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

Child Fatality Review

K.H.

September 2011
Date of Child's Birth

February 25, 2014
Date of Fatality

May 29, 2014
Child Fatality Review Date

Committee Members
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Executive Summary

On May 29, 2014, 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 two year old K.H. and her family. K.H. will be referenced by her initials throughout this report.

The incident initiating this review occurred on February 25, 2014, when K.H. was found non-responsive in the living room at her home. It was determined that K.H. died from blunt force abdominal trauma and her death was ruled a homicide. K.H. also sustained a skull fracture which was either healing or had healed at the time of her death.

K.H. was in the care of her mother, Monique Hachtel.[2] Ms. Hachtel was arrested and charged with Murder in the Second Degree in connection with K.H.'s death. Ms. Hachtel, her five-year-old daughter and three-year-old son were living with her sister-in-law and family. The children's father, Ms. Hachtel's husband, remained in Mexico. Ms. Hachtel and her children were primarily English speaking but appeared to communicate well in Spanish. The most recent intake prior to February 25, 2014, came in on November 24, 2013, alleging physical abuse. The last case activity conducted on that intake was February 10, 2014.

The Review Committee included members selected from the community with relevant expertise from diverse disciplines including a CA contracted provider who specifically serves minority populations, a homicide detective with a strong background in working child abuse cases, the Ombuds Office and a CPS Practice Consultant with CA. A medical professional was scheduled to sit on the Committee; however, she was unavailable due to a large traffic backup. She was traveling from quite a distance to attend the review. Neither CA staff nor any other Committee members had previous direct involvement with this family.

Prior to the review, each Committee member received a case chronology, a summary of CA involvement with the family and unredacted CA case documents (e.g., intakes, investigative assessments, investigative assessment tools, case

[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 near 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] Monique Hachtel is named in this report due to her current criminal charges of Murder II, in relation to K.H.'s death. The names of K.H. and her siblings are subject to privacy laws.[Source: RCW 74.13.500(1)(a)]

notes and medical records). Supplemental sources of information and resource materials were available to the Committee at the time of the review. These included the current case files, medical records, coroner report, law enforcement report, relevant state laws and CA policies.

The Committee interviewed the Child Protective Services (CPS) worker and CPS supervisor assigned to the November 24, 2013 intake.

Family Case Summary

This family had three intakes which were reviewed by the Committee. The family first came to the attention of CA on January 20, 2012; an intake was received by CA regarding allegations of medical neglect to K.H. At the time of that intake, K.H. was four months old and had a severe diaper rash and a rash on her scalp. The caller was concerned that the mother, Monique Hachtel, was not providing adequate care to treat the rashes. The intake was assigned for a CPS investigation. Ms. Hachtel admitted to the CPS worker it took her a long time to obtain medical care for K.H. and she had no explanation as to why.

During the CPS investigation, the CPS worker learned Ms. Hachtel was married and had three children with her husband. Ms. Hachtel's husband resided in Mexico. Ms. Hachtel lived in Washington with K.H., her almost two-year-old son and her three-year-old daughter. Ms. Hachtel said she left Mexico due to domestic violence perpetrated by her husband. The social workers offered voluntary mental health services but she refused. Before the conclusion of the January 2012 CPS investigation, Ms. Hachtel moved out of her home and it was believed she had moved back to Mexico. This investigation was closed as unfounded for Negligent Treatment and/or Maltreatment of K.H.[3]

On November 24, 2013, CA received an intake when K.H. was taken to the hospital for a broken femur. K.H. also had bruising on her chest. Ms. Hachtel reported the bruising was caused by older children playing too rough with K.H. She stated K.H. was in the care of her brother-in-law when K.H. fractured her femur. Ms. Hachtel reported the broken femur was caused by K.H. falling off the bed and catching her leg in the gap between the bedframe and mattress.

Ms. Hachtel's relatives, with whom she lived, are primarily Spanish speaking. They have five children, four under the age of 18 and one 18-year-old who lived in the home. The two older children spoke both English and Spanish. Ms. Hachtel's brother-in-law was the subject of the November 2013 intake regarding

[3] Unfounded means: The determination following an investigation by CPS that, 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 as defined in WAC 388-15-009. RCW 26.44.020

the broken femur. The CPS worker interviewed the brother-in-law and used Ms. Hachtel as the interpreter. No other household members were interviewed.

