RCW 74.13.640

Washington State Department of Social & Health Services
CA Children's Administration

Department of Social and Health Services
Children's Administration
Child Fatality Review

H.P.

November 2009
Date of Child's Birth

July 27, 2012
Date of Child's Death

November 2, 2012
Child Fatality Review Date

Committee Members:

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Executive Summary

On November 2, 2012, the Department of Social and Health Services (DSHS), Children's Administration (CA) convened a Child Fatality Review[1] (CFR) to review the department's practice and service delivery to 2-year-old H.P. and his family. On the day of his death the mother's boyfriend, J.K., called 911 and reported H.P. had fallen down two steps and needed medical attention. Spokane County Sheriff officers and Emergency Medical Services (EMS) responded and H.P. was transported to Sacred Heart Medical Center where he was pronounced dead. The Spokane County Medical Examiner later determined the manner of death to be undetermined.

The CFR committee included community members selected from diverse disciplines with relevant expertise, including representatives from public health, domestic violence advocacy, mental health, law enforcement, Children's Administration, and the Office of the Family and Children's Ombudsman. Committee members, including CA staff, had no prior involvement with the family.

Prior to the review each committee member received a case chronology, summary of CA involvement with the family and non-redacted CA case documents (e.g., intakes, case notes, safety assessments, investigative assessments, medical records, Child Protective Services investigative reports).

Supplemental sources of information and resource materials were made available to the committee at the time of the review. These included (1) additional documents obtained post-fatality (e.g., H.P.'s medical records, police reports), (2) CA practice guides relating to Child Protective Services (CPS) investigations, (3) Safety Framework (a practice model centered on safety that informs and guides all decisions made during a case) and (4) copies of state laws and CA policies relevant to the review.

During the course of the review both CPS investigators and the CPS supervisor were interviewed by the committee.

Following a review of the case file documents, interview of the CA social workers, discussion regarding department activities and decisions, the committee made findings and recommendations which are detailed at the end of this report.

Case Overview

H.P. is a Caucasian male who was born in November 2009. H.P.'s household at the time of his death consisted of his mother, mother's boyfriend, and two siblings. H.P.'s mother

[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.

is E.W. who is a 29-year-old Caucasian female. The mother's boyfriend is J.K., a 31-year-old male with Native American ancestry. H.P.'s father is M.P., a 26-year-old Caucasian male. M.P. resided in Alaska at the time of H.P.'s death. H.P. has two siblings named B.R. and B.K. B.R. is a male who was born in April 2003. B.K. is a female who was born in February 2012.

On December 4, 2010, Washington State Children's Administration (CA) received a telephone call alleging E.W. was using alcohol to put H.P. to sleep [redacted] The mother and B.R. were both interviewed about the allegations and they both denied the allegations. [redacted] The referrer recanted the allegation when contacted by the social worker. The CPS social worker in Washington informed the committee that he found insufficient evidence to support a founded[3] finding. [redacted]. At the time of case closure, the social worker recommended the mother follow-up with a chemical dependency screening, maintain a clean and sober home environment and obtain counseling services for B.R. due to a history of domestic violence in the home.

J.K. and E.W. began their relationship in March 2011.

On September 11, 2011, CPS received a telephone call regarding suspected physical abuse. H.P. presented at Sacred Heart Medical Center emergency room with a buckle fracture[5] to his left proximal radius,[6] fractures through his left radius and through his left ulna.[7] The referrer, the treating emergency room doctor, expressed concerns about the age of the injury. E.W. reported H.P.'s left wrist was bruised and swollen when she

[redacted]

[3] Founded--The determination that, following an investigation by CPS, based on available information: it is more likely than not that child abuse or neglect did occur. WAC 388-15-005

[4] Urinalysis—The testing of urine for illegal drugs, alcohol or other controlled substances.

[5] A fracture in which one side of the bone bends, but does not actually break. This occurs when compressive force is placed on a tubular bone's long axis; the axial stress on the bone causes a buckling reaction. (www.medical-definitions.com/fracture/buckle-fracture.htm)

[6] A fracture of the proximal radius (radial head and/or neck) can occur with indirect or direct injury to the elbow joint or forearm. The elbow is a hinge joint composed of three bones: 2 in the forearm (radius, ulna) and 1 in the upper arm (humerus). These bones work together to allow movement and dexterity of the elbow, forearm, and wrist. The radius is the smaller of the two forearm bones, and it articulates with the ulna (radioulnar joint) to allow forearm rotation (supination, pronation). (www.mdguidelines.com/fracture-radius-proximal/definition)

[7] The ulna is one of two long bones in the forearm. The ulna is located at the side of the forearm closest to the body when a person's palms are facing forward.

checked on him in his room on September 6, 2011. She gave H.P. a Motrin and the symptoms reportedly decreased for a few days. On September 11, 2011, the mother brought H.P. to the emergency room as the symptoms had returned.

