Children's Administration

Executive Child Fatality Review

T.V. Case

Date of Birth: 05/05/2010
Date of Death: 10/05/2010
Date of Review: 02/04/2011

Committee Members
Steve Shumate, Sergeant, Grays Harbor County Sheriff's Department
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Nancy Liedtke, Grays Harbor County Child Protection Team Member
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Executive Summary

On October 3, 2010, Children's Administration (CA) accepted an intake from a social worker with Grays Harbor Hospital reporting that four-month-old T.V. was admitted to the hospital after his father, Michael Vanderveur,[1] called 911 when T.V. became unresponsive. Mr. Vanderveur told the treating emergency room doctor that the previous night (October 2) his son fell off a sofa and hit his head on table. He stated he observed his son that night and didn't feel he needed medical attention. The next morning he picked up his son and noticed that he arched his back, his eyes rolled back, and his stopped breathing. Mr. Vanderveur reported he called 911 and started CPR. T.V. was taken to Grays Harbor Hospital and was intubated. He was later transferred to Mary Bridge Children's Hospital.

Upon arrival at Mary Bridge, hospital staff noticed that T.V. had bruises on his chin, cheeks, chest, and abdomen. A CAT was completed and found significant bleeding in the brain and retinal hemorrhaging in both eyes. The scan also revealed bleeding in the brain that doctors reported was consistent with abusive head trauma. According to the medical record, the father's report that T.V.'s injuries were caused by the fall off a couch was not consistent with the severity of his injuries. T.V. remained hospitalized at Mary Bridge.

On October 4, 2010, Michael Vanderveur was arrested by Grays Harbor County Sheriffs and charged with Assault 1.

On October 5, 2010, Michael Vanderveur admitted to a detective with the Grays Harbor County Sheriff's Office that he shook T.V. the night of October 2, 2010. He reported he was frustrated as T.V. woke him with his crying. He stated he went to T.V.'s crib and picked him up and shook him. T.V. became quiet and was quiet for the remainder of the night. Mr. Vanderveur observed that T.V. was unresponsive the next morning and called 911.

On October 5, 2010, doctors at Mary Bridge conducted several neurological tests on T.V. and each examination found no evidence of brain function. Doctors determined T.V. was brain dead and the decision was made, with his mother's consent, to take him off mechanical ventilation. T.V. died later that day.

Given that T.V. was in at Mary Bridge Children's Hospital when he died, the Pierce County Medical Examiner conducted the autopsy to determine the cause and manner of death. The autopsy was completed and the Medical Examiner determined the cause of death was physical trauma due to abuse. The manner of death is homicide.

The criminal charges against Michael Vanderveur were amended and he was charged with homicide in the first degree. The criminal case is pending.

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[1] The full name of Mr. Michael Vanderveur 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. During the course of the law enforcement investigation it was found through DNA testing that Mr. Vanderveur is not the biological father of T.V. as noted on the birth certificate. The biological father of T.V. is not known. However, Mr. Vanderveur was recognized as T.V's father prior to his death. For this purposes of this report, Mr. Vanderveur will be referred to as T.V.'s father.

T.V. was in his father's care when he was injured. Mr. Vanderveur and Ms. E. did not have an established parenting plan. Ms. E. told law enforcement that she allowed Mr. Vanderveur to visit T.V. on September 8, 2010 and Mr. Vanderveur refused to return T.V. to her care. Ms. E. as told by police to file a parenting plan to regain custody of her son. Ms. E. filed a parenting plan on September 11, 2010. A court date was scheduled for October 11, 2011.

On February 4, 2011, CA convened a multi-disciplinary committee to review intake screening decisions, policy and practice in this family's case.[2] This was done pursuant to RCW 74.13.640 because T.V. and his parents had been the subjects of referrals to CA within the twelve months prior to his death. The fatality review team was represented by disciplines associated with the case and had no involvement or limited involvement with this family. The fatality review team members included, a medical professional, law enforcement, staff from a child advocacy center, director of the family birth center and a local Child Protection Team member. The team also included CA staff who had no direct connection to the case. Relevant case documents were made available to the fatality review team. These documents included: medical reports, law enforcement reports, family history including all intake information and a chronology of the case upon assignment of the case on October 4, 2010.[3]
The social worker on the case was interviewed by the review team. In addition, the investigating supervisor was also interviewed by the team. The Children's Administration Intake supervisor for Grays Harbor and Pacific Counties was also interviewed by the fatality review team.

During the course of the review, team members discussed screening decisions on intakes received prior to T.V.'s death, and intake screening policies. The team also discussed information sharing between CA and referring parties. In addition, the review team addressed issues related to information provided to CA intake by medical professionals and the impact that the lack of comprehensive information has on the screening of CPS intakes.

Following review of the case histories, medical and law enforcement records and discussion, the review team made findings and recommendations. The findings and recommendations are detailed at the end of this report.

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[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 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] The criminal case was pending at this time of the fatality review; therefore limited information regarding the criminal investigation is contained in this report to preserve the criminal proceedings of this case.

