RCW 74.13.640(d)

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

Children's Administration
Child Fatality Review

C.T.

November 2011
Date of Child's Birth

May 13, 2012
Date of Child's Death

September 6, 2012
Child Fatality Review Date

Committee Members:
Carmelita Adkins, Supervisor, Children's Administration
Karen Burke, Director, Domestic Violence and Sexual Assault Services (DVSAS)
Jamie Collins, Detective, Whatcom County Sheriff's Department,
Randy Kaui, LMHT, CPT Team Member, LIBC
Mary Meinig, MSW, Director, Office of Family and Children's Ombudsman
Patty Turner, Area Administrator, Children's Administration
Betsy Tulee, ICW Program Manager, Children's Administration

Observers/Facilitator's Aides:
Laurie Alexander, Area Administrator, Children's Administration

Facilitator:
Robert Larson, Critical Incident Case Review Specialist, Children's Administration

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Executive Summary

On August 7, 2012, Children's Administration (CA) convened a Child Fatality Review[1] (CFR) committee to examine the practice and service delivery in the case involving 6-month-old C.T. and her family. The incident initiating this review occurred on May 13, 2012 when C.T.'s father called 911 to report his daughter was not breathing. A medical exam showed C.T. was discovered in cardio-respiratory arrest. C.T. was resuscitated but did not regain consciousness and expired approximately four hours later. C.T. suffered from blunt cranial trauma and anal sexual trauma according to the autopsy.

The child fatality review committee included CA staff and community members selected from diverse disciplines with relevant expertise, including representatives from the fields of local law enforcement, domestic violence, Indian child welfare policy, the Office of the Children and Family Ombudsman, and social work. All committee members had no previous involvement with the case with the exception of Randy Kaui. Mr. Kaui is an active Lummi Nation Child Protection Team (CPT)[2] member and he participated in multiple meetings about C.T. preceding the fatality. Prior to the review each committee member received a chronology of known information regarding the family, and un-redacted CA case-related documents.

Available to committee members at the review were (1) additional case related documents (e.g., records, court records and case file) and (2) copies of relevant laws relating to CPS duties, and legal definitions involving child maltreatment. The CPS investigators and Lummi Children's Services Assistant Program Manager/Child Welfare Supervisor were made available for interview as part of the review process.

Following review of the case file documents, interview of CPS investigators, interview of the Lummi Children's Services Assistant Program Manager/Child Welfare Supervisor, and discussion regarding social work activities and decisions, the review committee made findings and recommendations which are detailed at the end of this report.

Case Overview

C.T. is a female member of the Lummi Nation who was born in November 2011. C.T. was born into a family that consisted of her mother, father and sister. C.T.'s mother is R.W. She is a descendent of the Lummi Tribe and was 23-years-old when C.T. died. C.T.'s father is L.T. He is also a descendent of the Lummi Tribe and was 22-years-old when his

[1] Given its limited purpose, a Child Fatality Review should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. The Child Fatality Review 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 will only hear from DSHS employees and service providers. It does 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 recommend personnel action against DSHS employees or other individuals.

[2] Executive Order 95-04 mandates the use of Child Protection Teams. The purpose of Child Protection Teams (CPTs) is to provide consultation and recommendations on all cases where there is a risk of serious harm to the child and/or where there is dispute over whether out-of-home placement is appropriate.

daughter died. C.T.'s sibling, [redacted], was born in [redacted] 2010 and [redacted] was 18-months-old at the time of C.T.'s death.

[redacted]

[redacted]

C.T. was born in November 2011. The social worker had completed the Lummi CPT requirements and was preparing to close the case. [redacted] The mother agreed to work with Lummi Children's Services (LCS). The Lummi Housing Department also [redacted]

On January 1, 2012, the Lummi Nation Police called CPS to report concerns of domestic violence (DV)[4] between the mother and father. The maternal grandfather was

[3] When an allegation is "Unfounded, " it means that CPS investigated the allegation and, based on the information available, determined that it was more likely than not that the alleged abuse or neglect did not occur, or that there was insufficient evidence to determine whether the abuse did or did not occur.

[4] Domestic Violence (DV) *behavioral definition* - "a pattern of assaultive and coercive behaviors, including physical, sexual, and psychological attacks, as well as economic coercion, that adults or adolescents use against their intimate partners".

