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

Children's Administration
Child Fatality Review

T.D.

November 2009
Date of Child's Birth

April 26, 2013
Date of Fatality Incident

October 3, 2013
Child Fatality Review Date

Committee Members:
Arthur Laur, Detective Sergeant, Aberdeen Police Department
Sue Bucy, Deputy Director, Child Advocacy Center of Grays Harbor County
Gloria Callaghan, Director, Domestic Violence Center Grays Harbor County
Bobette Webber, CDP, Social Treatment Opportunity Program
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RCW 74.13.640

Table of Contents

Executive Summary

On October 3, 2013, the Department of Social and Health Services (DSHS) Children's Administration (CA) convened a Child Fatality Review[1] (CFR) to examine the department's practice and service delivery to three-year-old T.D. and his family. The incident initiating this review occurred on April 26, 2013 when paramedics and law enforcement responded to a medical emergency call regarding an unresponsive child at the family residence. At the time of the incident T.D. was in the care of his father.[2] The child was determined to be deceased on scene. Autopsy results later determined that T.D. suffered blunt force trauma causing a subdural hematoma (but no skull fracture), and the manner of death was ruled "Undetermined." Child Protective Services had initiated an investigation of alleged neglect two weeks prior to the fatality.

The CFR Committee included CA staff and community members selected from disciplines with relevant expertise representing law enforcement, chemical dependency, domestic violence, parenting education, child advocacy, and public child welfare. None of the Committee members, including CA staff, had any prior direct involvement with the family.

Prior to the review, each committee member received a detailed case chronology of CA involvement. Committee members also received non-redacted CA case documents (e.g., intakes, case notes, safety assessments, investigative assessments) for two prior CPS investigations (2012-2013). Supplemental sources of information and resource materials were available to the Committee at the time of the review. These included copies of state laws, CA policies relevant to the review, law enforcement reports and autopsy findings, and miscellaneous case documents such as medical records.

During the course of the review, the Committee interviewed Aberdeen DCFS staff including the Area Administrator, a Child Protective Services supervisor and three

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[1] Given its limited purpose, a Child Fatality Review (CFR) should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. The CFR Committee's review is generally limited to documents in the possession of or obtained by DSHS or its contracted service providers. The Committee has no subpoena power or authority to compel attendance and generally only hears from DSHS employees and service providers. It does not hear the points of view of the child's parents and relatives, or of other individuals associated with the child. A 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 or other entities with legal responsibility to investigate or review some or all of the circumstances of a child's near fatal injury. Nor is it the function or purpose of a Child Fatality Review to recommend personnel action against DSHS employees or other individuals.

[2] The name of the father is not included in the report as the manner of death is "Undetermined" and there are no current charges regarding the fatality. The mother's name is not included in this report, as she was not involved in the investigation. Neither the name of the deceased child nor his sibling is included in this report.

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social services specialists involved in the case. A state Child Protection Medical Consultant[3] was available by phone had the Committee determined the need for any additional medical clarification. Following review of the case file documents, completion of the staff interviews, and discussion regarding department activities and decisions, the Committee made findings and recommendations presented at the end of this report.

RCW 74.13.515

Case Overview

At the time of T.D.'s birth in November 2009, CA had been providing Family Voluntary Services (FVS) for several months.[4] The parents engaged in services completing Homebuilders[5] and partially completing a parenting program. The case closed in early February 2010.

CPS again became involved with the family following two intakes (September-October 2010) alleging neglect – primarily parental failure to meet the children's basic needs including hygiene, supervision, and nurturance. Referrers also expressed concerns (non-allegations) regarding possible drug use by the parents, persistent chaotic living environments and lack of stable housing, and parental ambivalence.[6] The parents separated, each taking one of the children. At the mother's request, relatives assumed care of T.D. temporarily. The case closed in January 2011, with the children's father assuming sole caretaking of T.D. and his sibling. The mother's parental involvement appeared significantly diminished

[3] The tasks of the statewide Child Protection Medical Consultants (CPMC) network include providing telephonic consultations, case staffing/case review, training, court testimony, and written consults to CA staff, law enforcement officials, prosecuting attorneys, and physicians regarding child maltreatment cases.

