaration, Stone opined that Hartnagel's primary responsibility was to ensure W.M.'s safety. Further, Stone opined the Hartnagel was required to involve both parents in the investigation. And Stone opined:

> 6. Ms. [Hartnagel] obtained information that the Suboxone poisoning occurred at [Katelyn's] boyfriend's home in Gresham, OR. [Katelyn] was clearly spending time with WM at her boyfriend's, as she was putting up Christmas decorations and reported his house had baby gates. It was incumbent on Hartnagel to get his identity and check his background. CPS workers routinely share information from child abuse registries with workers from other states, because parents moving from one state to another is commonplace. A phone call to Oregon would have revealed Sam Rich's founded child abuse incident against a girlfriend's two-year-old child.

CP at 941. Stone also asserted that CPS should have contacted Teixeira directly and such contact would have revealed Katelyn's inconsistent stories regarding the Suboxone ingestion. Stone ultimately concluded:

> CPS had 60 days to investigate and determine whether the report of abuse/neglect against [Katelyn] was founded. During the entire time, WM's safety was supposed to be the first priority. The considerations are supposed to be embodied in a "Safety Plan." Such a plan does not necessarily or even frequently involve removal from the parent's custody. However, given what CPS should have known about [Katelyn] and Sam Rich, a safety plan would undoubtedly have included no contact with Sam Rich.

CP at 942. Stone also opined that, on the day of the Suboxone poisoning, CPS should have identified Rich as a threat to W.M. and required an agreement from Katelyn and her parents that W.M. would not go to Rich's home or be alone with Rich. In a supplemental declaration, Stone further explained:

> In this case, had Hartnagel or Palmquist taken the proper steps, they would have met with [Katelyn], confronted her with issues regarding her conflicting stories, the substance abuse concerns, and the child abuse history of Sam Rich. A safety plan would have included keeping WM away from Sam Rich. Given [Katelyn] was living with her parents and they were caregivers for WM, a meeting should have

> included [Katelyn]'s parents. This was the responsibility of the Department, separate from whatever action James . . . took in the custody case. Had the investigator met with [Katelyn] and determined she was not protective, and her parents would not ensure compliance, WM could have been removed and a dependency petition filed.

CP at 1099.

The State presented declarations from their own expert witness, Maria Scannapieco. Scannapieco summarized her opinion in a declaration:

> This is an unfortunate case involving a two-year old boy who sustained brutal injuries while in the care of Sam Rich, the boyfriend of W.M.'s biological mother, Katelyn . . . . This incident occurred just nine days after the State of Washington (State) investigated an unrelated incident in which W.M. accidentally ingested Suboxone. One of the questions I was asked to review and address is whether the State's investigation conformed with accepted standards of practice for social workers. Although the State had not completed its investigation at the time Sam Rich physically abused W.M., its investigation of the incident involving the accidental ingestion of suboxone conformed with accepted standards of social work practice. Further, it is abundantly clear the State acted with substantial care in its investigation of this incident.

CP at 493-94. Scannapieco recognized that CPS could have learned that Rich "had a prior founded finding of physical abuse concerning two young girls from six years earlier." CP at 496. However, Scannapieco opined that this additional information would not have been sufficient to remove W.M. from Katelyn's care. Scannapieco opined:

> At most, the State could have asked Katelyn . . . to enter into a voluntary safety plan. However, such a plan would have been, by definition, voluntary. It could not have been enforced in a court of law, and would not have served as a bar to Katelyn . . . allowing W.M. to stay with Sam Rich while she was at work on December 18, 2017. Thus, even if the State had gathered the additional information that we now know existed prior to December 18, 2017, no action could have been taken by the State to prevent W.M. from the physical abuse he suffered.

CP at 496. In her deposition, Scannapieco opined that prior to December 18, CPS had no basis for removing W.M. from Katelyn's home. Scannapieco also explained:

> Further, as there were no allegations or evidence that Mr. Rich ever abused or neglected WM in any way prior to December 18, 2017, even if [Katelyn] allowed contact between WM and Rich, that would not automatically or necessarily have justified the removal of WM from his mother's custody or the filing of a dependency petition. Rather, such information would have been folded into and considered along with all other known information at that time. Then a reasonably prudent social worker would conduct a new assessment to determine whether WM was, at that time, at risk of imminent harm. Again, what result would come from such a hypothetical assessment is pure speculation.

CP at 1142-43.

D. SUPERIOR COURT RULINGS

The superior court granted the State's motion for summary judgment and dismissed Olson's complaint. Olson filed a motion for reconsideration supported by an additional declaration from Stone. The superior court denied Olson's motion for reconsideration.

Olson appeals.

ANALYSIS

Olson argues that questions of fact exist whether the State's negligent investigation resulted in a harmful placement decision and was a proximate cause of W.M.'s injuries. We disagree.

A. STANDARD OF REVIEW

We review summary judgment orders de novo. *Desmet v. State by and through Dep't of Soc. and Health Servs.*, 17 Wn. App. 2d 300, 307, 485 P.3d 356 (2021). Summary judgment is appropriate if there are no genuine issues of material fact and the moving party is entitled to judgment as a matter of law. *Id.*; CR 56(c). A genuine issue of material fact exists if reasonable minds could disagree on the conclusion of a factual issue. *Sartin v. Estate of McPike*, 15 Wn. App. 2d 163, 172, 475 P.3d 522 (2020), *review denied*, 196 Wn.2d 1046 (2021). We review all facts

and reasonable inferences drawn from those facts in the light most favorable to the nonmoving party. *Id.*

"The party moving for summary judgment bears the initial burden to show there is no genuine issue of material fact." *Id.* If a moving defendant shows that there is an absence of evidence to support the plaintiff's case, then the burden shifts to the plaintiff to present specific facts that reveal a genuine issue of material fact. *Id.* "Summary judgment is appropriate if a plaintiff fails to show sufficient evidence that creates a question of fact about an essential element on which he or she will have the burden of proof at trial." *Id.* An expert opinion may be sufficient to create a genuine issue of material fact and defeat summary judgment. *Id.* But an expert's opinion must be grounded in fact, and statements that are speculative or based on assumptions will not preclude summary judgment. *Id.* at 173.

B. LEGAL PRINCIPLES OF NEGLIGENT INVESTIGATION

There is no general tort claim for negligent investigation against the State. *Desmet*, 17 Wn. App. 2d at 309. "A plaintiff does not have an actionable breach of duty claim against [the State] 'every time the State conducts an investigation that falls below a reasonable standard of care by, for example, failing to follow proper investigative procedures.'" *Albertson v. State*, 191 Wn. App. 284, 300, 361 P.3d 808 (2015) (quoting *Petcu v. State*, 121 Wn. App. 36, 59, 86 P.3d 1234, *review denied*, 152 Wn.2d 1033 (2004)).

However, in *Tyner v. Department of Social and Health Services*, the Supreme Court recognized and the State agreed that children have an implied cause of action against the State under RCW 26.44.050 for negligent investigation of child abuse allegations. 141 Wn.2d 68, 77, 1 P.3d 1148 (2000). "[A] claim for negligent investigation against [the State] is available only to

children, parents, and guardians of children who are harmed because [the State] has gathered incomplete or biased information that *results in a harmful placement decision*, such as removing a child from a nonabusive home, placing a child in an abusive home, or letting a child remain in an abusive home." *M.W. v. Dep't of Soc. & Health Servs.*, 149 Wn.2d 589, 602, 70 P.3d 954 (2003) (emphasis added). An essential element of a negligent investigation claim under RCW 26.44.050 is that the alleged negligent investigation was a proximate cause of a harmful placement decision. *Desmet*, 17 Wn. App. 2d at 310.

