Children's Administration

Executive Child Fatality Review

B.M. Case

Date of Birth: 02/ /2008
Date of Death: 08/25/2010
Date of Review: 01/06/2011

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Executive Summary

On August 25, 2010, Children's Administration (CA) accepted an intake from Toppenish Police Department (TPD) reporting the death of 2½ -year old B.M. The referent reported they responded to Toppenish Community Hospital after receiving a call from emergency room staff regarding a child's death. It was reported the child's mother's boyfriend, Juan Balverde Lopez,[1] brought the child to the hospital where the mother was a patient. Mr. Balverde was caring for the child while the child's mother was hospitalized.

B.M.'s mother told law enforcement officials Mr. Balverde contacted her the previous evening and told her B.M. was complaining of a stomach ache and not feeling well. She added he told her he had been roughhousing with his siblings and one of them had jumped on his stomach. She stated she told Mr. Balverde to wait until the morning to see how he was feeling. The mother reported Mr. Balverde had told her he took B.M. to bed with him that evening and at 5 a.m. he had crawled into bed with his sister, age 7. Mr. Balverde reported he found the child the next morning unconscious and his feet were purple in color. Mr. Balverde then proceeded to drive the child, along with his two siblings (ages 7 and 4), to the Toppenish hospital.[2] He left B.M. in the car in the emergency bay at the hospital and went to the mother's room to tell her of his concerns for B.M. The child's mother immediately went to her child and carried him into the emergency room where he was pronounced dead by hospital staff.

B.M. presented in the emergency room with multiple bruises and contusions. Given the injuries the Yakima County Coroner requested an autopsy to determine the cause and manner of death. The autopsy was completed on August 26, 2010 and noted *"cause of death: acute laceration of the small bowel and acute intra-abdominal hemorrhage due to blunt impact injuries to the abdomen; manner: homicide."*

After receiving the intake information regarding B.M.'s death, CA collaborated with the Toppenish and Sunnyside Police Departments in initiating an investigation into the fatality. During the course of the investigation, Mr. Balverde admitted to striking B.M. on at least one occasion. A witness in the home told investigating officials Mr. Balverde had hit B.M. multiple times the previous evening. Mr. Balverde was subsequently arrested and charged with murder in the 2nd degree.

In January 2011, CA convened an Executive Child Fatality Review[3] (ECFR). Given the departmental history referencing this family, including interventions in the 12 months prior to

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[1] The full name of Mr. Juan Balverde Lopez (aka Mr. Balverde) is being used in this report as he has been charged in connection to the incident and his name is a part of the public record.

[2] Family was residing in Sunnyside at the time of the fatality.

[3] 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.

this child's death, CA convened the review team pursuant to RCW 74.13.640[4]. The committee met to review the decisions, policy, practice and service delivery in this family's case.

The family's Child Protective Services (CPS) history began in 2008 and includes six previous intakes prior to B.M.'s death. Three intakes were accepted for investigation and identified B.M.'s mother as the subject of physical neglect and/or physical abuse; one was accepted as a low risk intake, and two intakes were screened out. The record reflects intakes investigated prior to the fatality resulted in unfounded findings and did not result in the initiation of services to the family or court intervention.

Committee members included a diverse group of CA staff, a medical professional, law enforcement, the Office of the Family and Children's Ombudsman, and the Department of Early Learning. Review committee members had no involvement with the B.M case. Team members were provided case documents consisting of family history/chronology[5] including all intake information, Yakima County Coroner's report, and child care records.[6]

During the course of the review team members discussed screening decisions on intakes received prior to the child's death, accessibility of historical information in FamLink,[7] diversity in staff roles and responsibilities related to intake and investigations within CA, and communications between CA and referring parties. In addition, the review team addressed issues related to medical follow up for children known to CA and the moral responsibility of citizens to report child abuse or neglect.

Following review of the case histories, child care records and discussion, the review committee made findings and recommendations which are detailed at the end of this report.

Case Overview

The review team was provided with CA case information for three families; the deceased child's mother's case, the deceased child's father's case and Mr. Balverde's case. Intakes referencing the families were reviewed in regards to service decisions and interventions, system issues, and policy implications.

B.M.'s Mother's History

The deceased child's mother's CPS history as a parent began in 2008. CA has received a total of six intakes prior to B.M.'s death in August 2010. Of the six prior intakes, three were accepted for investigation and identified the child's mother as a subject of physical neglect or physical abuse, one was accepted as a low risk/alternative response intake, and two intakes were screened out.

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[4] RCW 74.13.640

[5] Case history information was available for all the following families: deceased child's mother, father (separate case) and Mr. Balverde's case history affiliated with the mothers of his two children.

[6] The autopsy and the police report were not available at the time of review due to pending legal charges. The review team stated the availability of these reports would have been helpful in their review of this child's death.