[4] Family Voluntary Services support families' early engagement in services, including working with the family to create Voluntary Service Agreements or Voluntary Placement Agreements and providing ongoing case management services and assessment of safety and risk to children. Voluntary Case Plan are used to engage families willing to participate in services intended to reduce current and future abuse or neglect issues that do not require court intervention. Voluntary services are short-term to help increase parents' protective capacity and manage child safety. Continued assessment of child safety occurs throughout the case. [Source: *Children's Administration Practice and Procedure Guide*]

[5] HOMEBUILDERS® provides intensive, in-home crisis intervention, counseling, and life-skills education for families as a means to prevent future crises including out-of-home placement.

[6] Parental ambivalence relates to the nurturing and affectionate aspects of a parent-child relationship. It is often identifiable by behavioral or verbal indicators that suggest contradictory attitudes toward the relationship, incompatible expectations, mixed emotions, and self-doubt regarding being able to handle a parent/caretaker role.

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from that point forward. The CPS investigation resulted in the allegations being unfounded due to lack of evidence.[7]

One year later T.D.'s father contacted CA to request services. The father reported having difficulty with parenting and struggling with substance abuse relapse impulses and anger behaviors. The father agreed to a Voluntary Service Agreement that included participation in a parenting skill class, chemical dependency assessment, child developmental screening, and counseling. The FVS worker experienced resistance from both the father and his partner during monthly home visits. Multiple efforts to engage the father in individual and family services were unsuccessful and the father and his partner continued to deny access to the home and to any significant contact with the children. In June 2012, the father indicated he no longer wanted any CA services. The voluntary services case closed with no substantive progress, the family declining further services, and insufficient basis for legal intervention by the department.

On April 12, 2013, an Advance Registered Nurse Practitioner (ARNP) examined T.D. for flu-like symptoms and rectal bleeding possibly caused by hard stool. The examination showed two small bruises in the genital and rectal areas. The child stated his sibling had caused the injuries but did not provide a clear explanation. The ARNP contacted CA which accepted the intake for investigation of allegations of neglect as there was no clear indication at the time of any physical or sexual abuse caused by the child's parent. CA immediately forwarded the report to local law enforcement who then requested CPS not to discuss the subject of possible sexual abuse with the family until a detective could contact the family.

Law enforcement did conduct a welfare check several days later and found no apparent indications that T.D. was unsafe. A follow-up exam by the primary care physician (PCP) showed the bruise in the genital area had disappeared and the rectal area bruise had faded. The primary care physician encouraged the family to

[7] CA findings are based on a preponderance of the evidence. Child Abuse and Neglect are defined in RCW 26.44, WAC 388-15-009, and WAC 388-15-011. Findings are determined when the investigation is complete. Founded means the determination that, following an investigation by CPS, based on available information: it is more likely than not that child abuse or neglect did occur. Unfounded means the determination that, following an investigation by CPS, based on available information: it is more likely than not that child abuse or neglect did not occur, or there is insufficient evidence for the Department to determine whether the alleged child abuse did or did not occur.

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accept the referral made by the earlier medical provider for further examination at the local Child Advocacy Center[8] although documentation indicates that the PCP felt such an exam likely was unnecessary. Safety interviews conducted by CPS with both children did not reveal any present or imminent danger. T.D. unexpectedly died before a forensic interview could occur. A forensic interview of the sibling did occur. Based on the information available to CPS the allegations from April 12, 2013 were unfounded.

On April 27, 2013, CA received notification from Grays Harbor Sheriff's Office of T.D.'s death. On-scene responders (medical and law enforcement) saw no obvious indicators of trauma but the circumstances of death were described by the referrer as being "somewhat suspicious." Autopsy results later determined that T.D. suffered blunt force trauma causing a subdural hematoma (but no skull fracture) and the manner of death was ruled "Undetermined." There was no evidence of any other trauma or injuries. Toxicological results showed Carboxy-THC in T.D.'s system, likely representing passive inhalation of marijuana, but having no direct connection to cause of death. The CPS investigation found evidence of neglect by the father but no evidence of abuse or neglect directly related to T.D.'s death. The criminal investigation remains active without arrest or criminal charges at this time.

Discussion

Committee discussions focused on CA policy, practice and system responses in an effort to evaluate the reasonableness of decisions made and actions taken by the department. Committee members reviewed and briefly discussed early CA involvement in Lewis County when T.D. was in the care of both parents (2009-2010), but mainly focused on recent CA involvement when T.D. was under the primary care of his father in Grays Harbor County (2012-2013). Discussions occurring as to the family involvement with non-CA agencies were considered outside the purpose and scope of the Child Fatality Review but served to generate discussion on inter-agency collaboration.

