Executive Child Fatality Review

Department of Social and Health Services
Children's Administration

December 2006

Executive Child Fatality Review Committee Members:

Ross Sockzehigh, Committee Chair, Yakama Nation Tribal Council Member
Health, Employment and Welfare (HEW) Committee Chair

Delores Armour, Lead Social Worker 2 Nak Nu We Sha Tribal Social Services - Yakama Nation
Daryl Toulou, Children and Family Services Program Director- Confederated Tribes of the Colville Reservation
Betsy Tulee, Children's Administration Indian Child Welfare Program Manager
Bruce Thomas, Division of Children and Family Services (DCFS) Area Administrator, Region 6

Observers:
Mary Meinig, Office of Family and Children's Ombudsman (OFCO)
Phillip (Bing) Olney, Yakama General Tribal Council Chair
Joe Jay Pinkham, Yakama General Tribal Council Secretary
David Ward, Yakama Tribal Attorney.

Advisory:	Roberto Rodriguez, DCFS Region 2 Child Protective Services (CPS) Program Manager
Facilitator:	Sharon Ham, Practice Consultant, Office of Risk Management Children's Administration
Assistant:	Sara Smith, DCFS Administrative Secretary, Region 1

1

Scope of a Child Fatality Review (CFR) or Executive Child Fatality Review (ECFR)

The purpose of reviewing a case in which a child has died as a result of abuse and/or neglect or under suspicious circumstances is to evaluate the department's delivery of services to the family, as well as the system response to the identified needs of the family.
This evaluation or review of the department's services and community response to concerns about child abuse and neglect issues in a family will help to identify areas for improvement through education, training, policy or legislative changes.

Given its limited purpose, a Child Fatality Review by Children's Administration should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. A review is generally limited to documents in the possession of or obtained by DSHS or its contracted service providers and the panel may be precluded from receiving some documents that may be relevant to the issues in a case because of federal or state confidentiality laws and regulations. A review panel has no subpoena power or authority to compel attendance and generally will only hear from DSHS employees and service providers. The panel may not hear the points of view of a child's parents and relatives, or those of other individuals associated with a deceased child's life or fatality. A Child Fatality Review is not intended to be a fact-finding or forensic inquiry or to replace or supersede investigations by courts, law enforcement agencies, medical examiners or other entities with legal responsibility to investigate or review some or all of the circumstances of a child's death. Nor is it the function or purpose of a Child Fatality Review to take personnel action or recommend such action against DSHS employees or other individuals.

Table of Contents

Executive Summary

In December, 2006, the Children's Administration (CA) convened a multi-disciplinary committee to review the practice and events that occurred prior to the death of a 23-month-old, male child of Native American heritage. The death occurred in August, 2006, while the child was the subject of a dependency action in the Yakama Nation Tribal Court (YNTC) and under the supervision of the Department of Social and Health Services (DSHS or department). The custom of his Native American people is to not use the name of the deceased for a period of time. Out of respect, the child's name will not be used in this report. He will be referred to as "the deceased child" or "the child."

The purpose of this review is to evaluate practice, policies, programs and systems involved in the delivery of services to meet the needs of the family and the child.

The review benefited from input from two Native American tribes and from CA staff that provided services to the family over several years. Participants included three members of tribal councils, a tribal social services program manager, a tribal social worker, a tribal attorney, a CA Indian Child Welfare (ICW) program manager and a CA area administrator. Consultants included a child protective services (CPS) program manager, an assistant attorney general (AAG) and a program manager from the DSHS criminal background unit (BCCU).

The committee members interviewed five individuals from CA staff who had direct information about the case. They also reviewed CA case file information, medical, criminal and legal records.

Documents reviewed by the committee included:

- Chronology of significant events in the history of the case
- Native ancestry chart
- Minutes from Local Indian Child Welfare Advisory Committee (LICWAC) staffings
- Legal documents from tribal court
- Home study request and subsequent home study
- Criminal background check policy and documents
- Medical information
- Law enforcement reports
- *A System's Approach to Investigating Child Abuse Deaths,* an article by Eileen Munro
- Previous fatality review regarding Tyler DeLeon

The committee found that this case was unique in that it was administered legally from tribal court but the department was charged with supervision of the case as well as service provision to the family. The case was also shared between two regions of the department. It originated in the Toppenish Division of Children and Family Services (DCFS) office in Region 2. That office eventually arranged placement of the deceased child with relatives in Spokane in Region 1. The Spokane DCFS office also provided courtesy supervision of the child. Courtesy supervision cases require that the child is seen once every 90 days.

