Washington State Department of Social & Health Services

CA Children's Administration

Child Fatality Review

M.H-A.

RCW 74.13[redacted]**2018**
Date of Child's Birth

December 3, 2017
Date of Fatality

March 29, 2018
Child Fatality Review Date

Committee Members
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Table of Contents

Executive Summary

On March 29, 2018, 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 M.H-A. and [redacted] family.[2] The child will be referenced by [redacted] initials in this report.

On November 30, 2017, CA received a call on behalf of a physician with a local hospital's child abuse team with concerns for possible abuse to M.H-A. The allegations involved a facial injury to the child. A week prior, on November 22, 2017, M.H-A. was hospitalized for an infection on [redacted] face. [redacted] was released on November 25, 2017 and brought back on November 29, 2017 for a follow-up examination. The initial diagnosis at the time of the child's admission to the hospital was a possible infection. Upon returning to the hospital for the follow-up examination, the dermatologist and a physician who specializes in child abuse believed that the underlying injury leading to the infection was a possible immersion burn. M.H-A. was allowed to leave the hospital with [redacted] mother after the follow-up examination and a call was made to CA intake the following day.

On November 30, 2017, CA assigned a Child Protective Services (CPS) worker to investigate the allegations of abuse to M.H-A. The CPS worker was unable to locate the family because CA did not have a current address. The CPS worker made numerous attempts to locate the child and family between November 30 and Friday, December 1. Based on the lack of a current address for the family, the CPS worker was unable to request an after-hours response for Saturday.

On December 3, 2017, CA received a call from a [redacted] County Medical Examiner stating M.H-A. died in [redacted] home and D'Andre Glaspy was the only other person present at the time of death. D'Andre Glaspy was arrested and charged with Murder in the Second Degree. M.H-A.'s mother was not home when the child died.

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[1] Given its limited purpose, a Child Fatality Review (CFR) should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. The CFR Committee's review is generally limited to documents in the possession of or obtained by 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 CFR is not intended to be a fact-finding or forensic inquiry or to replace or supersede investigations by courts, law enforcement agencies or other entities with legal responsibility to investigate or review some or all of the circumstances of a child's fatal injury. Nor is it the function or purpose of a CFR to recommend personnel action against DSHS employees or other individuals.

[2] M.H-A.'s mother is not named in this report because she has not been charged in an accusatory instrument with committing a crime related to a report maintained by the department in its case and management information system. The mother's boyfriend, D'Andre Glaspy, has been charged with Murder in the Second Degree in connection with the death of M.H-A. [Source: RCW 74.13.500(1)(a)].

The CFR Committee included members selected from diverse disciplines within the community with relevant expertise including individuals from the Office of the Family and Children's Ombuds, law enforcement and child welfare. The Committee also included a medical professional who specialized in child abuse. The Committee members did not have any involvement or contact with this family.

Prior to the CFR, each Committee member received 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 CFR. These included the Medical Examiner's report, relevant state laws and CA policies.

The Committee interviewed the CPS supervisor for the April 2017 investigation and the CPS supervisor and worker on the November 20, 2017 investigation. The CPS worker who investigated the April 2017 intake terminated his employment with the department prior to this CFR.

Family Case Summary

On April 7, 2017, CA received an intake alleging physical abuse to M.H-A. by RCW 74 mother's boyfriend, D'Andre Glaspy. The report also stated the mother was made aware of the concerns by the caller and continued to allow D'Andre Glaspy to physically harm M.H-A. The intake states the child had scratches to RCW 74 face and a bruise on RCW 74 neck. This intake was screened in for a CPS investigation.

The intake was cross-reported to law enforcement who did not assign the case for investigation. The CPS worker made numerous attempts to contact the family between April 7 and April 13. The worker reached the mother by phone on April 13. On April 14, 2017, the CPS worker met the mother, M.H-A. and another adult female at a local library. The mother denied the allegations of physical abuse to M.H-A. by her boyfriend and the CPS worker did not see any injuries on M.H-A.

A second intake was received on April 21, 2017 from the prior referent with new allegations of a burn to the child's hand and that the mother and D'Andre Glaspy were using RCW 13.50.100 This intake was screened out, with the screening decision notes indicating that the allegations were documented in the previous intake. That same day, the referent spoke with the CPS worker; a case note documented the same information regarding the burn to the child's hand and allegations of RCW 13.50.1 use.

On May 22, 2017, the CPS worker walked through the residence where M.H-A. and RCW 74 mother were staying. The family friend whose house they were staying at

told the CPS worker that D'Andre Glaspy gave her a "bad vibe" and that he "has a weird persona." The family friend stated she would not put the accusations of abuse towards M.H-A. past D'Andre Glaspy and would not leave D'Andre alone with M.H-A.

