Washington State Department of Social & Health Services

CA Children's Administration

Child Fatality Review

G.B.

October 2009
Date of Child's Birth

April 18, 2015
Date of Child's Death

September 16, 2015
Child Fatality Review Date

Committee Members
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RCW 74.13.640

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Executive Summary

On September 16, 2015, the Department of Social and Health Services Children's Administration (CA) convened a Child Fatality Review[1] (CFR) to examine the department's practice and service delivery to RCW 13.50.100 G.B., whose parents are RCW 13.50.100. The child and two siblings were dependent Indian children[2] out of Port Angeles (Clallam County) and in tribally approved relative placement in Spokane County. On April 18, 2015, the child died from blunt force injuries suspicious for abuse while in placement with his paternal aunt Cynthia Khaleel.[3] The aunt subsequently pled not guilty to a charge of second degree murder and the criminal prosecution is currently pending.

The CFR Committee was comprised of CA staff, community members and Hoh tribal staff with pertinent expertise from a variety of fields and systems, including child abuse investigation, public child welfare services, Indian Child Welfare (ICW), and child advocacy. None of the Committee members had any previous direct involvement with the family with the exception of the representatives from the Hoh Tribe.

Prior to the review each Committee member received a narrative summary of CA involvement with G.B. and his biological family, and a separate chronology of CA involvement with Cynthia Khaleel including pre and post placement of G.B. and his siblings. Committee members also received reports to the court by both the CA worker and the Guardian ad Litem (GAL).[4] Relevant un-redacted case file documents from the Port Angeles and Spokane offices were provided to the Committee members, including worker and supervisor case notes, shared

[1] Given its limited purpose, a Child Fatality Review should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. The Child Fatality Review 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 will only hear from DSHS employees and service providers. It does 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 recommend personnel action against DSHS employees or other individuals.

[2] Washington state Indian Child means an Indian child meeting the definition of "Federally Recognized Indian Child" and whose tribe is a federally recognized tribe located within the state of Washington. [Source: Indian Child Welfare Manual 14.0]

[3] The full name of Cynthia Khaleel is used in this report because she was charged with committing a crime related to this report of abuse investigated by DSHS. The names of the deceased child and his siblings are subject to privacy laws. [RCW 74.13.500(1)(a)].

[4] A Guardian ad Litem (GAL) is an individual appointed by the court to represent the best interests of a child or incapacitated person involved in a case in superior court. [Source: Washington Courts]

planning meeting notes, and the home study report that was finalized post-fatality.

Available to Committee members at the time of the CFR were educational and medical records for G.B. and the Spokane County Medical Examiner's Office records regarding the child fatality (autopsy and ancillary studies).

During the course of the review, three Port Angeles field staff involved with the case and the Area Administrator were interviewed. The Child and Family Welfare Services (CFWS) worker, who had been assigned the case from July 2013 through December 2014, was not available for interview as she is no longer employed by Children's Administration. Additionally, two Spokane Children's Administration supervisors were interviewed.

Following review of the case file documents, completion of the staff interviews, and discussion regarding department activities and decisions, the Committee made findings and recommendations which are presented at the end of this report.

Case Overview

G.B. first came to the attention of Children's Administration in May 2011 following a report of a RCW 13.50.100 sibling with non-accidental injuries. Both children were placed into protective custody and the CPS investigation resulted in physical abuse allegations being founded RCW 13.50.100.[5] G.B. was subsequently found dependent by Clallam County Juvenile Court as to the RCW 13.50.100 only and the two siblings remained in the care of their mother. The dependency was dismissed when the father was RCW 13.50.100 in June 2012; the case closed in September 2012.

In May 2013, CPS initiated two investigations of allegations of negligent treatment by the RCW 13.50.100. A Family Team Decision Making (FTDM)[6] meeting was held in late May with tribal representation. The decision was made for G.B. and his sibling to remain in the care of their RCW 13.50.100. In June, while the case was still open, the family unexpectedly left the state for California. California CPS placed G.B. and his sibling and filed for dependency based on evidence of neglect. California dismissed the dependency matter and dependency was refiled in Washington (Clallam County) where the children were placed into temporary

[5] Founded means the determination that following an investigation by the department, based on available information, it is more likely than not that child abuse or neglect did occur [RCW 26.44.020(9)].

