Washington State Department of Social and Health Services

Transforming Lives

REPORT TO THE LEGISLATURE

Quarterly Child Fatality Report

RCW 74.13.640

July – September 2016

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Washington State Department of Social & Health Services
Transforming lives

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Executive Summary

This is the Quarterly Child Fatality Report for July through September 2016 provided by the Department of Social and Health Services (DSHS) to the Washington state Legislature. RCW 74.13.640 requires DSHS to report on each child fatality review conducted by the department and provide a copy to the appropriate committees of the legislature:

Child Fatality Review — Report

(1)(a) The department shall conduct a child fatality review in the event of a fatality suspected to be caused by child abuse or neglect of any minor who is in the care of the department or a supervising agency or receiving services described in this chapter or who has been in the care of the department or a supervising agency or received services described in this chapter within one year preceding the minor's death.

(b) The department shall consult with the office of the family and children's ombudsman to determine if a child fatality review should be conducted in any case in which it cannot be determined whether the child's death is the result of suspected child abuse or neglect.

(c) The department shall ensure that the fatality review team is made up of individuals who had no previous involvement in the case, including individuals whose professional expertise is pertinent to the dynamics of the case.

(d) Upon conclusion of a child fatality review required pursuant to this section, the department shall within one hundred eighty days following the fatality issue a report on the results of the review, unless an extension has been granted by the governor. A child fatality review report completed pursuant to this section is subject to public disclosure and must be posted on the public web site, except that confidential information may be redacted by the department consistent with the requirements of RCW 13.50.100, 68.50.105, 74.13.500 through 74.13.525, chapter 42.56 RCW, and other applicable state and federal laws.

(2) In the event of a near fatality of a child who is in the care of or receiving services described in this chapter from the department or a supervising agency or who has been in the care of or received services described in this chapter from the department or a supervising agency within one year preceding the near fatality, the department shall promptly notify the office of the family and children's ombuds. The department may conduct a review of the near fatality at its discretion or at the request of the office of the family and children's ombuds.

In April 2011, SHB 1105 was passed by the legislature and signed into law by Governor Gregoire. The revised child fatality statute (RCW 74.13) became effective October 22, 2011 and requires the department to conduct fatality reviews in cases where a child death is suspected to be caused by abuse or neglect. This eliminated conducting formal reviews of accidental or natural deaths unrelated to abuse or neglect. The revised statute requires the department to consult with the Office of Family and Children's Ombuds (OFCO) if it is not clear that the fatality was caused by abuse or neglect. The department can conduct reviews of near-fatalities or serious injury cases at the discretion of the department or by recommendation of OFCO. The statutory revision allows the department access to autopsy and post mortem reports for the purpose of conducting child fatality reviews.

This report summarizes information from completed reviews of one (1) fatality and one (1) near-fatality that occurred in the third quarter of 2016. All child fatality review reports can be found on the DSHS website: https://www.dshs.wa.gov/ca/publications/childrens-administration-child-fatality-reports

The reviews in this quarterly report include child fatalities and near fatalities from three regions.

Region	Number of Reports
1	1
2	1
3	0
Total Fatalities and Near-Fatalities Reviewed During 3rd Quarter 2016	2

This report includes Child Fatality Reviews conducted following a child's death that was suspicious for abuse and neglect and the child had an open case or received services from the Children's Administration (CA) within 12 months of his/her death or injury. A critical incident review consists of a review of the case file, identification of practice, policy or system issues, recommendations and development of a work plan, if applicable, to address any identified issues. A review team consists of a larger multi-disciplinary committee including community members whose professional expertise is relevant to the family history. The review committee members may include legislators and representatives from the Office of the Family and Children's Ombuds.

The charts below provide the number of fatalities and near-fatalities reported to CA and the number of reviews completed and those that are pending for calendar year 2016. The number of pending reviews is subject to change if CA discovers new information through reviewing the case. For example, CA may discover that the fatality or near-fatality was anticipated rather than unexpected, or there is additional CA history regarding the family under a different name or spelling.

Child Fatality Reviews for Calendar Year 2016			
Year	Total Fatalities Reported to Date Requiring a Review	Completed Fatality Reviews	Pending Fatality Reviews
2016	10	6	4

Child Near-Fatality Reviews for Calendar Year 2016			
Year	Total Near-Fatalities Reported to Date Requiring a Review	Completed Near-Fatality Reviews	Pending Near-Fatality Reviews
2016	7	6	1

The child fatality review referenced in this Quarterly Child Fatality Report is subject to public disclosure and is posted on the DSHS website.
https://www.dshs.wa.gov/ca/publications/childrens-administration-child-fatality-reports

Near-fatality reports are not subject to public disclosure and are not posted on the public website nor included in this report.

Notable First Quarter Findings

Based on the data collected and analyzed from the one (1) fatality and one (1) near-fatality during the 3rd quarter, the following were notable findings:

- One (1) of the two (2) cases referenced in this report was open at the time of the child's near-fatal injury.
- The child referenced in the near fatality case was under 2 years of age when the near fatality occurred.
- The near fatality incident occurred when a 16-month-old ingested his mother's methadone.
- The youth in the fatality case was 14 years old when he died.
- One (1) child fatality was coded as suicide by a medical examiner. This child died from a gunshot wound while playing Russian roulette.
- Both cases referenced in this report were the result neglect by the children's parents.
- One (1) was Native American and one (1) was African-American.
- Children's Administration received intake reports of abuse or neglect in the two (2) cases prior to the death or near-fatal injury of the child. Of the two (2) cases, one (1) had six (6) intakes reported to CA prior to the critical incident, the other case had one (1) prior intake.
- Due to the small sample of cases reviewed, no statistical analysis was conducted to determine relationships between variables.

Child Fatality Review

J.J.

March 2001
Date of Child's Birth

January 26, 2016
Date of Fatality

June 23, 2016
Child Fatality Review Date

Committee Members
Mary Moskowitz, JD, Ombuds, Office of the Family and Children's Ombuds
Taku Mineshita, Continuum of Care Project Manager, