Children's Administration

Executive Child Fatality Review

N.L.

August [redacted] 2009
Date of Child's Birth

May 9, 2011
Date of Child's Death

September 12, 2011
Executive Child Fatality Review Date

Committee Members:
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Bradley Graham, Detective, Tacoma Police Department
Bolesha Johnson, Family to Family Supervisor & Court Service Manager, Children's Administration, Region 2 South
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RCW 74.13.515

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Executive Summary

On May 9, 2011, Children's Administration (CA) Central Intake (CI) accepted an intake from Pierce County Sheriff's office reporting the death of 20-month old, N.L. The referrer stated that they responded to the family home along with Emergency Medical Technicians (EMT) after receiving a 911 call from the child's mother. N.L.'s mother had been at work at a location close to her home when her boyfriend, Charles Mann[1] called her and informed her that N.L. was in distress. Mr. Mann was caring for N.L. and her two month old half sister [redacted] Upon returning to the home, the mother found N.L. was not breathing and had vomited. N.L. was brought to Mary Bridge Children's Hospital emergency room by the EMT's who attempted to revive the child however were unsuccessful. Given the condition of N.L. and the unknown origin of her injuries, law enforcement placed V.M., N.L.'s younger sibling into protective custody.

In an interview with investigating officers, Mr. Mann stated N.L. had apparently drowned while he was attending to the infant, V.M. in another room. Mr. Mann stated that he attempted to revive N.L. by pumping her stomach to remove water. Following an autopsy on May 10, 2011, the Pierce County Medical Examiner concluded that the manner of N.L.'s death was homicide, and that blunt force trauma to her abdomen caused fatal bleeding. It was the opinion of the medical examiner that N.L. died within three hours of being struck. No water was found in the child's lungs.

After learning of the autopsy results, Mr. Mann changed his account of the incident and subsequently said he accidentally punched N.L. while pretending to box her. On May 10, 2011, Mr. Mann was arrested and charged with second degree murder. The criminal case is pending.

A review of the family's history with CA notes [redacted] intakes prior to N.L.'s death. One intake, dated February 18, 2011, identified N.L., as an alleged victim of child abuse or neglect.

[redacted]

[redacted] The fifth intake received on February 18, 2011 involved allegations of neglect of N.L. by her mother. This intake was assigned for a CPS investigation; however no finding was made prior to N.L.'s death and the CPS case was open at the time of the child's death.

In September 2011, CA convened an Executive Child Fatality Review[2] (ECFR) committee to review the practice and service delivery in the case of 20-month old N.L. and her family. The fatality review

[1] The full name of Charles Mann is being used in this report as he has been charged in connection to the incident and his name is a part of public record.

[2] 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

committee members included CA staff and community members representing disciplines relevant to the case. Committee members had no involvement in N.L.'s case. Committee members received the following case documents prior to the review: a chronology of the case prepared for the review, [redacted] Available to committee members at the time of the ECFR were the un-redacted CA case records, and copies of CA policy regarding child protective services (CPS) investigations. During the course of the review, the CPS supervisor overseeing the February 2011 investigation was interviewed by the committee. The CPS social worker assigned to the investigation was available for questions but the committee declined to interview her.

During the course of the review, committee members discussed issues related to CPS investigative practice and procedures, Pierce West CPS workload, supervision, and availability and access to FamLink[3] reports.

Following review of the documents, case history and consultation with the social worker supervisor, the review committee made findings and recommendations which are detailed at the end of this report.

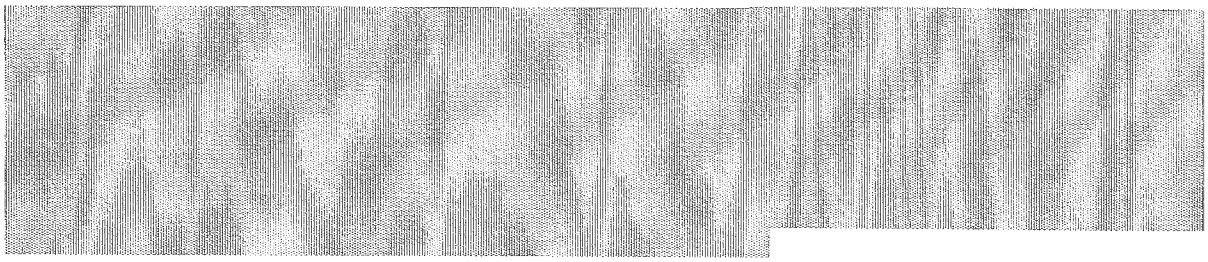
Case Overview

[redacted]

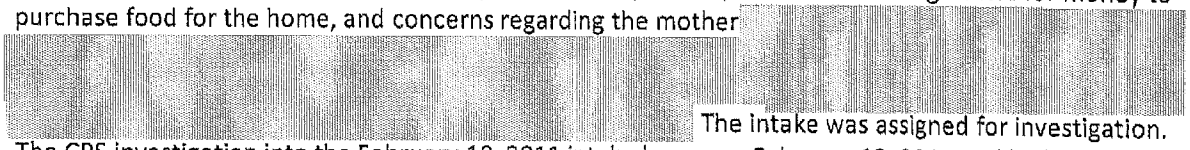
or state confidentiality laws and regulations. A review panel has no subpoena power or authority to compel attendance and generally will only hear from DSHS employees and service providers. The panel may not hear the points of view of a child's parents and relatives, or those of other individuals associated 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.

[3] FamLink – CA's Case Management Information System

RCW 74.13.515

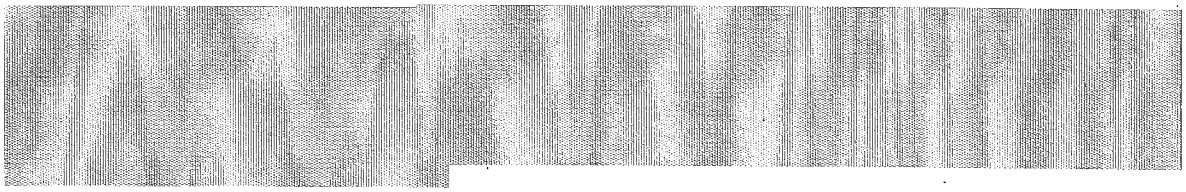


On February 18, 2011 the department received its first intake referencing N.L. as a victim of child abuse and/or negligent treatment. This intake was received from a child care provider who reported that N.L. presented with a black eye in December 2010 or January 2011. According to the child care provider the mother reported N.L. had fallen in the bathtub. The child care provider identified other concerns including N.L. coming to the day care dirty and with diaper rash, the mother asking others for money to purchase food for the home, and concerns regarding the mother



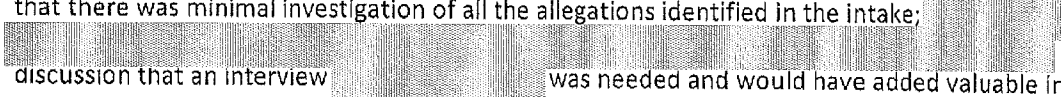
The intake was assigned for investigation. The CPS investigation into the February 18, 2011 intake began on February 19, 2011 and had not yet been concluded when notification of N.L.'s death was received on May 9, 2011.

On May 9, 2011 CA was notified of N.L.'s death by the Pierce County Sheriff's office. N.L. died from severe trauma resulting from physical abuse reportedly inflicted by Mr. Mann. He was arrested on May 10, 2011 and charged with second degree murder. In charging documents, Mr. Mann maintained that he had found N.L. under water in the bathtub, but when confronted with the autopsy results, he added that he had accidentally struck the child in the abdomen while pretending to box her. It was the medical examiner's opinion that the bruising found on N.L.'s abdomen was not consistent with a single blow from a closed fist.



Committee Discussion

The review committee discussed at length, the intake history and related investigations regarding this family. Regarding the investigation related to the February 2011 CPS investigation, the committee noted that the initial face to face contact with the alleged victim, N.L., did occur within the 72 hour required time frame and during this contact, the child was assessed to be safe and free from observable injury. However, the committee noted the lack of a thorough and comprehensive investigation as several investigative standards and requirements were missed. During the discussion it was pointed out that there was minimal investigation of all the allegations identified in the intake;



There was discussion that an interview was needed and would have added valuable information to support critical decision making on the case. Additionally, the committee identified that the investigation was not completed within 45 days per CA policy. While CA policy does not require children

[4] N.L.'s older brother was having unsupervised visitation with his mother.

to be seen monthly when a case is open for CPS investigation only, and in this case, there was one home visit and one attempted home visit with N.L. by the social worker, the committee discussed that changing family conditions (i.e. the mother due to give birth) may have warranted an additional home visit for a more comprehensive assessment.

The committee members discussed the lack of supervisory oversight on this case as the case remained open past the 45 day mark without a supervisory review to determine what additional investigative activities or actions may have been needed to complete the investigation. The review committee highlighted the importance of the supervisors in reviewing social worker documentation on an ongoing and systematic basis in addition to meeting with the social worker to analyze and discuss information regarding a family.

At the request of the review committee, the social work supervisor met with them to discuss workload and case assignment issues in the Pierce West office at the time this family was referred to the department. The social work supervisor stated to the review committee that they have 18 CPS investigator positions assigned to the Pierce West office. The supervisor reported that she supervises six social workers and her unit handles all of the CPS investigations involving military families, although they also investigate civilian cases.[5] There was some discussion regarding the complexities involved with coordinating investigations with the military, and the supervisor stated the military cases increase the workload for this unit. The supervisor indicated that workload was extremely high in her unit, as well as in the other two CPS units. There was a high number of intakes needing assignment; additionally, the area manager had reported prior to the review that there were at least two vacancies in the CPS section between January and March 2011. Additionally CA was unable to assign full caseloads to two other investigators and this impacted workload for the remaining investigators. The investigative social worker assigned to the February 2011 intake received an average of 13.7 new investigations per month between January and May 2011. The new investigations assigned per month were in addition to the worker's ongoing investigations carried over from the previous month. For investigative workers in child protective services, the Council on Accreditation Standards (COA) recommends that caseloads do not exceed 15 investigations or 15-30 open cases. [6]

Further discussion with the supervisor included challenges to completing investigations within the required 45 days and whether this is a realistic time period given the workload in some offices. The supervisor spoke to the difficulties social workers have, in general, finding the time to complete comprehensive investigations within the 45 day time frame particularly when front end case assignment is high.

The social work supervisor spoke at length with the committee regarding her approach and ability to provide clinical supervision and oversight to the social workers in her unit. She indicated that she struggles to complete monthly supervisory reviews with each of her six workers on all of their cases. She stated that she frequently staffs cases with her workers but does not always have time to document the discussion. She described that each of the three CPS supervisors in the office rotate weekly responsibility for assigning intakes and that this additional responsibility significantly impacts the time she has available to provide direct clinical supervision to her workers.

The social work supervisor described a "second level" of screening of intakes she completes which she

[5] This was not a military case.

[6] http://www.coastandards.org/standards.php?navView=public&core_id=416

indicated is often necessary to verify information in the intake. The supervisor reported that in addition to assigning and reviewing intakes, she may also be required to attend Family Team Decision Making (FTDM) meetings, thus further impacting her availability. The committee members agreed that other job duties, specifically the social work supervisor's responsibilities around intake assignment and what appeared to be efforts duplicative of the responsibilities of the intake supervisor, need to be reviewed.

In addition to discussing past service delivery to the family and the details of the fatality investigation, the review team also spent some time discussing the issue of domestic violence, including resources and training, as domestic violence was a threat present throughout this case.

Review Committee Findings and Recommendations

The review committee made the following findings and recommendations based on interviews, review of the case records, and department policy and procedure, the Revised Code of Washington (RCW) and Washington Administrative Code (WAC).

Findings

Investigations

The review committee discussed at length the CPS investigations and service recommendations made in this case over the course of the family's involvement with CA. They found the following:

- During February and March 2011, high intake assignment impacted the CPS unit in which the February 2011 intake referencing this family was assigned. Key standards of a CPS investigation required by CA policy[7] did not appear to have occurred. Investigative standards should include:
    - Investigation of all allegations identified in the intake
    - Contact with the referrer to clarify information in the intake
    - Contact with collaterals that were reported to have or may have had firsthand knowledge of the family (e.g., medical providers and other professionals involved with the family, relatives)
    - Completion of the investigation within the required 45 days or an extension of this requirement approved by the supervisor
    - Monthly supervisory review as a means to monitor case progress and to determine if the investigation was not complete and what additional action was necessary
    - Documentation of case activities in a timely manner

- Subsequent to the initial contacts with the alleged victim and mother, there was approximately a 75 day period without any significant investigative follow-up activity or visit by the CPS social worker. During this time, the mother gave birth to another child, which the committee felt may have warranted another visit to the home.

- The review committee confirmed in cases where a child is dependent or a family is receiving voluntary services, CA policy is that each child in the home will be seen monthly. Current CPS investigations policy does not require monthly visits to a home when a case is open 30 or more days for CPS investigation only.

Supervision

- The review committee found after reviewing FamLink data regarding intake assignment in the

[7] CA Practices and Procedures Guide, Section 2331, Investigative Standards

Pierce West office and meeting with the social work supervisor that monthly supervisory consultation or staffings were difficult to maintain due to the unit's workload.

Workload

- The committee found after interviewing the social work supervisor, the ability of the CPS social worker to meet practice expectations appeared to be compromised by her caseload. The social worker was experienced. However, due to vacancies in the CPS section and the number of intakes needing to be assigned for investigation, the social worker was getting an average of 13.7 new intakes assigned for investigation between January and May 2011. The social worker had 32 open cases assigned to her at the time of the child's death. The COA standards recommend that a CPS social worker have no more than 30 active cases.

- The supervisor's availability to provide clinical case consultation, monitoring, and feedback to her staff on an ongoing and systematic basis may be impacted by the intake assignment process in the office. CPS supervisors rotate the responsibility of assigning intakes for the section on a weekly basis; much of their time appears to be spent duplicating the efforts of the intake supervisor.

- The supervisor manages a unit that primarily handles military cases, although they do handle civilian cases as well. Coordination with the military can often require additional requirements when conducting investigations, which may increase the investigator's or supervisor's workload.

Recommendations

Practice

- CA may want to consider implementing a monthly visit practice for families who have a CPS case open longer than 30 days. Similar to cases involving dependent children and families receiving voluntary services, children in cases that are open to CPS should be seen monthly.

Supervision

- The review committee recommended that supervisors receive the FamLink report on a monthly basis regarding CPS investigations open for longer than 45 days without an extension as a means to support supervisors in monitoring workload. The committee recommended pulling a statewide report regarding the occurrence of monthly supervisory reviews by office and program area to determine where there may be barriers to completing the reviews.

Workload

- A review of the workflow process from CPS intake to assignment and investigation should occur in the Pierce West and East offices to determine if there are barriers and duplication of job duties.

- A statewide review should occur of the protocols and systemic issues related to coordination of investigations between CPS and the military. Consideration as to whether caseloads involving military cases should be weighted is recommended.

Training/Resources

- The review committee discussed the complexities of cases involving domestic violence. The development of the CA Social Worker's Practice Guide to Domestic Violence in 2010 was identified as a positive step in assisting CA social workers in their work with families

experiencing domestic violence. However, the committee recommended that training be developed in collaboration with community partners and implemented for CA staff regarding the Guide. Recommended training methods such as video or web based training can be developed to effectively and efficiently deliver the training.

- Based on funding availability and partnership with community agencies, a domestic violence advocate should be co-located in CA offices for the purpose of consultation, intervention, and planning on cases involving domestic violence. Research shows that domestic violence often co-exists with child maltreatment.