Children's Administration

Executive Child Fatality Review

Santiago Twohearts

January 19, 2011

Committee Members:
Donald Ashley, MD, Regional Medical Consultant, Dept. of Social and Health Services
Brent Borg, Area Administrator, Children's Administration, Region 1
Chauntelle Bryant, Legal Advocate, YWCA, Spokane
Nancy Foll, Director, Kids First Child Advocacy Center, Colville
Dwayne Johnson, Detective, Colville Police Department
Robert Palmer, CPS Program Consultant, Children's Administration, Region 5
Marilee Roberts, Practice Consultant, Children's Administration
Daryl Toulou, Regional Manager, Office of Indian Policy, DSHS
Jill Volke, Community Corrections Officer, Department of Corrections, Spokane

Observers:
Mary Meinig, Director, Office of the Family and Children's Ombudsman
Rachel Pigott, Ombudsman, Office of the Family and Children's Ombudsman

Invitee:
Thomasine Iron, Representative for the Standing Rock Sioux Tribe[1]

Facilitator:
Nicole LaBelle, Regional Programs Administrator, Children's Administration

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[1] The Standing Rock Sioux Tribe identified a representative to participate on the review committee. However due to unforeseen circumstances was unable to participate the day of the review.

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Executive Summary

On September 29, 2010, Children's Administration (CA) Central Intake (CI) received an intake that a child , 4-years-old, had been injured and another child, S.T., 13-months-old, had died. The referent, 's father, stated he saw this information had been reported on the local news and was concerned for his son, . The referent stated he called law enforcement and learned his son, , was currently with 's mother.

CI contacted Spokane Police Department (SPD) and received limited information until receiving hard copies of preliminary police reports. The police confirmed that S.T. had suffered injuries indicative of non-accidental trauma and was pronounced dead at a local hospital. SPD contacted James Cooley[2] as a person of interest, and he was later arrested and charged with first degree murder. S.T.'s older sibling, presented with non life threatening injuries and law enforcement left him in the care of his mother. 's father located and obtained from his mother.

CA agreed should remain in his father's care.

's statements revealed he had witnessed the death of his half-brother, S.T.

On September 29, 2010 a detective conducted an interview with James Cooley regarding the death of S.T. During the interview on September 29, 2010, Mr. Cooley admitted responsibility for the fatal injuries to S.T. and injuries to another child in a previous incident. Law enforcement reported that Mr. Cooley had also been a person of interest in another criminal child abuse investigation which caused serious injuries to a 6-month-old infant, In May 2010 was hospitalized when he suffered serious injuries from what appeared to be shaking and assault.[3]

Following S.T.'s death, the Spokane County Medical Examiner's office conducted an autopsy and determined S.T.'s cause of death: *non-accidental head trauma with contributing factor, liver lacerations* and the manner of death: *homicide.*

[2] The full name of James Cooley is being used in this report as he has been charged in connection to the incident and his name is part of the public record.
[3] Mr. Cooley has been charged with felony assault referencing A.G.'s injuries and murder in the 2nd degree for S.T.'s death.

CA history referencing S.T. and his family includes two prior intakes. The intakes received in April 2008 and December 2009 referenced issues related to domestic violence. Both intakes were screened out for investigation as there was no indication the children living in the home at the time were present or affected by the alleged incidents.

In January 2011, CA convened an Executive Child Fatality Review[4] committee to review the case practice and decisions regarding 13-month-old child, S.T. and his family. The fatality review members included CA staff and community members who had no involvement in the case. S.T. was eligible for enrollment as a member to the Standing Rock Sioux tribe. His father is an enrolled member. Tribal representatives were invited to participate in the January review.

Committee members received documents including a case summary of the CPS history of the deceased child's family. In addition, committee members were provided information from two other cases in which Mr. Cooley was involved and a copy of a critical incident briefing paper referencing the fatality, dated October 5, 2010. Complete case records of all three families were available to the committee for review and were referenced during the fatality review meeting.

The review committee addressed issues related to intake practice and procedures, investigative policies and practice related to information gathering and documentation and training of CPS social workers.