C. HARMFUL PLACEMENT DECISION

Olson argues that there was a harmful placement decision in this case because a harmful placement decision includes when the State allows a child to remain in a home and abuse later occurs. We disagree because there are no genuine issues of material fact as to whether the State made a harmful placement decision.

This court recently addressed a similar question in *M.E. v. City of Tacoma*, 15 Wn. App. 2d 21, 471 P.3d 950 (2020), *review denied*, 196 Wn.2d 1035 (2021). In *M.E.*, law enforcement had contact with the children in October 2011 and January 2012. *Id.* at 24-25. In April 2013, law enforcement began investigating allegations that the children's mother's boyfriend, who lived in the home with the children, had sexually molested another child. *Id.* at 27-28. The boyfriend was eventually located and arrested in August 2013. *Id.* at 28. Later, one of the children disclosed that she had been sexually abused by the mother's boyfriend from the fall of 2012 until the summer of 2013. *Id.* at 30. The children sued law enforcement for negligent investigation. *Id.* at 23.

This court in *M.E.* held that there could be no cause of action for negligent investigation based on the 2011 and 2012 investigations because the children were not left in an abusive home.

Id. at 33-34. As to the 2011 investigation, *M.E.* explained, "based on M.E.'s own disclosure, the [Tacoma Police Department (TPD)] did not leave her in an abusive home following the welfare check [in 2011] because, at the time, there was no disclosed abuse occurring in the home." *Id.* at 33. And as to the 2012 investigation, *M.E.* explained, "based on M.E.'s own disclosure, the TPD did not leave her in a sexually abusive home following the [2012] welfare check because, in January 2012, there was no evidence that sexual abuse was occurring in the home." *Id.*at 34. Thus, there must be some evidence that abuse has occurred or abuse was occurring in the home *at the time of the placement* in order for the child to be left in an abusive home. *See Id.* at 33-34.

Here, the alleged harmful placement decision occurred when the State allowed W.M. to leave the hospital and return home with Katelyn after the Suboxone ingestion. At the time that W.M. left the hospital there was no evidence that any abuse had occurred in either Katelyn's or Rich's homes. Significantly, there are no allegations that Rich had engaged in any acts of physical abuse toward W.M. prior to the assault on December 18. Therefore, between December 10 and December 18, W.M. could not have been placed or left in an abusive home because there was no evidence that abuse had occurred or was occurring in Katelyn's home.

Furthermore, the "placement decision" that was ultimately harmful was not the decision the State made. It is undisputed that the abusive conduct was committed by Rich, at Rich's home. Significantly, the State did not make the decision to place W.M. with Rich as his caregiver. Here, the placement decision that the State made was to allow W.M. to remain in Katelyn's care in her parent's home.

And the State did not place W.M. in Rich's home or even make the decision to allow W.M. to remain in Rich's home. Again, the placement decision that the State made was to allow W.M.

to remain in Katelyn's parents' home under Katelyn's care. Although Katelyn was spending time at Rich's house, it is undisputed that her parents' home was still her residence at the time of both the Suboxone ingestion and the December 18 abuse. And neither Katelyn nor Sally identified Rich as one of W.M.'s caregivers. Therefore, the State did not make the decision to place W.M. in a home and/or with a caregiver that ultimately resulted in the harm to W.M.

Because there was no evidence that abuse had occurred or was occurring at Katelyn's home, the State did not make a harmful placement decision by allowing W.M. to go home from the hospital with his mother.

D. PROXIMATE CAUSE

Olson argues that questions of fact exist whether the CPS's negligent investigation was a proximate cause of W.M.'s injuries because had the State done a background check on Rich, W.M. would not have been injured. We disagree.

Proximate cause typically is a question for the jury. *McCarthy v. Clark County*, 193 Wn. App. 314, 329, 376 P.3d 1127, *review denied*, 186 Wn.2d 1018 (2016). But proximate cause cannot be based on mere speculation. *Estate of Bordon v. Dep't of Corr.*, 122 Wn. App. 227, 241-42, 95 P.3d 764 (2004), *review denied*, 154 Wn.2d 1003 (2005).

Here, Olson relies on mere speculation to support causation. Any claim that the State would have prevented the harm to W.M. by conducting a background check on Rich is purely speculative. Olson contends that W.M. would not have been injured if the State had done a background check because the State would have put a safety plan in place preventing Rich from having contact with W.M. once it discovered Rich's prior involvement with Oregon Child Welfare and the State would have removed W.M. from Katelyn had she not followed the State's safety

plan. But even assuming that Hartnagel or Palmquist ran a background check on Rich during the nine days between allowing W.M. to go home with Katelyn from the hospital and Rich's abuse of W.M., to say that injury to W.M. would have been prevented because a safety plan would have been put in place to prevent contact between W.M. and Rich and that the State would have removed W.M. from Katelyn had she not followed the hypothetical safety plan is completely unsupported by any actual evidence in the record.

And even if Hartnagel or Palmquist ran a background check on Rich during the nine days after receiving the referral and learned of his prior history with Oregon Child Welfare, the evidence establishes that such information would have led to a social worker having a conversation with Katelyn about the discovery.

Further, even if that conversation between a social worker and Katelyn led to the implementation of a voluntary safety plan, there is simply no evidence in the record that Katelyn would have followed whatever voluntary safety plan that may have been put into place. In fact, the evidence in the record shows that Katelyn would not have followed the voluntary safety plan because Katelyn was supportive of and defended Rich, even after Rich abused W.M.

There also is no evidence that establishes what action Hartnagel or Palmquist would have considered appropriate if they had discovered Rich's six year old history with Oregon Child Welfare, made Katelyn aware of the information, and Katelyn rejected the information. Also, Rich's prior history with Oregon Child Welfare, while cause for concern, does not dictate that Katelyn must terminate all contact between Rich and W.M. or that W.M. would automatically be removed from Katelyn's home if she did not comply with any voluntary safety plan that may have been put in place.

Thus, while proximate cause typically is a question for the jury, proximate cause cannot be based on mere speculation. *McCarthy*, 193 Wn. App. at 329; *Bordon*, 122 Wn. App. at 241-42. Here, there is no evidence of causation and any possible question of fact relating causation is too speculative to defeat summary judgment.

CONCLUSION

There are no genuine issues of material fact as to whether the State placed or allowed W.M. to remain in an abusive home because there was no evidence that W.M. had been or was being abused—by Katelyn or Rich. Therefore, the CPS's decision to place W.M. with Katelyn did not result in a harmful placement decision. Further, any claim of causation based on the failure to do a background check is too speculative to defeat summary judgment. Thus, the State was entitled to judgment as a matter of law, and the superior court did not err in granting summary judgment in favor of the State. We affirm.

Lee, C.J.

I concur:

Sutton, J.P.T.

MAXA, J. (dissenting) – Samuel Rich, the boyfriend of WM's mother, beat WM nearly to death in Rich's home. WM's expert testified that (1) the State's investigation of WM's Suboxone poisoning was negligent because the investigation failed to reveal that Rich had a founded finding for child abuse against a previous girlfriend's 2-year-old child, and (2) the State should have developed a safety plan that included no contact between WM and Rich. Questions of fact exist regarding negligence – and gross negligence if RCW 4.24.595(1) applies – and proximate cause.

Nevertheless, the majority holds that the State cannot be liable for its negligent investigation and its failure to remove WM from contact with a known child abuser even though, when viewed in a light most favorable to WM, that negligence was a cause of WM's injuries. The majority says that Rich's home was not an "abusive home" at the time of the State's investigation because Rich had not yet abused WM, and therefore the State cannot be liable as a matter of law. This holding makes no sense, and I dissent.

