Washington State Department of Social & Health Services

CA Children's Administration

Child Fatality Review

K.S-H.

August 2014
Date of Child's Birth

January 11, 2015
Date of Fatality

March 26, 2015
Child Fatality Review Date

Committee Members
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Executive Summary

On March 26, 2015, the Department of Social and Health Services (DSHS), Children's Administration (CA) convened a Child Fatality Review (CFR)[1] to assess the department's practice and service delivery to five-month-old K.S-H. and her family.[2] The child (K.S-H.) will be referenced by her initials throughout this report.

The incident initiating this review occurred on January 11, 2015 when K.S-H. was brought to a local hospital by her mother and her mother's boyfriend. The hospital staff observed K.S-H. to be limp and apneic. Medical intervention was attempted but failed to revive K.S-H.

At the time of the fatality, K.S-H. and her nineteen-month-old sibling were in the care of their mother. K.S-H. and her sibling previously resided with their maternal grandparents. Care of the children was shared between the maternal grandparents and the mother. However, days prior to the fatality the mother and her boyfriend moved into an apartment with another family. The father of the children was incarcerated at the time of the death.

At the time of K.S-H.'s death, there was an open Child Protective Services (CPS) investigation. The allegations stated the mother failed to adequately provide care on an on-going basis for the children, would leave the children with persons unknown to the extended family. In addition, K.S-H.'s sibling had RCW 74.13.500 RCW 74.13.500 unknown origin.

The review Committee included members selected from diverse disciplines within the community with relevant expertise including social work instruction with a specialization in Cambodian culture, domestic violence services, the Children's Ombuds Office, a CA program manager specializing in Safety and Family Assessment and Response (FAR) and a Child and Family Welfare Services (CFWS) program manager with CA. Neither CA staff nor any other committee members had previous involvement with this family.

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[1] Given its limited purpose, a Fatality Review (CFR) should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. The CFR Committee's review is generally limited to documents in the possession of or obtained by DSHS or its contracted service providers. The Committee has no subpoena power or authority to compel attendance and generally only hears from DSHS employees and service providers. It does not hear the points of view of the child's parents and relatives, or of other individuals associated with the child. 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 or other entities with legal responsibility to investigate or review some or all of the circumstances of a child's near fatal injury. Nor is it the function or purpose of a Child Fatality Review to recommend personnel action against DSHS employees or other individuals.

[2] No criminal charges have been filed relating to the incident and therefore neither the mother nor father's names are identified. The name of K.S-H.'s sibling is subject to privacy laws. [Source: RCW 74.13.500(1)(a)].

Prior to the review, each committee member received a case chronology, a summary of CA involvement with the family and un-redacted CA case documents (e.g., intakes, investigative assessments, and case notes). Supplemental sources of information and resource materials were available to the Committee at the time of the review. These included medical reports, relevant state laws, and CA policies.

During the course of this review the Committee interviewed the CPS worker and CPS supervisor. Following the review of the case file documents, completion of interviews and discussion regarding department activities and decision, the Committee identified areas where practice could improve and made one recommendation. The findings and recommendation are at the end of this report.

Family Case Summary

This family came to the attention of CA on December 17, 2014, when two intakes were generated regarding allegations of neglect by the mother and a RCW 74.13.500 the older child RCW 74.13.500 Both intakes were initially screened out. However, upon an intake supervisory review, the supervisor changed the screening decision to be assigned for CPS investigation based on neglect RCW 74.13.500 nineteen-month-old RCW 74.13.500 Contact was made with the children and maternal grandmother by the assigned CPS worker. The CPS worker also spoke with the maternal aunt by phone. The maternal aunt assisted the CPS worker with translating for the grandmother. The grandmother did not want a Cambodian interpreter and requested the worker utilize the maternal aunt for interpreting.

The children appeared well cared for during the initial face-to-face contact. The CPS worker did not observe a bruise on the sibling's face. The grandmother and aunt stated the children were often cared for by the maternal grandparents while the mother worked or left for extended periods. It was reported that the mother would often not communicate with the grandparents about her plans to return. The family was also concerned that when the mother did take the children she would leave them with unknown persons and this appeared to cause the oldest child to have anxiety upon her return to the maternal grandparents. The CPS worker provided the maternal grandmother with information regarding third party custody. The case was staffed during the course of a regular monthly staffing review on January 6, 2015 between the CPS worker and her supervisor. The case note indicated the case was ready for closure.

On January 11, 2015, an intake was received stating K.S-H. was brought to the hospital by her mother and mother's boyfriend. The medical staff was unable to

revive K.S-H. Law enforcement was notified and a criminal investigation was initiated. The medical examiner's report ruled the death a homicide.

Committee Discussion

For purposes of this review, the Committee focused on case activity starting with the December 17, 2014 intake up to the fatality. There was discussion regarding the fatality, the criminal investigation, and status of the case.

