Children's Administration

Executive Child Fatality Review

Michael Ravenell

September 16, 2008

Committee Members:
*Lanelle Anderson, Detective, Pierce County Sherriff's Office
*Yolanda Duralde, MD, Child Protective Services (CPS) Medical Consultant, Region 5
*Senator Rosa Franklin, Washington State Senate - 29th District
*Amy King, Detective, Olympia Police Department
*Yen Lawlor, Area Administrator, Division of Children & Family Services (DCFS), Region 3
*Tami Mistretta, Social Worker 4, DCFS, Region 6

Observers:
*Mary Meinig, Director, Office of the Family and Children's Ombudsman
*Bob Palmer, CPS Program Manager, DCFS, Region 5
*Jennifer Strus, Senior Coordinator/Counsel, Senate Human Services & Corrections Committee
*Nancy Sutton, Regional Administrator, DCFS, Region 5

Facilitators:
*Marilee Roberts, Practice Consultant, Office of Risk Management, Children's Administration
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Executive Summary

In September 2008, Children's Administration (CA) convened an Executive Child Fatality Review[1] committee to review the practice and procedures in the case of three-year-old, African-American/Native Hawaiian, Michael Ravenell (M.R.) and his family. M.R.: Date of Birth: December [redacted] 2004 Date of Death: May 28, 2008.

On May 28, 2008, CA Central Intake (CI) accepted a referral reporting the death of M.R. The referent, M. R's father, told CI the mother and other family members brought the child to the St. Clare Hospital emergency room. The mother reported that he fell off toys at the playground. M.R. received cardiopulmonary resuscitation and died despite resuscitative efforts. The referent said the Pierce County medical examiner found the death suspicious, and Tacoma Police Department (TPD) was investigating.

A review of the family's history with CA noted one prior referral on April 2, 2008 reporting bruising to the child's chest and eyes. The April 2, 2008 report was assigned for a Child Protective Services (CPS) investigation, however no finding had been made in regards to this referral prior to M.R.'s death. The CPS case was open at the time of the child's death.

Fatality review committee members included CA staff and community members who had no involvement in the case. The review committee addressed issues related to investigative practice and procedures, Region 5 hiring practices, social worker (1, 2, and 3) job classifications, supervision, and training protocols for social work staff.

Committee members received case documents including the following:

- CPS referrals regarding Ravenell family
- Ravenell case chronology
- Noah Thomas (mother's boyfriend)[2] case chronology
- CA Practice and Procedure Manual – Chapter 2000 Child Protective Services
- Case Service Policy Manual – Chapter 3000 Assessment
- Operations Manual Chapter - 5100 – Health and Safety

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[1] 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.

[2] The full name of Mr. Noah Thomas 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.

- Operations Manual Chapter - 5500 Criminal History and Child Abuse and Neglect History Checks
- Class Specifications for Social Worker 1, 2, and 3[3].

The committee interviewed the social work supervisor on this case. While the CPS program manager and Region 5 Regional Administrator attended the review as observers, the team asked them questions regarding hiring, training, and supervision expectations for the region.

The team determined several important steps in the investigative process were missed by the assigned social worker. The review committee noted that the CPS social worker on the case had little child welfare or social services experience prior to being hired and identified concerns about hiring candidates with limited professional work experience to work with families at high risk of abuse and/or neglect. The review committee explored current system limitations and constraints facing CA managers accessing qualified candidate pools. The review committee also noted newly hired, inexperienced social workers are assigned CPS investigations after completing their mandatory academy training.

The committee felt assigning high risk investigations to newly hired and inexperienced CPS social workers may present risk issues for CA. Academy training and other mandatory training provided by CA for these social workers cannot by itself compensate for a lack of direct child welfare or investigative experience. Supervisors do not have the time to provide the level of supervision that inexperienced staff require. It was noted the lack of qualified candidates and the transfer of social workers from other departments within DSHS who do not possess child welfare practice experience may affect the quality of practice and increase the risk of liability to CA.

Region 5 may not be the only region within CA facing these hiring challenges. If this challenge is faced by other regions, it is expected the quality of practice may be impacted throughout the agency, creating system vulnerability. The committee recommended additional training, mentoring, and extended on-the-job training. The committee also recommended developing pools of trained social workers to fill vacancies as they occur. Further detail on these recommendations, additional findings and recommendations are found at the end of the report.

