Child Fatality Review

J.C.

February 1999
Date of Child's Birth

February 27, 2015
Date of Child's Death

May 21, 2015
Child Fatality Review Date

Committee Members
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Executive Summary

On May 21, 2015, the Department of Social and Health Services Children's Administration convened a Child Fatality Review[1] (CFR) to examine the department's practice and service delivery to 16-year-old J.C. and her family. On February 27, 2015, the teen was shot and killed by her mother who subsequently shot herself after leaving a suicide note. The family was receiving Family Assessment Response (FAR) services from Children's Administration Pierce East office at the time of the incident.[2]

The CFR Committee was comprised of CA staff and community members with pertinent expertise from a variety of fields and systems, including clinical psychology, developmental disabilities, public child welfare, and child advocacy. None of the Committee members had any previous direct involvement with the family.

Prior to the review each Committee member received a chronology of CA involvement and un-redacted case file documents. Other relevant documents were made available to Committee members at the time of the CFR. These included investigative and post-mortem findings from the Pierce County Medical Examiner's Office, and both medical and medication records for the child. Also made available to Committee members were relevant Children's Administration policy and practice guidelines.

During the course of the review several Pierce East Division of Children and Family Services staff were interviewed by the Committee, including workers from Child Protective Services (CPS), Family Voluntary Services (FVS), and Family Assessment Response (FAR). Following review of the case file documents, completion of the staff interviews, and discussion regarding department activities and decisions, the Committee made findings and recommendations which are presented at the end of this report.

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[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.

[2] Family Assessment Response (FAR) is a Child Protective Services alternative to investigations of low to moderate risk screened-in reports of child maltreatment.

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Case Overview

RCW 74.13.500

Eight years later a CPS investigation was initiated following allegations that J.C. had been bruised by an object thrown by her mother. Information gathered at that time indicated that the then 12-year-old had significant behavioral and other special needs, including Asperger Syndrome.[3] The two-month investigation resulted in the allegations being unfounded and the case closed in late October 2011.[4]

In November 2013, CPS investigated an alleged non-accidental facial bruise on J.C. The mother's partner admitted to having struck the child and was founded for physical abuse. The mother was founded for negligent treatment for having been aware of the incident and continuing to allow her partner unsupervised access to the child who was taking multiple medications to control behavior and mental health issues. Based on an assessment of risk, the case was transferred to Family Voluntary Services.[5] A state contracted provider was engaged to provide FAST services in the home.[6] Due to J.C.'s demonstrated serious emotional

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[3]Asperger syndrome (AS) is an autism spectrum disorder (ASD), one of a distinct group of complex neurodevelopment disorders characterized by social impairment, communication difficulties, and restrictive, repetitive, and stereotyped patterns of behavior. Other ASDs include autistic disorder, childhood disintegrative disorder, and pervasive developmental disorder not otherwise specified (usually referred to as PDD-NOS). ASDs are considered neurodevelopmental disorders and are present from infancy or early childhood. Although early diagnosis using standardized screening by age 2 is the goal, many with ASD are not detected until later because of limited social demands and support from parents and caregivers in early life. [Source: National Institute of Neurological Disorders and Stroke]

[4] CA findings are based on a preponderance of the evidence. Child abuse and neglect are defined in RCW 26.44, WAC 388-15-009, and WAC 388-15-011. Findings are determined when the investigation is complete. Founded means 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. Unfounded means 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.

[5] Family Voluntary Services (FVS) support early engagement in services, including providing ongoing case management services and assessment of safety and risk to children. Voluntary Case Plans are used to engage families willing to participate in services intended to reduce current and future abuse or neglect issues that do not require court intervention. Voluntary services are short-term to help increase parents' protective capacity and manage child.

[6] Family Access Stabilization Team (*FAST)* is now referred to as Intensive Stabilization Services. These support services are provided to families with children at risk of out of home placement. This is a short-term (up to 90 days) community-based alternative to psychiatric hospitalization or foster care placement. Intended outcomes are increased safety, stabilization, and ensuring children have a permanent family resource.