A child has a claim for negligent investigation against the State only if the State's negligent investigation results in a "harmful placement decision, such as removing a child from a nonabusive home, placing a child in an abusive home, or letting a child remain in an abusive home." *M.W. v. Dep't of Soc. & Health Servs.*, 149 Wn.2d 589, 602, 70 P.3d 954 (2003). The State's placement decision allowed Rich to have contact with WM. The issue here is whether that placement decision was "harmful."

Of course the State's placement decision was harmful to WM. This fact is undisputed. The State's placement decision resulted in Rich savagely beating WM and causing him permanent disabilities.

The majority focuses on whether the State allowed WM to remain in an "abusive home." But the actual requirement is a "harmful placement decision." *Id.* The three examples of a harmful placement decision listed in *M.W.* are preceded by the words "such as." *Id.* Use of "such as" indicates an illustrative list, not an exclusive list. *Schnitzer W., LLC v. City of Puyallup*, 190 Wn.2d 568, 582, 416 P.3d 1172 (2018). Therefore, there may be other types of harmful placement decisions not listed; they must only be similar in type to the three examples. *Id.*

Allowing a child to remain in close contact with a man whose background creates a significant risk that he would abuse the child is similar in type to allowing a child to remain in an abusive home. Therefore, I believe that at least a question of fact exists as to whether the State's decision to allow Rich to have continued contact with WM was a harmful placement decision.

I would reach the same conclusion even if an "abusive home" is required. A home where there is a significant risk that a child will be abused is by definition an abusive home, regardless of whether some abuse has yet occurred. The risk of and potential for abuse makes the home abusive. A few simple examples are illustrative. A structurally unsound house that could collapse at any time is dangerous, even though the house has not yet collapsed. A house containing a ticking time bomb is dangerous, even though the bomb has not yet exploded. Here, Rich was a ticking time bomb, creating a significant risk that he would once again abuse a young child.

A more pertinent example is the State letting a child remain the home of a man who has molested several young children previously. Under the majority's decision, the State would have no potential liability, even though some abuse is virtually inevitable, simply because no abuse

has occurred *yet*. That result would be absurd. Such a home necessarily is abusive, and the State should be subject to liability when the inevitable abuse occurs.

I would hold that a home containing a person whose background creates a significant risk that a child living in the home would be abused is an "abusive home" for purposes of negligent investigation liability, even if no abuse has yet occurred. Whether a person's background created such a significant risk would be a question of fact for the jury.

Such a rule would not be inconsistent with the result in *M.E. v. City of Tacoma*, 15 Wn. App. 2d 21, 471 P.3d 950 (2020), *review denied*, 196 Wn.2d 1035 (2021). In that case, ME lived with her mother and the mother's boyfriend. *Id.* at 24. ME alleged that her mother's boyfriend molested her beginning in the fall of 2012. *Id.* at 30. Tacoma police officers investigated ME's home in 2011 and January 2012 and did not remove ME from the home. *Id.* at 24-27. During the January 2012 investigation, ME actually was examined and interviewed at Mary Bridge Children's Hospital and denied any abuse. *Id.* at 25-27. The court held that these investigations did not result in harmful placement decisions because there was no evidence that sexual abuse of ME had occurred at the time of the investigations. *Id.* at 33-34.

In *M.E.*, there was no abusive home because there was no evidence that the boyfriend's presence in the mother's house created a significant risk that ME would be abused. Nothing in the record suggests that the boyfriend had a history of abuse when the 2011 and 2012 investigations were conducted.

Here, the State's placement decision was harmful to WM. The State should be subject to liability – if WM can prove all the elements of his case – for making that harmful decision. I dissent because the majority wrongfully rules otherwise.

The majority opinion also includes a section on proximate cause that is dicta and nothing more than a gratuitous advisory opinion. The majority ignores the fact that this case was decided on summary judgment and therefore all reasonable inferences must be viewed in favor of WM, the nonmoving party. *Sartin v. Estate of McPike*, 15 Wn. App. 2d 163, 172, 475 P.3d 522 (2020), *review denied*, 196 Wn.2d 1046 (2021). The majority states that even if the State had directed WM's mother not to allow Rich to have contact with WM, she would have ignored that directive. But this is an *inference* – no evidence supports that statement. And the majority is viewing that inference in favor of the State. *Viewed in the light most favorable to WM*, a reasonable inference is that WM's mother would have followed such a directive and WM would not have been injured. Therefore, there is a question of fact regarding proximate cause.

Maxa, J.

MAXA, J.

Washington State Department of Social & Health Services
CA Children's Administration

CHILDREN'S ADMINISTRATION
Investigative Assessment
CPS

Assessment ID: 72696396
Completion Date: 02/20/2018 4:08 PM

Case: Lawson, Katelyn (2383833)
Worker: PALMQUIST, KATIE
Office: Vancouver - Cascade
Provider Type:

ALLEGATIONS

Intake ID: 3776779
Victim: Maney, Wyatt (102667089)
Subject: Lawson, Katelyn (102667091)
CA/N: Negligent Treatment or Maltreatment
Findings Founded
Relationship to Victim: Parent Birth/Adoptive

Support of Findings/CAPTA Narrative:

The Department has gathered evidence to determine that negligent treatment occurred to Wyatt Maney by Ms. Katelyn Lawson. Ms. Lawson admitted to knowing that Wyatt could climb up on the stools in Mr. Samuel Rich's kitchen, but still left him alone with access to the stools and in reach of a controlled substance which he gained access to and ingested during the time her was left unsupervised. Ms. Lawson also provided conflicting information to the hospitals about how and where Wyatt ingested the medication, which could have interfered with his medical treatment.

Intake ID: 3782723
Victim: Maney, Wyatt (102667089)
Subject: Lawson, Katelyn (102667091)
CA/N: Physical Abuse
Findings Unfounded
Relationship to Victim: Parent Birth/Adoptive

Support of Findings/CAPTA Narrative:

The Department did not find evidence that there was physical abuse done to Wyatt Maney by Mrs. Lawson.

Intake ID: 3782723
Victim: Maney, Wyatt (102667089)
Subject: Lawson, Katelyn (102667091)
CA/N: Negligent Treatment or Maltreatment
Findings Founded
Relationship to Victim: Parent Birth/Adoptive

Support of Findings/CAPTA Narrative:

The Department gathered evidence to determine that the allegations of negligent treatment that occurred to Wyatt Maney by Ms. Katelyn Lawson were FOUNDED. Ms. Lawson gave conflicting stories about how Wyatt's injuries occurred and delayed medical attention for Wyatt, which was negligent in his treatment.