Case Overview

CPS history for this family noted one referral prior to the child's death. A referral received on April 2, 2008, reported that M.R had bruising near his left eye area and that he had bruising several weeks prior on his chest. According to the referent, M.R.'s father, the child's mother admitted inflicting the bruises on M.R.'s chest. The referent noted the child's maternal aunt confirmed the child had a bruise on his chest and that she did not report the bruising. The referent said when he asked M.R. about the bruise around his eye, the child told him "Noah did it." The referent did not know "Noah's" last name at time of referral but said he was the mother's boyfriend. The referral was assigned for a CPS investigation. The referral notes the referent said a report was made to the Pierce County Sheriff's Office. (CA later determined the correct jurisdiction was Tacoma Police Department [TPD]).

[3] Source: Washington State Department of Personnel Class Specifications 351O, 351P and 351Q

The case record reflects that the CPS social worker responded and had initial face-to-face contact with M.R. on April 4, 2008 within mandatory timelines. Despite the child's young age, he was able to participate in an interview and told the investigating social worker that his mother had punched him in the stomach. When questioned about "Noah" M.R. stated he did not like him. M.R. did not report any injury inflicted by "Noah." The social worker noted no discernable bruising to M.R.'s chest or face at the time of the initial contact. The social worker did not take photographs during the contact.

The initial interview with M.R. was conducted at his maternal aunt's home, who provided regular child care for him. Additional investigative steps were completed including an interview with the maternal aunt, M.R.'s mother, his maternal grandmother, and his father. The maternal aunt told the social worker she and the maternal grandmother saw the bruise on M.R. and that M.R.'s grandmother took a picture of the bruise with her cell phone, which was later deleted. She also told the social worker she suspected illicit drug use by both M.R.'s mother and "Noah." She said she did not know "Noah's" last name.

On April 7, 2008 the social worker interviewed M.R.'s mother and asked about her son's bruises. The social worker documented that M.R.'s mother said she was aware of the bruise to her son's eye and explained her 16-month-old daughter may have caused the injury. Regarding the bruise to M.R.'s chest, his mother stated she had poked him in the chest, but did not realize she had hit him so hard until the bruise began to appear. She justified her action as discipline, indicating the child was being punished for soiling himself and trying to blame his sister for messing up his room. The social worker asked M.R.'s mother if "Noah" was ever alone with her children, and she replied "no."

An interview with M.R.'s father took place on the same day. Mr. Ravenell confirmed his report in the referral and that photographs were taken of M.R. He said they did not come out well and were deleted off the maternal grandmother's cell phone. The social worker also interviewed M.R.'s maternal grandmother regarding the bruising to his chest. She said she saw the injury during bath time and asked both her husband (the maternal grandfather) and the maternal aunt if they had noticed the bruising. She stated no one was overly concerned because M.R. did not report that anyone had hit him or how he had gotten the bruise. She stated given the family's ethnicity and the tendency to bruise easily, she did not think the bruising was significant at the time.

On April 9, 2008, the CPS social worker completed a safety assessment per CA policy. The assessment documents an incident of high-risk physical abuse in the family in the last 90 days, and that the child was expressing fear of people living in the home. CA policy requires the development of a safety plan when preliminary facts in the case indicate threats to child safety are evident. During the development of the safety plan, M.R.'s mother disclosed the full name of "Noah" as Noah Thomas. With the identity of Mr. Thomas now known, the social worker included him in the safety plan. M.R.'s mother agreed in the safety plan that she and Mr. Thomas would use no corporal punishment on the children, and she would continue to use her family for support and child care. The social worker planned to refer the family for services.

The social worker made several attempts to speak with Mr. Thomas through M.R.'s mother. She asked that the mother request Mr. Thomas call the social worker. It is not known if Mr. Thomas received the request, and he did not contact the social worker for an interview.

On May 22, 2008, M.R.'s father left a message on the social worker's voice mail. He reported he had seen more bruising on both his children and that he had continued concerns regarding Mr. Thomas and the mother's care of the children. The social worker returned his call and left a message suggesting he contact law enforcement and make a referral to CPS intake reporting his concerns. There is no record of these concerns being reported to CPS intake by the father, social worker, or anyone else involved.

