Washington State Department of Social & Health Services

CA Children's Administration

Child Fatality Review

T.D.
Date of birth: April 2010
Date of Fatality: May 7, 2013
Date of Child Fatality Review: September 10, 2013

Committee Members:

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RCW 74.13.640

A child fatality or near-fatality review completed pursuant to RCW 74.13.640 is subject to discovery in a civil or administrative proceeding, but may not be admitted into evidence or otherwise used in a civil or administrative proceeding except pursuant to RCW 74.13.640(4).

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Executive Summary

On September 10, 2013, Children's Administration (CA) convened a Child Fatality Review[1] (CFR) Committee to examine the practice and service delivery in the case involving a three-year-old Caucasian male child and his family. The child will be referenced by his initials, T.D. in this report. At the time of his death, T.D. shared a home with his mother, his younger sibling (19 months old) and Derrick Myers,[2] with whom T.D's mother maintained a personal relationship. The identity of T.D's father is unknown.

The incident initiating this review occurred on May 7, 2013 when T.D. died shortly after being brought to a hospital by his mother. Following his death, T.D. was diagnosed by a team of medical professionals to have multiple non-accidental blunt force injuries.

When a child dies from alleged child abuse or neglect and the child's family received services from Children's Administration within a year of the child's death, Washington state law requires CA to conduct a CFR. While T.D. and his family did not receive direct services from CA, they were referred by CA in December of 2012 for voluntary Early Family Support Services (EFSS) from a contracted community agency.

The review is conducted by a team of CA staff and community members with relevant expertise from diverse disciplines. Neither CA staff nor any other committee members had previous direct involvement with the case.

Prior to the review, each committee member received a chronology of known case information, and un-redacted CA case-related documents. Additional documents were made available to the Committee at the time of the review. These included copies of medical and law enforcement reports, media coverage of the incident, the Early Family Support Services contract, and copies of relevant CA policies and practice guides.

During the course of the review, the CFR Committee members interviewed the CA staff and contracted service providers involved with the case prior to T. D.'s death.

1Given 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 deceased child's life or death. 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 or 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 T.D's mother is not named in this report because she has not been charged in an accusatory instrument with committing a crime related to a report maintained by the department in its case and management information system. Derrick Myers, her boyfriend, is named because he was charged with two counts of murder. [Source-Revised Code of Washington 74.13.500(1)(a)]

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Following review of the case file documents, interviews, 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

CA's involvement with T.D. and his family began on December 13, 2012 when a hospital social worker, on behalf of a licensed physician, contacted CA to report T.D. and his younger sibling were not immunized and did not have a primary care physician. The physician noted these concerns after meeting the family for the first time after T.D. had been brought to a hospital emergency department by his mother for treatment of an upper respiratory infection. CA's policy mandates accepting for investigation all intakes[3] involving young children made by (or on the behalf) of a licensed physician. The policy also allows for the intakes to be screened-out for investigation upon review by a CA administrator or regional CPS program manager.[4] An intake, indicating the family consisted of T.D., his mother and his younger sibling, was completed by an intake social worker and assigned a response time of non-emergent investigation by Child Protective Services.

On December 14, 2012 an intake supervisor, a CPS supervisor and an intake program administrator reviewed the intake and determined the allegations did not meet Washington state's legal definition[5] of child maltreatment. The intake screening decision was changed from a non-emergent investigation response to a 10-day response by a contracted provider to offer the family EFSS services.

Families reported to CPS for allegations considered low-risk for maltreatment[6] are eligible for contracted EFSS. Community agencies are contracted and paid by CA to work directly with families to create a voluntary service plan focusing on the following goals:

- Reduce risk of abuse or neglect of children in the home.
- Enhance parenting skills, family and personal self-sufficiency, and family functioning.

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3 CA intake social workers receive, gather, and assess information about a child's need for protection or request for service. Intake social workers determine program response type and response times (emergent or non-emergent) for an investigation. Once an intake screens in, the intake worker determines how soon contact should be made with the family and child.

4 CA Intake staff must screen in intake reports involving a child (birth to 5 years old), reported by a licensed physician or medical professional on "the physician's behalf." An Intake Supervisor must consult with local Area Administrator or regional CPS Program Manager when they are recommending the intake be screened out. All screening decision made as a result of a consultation must be documented in FamLink. [Source Children's Administration Practices and Procedures Guide 2210.]

