

**Children's Administration - DSHS
ADMINISTRATIVE REPORT OF INCIDENT
Michael-Kekoa Ravenell**

Incident Type	Child Fatality : Homicide (by Abuse)	
Fatality Review Required?	Yes	
Death Expected?	Unexpected	
High Profile : Media Interest	Michael's death has been reported in the media. As of 2:30am on 5/29/08, it was on internet sites for the major Seattle TV stations.	
Incident Related To A Facility?	No	
Date/Time Of Report	5/29/2008 : 05:25:50	
Region Reporting	5	
Office Name	Tacoma (Pierce)	
Referral Number (If Applicable)	1915730	
Case Number (If Applicable)	27D5804900	
Date Of Incident	5/28/2008	
Location Of Incident	FamHome	
County	Pierce	
System ID	2449	
Case Status At Time Of Incident	Open	
Primary Program In Which Activity During Last 12 Months Occurred	CPS - DCFS	
Child's Legal Status At Time Of Incident	Parental Custody	
Child's Residence Type	Family home	
Was There An Allegation Of Neglect Regarding This Incident In The Referral?	Yes	
Was There An Allegation Of Abuse Regarding This Incident In The Referral?	Yes	RCW 74.13.500

NAME OF CHILD(REN) INVOLVED IN INCIDENT

Child Name (Last,First)	Role	Sex	DOB -- Age	Ethnicity/Race	Legal Status
Ravenell, Michael-Kekoa Na'Auali'i	Primary Child	Male	12/ /2004 -- 3yr-5mo	Hawaiian	Parental Custody

Residence Type:Family home : Date of Death: 5/28/2008 : Type of Death:

Homicide - By Caretaker :

[REDACTED] Sibling : Female [REDACTED]/2006 -- Hawaiian Parental
 Relation:Sibling 1yr-6mo Custody

Residence Type:Family home :

Shortly after the death of her sibling, [REDACTED]'s biological father gained temporary legal custody.

NAME OF STAFF, ADULTS OR PROVIDERS INVOLVED IN INCIDENT

Adult Name (Last,First)	Role	RCW 74.13.500	Sex	DOB -- Age
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[REDACTED]	Caretaker, Present At Death, Adult Living In Home, Subject of CA/N Allegations, Birth Parent		Female	[REDACTED]/1982
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City/State:Tacoma, WA : Zip:98444 :

Caretaker Characteristics: Familial/Environmental Stressors, Prior allegations of perpetrating CA/N

Thomas (Lorenzo), Noah Jeremiah	Caretaker, Present At Death, Adult Living In Home, Subject of CA/N Allegations, Parent Paramour		Male	[REDACTED]/1983
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City/State:Tacoma, WA : Zip:98444 :

Caretaker Characteristics: Criminal History, Assaultive Behavior, History of CA/N as a Child, [REDACTED], Familial/Environmental Stressors, Prior allegations of perpetrating CA/N

[REDACTED]	Birth Parent		Male	[REDACTED]/1974
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City/State:Tacoma, WA :

Staff With Access To Incident

Name	Role	CA 300 ID	Phone Number
Saunders, Tom	Administrative Assistant	SAUT300	360-902-7967
Soule, Tom	CI Supervisor	SOTO300	206-341-7356
Cooper, Dawn	DCFS Area Manager	NEDA300	(253) 983-6260
Sebastian, Toni	HQ Staff	SETO300	(206) 341-7310
Hurd, Dorene	Administrative Assistant	HURD300	(253) 983-6260
Lee, Karen	HQ Staff	LLEKP	

Chesterfield, Diana	CI Area Manager	CHDI300	206-341-7378
DeCoteau, Janelle	CI Supervisor	DECJ300	206-341-7379
Payne, Beverly	CI Supervisor	PAYB300	206-641-7377
Slaughter, Julie	DCFS Supervisor	SLJU300	253-983-6146
McKenzie, Joy	DCFS Social Worker	TRAP300	253-983-6160
Mitchell, Judy	DCFS Supervisor	MITJ300	253-983-6308
Payne, Beverly	Other	PAYB300	
Muggoch, Susan	HQ Staff	MUSU300	360-902-8062
Sutton, Nancy	Regional Administrator	SUTN300	253 983 6324
Meinig, Mary	Other	MEIM300	
Thomas, Linda	Deputy RA	THOL300	(253)983-6353
Wickmark, Steven	HQ Staff	WCKM300	
Geiger, Barbara	DCFS Area Manager	GEIB300	
Muller, Nicole	HQ Staff	NIMC300	360/902-0217
Lee, Karen	HQ Staff	LEKP300	360-902-7892
Greenwood, Deborah	Administrative Assistant	GRDB300	