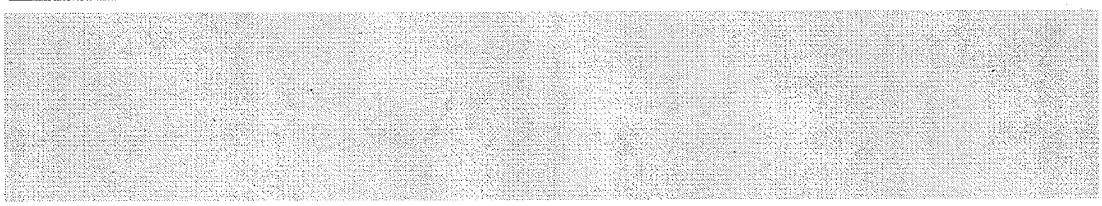
Case Overview

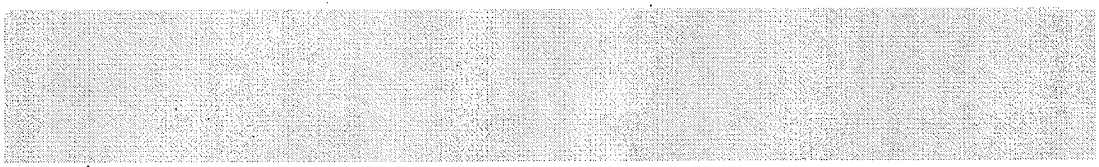
The review committee was provided case information regarding three families as a means to gain an understanding of the events leading up to S.T.'s death and to review CA's

[4] 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.

practice and delivery of services to the respective families. A search of FamLink[5] revealed that Mr. Cooley's connection with three different families all included allegations of physical abuse, neglect and domestic violence.

Family #1 – S.T.'s Family





The review committee discussed the screening decision for the April 2008 intake at length. The screening decision was based on factors that included: no specific allegations of child abuse and/or neglect, no previous CPS history for the family, and the child appeared to be in good health with no injuries. The review committee agreed that based on the information provided at the time of the intake, the "information only" screening decision was appropriate.

The committee did note that although a collateral contact was made to law enforcement regarding this intake the full name of the man who had contacted the referent was not known or obtained. The disposition of the incident was not obtained from law enforcement and a police report was not requested. As a result, the review committee discussed the documentation completed by intake when collateral contacts are made. The committee encourages as near-verbatim documentation as possible to explain/support the intake screening decision and response time.

Additionally, questions specific to domestic violence and safety in the home were not reflected in the intake report. CA has since implemented a universal domestic violence screening question[6] at the point of intake, beginning in February 2009.

On December 7, 2009 CA intake received a written police report dated December 4, 2009 (09-40124). S.T.'s mother and father were involved in a domestic violence incident. Reports stated S.T.'s father hit S.T.'s mother multiple times in the head with his fists and choked her. S.T.'s father admitted to law enforcement that he had hit the child's mother

[5] CA's Management Information System

[6] *"Has anyone used or threatened to use physical force against an adult in the home?"* The universal screening question is used to help the intake worker identify if DV is an issue. It is not used for sufficiency screening because DV, in and of itself, is not child abuse or neglect. (RCW 26.44.020 (13). Intake workers must screen all intakes for DV to assess whether a child is in clear and present danger from DV. If the universal screening question is answered yes, then intake workers: Complete the remaining DV questions in FamLink. Ask who did what to whom and document in the Additional Risk Factors section.