On September 16, 2011, the social worker met with J.K. to discuss the broken arm. J.K. reported he was at work on September 6, 2011 when the mother called and told him H.P. had hurt his arm. J.K. told the social worker that H.P. babied his arm for a couple of days and then acted fine. H.P. was reportedly always falling down and had fallen down a few days prior to going to the emergency room.

J.K. told the social worker H.P. had had fallen off a porch earlier in the summer. H.P.'s lip was cut as a result of this fall. Medical records show H.P. was seen by a doctor on June 25, 2011 for his injuries related to falling off a porch.

On September 19, 2011, B.R. was interviewed by the social worker. He stated that he didn't know what had happened to H.P.'s arm and he reported feeling safe in his home. B.R. stated J.K. does nice things for his mom and he reported liking J.K.

On November 1, 2011, a Child Abuse and Neglect consult was completed for CPS.[8] The doctor's report documented that H.P. had fractures to both the radius and ulna. Pediatric Radiology reported that due to the appearance of the fracture and bone growth, i.e. callus, these fractures could be up to several weeks of age. Of note, this child did have a negative bone survey of the rest of his body. The doctor's report concluded that, "a child of this age certainly could have accidentally fallen and injured his arm in this fashion. It is concerning, however, that the child's caregiver seems to have no story as to how the injury could have occurred or awareness of when it occurred."

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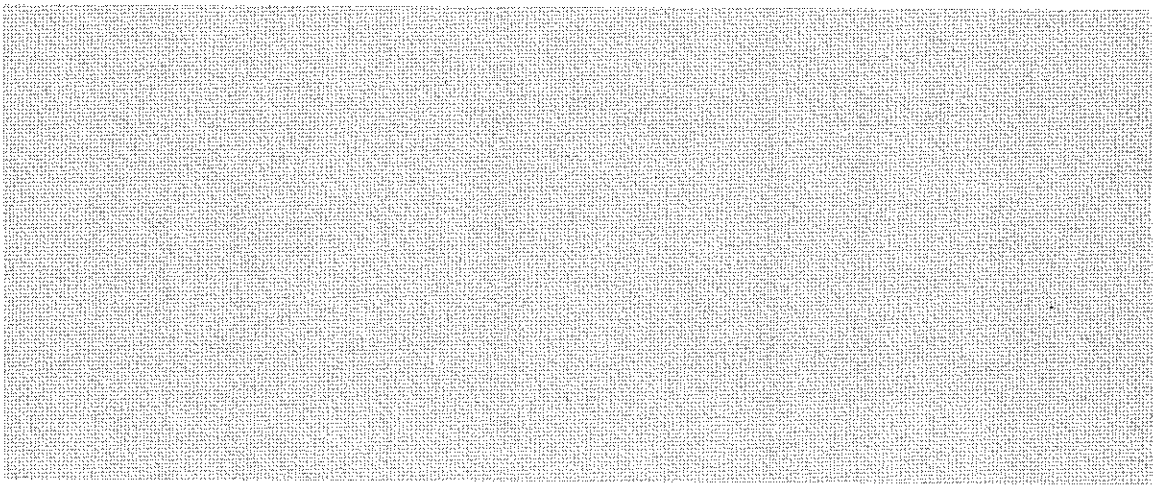

[8] Child Abuse Consultants are a team of physicians who provide statewide consultation and training regarding medical findings in cases of alleged child abuse and neglect.

[redacted]

H.P. was last seen by a physician on July 24, 2012. Medical records indicate H.P. was not scheduled to see a doctor on July 24, 2012, however, he was seen by a doctor during his sister's well-child appointment. The treating physician ordered an x-ray on H.P.'s arm due to reported forearm pain. Medical records indicated H.P. had a "non-displaced fracture of his radius" on his left forearm. E.W. reported H.P. had injured his arm when he fell next to the pool two days earlier.

[redacted]

On July 27, 2012, at 7:42 p.m. H.P. died of unknown causes. J.K. reported the family was playing in the swimming pool area. H.P. got wet and J.K. took him back to the apartment to change his clothes. J.K. let go of H.P.'s hand to unlock the door. H.P. then fell down two steps. H.P. was taken into the apartment where he started to show signs of a seizure. J.K. called 911 and screamed for help. A neighbor and emergency response arrived and attempted to revive H.P. The names of the parents are not being used in this report as neither has been charged in connection to the fatality incident.

Committee Discussion:

While the committee found that there were no apparent critical errors in terms of decisions and actions taken during the involvement by the CPS social workers, the committee did find instances where additional/different social work activity or decisions may have been considered. However, the absence of these additional

activities/decisions was found to have no reasonable discernible connection to the child's death. Thus the identified issues below serve as noted opportunities where improved practice may have been beneficial to the assessment of the family situation but were not found to be critical oversights that could have prevented the child fatality.

The committee reviewed the investigation related to the December 2010 intake. The committee noted the investigation was thorough and complete. The committee believes all of the areas of concern were investigated and appropriately addressed. The committee spent considerable time discussing the specific allegation regarding the mother giving her infant alcohol. The social worker was interviewed by the committee and he explained that he looked for alcohol in the family's cupboards, refrigerator and trash. The social worker had asked for and received permission prior to checking the aforementioned areas of the home. The home visit was unannounced so the social worker believed he was able to get an accurate assessment of the home environment.

The investigative assessment[9] (IA) associated with the December 2010 intake was completed approximately four months after case assignment. Per policy, IA's should be completed within 45 days. The committee also noted the investigator did not contact the referrer for several months after receiving the assignment. The committee believes referrers should be contacted shortly after receiving a new intake in an effort to verify the information in the intake and to determine if additional information is available.

In September 2011, a second intake was screened in for investigation. This intake was assigned to a different investigative social worker. The social worker actively investigated the allegation from September 2011 through November 2011. After November 2011, the social worker ceased to actively work on the case until after the fatality in July 2012. The supervisor and social worker did staff the case on a monthly basis from September 2011 through the fatality.

The committee believes the social worker should have concluded her investigation in November 2011. The social worker informed the committee that the case remained open due to the need for additional collateral contacts. The social worker informed the committee that she needed to contact the primary care physician, dentist and a character reference. She further reported receiving nine or more intakes per month during the time the case was open. The social worker believed the high volume of intakes caused a need to triage her cases. The committee understood the need to prioritize workload, but believed the strategy implemented by the social worker was unproductive. Maintaining an open case is time intensive for social workers and supervisors regardless of the level of activity by the social worker. The committee believes all necessary collateral contacts need to be completed timely as they should be linked to the safety concerns in the case. Waiting 10 months to complete a collateral

[9] A completed investigative assessment will contain the following information: A narrative description of the alleged child abuse or neglect allegation, the known prior history of child abuse or neglect. Structured Decision Making risk assessment tool. Documentation regarding the probability of alcohol or controlled substances contributing to the alleged abuse or neglect. Description of the status of the case with CA. Documentation regarding the social workers findings regarding abuse or neglect.

contact implies they are not critical to the outcome of the case and are not directly related to a safety concern. Collateral contacts are important to the investigative process, however any relevant collateral contacts cannot wait ten months for completion.

The committee noted that there was no contact between the social worker and family for several months. CA policy does not require a CPS social worker to complete a monthly health and safety[10] check. CA policy clearly states FVS[11] and CFWS[12] social workers are required to complete monthly health and safety checks. The committee discussed how CPS social workers should be required to complete a monthly health and safety similar to the requirement for a FVS and CFWS social worker.

It is not the role or responsibility of the committee to determine the cause of injuries or the manner of H.P.'s death. However, the committee's objective is to review information, ask critical questions and to make recommendations and findings that improve CA's ability to protect children in the future. For that reason, the committee spent a significant length of time reviewing the sequence of events and injuries prior to H.P.'s death. Upon review, the committee found H.P.'s pattern of injuries and weight loss to be concerning and noted a strong correlation between H.P.'s injuries, H.P.'s weight loss, and J.K.'s arrival in the family home.

The committee noted J.K. and E.W. started their relationship in March 2011. Medical records indicated H.P. was a healthy 18-month-old child as of March 31, 2011. He weighed 29.04 pounds and was listed at the 91.5 percentile. Three months after J.K. arrived in the home H.P. had his first known significant injury. In June 2011, H.P. fell off a porch and cut his lip while in J.K.'s care. In July 2011, H.P. had his second injury when he fell off a trampoline and injured his leg. H.P.'s leg was x-rayed and it was determined not to be broken. In September 2011, H.P. broke his arm. This incident was of particular concern to the committee due to the mother's failure to seek medical care for five days following the injury.

On December 19, 2011, H.P. was 24-months-old and his weight had dropped to 23.61 pounds. H.P. was down to the fourth percentile. The committee noted the lack of a medical explanation for an 85 percentile weight drop. On May 8, 2012, H.P. was 29-months-old and his weight had increased back up to the 28 pound mark, 1.04 pounds less than 14 months earlier.

In July 2012, H.P. broke his arm for a second time. The committee found it concerning that the mother again failed to seek medical treatment in a timely manner. The mother reported a two day delay between the time of injury and treatment.

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[10] Health and Safety—CA social workers are required to visit with all children in person on a monthly basis if the case is open for services. The goal of these visits is to ensure the child is safe and the child's basic well being needs are being met.
[11] FVS social worker—Family Voluntary Services social workers offer parents services designed to reduce the safety threats while the children remain in the care and custody of their parents.
[12] CFWS social worker—Child and Family Welfare social workers assume responsibility of a child welfare care after the children have been removed from their caregivers and a dependency petition filed.

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At the time of the fatality H.P. had facial abrasions on the left side, contusion and abrasion on his right scalp with subgaleal hemorrhage, chest contusions, lower extremity contusions, right elbow abrasions, contusion of right side of pubis and global hypoxic-ischemic brain injury.

H.P. had a total of six significant injuries between 18 and 32 months of age. He also had a significant unexplained loss of weight. Whereas the committee acknowledged some of these injuries may have been accidental and explainable, the committee also believed it is unlikely that any child would receive so many significant injures and weight loss without a strong possibility of abuse and/or neglect. In addition, J.K.'s documented DV history with E.W. [redacted]. increased the committee's concerns regarding J.K.

The committee noted the significant pattern of injury did not become fully evident until after the fatality.

The CPS social worker informed the committee that her investigation into the September 11, 2011 intake was complete and the allegation was unfounded. The committee agreed with the unfounded finding for the September 11, 2011 investigation.

The CPS social worker further reported that her investigation into the July 27, 2012, intake was complete and the allegation was unfounded.[13] The committee spent a significant amount of time discussing the unfounded finding related to the July 27, 2012 intake and the legal requirements for a founded finding. Upon review the committee believed the social worker did not gather all necessary and available information to complete her investigation and determine a finding. Specifically, the social worker had not reviewed the autopsy photographs from the time of the fatality, obtained a completed Child Abuse and Neglect consult, or interviewed J.K.'s children. In addition, the committee believed the social worker needed to make additional inquiries to medical professionals as to the degree of probability or actual likelihood that the injuries were intentional.

At the time the social worker completed her investigation into the July 27, 2012, intake she had received a preliminary Child Abuse and Neglect Consult that was completed by Dr. Kenneth Feldman. The preliminary consult stated, "H.P.'s cause of death remains unclear. However it appears most likely that he died of an acute brain trauma with associated brain injury and mild swelling. The multiplicity of scalp injuries could not be explained by a single fall onto the back of his head. Had he sustained such a fall it is much more likely he would have been immediately concussed, though he could have had a post-traumatic seizure sometime after injury. To have sustained so severe a brain injury, it would be common to also have a skull fracture from the described fall. Overall, the findings are highly concerning for an abusive cause of death."

[13] Unfounded--The determination that, following an investigation by CPS, based on available information: it is more likely than not that child abuse or neglect did not occur, or there is insufficient evidence for the Department to determine whether the alleged child abuse did or did not occur. WAC 388-15-005.

The autopsy report found the cause of death to be "undetermined." The autopsy report indicates, "Although the external injuries do not fully correlate with the witness statement, these external injuries would not have caused death in-and-of themselves. Because of these considerations, the cause of death is undetermined after complete autopsy."

The CPS social worker used the "undetermined" cause of death as an additional justification in her unfounded determination. The committee noted that the autopsy included other information that warranted further evaluation and consideration. Those other factors included the various unexplained injuries and the inconsistent explanation for the external injuries. The committee believed the social worker did not look for additional information as she apparently believed the "undetermined" finding was sufficient to make a determination related to child abuse or neglect. In addition, the committee did not find where the social worker made additional inquiries as to the degree of probability or actual likelihood that the injuries were intentional. It was the position of the committee that while the cause of death is an important factor when determining a finding, it should not be the sole factor used when determining the probability of abuse or neglect. The committee noted that it is not uncommon for a child to die from undetermined causes and still be a victim of physical abuse.