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

relative care, which was supported by the Hoh Tribe. A RCW 13.50.1sibling born in late RCW 13.50.10013 was also placed into out-of-home care following the filing for dependency on her behalf.

In March 2014, following contact with paternal Aunt Cynthia Khaleel, a FTDM was held to explore permanent placement of the children. At the time, the aunt resided in RCW 13.50.100 and her husband was RCW 13.50.100. In April, the aunt came to the Port Angeles area for an intensive one week visitation with G.B. and his siblings. Following numerous visits with the children throughout that week, Cynthia Khaleel indicated a desire to have all of the children placed in her home. She moved to RCW 13.50.100, Washington with her three biological children. Her husband remained RCW 13.50.100. The Port Angeles social worker reported conducting a walk-through of the Khaleel home in July.

G.B.'s mother RCW 13.50.100. Soon after, G.B. and his RCW 13.50.100 went on court approved extended visitation with their aunt. The Hoh Tribe recommended the boys remain permanently with Cynthia Khaleel. G.B. and his RCW 13.50.100 were legally placed with their paternal aunt in early September following review by LICWAC.[7] The assigned worker from Port Angeles documented that she had conducted in-person monthly health and safety visits with G.B. and his caregiver in September, October, and November of 2014. This documentation was questioned by the department in December due to activities that were recorded but could not be reconciled.

On December 12, 2014, Spokane intake received a report that G.B. had been observed at school with bruises and marks on his face and head that may or may not have been accidental or self-inflicted. Additional concerns were noted for supervision of the children in the home. Intake identified G.B. as having an active child welfare case out of Port Angeles and notified that office. The Spokane office had been unaware of the placement of G.B. and his sibling in the home of Cynthia Khaleel. At intake it was also discovered that Cynthia Khaleel had two prior CPS investigations. One occurred in 2008 regarding a RCW 13.50.100 (unfounded). The second occurred in November 2013 when Cynthia Khaleel allegedly failed to properly supervise a non-related child RCW 13.50.100 (unfounded). Cynthia Khaleel was visiting from RCW 13.50.100 at the time. The two

[7] Local Indian Child Welfare Advisory Committee (LICWAC) is a body of department approved and appointed volunteers who staff and consult with the department on cases of Indian children who are members of a federally recognized tribe or are members of a tribe but for whom the tribe has decided not to intervene or has not responded. The child's tribe may officially designate the LICWAC to speak for the tribe. [Source: Indian Child Welfare Manual 10.0]

investigations were not linked and the identified last name in the 2013 intake was not Khaleel.

Spokane CPS responded within 24 hours to the allegations reported on December 12, 2014. During the initial contact at the Khaleel, home a worker did observe and photograph a fading bruise on G.B.'s forehead, a small bruise on his eye and on the bridge of the nose, and a small scratch on his cheek. Cynthia Khaleel stated that G.B. hit his head on a bathroom vanity and also got injured during roughhousing around the sofa. She denied the allegations of poor supervision. The intake and photos taken by the Spokane CPS worker were sent to law enforcement which declined to investigate. Notification of the intake was made to the Hoh Tribe. Spokane staff contacted the Port Angeles worker to review the case and to raise concerns that neither a request for courtesy supervision nor a home study had been requested by Port Angeles prior to placement of G.B. and his sibling.

All the children in the Khaleel home were allowed by Cynthia Khaleel to be interviewed by CPS, but only in her presence (sitting behind the children when interviewed). G.B. was examined and assessed at the Child Advocacy Center in Spokane. The medical child abuse specialist concluded that the injuries could have occurred as explained by Cynthia Khaleel. The allegations were determined to be unfounded by the CPS investigator and the CPS case closed.

A previously scheduled LICWAC staffing occurred in mid-December with participation by the Hoh Tribe and staff from both the Port Angeles and Spokane Children's Administration offices. At that staffing it was recommended that the department initiate a home study and courtesy supervision out of the Spokane office. During a subsequent staffing between the Spokane and Port Angeles offices, several social service needs were recommended by Spokane staff. In addition to the need for immediate initiation of courtesy supervision and home study, it was recommended that the Port Angeles worker help the aunt obtain financial help, provide respite care for Cynthia Khaleel as needed, and to provide educational advocacy to improve services for G.B. and his sibling.