Case Overview

The review team was provided with CA case information for two families; the deceased child's mother's case and the case related to T.V. [redacted] The review team also reviewed and discussed the intakes regarding Mr. Vanderveur's care of T.V. Intakes referencing the families were reviewed in regards to screening decisions and interventions.

[redacted]

On September 12, 2010, an intake was received by CA Central Intake from staff at Grays Harbor Hospital. T.V. was taken to the hospital by his father Michael Vanderveur. Mr. Vanderveur told hospital staff that Ms. E. was allowing small children to carry T.V. and he thought T.V. had been dropped by the other children. He also reported that there was a pit bull in the home that was unsupervised around the children. T.V. was previously diagnosed with esophageal reflux and the mother refused to give the father T.V.'s medication. Hospital staff reported that T.V. had old scratches on his head and one on his arm. None of these scratches required medical attention. The hospital staff reported that T.V. appeared healthy. This intake was initially screened in by the intake worker for alternate intervention. The intake supervisor changed the screening decision and screened out the intake because a medical professional reported that the child was okay.

During the fatality review it was discovered that law enforcement spoke to the father about this incident and did not generate a report of abuse and neglect. It was also discovered that T.V. had been seen at the hospital approximately three months prior to this intake after he had been stepped on by a dog. T.V. would have been a little over a month old at the time of this incident. Ms. E. followed up with getting T.V. medical treatment and no intake was received by the department regarding this incident. This information was provided to the review team by law enforcement who is investigating the death of T.V. The Grays Harbor Hospital staff who reported the intake on September 12, 2010, did not mention any history of seeing T.V. prior to September 2010. It is unclear from the intake if the intake worker asked the hospital staff if they had a history of seeing this child. The review team agreed with the initial screening decision by the intake worker and would have left the intake screening decision as alternate intervention.

[4] M is T.V's half brother and Michael Vanderveur is not M's father.

An intake was received on September 13, 2010 by Central Intake. This intake was called in by Ms. E. who reported that five days earlier T.V. had bruises "covering his back" after he had a visit with his father. Ms. E. stated that she took photos and took her son to a doctor. Ms. E said the doctor " didn't do anything." There was no report from the doctor taken by CA intake. Ms. E. reported that earlier that evening Mr. Vanderveur took T.V. and would not give him back to her. Ms. E. told intake staff that police were talking to Mr. Vanderveur while she was calling in this report to intake. Central Intake staff contacted law enforcement who reported the parents were having a custody dispute, T.V. was fine, and the officer was ready to clear the scene. Law Enforcement did not make a report to CA intake on this incident. The review team agreed with the intake screening decision based on the information received at intake. Law enforcement went to the home and saw T.V. and did not believe that he was in danger. T.V. had been seen at the hospital the previous day and hospital staff did not indicate that T.V. had bruising on his back and also stated that the child looked fine.

Two intakes were received during the month of October 2010; the first intake was received on October 1, 2010. This call came in from HeadStart staff reporting that T.V.'s grandmother picked him up for a visit with his father. The father then called the mother and told her that he was not bringing the child back to the mother. The mother told HeadStart that she had photos of bruising on T.V.'s back between his shoulders. Central Intake screened this intake out indicating that the bruising had been previously reported. During the review of this intake it was stated that the HeadStart worker felt that she was dismissed by the Central Intake worker and was informed by the intake worker that this was a custody issue between the parents. The review team felt that this intake was screened properly based on the information provided at intake. However it was unclear if further questions were asked of the referrer regarding the bruises and whether they were seen by the referrer.