Description Of Incident

Child death by homicide. The first call to intake was from the social worker at St. Claire Hospital at approx. 9:45pm. He stated only that Michael had been brought to he emergency room by mother and the story was that Michael had fallen off some toys in the playground. Later, the Pierce Co. Medical Examiner, Burt Osborne, called to report Michael's death. According to referrer's information mother left Michael with her boyfriend, Noah (referrer had no last name). Noah does not live with the mother but was watching Michael today. At 16:00 or so the mother returned home and was told by Noah that Michael fell down at 14:30 from a big toy (jumping stones) at the apartment complex playground. Michael was awake and alert. Mother asked Michael if he was OK and he said, no. She gave him some water and crackers, he ate some and lay down. At 16:45 the mother brought Michael to the St. Clare Hospial's ER, he had no life signs. The ME stated that he spoke to the Michael's father who told referrer that yesterday, 5/27/08, Michael had some bruises on his body; he had a bruise on his shoulder, he had a tong laceration and a bruise on his head. The father stated that he took Michael to Multicare Clinic because he was concerned. Referrer stated that at this time he has no other information to report. He will contact Multicare tomorrow to find out more details. Referrer reported that Tacoma PD is already working on this case, he had no report #. A request for a child welfare check was made of the Tacoma PD. At about 2am, Det. Jennifer Quillio called back. She stated that **RCW 74.13.500** is with her father at this time. Noah has been booked into jail on Murder 2 charges. Reportedly, he originally told police that Noah hit his head at the park,

but later said that he got frustrated with Michael because he was whining and not eating. He threw Michael around and hit his head. Noah told police he tried to resuscitate Michael by putting his arms around his neck. It's not clear how he thought choking Michael was going to resuscitate him. When Michael did not respond, Noah put him to bed and told mom to check on him. At first, mom thought Michael was asleep, but when she found he wasn't breathing, they took him to the hospital.

Description Of Actions Taken

_____ is with her father, who is not a subject or suspect.

Description Of Safety Plan

_____ 's care was assumed by her biological father shortly after the fatality incident.

Tribal Involvement

RCW 74.13.500

Law Enforcement Jurisdiction

Tacoma PD

WSP Referral Made?

N/A

Local Law Enforcement Notified?

Yes

Law Enforcement Case Number

081580328

Report Prepared By Tom Soule

CA 300 ID SOTO300

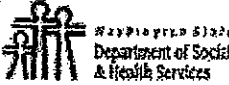
Title CI Supervisor

Phone Number 206-341-7356

NO FOLLOW UPS ON FILE

Approved By _____

Title _____

		Child Fatality Review Childrens Administration - DSHS		Michael-Kekoa Ravenell Date of Death: 5/28/2008	
General Information					
REPORT DATE 9/16/2008	REPORT STATUS Closed	REFERRAL NUMBER 1915730	SYSTEM ID 2449	TYPE OF LICENSED FACILITY	
REGION REPORTING 5	OFFICE Tacoma (Pierce)	DIVISION DCFS	CASE STATUS AT TIME OF DEATH Open , CPS - DCFS	CAUSE OF DEATH Traumatic bodily injury	
Deceased Child Information			RCW 74.13.500		
NAME (LAST, FIRST) Ravenell, Michael-Kekoa Na'Auali'i		ROLE(S) Primary Child	DOB - AGE 12/2004 -- 3yr-5mo	GENDER Male	
STREET ADDRESS		CITY	STATE - ZIP WA	LEGAL STATUS Parental Custody	CAMIS ID 3159067
ETHNICITY Hawaiian	HISPANIC No, Not Hispanic	PRIMARY PROGRAM	RESIDENCE TYPE Family home	RESIDENCE COUNTY Pierce	DATE OF DEATH 5/28/2008
NATURE OF DEATH Homicide - By Caretaker	SPECIAL CHARACTERISTICS / OTHER ISSUES				
OFFICIAL MANNER OF DEATH Homicide (by Abuse)	DETERMINED BY Medical Examiner	HAS THE CHILD EVER BEEN PLACED IN OUT OF HOME CARE? No			
Summary of How Death Occurred					
<p>On May 28, 2008 intake was notified of the death of three year old Michael-Kekoa Ravenell from probable non-accidental trauma.</p> <p>The mother had left Michael with her boyfriend Noah Thomas who reportedly did not live with the mother. At approximately 4:00 P.M. the mother returned home. At some point the mother discovered the boy not breathing and around 4:45 that afternoon the child was brought St. Clare Hospital's Emergency Room - the child had no life signs.</p> <p>Mr. Noah Thomas subsequently admitted to having thrown the child and then attempted to resuscitate the unresponsive child by grabbing the child around the neck. Mr. Thomas was arrested and booked into Pierce County Jail on murder charges. The death has been determined to be a homicide.</p>					
Location Information					
RESIDENCE AT TIME OF DEATH Family home	COUNTY RESIDING IN Pierce	LOCATION WHERE DEATH OCCURRED Family Home	COUNTY WHERE DEATH OCCURRED Pierce		
Incident is NOT Related to a Facility					
Birth/Adoptive Parents					
NAME (LAST, FIRST) [REDACTED]	ROLE(S) Caretaker, Present At Death, Adult Living In Home, Subject	GENDER Female	DOB - AGE [REDACTED] 1982		