A medical consultant with expertise in child abuse found the broken femur injury to K.H. could have been caused by accidental trauma as reported by Ms. Hachtel. The CPS supervisor reported that he called the appropriate law enforcement jurisdiction and they were not going to investigate the broken femur based on the finding by the physician.

In November 2013, following K.H.'s discharge from the hospital, the CPS worker conducted two home visits. No concerns were noted at the time, and the case was closed on February 12, 2014, following a final phone contact with the mother.

On February 25, 2014, an intake was received from law enforcement requesting assistance regarding the protective custody of K.H.'s siblings and cousins immediately following K.H.'s death. K.H. was found non-responsive in the family living room. According to the family members, K.H. was exhibiting signs of significant distress and pain for days before her death. Family members urged Ms. Hachtel to obtain medical care for K.H. Ms. Hachtel was questioned by law enforcement and was subsequently arrested and charged with Murder in the Second Degree. K.H. sustained multiple injuries due to blunt force abdominal trauma and her death was ruled a homicide. K.H. had also sustained a skull fracture which was healing or had already healed at the time of her death.

Committee Discussion

While the Committee's primary focus was on the actions and decisions made by CA during the period of November 2013 until February 12, 2014, the entire CA history of involvement with the family was reviewed and discussed.

The Committee agreed with the supervisor's decision to upgrade the response time in the first intake on January 20, 2012 from an alternate intervention 10-day response[4] to a 72-hour CPS investigation.[5] The Committee believed the CPS

[4] In 2012, CA intakes determined to involve low to moderate low risk were assigned as 10-day alternate response. An alternative response intervention connects families to services, concrete supports, and community resources. Where available, such intakes could be forwarded to an Early Family Support Service (EFSS) or other community agencies that were willing to accept the intake for services and/or monitoring. After October 20, 2013, legislated changes required CA to implement a differential response system designed as an alternative pathway for accepted reports of low to moderate risk of child maltreatment. This pathway, known as Family Assessment Response (FAR), provides a comprehensive assessment of child safety, risk of subsequent child abuse or neglect, family strengths and need. A family's involvement in the Family Assessment Response program is voluntary. [Source: http://www.dshs.wa.gov/ca/about/far.asp]

[5] A non-emergent investigation response is required for children who are NOT in present or impending danger. A non-emergent investigation response requires CA workers to have face to face contact with all alleged child abuse or

investigative practice could have been enhanced by a more thorough assessment of Ms. Hachtel's mental health issues and domestic violence allegations. Specifically, the Committee noted there was no documentation of daily functioning of Ms. Hachtel or her children. The Committee also noted a lack of assessment related to her attachment with her children and the investigation focused on the identified victim and did not appear to include assessment of the two other children in the home.

Regarding the January 2012 intake, the Committee believed the CPS worker should have followed up with K.H.'s pediatrician because the caller alleged medical neglect. Ms. Hachtel declined voluntary services that were offered to her that included a mental health assessment and the Birth to 3 Program. This decision to decline supportive services was a red flag to the Committee. The Committee discussed the unfounded finding associated with the January 20, 2012 intake. The Committee believed a more appropriate finding would have been inconclusive or unable to determine; however, there is no legal basis for such a result and the Committee noted the only options allowed by statute for investigative findings were unfounded or founded at the time of this investigation.[6]

The focus of the discussion moved to the November 2013 intake. The supervisor indicated he called the manufacturer to corroborate the improper fit of the mattress with the bedframe that reportedly caused the fractured femur which the manufacturer confirmed. He also stated he called the appropriate law enforcement agency rather than faxing the report. The Committee was concerned by the lack of case notes by the CPS supervisor documenting contact with law enforcement to fulfill the policy requirement for cross reporting. The second concern was the lack of documentation regarding the phone call made by the supervisor to the furniture manufacturer.