PARTICIPANTS

Roles: AP=Alleged Perpetrator; CL=Client; CO=Collateral; CS=Courtesy Supervisor; HM=Household Member; IC=Identified Child; IN=Intake Name; NM=Non-Household Member; PR=Parent/Parental Role; ST=Staff; SB=Subject; V=Victim; WT=Witness

Name: TEIXEIRA, ANTOINETTE (3200345)
Ethnicity: Unable to determine
Race: Unable to determine
Gender: Female
Date of Birth: [redacted]
Primary Language: English
Roles: RF

Name: Burke, Amy (101641339)
Ethnicity: Not Hispanic/Latino
Race: White/Caucasian
Gender: Female
Date of Birth: null
Primary Language: English
Roles: RF

Name: Lawson, Dwayne (102667083)
Ethnicity:
Race:
Gender: Unknown
Date of Birth: 04/11/1964
Primary Language: English
Roles: HM

Name: Lawson, Sally (102667084)
Ethnicity:
Race:
Gender: Unknown
Date of Birth: 02/27/1968
Primary Language: English
Roles: HM

Name: Benfield, Ruth (102667085) **Ethnicity:** **Race:**	**Gender:** Unknown **Date of Birth:** null **Primary Language:** English	**Roles:** HM
Name: Buck, Justin (102667086) **Ethnicity:** **Race:**	**Gender:** Unknown **Date of Birth:** 01/01/1985 **Primary Language:** English	**Roles:** HM
Name: Maney, Wyatt (102667089) **Ethnicity:** **Race:** White/Caucasian	**Gender:** Unknown **Date of Birth:** 07/17/2015 **Primary Language:** English	**Roles:** HM, V
Name: Maney, James (102667090) **Ethnicity:** **Race:**	**Gender:** Unknown **Date of Birth:** 12/09/1989 **Primary Language:** English	**Roles:** NM, PR
Name: Lawson, Katelyn (102667091) **Ethnicity:** **Race:**	**Gender:** Unknown **Date of Birth:** 07/27/1993 **Primary Language:** English	**Roles:** HM, IN, PR, SB
Name: Rich, Samuel W. (102680285) **Ethnicity:** Caucasian **Race:** White/Caucasian	**Gender:** Male **Date of Birth:** 05/16/1989 **Primary Language:** English	**Roles:** NM, PR, SB

GATHERING QUESTIONS

Describe the nature and extent of maltreatment.

The Department received a first intake on 12/9/17 due to concerns of neglect by Ms. Lawson to her son, Wyatt Maney (2), because he had ingested Soboxone medication while in her care. Ms. Lawson brought Wyatt to the hospital near her boyfriend's home and he was later transferred to Randall's Children's Hospital for further observation. Wyatt experienced withdraw symptoms from the Suboxone medication.

Ms. Lawson provided an explanation for how Wyatt got into the medication while she had gone into another room to put up deocrations in her boyfriend's house to surprise him before he got off work. She said she only left Wyatt in the kitchen for a little bit, and during that time he pushed a stool up to the sink area where there were open shelves on the sides of the cabinets where the bottle of Suboxone medication was located. She said that Wyatt must have grabbed the bottle and taken a pill out of it and taken one. She explained that she called poison control and they told her to monitor him for any behavior changes and she decided to just take him to the hospital around the corner from Mr. Rich's house instead. It was later discovered that Ms. Lawson had first provided a report to the first hospital that she and Wyatt were at Ms. Lawson's parent's home in Ridgefield, WA, which is also where they alleged to reside, and that Wyatt had gotten access to and ingested the Suboxone at that home, she said she then called poison control on her way to Mr. Rich's home in Gresham, and decided to just take him to the hospital by Mr. Rich's home instead of Legacy Salmon Creek because she was already closer to Mr. Rich's home by then. Ms. Lawson's story changed to her being at Mr. Rich's home when the incident occurred when Wyatt was transferred to Randall's, but the discrepancies weren't discovered by this investigator until records and all reports where received.

Collaterals report concerns for Mr. Lawson's change in stories and her timeline of how Wyatt accessed the Suboxone pill. She offered no explanations for her inconsistent stories and was defensive when asked about her change in stories. Ms. Lawson was cooperative with afterhours SW Hartnagel and explained that this was an accident and that Wyatt is very active and constantly getting into things, but that she understood that this shouldn't leave him alone in the future and the need to check her surroundings for possible safety hazards her could access in the future.

Assigned investigator Palmquist made contact with Ms. Lawson when assigned the case and made arrangements to see her and complete further questions the following week, due to her conflicting work schedule. Wyatt was cared for by his maternal grandma, Ms. Sally Lawson, at their home in Ridgefield, so this investigator went out to their home to assess the safety of Wyatt in the home, see Wyatt, and meet MGM Ms. Lawson as his caretaker. The home was extremely well kept and there were several baby gates in various areas to keep Wyatt from getting into things and from roaming up the stairs. Ms. Sally Lawson had no concerns for Ms. Katelyn Lawson caring for Wyatt and said that this was just an accident that

Wyatt got a hole of a medication like that and that she also had no concerns for Mr. Sam Rich caring for Wyatt. Ms. Sally Lawson confirmed that Wyatt and Ms. Katelyn Lawson resided in her home in Ridgefield and not with Mr. Rich in Gresham and that they were only visiting at Mr. Rich's home to decorate him home for Christmas as a surprise while he was at work. Wyatt was a happy, active 2 year old who attempted to communicate with this investigator during the visit but was still unable to say most words or form sentences.

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8 days later, on 12/18/17, there was a second intake received with concerns for abuse to Wyatt. He had been brought to the ER in Gresham by Mr. Rich and Ms. Lawson and it he was unresponsive and not breathing. His body and clothes were wet and his body temperature was 91 degrees. The referent reported inconsistent stories from Ms. Lawson about how the injuries to Wyatt occurred. Ms. Lawson started to tell hospital staff that she saw Wyatt fall down the stairs at her boyfriend, Mr. Sam Rich's, home, causing him to go unconscious, but her mom, Ms. Sally Lawson, stepped in an told her that Mr. Rich had told her what happened and that she needed to tell people the truth from the start. Ms. Katelyn Lawson went on to explain that she was actually driving to Mr. Rich's apartment after work to pick up Wyatt and that Mr. Rich had called her to tell her that Wyatt fell out of his highchair and onto the hard flooring, causing him to go unconscious. Another account of this story by Ms. Lawson to hospital staff was that Mr. Rich called her to tell her that Wyatt had fallen down a whole flight of stairs and hit his head on the tile flooring at the end of it, but then that changed to 8 or 9 steps, and then to 3 or 4 steps and that the dog might have tripped him. It was also reported that Mr. Rich had likely delayed medical attention, despite being around the corner from the ER, having a car available to take him, and that he reported not knowing how to do CPR but that Wyatt's breathing was very shallow and he was non-responsive so he knew he needed medical attention. When asked by medical staff why Mr. Rich hadn't taken Wyatt to the hospital or attempted to call 911, Ms. Lawson said that Mr. Rich doesn't have children of his own so he just didn't know what to do. Stories also were inconsistent about whether Ms. Lawson had attempted CPS on Wyatt or not prior to coming to the ER.

Collaterals reported concerns for abuse done to Wyatt by Mr. Rich, causing the injuries on Wyatt and his hospitalization. Randall's CARES NW team reported that Wyatt's injuries were non-accidental and were caused by physical abuse done to him and a delay in medical attention by Mr. Rich. Gresham PD opened a criminal investigation and are continuing to examine evidence in order to make a decision on what will happen criminally. Wyatt's GAL reported concerns for Wyatt's care with his mother and had determined that Mr. Maney should've had primary custody of Wyatt. Mr. Maney reported concerns for his child in the care of Ms. Lawson and had been attempting to gain primary custody of Wyatt since Ms. Lawson left, unannounced, to WA with Wyatt. Mr. Rich was cooperative for the first week of the criminal investigation, but obtained a defense lawyer shortly after and no further information was gained from him. Mr. Rich has CPS history in Oregon, with one founded finding for physical abuse done by Mr. Rich to an ex-girlfriend's 2 year old daughter. Ex-girlfriends reported concerns for his abusive and controlling behaviors as well. Ms. Lawson did not answer this investigator's phone calls or return voice messages or text messages, so no further information was able to be gathered from Ms. Lawson about either intakes.

Mr. Maney did an emergency parenting plan and protection order against Ms. Lawson and was able to move Wyatt back to Tennessee, after he was successfully taken off of life support and his skull was put back on without immediate issues and he was stable enough to do so.