		of CA/N Allegations, Birth Parent			
STREET ADDRESS		CITY Tacoma	STATE WA	ZIP WA	PHONE
NAME (LAST, FIRST)		ROLE(S) Birth Parent		GENDER Male	DOB - AGE /1974
STREET ADDRESS		CITY Tacoma	STATE WA	ZIP WA	PHONE
Neglect and/or Abuse Allegations RCW 74.13.500					
WAS THERE AN ALLEGATION OF NEGLECT BY A CARETAKER REGARDING THIS FATALITY IN THE REFERRAL? Yes		WAS AN OFFICIAL FINDING OF NEGLECT BY A CARETAKER DETERMINED A FACTOR IN THIS DEATH? Yes		IF YES, WAS IT PHYSICAL OR MEDICAL? Medical	
There is sufficient evidence that Noah Thomas, after having caused severe injuries to Michael-Kekoa Ravenell, failed to contact emergency medical response or obtain medical care.					
WAS THERE AN ALLEGATION OF ABUSE BY A CARETAKER REGARDING THIS FATALITY IN THE REFERRAL? Yes			WAS AN OFFICIAL FINDING OF ABUSE BY A CARETAKER DETERMINED A FACTOR IN THIS DEATH? Yes		
Mr. Noah Thomas has admitted to having caused injuries to Michael-Kekoa Ravenell which resulted in the child's demise.					
DOMESTIC VIOLENCE INDICATOR? Yes		CRIMINAL HISTORY INDICATOR? Yes		SUBSTANCE ABUSE INDICATOR? Yes	
PRENATAL DRUG EXPOSURE? Undetermined		LAYOVER OR CO-SLEEPING WITH AN INFANT? N/A			
DOMESTIC VIOLENCE HISTORY					
CRIMINAL HISTORY					
Surviving Siblings Under Age 18					
NAME (LAST, FIRST)		ROLE(S) Sibling	DOB - AGE 2006 -- 1yr-6mo	GENDER Female	RELATION Sibling
STREET ADDRESS		CITY	STATE - ZIP WA	LEGAL STATUS Parental Custody	CAMIS ID 3159080
ETHNICITY Hawaiian	HISPANIC No, Not Hispanic	PRIMARY PROGRAM	RESIDENCE TYPE Family home	RESIDENCE COUNTY Pierce	DATE OF DEATH
NATURE OF DEATH		SPECIAL CHARACTERISTICS / OTHER ISSUES			
Shortly after the death of her sibling, [redacted]'s biological father gained temporary legal custody.					

Other Non-Sibling Children Residing in the Home at Time of Death: (None Indicated)

Child Protection / Safety Plans / Licensing Actions

WHAT ACTION WAS TAKEN TO PROTECT OTHER CHILDREN IN HOME/FACILITY? Removed From Home/Facility	IF THE CHILD REMAINED IN THE HOME/FACILITY, WAS A SAFETY PLAN PUT INTO PLACE? N/A
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DESCRIBE SAFETY PLAN
RCW 74.13.500
[REDACTED]'s care was assumed by her biological father shortly after the fatality incident.

WHAT LICENSING ACTIONS HAVE OCCURRED AS A RESULT OF THIS DEATH?

Prior Child Deaths in Family and/or Facility: (None Indicated)

Adults Living in Home/Facility Where Death Occurred

NAME (LAST, FIRST) [REDACTED]	ROLE(S) Caretaker, Present At Death, Adult Living In Home, Subject of CA/N Allegations, Birth Parent	GENDER Female	DOB - AGE [REDACTED] 1982
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STREET ADDRESS	CITY Tacoma	STATE WA	ZIP WA	PHONE
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NAME (LAST, FIRST) Thomas (Lorenzo), Noah Jeremiah	ROLE(S) Caretaker, Present At Death, Adult Living In Home, Subject of CA/N Allegations, Parent Paramour	GENDER Male	DOB - AGE [REDACTED] 1983
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STREET ADDRESS	CITY Tacoma	STATE WA	ZIP WA	PHONE
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Caretaker Characteristics