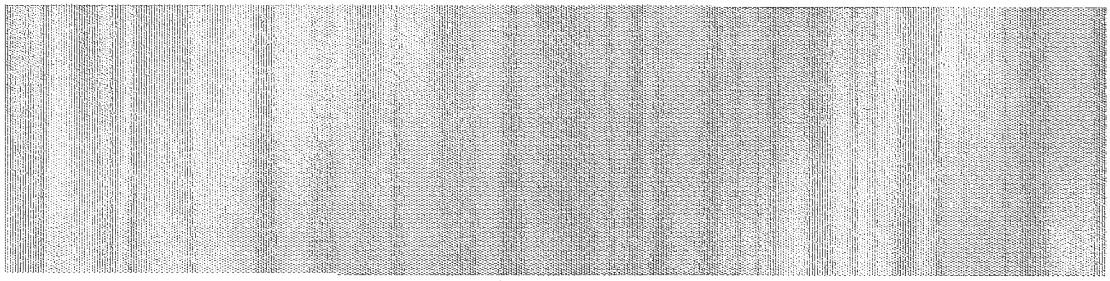
attempting to intervene when law enforcement responded to the home. The intake was screened in for investigation. The assigned social worker and LCS contacted the family. The two social workers met with the mother at her house and again at the LCS office. The social workers wanted to provide the mother with an opportunity to talk in a safe environment away from L.T. The mother admitted that she had an altercation with L.T., but denied any ongoing domestic violence. The mother reported that she had thrown the object that had resulted in a broken window. The social worker documented that the mother blamed the maternal grandfather for spreading rumors. The case was staffed with the Lummi CPT who recommended case closure.

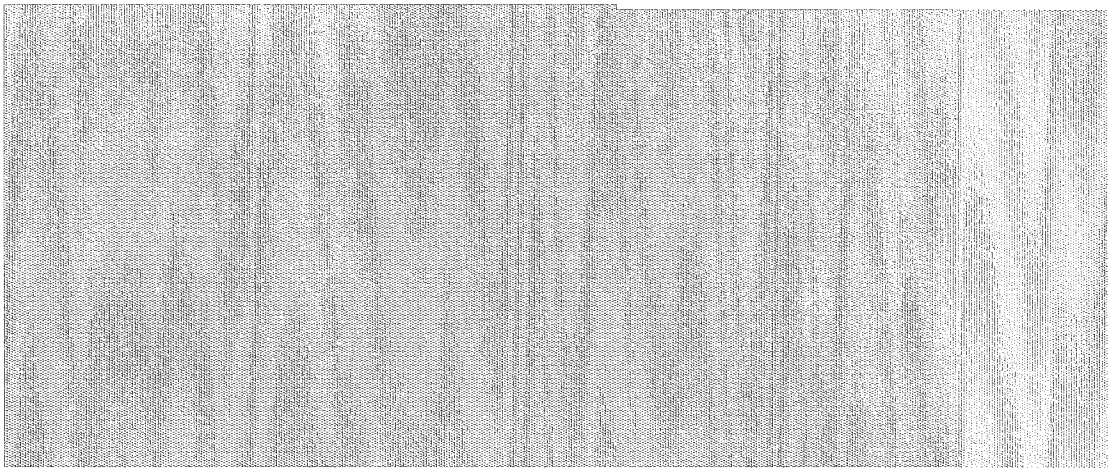
On May 13, 2012, the Lummi Nation Police called an intake to report a pending fatality due to sexual and physical abuse. C.T. passed away at 11:58 a.m. from the injuries. The manner of death according to the County Medical Examiner was homicide. The County Medical Examiner reported, "The decedent is a six-month-old Native American female discovered in cardio respiratory arrest by the father. The child was resuscitated but did not regain consciousness and expired approximately four hours later. The child suffered from blunt cranial trauma and anal sexual trauma. From pattern of the cranial injuries, I suspect elements of both crushing/squeezing and impact against a surface."

The father admitted to causing the physical injuries that resulted in C.T.'s death, but denies sexually abusing C.T. The sibling of C.T. was placed into protective custody and a dependency petition was filed. C.T.'s sibling remains in foster care as of September 2012.

Committee Discussion

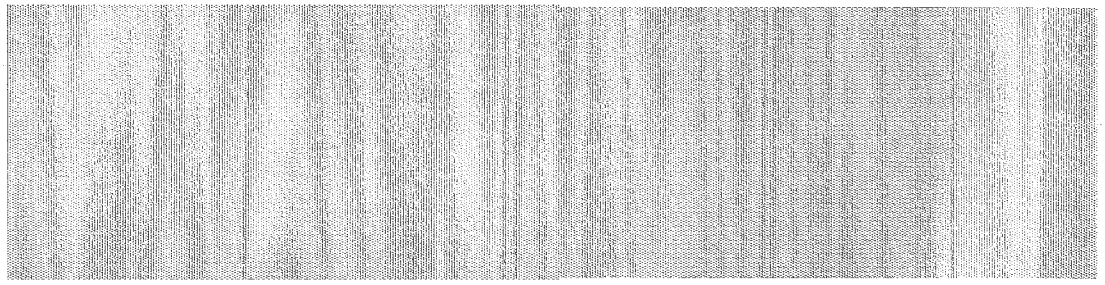
Committee members reviewed and discussed the documented social work activities completed by Children's Administration from intake to case closure. As a means to provide structure and context to reviewing social work practice, the committee was provided a case summary and had access to C.T's case file. In addition, the committee was provided with information on policy and procedure as it relates to the investigation of child abuse and neglect so committee members were better able to evaluate the reasonableness of actions taken and decisions made by Children's Administration social workers. In addition to social work practice, discussions occurred around policy issues. The discussions largely focused on the following areas: the initial intake and how CPS investigators investigated the child's injuries, the ongoing concerns of domestic violence, the use of investigative tools, the intake decisions, and services provided to the family.