A significant portion of discussion surrounded third party custody. Third party custody may be utilized by families or fictive kin to obtain custody of children without DSHS intervention. However, within the department some staff believe that if DSHS recommends or even educates a family member on this option, it is in a way indicating that the department endorses the placement and has not done due diligence in investigating the safety of the possible petitioner. Further, this practice may be questioned when the information is provided to a family in English instead of their first language and a discussion has not occurred as to whether the family's culture is supportive of the process.

In this particular case, the Committee was educated that in the opinion of the consultant, traditional Cambodian families would not utilize this legal process. The Committee was also concerned that the information was provided in English. The CPS worker stated the maternal grandmother was struggling to understand the conversation. The Committee discussed that a follow up conversation including a certified interpreter, even by phone, would have been appropriate to further discuss this option with the family.

The Committee was confused by the completion of two separate Investigative Assessments.[3] During the interviews with the CPS worker and supervisor, they both stated it is office practice to complete separate Investigative Assessments unless the allegations in each new referral are the same type of alleged abuse. In this particular case, the CPS worker and supervisor did not feel the allegations correlated closely enough to combine the two assessments. However, the Committee noted the documents were completed on the same day with inconsistent information. The Committee also noted it would have been easier to read one document that identified differences based on information gathered by the CPS worker before the fatality and after it. It was also debated as to whether

[3] CA investigators complete the investigative assessment (IA) for all CPS and DLR/CPS investigations. The IA contains all the tools (i.e. assessments and screens) and documentation related to the investigation. The IA is a shell that houses all the components of the investigation. [Source: CA Practice Guide to Intake and Investigative Assessments; CA Practices and Procedures Guide, Chapter 2540]

there had been adequate gathering of information to complete an assessment on the December 17, 2014 intake.

The CPS worker also documented that she did not see any bruising on K.S-H.'s older sister. However, when asked about this during her interview, she stated she did not observe her entire body. The Committee noted the child was not potty trained and could have been fully observed during a diaper change.

Caseloads and employee staffing were discussed during the staff interviews. The staff in Kent stated they regularly receive the highest case assignments and have higher caseloads than other offices. While it is accurate to state the office has struggled to maintain regularly staffed units, there is progress being made to stabilize the office. A caseload report was gathered for the CPS worker for the day of the fatality. The report indicated the worker's caseload was similar to those of other CPS workers across the state.

The CPS worker and supervisor were asked if the initial screening decision to screen out the December 17, 2014 intake, which was then screened up to a CPS investigation, created a bias as to the legitimacy of the assignment. The CPS worker stated she discussed the decision with her supervisor but did not feel it created a bias and therefore did not impact her ability to complete the investigation. The CPS supervisor provided a similar statement to the Committee.

Findings

The Committee noted based on their review of the case documents and interviews with staff, that there were no critical errors made by department staff. However, there were areas where practice could be improved.

The Committee believed policy requires staff to utilize a certified interpreter once the CPS worker realized the maternal grandmother did not readily speak English.[4]

The Committee pointed out that the intake supervisor who changed the screening decision on the December 17, 2014 intake from screened out, to screened in for CPS investigation, made a good decision. However, the Committee also felt it would have been prudent for the allegations to then include physical abuse since there were unanswered questions as to RCW 74.13.500 RCW 74.13.500 one-year-old child mentioned in the decision notes.

The Committee noted the supervisory case note dated January 6, 2015, indicated the case was ready for closure. However, there had not been an adequate

[4] CA Operations Manual 4320 - Limited English Proficiency and CA Practices and Procedures Manual 2210 - Eligibility, 11

gathering of information based on the documentation to support this decision. The Committee believed the supervisor should have directed the CPS worker to contact the parents and to make collateral contacts beyond the maternal grandmother and aunt who were also the referral sources. The CPS worker had been given a phone number for the mother but the grandmother said it may not work. The CPS worker could have attempted contact through that number. The grandmother also identified the mother's employer. Some other collaterals that may have been beneficial and meaningful would have included the children's pediatrician and paternal relatives.

The CPS worker did not discuss items included in the Practices and Procedures Guide, Chapter 1135, Infant Safety Education and Intervention to include safe sleep and Period of Purple Crying with the maternal grandmother.[5]

It was unclear by reading the case notes and during the interview as to when the actual face-to-face contact occurred between the CPS worker and the children. There had been a request for an extension of the initial face-to-face but the CPS worker's case note appears to document it occurred within the appropriate timeframes. The Committee noted the date of the initial contact was vital because a fading bruise could have easily resolved within the small amount of time between intake and when the child was observed by the CPS worker.

Recommendations

Clarification and guidance should be provided from CA leadership regarding informal and formal placements and third party custody to the field. The Committee also suggested that CA should consider providing field staff with a uniform position by CA regarding third party custody.

[5] CA Practices and Procedures Guide, Chapter 1135