STATE OF COLORADO

Colorado Department of Human Services
people who help people

OFFICE OF CHILDREN, YOUTH AND FAMILY SERVICES
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Bill Ritter, Jr.
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Karen L. Beye
Executive Director

March 19, 2010

Richard Bengtsson, Director
El Paso County Department of Human Services
105 North Spruce
Colorado Springs, CO 80905

Dear Mr. Bengtsson:

Please find enclosed the final child fatality reports on the death of Ashya Joseph for your records. We apologize for the delay in providing you a copy of the report, which is the result of a records review by the Child Protection Intake Administrator and review by the Colorado Department of Human Services State Child Fatality Review Team. Please provide to the Colorado Department of Human Services a letter indicating any policy or practice changes that have been implemented since the county internal review and state child fatality review of the death of Ashya Joseph. This documentation shall be provided to CDHS within 45 days of the receipt of this report.

We are committed to releasing these reports more timely in the future and appreciate your patience.

This state fatality review report is available through my office to anyone requesting a copy.

Sincerely,

Ruby Richards

Ruby Richards
Child Protection Intake Administrator

Enclosure: Final Child Fatality Report

cc: Karen L. Beye, CDHS Executive Director
George Kennedy, CYF Deputy Executive Director
Lloyd Malone, Child Welfare Services Director

CONFIDENTIAL
Colorado Department of Human Services
Child Fatality Review Team
May 31, 2008
Child Fatality Summary

A. Identifying Information:

Child: Ashya M. Joseph	**D.O.B** 09/25/2006	**D.O.D.** 01/28/2008
Biological Parents:		
Mother: Maria Gardner	**D.O.B.** 10/30/1982	
Father: Simeon Joseph	**D.O.B.** 08/04/1980	**D.O.D.** 10/09/2007
Surviving Siblings:		
Brother:	**D.O.B.** 7/21/1998	
Brother:	**D.O.B.** 9/1/1999	
Sister:	**D.O.B.** 12/7/2002	
Brother:	**D.O.B.** 7/2/2004	

Subject of Investigation: Maria Gardner

B. Involved County:
El Paso County Department of Human Services (EPCDHS)

C. Introductory Statement:

The Colorado Department of Human Services (CDHS) Child Fatality Review Team conducted the review of the circumstances surrounding the death of Ashya Joseph. The purpose of the review is to examine existing practices and policies and how they currently affect the county child welfare programs. These findings should not be construed to link the county's actions to the actions allegedly perpetrated on this child by her guardians/caregivers.

Statutory authority for this review is in Title 26-1-111, Colorado Revised Statutes. The Colorado Department of Human Services supervisory authority is outlined in the areas of child welfare and other programs as specified. It is in the capacity of supervision of the county's administration of child welfare programs that the state has the legal responsibility to require the corrective actions and to conduct follow-up reviews.

D. Case Summary:

Ashya Joseph died on 01/28/2008 as a result of smoke inhalation and thermal injuries because of a fire that her mother, Ms. Gardner, intentionally set at the family's residence. The manner of death was listed as homicide. Her remaining siblings were seriously injured in the fire and were hospitalized. The extent of the children's burns

on their bodies ranged from 20% to 90%. All but one of the surviving siblings reside with the paternal grandmother. The most severely burned child is still hospitalized out of state.

The victim's father, Mr. Joseph, committed suicide on 10/09/2007. This was a precipitant for Ms. Gardner's actions on 01/28/2008, as she had reported that she felt responsible for Mr. Joseph's death and wanted to die, along with her children. She had made elaborate plans for her own death and burial that she had recorded on a DVD, in letters to her family, and in a journal.

E. Chronology:

The family was originally referred to EPCDHS on 05/04/2004 for physical abuse to one of the victim's siblings by Mr. Joseph. There have been seven referrals on the family, primarily for allegations of physical abuse.