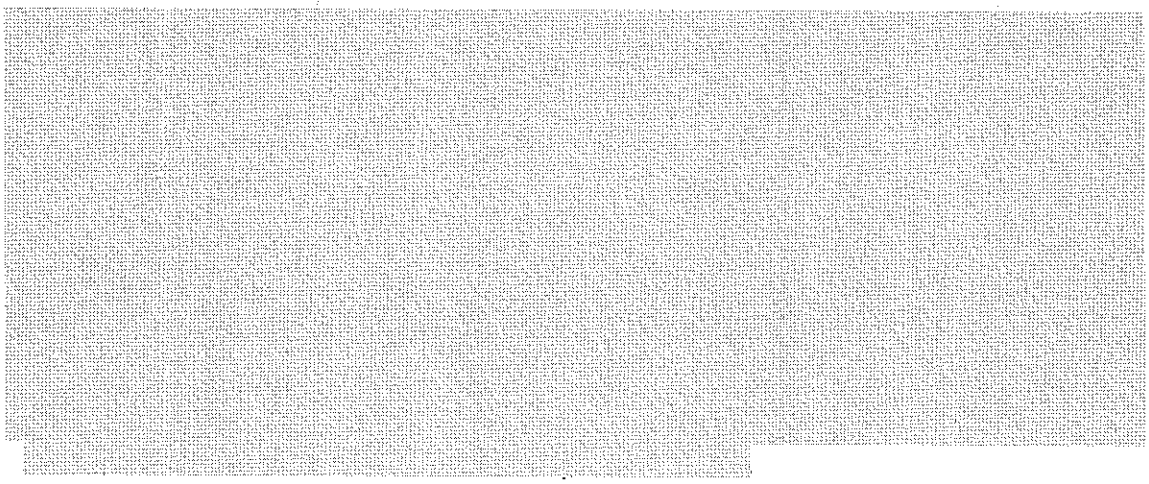
The committee expressed concern that this case may have been impacted by the presence of confirmatory bias after the fatality. Confirmatory bias is present when an individual seeks information and gives greater weight to information that confirms their current beliefs. This was evident when the committee asked the CPS social worker regarding her thoughts about the September 2011 broken arm. The social worker stated that she consulted with medical professionals about the broken arm and also reviewed the medical professional's final report. The social worker stated her phone contact and the medical report both stated the broken arm was an accident. The committee reviewed the medical report referenced by the social worker and noted the following statement, "A child of this age certainly could have accidently fallen and injured his arm in this fashion. It is concerning, however the child's caregiver seems to have no story as to how the injury could have occurred or awareness of when it occurred." The committee noted that the medical provider clearly did not state the injury was accidental only that it could have been accidental.

The committee stated that the CPS social worker would have benefitted from pictures of the various bruises, scrapes and marks related to the fatality on July 27, 2012. H.P.'s diaper also had scuff marks that were described but not seen by the CPS social worker, supervisor or new CWFS social worker. The committee asked the assigned CPS social worker if she had observed or obtained a copy of the photographs from law enforcement. The CPS social worker stated that she had not obtained the photographs. The committee asked the CPS social worker if she thought these photographs would have been beneficial to her investigation. The CPS social worker did not think the pictures would have been useful as she "relies on the autopsy and medical consult when

making a determination regarding abuse or neglect." The committee felt photographs are a critical piece to any investigation and should be placed in the CA case file whenever reasonably possible and accessible. The photographs can be used to supplement the reports from other professionals. The committee felt it was important for CA to form their own opinion regarding the presence of abuse or neglect as CA is governed by its own laws and policies that vary significantly from law enforcement and medical examiner standards and laws.