The CPS worker made a collateral contact with M.H-A.'s pediatrician and confirmed that M.H-A. was up to date on RCW 7[redacted] medical needs.
M.H-A.'s mother requested assistance in obtaining child care; the CPS worker sent M.H-A.'s mother a letter indicating she could obtain child care by calling the phone number provided in the letter.

The CPS worker mailed a letter to the last known address for D'Andre Glaspy. The letter was an attempt to contact him and discuss the allegations in the intake. The CPS worker had attempted to call D'Andre Glaspy but was unable to reach him. There was no other documentation in the case file on efforts to locate D'Andre Glaspy.

The CPS investigation was closed as unfounded on June 2, 2017. On June 7, 2017, the family friend where the mother and M.H-A. were residing called the CPS worker and left a voicemail message. The CPS worker documented receiving the voicemail in a case note with no further details; the CPS worker did not return the family friend's call.

On November 30, 2017, CA received an intake stating M.H-A. was admitted to the hospital on November 22 for an infection to RCW 7[redacted] face, discharged on November 25, and brought back in on November 29 for a follow-up examination. After the examination, M.H-A. left with RCW 7[redacted] mother. The infection had resolved but the dermatologist indicated it appeared there was an underlying burn around the child's mouth involving the chin, cheeks and lips. The dermatologist consulted with another physician at the hospital who is a child abuse expert; it was determined that the injury may have been an immersion burn which became infected.

On November 30, 2017, the intake was assigned to a CPS worker for an investigation. The CPS worker reviewed the CA history of both the mother and D'Andre Glaspy and then sent a copy of the intake to law enforcement. The CPS worker called law enforcement twice to ask for a detective to go out to locate the family but was told no one was available. The CPS worker did not request a patrol officer to accompany her when she attempted to visit the family. The CPS worker then called the referring physician and discussed the intake.

The CPS worker went to the address listed on the intake the next day but no one answered the door. She then called the phone number listed for the child's

mother. She ended up speaking with the maternal grandmother who said she would have the mother call the CPS worker. The grandmother denied knowing the whereabouts of M.H-A. The CPS worker then received a call from an aunt of the mother stating the grandmother often watches M.H-A. when the child's mother is working. The aunt did not know the mother's current address or where M.H-A. was currently at. The CPS worker spoke with one of the physicians who consulted on M.H-A.'s case. The physician provided some historical information including knowing that the family had recently moved but that a current address was not obtained by hospital staff prior to the mother and M.H-A. leaving the hospital on November 29.

On December 2, 2017, CA received a call from a RCW 74.13. County Medical Examiner stating M.H-A. had been found deceased by RCW 74. mother's boyfriend, D'Andre Glaspy. There were no other people in the residence when the child died. The Medical Examiner's final report listed the cause of death as multiple blunt force injuries and the manner of death was homicide. The autopsy identified multiple acute injuries as well as prior injuries. There were multiple fractures in various states of healing which were consistent with non-accidental trauma. M.H-A.'s mother has not been charged in relation to RCW 74 death or prior injuries. At the conclusion of the CPS investigation, the mother received a founded finding for negligent treatment for failing to protect her RCW 74.1 from abuse by D'Andre Glaspy. D'Andra Glaspy received a founded finding for physical abuse.

Committee Discussion

The Committee discussed at length the need for mandatory reporters to follow RCW 26.44.030, which outlines mandatory reporting responsibilities. There were multiple points documented in the medical records indicating that the injury to M.H-A.'s face may have been an infection but that it may also have been a result of non-accidental trauma, yet an intake was not called in until after the child had been discharged from the hospital. There was enough concern that the Committee contacted the Suspected Child Abuse and Neglect (SCAN) team at the hospital where the child was previously treated to review their records. The Committee noted, based on the documented concerns regarding the etiology of the injuries, that it would have been appropriate for medical professionals to call law enforcement or CA prior to discharging M.H-A. on November 25, 2017.

The Committee discussed how children under 2 years old are often given a full skeletal survey as part of an assessment for possible abuse or neglect because often times children this young are unable to verbally describe how they received an injury. A full skeletal survey is a tool utilized to assist in this evaluation process. M.H-A. was just over that age cut-off. However, D'Andre Glaspy's history

with two similarly aged children, and those children's injuries, may have provided the added component necessary to consider whether a full skeletal survey would have been appropriate for this assessment.