- **05/04/2004:** A five-year-old sibling of the victim had five cuts on his right forearm (one and a half to two inches long), three cuts on his right thigh (three to three and a half inches long), and two cuts on his back (three to four inches long). He reported that his younger sibling accidentally hit him. Ms. Gardner reported that he had received a "whoopin" from Mr. Joseph, for trying to jump out of a window. Ms. Gardner said that she was outside when the five-year-old was "disciplined" by his stepfather and she advised that this was the first time Mr. Joseph had ever used physical punishment. Ms. Gardner denied any domestic violence or substance abuse problems. She also said that she had little confidence in child protective services, as they were involved with her family when she was a child. Ms. Gardner and one of her sisters had been sexually abused by a brother, and two of Ms. Gardner's sisters are currently involved with EPCDHS because of child protection issues. When questioned again, the five-year old reported that he had gotten in trouble because he did not want to take a nap and was going to jump out of the window. He said that "Dad" hit him hard with two belts and one spoon. He said that he gets "whooped" and has to do exercises when he gets in trouble, but he reported that this was the first time that he sustained any injuries. The other children were interviewed and denied any abuse. Mr. Joseph was interviewed ten days later on 05/14/2004 and he reported the five-year old had been getting into trouble at school because of a classmate who is a bad influence. Mr. Joseph reported he "lost it" and wanted some help with learning better methods of discipline. He agreed to receive home-based services from Team Success. The allegation of medium physical abuse by Mr. Joseph was founded for this child. This referral was closed on 05/21/2004.

- **08/04/2004:** A referral was made because a four-year-old sibling of the victim had a bruise on the inside of his elbow; the report also alleged that the five-year-old sibling smelled of urine. The referral was assigned for assessment. The investigator saw all the children in the household. The two named children told different stories. Ms. Gardner denied any physical abuse or domestic violence.

Mr. Joseph was interviewed by phone on 9/13/04 and denied spanking the children. The hygiene issue was never addressed and the assessment was closed on 12/21/2004 as inconclusive.

- **09/10/2004:** A referral was made for possible minor physical abuse to the five-year-old sibling of the victim, as was the subject of the 05/04/2004 report. He was observed to have a mark below his eyebrow. He had come to school with a black left eyelid. He and his older sibling told completely different versions of what happened. The five-year-old reported that his mother threw a popsicle at him and it hit him in the eye. This referral was screened out, as there was no available information that would allow the referral to meet the legal definition of child abuse and/or neglect and determined to be an accident. The referral information was sent the Team Success caseworker.

- **09/25/2007:** A referral regarding domestic abuse was received because the Mr. Joseph allegedly shot at his wife in their yard with all the children present. He then left the home before the police arrived. Mr. Joseph committed suicide four days later after returning to the home; he died on 10/09/2007. The Safety Assessment did not find any safety concerns. The mother denied that the father had tried to shoot her. The referral was closed on 10/10/2007 as inconclusive for medium physical abuse and medium environment injurious by Mr. Joseph.

- **01/23/2008:** A referral was received from a community services provider stating the mother was making funeral arrangements for herself and the children. Her plan was very complete, including admitting if child welfare intervened, she would deny everything and then kill herself and the children. The mother reported feeling responsible for Mr. Joseph's death.

  A caseworker responded to the home and Ms. Gardner denied any suicidal ideation. She reported she had just insisted her sister and her sister's children leave her home, where they had been residing with Ms. Gardner and her children, as she (Ms. Gardner) felt she could no longer deal with her sister's problems. Ms. Gardner's sister has been receiving services from EPCDHS because of substance abuse. The caseworker tried to problem-solve with Ms. Gardner, including making a plan to take the children to a babysitter so that Ms. Gardner could go to the Crisis Center that night for an evaluation. The mother agreed to sign a one-week Protective Plan, which involved going to the Crisis Center and having the therapist call the caseworker. Ms. Gardner went to the Crisis Center and the therapist called the caseworker at 7:00 P.M., advising that Ms. Gardner did not need to be hospitalized and had gone home after the session. The caseworker called Ms. Gardner the next day and Ms. Gardner told her she was fine. No safety concerns were identified and the mother continued to deny any suicidal ideation. The plan was to close the referral with an inconclusive finding.