The Committee was made aware of significant turnover and continuous vacancies in this office. This led to higher caseloads for workers and a larger span of supervision responsibilities. The Committee understood that it was difficult to accurately and timely document all contacts as well as complete and close out CPS investigations when the volume of new assignments out paces the employee's ability to complete prior assignments

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neglect victims within 72 hours from the date and time CA receives the intake. [Source: Children's Administration Practices and Procedures Guide 2310(B)(5)]

[6] "Inconclusive" means the determination following an investigation by the department, prior to October 1, 2008, that based on available information a decision cannot be made that more likely than not, child abuse or neglect did or did not occur.[Source: previous version RCW 26.33.020]

While taking into consideration vacancies and high caseload counts, the Committee questioned the CPS worker's decision to not interview all persons residing in the home during the femur fracture investigation. The CPS worker and supervisor both stated it is too time consuming to comply with the request for an interpreter and that the requests were rarely filled.

During the discussion, contact was made with the Limited English Proficiency (LEP) program manager. She was able to educate the Committee regarding the process and challenges, for the Tumwater CA office particularly, regarding filling in-person interpreter requests. An analysis of the month of November 2013 revealed one request by CA for an interpreter and that request went unfilled (there is no information provided as to why it was not filled). The Tumwater CA office continues to lack a certified Spanish speaking employee. An alternative option is to utilize the Language Line. Language Line is a resource utilized by CA staff via a phone to interpret conversations.

The CPS worker stated she did not interview the siblings, ages three years and four years, because they were not of an age where the worker believed they could provide reliable information. There were also other children living in the home, ages five years, seven years, twelve years and eighteen years, who were not interviewed. The Committee believed best case practice would be to interview all children, regardless of age, and/or to clearly document the attempt. It is understood that children have varying levels of verbal skills at differing ages. The CA workers should document a child's developmental levels to include verbal skills in a case notes.

The Committee noted it was also alleged by Ms. Hachtel that the older children caused the bruise to K.H.'s chest. The Committee believed investigation around this injury was insufficient. The Committee believed the CPS worker should have requested permission from the mother to have the two siblings evaluated by their pediatrician and the medical records for all children should have been reviewed. The Committee believed that even though K.H. was the identified victim, it is important that all children be included in a CPS assessment.

The Committee asked about the lack of photographs regarding the mattress and bedframe. The CPS worker said she had not been trained regarding photographing the scene of a possible non-accidental trauma site. When discussion moved to the CPS history for the relatives where the family was residing, the CPS worker stated she relied heavily on what was reported in the intake. The Committee believed the alleged subject's name was incorrectly spelled; therefore, inaccurate information was obtained regarding CPS history.

When asked about conducting her own search in CA's client database, the CPS worker said she was not trained on how to conduct detailed person searches within FamLink.[7] The CPS worker said she is now aware that history provided in an intake is not always complete and workers should review this as part of regular case practice. The Committee discussed the challenges with FamLink and the limitations presented by the need for accuracy related to the spelling of a person's name to accurately obtain information. It was suggested that good practice would be verifying all household member's names with appropriate identification.

The Committee discussed concerns that a CPS worker with less than one year experience was routinely assigned high risk critical cases. [8] This specific CPS worker was utilized in this manner due to her extensive background in the mental health field. While this concern was shared by all of the Committee members, it was also discussed that offices have limited staff resources to draw from. At the time of the fatality and November 2013 intake, this office was utilizing social workers from other offices to temporarily fill vacancies.

The Committee identified several opportunities where additional reasonable actions by the CPS worker might have served to enhance the assessment of K.H. and her siblings' well-being and safety. These suggestions are outlined in the findings below.

Findings

- The Committee identified areas of improvement related to the November 24, 2013 investigation to include obtaining correct spelling of household members' names to obtain accurate CPS history, which could have enhanced the safety assessment of the children in the home. This information should have been utilized in order to accurately complete the Structured Decision Making Risk Assessment® Tool (SDMRA).[9] Timely completion of the Safety Assessment and utilization of criminal background checks would also have strengthened the investigation.
- The CPS social worker should have interviewed all household members to include K.H.'s siblings. Utilization of interpreter services as outlined in the

[7] FamLink is the name of CA's Statewide Automated Child Welfare Information System (SACWIS) that replaced CAMIS.
[8] DSHS Strategic Plan Metrics – Children's Administration (April 2014): "It takes an average of two years for an investigator to become proficient. It takes an average of 3 months to hire a new CPS investigator. The high turnover rate also impacts staff that remains. They are burdened with higher caseloads and mentoring new staff."
[9] The Structured Decision Making Risk Assessment® (SDMRA) is a household-based assessment focused on the characteristics of the caregivers and children living in that household. By completing the SDMRA following the Safety Assessment, the worker obtains an objective appraisal of the risk to a child. The SDMRA informs when services may or must be offered. [Source: Children's Administration Practices and Procedures Guide Section 2541]

Limited English Proficiency (LEP) Policy 4320 Operations Manual should have occurred as appropriate.