After working with Randall's CARES NW team, nurses and doctors, Ms. Lawson and her side of the family, Mr. Maney and his side of the family, Gresham law enforcement detectives, and reviewing history and collateral concerns, this investigator has evidence to conclude the first investigation as a FOUNDED for neglect of Wyatt Maney by his mother, Ms. Katelyn Lawson, and the second investigation as a FOUNDED for neglect of Wyatt Maney by his mother, Ms. Katelyn Lawson and FOUNDED for physical abuse to Wyatt by Mr. Samuel Rich.

Sequence of Events: What surrounding circumstances accompany the maltreatment?

Mr. Maney reported that he and Ms. Lawson had been having marital problems when they lived in Tennessee and that he had caught her cheating on him and texting other men while she was still living there. Mr. Maney denies any abuse or controlling behaviors by himself to Ms. Lawson and said that he just expected his wife to be faithful to him, which bothered her when she got caught cheating. Mr. Maney said that he came home from work one day and that Ms. Lawson had left with Wyatt and their family dog to Washington state, without telling him. He said that he had no idea she was planning to do this but that he was soon served court paperwork which included a no contact order between him and Ms. Lawson due to allegations that he was abusive toward her and an emergency parenting plan that granted Ms. Lawson primary custody of Wyatt and to stay living with her in WA. Mr. Maney said that he had been trying to get this parenting plan changed and fight the allegations that she made against him for months but that due to jurisdiction issues, it has just recently been adjusted and his out of state visits were to begin the week after Christmas. Mr. Maney said that Ms. Lawson was the verbally abusive

one between the two of them and that he even has text messages of her apologizing to him for verbal and physical abuse that she did to him in the past. Mr. Lawson said that Wyatt's GAL even found that Mr. Maney should have primary custody and that Ms. Lawson was not a stable full-time caregiver for Wyatt. Mr. Maney denied ever changing his phone number since Ms. Lawson moved to WA and said that no one contacted him about Wyatt ingesting a Suboxone pill, but that he found out about it through his insurance because he pays for Wyatt's insurance. The next thing he heard was from this investigator and supervisor Gorder about Wyatt's critical condition and he was able to get on the next flight to WA to be with Wyatt. Mr. Maney said that Ms. Lawson and her parents told him that Wyatt was in the ER, but that he just had a little fall down stairs and would be find by the time Mr. Maney got there the following week to take him to Tennessee for their visitation.

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Ms. Lawson reported that she had moved away from Mr. Maney in Tennessee because she was fearful of him due to verbal abuse and controlling behaviors. Ms. Lawson reported that Mr. Maney wasn't an involved parent and that he had changed his phone number so she would have her attorney attempt to contact him about Wyatt accidentally ingesting a Suboxone pill. Ms. Lawson said that she was living at her parents' home in Ridgefield, WA and that her mom, MGM Sally Lawson, was Wyatt's only caregiver while she was at work each day. Ms. Lawson said that she and Wyatt stayed the night at Mr. Rich's home occasionally, but gave no indication that Wyatt was ever left alone in Mr. Rich's care while she was at work. Ms. Lawson reported to hospital staff and law enforcement (she wouldn't follow up with this investigator) that she did not believe that Mr. Rich had been abusive to Wyatt at any point and that he was not the cause for Wyatt's hospitalization. She reported that she felt bad that people would think Mr. Rich had caused Wyatt's injuries and has continued a relationship with Mr. Rich, despite doctors, nurses, hospital social workers, and law enforcement detectives stating to her that Wyatt's injuries are consistent with physical abuse done to Wyatt and not matching with a fall down 3-4 stairs.

Describe how child(ren) function on a daily basis.

Ms. Lawson described Wyatt as a very active two year old who was always getting into things. She said that she had to put the stools at Mr. Rich's home down on the ground on their sides usually, so that he wouldn't climb up on them like he did when he grabbed the medication and ingested it. Ms. Lawson displayed attachment to Wyatt when AH SW observed them at the hospital during the first intake report follow up. Ms. Lawson reported that Wyatt's PCP was in Woodland, WA and that he had no health problems.

Mr. Maney described Wyatt as a happy, loving child, and that they went on adventures together when he spent time with him. Mr. Maney said that they still had a strong bond, despite so much time away from each other since Ms. Lawson left and moved to Washington with him.

Mrs. Sally Lawson was another identified caretaker for Wyatt during these investigation and she described Wyatt as an active child and was bigger and more advanced than a typical 2 year old. She reported that he lived at her home and with Ms. Lawson and that he had no health issues or developmental problems that she was aware of.

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Due to the incidence(s) that led to Wyatt's injuries, Wyatt's health and development have changed drastically since the first intake was received on 12/9/17. It was reported that Wyatt would most likely not survive past the first night he was brought the ER on 12/18/17, but he survived and physicians reported that his future is unknown in terms of how long he will live and what his quality of life will look like. He is in Tennessee with his dad, unable to move other than when he yawns, coughs, blinks, or swallows, and it is unknown whether he will regain his sight or speech again.

Describe how each parent(s)/caregiver disciplines the child(ren).

All interviewed caregivers reported no physical discipline used for Wyatt, but that they used redirection and time outs.

What are the overall parenting/child care practices used by the caregiver?

Mr. Maney reported that he and Ms. Lawson did not plan to get pregnant and that it was a big surprise, but they were happy about having Wyatt. He said that they had moved to Tennesse to be closer to Wyatt's cousins and Mr. Maney's family because he and Ms. Lawson were so young and needed the family support and also wanted Wyatt to have his cousins to play with. Mr. Maney reported loving being a dad and that he liked watching Wyatt learn new things and going camping and exploring with him. Mr. Maney showed protectiveness for Wyatt when he immediately got on an airplane and flew to be with Wyatt in Washington state after being told about the seriousness of his son's condition by CPS. He stayed by Wyatt's side at the hospital to ensure his needs were met and to be informed on what was going on and also follow through with necessary court intervention to obtain full custody of Wyatt and not allow Wyatt to have unsupervised contact with Ms. Lawson at this time, due to safety concerns in her care. Mr. Maney had attempted to be protective prior to this by following

up with court actions and working with the GAL to get work toward primary custody.

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Ms. Lawson brought Wyatt to the ER during both incidences reported to the Department. She presented as concerned and understanding of why the Department was involved during the first incident of Wyatt ingesting Suboxone and had agreed to keep all medications out of his reach in the future and comply with CPS follow up. Ms. Lawson consistently changed her stories with hospital staff during both incidences that brought Wyatt to the ER, which does not show protectiveness for Wyatt by her. Ms. Lawson also withheld medical information and the seriousness of both of these incidences from Mr. Maney, which interfered with his ability to be protective of Wyatt.

Describe the everyday life task(s) that contribute to the maltreatment.

Wyatt is at preschool age which means at each respective home, the everyday life tasks include: potty training, doctor visits, managing illness, managing discipline, sleep schedules, constant supervision, daycare/babysitter and household tasks.

How does the parent(s)/caregiver manage his/her own life on a daily basis?

Mr. Maney denied any relationships with DV, no current or past MH DX, no past or current drug or alcohol abuse, although he admitted to recreational use of marijuana but not for several months. He denied any criminal history or abuse/neglect as a child. He said that he graduated high school and completed some college and is now the executive chef for a Tennessee college restaurant through a company called Sudexo.

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Ms. Lawson denied any past/current mental health diagnosis, no past or current drug/alcohol abuse, although she reported a past of using marijuana but stated she does not anymore due to UAs she takes for the parenting plan. Ms. Lawson reported working full time for State Farm Insurance in Oregon, but residing with Wyatt at her parents' home in Ridgefield, WA. No other SDM questions were asked of Ms. Lawson at initial meeting during AH, and Ms. Lawson did not return this investigator's calls to provide any further answers to questions. Ms. Lawson's inability to understand the seriousness of what hospital staff told her about Wyatt's injuries being consistent with child abuse, her inability to adequately supervise Wyatt and keep harmful medications out of his reach, and her consistent dishonesty and changes to stories about how, when, and why these incidences have occurred contributed to a threat to Wyatt's safety.