5 "Negligent treatment or maltreatment" means an act or a failure to act, or the cumulative effects of a pattern of conduct, behavior, or inaction, that evidences a serious disregard of consequences of such magnitude as to constitute a clear and present danger to a child's health, welfare, or safety, including but not limited to conduct prohibited under RCW 9A.42.100. When considering whether a clear and present danger exists, evidence of a parent's substance abuse as a contributing factor to negligent treatment or maltreatment shall be given great weight. The fact that siblings share a bedroom is not, in and of itself, negligent treatment or maltreatment. Poverty, homelessness, or exposure to domestic violence as defined in RCW 26.50.010 that is perpetrated against someone other than the child does not constitute negligent treatment or maltreatment in and of itself.

6 Families are also eligible for EFSS services following a CPS investigation and the risk on the closing Structured Decision Making (SDM) risk assessment is low to moderate, and is appropriate for EFSS services. SDM is an assessment tool used by CPS to help identify families who are most likely to experience child abuse or neglect.

- Reduce stress on the family.
- Reduce the likelihood of additional referrals to CPS; and
- Enhance the health status of families and linkages to health services.

CA did not provide direct case management services to T.D. or his family. An open case was maintained by CA for administrative purposes only while the family voluntarily participated in contracted EFSS services.

Between January 22, 2013 and April 8, 2013, the EFSS contracted provider documented completing nine in-person individual meetings with T.D's mother or family meetings with the mother and her children. The meetings focused on providing T.D's mother with parent training, connecting to community resources and finding furnishings for the family's apartment. Eight of the nine meetings occurred at the contractor's office or in a community setting. T.D's mother successfully completed a ten-part parenting skill training offered by the contracted provider. In a summary report dated May 2, 2013, the contractor documented "the children appeared healthy, happy, and clean and bonding with the mother."

On May 7, 2013, T.D. and his younger sibling were left in the care of their mother's boyfriend, Derrick Myers, while their mother was at work. After caring for the children for several hours, Mr. Myers contacted T.D's mother at her workplace and requested she return home immediately because T.D. was ill. When she arrived home, she found T.D. complaining of stomach pain. She initially attributed his pain to constipation but as his symptoms worsened to include vomiting and the inability to stand, she drove T.D. to a hospital. When they arrived at the hospital, T.D. was unresponsive and his mother had to carry him from her car into the emergency department where medical staff began immediately performing emergency life-saving procedures. Despite their efforts, T.D. could not be resuscitated and was pronounced dead a short time later. An examination of his body revealed numerous injuries including a distended abdomen, and bruising to his chin, knees, buttocks, lower spine, arms, hands, chest and abdomen. The postmortem examination completed on May 8, 2013 indicated homicide as the manner of death caused by acute blunt force injuries of the head and abdomen. In addition, the medical examiner's report details acute anal lacerations, blunt force injuries to all body regions and previous head injuries.

CPS and local police initiated investigations after receiving notification from the hospital that T.D. had died from suspected child abuse. During interviews with a police detective, T.D's mother reported she and Mr. Myers had argued about his verbal and physical aggression toward her children. When further investigation revealed T.D's sibling also had non-accidental injuries and was significantly underweight, both law enforcement and CPS took action to ensure her safety. On May 8, 2013, Derrick Myers was arrested

and charged with two counts of murder related to the death of T.D. Mr. Myers remains incarcerated while awaiting trial.
The CPS investigation, completed on June 4, 2013, substantiated the allegations of child physical abuse by Mr. Myers and child neglect by T.D's mother.[7]

Committee Discussion

After reviewing the case documents and interviewing the involved staff from both CA and the contracted community agency, the Committee discussed the allegations reported on December 13, 2012. The Committee agreed the reported allegations did not meet the legal definition of child abuse and the allegations were not sufficient for an investigation by CPS. The Committee found no evidence of critical errors or oversight by the involved CA staff. The Committee supported the decision to refer the family for voluntary services available from a contracted community provider instead of screening out the intake as permitted by CA policy. The Committee recognized the initial allegations and available case information did not foreshadow the death of T.D. by an unrelated caregiver unknown to both CA and the contracted provider.

The Committee noted the contracted provider addressed the concerns initiating CA's involvement with this family by assisting the mother in obtaining immunizations for her children and to identify a primary health care provider. The engagement of T.D's mother in a voluntary service, providing an evidence-based parent training program and contacting the hospital social worker who reported the allegations in December 2012 were identified by the Committee as examples of strong practice by the contracted provider. Believing services are best delivered to families in their own home, the Committee questioned why the contracted provider only provided services once in the family home. The contracted provider explained he was responding to T.D's mother's expressed preference to meet in his office or community locations. The Committee agreed the need to maintain a relationship with the mother and keep her engaged in services was more important than the location of the service delivery.

Findings and Recommendations

The Committee made no findings or recommendations.

7 Following an investigation, a CPS social worker, based on available information, determines if it is more likely than not that child abuse or neglect did occur.