- The November 2013 investigation would have been improved by taking photographs of the bedframe and mattress. The Committee agreed photographs would have aided the child abuse medical consultant's assessment of the reported mechanism of injury to K.H. Some Committee members who have had CPS investigative experience discussed providing all known criminal history and CPS history of alleged subjects to medical consultants. The Committee agreed this would have been best case practice as it related to Ms. Hachtel's brother-in-law as the identified subject.
- The Committee found that the department did not fully assess K.H.'s well-being by not contacting medical professionals to confirm that Ms. Hachtel obtained the proper follow up care for K.H. related to her femur fracture. The Committee believed that a home visit should have occurred before closing the case February, 12, 2014.
- The Global Assessment of Individual Needs (GAIN) form should have been completed by the CPS worker.[10] Per policy, this form is to be completed within 45 days on all adults as a subject on the referral, parents and or persons acting in loco parentis and living in the child's home. Both mental health and chemical dependency issues were identified previously regarding Ms. Hachtel.
- The intake on November 24, 2013, should have been faxed to the appropriate law enforcement agency and this action should have been documented.
- The contact with the furniture maker should also have been documented. The cross reporting of an alleged non-accidental injury is a policy driven action.[11] However, the contact with the furniture maker is a vital collateral

[10] The GAIN-SS is a validated screening tool used with adults (parent(s), guardian(s) or legal custodian(s)) and youth, age 13 and over. It identifies a need for a chemical dependency, mental health or co-occurring assessment to be completed by a community professional. The GAIN-SS does not identify service needs. The goal of the screen is to increase the number of people identified for a mental health, substance abuse or co-occurring disorder assessment. [Children's Administration Policy, GAIN SS, http://ca.dshs.wa.gov/intranet/pdf/policy/2007_04/GAINPolicy.pdf]

[11] The social worker or supervisor shall report, as required by RCW 26.44.030(4) and 74.13.031(3), to law enforcement within 24 hours of receipt of a report by the department in cases where the response time is labeled "emergent" and the child's welfare is believed to be in immediate danger. With the exception of a child fatality, which the social worker or supervisor shall report immediately, the social worker or supervisor shall notify law enforcement within 72 hours of receipt of any reported incident of: Sexual abuse. Non-accidental physical injury of a child. Incidents where the investigation reveals reasonable cause to believe that a crime against a child may have been committed.
Unless otherwise agreed in a local written working agreement with law enforcement, developed in consultation with the Attorney General's Office, DCFS staff making an oral report to law enforcement shall, within five days of receipt of the intake, also report in writing. The person making the report shall file a copy in the department case record or in an administrative file when no case record exists. A FamLink Law Enforcement Report or a legibly completed Report of Child Abuse and Neglect (Intake/Referral), DSHS 14-260, may be used to comply with the requirement for a written referral. [Source: Children's Administration Practices and Procedures Guide 2571 Section A and B]

contact that the Committee agreed would carry substantial weight in assessing the viability of the explanation provided by Ms. Hachtel and her brother-in-law in conjunction with what the CPS worker personally observed.

- The Committee noted the CPS social worker provided Ms. Hachtel with a crib. This was an added support to the family and provided a safe sleeping environment for K.H.
- The CPS supervisor informed the Committee that before he took his new position, he obtained access to barcode and ACES for all of the CPS workers. These are computer programs through Temporary Assistance for Needy Families (TANF) that aid workers in locating and contacting clients. The Committee was pleased with the diligence needed to obtain these beneficial resources for staff.

Recommendations

- The Tumwater CA office should standardize the process for requesting interpreters to lessen the burden on social workers and supervisors. Once standardized, there should be training for all staff regarding the process of requesting an interpreter.
- Regional Core Training through the Alliance for Child Welfare Excellence should include specific training on searching for history on individuals named in intakes.