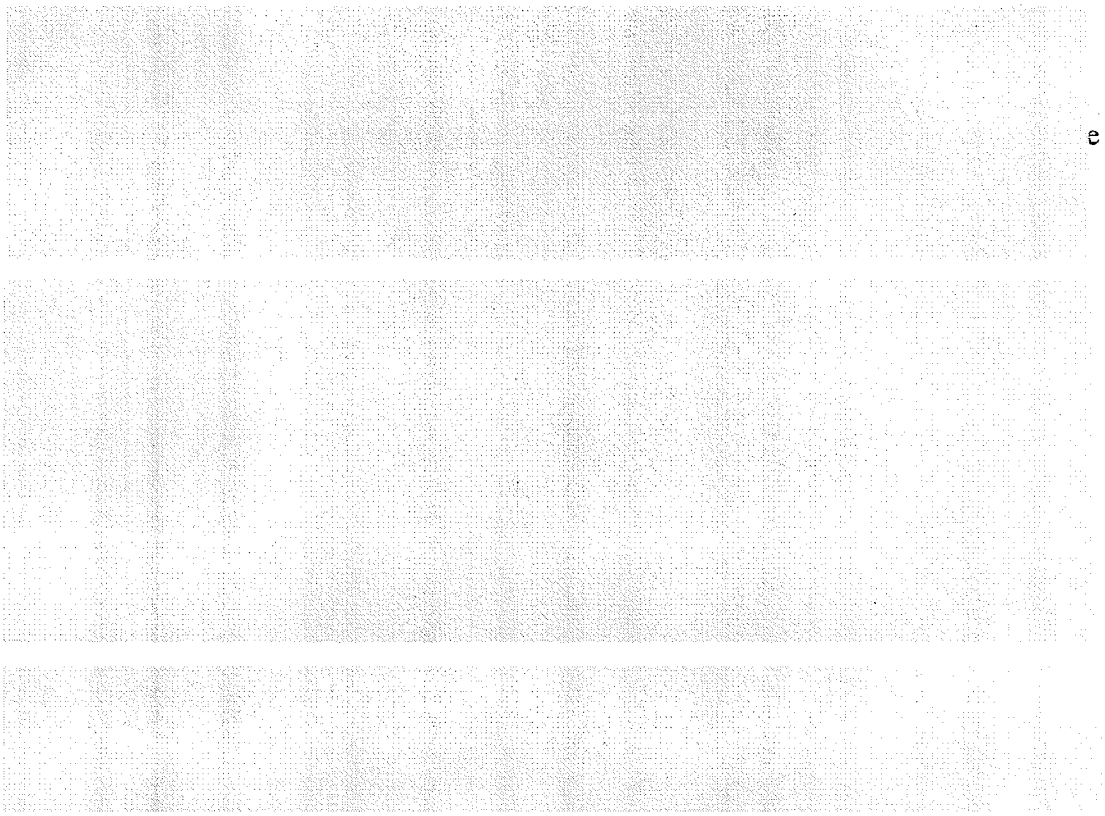
in the head, chest, and face. S.T.'s mother had marks on her neck and her face was swelling. The whereabouts of the children was not documented in the police report.