[8] The Child Advocacy Center of Grays Harbor is a member of the Washington State Chapter of the National Children's Alliance (NCA), which is the accrediting organization. The NCA has established standards for CACs that include (1) child-focused, child-friendly facilities for children and their non-offending family members, (2) multidisciplinary team case staffing participation by law enforcement, prosecution, medical experts, social work, and advocacy, (3) medical evaluation onsite or through referral, (4) therapy onsite or through referral, (5) onsite forensic interviews, (6) and case tracking. [Sources: Children's Advocacy Centers of Washington www.wsacac.org]

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The Committee looked at both risk factors[9] and family strengths assessed by CA throughout the span of contact with the family. Persistent "red flag" risk factors included episodes of severe anger and intimate partner violence by the father, substance abuse and resistance to chemical dependency services, frequent unstable housing, struggles with effective parenting, and parental ambivalence[10] particularly by the father toward T.D. Strengths frequently documented included the family's occasional willingness to seek help and take advantage of services offered, utilizing relative resources for support, and intervals between reports of alleged child abuse or neglect.

The Committee reviewed the quality and level of interventions by CA in consideration of the limits of legal authority accorded the department to intervene (e.g., RCW 26.44 and RCW 13.34). The Committee noted possible opportunities for more assertive intercession by CPS in 2009-2010. During the FVS involvement (2012), the worker documented multiple efforts to engage the father who, despite having requested such services, was not responsive. The Committee was unable to determine with any certainty how more aggressive intervention during earlier involvement with the family would have affected the circumstances of the child fatality in 2013.

The Committee discussed at length the April 12, 2013 intake accepted for investigation two weeks before the fatality. The Committee was unable to reach full consensus as to whether the intake should have been designated for 24-hour (emergent) response rather than the 72-hour (non-emergent) response or even if a more immediate response would have had any perceptible impact on the fatality two weeks later.

Findings

Given that the manner of the child's death remains undetermined, the Committee found it difficult to come to any conclusions with regard to actions taken and decisions made by the department. The Committee found no obvious critical oversights and the social work appeared to generally meet CA policies, procedures and practice expectations. The documentation by the CPS worker

[9]Allegations of child abuse or neglect assert specific events, incidents, patterns and conditions defined by law and policy as child abuse and neglect. Allegations always describe past events, incidents, conditions, etc. Risk factors include all other information that lacks assertions of abuse or neglect but which are relevant to assessing the likelihood of future child abuse and neglect.

[10]Parental ambivalence relates to the nurturing and affectionate aspects of a parent-child relationship. It is often identifiable by behavioral or verbal indicators that suggest contradictory attitudes toward the relationship, incompatible expectations and mixed emotions, and self-doubt regarding being able to handle a parent/caretaker role.

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investigating the pre-fatality allegations made on April 12, 2013, appeared to be exceptional.

While having no direct impact as to the fatality incident, the Committee notes two systems issues that appear to be persistent barriers to inter-agency communication and collaboration in Grays Harbor County. (1) Aberdeen CA staff reported having great difficulty getting direct access to medical providers for a particular local medical facility, often given medical information from facility staff rather than from physicians as requested by workers. (2) The process of forwarding CA intakes to one specific law enforcement agency in the county appears to be unreliable, resulting in occasional "lost" faxes and delays in the assignment to detectives from that agency.

Recommendations

- The Committee recommends that the Aberdeen DCFS Area Administrator initiate contact with the local medical facility identified during the review where staff experience difficulty getting direct contact with medical providers. The goal should be to engage in dialog to explore ways to improve information sharing as permitted by RCW 26.44 and to explore opportunities for agency cross training.
- The Committee recommends that Aberdeen DCFS attempt to work toward improving the referral process with the specific law enforcement agency identified during the review. The goal would be to develop a more reliable system for forwarding and tracking the intakes sent to the law enforcement agency thereby improving timely assignments to detectives.

Nondiscrimination Policy

The Department of Social and Health Services does not discriminate and provides equal access to its programs and services for all persons without regard to race, color, gender, religion, creed, marital status, national origin, sexual orientation, age, veteran's status or the presence of any physical, sensory or mental disability.

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