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

Child Fatality Review
N.T.

April 2012
Date of Child's Birth

December 26, 2014
Date of Child's Death

April 15, 2015
Child Fatality Review Date

Committee Members
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Executive Summary

On April 15, 2015, the Department of Social and Health Services (DSHS) Children's Administration (CA) convened a Child Fatality Review (CFR) to assess the department's practice and service delivery to a 2-year-old boy and his biological family.[1] The child is referenced by his initials, N.T.,[2] in this report. At the time of his death, N.T. resided with his parents and younger sibling in Kennewick. The department had previously removed N.T. from his parents' care in July 2012 based on allegations that he was the victim of physical abuse. N.T. was in out-of-home care from that time until April 2014 when he was returned to his mother's care. The dependency was dismissed in October 2014. The incident initiating this review occurred on December 26, 2014 when N.T. died as a result of non-accidental trauma.

The CFR Committee included CA staff and community members selected from diverse disciplines with relevant expertise, including child welfare, mental health, law enforcement, and the Office of the Family and Children's Ombuds. None of the committee members had previous direct involvement with this family.

Prior to the review each committee member received a case chronology, a family genogram, a summary of CA involvement with the family, and un-redacted case documents including referrals, case notes, assessments, and medical records. The hard copy of the file was available at the time of the review. Supplemental sources of information and resource materials were also available to the Committee including copies of state laws and CA policies relevant to the review and workload and case assignment data for this unit during the time that the case was open.

The Committee interviewed the CA social worker and supervisor who had previously been assigned to the case and the Area Administrator who supervised the Richland Office for the majority of the time the child was dependent. Following a review of the case file documents, completion of staff interviews, and

[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 the 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 fatal injury. Nor is the function or purpose of a Child Fatality Review to recommend personnel action against DSHS employees or other individuals.

[2] The parents and relatives are not identified by name in this report because no criminal charges were filed relating to the incident.

discussion regarding department activities and decisions, the Committee made findings and recommendations that are presented at the end of this report.

Case Overview

On December 23, 2014, N.T. was airlifted to Sacred Heart Medical Center (SHMC) in Spokane where it was found that he was suffering from anoxic brain injury[3] as well as human bites, multiple bruises of differing ages, a fractured arm, possible ligature marks, and lip abrasions. He was pronounced dead on December 26, 2014. The cause of death has been identified as child abuse and the manner of death as homicide. At the time of the fatal incident N.T. resided with his mother, N.B., and his younger brother. It is unclear if his father, M.T., resided in the home at the time. N.T. was the subject of a prior dependency in Benton County from July 2012 to October 2014. At the time of N.T.'s death, the case was inactive pending completion of paperwork. At the time of this review, this case was open for Child and Family Welfare Services (CFWS)[4] and his younger sibling was in out-of-home care.

Case Summary

This family first came to the attention of Children's Administration on June 28, 2012 when 2-month-old N.T. was admitted to SHMC in Spokane with multiple subdural hematomas and retinal hemorrhages. The examining physician diagnosed N.T. with abusive head trauma. The parents stated they did not know how their son was injured but provided several possible explanations, none of which were considered by the attending physician to be consistent with the injuries. The department filed a dependency petition on N.T.'s behalf on July 11, 2012 and upon his release from the hospital he was placed in the care of relatives.

In October 2012, the parents signed an agreed order of dependency in which they denied knowing the cause of the child's injuries but acknowledged that there was sufficient basis to determine that there was no parent willing and capable of safely caring for their child. The parents were court-ordered to participate in parenting assessments, attend all meetings related to the care of the child, and participate in the visitation plan. The father was ordered to complete a drug and alcohol evaluation, an anger management assessment, and follow all treatment recommendations from those assessments. The parents were allowed up to three supervised visits per week with their child.

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[3] Anoxic Brain injury results from a total lack of oxygen to the brain. [Reference: BrainandSpinalCord.org]

[4] Child and Family Welfare social workers assume responsibility of a child welfare care after the children have been removed from their caregivers and a dependency petition filed.

N.T. remained in out-of-home care with a relative from July 2012 through April 2014. His mother completed a parenting assessment, parent education, and a psychological evaluation prior to his return. She was offered visits up to three times per week but often did not attend all of them. The father completed a parenting assessment and through he initially visited his child weekly, his participation in all aspects of the service plan ceased in January 2013. From that point, he had no contact with the department, with providers, or with the court regarding his child. The law enforcement investigation into the alleged assault of N.T. was reviewed by the Yakima County Prosecutor's Office but they declined to pursue charges based on the absence of a specific identified perpetrator. In May, after the entry of a No Contact Order between the parents, the mother's visits were changed from supervised to monitored[5] and began occurring in her home. The No Contact Order was entered through the Dependency Court, though the mother denied domestic violence between her and the baby's father.