The Committee did note that between April 7 and April 13, 2017, the CPS worker did make numerous efforts to locate M.H-A. and [RCW 74] mother. Those efforts were impressive, especially since the family did not have a consistent residence. However, after the contact was made, there did not appear to be the same fervor to locate D'Andre Glaspy in order to fully assess the situation and interview all subjects of the investigation. There were indications that D'Andre Glaspy could have been located via social media, but the CPS worker did not attempt to find him this way.

The Committee discussed how the CPS worker assigned to the April 2017 investigation provided the mother with a letter pertaining to her request for childcare assistance. The Committee discussed that it may have been beneficial to have a follow-up conversation with the mother to help her obtain this service as opposed to a short letter only containing an informational phone number. It is often seen as a positive support to have other persons, especially mandatory reporters such as childcare providers, have ongoing contact with children.

The Committee discussed how neither a Multi-Disciplinary Team (MDT) nor Child Assessment or Abuse Center (CAC) was used on this case. It was the Committee's understanding that a CAC is available through one of the hospitals in [RCW 74.13.] County, but this was not known for sure. The ability for CA staff to discuss a case with a multifaceted team such as an MDT or CAC allows for shared decision making as well as critical thinking to occur from differing disciplines. The Committee believed these types of support in shared decision making and staffing would be beneficial to all staff in [RCW 74.13.] County as well as specifically for this case.

Findings

Based on the review of the case documents and interviews with staff, the Committee did not identify any critical errors made by CA that contributed to the death of M.H-A. The Committee did identify missed opportunities within the assessment and casework with this family as well as systemic barriers to consistent supervision and case practice.

This intake was assigned on April 7, 2017. On May 1, 2017, the assigned CPS worker was given a new supervisor; the new supervisor had been with CA for 18 months prior to his promotion to a supervisory position. By July 2017, this supervisor was managing two units and continue to manage both units for eight months. A majority of this time, the area administrator was out on leave. While

there was an area administrator for the other office located in the same building, and at times the area administrator's supervisor was in the office, this often left the new supervisor to access only peers as a way to receive support and guidance. The Committee believes the issue of retention and longevity of staff prior to promotion to a supervisory position are ongoing statewide issues.

The Committee believes that the April 21, 2017 intake should have screened in for a CPS investigation as opposed to being screened out. The alleged burn to M.H-A.'s hand and alleged RCW 13.50.100 use by the mother and D'Andre Glaspy while caring for the child were not previously reported. The concern about this particular screening decision has already been addressed by the field office through a training by the CA Intake Program Manager on April 18, 2018 with the intake location and their staff.

Collateral contacts are utilized by CA staff for a better understanding of a family's situation, needs and dynamics. The Committee identified the need for more collateral contacts in this case. Some examples would be following up with the family member that the mother and M.H-A. lived with that said she would not leave the child alone with D'Andre Glaspy. That same person also called and left a voice mail message for the CPS worker days after his assessment was closed but the CPS worker did not call her back. The Committee also suggested that the department could have requested an evaluation by M. H-A.'s primary physician. Due to the time lapse between the initial screened-in intake and the time that the CPS worker saw M.H-A., any possible injury may have resolved. Requesting a urinalysis from the mother and D'Andre Glaspy would have been another resource to assess the allegations of RCW 13.50.100 use.

Another avenue that is often considered a collateral contact is the history available to CA staff within our own FamLink computer system. Regarding this case, the CPS worker for the April 7, 2017 intake stated he reviewed the history of the mother and D'Andre Glaspy as adults only. He indicated that there were no founded findings of abuse or neglect against either adult. However, the CPS worker on the November 30, 2017 intake reviewed the history of the mother as a child and adult and looked further at the investigation involving D'Andre Glaspy with two other young children. Those two actions provided the CPS worker with more details surrounding RCW 13.50.100 ; details regarding historical, child welfare issues related to the RCW 13.50.100 as well as allegations, though no founded findings, of physical abuse to similarly-aged boys as M.H-A. by D'Andre Glaspy.

Recommendations

CA should have a Child Abuse Medical Consultation Network (MedCon) discuss mandatory reporting responsibilities with [redacted] Hospital. This case highlighted a need for more urgency regarding the need for mandatory reporting which can be made to law enforcement or CA. Law enforcement often has the ability to respond immediately as opposed to CA's response time. The Committee also wanted MedCon to discuss that CA cannot place children in protective custody. Placement in protective custody by law enforcement, an order through a dependency case and a hospital hold by a treating physician are the only means to immediately remove a child from the home legally.

CA should consider reminding offices that utilizing regional supports such as Safety Administrators, Quality Practice Specialists, program managers or headquarters staff as well as MDTs and CPTs are good resources for shared decision making.

CA should create a policy regarding the use of social media as it pertains to communication between CA staff and clients.