CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

January 2022

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The Washington State Department of Children, Youth, and Families (DCYF) does not discriminate and provides equal access to its programs and services for all persons without regard to race, color, gender, religion, creed, marital status, national origin, sexual orientation, age, veteran's status, or the presence of any physical, sensory, or mental disability.

January 2022

Full Report

Child

- P.A.

Date of Child's Birth

- RCW 74.13.515 2019

Date of Fatality

- July 24, 2021

Child Fatality Review Date

- Oct. 14, 2021

Committee Members

- Patrick Dowd, JD, Office of the Family and Children's Ombuds, Director
- Christine Kerns, MSW, Alliance for Child Welfare Excellence University of Washington, Regional Education and Training Administrator
- Renee Tabor, MSW, Department of Children, Youth, and Families, Quality Practice Specialist, Region 2
- Stephanie Frazier, MSW, Department of Children, Youth, and Families, Intake and Safety Area Administrator Region 6

Consultants

- Koke and Tofu Asaeli, RCW 13.50.100 Church, Pastors

Facilitator

- Libby Stewart, Department of Children, Youth, and Families, Critical Incident Review Specialist

Executive Summary

On Oct. 14, 2021, the Washington State Department of Children, Youth, and Families (DCYF)[1] convened a Child Fatality Review (CFR)[2] to examine DCYF's practice and service delivery to P.A. and RCW 74. family.[3] RCW 74.1 will be referenced by RCW 74. initials throughout this report.

On July 24, 2021, DCYF received a telephone call from a hospital and was told that P.A. was taken to the hospital by ambulance. Attempts were made at the hospital to revive RCW 74. but RCW 74. was declared dead. The hospital reported RCW 74. had bruises all over RCW 74. body. This intake screened in for a Child Protective Services (CPS) investigation.

That same day intake received another telephone call, this time from law enforcement. That caller reported that P.A.'s father, Telenise "Junior" Aunai, was suspected of causing his RCW 74.13.515 death. Law enforcement also reported that Mr. Aunai's fiancé, Tina Ma'ae, took P.A.'s siblings to the fiancé's sister's home. It was also reported that Ms. Ma'ae was not cooperating with law enforcement. Due to the duplicate allegations of abuse, which were also in the initial intake, this intake was screened out.

P.A. was RCW 74.13.515 old at the time of RCW 74. death. The county coroner's office determined the cause of death was multiple blunt force traumas. The manner of death was classified as a homicide. Telenise "Junior" Aunai and Tina Ma'ae were both charged with second degree murder. Mr. Aunai and Ms. Ma'ae were also charged with additional criminal charges related to injuries found on P.A.'s surviving siblings.

A diverse CFR Committee (Committee) was assembled to review this case and to evaluate DCYF's service delivery to the family. The Committee included community partners and DCYF staff. Prior to the review, no Committee members had any direct knowledge of, or involvement with, the family. Committee members received copies of the DCYF case history that included CPS intakes, case notes, assessments, timelines, a family genogram, law enforcement reports, and medical records. The consultants listed on page 1 of this report originally were Committee members. However, due to an unforeseen emergency on the day of the scheduled review, they could not attend the Committee review itself. They graciously made themselves available the following week to discuss the Committee's culturally specific questions.

On the day of the review, the Committee met with the CPS supervisor and caseworker who were assigned the most recent CPS/Family Assessment Response (FAR) assessments. FAR is an alternative response within the

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[1] Effective July 1, 2018, DCYF replaced the Department of Social and Health Services (DSHS) Children's Administration (CA) as the state agency responsible for child welfare; and the Department of Early Learning for childcare and early learning programs. For purposes of this report, any reference to DCYF and events that occurred before July 1, 2018, shall be considered a reference to DSHS.

[2] "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)]." RCW 74.13.640(4)(a). 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 a child. The CFR Committee's review is generally limited to documents in the possession of or obtained by DCYF or its contracted service providers.
The Committee has no subpoena power or authority to compel attendance and generally hears only from DCYF 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 CFR 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 it the function or purpose of a CFR to recommend personnel action against DCYF employees or other individuals.