Courtesy supervision by Spokane began mid-January and the Spokane home study worker made in-home contact with Cynthia Khaleel in late January 2015. The home study worker documented numerous challenges facing the aunt in attempting to parent five small children on her own. In early February, the home study worker emailed the Port Angeles CFWS worker expressing reservations about the anticipated placement of the RCW 13.50.100 in the Khaleel home. Concerns had surfaced from conflicting statements by Cynthia Khaleel as to the status of

her RCW 13.50.100 the parentage of her children, her history with the department, and her reliance on her extended family for support. In addition, the home study worker expressed concern that he could not find documentation that the maternal grandparents, who reportedly had unsupervised access to G.B. and his RCW 13.50.100, had completed background checks.

In early February 2015, the RCW 13.50.100was court ordered into placement with her siblings' paternal aunt Cynthia Khaleel. The placement was supported by the Hoh Tribe. On February 17, 2015, a CFWS worker from Spokane conducted a routine health and safety visit at the Khaleel home. It was at this contact that the Spokane office became aware that the RCW 13.50.100 had been placed in the home by court order. Following the courtesy supervision visit to the home, the case was again staffed by the Port Angeles and Spokane offices. The courtesy worker expressed concerns that the home was "chaotic" and while the aunt appeared well intentioned, she was struggling to meet the needs of six children both financially and otherwise.

In early March, the home study worker and his supervisor met with the aunt to discuss concerns and discrepancies that had arisen during the home study process. On March 24, 2015, the home study worker contacted the Port Angeles worker to review the progress of the home study which had been delayed due to a failure of required forms to be returned. At a home visit in early April, the home study worker met with Cynthia Khaleel and her husband, who was RCW 13.50.100. Again, a list of paperwork that needed to be completed prior to completion of the home study was provided by the home study worker.

On April 17, 2015, CA intake was notified that G.B. had been admitted to a RCW 13.50.100 hospital and was not expected to survive. The child was observed to have multiple injuries and skull fractures and had suffered a massive stroke. Cynthia Khaleel stated that early in the morning of April 17, she had heard a loud "bang" and screaming coming from the bedroom shared by G.B. and his brother. She found G.B. on the floor between his bed and a dresser, with a crib partially tipped over and resting on the dresser. At that time she believed G.B. had fallen while getting into his RCW 13.50.100 crib. She observed no injuries although the child was crying and saying his ear hurt. She put G.B. back to bed, gave him some ice and Motrin, and propped him on a pillow. At about 6:00 a.m., while in the process of getting the children ready for the day, she attempted to wake G.B. He did not move and his pupils were of different sizes. Cynthia Khaleel called 911 and upon arrival the first responders called for a Medivac helicopter for emergency transport.

G.B. was removed from life support on April 18, 2015 and passed away. Upon autopsy, G.B. was found to have multiple external and internal injuries, including bilateral skull fractures, abdominal trauma, and multiple skin contusions involving the head, torso and extremities. The CPS investigator contacted a state Child Protection Medical Consultant (CPMC)[8] who, based upon the medical and law enforcement reports, believed that G.B. had sustained multiple traumas including an abdominal injury that was the result of a deep penetrating force. The complexity and severity of the head injuries suggested a very severe blow that would have caused immediate concussion and would have made it unlikely for the child to have any period of lucidity as described by Cynthia Khaleel.

Cynthia Khaleel was arrested and charged with the death of G.B., subsequently pleading not guilty to the charges.

CFR Committee Discussion

The Child Fatality Review Committee largely focused on case activities and decisions from when the department considered G.B.'s paternal aunt as a possible placement (March 2014) until his death while in her care (April 2015). The Committee spent considerable time evaluating the department's level of compliance with a number of CA policies relating to placement of dependent children, including those regarding out-of-area placement, courtesy supervision, home study requests, and health and safety visit requirements. The Committee also briefly considered requirements under the federal Indian Child Welfare ACT (ICWA) and the Washington state Indian Child Welfare Act (ICWA).