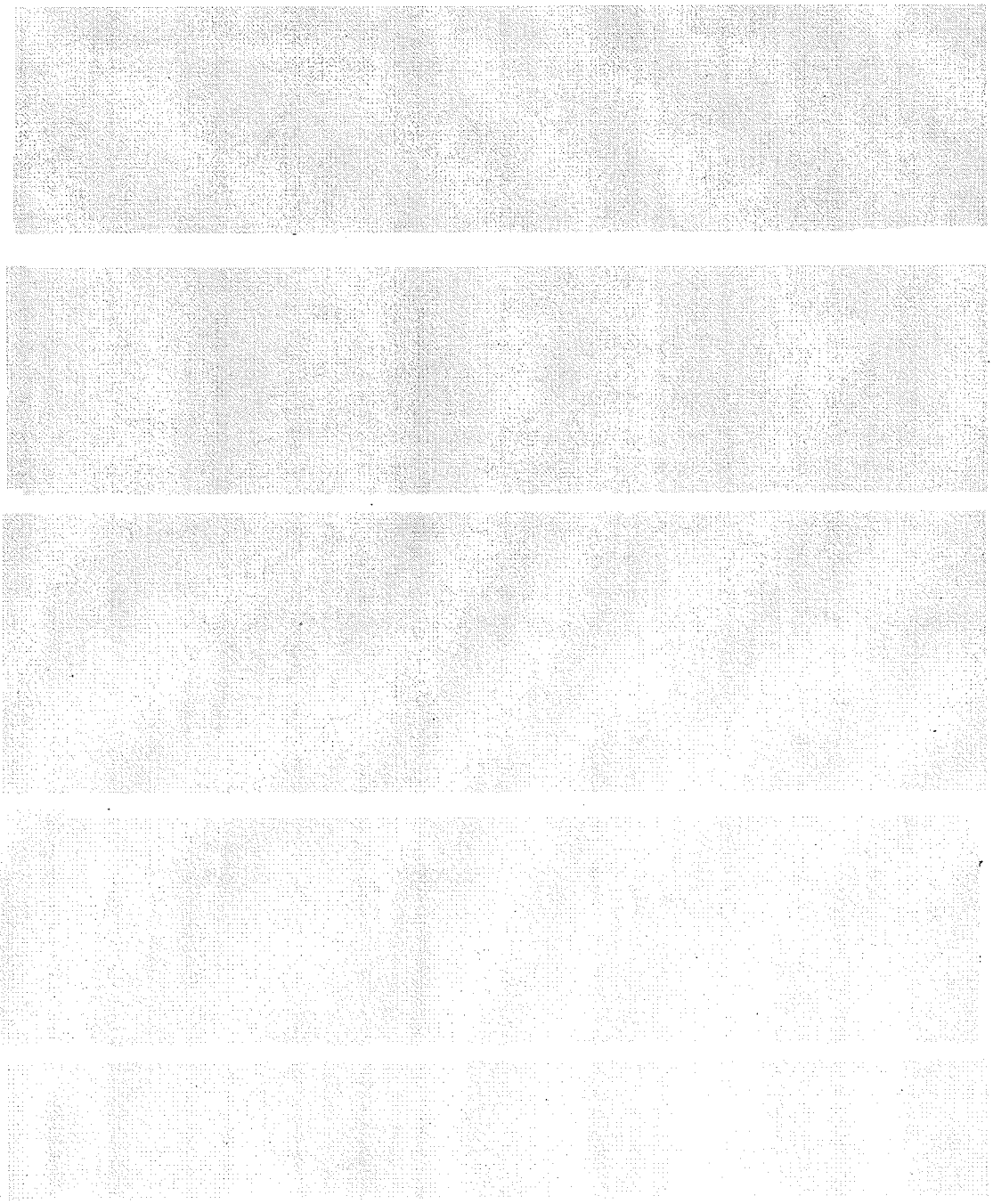
The intake was screened as information only. The committee agreed that based upon the information known at the time, the screening decision was accurate.

The committee commented that even with the domestic violence screening question being asked, the use of language in the documentation is an important factor. Domestic violence is not between two people but rather domestic violence is committed by a perpetrator against a victim. The December 7, 2009 intake identified that S.T.'s mother had been choked during the domestic violence incident. The word "strangulation" is preferred as it denotes the true violence of the action.

The next intake received by CA referencing S.T. and his family is the fatality intake received on September 29, 2010. CPS intake received a call from the father of the deceased child's sibling stating that he saw on the local news that his son, , had been injured and another child, S.T. had died. Intake called law enforcement and learned that the paramour of S.T.'s mother was arrested and was being charged with first degree murder in the death of S.T. was left in the care of his mother by law enforcement and the referent was concerned for his safety. The committee noted that CPS had not been contacted by law enforcement, the hospital or any of the first responders regarding the fatal incident.

Family # 2





The committee discussed the value of utilizing Multi-Disciplinary Teams (MDTs) when multiple systems are involved with individuals related to critical incidents. In this particular case, a warrant was filed by county corrections for Mr. Cooley's arrest from Kitsap County on May 5, 2010 related to his activities involving another woman and his children. May 5, 2010 was the same date . presented at Sacred Heart Hospital with critical injuries in Spokane. The committee identified the possibility that had the systems

involved with Mr. Cooley staffed their respective information Mr. Cooley may have been arrested on the warrant prior to S.T.'s death.