[3] The name of P.A.'s mother is not used in this report because she has not been charged with a crime related to P.A.'s death. P.A.'s father, Telenise "Junior" Aunai, and his fiancé, Tina Ma'ae, have been charged with crimes related to P.A.'s death and are therefore named in the report.

CPS program and is utilized for cases that include allegations of child abuse or neglect that are considered lower in risk. The Committee also met separately with the area administrator, CPS supervisors, and the caseworker from the office that handled a request for a courtesy initial face-to-face and walk-through of Mr. Aunai and Ms. Ma'ae's home.

Case Overview

Between 2017 and 2019 there were five intakes associated with P.A's mother's name and case number. The first intake involving this family was received in 2017 and was created under P.A.'s mother's name. Four of the five intakes were received in 2017 and the fifth intake was received in 2019. Two of the four intakes from 2017, and the 2019 intake screened out for CPS investigations. The allegations related to a lack of medical care for the children. There were no founded findings of abuse or neglect.

In 2018, DCYF received and assigned an intake under one of P.A.'s RCW 74.13.515. During the assessment of that intake, P.A.'s two oldest siblings, both parents, and other relatives were also all living together in the grandparents' home. There were three FAR assessments assigned between 2018 and 2021. Allegations included severe dental neglect, neglect related to the conditions of the home, and an undiagnosed skin condition on RCW 74.13.515 face. After the assessments were concluded, the cases were closed and no services were opened for the family. Some of P.A.'s siblings were identified in those intakes. P.A. was never identified as a family participant.

As a part of a 2018 FAR assessment under the RCW 74.13.515 case number and name, one of the children in the family reported the family had moved from Samoa to the United States in 2016. It was also reported that P.A.'s paternal grandparents and a paternal aunt provided the majority of care for P.A's siblings since birth. The family constellation was very fluid with family members frequently moving to different family homes. The most recent case involving Mr. Aunai's children was opened in April 2021, under the RCW 74.13.515 name. This case was closed on June 15, 2021. P.A. was not included in any of the FAR assessments conducted by DCYF, meaning RCW 74. was not observed or assessed. At the time of the June 2021 case closure, DCYF was aware that P.A. and RCW 74. three siblings were living with their father and his fiancé in RCW 74.13.515 County. The fiancé's two adult siblings were also living with the father, the fiancé, P.A., and P.A. siblings.

Committee Discussion

The Committee discussed DCYF's actions and decisions. The Committee also discussed a lack of comprehensive assessments. The Committee understands this case was challenging because there were multiple families living together at different times. This created confusion regarding identification of the members of the household. This changing dynamic regarding who was living where made it difficult for the caseworkers to contact and assess all family members. There were family members identified on intakes and also identified during conversations with other family members that were never contacted or assessed by DCYF caseworkers. There were both adults and children that should have been assessed.

The Committee also discussed the assessment which closed in June 2021 and the functionality of Famlink, the computer system used by DCYF. In particular, the Committee discussed that under the Famlink system, FAR assessments do not prepopulate the names of parents and children. CPS caseworkers must select each name to include in the assessment. The system does not include all of the known persons associated with a

particular household. The Committee opined that this may have contributed to the lack of a comprehensive assessment. The Committee discussed that the caseworkers need to be aware of who is living at a home or regularly caring for the children. It was noted by the Committee that during case reviews and ultimately at case closure, supervisors are tasked with being aware of who is residing at the home or regularly caring for the children.

When the May 2021 intake was created, the case remained under RCW 74.13.515 case number and name. The Committee understands this case is complex; in light of all the moving parts included in the intake process, there was a short timeline to make intake screening determinations. However, there was discussion that corrections should have been made after the intake was assigned for assessment and upon review by the assigning supervisor. Instead of being opened under the RCW 74.13.515 name, the case should have been opened under the father's name (and differing case number than the RCW 74.13.515) and assigned to the office associated with where the father lived.