On May 28, 2008 CA was notified of M.R.'s death by St. Clare Hospital staff. The next contact CA had with M.R.'s father was on May 29, 2008 when he left a voice mail message for the assigned worker reporting M.R.'s death.

Three-year old M.R. died from severe trauma resulting from physical abuse inflicted by Mr. Thomas. TPD noted on May 29, 2008 that Mr. Thomas was arrested and charged with second degree murder in the death of M.R. In the charging documents, Mr. Thomas admitted to inflicting the injuries resulting in M.R.'s death.

Findings and Recommendations

The committee made the following findings and recommendations based on an interview with the CPS supervisor, review of case records, CA policies, procedures and protocols, and Washington State Department of Personnel Class Specifications for Social Worker 1, 2 and 3.

Findings

- Important CPS investigation steps were not completed.
    - Upon learning "Noah's" last name on April 9, 2008 the social worker did not conduct a Children's Administration Management Information System (CAMIS) search of Mr. Thomas. Mr. Thomas had three prior founded findings of physical abuse against his biological children. The CAMIS search should have led to a criminal history check which would have revealed a prior criminal conviction for 3rd degree assault of a child against his biological children.
    - There was no coordination between CPS and law enforcement regarding the April 2, 2008 referral. The CPS social worker did not establish contact with law enforcement to determine what information they had or what they intended to do regarding the referral.
    - Information regarding possible bruising to the chest to M.R should have prompted CPS to recommend an examination by his primary care physician or prompt consultation with the Regional CPS Medical Consultant.

- When interviewed by the review committee the CPS supervisor noted supervisory consultation was done with the assigned social worker on several occasions during the course of the investigation. However, case notes do not reflect any documentation of supervisory consultation or staffing. The supervisor said interruptions to case staffings were commonplace due to unit workload and at times a thorough review of cases was not possible.

- The CPS social worker was employed with CA for approximately three months at the time of case assignment. The social worker had completed CA Social Worker Academy training and Harborview interviewing training. Her caseload at the time of the investigation and M.R's death was 30 cases.

- The review committee noted the level of experience of the assigned social worker and her assigned workload supported the need for close supervision and consultation. Region 5 best practice expects supervisors to develop initial on-the-job training plans and meet with their staff monthly to review work. Supervisory workload does not allow supervisors to spend 100% of their time training and supervising new staff. It is not reasonable to expect a CA supervisor to provide enough training to educate and remediate an employee's gaps in knowledge or lack of child welfare experience.

- Related to this, it is difficult for a supervisor to provide quality clinical supervision to a unit of social workers 1, 2, or 3's who present with and demonstrate varied levels of competencies relevant to child welfare practice.

- The current academy and initial mandatory trainings for new employees are not sufficient to teach and train new employees who have no direct experience, education, or knowledge of child welfare. While CA social workers are required to have a social work or equivalent degree, it should not be assumed that a social work curriculum or degree provides a good foundation for the skills or knowledge required by CA social workers.

- Current training provided by CA is not designed for social workers with no experience or education in child protection and /or child welfare issues. During initial training, new social workers should be able to demonstrate the capacity to understand and apply basic child welfare concepts of safety, permanency, and well-being. At the end of the initial training social workers should be able to demonstrate the acquisition of key child protective/child welfare competencies.

Recommendations

- Develop training models to ensure demonstration and retention of core competencies. Examples:

    - Law enforcement has been successful with a Field Training Officer (FTO) training model. The FTO model partners and mentors new staff with experienced officers to develop and ensure demonstration of core competencies. New officers

are partnered with field officers for six months before they are allowed to work on their own. This model appears suited to child welfare where new social workers can learn from senior workers as they do their work. This may reduce exposure to liability, share workload and decision making, improve morale, and reduce need for the high level of oversight required of supervisors on day-to-day work.

- Create training units where new staff can be supported by close supervision until they are able to demonstrate the key competencies affiliated with child protective/child welfare practice.

- Establish a pool of experienced social workers or a statewide support unit to step into vacancies as they occur. This will relieve the immediate stress of vacancies, may decrease the likelihood of supervisors having to carry caseloads, and allow supervisors more time to negotiate the hiring process, seek out, and hire qualified candidates.