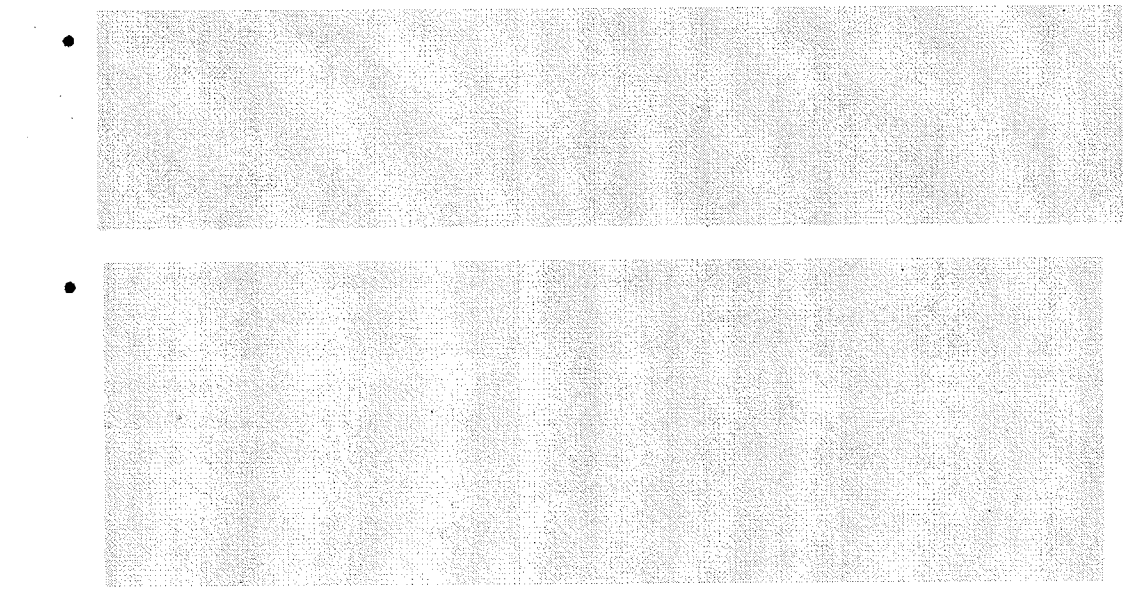
The review committee identified the inability to add or modify the alleged subjects in the intakes as a potential barrier to history searches on specific individuals. FamLink allows for additional subjects to be added to the investigative assessment tool but does not automatically link that individual to the case. This may contribute to time intensive history searches on individuals since each investigative risk assessment tool needs to be opened and reviewed for subject findings.

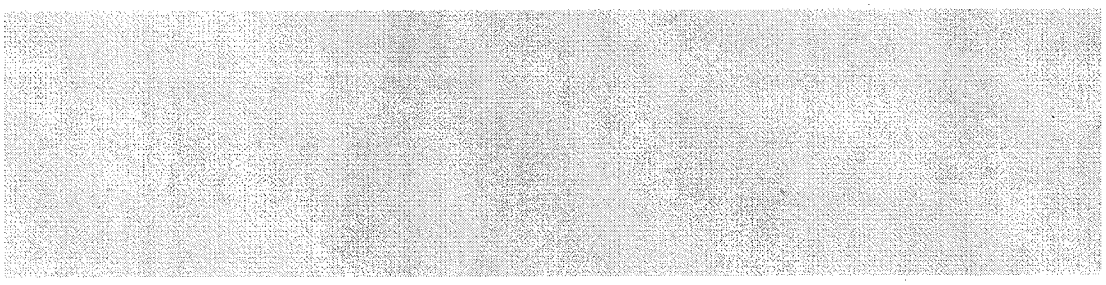
Family # 3

The committee had concerns that a referent was directed to call law enforcement instead of CA intake contacting law enforcement. As a result there was no verification that law enforcement was actually called by the referent.

RCW 74.13.500

RCW 13.50.100





Findings and Recommendations

The committee made the following findings and recommendations based on review of the case records, department policy and procedures, Revised Code of Washington (RCW), Washington Administrative Code (WAC), and medical documents.