NAME (LAST, FIRST) [REDACTED]	ROLE(S) Caretaker, Present At Death, Adult Living In Home, Subject of CA/N Allegations, Birth Parent	GENDER Female	DOB - AGE [REDACTED] 1982
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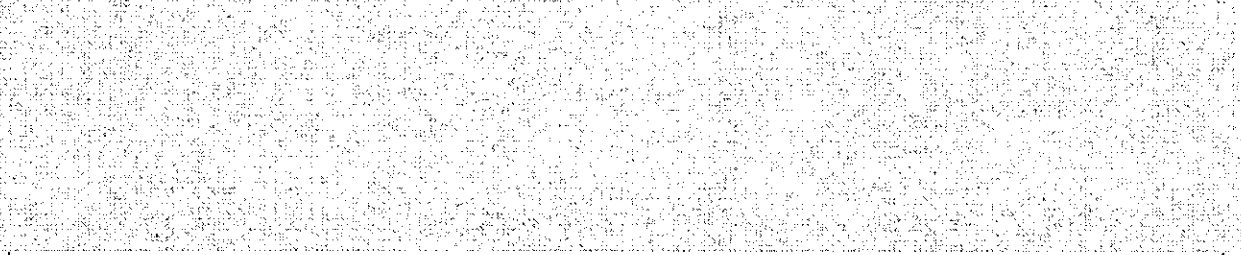
STREET ADDRESS	CITY Tacoma	STATE WA	ZIP WA	PHONE
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NAME (LAST, FIRST) Thomas (Lorenzo), Noah Jeremiah	ROLE(S) Caretaker, Present At Death, Adult Living In Home, Subject of CA/N Allegations, Parent Paramour	GENDER Male	DOB - AGE [REDACTED] 1983
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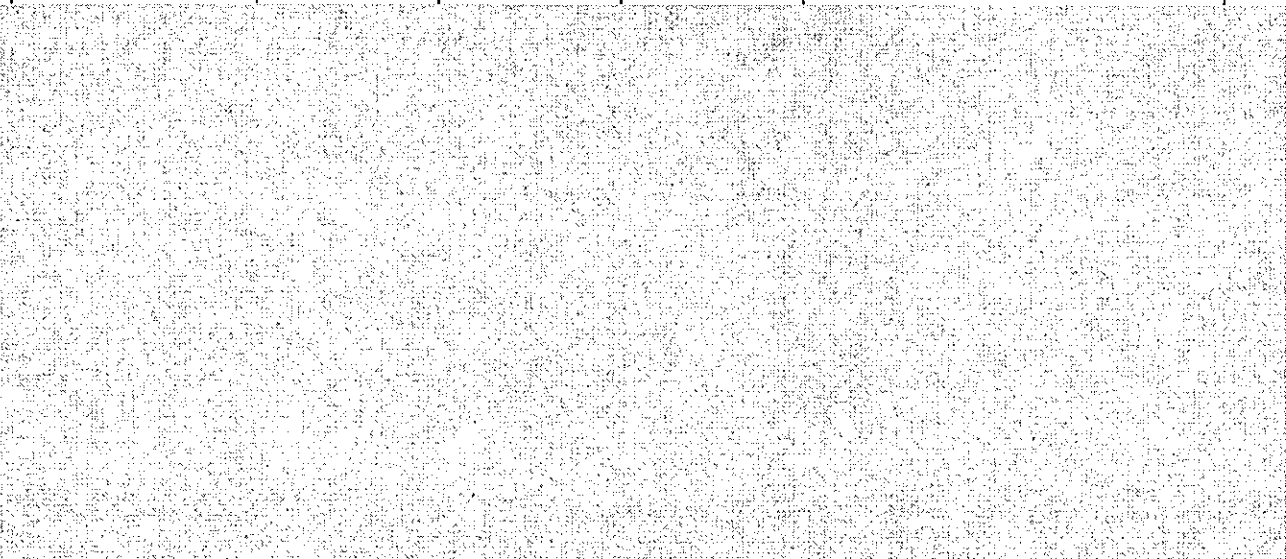
STREET ADDRESS	CITY Tacoma	STATE WA	ZIP WA	PHONE
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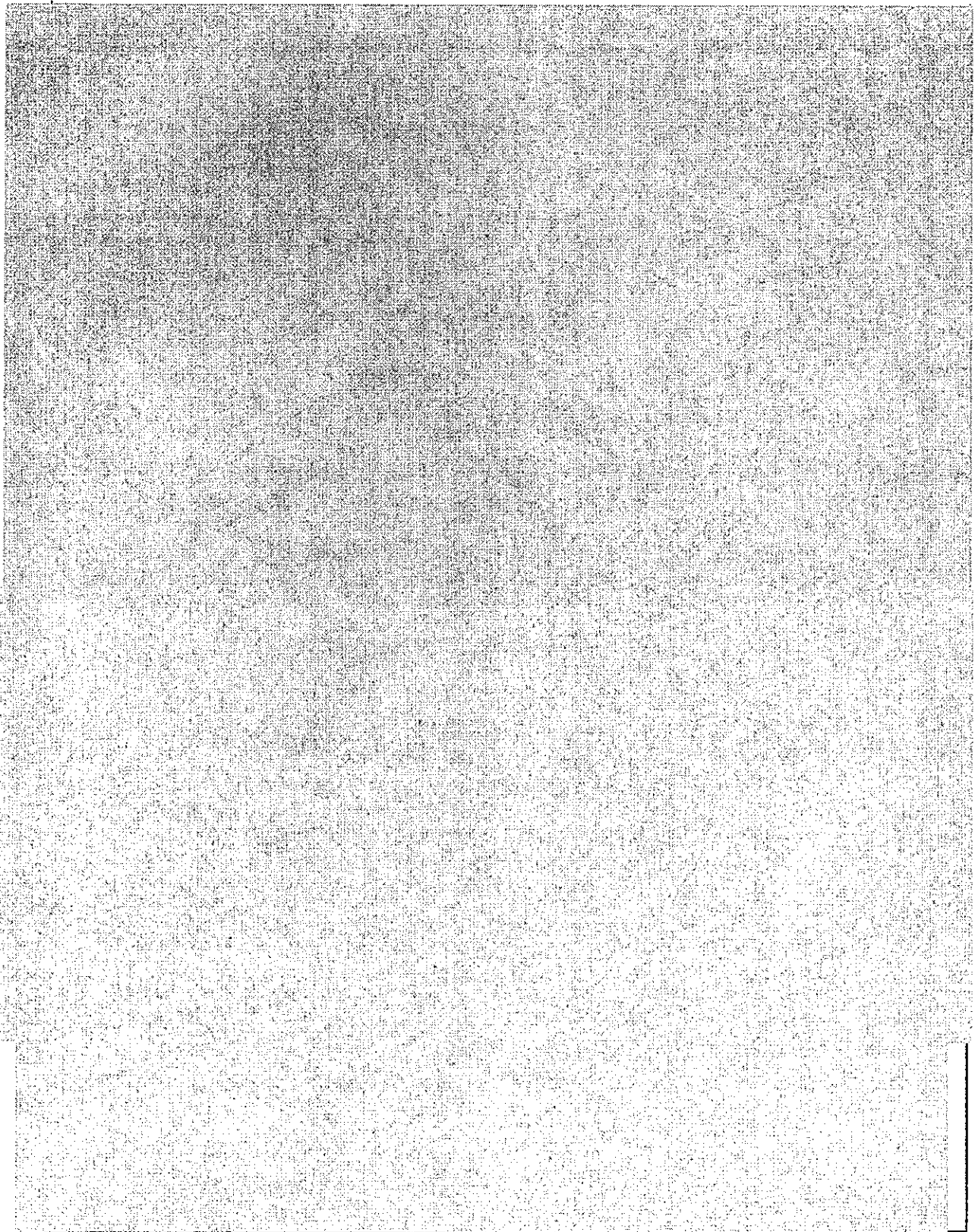
Family Referrals