The Committee heard from the CPS caseworker and learned the caseworker did not have concerns about the father's care of his children. On May 5, 2021, the caseworker observed a mark on one of P.A.'s RCW 74.13 515 sibling's face. The medical consultation identified the mark was likely RCW 74.13.520 and not a result of abuse. This information from the medical consultant was provided on the same day the intake was made. Despite the medical consultant's determination and for purposes of the intake, the Committee was concerned the father had never previously provided the primary care for his four children, who were all under the age of five. The Committee was also concerned there was little known about the father, his fiancé, and her adult siblings who were residing in the home. Likewise, there was not a foundational understanding about how the father was going to meet the children's physical or emotional needs, a lack of understanding about the father's relationship with his family, and whether the family was available to assist the father if he asked for help. It was the Committee's understanding that the youngest child had really only known the paternal grandmother and aunt as a care provider, and the majority of care provided to the other siblings had been from those same family members.

The first assessment under P.A.'s mother's case number refers to the paternal grandfather and his struggle to speak English. In the same assessment, the parents were asked if they wanted an interpreter, by telephone, and they declined. During the assessment, Mr. Aunai and P.A.'s mother said they spoke Samoan and English. The Committee discussed that even though the parents and family may have declined the offer to receive interpretive services, concerns remained about the family's ability to understand English.

On the day of the Committee's review, pastors Tofu Asaeli and Koke Asaeli were unable to participate. However, the Committee's facilitator was able to meet with the pastors the week after the review occurred. Committee members were also invited, but only Patrick Dowd was able to attend. During the Committee's CFR, the Committee prepared questions for the pastors. During the meeting with the pastors, the case was discussed and the questions asked. The Committee discussed that as a part of a comprehensive assessment, the staff should have taken steps or made efforts to learn about the family's culture. This family had only been in the United States for a relatively short period of time.

Pastors Tofu and Koke Asaeli shared information about medical and dental care, education, child protective services, discipline, and family roles and expectations in Samoa. They shared that within Samoan families, the mother is responsible for the children's daily activities and the father is responsible for discipline. Extended family is very important, and the community may consider children "their own" even though they are not biologically related. The pastors said that under the Samoan culture, there is no justification for the injuries that were received by P.A.

The pastors discussed the differences between families living in Samoa and families who move from Samoa to the United States. They discussed the cultural changes that have occurred during the last 40 years. They also talked about the importance of titles for families within the Samoan culture and the role of pastors. They strongly recommended DCYF engage pastors when communicating with Samoan families to help facilitate open and honest conversations and engagement in services. Working with pastors would also provide the caseworkers with necessary information about the Samoan culture that the caseworkers may find helpful during their interactions with the families and their children.

Findings

The Committee made two findings that were identified as areas that could have been improved upon. The Committee determined the findings are unrelated to the critical incident.

DCYF did not conduct a comprehensive assessment during the April and May 2021 assessments. During the time P.A. and RCW 74. siblings were living with the paternal relatives, there were children and adults who were not assessed. When the case closed, the children were living with Mr. Aunai and Ms. Ma'ae. Once again, there were children and adults living in the home that were not assessed. For purposes of the assessments that were assigned under the RCW 74.13.515 case, DCYF did not attempt to contact P.A.'s mother.

The Committee believes the May 2021 intake should have been assessed by the office located in the same area as where the father resided, not the RCW 74.13 County office. The Committee also believes the case should have been opened under either P.A.'s mother's name or Mr. Aunai's name, not the RCW 74.13.515. The Committee discussed that because of the nuances associated with this family's DCYF history, and the short amount of time allowed for intake screening decisions, the supervisor in RCW 74.13 County (Region RC) should have determined the intake needed to be reassigned to the RCW 74.13.515 DCYF office. The Committee also determined the intake was initiated well beyond the RCW 26.44.030 48-hours mandatory reporting requirement. The skin condition described by the RCW 13.50.100 during the intake call was first observed 17 days before the RCW 13.50.100 called intake.

Recommendations

The Committee did not make any recommendations.