The deceased child was born prematurely, with cocaine in his system. A petition for dependency was filed in Yakama Tribal Court. He was placed with his mother [redacted]

RCW 70.02.020

4

just after his birth [redacted]. The child was then placed with a foster family in the Yakima area where he remained for approximately one year. At that time, paternal relatives from Spokane came forward asking for placement in their home. A brief assessment of the suitability of the relatives' home was done by staff of the Spokane office, in lieu of a full home study. This assessment did not include details of the child's condition or the criminal history on the relative family. The Toppenish social worker had this information. Under DSHS policy, the criminal history would have precluded placement with the relatives.

This placement lasted for approximately eight months, ending when the child died as a result of physical abuse at the hands of his uncle.

During the child's placement with relatives in Spokane, the child was seen for regular 90-day-health and safety checks. Social workers who saw the child and his sibling in this home detected nothing that would indicate concern or alarm. The reports were positive. Conversely, no mention was made of the child's developmental delays or services needed or provided to the relative. The Spokane office did not observe anything that would have indicated the family dynamics of this placement needed closer scrutiny. However medical reports that were reviewed after the death of the child reflect that the aunt, with whom he was placed, had concerns about the child's developmental delays as well as his behaviors.

In reviewing this case, the committee focused on the collective systemic circumstances of the case as well as the different dynamics of cases being heard in tribal courts. Where a tribal court is hearing a case and orders the case be managed by state social workers, those social workers are subject to tribal code and appear in court without legal representation. State social workers appearing in Tribal Court without legal representation occurs only in Yakama Tribal Court and one other tribal court in Washington.

The committee identified a number of issues for review. These included background checks, communication with the tribe, social work practice and training.

The committee also wanted to recognize the diligence of CWS social worker in the Toppenish office for the good work done with the parents and the children while they were residing in the Toppenish area.

Case Summary

The deceased child, son of Helen Miller and alleged father Ralph Quiltenenock, was born on November 12, 2004. He was born prematurely at 38 weeks and tested positive for cocaine at birth. Throughout his life, social services were provided by DCFS but legal authority for case management and legal oversight was in Yakama Nation Tribal Court.

RCW 70.02.020

The child was made a ward of tribal court and placement responsibility was given to the department. The child was placed from the hospital with his mother [redacted] in Spokane on November 16, 2004. The mother aborted treatment on December 6, 2004, and Spokane DCFS placed the child in foster care in Spokane. He was later moved to a foster home in the Yakima area and remained in that home until December, 2005.

In the time between the child's birth and December, 2005, there were a number of LICWAC staffings. In these staffings, recommendations were made for service provision for the mother and the alleged father in order to have the child returned to their care. These recommendations included filing a dependency on the child in tribal court, drug treatment, parenting classes, day care, visitation, and fostering a stable living situation. The tribe encouraged enrollment of the child if the child qualified.

In March, 2005, a fact finding hearing was held in YNTC. The court ordered a chemical dependency evaluation as well as domestic violence counseling for the mother. Throughout this period of time, the mother and alleged father moved back and forth between Spokane and Toppenish. Neither fully engaged in any services. Relative placement was sought for the child through the maternal great-grandmother. She was not able to care for the child but provided names of several maternal family members as possible placement options.

The Toppenish DCFS social worker visited the child in the foster home at regular intervals and was involved with medical service providers in the Yakima Valley. The child experienced developmental delays in hearing, speech and gross motor ability as a residual effect of the mother's drug involvement throughout the pregnancy.

In July, 2005, a referral was made on the child's Yakima foster home. The room where the child slept was allegedly cluttered and out of listening distance of the foster parents. This created concern about the supervision provided for the child. This referral was investigated, and the finding was unfounded.

[redacted]

RCW 13.50.100

[redacted] A number of paternal relatives were present at this hearing including Angelique and Avery Sam of Spokane who expressed strong interest in having the baby, as well as her brother, the deceased child, placed in their home. Criminal background checks were submitted on both of the Sams, and Toppenish DCFS staff requested that the Spokane DCFS office conduct a home study to determine if their residence was appropriate and suitable for placement of the two children.