NUMBER OF REFERRALS PRIOR TO DEATH	DATE OF FIRST REFERRAL	DATE OF LAST REFERRAL
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Family Referral History					RCW 74.13.500				
REFERRAL DATE	REFERRAL ID	SUBJECT	PROGRAM	DECISION					
6/10/2008	1919151	[REDACTED] and Noah Thomas	CPS	Accepted					
ACTION		CA/N CODES		FINDING					
Case Closure, Other actions taken: Biological father gained temp legal custody of surviving child		Physical Abuse Negligent or Maltreatment		Founded Founded					
REFERRAL COMMENTS									
Evidence gathered post-fatality indicates surviving sibling has also been abused by the biological mother, the mother's boyfriend, or both.									
REFERRAL DATE	REFERRAL ID	SUBJECT	PROGRAM	DECISION					
5/28/2008	1915730	Noah Thomas and [REDACTED]	CPS	Accepted					
ACTION		CA/N CODES		FINDING					
Case Closure		Physical Abuse Negligent or Maltreatment		Founded Founded					
REFERRAL COMMENTS									
Fatality Notification. Child died of trauma, and explanation provided by the non-related caretaker of the child (biological mother's boyfriend) was not consistent with the injuries. Mr. Thomas arrested and charged.									
REFERRAL DATE	REFERRAL ID	SUBJECT	PROGRAM	DECISION					
4/2/2008	1899802	[REDACTED] and Noah Thomas	CPS	Accepted					
ACTION		CA/N CODES		FINDING					
		Physical Abuse Negligent or Maltreatment		Founded Inconclusive					
REFERRAL COMMENTS									
Biological father reporting bruising on his son Michael-kekoa Ravenell. Recent bruise on the child's chest from the biological mother [REDACTED], and a bruise to the child's left eye allegedly caused by the mother's current partner, Noah Thomas.									
REFERRAL DATE	REFERRAL ID	SUBJECT	PROGRAM	DECISION					





Services Offered To Family

GAIN-SS

Offered/Accepted

Prior to her involvement with Noah Thomas, Ivory Wong had no involvement with Children's