The Committee deliberated on a number of practice issues that surfaced from review of case documents and interview responses by CA staff from both the Port Angeles and Spokane offices. Full consensus was not reached as to the significance of each identified practice issue, but some issues were deemed substantive in terms of consequences on the fatality and are so noted in the findings section of this report. Additionally, the Committee discussed the compilation of multiple practice deficits that converged to collectively impact the outcome of the case more than any single factor.

In terms of individual practice issues, the Committee discussed the quality and reliability of information gathered by the CFWS worker as to the aunt for both

[8] The CPMCs are a team of physicians who provide statewide consultation and training regarding medical findings in cases of alleged child abuse and neglect. The tasks of the statewide CPMC network include providing telephonic consultations, case staffing/case review, training, court testimony, and written consults to CA staff, law enforcement officials, prosecuting attorneys, and physicians regarding child maltreatment cases.

pre-placement vetting (mid 2014) and post-placement follow up (September-December 2014). This included concerns by the Committee as to a lack of collateral contacts (e.g., school staff) and whether the CFWS worker provided complete and corroborated information to the Hoh Tribe and to her supervisors. The information documented was viewed in contrast to information uncovered by the Spokane home study worker between January and April 2015 that raised concerns as to the aunt's history and current family situation. The Committee also reflected on the post-placement activities, including apparent lack of ongoing assessment and timely follow-up for recommended services and the general inadequate service delivery to G.B. and his siblings and support services to the relative caregiver. Also discussed was the apparent failure of Port Angeles staff to give sufficient consideration to concerns expressed by the Spokane home study and courtesy worker in Spokane in February and March 2015 as to the chaotic placement environment and what appeared to be an overburdened caregiver. The Committee noted the information gathering and assessment of the placement by the home study worker was thorough and of good quality.

The Committee was made aware that some documentation by the primary child welfare worker from the Port Angeles office has now been questioned by the department as having occurred as recorded. The discrepancies were not discovered until December 2014 resulting in the removal of the worker from the case. This resulted in discussion by the Committee as to the reliability and credibility of what had been reported by the worker, who was not available for interview by the Committee as she is no longer employed by the department. The Committee was further hampered by the unavailability, due to various circumstances, of several Hoh Tribal staff that had been involved in the case and who may have been able to provide clarification and relevant information.

Members of the Committee considered statements made by Port Angeles supervisors that they were aware that the worker appeared to be enmeshed with the aunt, exhibited confirmatory bias,[9] and significantly relied on the aunt as the primary source of information as to G.B.'s "positive" transition to his Spokane placement. These conditions, along with the apparent distraction with legal conflicts in Family Court between the foster parent of G.B.'s RCW 13.50.100 and the Hoh tribe regarding placement, may have contributed to the worker assertively pursuing relative placement when other information did not support such

[9] Confirmation biases are effects in selective collection of evidence and information processing that explains how people search through available information, interpret that information, and hence reach conclusions. Studies of social judgment provide evidence that people tend to overweight positive confirmatory evidence or underweight negative discomfirmatory evidence.

urgency to move G.B. and his RCW 13.50.100. Additionally, the Committee was made aware that the primary worker had a noted pattern of not meeting timelines for documentation and completion of work and was known to be difficult to supervise, but had never had a critical incident previously on her caseload. While discussing personnel issues are not normally within the scope of conducting Child Fatality Reviews, the Committee found such to be critically relevant to evaluating the impact of the worker's practice in this case as well as the quality of the supervisory oversight.

Some exploratory discussions occurred as to conditions specific to the Port Angeles office. This included consideration of the office culture, such as a high field staff turnover rate resulting in more supervisory focus on inexperienced workers and less on experienced field staff. The Committee considered the reported usual practice in the Port Angeles office for requesting a home study prior to placement of a child into relative care, the process of requesting courtesy supervision by another state office, the level of initial and ongoing inter-office communication, and intra-office case transfer procedures. This was for the purpose of trying to determine if the identified issues and policy violations in this case were anomalous or systemic in that office. Additionally, the Committee discussed the relative search responsibilities in the Port Angeles office, as well as the lack of identified ICW specialists in an area that serves six federally recognized tribes.