RCW 13.50.100

On January 13, 2006 a tribal staffing was held in Toppenish. There was agreement by all parties at this staffing that the children should be placed with the Sams, provided the background checks were completed and approved. [redacted]

The background information received on the Sams indicated that Avery Sam had five convictions - 2 misdemeanors, 2 gross misdemeanors, and a Class C felony drug conviction. His record documented a 2003 gross misdemeanor Theft 2. Under DSHS policy, this offense should have precluded the placement of the children in the home of Angel and Avery Sam for at least 5 years after the date of conviction. The Sams would have been eligible for consideration as placement resources in 2008. This information was not well articulated in the YNTC proceeding which was held to determine placement of the children. However, the state social worker, in an affidavit presented to the court on January 17, 2006, did advise the court of the criminal history of both of the Sams known to the department at the time.

It was later discovered that Mr. Sam had been charged in federal court with Involuntary Manslaughter in Nevada in 1991. This charge was reduced to Reckless Driving in 1996. The Toppenish social worker had no knowledge of this crime until after the death of the child. Although the Reckless Driving charge would not have precluded placement of the child with the Sams, it is concerning that the complete criminal history was not available to the social worker at the time of the placement hearing. The Sams did not reveal this information to the department.

On January 17 and 18, 2006, two referrals were received on the Yakima foster family with whom the children were placed. Both referrals alleged that the home was inappropriate for the children, and that the deceased child was sleeping in the bed with the foster parent. The referent indicated that the child had access to houseplants which he ate as well as the houseplant dirt. These referrals were investigated and found to be valid. The foster mother corrected the situation and also relinquished her day care license as part of the compliance plan developed by the Division of Licensed resources (DLR).

On January 20, 2006, a Spokane DCFS worker responded to the Toppenish DCFS worker's request for a home study of the Sams' home. The response consisted of an email to the Toppenish DCFS social worker indicating that the Spokane worker had been to the Sam home and approved it for placement of the children. The email also stated that the Spokane office would accept courtesy supervision of the case.

The Spokane social worker later stated that he could not recall whether the information on the criminal history of the Sams had been shared with him. On January 20, 2006, the YNTC ordered the placement of the deceased child and his younger sister in the home of the relatives, Angel and Avery Sam. The children were placed with the Sams shortly thereafter.

[redacted] A recommendation was made to move the children [redacted] with their mother on April 15, 2006. [redacted]. Angel Sam, through her attorney, opposed placement with the mother on the basis that it was too soon. The tribal court set another hearing for April 25, 2006 to discuss this placement.

RCW 13.50.100

[redacted]

RCW 70.02.020

Three health and safety visits were completed in the Sam home between February and July, 2006. Documentation in the case record reflects that the children were healthy and interacted well in the home. No reference was made to the ongoing developmental delays experienced by the children as a result of the in utero drug exposure. These developmental delays are documented elsewhere in the file, but it is not clear they were observed or known to the Spokane staff conducting the home visits. It is also unclear who the primary caregiver of the children was during that time.

On August 3, 2006, the older child (the deceased child) was brought to Holy Family Hospital in Spokane by the Sams. The child had been vomiting for 24 hours. The aunt told the doctor that the child had fallen in the bath tub the previous day and had struck the left side of his head. A CT scan completed on the child was interpreted as negative. The hospital's assessment at the time was a closed head injury. The child was discharged in stable condition but the relatives were instructed to return to the hospital immediately if any problems occurred.

On August 4, 2004, the child was once again brought to the emergency room at Holy Family Hospital. He was actively seizing at the time. There was swelling in the left temporal and forehead region but no laceration. A new CT scan showed a left frontoparietal acute subdural hematoma. The child was airlifted to Sacred Heart Hospital in critical condition. The child's condition continued to deteriorate throughout the following day.

On August 6, 2006, the child was pronounced brain dead and life supports were removed.