Findings

- The committee found that CPS was not contacted by law enforcement, the hospital or any of the first responders to the fatal incident involving S.T. Many of these individuals are mandated reporters in Washington State.

- The investigation from the June 3, 2010 intake regarding Mr. Cooley's daughter does not include an interview with the babysitter of the children. This individual was identified as an eye witness to the circumstances of how the child's arm was broken.

Recommendations

- The review committee recommends Children's Administration develop procedures for obtaining and maintaining police reports on both screened in and screened out intakes. Information should include full names of participants in the incident and law enforcement's disposition of the incident. The information should be documented in FamLink and police reports uploaded into FamLink.

- When speaking with collateral contacts at the point of intake, particularly law enforcement, Children's Administration staff should request details about the case and document those details near-verbatim. The police report number, full names of all parties involved and the name of the officer or individual providing the information should also be obtained and documented.

- Children's Administration should develop domestic violence curriculum and provide domestic violence training to accompany the *"Social Worker's Practice Guide to Domestic Violence."*[7] The training should include local community

[7] The "Social Worker's Practice Guide to Domestic Violence" was published by Children's Administration in February 2010 and disseminated to all case carrying social workers and their supervisors. CA developed this practice guide to provide direction to social workers working with families experiencing domestic violence. While varying definitions for "domestic violence" appear within Washington statute, it is important to note that this guide addresses best practices for working with families experiencing domestic violence occurring between intimate partners. The guide focuses on the knowledge and skills needed by all

resources involved with domestic violence, as well as, information regarding the judicial system and issues related to "No Contact Orders". Many "No Contact Orders" restrict contact with the adult victim but allow for unsupervised visitation between the adult perpetrator and their children. The training should be made available to social work staff on an annual basis.

- Children's Administration should consider initiating the development of a Domestic Violence and Child Maltreatment coordinated response guideline for local communities similar to that of King County, WA. Primary participants should include the judicial officers and other program staff in criminal and civil courts; law enforcement agencies; the Office of the Prosecuting Attorney; the Washington State Attorney General; Public Defender Agencies; and the Washington State Department of Social and Health Services, Children's Administration.
- The committee found CA best practices include asking the referent if they would like a call back regarding CA's decisions or actions on the information provided. The committee suggested that when call backs to referents are completed the referent may provide additional information or make subsequent calls of concern. Call backs to referents elicit support from referents and the community in reporting child abuse and neglect.
- Mandated reporters identified in RCW 26.44.030[8] should be required to review the Department of Social and Health Services mandated reporter training materials on an annual basis.

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workers, not solely DV specialists. The guide reflects new insights in effective child welfare responses, so it is relevant for both experienced and new workers.

[8] When any practitioner, county coroner or medical examiner, law enforcement officer, professional school personnel, registered or licensed nurse, social service counselor, psychologist, pharmacist, employee of the department of early learning, licensed or certified child care providers or their employees, employee of the department, juvenile probation officer, placement and liaison specialist, responsible living skills program staff, HOPE center staff, or state family and children's ombudsman or any volunteer in the ombudsman's office has reasonable cause to believe that a child has suffered abuse or neglect, he or she shall report such incident, or cause a report to be made, to the proper law enforcement agency or to the department as provided in **RCW** 26.44.040.

(b) When any person, in his or her official supervisory capacity with a nonprofit or for-profit organization, has reasonable cause to believe that a child has suffered abuse or neglect caused by a person over whom he or she regularly exercises supervisory authority, he or she shall report such incident, or cause a report to be made, to the proper law enforcement agency, provided that the person alleged to have caused the abuse or neglect is employed by, contracted by, or volunteers with the organization and coaches, trains, educates, or counsels a child or children or regularly has unsupervised access to a child or children as part of the employment, contract, or voluntary service. No one shall be required to report under this section when he or she obtains the information solely as a result of a privileged communication as provided in **RCW** 5.60.060.

Nothing in this subsection (1)(b) shall limit a person's duty to report under (a) of this subsection.