Describe each parent(s)/caregivers' support system and how these support systems can help protect the child(ren). Description of Strengths and Protective Factors.

Mr. Maney has a large family support system in Tennessee, where he has moved back to with Wyatt. He also has the support for Wyatt from church members who are nurses. He reported that they have volunteered to provide home nursing care for Wyatt in Tennessee. Mr. Maney lives alone in an apartment in Tennessee and his mom and dad live close by. They drove across the US to Washington, during snow storms and Christmas time, to be supportive to Mr. Maney and Wyatt at the hospital. Mr. Maney works full time at a local college as the head chef for Sudexo, is able to provide for him and Wyatt financially and has health insurance for Wyatt.

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Ms. Lawson reported working full time for an insurance company in Gresham, OR. She reported that she lived in Ridgefield, WA with her parents and Wyatt and that she did not pay rent to live there so was able to support Wyatt with her wages. Ms. Lawson appeared to also be living with Mr. Rich, after a video walk-through was observed of Mr. Rich's home where a bedroom was set up for Wyatt , he had his own bathroom, and there were a lot of Wyatt's toys and items throughout the home, including a stocking with Wyatt's name on it by the fireplace. Ms. Lawson reported Mr. Rich being her biggest support and that he was very good with Wyatt when they were together. This investigator was unable to gather other information to determine what supports Ms. Lawson did have or may have been in need of prior to closing these investigations, due to Ms. Lawson no longer communicating with the Department.

INVESTIGATIVE DETAILS

Narrative describing facts obtained from Investigation and sources used to verify.

INTAKE #1:

The Department received a first intake on 12/9/17 due to concerns of neglect by Ms. Lawson to her son, Wyatt Maney (2), because he had ingested Soboxone medication while in her care. Ms. Lawson brought Wyatt to the hospital near her boyfriend's home and he was later transferred to Randall's Children's Hospital for further observation. Wyatt experienced withdraw symptoms from the Suboxone medication.

INTAKE #2:

8 days later, on 12/18/17, there was a second intake received with concerns for abuse to Wyatt. He had been brought to the ER in Gresham by Mr. Rich and Ms. Lawson and it he was unresponsive and not breathing. His body and clothes were wet and his body temperature was 91 degrees. The referent reported inconsistent stories from Ms. Lawson about how the injuries to Wyatt occurred. Ms. Lawson started to tell hospital staff that she saw Wyatt fall down the stairs at her boyfriend, Mr. Sam Rich's, home, causing him to go unconscious, but her mom, Ms. Sally Lawson, stepped in an told her that Mr. Rich had told her what happened and that she needed to tell people the truth from the start. Ms. Katelyn Lawson went on to explain that she was actually driving to Mr. Rich's apartment after work to pick up Wyatt and that Mr. Rich had called her to tell her that Wyatt fell out of his highchair and onto the hard flooring, causing him to go unconscious. Another account of this story by Ms. Lawson to hospital staff was that Mr. Rich called her to tell her that Wyatt had fallen down a whole flight of stairs and hit his head on the tile flooring at the end of it, but then that changed to 8 or 9 steps, and then to 3 or 4 steps and that the dog might have tripped him. It was also reported that Mr. Rich had likely delayed medical attention, despite being around the corner from the ER, having a car available to take him, and that he reported not knowing how to do CPR but that Wyatt's breathing was very shallow and he was non-responsive so he knew he needed medical attention. When asked by medical staff why Mr. Rich hadn't taken Wyatt to the hospital or attempted to call 911, Ms. Lawson said that Mr. Rich doesn't have children of his own so he just didn't know what to do. Stories also were inconsistent about whether Ms. Lawson had attempted CPS on Wyatt or not prior to coming to the ER.

IFF #1:

On 12/9/17, afterhours SW Hartnagel completed IFF with Wyatt at Randall's Children's Hospital. SW Hartnagel observed Wyatt in the safe hospital crib where he could not fall out. Wyatt appeared externally physically healthy with some redness to his face where mother and R.N. reported Wyatt was itching, a possible side effect of having ingested suboxone. Wyatt was also talking to mother and had been observed by AH worker saying goodbye to maternal grandparents when they left. Wyatt appeared to be developmentally on target. As AH worker was talking with mother, Wyatt became a little fussy and kept closing his eyes as if he were tired. Mother reported that the Suboxone had made him very tired an he had been "in and out of sleep" all afternoon and evening". Mother ran her fingers through Wyatts hair and rubbed the back of his head when he was fussy and Wyatt fell asleep.

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On 12/12/17, assigned investigator Katie Palmquist went to Wyatt's home in Ridgefield, WA to see his home environment and check in with him since he got released from Randall's this weekend after accidentally taking his mom's boyfriend, Samuel Rich's, Suboxone pill at his home. The house was very clean, decorated for Christmas, and the kitchen was being remodeled. Everything in the other areas of the home were brand new and there were lots of baby gates and safety locks around the home. After MGM Sally Lawson answered the door and invited this investigator into the home, Wyatt came up to he baby gate to be let out from the living area where Sally's mom was playing with him and a large bull dog. Wyatt came out of the play area and came and said hi to this investigator. He was wearing a white shirt, pants, socks, and had a sippy cup in his hands. He tried to say something to this investigator but his words were not clear enough to make out. Sally said that he doesn't form sentences yet and that he is slowly gaining more words that he can say. Wyatt smiled at this investigator and pointed to his dog a lot while this investigator talked with Sally further about the concerns due to the incident that happened at Katelyn's boyfriend's home. Wyatt continued playing and walking back and forth in the front hallway. Wyatt appeared to be of normal developmental size and he was moving and walking around like a typical 2 year old.

IFF #2:

On 12/19/17, due to second intake with allegations of physical abuse to Wyatt, Investigator Palmquist and Investigator Bowman went to Randall's Children's Hospital to see Wyatt and talk to the nurse or Dr. working with Wyatt. Wyatt was observed through the window of his hospital room by this investigator. Ms. Lawson and her parents (MGPs) were also in the room with Wyatt, and this investigator did not enter the room since LE requested no contact be made with them yet, if possible. Wyatt was lying on his back in the hospital bed, had a neck brace on, tubes and wires were connected to him and around him and there were multiple machines hooked up around him. The lights were off in the room and the only light was from the cracks in the blinds and the machine's lights.

The day nurse, Vicky Rice, came out of the hospital room to talk to both Investigators about Wyatt's current state. She said that she was not here why Wyatt arrived but his notes say that he was transported from Mt. Hood Medical Center and arrived at about midnight last night. She said that he arrived to Mt. Hood unconscious and they did CPR to resuscitate him, his temp was 94 degrees F, and he had bruising around his eyes and bruising all up and down his body. She said that mom drove Wyatt to the hospital and she wasn't sure if mom's boyfriend came with or not.

Nurse Vicky Rice said that Wyatt is in critical condition now. They have been unable to do full body scans of him because he is not stable enough yet, and they have not scanned his brain activity yet either. He has bilateral extra axial hemorrhages, diffused cerebral medina, was covered with bruises not consistent with the accident, and he had "raccoon eyes" that don't match what happened. She said that Wyatt has an ICP bolt, and ventricular drain. The boyfriend is not allowed to come visit. They have not found any broken bones yet and no fractures, but since the full skeletal can't happen yet they aren't sure. His thoracic and lumbar scans are cleared but his C-spine is not yet.