Issues Reviewed with Recommendations

Background Checks

The child's paternal relatives, Angel and Avery Sam, were not truthful in completing the criminal background check form. Section 2 - Item 11 on the form specifically asks: "*Have you ever been convicted of, or do you have any charges pending for any crime?*" Both denied any prior criminal activity. The results of the inquiry forms returned from the Background Check Central Unit (BCCU) showed otherwise. There was no consequence assigned to the relatives, and the department did not take any steps to address this issue.

The criminal history background check received by the Toppenish office indicated that the relative, Avery Sam, had a disqualifying crime which would preclude him from having a child placed in his care. This 2003 conviction for the crime, Theft 2, was a gross misdemeanor. Under Children's Administration (CA) policy, this crime would disqualify the subject from having a child placed in his/her home for five years from the date of conviction.

It was later discovered that in addition to Mr. Sam's criminal history, he had a 1995 charge of involuntary manslaughter in Reno, Nevada. This charge was later reduced to a conviction of reckless driving. This information was not available to the requesting social worker who received the background check in Washington State. The information was available through a check with the National Crime Information Center (NCIC). At the time of this case, Children's Administration social workers did not have access to this data base, unless the individual has lived in the state of Washington for less than three years.

Recommendations:

1. The department should mandate that deliberately providing false information on the Criminal Background Check form automatically disqualifies the applicant for placement of any child in his/her home. The potential for disqualification on this basis should be explicitly and prominently stated on the form.

2. Enable tribal and state staff to access the National Crime Information Center (NCIC), Juvenile Court Information System (JUVIS), and Superior Court Information Management System (SCOMIS).

Communication With Tribal Court

The communication of the criminal background information by the department to the Yakama Nation Tribal Court (YNTC) which had the legal jurisdiction of this case was not clear.

This information appeared to be confusing to the social worker who informed the court of Mr. Sam's complete criminal history of convictions but indicated that the background check had cleared. Source documents were not provided to the court but the list of convictions for the relatives as well as the outstanding warrants on Ms. Sam were outlined in an affidavit presented to YNTC by the Toppenish DCFS social worker.

In the affidavit to YNTC, there was an emphasis on reviewing the relative's substance abuse issues and trying to determine if these were still a relevant factor in this home. There was no formal mention of the Theft 2 conviction which was the disqualifying crime unless an administrative waiver was granted.

Recommendations:

1. Recommendations to the court should be clear and concise with supporting source documents.

2. The cover letter from BCCU that accompanies returned criminal background checks should clearly and prominently state which listed crimes are disqualifying under department policy so that there is no confusion when there are multiple crimes on a criminal history report.

3. The Individual Safety and Service Plan (ISSP), which is the document used by the department to update the court on the current status of a case should be reformatted: the top page should completely embody, in very clear, brief form, the recommended service plan for the next review period.

Practice Issues

Several practice issues became evident as this case was reviewed.

- **The Colville tribe was not notified of the dependency action on the children.**

  According to the Department's Indian Child Welfare policy all tribes involved with a family should be notified of children placed out of the care of their parents in the state child welfare system.

  The Indian Child Welfare manual Section 03-30 (D) states:
  If the child is affiliated with more than one Tribe, the social worker contacts each Tribe by telephone and sends each Tribe a written request for verification of the child's Indian status.

The child was placed in the Yakama Nation child welfare system. Yakama Tribal Court had legal custody of the child from the beginning of the placement. Although this child had heritage from both the Yakama Nation and the Confederated Tribes of the Colville Reservation, only the Yakama Nation knew that the child was dependent.

- **Pressure from the tribal court and some family members impacted the decision making on the case.**

Throughout the month of January, 2006, there was pressure placed on the Toppenish social workers by the tribal court and the extended paternal family to place the child and his sister in the home of the relatives in Spokane.

During this time, as well, the workers were called to meetings with the family and members of the tribal legal system to update them on the progress of the potential placement. At these meetings the family expressed that they wanted the child and his infant sister placed in the Sam home. On one occasion, the mother was also present and expressed her desire to have the children placed in this home.

Throughout these meetings and in all tribal court hearings, the DCFS social workers did not have legal representation. Social workers who appear in state court are represented by assistant attorneys general.