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symptoms, self-destructive behavior, and lack of behavioral control that resulted in provoking dangerous reactions in caregivers, a Safety and Supervision Plan was initiated with regard to controlling access to J.C. by the mother's partner.

On January 21, 2014, while the case was still open with FVS, the contracted provider reported that the mother's partner had been left unsupervised with J.C. in violation of the Safety and Supervision Plan. CPS again became involved and the mother admitted to having left her daughter unsupervised with the partner. The mother was founded for negligent treatment. The partner reportedly moved out of the residence and both the CPS and FVS cases closed in mid-April 2014.

On April 28, 2014, a report was received by CPS intake alleging that J.C. had been hit (no injuries) by a book thrown by the mother's partner who was staying at the home for a few days. Based upon information gathered during the CPS investigation, there was no evidence that abuse or neglect occurred to J.C. and the allegations were determined to be unfounded; the case was closed in July 2014.

In January 2015, concerns of possible maltreatment were reported by a medical facility regarding the mother's lack of follow through with recommended psychiatric services for J.C., and that the mother's partner may have, at some undefined time, held J.C. by her neck. The case was assigned for differential response (FAR) and the mother signed a Family Participation Agreement. As J.C.'s biological father was in the military, a referral was made to the Family Advocacy Program (FAP) at Joint Base Lewis-McChord (JBLM). On March 18, 2015, the JBLM FAP Committee Review Board reviewed the case and determined it did not meet the criteria for neglect or abuse services per the military protocol.[7]

Ten days later local media reported the deaths of a 16-year-old and her mother from a likely homicide/suicide incident occurring on March 27, 2015. The identification of the two individuals came to the attention of CPS on April 2, 2015. Subsequently records from the Pierce County Medical Examiner's Office confirmed J.C. died from multiple gunshot wounds perpetrated by her mother.

[7] For FAP to be involved in reports of child abuse, alleged victims must be under age eighteen or incapable of self-support due to physical or mental incapacity, and in the legal care of a service member or military family member. FAP staff members are trained to respond to incidents of abuse and neglect, support victims, and offer prevention and treatment. For the purposes of military family services, the Department of Defense defines child abuse and neglect as injury, maltreatment, or neglect to a child that harms or threatens the child's welfare.

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CFR Committee Discussion

Committee members reviewed and discussed the CA documentation and the additional verbal accounts presented by the CA workers who were interviewed during the review. The Committee considered relevant CA practice and procedural standards for intervention and service response. The Committee also acknowledged the challenge for CA workers to be knowledgeable and responsive to complex issues such as mental health, chemical dependency, and domestic violence. The Committee also discussed the impact of the caseloads and workloads of the CPS and FVS workers involved in the case.[8]

In an effort to evaluate the reasonableness of decisions made and actions taken by the department, and as a balance to simply reviewing defined minimal practice measures, the Committee spent considerable time discussing the qualitative nature of the information gathering, assessment, and service delivery by the workers assigned to the case. This included reviewing and discussing the quality of the critical thinking, curiosity, collateral contacts, corroboration of information, collaboration with outside agencies, communication (internal and external), and comprehensiveness of the understanding of the family by the workers who were involved.[9]

Thus the Committee discussed whether the workers, in the process of conducting safety and family assessments, sufficiently gathered, probed, and understood the family members individually and collectively. The Committee looked at workers' understanding of the nature of the relationships within the family system (mother-child, mother-partner, partner-child, and biological father-child), the mother's situation (psychological health, physical health, coping strategies and social support network), and aspects of stability and dysfunction that each family member contributed to the family unit. Such discussions were important in evaluating whether the services offered by CA were the most appropriate to meet the needs of the family.

Findings

The Committee found no apparent critical errors in terms of decisions and actions taken by CA. The Committee found that the assigned CA workers appeared invested in child safety and child well-being and were actively engaged

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[8] Caseload and workload are not synonymous. While a worker's caseload generally equates to the number of assigned cases, workload involves the complexity of cases requiring intensive intervention and additional administrative requirements. [Source: U.S. Department of Health & Human Services, Administration for Children & Families, Child Welfare Information Gateway]

[9] These domains, known as The Seven Cs, have recently been incorporated into the statewide Children's Administration Lessons Learned Training to guide discussions about key areas for qualitative evaluation of practice.