In the context of looking at possible recommendations emerging from the review, the Committee discussed post-fatality actions reported to have taken place in the Port Angeles office after the death of G.B. This included information provided by the Area Administrator of increased guidance and training for workers and supervisors in the areas of courtesy supervision and home study request procedures and policies. The Committee also briefly discussed the fact that significant information came to CA's attention after the fatality regarding Spokane school staff having failed to report several incidents of concerning injuries to G.B. in 2014. The Committee was satisfied that Spokane staff followed procedures to report the failure of the mandated reporters to report the suspicious injuries. No further discussion occurred as to that issue, as reviewing non-CA systems are outside the scope of the Child Fatality Review Committee.

Findings

1. The Committee found several examples where the placement of G.B. and his siblings in the unlicensed home of the paternal aunt was not conducted in accordance with CA policy. Although not reaching full consensus, a

majority of Committee members concluded that critical errors were made in the relative placement process. The most notable issues were:

a. Home Study. The request to evaluate Cynthia Khaleel's home was not made in a timely manner. Policy requires that a home study be completed prior to placement unless it is an emergent or urgent placement. The Committee noted that Cynthia Khaleel moved to Washington state in July and the fact that the children were not legally placed in the home until two months later indicates it was not an emergent situation. The Committee felt there was ample opportunity to more thoroughly assess the caregiver prior to placement and that a timely home study may have raised questions earlier about her character and suitability as a placement for the children. [10]

b. Courtesy Supervision. When it is necessary for children to be placed outside of the jurisdiction of a local office, that office is to notify the CA office that services the area of the proposed placement in advance and request courtesy supervision. Courtesy supervision was not requested on this case until the children had been in the Spokane area for over four months.[11]

2. Documentation of the health and safety monitoring visits by the assigned Port Angeles social worker did not appear to be in accordance with CA policy. Specifically, CA policy requires an initial health and safety visit within seven days of the child's placement and this does not appear to have occurred. Further health and safety visits are to be conducted monthly with the majority of the contacts occurring in the child's home, and this did not appear to have occurred.[12]
3. Although supervisory reviews regarding the primary CFWS case were regularly conducted and documented, there were conspicuous missed opportunities for key supervisory actions. This included making sure the worker completed the courtesy supervision request and home study request per policy; that the worker followed through on recommendations (e.g., from Shared Planning meetings, LICWAC, prior monthly supervisory

[10] CA Practices and Procedures Guide 5110 was recently issued to address this and clarifies that if a home study has not been completed prior to placement, a request must be made within thirty days of placement.
[11] Courtesy supervision safely supports a child, in the care and custody of the department, when placed outside of the originating office catchment area. Provides consistent support for children and families when cases are shared between offices and regions. [Source: CA Practices and Procedures Guide 4430]
[12] All health and safety visits and monthly visits must be conducted by the assigned CA worker or another qualified CA staff. The number of visits conducted by another qualified CA staff is not to exceed four (4) times per year with no two (2) visits occurring in consecutive months. [Source: CA Practice and Procedures Guide 4420]

reviews, and from Spokane CPS, courtesy supervision, and home study staff); that the worker was actively providing support services for G.B. and his caregiver; that the worker was providing sufficient ongoing management of risk and safety.[13]

Recommendations

1. The Committee recommends that CA continue its current efforts to streamline the courtesy supervision process, to reduce delays in courtesy supervision case assignment, and to make clear the division of duties and required communications between the sending and receiving offices.
2. CA should continue to pursue integrating the courtesy supervision referral and home study request processes in FamLink so that there is connection to the case management system that is easily reviewed and tracked electronically.[14]
3. CA Policy and Program staff develop and initiate "Quick Tip" practice suggestions to serve as reminders for staff regarding the timeframes for courtesy supervision and home study requests. [15]

[13] Social work supervisors must conduct monthly supervisor care reviews with each assigned social worker and document each case reviewed in the client electronic file. [Source: CA Practice and Procedures Guide 46100]

[14] FamLink is the case management information system that Children's Administration implemented on February 1, 2009; it replaced CAMIS, which was the case management system CA had used since the early 1990s.

[15] Quick Tip is a weekly electronic message which appears when CA staff log into their computers. Quick Tips provide practice tips, policy reminders and general CA information. Quick Tips were implemented in August 2014 as a result of a workgroup recommendation to improve regular communication with all staff.