In June 2013, the couple's second child was born and a new intake was made in July documenting concern about the safety of this child, based on the fact that N.T. had experienced serious injuries of unknown origin while in the care of his parents. At a Family Team Decision Making Meeting[6] held shortly after the baby's birth, a consensus was reached that the new baby would remain in the mother's care, and the mother agreed to continue to participate in court-ordered services. The mother changed residence several times through this period, often staying with family members. The mother made conflicting statements about the status of her relationship with the father of her children to the department and to providers. Though she reported that she did not have contact with him, the department received collateral information that seemed to indicate that they were in contact.

At the Dependency Review Hearing in April 2014, the department recommended continued out-of-home placement based on the fact that it remained unclear who abused N.T. The child's Guardian ad Litem (GAL) and the parents' attorneys opposed this and on April 22, 2014 an agreed Dependency Review Order was entered that returned N.T. to his mother's care. The order stated that the mother

[5] Supervised visits require the presence of another assigned adult who maintains sight and sound supervision of parent-child contact and intervenes as needed. Monitored visits require another assigned adult to monitor the parent child contact periodically and interview as needed.

[6] Family Team Decision Making Meetings (FTDM) bring people together who are involved with the family to make critical decisions regarding the removal of a child from their home, changes in out-of-home placement, and reunification or placement into a permanent home. [Source: CA Practices and Procedures Guide, Chapter 1720]

was to participate in Family Preservation Services (FPS),[7] maintain contact with the GAL and assigned social worker, and reside with her sister in Kennewick. The department also recommended that N.B. participate in individual counseling but this was not ordered by the court. An FTDM was held on May 2 where a transition plan was developed to ease N.T.'s return home. The plan stated that in addition to the services ordered by the court, N.T. would attend licensed day care and continue with his speech therapy. At the time of his return home, N.T. was reported to be in good health and receiving services with Early Head Start.

After N.T.'s return home, the social worker was unable to maintain regular contact with the mother and see the children in their home. The mother reported that her work schedule prevented her from meeting with the worker; because of this the social worker made most of her contacts with N.T. at the home of a relative in Grandview who the mother identified as the child's day care provider. The FPS provider also had difficulty engaging the mother and noted it took two months to complete the intake. However, even when engaged in services, the mother cancelled and re-scheduled appointments with the FPS provider multiple times.

At the September Dependency Review Hearing, the department reported that N.B. had made good progress and asked that the dependency continue. The Review Order continued the dependency but stated that the case could be dismissed ex parte in October after N.T. had been with his mother for six months. On October 24, 2014, the dependency was dismissed by ex parte order with agreement of all parties. The social worker made one more contact with the family shortly after this date.

On December 23, 2014, the department received an intake stating that N.T. was taken to Sacred Heart Medical Center with human bite marks, multiple bruises of different ages, lip abrasions, a fractured arm, possible ligature marks, and anoxic brain injury. The attending physician's assistant who documented the injuries reported N.T. had been severely medically neglected and chronically and severely physically abused. Both N.T. and his brother were placed into protective custody. N.T. was declared deceased on December 26, 2014.

Committee Discussion

The Committee discussion focused on CA policy, practice, and systems responses in an effort to evaluate the reasonableness of decisions made and actions taken

[7] Family Preservation Services (FPS) are short-term, family-based services designed to assist families in crisis by improving parenting and family functioning while keeping children safe. [Source: CA Practices and Procedures Guide, Appendix A: Definitions]

by department staff. Though the primary focus was on the actions and decisions made by department staff during the period of the child's dependency (July 2012 – October 2014), some discussion occurred about information gathered during the fatality investigation which provided previously unknown insight into the family relationships during the dependency. The Committee utilized staff interviews to provide additional information related to caseload size, staff turnover, changes in management, and a basic overview of the court system. At the completion of the review of the case file documents, staff interviews, and discussions regarding CA activities and decisions, the Committee identified several areas of practice improvement that could serve to strengthen practice and improve child safety.

The Committee spent a considerable amount of time in discussion and with staff gaining an understanding of the progression of the case from the initial investigation through the dismissal of the dependency in October 2014. The Committee recognized that it is very challenging to develop and maintain a case plan when a child has significant unexplained injuries and no specific perpetrator is identified or charged. While there was solid medical evidence that N.T. had been abused, the lack of resolution of the criminal investigation narrowed the focus of the intervention and impacted the department's ability to articulate a clear risk of harm to the court.

The Committee also felt that the lack of clear identification of the abuser led to an inability to articulate the parental deficiencies in the context of risk and danger to the child shaped the provision of services. There was ongoing discussion that the actual services identified in the court report and therefore ordered by the court lacked a specific focus on the primary issue of severe unexplained physical abuse and trauma to the child. Though the initial case plan included a provision stating additional services for the parents would be evaluated as the criminal investigation progressed, this issue was not revisited when it eventually became apparent there would be no resolution to the criminal investigation. As a result, the services provided were not specific to the identified safety threats. In reviewing the ongoing assessments done on this case, the Committee noted that there were several components of the Child Safety Framework[8] that were not followed. The Committee felt that this was unlikely to have affected the outcome of the case but it could have provided a consistent

[8] In partnership with the National Resource Center for Child Protective Services, (NRC-CPS), Washington state Children's Administration implemented the Child Safety Framework in November 2011. A key concept of this model is that the scope of child welfare work is not defined by determining the presence or absence of injuries or incidents, but rather in identifying present or impending safety threats, and working with families to mitigate those threats.

structure to gather additional information needed to reassess family functioning and target services to address parental deficiencies.