- **01/29/2008:** A referral from law enforcement was received reporting that on 01/28/2008, the mother attempted to kill herself and her children by dousing the

children with gasoline and setting fire to her house. Ashya Joseph died in the fire and Ms. Gardner and her four surviving children were hospitalized with serious injuries. EPCDHS obtained protective custody orders so the children could receive prompt medical attention while the investigation was completed. Ms. Gardner was initially picked up by a fire department paramedic several blocks from the house and transported to the hospital where she was interviewed by the police and then incarcerated at the El Paso County Justice Center.

F. Policy Findings:

Policy findings result from county child welfare actions that are found to be in violation of State statute or rule. Corrective actions are required by EPCDHS in response to each finding listed below.

1) EPCDHS caseworkers did not contact reporting parties to obtain additional information and clarification before deciding what actions to take on 09/10/2004 and 09/20/2004 referrals. These referrals were identical, except for the date. Notation indicates that it was sent to a Team Success caseworker and identified as an "accident." These actions are in violation of Volume 7, Section 7.202.4 C, D (1-3) which states:

   7.202.4 Initial Assessment

   C. The county department shall provide appropriate referral information to the reporting party in those situations in which there are inadequate grounds to constitute assignment for assessment and investigation. Either casework or supervisory staff shall inform, whenever possible and appropriate, the reporting party of the decision not to investigate and the reasons for that decision.

   D. The county department shall review all reports and conduct an initial assessment. The initial assessment shall decide the appropriateness of further investigation. It shall include, but not be limited to, the following activities:

   1. Checking the State Department's automated system
   2. Reviewing county department files.
   3. Obtaining information from collateral sources, such as schools, medical personnel, law enforcement agencies, or other care providers.

2) EPCDHS did not document the circumstances for going beyond 30 days to achieve completion of the 08/04/2004 and 09/25/2007 investigation assessments. There was no documentation as to why the assessments remained open. The 08/04/2004 investigation was closed on 12/21/2004. During this time period, referrals were received and screened out on 09/10/2004 and 09/20/2004. The 09/25/2007 referral was not closed until 01/31/2008 and during this period of time, referrals were received on 01/23/2008 and 01/28/2008. There was no documentation that the caseworkers had entered for the subsequent referrals.

   These actions regarding contact and completion are in violation of Volume 7, Sections 7.001.6 (A) and 7.202.56 (A) (C) that state:

7.202.56 Conclusion of Investigation
A. An investigation shall be completed within 30 calendar days of the date the investigation/assessment was assigned, unless there are circumstances that have prevented this from occurring. Such circumstances shall be documented in the case record.

3) EPCDHS completed the Colorado Safety Assessment in the 08/04/2004 and 09/25/2007 investigations prior to interviewing the father, who was the "person responsible for the abuse/neglect." The completion of the Safety Concerns list, without his information concluded there were not safety concerns, despite the risk assessment results that consistently showed a final risk level of medium. The lack of interviewing the alleged perpetrator may have helped to lead to an erroneous conclusion that there were no current concerns for the children's safety.

Areas on the Safety Concerns list that could have been identified were: 1) Caregiver has caused harm to child; 2) Domestic violence exists in the home; 3) Caregiver previously abused or neglected a child; 4) Caregiver's alleged or observed emotional instability seriously affects ability to protect child. This is both a practice and policy violation of Volume 7, Section 7.202.534 (D) that states:
7.202.534 Safety Assessment Conclusion

1. If none of the fifteen (15) safety concerns are identified at the conclusion of the safety assessment process, then there is no impending danger to a child and no further safety intervention is required. Although risk issues may be identified, the assessment may be closed and further intervention is a county option.

2. If one or more of the fifteen (15) safety concerns are identified, then it is necessary to consider the child's vulnerability to determine if there is impending danger.

3. If an assessment does not determine there is a vulnerable child in the home, then there is not a threat to child safety and no further safety intervention is necessary. Although risk issues may be identified, the assessment may be closed and further intervention is a county option.