- **The home study completed on the relatives was hurried and incomplete.**

The desire for a relative placement and the need to change the placement of the children, coupled with pressure from the tribe and the family, caused the Toppenish DCFS social worker for the infant sister of the deceased child to request an expedited home study on the Sams through the Spokane DCFS office. The Toppenish social worker did not provide the Spokane social worker with the Sams' criminal history, nor did the Spokane social worker inquire about the results of their criminal history. Consequently, the Spokane social worker did not discuss criminal history with the Sams and approved the home for placement absent that information.

The home study was incomplete with little information regarding the living situation of the relatives. The Spokane supervisor who received the referral did not assign the case but completed the home study himself. He stated that the home study was not in depth because his unit was inadequately staffed at the time.

Chapter 5000-Section 5231 of the Children's Administration Practices and Procedures Guide states that in addition to the general requirements for the completion of a home study the "social worker shall document an assessment of appropriateness, including:

- *a formal criminal history and background inquiry, using the DSHS 09-693 to the Washington State Patrol and to local law enforcement.*

In this case, the criminal history background check was completed but not considered in the assessment for the appropriateness of the placement.

- **There was confusion about the roles and responsibilities involved with cases sent from one office to another for courtesy supervision.**

  Along with a request for courtesy supervision of a case from one DCFS office to another, the sending office should provide the receiving office with all pertinent documentation on the child as well as inform the office of any outstanding concerns about the case. This case does not indicate that the social work staff in the Spokane office were totally informed regarding the child's special needs or behavioral problems. Both the children placed in the Sam home were born premature and drug exposed. The deceased child had been involved with medical providers in the Yakima area and yet the social workers in the Spokane office seemed unaware of the medical issues of the child and no mention was made of them in completed 90-day health and safety reports.

Recommendations:

1. To ensure that ICW policy is thoroughly followed in cases involving Native American children, staff should receive regular ICW training.

2. Placements of children shall not occur unless policy is followed.

3. Tribal and/or LICWAC staffing shall be completed prior to a change of placement of Native American children unless immediate placement is court ordered in which case the staffing should occur as soon thereafter as possible.

4. CA needs to clarify the roles and responsibilities in the process of home study requests and subsequent courtesy supervision placements.

Training Issues

There appeared to be confusion by staff around a number of departmental policies and procedures in this case. The criminal history background check specifically stated that Avery Sam had a disqualifying crime but workers seemed unsure as to what the crime actually was.

The form which lists these crimes divides them into groups of permanent disqualifiers and those which disqualify the subject for five years. It also categorizes them into misdemeanor, gross misdemeanor and felony. The Toppenish worker focused on Avery Sam's drug history and emphasized this in the affidavit to the tribal court when reporting his criminal history. She did not address a conviction for Theft 2 which was a five-year disqualifying crime committed in 2003. The worker also seemed unaware of the current department policy and cited the Revised Code of Washington (RCW) as her source of information on disqualifying crimes. The Revised Code of Washington (RCW) does not specifically detail disqualifying crimes for potential placement options for children. The categories of disqualifying crimes are set out in the Washington Administrative Code (WAC). The WAC is not identical to the

agency policy.

Recommendation:

1. The department should provide regular training to all staff on the disqualifying crimes and the time frames that outline them.

Other

This case was unique in that it was involved in tribal court, and the court was an integral part of the placement of the child with the relative. The committee made several findings and recommendations for the Yakama Nation Tribal Court to consider:

- There was not a Guardian ad Litem (GAL), CASA or other individual at court to speak on behalf of the best interest of the child.

- There is not consistent information sharing and discussion between the department, the tribe and the legal parties involved with cases administered through the YNTC. This can lead to situations which result in decisions that are less than optimal for tribal children or place those children at significant risk.

Recommendations:

1. The YNTC should appoint a GAL for children in dependency cases.

2. Regular meetings should be established which involve the Yakama Nation staff, judges, tribal prosecutor, Nak-Nu-We-Sha staff and Children's Administration staff and supervisors appearing in YNTC in order to discuss procedures, issues, communication and other items of mutual concern. The assistant attorney general (AAG) representing CA in state court should be invited to attend these meetings.

forensic enquiry or to replace or supercede investigations by courts, law enforcement agencies, medical examiners or other entities with legal responsibility to investigate or review some or all of the circumstances of a child's death. Nor is it the function or purpose of a Child Fatality Review to take personnel action or recommend such action against DSHS employees or other individuals.