J.K. has three children from a previous marriage. All three of the children were visiting the family at the time of the fatality and could provide details about the home environment preceding the fatality. CA generally follows law enforcement's direction related to the interviewing of subjects, witnesses and victims when a joint investigation is being conducted. In this case, law enforcement requested CPS to not interview these three children. The CPS social worker waited several months following the fatality and then asked the assigned detective if law enforcement would be following up with any additional contact with J.K.'s children. The detective reported he had spoken with the children's mother. He did not feel additional contact was necessary as the children were at the swimming pool at the time of the fatality and they could not provide any additional information related to the time of the fatality. **RCW 74.13.520**

The committee noted the law enforcement investigation was focused on the day and time of the fatality. CA's investigation has a broader mandate that requires a more global safety assessment. For this reason, the committee felt K.B.'s children should have been forensically interviewed by a CA social worker. In addition, J.K.'s daughter, M.K, reportedly witnessed J.K. swing H.P. by the arm. "[J.K.] had swung H.P. by his arm and he [J.K.] didn't seem like he was playing or happy." The committee is concerned that this statement has not been further investigated and the timing of this incident coincides with the second broken arm in July 2012.



The committee expressed concern that an intake was not completed by the medical professional treating H.P.'s broken arm in July 2012. In addition, H.P. had a significant

and unexplained weight loss during the course of this investigation. This sudden weight loss may have warranted an intake to CPS by his treating doctors.

The allegations into H.P.'s broken arm in September 2011 warranted law enforcement's participation in the investigative process. The CPS social worker informed the committee they routinely coordinate with law enforcement and that law enforcement was notified by fax. The committee believes the best practice was for the CPS social worker to have contacted law enforcement by phone and asked the status of their investigation due to the concerning nature of this intake.

The committee discussed the continued involvement of the same CPS social worker following a child fatality. Some committee members expressed that CA should consider changing social workers after a child fatality. Committee members felt that a change in social workers may help ensure an unbiased view of the case. CA social workers often have a dual role of helping a family while investigating them at the same time. This role is naturally conflicted and becomes more conflicted post-fatality. Social workers who handle a case before and after a fatality are forced to look at their own decisions and actions while determining future actions on a case. For this reason, some bias may be unavoidable.

Other committee members contend that knowledge and experience could get lost at a critical point should the social worker be changed. Many case files are very complex and it may prove challenging to change social workers due to the time it takes to review a case file and become familiar with the family and their supporting community. The committee did not come to a consensus on this topic.

The committee noted that additional information was gathered post-fatality via a social media website. The committee noted CA does not have standardized guidelines for the accessing and use of information obtained from social media websites and believed CA would benefit by developing clear guidance for social workers.

Workload is often cited as a challenge of casework and a barrier to quality practice. The CPS social worker at the time of the fatality had over 40 open CPS investigations. Since this child's death, a new CPS unit has been added to the Spokane office and the amount of cases per social worker has dramatically decreased. Workload may have been a factor related to the duration this case remained open, but it should be noted that many of the open cases only needed additional collateral contacts to complete the investigations or were ready for closure following supervisory review.

Findings

1. The documentation was thorough, complete and submitted timely. Both CPS social workers completed their initial interviews and face-to-face contacts within required time frames. The case was staffed monthly.
2. H.P. had a total of six significant injuries between 18 and 32 months of age. He also had a significant unexplained loss of weight. Whereas the committee acknowledged

some of these injuries may have been accidental and explainable, the committee also believed it is improbable that any child would receive so many significant injures and lose as much weight without a strong possibility of abuse and/or neglect. The committee noted the significant pattern of injury did not become fully evident until after the fatality.

3. The committee believed the social worker did not gather all necessary and available information to complete her investigation and determine a finding. Specifically, the social worker had not reviewed the autopsy photographs from the time of the fatality, obtained a completed Child Abuse and Neglect consult, or interviewed J.K.'s children. In addition, the committee believed the social worker needed to make additional inquiries to medical professionals as to the degree of probability or actual likelihood that the injuries were intentional.
4. The mother should have been offered information about local DV victim services in November 2011.

Recommendations

1. The committee believes CPS social workers should be required to complete a monthly health and safety check of the children similar to the policy requirement for cases in a FVS or CFWS program.
2. The CPS unit that handled this investigation should invite a representative from the local DV advocacy center to join them at a unit meeting. The advocate and social workers should participate in a discussion about the different forms and patterns of DV.
3. The committee reviewed and agreed with the screening decision related to the July 25, 2012 intake. The intake social worker noted the subject of this intake was also related to E.W.'s case. FamLink is designed to notify social workers of any new intake associated with an open case; however, FamLink will not notify social workers when a subject is connected with a different family. In this case, the new intake was opened under K.B.'s name. For this reason the CPS social worker did not receive notice of the new screened out allegation. The committee recommends the supervisor and social worker automatically receive notification via email any time a subject is connected to an open case.