4. If an assessment indicates that there are one or more safety concerns and there is a vulnerable child in the home, then it is concluded that impending danger is present and an evaluation must be made regarding caregiver protective capacities to manage and address safety concerns.

4) EPCDHS made a referral on 05/20/2004 for this family to a program in the department under TANF for supportive services. There appears that there was only one contact with the Team Success caseworker on 9/20/04 when she was

notified that a referral was referred to her. There was no recorded documentation of the involvement; however the caseworker said there were numerous delays after the family was referred to another agency for services. She said the delay was about two-three months as a result of administrative problems with the organization. There is no record of any referrals from the Team Success caseworker despite a number of referrals from other organizations in the community.

This represents a violation of 7.200.5 Mandatory Reporting of Child Abuse and Neglect by all county staff employees. It also is a violation of 7.202.52, which requires that all collateral parties be interviewed when there is an investigation of abuse and neglect; this involved investigations from August 2004 until January 2008.

5) At the time of the fatality, the county was involved with three of Ms. Gardner's sisters and her mother. Her sister's three children and her mother had lived with Ms. Gardner at different times. A review of all the referrals received during the county involvement, which goes back to Ms. Gardner, as a child and Ms. Gardner and her first husband would have revealed this history. Trails reports list referrals on all the families, as they are connected to Ms. Gardner. This is in violation of 7.202.4 C, D (1-3), as stated in finding #1 listed above.

6) EPCDHS did not develop a safety plan that was focused on controlling safety concerns for the children when the caregiver has stated she wanted to kill herself and her children on 1/23/08. The plan did not include anyone to provide safety management.

This is in violation of 7.202.535 Safety Planning and Documentation (B), (C), (D), and (E) which states,

B. A safety plan shall be developed for all other situations in which the safety intervention analysis has indicated that an in-home safety plan can sufficiently control safety concerns. It shall be documented in the state's automated system. All children in the household assessed to be unsafe shall be included in one plan.

C. All safety plans must include the following:

1. Safety responses that are the least restrictive response for assuring safety;
2. Safety responses that have an immediate impact on controlling safety concerns;
3. Activities that correspond to each specific safety concern and describe the frequency of each action;
4. Safety response(s) that are readily accessible at the level required to assure safety;
5. Identification of each family member and safety management provider participating in the plan;

6. Parental acknowledgement of safety concerns and a willingness to participate in the safety plan; and;
7. Caseworker activities to oversee the safety plan.

D. Parents, caregivers, and others who are a part of a safety plan shall sign the safety plan and receive a copy, and the signatures and paper form shall be retained in the file.

7) During the 1/29/08 fatality investigation it appears that the caseworker experienced some frustration in obtaining a protective court order and working with police officers that rarely work with El Paso DHS. These situations do not impact staff on a daily basis but represent an area that can be addressed administratively. There is not a written memorandum of understanding with the police department and El Paso DHS that has been administratively approved at all levels in accordance with 7.202.51.

This is in violation of 7.202.51 (A) which states: the county department shall develop written cooperative agreements with law enforcement agencies that include:

1. Protocol for cooperation and notification between parties on child abuse and neglect reports and child maltreatment deaths.
2. Proocol for distributing the Notice of Rights and Remedies when required by Section 19-3-212, C.R.S., and Section 7.200.3, G, of this staff manual.
3. Joint investigation procedures.
4. Procedures for independent investigation by either party.

8) There is no documentation in the case record of any investigations being reviewed by a county Child Protection Team (CPT).

This is in violation of 7.202.61 which states: a county department of social services receiving 50 or more reports of child abuse and neglect per year shall have a multi-disciplinary child protection team in accordance with Sections 19-1-103(22) and 19-3-308(6), C.R.S.

G. County Actions Taken:

El Paso County Department of Human Services will provide to the Colorado Department of Human Services a letter indicating any policy or practice changes that have been implemented since the county internal review and state child fatality review of the death of Preston Cheever. This documentation shall be provided to CDHS within 45 days of the receipt of this report.