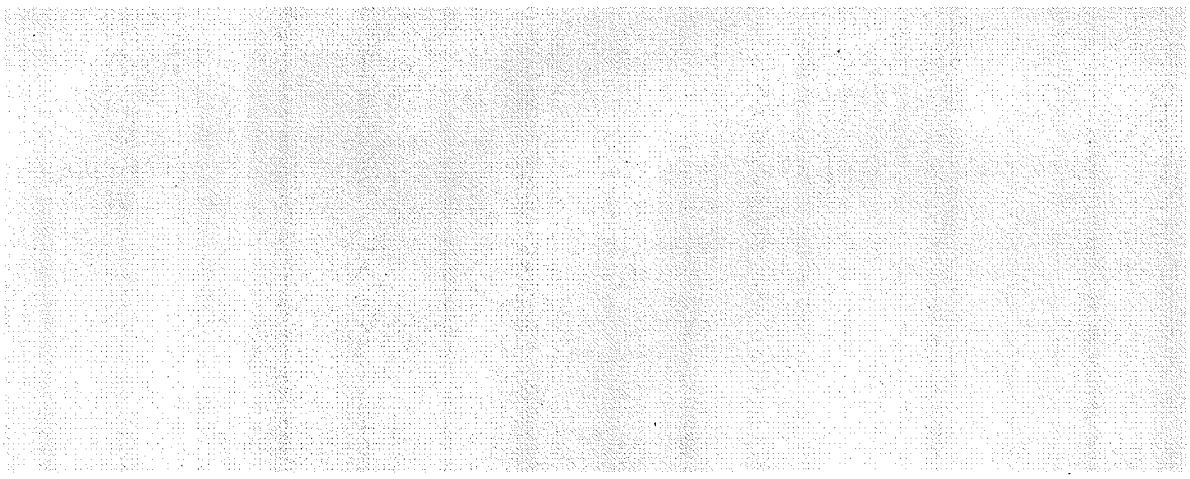
The final intake on this family was received by Central Intake on October 3, 2010. The report indicated that T.V. was taken to the hospital from his father's home via ambulance. Mr. Vanderveur told Grays Harbor Hospital staff that T. V. had fallen off the couch and hit his head on the table the previous night and that he did not feel that T.V. needed medical attention. The next morning T.V. stiffened and arched his back and eventually went limp. Mr. Vanderveur reported he then called 911. T.V. was taken to Grays Harbor Community Hospital where he was intubated and transported to Mary Bridge Children's Hospital in Tacoma. The social worker from the Grays Harbor Community Hospital initially reported that there was no indication of child abuse and neglect. Central Intake called Mary Bridge Children's Hospital who indicated that T.V. had a purple bruise on his chin and additional bruising to his forehead. He also had older bruising to his arms and knees. A CT scan of the brain revealed that brain bleeding was consistent with abusive head trauma. The intake was screened in for investigation with a 24 hour response time. The review team agreed with the screening decision on this intake.

October 2010 Fatality Investigation

On October 3, 2010, CA received a report that T.V. was taken to Grays Harbor Hospital after he became unresponsive. He was in the care of his father, Michael Vanderveur, at this time. Information provided by medical staff and law enforcement noted bruising to T.V. and a brain injury consistent with being shaken. The intake identified Mr. Vanderveur as the subject of physical abuse. A review of the medical reports by Dr. Yolanda Duralde, Director of the Child Abuse Intervention Department at Mary Bridge, indicated that T.V. received a life-ending injury due to abusive head trauma while in the care of Mr. Vanderveur.

Based on information from Ms. E. and the police officer's interview with Michael Vanderveur, it can be concluded that Mr. Vanderveur took physical custody of T.V. on September 8, 2010 without the consent of the child's mother. On the night of October 2, 2010 T.V. suffered a severe injury to the brain which resulted in his death three days later. A hearing on custody was pending in family court at the time of the child's death. The Pierce County Medical Examiner subsequently determined the cause of T.V.s death was physical trauma caused by abuse and that the manner of death was homicide. Mr. Vanderveur was arrested and has been charged with homicide in the first degree.

Mr. Vanderveur admitted to law enforcement officers he shook his son the night before he was hospitalized. Mr. Vanderveur declined to be interviewed by a CA social worker during the CPS investigation of T.V.'s fatal injuries. The CPS investigation was closed with a founded finding for physical abuse of T.V. by Michael Vanderveur.



Findings by the Review Team

Intake Decisions

The review team discussed the screening decisions related to intakes involving this family. The team also discussed information sharing by mandated reporters. The findings include the following:

- In the October 1, 2010 intake, the review team felt the intake was screened appropriately based on the information that was provided to intake by the referrer. The review team felt it was unclear if the referrer was asked additional questions about the

alleged bruising on the child, specifically if the referrer had seen pictures Ms. E reports she had of the bruising.

- In the September 12, 2010 intake, the review team agreed with the initial screening decision by the intake worker to assign the case for alternate intervention. The intake supervisor changed the screening decision to Information Only and was screened out.

- While the review team agreed with most of the intake screening decisions they felt that significant information regarding T.V.'s medical care was not properly conveyed at the time intakes were called into the department. Law enforcement discovered that T.V. was seen in June 2010 at both the Grays Harbor Community Hospital and Mary Bridge Hospital when he was stepped on by a dog. Neither hospital called in an intake regarding abuse and neglect of T.V. at the time he was treated in June 2010. T.V. was also seen on September 3, 2010 at Providence Hospital in Centralia; there was no call from Providence Hospital regarding concerns of abuse and neglect.

- The review team felt that intake staff did not get specific enough information regarding T.V.'s medical treatment and whether the callers had concerns regarding the safety and care of T.V. while in his parent's care.

Recommendations

Intake Decisions

- The review team recommended that mandatory reporting training be provided to staff at the Grays Harbor Community Hospital and that this training should be completed by April 15, 2011.

- The review team recommends that Region 6 and Central intake supervisors review and discuss the new intake policy that goes into effect on March 1, 2011 regarding intakes reported by a licensed physician or medical professional on "the physician's behalf" or a non-mobile infant (birth to 12 months) with bruises, regardless of the explanation for how the bruises occurred. A meeting is scheduled with all Region 6 intake supervisors on March 1, 2011. The new policy will be discussed with supervisors at that meeting.