The Area Administrator reported that the Richland CA office experienced significant staffing shortages during 2014 that led to increased workloads and caseload in all the CFWS units. The assigned worker's caseload increased from 21 children in April 2014 to 32 children when the court case was dismissed six months later.[9] The Committee recognized that this increase in workload may have impacted the worker's ability to have regular contact with the mother and her children in their home as well as her ability to gather sufficient information from service providers and extended family to fully assess household composition and functioning.

The Committee noted several areas of strength. The records were well-organized and case notes were clear. Monthly contacts with the child were done consistently throughout the dependency. The Committee noted some delay in entry of documentation but understood that timeliness can be a challenge when faced with high caseloads and chose not to make a finding about this issue. Shared decision making was used at key points throughout the case to enhance critical thinking. The Committee appreciated the candor staff brought to the review process as well as their commitment to child welfare.

Findings

1. **Child Safety Framework (CSF):** The Committee found several aspects of the CSF that were not used at key points as required by policy.
    - **Investigations:** The Committee felt that the investigative assessments done in 2012 and 2013 were incident-focused and lacked sufficient information to do a comprehensive assessment of the household.
    - **Family Assessment:** Though the policy requiring the use of a family assessment was suspended for a period of time during N.T.'s dependency, it was reinstated as a requirement in October 2013. The Committee noted that insufficient information was gathered throughout the case to adequately assess parenting functioning and parental capacity. The Committee felt there were missed opportunities to gather and document additional information about parental functioning from collateral sources, such as family members, the child's service providers, or from the parents themselves. The Committee recognized that the department's inability to engage the father made it difficult to assess his functioning but also noted that he has another

[9] Recommended caseload size for CFWS workers, per the Braam settlement, is 18 children.

family and their input may have helped to assess his parental functioning.

- **Safety Assessments:**[10] Ongoing safety assessments were not used at key decision points to assess child safety and inform decision making. The safety assessments done in July and August of 2012 identified safety threats, yet a subsequent safety assessment completed when the new baby was born in 2013 was not consistent with the assessments; this discrepancy is not reconciled in the documentation. The Committee could not find that safety assessments had been conducted prior to consideration of N.T.'s return home or prior to case dismissal. The Committee felt that consistent use of the safety assessment could have provided an ongoing structure to the case plan and focus on the issues of child safety.
- **Safety planning:**[11] The Safety Plan was not revised through key points in the case, such as changes in household composition, the birth of the new child, and prior to N.T.'s return home. Though there appeared to be efforts to address safety planning at the FTDM held prior to N.T.'s return home, the Committee felt the plan could have been stronger if it had included input and participation from key participants in the child's life, such as his paternal relatives, his therapeutic provider, and his primary care physician.

2. **Health and Safety Contacts**: The Committee found that health and safety contacts were not conducted according to policy that the majority of health and safety contacts be conducted in the family home. While the worker saw the child two times per month after his return home, the worker's inability to see the child in his home impaired the ongoing gathering of information needed to assess child safety. This put the worker in a position to accept the mother's statements about her relationship with the child's father at face value.

Recommendations

1. The Committee recommended that the department collaborate with the Alliance for Child Welfare to provide training on the Child Safety Framework that is specific to CFWS cases. It is recommended that the training focus the following:

[10] Safety Assessment is used throughout the life of the case to identify impending danger and determine whether a child is safe or unsafe. It is based on comprehensive information gathered about the family at the time the safety assessment is completed. [Source: CA Practices and Procedures Guide, Chapter 1100]

[11] A safety plan is required for all children where there is a safety threat(s) indicated on the safety assessment. The safety plan is written arrangement between a family and CA that identifies how safety threats to a child will be immediately controlled and managed.

- Global assessment and gathering of information throughout the case in order to identify parental deficiencies and correctly identify tasks and services that can address those deficiencies and measure progress in addition to compliance.
- Safety assessment at key decision points.
- Safety planning, including understanding key elements of strong safety plans, and implementing safety plans when children are returned home.

2. The Committee recommended that challenging cases like this where there are unexplained injuries to a child, that supervisors and line staff consider seeking assistance from the CPS Regional Practice Consultant or CPS Program Manager to help articulate their case to the court and to clearly frame services so that they are targeted to address parental deficiencies.
3. The Committee suggested that best practice would be to require the establishment of a parenting plan prior to dismissal of the case.
4. The Committee noted that there seem to be variations in practice regarding the department's response when new children are born to families who have dependent children. The Committee recommended that the department use Regional Program Consultants to promote consensus and clarity about who is responsible to call intake and how these intakes are assigned. In addition, the Committee recommended that the Richland office consider having shared planning meetings with families prior to the birth of new children on open CFWS cases.