RCW 74.13.500

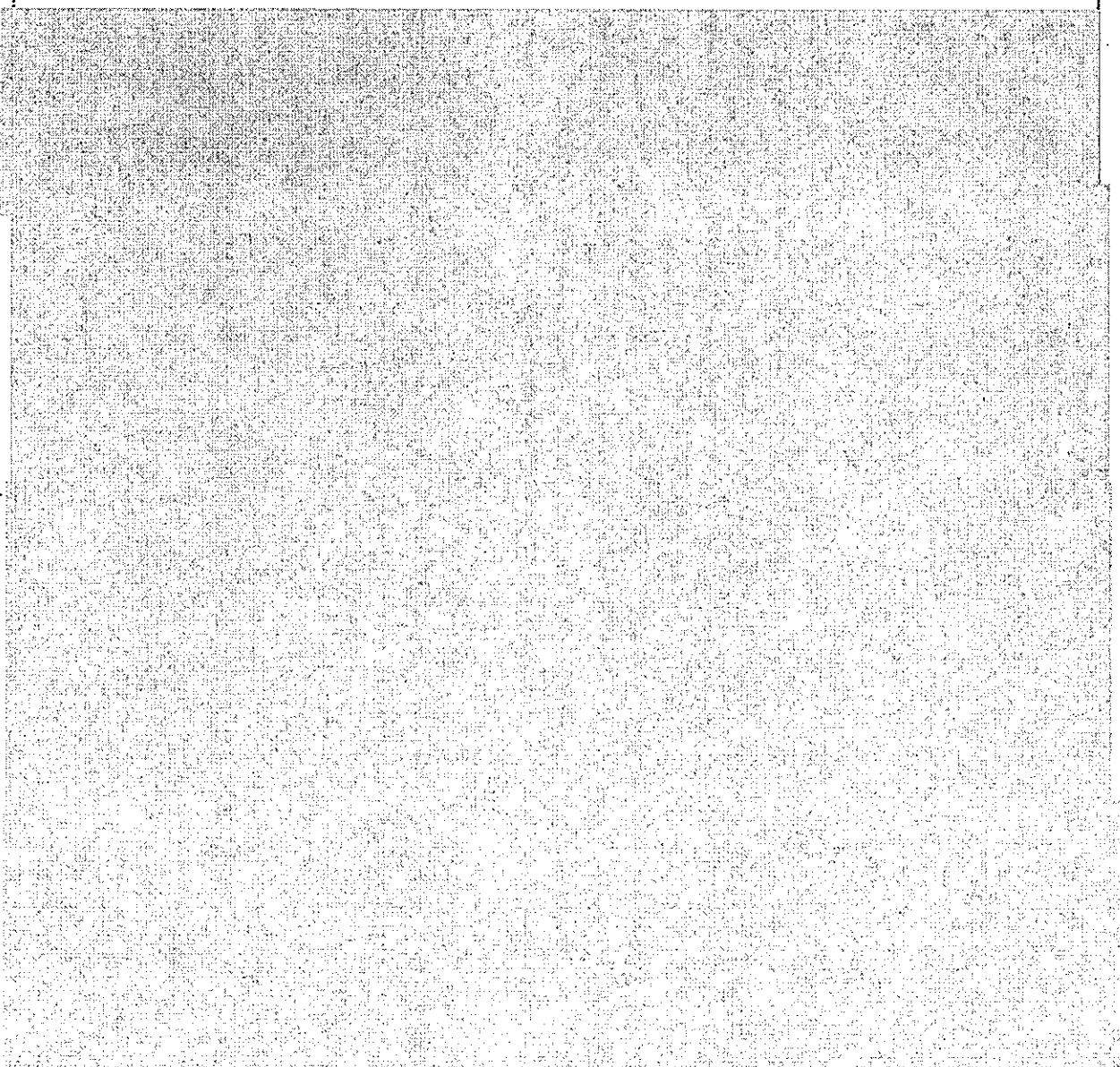
Administration. During the pre-fatality CPS investigation Ms. [REDACTED] completed the GAIN-SS - a screening tool for mental health and [REDACTED]. At that time Ms. [REDACTED]'s responses indicated a need for a mental health assessment. The investigation was in progress when the fatality incident occurred. No other services were offered prior to the fatality.