7 Children's Administration's Management Information System.

In the summer of 2008, CA received two separate intakes alleging neglect/negligent treatment to B.M.'s siblings. In June 2008 it was alleged B.M.'s mother was driving while under the influence of substances with children in the car, living conditions posed a safety and health risk to the children in her care, and inadequate supervision resulted in injuries to her children. In July 2008 it was alleged B.M.'s mother was not providing adequate supervision for her children resulting in one child suffering an injury to his foot requiring stitches. CA assigned both intakes for investigation. CA conducted several home visits, interviewed the children's child care provider, obtained medical records, and contacted law enforcement and family members for additional information. In addition, the children's mother submitted to urinalysis on two separate occasions. Both investigations resulted in unfounded findings with no post investigation services provided.

In March 2009, CA received a report referencing possible burn marks on the thighs and fingers of B.M. who was 13 months of age at the time. The referent (family friend requesting anonymity) was unaware if the mother had taken the child to a doctor. This intake was screened in as low risk and an alternative response resulted in a letter being sent to the mother notifying her of the intake and services in the community she could access. No other services were provided.

In July 2010, CA received two intakes referencing B.M.'s family from the child's child care provider. Both intakes alleged injuries to B.M. and an older sibling, age 4.

- The July 14, 2010 intake noted B.M. presented with a black eye. The referent stated the mother's boyfriend had dropped the child off and said he had fallen off the bed and injured his eye. When making the report to CA the referent was asked by CA intake staff to contact the mother and confirm the explanation. The referent did as asked and reported back to CA the mother said the child had fallen off the bed. CA did not get the name of the boyfriend and screened out this intake.
- The July 27, 2010 intake noted bruises to both B.M. and his older brother. Again, the referent (same referent from the July 14, 2010 intake) stated the mother's boyfriend dropped the children off and stated the children did not appear fearful of the boyfriend. The referent stated the mother said the child had fallen off the bed. CA did not obtain the name of the boyfriend from the referent at the time of this intake. The intake was screened out.

RCW 13.50.100

[redacted]

Mr. Balverde's Case History

Mr. Balverde (Lopez) is affiliated with five intakes received by CA. Information available to CA indicates he is the father of two children, ages 4 and 2, by two different women.

This intake notes that Mr. Balverde was arrested for assault in the 4th degree, domestic violence, for the same incident that led to the referral. This intake was screened out. RCW 13.50.100

The fourth intake in August 2010 references Mr. Balverde's role in the death of B.M.

August 2010 Fatality

In August 2010, CA received a report that B.M. had been transported by the child's mother's boyfriend to the Toppenish Community Hospital and was deceased. Information provided by medical staff and law enforcement noted significant bruising to B.M. and an autopsy would be conducted to determine cause of death. The intake identified Mr. Balverde as the subject of physical abuse and neglect/negligent treatment and B.M.'s mother as a subject of neglect/negligent treatment.

The Sunnyside Police Department's photographs taken at the hospital showed that B.M. had a large bruise on his forehead, a left black eye, a large mark running down from his forehead to his cheek, a purple bruise above his navel and a purple bruise in the middle of his back. An autopsy was completed on August 26, 2010 by the Yakima County Coroner's office and the preliminary results of the autopsy listed *"cause of death: acute laceration of the small bowel and acute intra abdominal hemorrhage due to blunt impact injuries to the abdomen; manner of death: homicide."*

During the course of the investigation into B.M.'s death CPS and law enforcement conducted interviews with several people including family members[8] living in the home with Mr. Balverde. B.M.'s sister disclosed Mr. Blaverde had punched B.M. in the stomach the previous evening and then he later fell off the bed and hit his head. When she awoke the next morning she knew B.M. was dead. She stated Mr. Balverde made her 'pinky promise' she should say she had jumped on B.M. When interviewed by detectives, Mr. Balverde admitted to striking B.M. one time. Mr. Balverde has been charged with murder in the 2nd degree.[9]

As a result of B.M.'s death his siblings were placed into protective custody by law enforcement on August 25, 2010 and placed in the care of B.M.'s father and his partner. Mr. Balverde's

[8] Mr. Balverde shared a home with his father, three siblings, his own daughter and the deceased child's mother and two siblings.

[9] Mr. Balverde remains incarcerated at this time pending completion of legal proceedings.

daughter, who was living in the home, was also placed in protective custody on August 25, 2010 and placed in foster care. CPS investigative findings resulted in founded findings for physical abuse and neglect/negligent treatment for Mr. Balverde and founded findings for neglect/negligent treatment for the child's mother.