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with the family. The FAR worker's connection to the family appeared particularly strong and genuine. The Committee did find instances where additional or alternative social work activity may have been considered and these issues, identified below, serve as noted opportunities where improved practice may have been beneficial to the assessment of the family situation and service delivery.

1. While noting instances of appropriate collateral contacts for information gathering (e.g., school staff and the child's primary care physician), the Committee found that there were also missed opportunities for additional collaterals throughout the multiple interventions by CPS, FVS, and FAR workers. This was particularly evident in the lack of information sought by CA workers regarding the mother's mental health and medical issues (including prescribed medications). The Committee found that what little information was gathered largely came from the mother's accounts without significant probing or seeking corroboration.
2. Although reasonably evident as early as 2011 that J.C. likely qualified for Social Security Income (SSI) benefits and state developmental disability services, there appeared to be missed opportunities from multiple CA staff to be more persistent in helping to connect the child with both SSI and Developmental Disabilities Administration (DDA). Such enrollments may have provided valuable support services to the family such as financial support, intensive in-home services, respite care, and parent support. Based on the interview responses, the workers involved did not appear to be aware of DDA programs and services.
3. Case file documentation showed multiple notations by CA staff regarding the contracted provider not having satisfied the expected service delivery. Comments from staff interviewed appeared to indicate a lack of awareness as to what action steps were available to them to address complaints about contracted providers.
4. The CA workers (2013-2014) largely focused on the mother's partner as the predominant issue (allegation and safety threat) to be resolved resulting in the referral to FAST as a "placement prevention service" with a goal of limiting the boyfriend's presence in the home. This incident-focused approach appeared to result in an understanding of individual and family functioning and service needs that may have been influenced by worker biases as to the boyfriend's PTSD condition and his access to weapons (including a concealed weapons permit).
5. While the FAST services were not without benefit, including safety and supervision planning, some consideration might have been made for more

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appropriate in-home services such as an Applied Behavior Analysis (ABA) program.[10]

6. CA workers did document numerous situations, behaviors, and comments by the mother that in isolation may reasonably have seemed marginally important but collectively had possible significance as risk factors for serious depression and suicide.[11] These included the mother having no stable employment, limited financial resources, raising a special needs child, subtle expressions of hopelessness and shame, isolating behaviors, excuses for not following through with commitments, relationship issues, limited support, sleeping all day, history of trauma, significant medical conditions, access to lethal means, and expressions of being overwhelmed at times. While the Committee found it unreasonable to expect CA staff to have expertise in the field of mental health, recognition of such risk factors may have created an opportunity for more in depth conversations with the mother.

Recommendations

- CA should consider making available to any CA staff a (non-mandatory) presentation (e.g., web-based) that provides basic information regarding both risk factors and warning signs for suicide.[12]
- CA should evaluate the need and/or benefit of cross-training opportunities with DDA that would include information as to the agency collaboration and the current interagency Memorandum of Understanding.
- In order to improve accountability of contracted providers, CA should explore continued and improved ways to message out to CA staff the agency expectations and process for forwarding concerns about contracted provider service delivery. This would include clear reminders to workers, supervisors, and administrators on how to proceed with concerns about contracted providers.

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[10] Applied behavior analysis (ABA), previously known as behavior modification, is a process of systematically applying interventions based upon the principles of learning theory to improve socially significant behaviors to a meaningful degree, and to demonstrate that the interventions employed are responsible for the improvement of behavior. Methods in applied behavior analysis range from validated intensive behavioral interventions--most notably utilized for children with an autism spectrum disorder (ASD).

[11] Risk factors are often incorrectly confused with warning signs of suicide, as factors identified as increasing risk are not factors that cause or predict a suicide attempt. Risk factors are characteristics that make it more likely that an individual will consider, attempt, or die by suicide, but do not cause or predict a suicide attempt.[Source: Suicide Prevention Resource Center]

[12] Suicide is the eighth leading cause of death among all Washington residents and the second leading cause among youth ages 15-24. [Source: Washington State Department of Health]

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