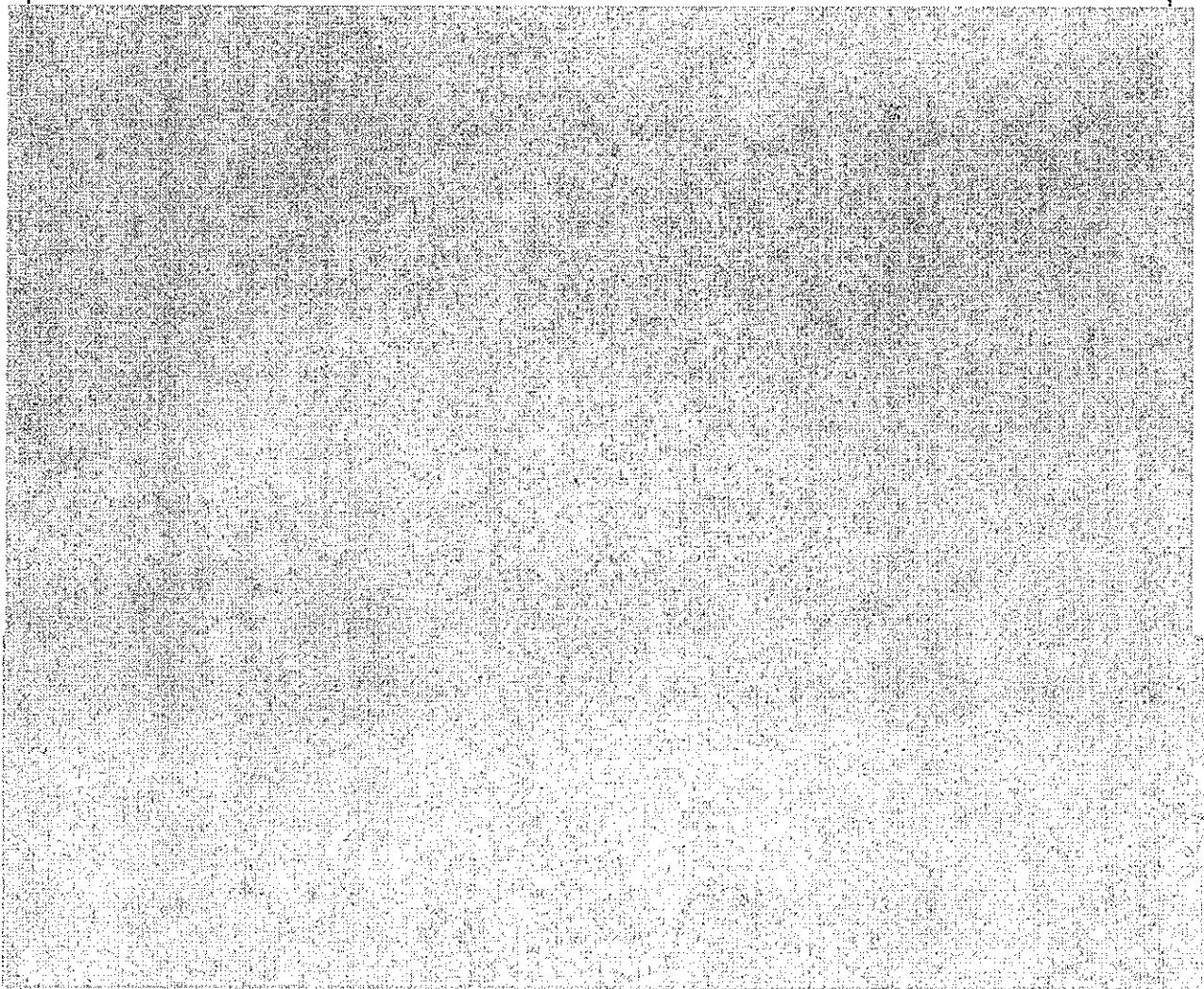
Noah Thomas had previously received a number of services while involved with CPS and Juvenile Court (Drug Court Program). Throughout the dependency of his biological children Mr. Thomas received anger management, couples counseling, individual counseling, and Family Preservation Services (FPS) which addressed parenting skills. He completed [REDACTED]

Facility Referrals (Not Applicable)

Factual Summary Of The Child / Family Case

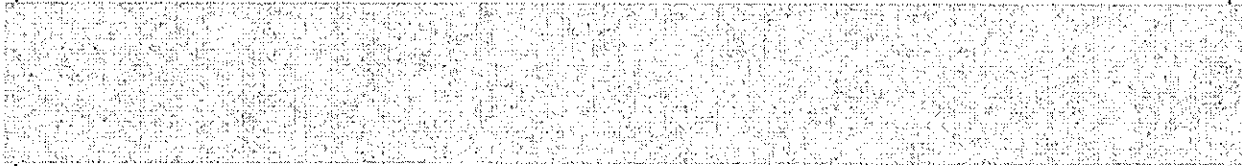
Case History for Noah Thomas:





Case History for Ivory Wong:

RCW 74.13.500



In March 2008 Ms. [REDACTED] reportedly began cohabitating with Noah Thomas. Several weeks later the biological father of Michael-Kekoa Ravenell reported to both CPS and law enforcement that his son had a fading bruised eye. His son had stated that Noah had caused the injury. [REDACTED] also reported that his son had suffered a chest bruise weeks prior. A day after the report Ms. [REDACTED] filed for an Order for Protection against [REDACTED]. While the CPS investigation was still in progress Michael-Kekoa Ravenell died from injuries caused by Noah Thomas. Mr. Thomas was subsequently charged with murder. Medical evidence gathered post-fatality indicated that both Michael-Kekoa and [REDACTED] had prior non-accidental injuries. The biological father obtained temporary custody of the surviving sibling.