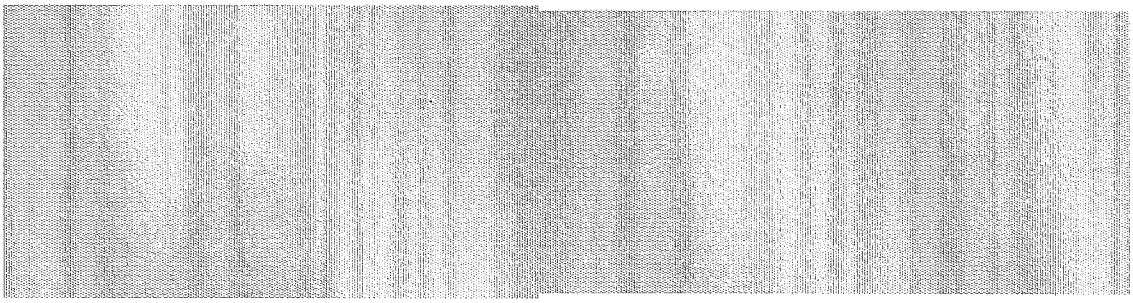
C.T.'s family was offered services throughout this case; however, the family refused services from the state. The family reported that they were able to receive services through the Lummi Nation and this was evidenced through their utilization of the housing program, chemical dependency services and mental health services. The committee discussed the family's Lummi heritage and how it is not unusual for a tribal member to seek services through their own tribe. Overall, the committee noted that active efforts were completed by the assigned social workers. The committee also noted that the family had two young children and determined it would have been beneficial for the family to receive Public Health Nurse (PHN) services. The committee could not determine if the family was receiving PHN services at the time of the fatality.

Children's Administration learned through their contact with the Lummi Tribe, community members, family members and law enforcement that DV was an underlying concern with C.T.'s family. The CPS investigators both noted during their interview that they spoke with the mother separately from the father and that she denied any domestic violence. The CPS investigators noted that they remained concerned about domestic violence, but they could not locate significant evidence supporting the presence of domestic violence. The lack of significant evidence and the parents' denial of domestic violence was a significant barrier to domestic violence related services. The committee discussed how the mother may have benefitted from the receipt of an informational DV brochure and the official offer of DV victim services.

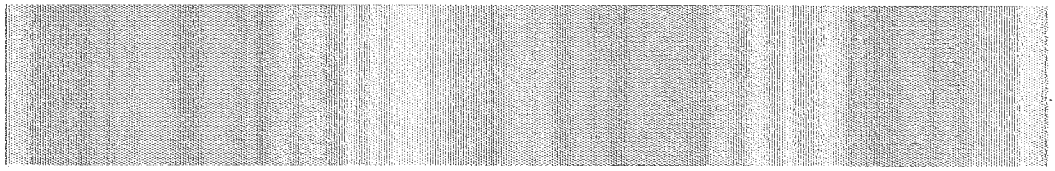


Three different state social workers were assigned to this case from August of 2011 until the fatality in May of 2012. The second social worker reported she was unable to

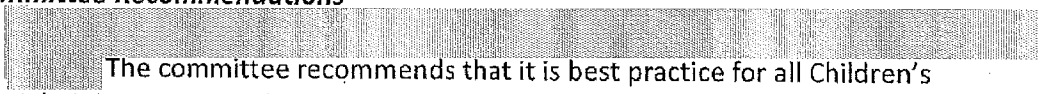
complete all of her documentation due to work demands before she left for an anticipated extended leave. Some documentation was inputted approximately six months late. The committee discussed the significant amount of paperwork and activities involved in an investigation regarding child abuse. The committee determined that the agency would continue to benefit from streamlining the investigative tools.



Committee Findings

1. The committee determined that the safety concerns and risks associated with this case were adequately assessed by the worker. After review, it was determined that there was no way of predicting the eventual abuse to C.T.
2. The assigned social workers used the available community resources in their investigation and efforts to assist the family including law enforcement, Lummi Tribal contacts, and CPT. The committee noted the positive and productive relationship between the Lummi Nation and the Bellingham Children's Administration office.
3. 

Committee Recommendations

1.  The committee recommends that it is best practice for all Children's Administration social workers to take photographs whenever reasonably possible for documentation purposes to prove a child was or was not injured. The committee believed photographs should be taken even when a mark is not present. The committee determined that the use of photographs would help with future investigations and case reviews. In addition, the committee stated that each social worker should have quick access to a camera and/or phone with a camera. The camera should include the ability to quickly upload the photograph into FamLink.
2. Children's Administration should conduct a review of the FamLink investigative tools in an effort to decrease the impact on workload due to possible duplication of documentation related to the investigative tools.