Findings by the Review Team

Intake Decisions

The review team discussed the screening decisions related to intakes involving B.M.'s family in March 2009 and July 2010. Findings include the following:

- Alternative Response System[10] (ARS): ARS services were intended to improve family cohesiveness, prevent re-referrals of the family, and improve the health and safety of children. Contracted providers, such as public health nurses followed up with families when an intake had been screened as ARS or low risk. However, in October 2008 budget impacts in Region 2 limited contracted providers ability to follow up with families and confirm medical care was accessed. The review team found limitations to ARS resources impacts CA's ability to ensure a family has followed through with accessing any recommended services, including medical care, unless an intake is screened in for further investigation.
- In the July 14, 2010 intake, CA requested the referent seek an explanation for the injury from the parent. The review team found when additional information, such as medical status of a child or cause of an injury, would assist in making an intake decision it is the responsibility of CA staff and not the referent to obtain this information.
- Information provided in the July 2010 intakes referencing the deceased child and his sibling suggested further inquiry at intake was recommended. Documenting the name of the mother's boyfriend and retrieving historical person and case information could have provided additional information when making intake decisions. The review team discussed CA's management information system, FamLink. FamLink provides limited person or case history information up front and requires staff to conduct time intensive research to ensure an adequate assessment of a family's history is obtained and applied to any decision making.[11] This limits CA's ability to obtain a quality assessment of a person's CPS history at intake. The review team found the intake decision on July 14, 2010, given its limited information may not have warranted further inquiry, however the July 27, 2010 intake coupled with the family's history supported assignment for investigation.
- The review team found CA best practices include asking the referent if they would like a call back regarding CA's decisions or actions on the information provided. The review team found calling back the referent in regards to the July 2010 intakes involving B.M. may have elicited additional information and would have notified the referent of any intervention by CA. Child care information reviewed post fatality indicated B.M.

[10] ARS services included Early Family Support Services and Early Intervention Programs.

[11] A review of Mr. Balverde's history in FamLink revealed the November 2008 intake referencing his arrest for assault 4, domestic violence is documented in the system. However the intake is not connected to his person or case information affecting CA intake staff from retrieving historical information efficiently.

continued to present with bruises in early/mid August 2010 and should have resulted in a call to CA. The review team found when call backs to referents are completed the referent may provide additional information or make subsequent calls of concern. Call backs to referents elicit support from referents and the community in reporting child abuse and neglect.

Roles and Responsibilities

The team discussed roles and responsibilities of persons involved in ensuring the health and safety of children. Findings regarding roles and responsibilities are as follows:

- The review team asserted child health and safety is the collective responsibility of all CA staff regardless of role and responsibility. The review team discussed when intake staff make inquiries from referents about child abuse and neglect their primary role is one of active listener and recorder. CPS intake staff receive and assess available information to make intake screening decisions. Whereas the CPS investigator is responsible to conduct investigations seeking facts about the family's current situation as a means to assess for impending dangers or threats to child health or safety. The review team found intake staff in July 2010 in the office was staffed by a CPS investigator who had not been afforded the opportunity to attend intake training and may not have had a clear understanding of the intake role and its duties.
- CA currently does not have statutory authority to access autopsy results through the course of an investigation or for purposes of a fatality review on cases that CA was involved within 12 months of a child's death. The review team found that limited access to the autopsy report was a barrier in discussing medical issues during the course of the review.
- The Revised Code of Washington 26.44.030[12] defines the duties and authority for those persons who are mandated to report when they have reasonable cause to believe that a child has suffered from abuse or neglect. The law defines the roles of professionals and practitioners who are mandated to report. The review team found given the nature of this child's injuries, others in the home knew of this child's distress but failed to report concerns.

Recommendations

Intake Decisions

- CA's Central Case Review Team in consultation with CPS Program Managers have developed a tool for the purpose of reviewing intake decisions. It is recommended the Central Case Review Team pilot the new review tool in the Sunnyside CA office in 2011.
- FamLink Historical Information Access: CA's continued efforts in merging case and person information in FamLink will support efficient retrieval of case/family history to

[12] RCW 26.44.030

support effective decision making. Also, CA might consider including abuse/neglect[13] type in the *Prior Involvement* section of the intake.

Roles and Responsibilities

- The review team found that given the complexity of positions within Children's Administration, it suggests staff should clearly understand the varied roles and responsibilities of each position in the event they are asked to fill in or assume other duties for a time. CA should give consideration to ensuring all staff are cross trained and aware of the varied roles and responsibilities within CA. This is especially critical in smaller offices where staff perform multiple roles and functions or are asked to fill in during staff shortages and emergencies.
- The review committee recommends an addition to RCW 68.50.105[14] to allow release of an autopsy report to CA when a child's death is the result of alleged abuse or neglect.
- No one residing in the child's home falls within the category of those who are mandated to report; therefore they did not have a legal duty to report, absent serious abuse[15]. Nevertheless, the review team found that, given the nature of this child's injuries, others in the home knew of the child's distress but did not report concerns. Therefore the review team recommends that consideration be given to amending RCW 26.44.030 to include *any person* who has reasonable cause to believe or suspect a child has suffered from *any abuse or neglect* shall make a report.

[13] Physical abuse, Neglect/Negligent Treatment, Physical Neglect and Sexual Abuse.
[14] RCW 68.50.105
[15] RCW 26.44.030 defines… "severe abuse means any of the following: Any single act of abuse that causes physical trauma of sufficient severity that, if left untreated, could cause death; any single act of sexual abuse that causes significant bleeding, deep bruising, or significant external or internal swelling; or more than one act of physical abuse, each of which causes bleeding, deep bruising, significant external or internal swelling, bone fracture, or unconsciousness.