Factual Summary Of Facility Licensing History (Not Indicated)

Participants in Review Process : (None Indicated)

Information Used in Review Process

DCFS CASE FILE / SUMMARY OF FILE	AUTOPSY	LICENSING FILE / SUMMARY OF FILE	LAW
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Used in Review	REPORT Not Available	Not Applicable	ENFORCEMENT REPORTS Used in Review
DLR/CPS FILE / SUMMARY OF FILE Not Applicable	MEDICAL RECORDS Used in Review	PROSECUTOR'S OFFICE REPORTS Not Available	DEATH CERTIFICATE Not Available
CORONER'S OFFICE REPORTS Not Available	CRIMINAL HISTORY Used in Review	RECORDS OF CONTRACTED PROVIDER Not Applicable	CPS RECORD CHECK Used in Review

The following areas should be considered when answering the above questions. Intake policies and procedures; required time frames; required contacts; staffing and shared decision making requirements; supervisory reviews; legal authorities and requirements; risk assessment policies and procedures; documentation; other policies, practice, and systems issues appropriate to the case. Any specific personnel actions related to this case as a result of this review are not documented in this report.

Identified Issues and Recommendations

CATEGORY PRACTICE ISSUE DESCRIBED	RECOMMENDATION
<p>Important CPS investigation steps were not completed.</p> <ul style="list-style-type: none"> o 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. The CAMIS search should have led to a criminal history check which would have revealed a o 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. o 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. <p>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.</p>	<p>Develop training models to ensure demonstration and retention of core competencies. Examples:</p> <ul style="list-style-type: none"> o 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. <p style="text-align: center;">RCW 74.13.500</p>
<p>CATEGORY PRACTICE ISSUE DESCRIBED</p> <p>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</p>	<p>RECOMMENDATION</p> <p>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.</p>

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 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 employees 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 3s 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.

**CATEGORY SYSTEM
ISSUE DESCRIBED**

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.

RECOMMENDATION

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.

Summary of Review and Recommendations

Executive Review Comments

The full Executive Review Child Fatality Review can be viewed at <http://www.dshs.wa.gov/ca/pubs/fatalityreports.asp>

DOES THE REVIEW TEAM RECOMMEND A WORK PLAN BE DEVELOPED?
No

WORK PLAN DUE DATE

Review Approval

APPROVED BY

TITLE

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. 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 enquiry or to replace or supercede 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.

Staff Authorized to Access Incident

NAME (LAST, FIRST)	ROLE	PHONE	300 ID
Chesterfield, Diana	CI Area Manager	206-341-7378	CHDI300
Cooper, Dawn	DCFS Area Manager	(253) 983-6260	NEDA300
DeCoteau, Janelle	CI Supervisor	206-341-7379	DECJ300
Geiger, Barbara	DCFS Area Manager		GEIB300
Greenwood, Deborah	Administrative Assistant		GRDB300
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Lee, Karen	HQ Staff		LEEKP
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Muggoch, Susan	HQ Staff	360-902-8062	MUSU300
Muller, Nicole	HQ Staff	360/902-0217	NIMC300
Payne, Beverly	Other		PAYB300

NAME (LAST, FIRST) Payne, Beverly	ROLE CI Supervisor	PHONE 206-641-7377	300 ID PAYB300
NAME (LAST, FIRST) Saunders, Tom	ROLE Administrative Assistant	PHONE 360-902-7967	300 ID SAUT300
NAME (LAST, FIRST) Sebastian, Toni	ROLE HQ Staff	PHONE (206) 341-7310	300 ID SETO300
NAME (LAST, FIRST) Slaughter, Julie	ROLE DCFS Supervisor	PHONE 253-983-6146	300 ID SLJU300
NAME (LAST, FIRST) Soule, Tom	ROLE CI Supervisor	PHONE 206-341-7356	300 ID SOTO300
NAME (LAST, FIRST) Sutton, Nancy	ROLE Regional Administrator	PHONE 253 983 6324	300 ID SUTN300
NAME (LAST, FIRST) Thomas, Linda	ROLE Deputy RA	PHONE (253)983-6353	300 ID THOL300
NAME (LAST, FIRST) Wickmark, Steven	ROLE HQ Staff	PHONE	300 ID WCKM300

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
- *Toni Sebastian, 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 Review¹ 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 27, 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

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 3³.

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. [REDACTED] 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.