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On 12/26/17, Mr. Maney invited Investigator Palmquist and Supervisor Gorder into Wyatt's hospital room after completing parent interview with him in a conference room at Randall's. Mr. Maney explained that it needed to be very quiet and that touching Wyatt is limited because it spikes his heart rate and irritates him. Mr. Maney's dad was sitting on the couch and looked and waved and remained quiet. Wyatt was lying on his back in the hospital bed, he had a colorful owl blanket over his body and one of his arms was partially uncovered. His head was wrapped in gauze bandages and he has a lot of tubes and monitors hooked up to him. His eyes were very puffy and they were closed. Mr. Maney said that his right eye has been very swollen ever since he got there and that the surgery made his left eye also get puffy. He lifted Wyatt's blanket and showed Wyatt's hands where were very swollen. Investigator Palmquist and Supervisor Gorder stayed in the room for a few minutes, then washed hands, said goodbye to Mr. Maney, and left the hospital.

SUBJECT INTERVIEW (Katelyn Lawson):

On 12/9/17, afterhours SW Hartnagel went to Randall's Children's Hospital and talked with Ms. Katelyn Lawson after completing IFF with Wyatt due to first intake with concerns for neglect by Ms. Lawson after he injested a soboxone pill while in her care. Mother reported that she lives at the address in Ridgefield, WA, that is on the Intake, stating that her parents just sold their house in Kalama, WA, and moved to Ridgefield and that she and child are living with them. Mother reported she has a boyfriend who lives in Troutdale, OR, and the incident of ingestion reportedly occurred there. Mother reported that she went to boyfriend's house with child in order to surprise him when he comes home from work tonight with Christmas decorations. Mother reported that she was putting up Christmas decorations when she left the room for a minute and child had gotten up onto the kitchen counter and into the "medicine cabinet" which this worker clarified was a kitchen cabinet next to the kitchen sink where her boyfriend keeps medications. Mother reported that her boyfriend has an old prescription for suboxone that he used to take and she was not sure if child had ingested it but called Poison Control as she looked for the medication. She said it appears child took one long lasting tablet of the suboxone. Poison Control reportedly informed her to watch for certain symptoms in child and to take him to the Emergency Department so she took him to LEGACY Mt. Hood Medical Center in Gresham, near her boyfriend's residence.

Mother said she is aware child can get up on the kitchen counters so she usually lays down the bar stools that are in the kitchen to prevent it but that she left the room to get Christmas decorations and when she came back a few minutes later, child had gotten up onto the kitchen counter and into the medication. Mother reported she has been dating her boyfriend for approximately 6 months but that she does not know what he was prescribed suboxone for, stating she is only aware that he was in a bad car accident and not aware of any substance issues. Mother reported boyfriend was not home, only her and child at his place, stating her boyfriend is a car salesman who works long hours. Mother denied any awareness of substance abuse issues with boyfriend and also denied any substance abuse issues for herself. Mother denied the current

use of legal marijuana stating the last time she used was approximately 6 months ago. Mother reported she provides UA's to the Court in Cowlitz Co. as well as nail follicles per her custody Court case of child with father whom she reports lives in TN near his family. Mother reported neither her nor child's father are to use substances. Mother denied any mental health issues, including depression, and denied any awareness of boyfriend having any mental health issues. Mother reported that there are baby gates at boyfriend's residence but that they obviously were not in a place that kept him from getting up on the kitchen counter. Mother also reported there are baby gates "everywhere" at her home with maternal grandparents. Mother reported the address of her boyfriend as 2867 SE Faith Ct, Troutdale, OR. Mother reported the incident occurred at approximately 12:45 p.m. this afternoon.

Mother reported that father is supposed to provide the health insurance for child but both cards, and both types of insurance father has had on child recently, have expired. Mother reported child used to have United Health Care and Blue Cross/Blue Shield through father but that father had not advised her that the insurance(s) had lapsed. Mother reported father does not yet know about 2 year old Wyatt ingesting suboxone because she reportedly has no way of reaching him. Mother reported she would be advising her attorney on Monday and that her attorney will tell father's attorney that baby was/is hospitalized and about the incident. Mother reported child had a doctor in Woodland but once insurance is sorted out, she will be switching him to a doctor in the Ridgefield or Vancouver, WA area.

During the interview, mother presented well and this worker observed, or had, no concerns with mother's apparent appropriateness. Mother acknowledged an understanding of the extent of the harm that could have come to child as a result of him getting into the medication. Mother appeared to be appropriately concerned and attentive to child during visit. This worker informed mother that there would be a worker assigned to case and that follow up will be conducted. Mother reported that she works during the week and will be at work on Monday but assigned worker can reach her at (360) 218-9508 which is her cell phone number. Mother reported she works for State Farm insurance in Gresham, OR.

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On 12/11/2017, assigned investigator Palmquist called Ms, Lawson and talked with her to follow up from SW Hartnagel seeing her and Wyatt this weekend at Randall's and let her know that this investigator needs to come by their home and see their home environment and to ask her some more questions. She said that she works M-F from 8-5:30 and that it takes her about an hour to get home each day. She said that her mom, Sally, watched Wyatt at home (they live with her in Ridgefield) each day so this investigator could arrange to go out there and see him and talk to her during a weekday and then she and this investigator could get the other questions done over the phone another time (lunch break or after work time). Investigator asked that she give her mom a heads up that this investigator will be calling to schedule that with her. Investigator Palmquist called Sally and made arrangements to come out to her home and see Wyatt on Wednesday, 1213/17.

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Due to ongoing law enforcement investigation, this investigator was unable to complete further gathering questions with Ms. Lawson, and when the okay to talk to her further was given to this investigator, Ms. Lawson would not answer her phone or return this investigator's messages. No further information was gathered from Ms. Lawson.

SUBJECT INTERVIEW (Samuel Rich):

This investigator observed video walk-through recorded by Gresham Police detectives of Mr. Rich's home. He provided a walk through of his home and a walk-through play-by-play description of the alleged incident that led to Wyatt's hospitalizations. Due to ongoing law enforcement investigation, it was requested that this investigator not include notes regarding that walk-through or information gathered from Gresham PD. That being said, this investigator did not find Mr. Rich's description of the incident to be truthful and the timeline of the events did not make sense. This investigator was unable to interview Mr. Rich due to the open law enforcement investigation.

PARENT INTERVIEW (James Maney):

Investigator Palmquist spoke with Mr. Maney several times throughout the course of these investigations, and also met him in person to complete full interview questions at Randall's Children's Hospital.

On 12/20/17, due to the critical condition of Wyatt and the sense that Ms. Lawson and maternal grandparents were not

being fully honest with Mr. Maney about Wyatt's critical condition, supervisor Gorder and Investigator Palmquist contacted bio-father James Maney.

James said he has been in contact with Katelyn's father who told him that Wyatt's condition had improved and they took him off the respirator. He said that he was aware that Wyatt had an injury from falling down the stairs. He said he called the hospital and they would not give him any information. He contacted his insurance company and they told him that Wyatt had been hospitalized for three days from poisoningrecently. No one from the hospital has spoken with him.

James was informed that the Department believes this injury to be from abusive trauma. He was informed there is increased brain swelling and Wyatt is on life support. James was instructed to come out to the hospital and provided with hospital name, location and treating doctor.. James said he would get on a plane and fly out as soon as possible.

James reported he has had concerns about Katelyn. There is a No Contact Order between them, but not between him and Wyatt. They have been in court a lot over custody of Wyatt. There was a GAL appointed (he could only remember "Jan C") who "ruled" that James should have full custody due to Katelyn's emotional instability and being verbally and physically abusive towards him. Katelyn was assessed while living at her parent's "old house" but then the GAL found that she had been essentially staying with her boyfriend, whom James has never met. The boyfriend had dropped off Wyatt at one of the exchanges and that is how the GAL found out about the boyfriend.

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On 12/26/17, Investigator Palmquist and Investigations Supervisor Gorder went to Randall's Children's Hospital and met with Mr. Maney, as scheduled. Nurse provided an empty conference room on the 5th floor down the hall from Wyatt's room to meet in.

Mr. Maney answered majority of gathering questions and expressed his concerns for Ms. Lawson not being able to safely care for Wyatt and make safe and healthy choices for Wyatt's ongoing medical care while in the hospital. Mr. Maney said that he doesn't know anything about Mr. Sam Rich but that he did see him during some exchanges of Wyatt and that it has bothered him that Katelyn would introduce Wyatt to a man she barely knew and have him watch Wyatt on his own. Mr. Maney also said that he hasn't ruled out in his mind that Katelyn had something to do with Wyatt's accident, but he also didn't have any specific examples of concerns for Katelyn ever abusing Wyatt. He said that Katelyn had lost her temper and hits walls before, but he never saw Katelyn hit Wyatt.

Mr. Maney talked with Investigator and Supervisor about Wyatt's possible future and what that might look like. He said that if Wyatt lives then he plans to bring him back to Tennessee and that he has a couple of church members who are nurses who have already offered to care for Wyatt once he is stable enough to be moved down there. Mr. Maney was also very realistic about Wyatt's prognosis at this time and said that he does not want Wyatt to have a poor quality of life where he lives in a "veggie state" and does not want him to be in pain. He hopes that Ms. Lawson gets on the same page as him about not keeping Wyatt on life support forever or allow him to stay alive if his quality of life is poor.

Mr. Maney denied that he was ever verbally or physically abusive to Ms. Lawson and that it was actually the other way around. He said that she was physically and verbally abusive to him and that he has proof of those things, and that she was able to say that he did the things she did to him to her and that is how she was able to get a restraining order and keep Wyatt from him for so long. Mr. Maney said that regardless of what the newest ex parte order states about Ms. Lawson's limited visitation with Wyatt right now, he has agreed to allow her every other night to sleep at the hospital with Wyatt and they are now on an every 2 hour rotation for visiting in Wyatt's room since Ms. Lawson doesn't feel comfortable with him around. Mr. Maney said that he will abide by that visitation plan unless Wyatt suddenly makes a turn even worse and there is an important decision that needs to be made which he would then be needed in the room during Ms. Lawson's time.

Mr. Maney said that Ms. Lawson is refusing to give him Wyatt's birth certificate, even though he needs it for insurance purposes and has said that she isn't staying at home to get it for him, which makes him believe she is still staying the nights with Mr. Rich.

COLLATERALS:

Multiple collateral contacts made throughout these investigations. All collateral contacts have been well documented, from referents, doctors, nurses, CARES NW social worker and physicians, law enforcement detectives, family members from

both maternal and paternal sides, friends of Ms. Lawson, friends of Mr. Maney, GAL for Wyatt, parent's attorneys, criminal history and CPS history of Mr. Rich, acquaintances of Mr. Rich, law enforcement records and staffings, medical records, internet searches, and numerous CPS staffings.

CLOSING SUMMARY:

SDM Risk Assessment for Mr. Maney is Moderate and it is Moderately High for Ms. Lawson. After arriving to Washington state from Tennessee, and learning about the critical condition of Wyatt and belief that Mr. Rich had abused Wyatt, causing his injuries and hospitalization, Mr. Maney completed an emergency parenting plan and protection order against Ms. Lawson and was able to move Wyatt back to Tennessee. This move was completed after Wyatt was successfully taken off of life support and his skull was put back on without immediate issues and he was stable enough to do so.

After working with Randall's CARES NW team, nurses and doctors, Ms. Lawson and her side of the family, Mr. Maney and his side of the family, Gresham law enforcement detectives, and reviewing history and collateral concerns, this investigator has evidence to conclude the first investigation as a FOUNDED for neglect of Wyatt Maney by his mother, Ms. Katelyn Lawson, and the second investigation has been concluded with a FOUNDED finding for neglect of Wyatt Maney by his mother, Ms. Katelyn Lawson and a FOUNDED finding for physical abuse to Wyatt by Mr. Samuel Rich. CARES NW team confirmed that Wyatt's injuries, in conjunction with the changing stories and behaviors of Mr. Rich and Ms. Lawson, and the delay in medical treatment of Wyatt by Mr. Rich was consistent with and likely a result of child abuse and neglect. Law enforcement in Gresham, OR continues to work on their criminal investigation and will determine whether Mr. Rich will be arrested for allegedly abusing Wyatt. This investigator was unable to complete further questioning of Mr. Rich or Ms. Lawson in order to obtain further clarification or their sides of the story behind both incidences involving Wyatt, but enough information has been gathered in order to complete both investigations.

Due to Mr. Maney taking protective actions to ensure that Ms. Lawson will not have unsupervised contact or decision making abilities for Wyatt, the Department is able to close their case without taking further action. Mr. Maney reported that Ms. Lawson has petitioned with the courts in order to regain custody and have unsupervised visits with Wyatt, and that they next court date is at the end of February. He has reported that he will be petitioning to maintain full custody and argues that Wyatt is in no condition to travel back and forth from Tennessee and Washington for visits with Ms. Lawson and that she has proven herself to be unable to safely care for Wyatt and unable to protect him from abuse and neglect. The Department agrees with Mr. Maney in regards to Ms. Lawson's ability to safely parent and protect Wyatt and would strongly suggest Ms. Lawson not be allowed to have unsupervised contacts with Wyatt until further assessment is completed. Mr. Maney has agreed to call Washington CPS if Ms. Lawson is granted unsupervised visits with Wyatt.

CONTACTS

Activity	Participant	Location	Date/Time Occurred	Date/Time Created
Child - Face to Face with Child	Maney, Wyatt (102667089)	Parental Home	12/12/2017 09:45 AM	12/13/2017 09:44 PM
Child - Face to Face with Child	Maney, Wyatt (102667089)	Medical Facility	12/26/2017 10:00 AM	12/28/2017 05:40 PM
Child - Face to Face with Child	Maney, Wyatt (102667089)	Medical Facility	12/26/2017 10:00 AM	12/28/2017 05:40 PM
Child - Initial Face to Face with Child	Maney, Wyatt (102667089)	Medical Facility	12/09/2017 08:30 PM	12/09/2017 10:32 PM
Child - Initial Face to Face with Child	Maney, Wyatt (102667089)	Medical Facility	12/19/2017 09:00 AM	12/21/2017 04:16 PM
Child - Initial Face to Face with Child	Maney, Wyatt (102667089)	Medical Facility	12/19/2017 09:00 AM	12/21/2017 04:16 PM
Contact - Care Provider or Facility Provider	Maney, Wyatt (102667089)	Medical Facility	12/19/2017 09:00 AM	12/19/2017 11:14 AM
Contact - Care Provider or Facility Provider	Maney, Wyatt (102667089)	Medical Facility	12/19/2017 10:30 AM	12/19/2017 12:32 PM
Contact - Care Provider or Facility Provider	Maney, Wyatt (102667089)	By Phone	12/19/2017 11:00 AM	12/19/2017 04:15 PM

CARNEY BADLEY SPELLMAN

December 02, 2021 - 1:24 PM

Filing Petition for Review

Transmittal Information

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Appellate Court Case Number:	Case Initiation
Appellate Court Case Title:	W.M. and Erin Olson et al, v. State of Washington, Respondent (550075)

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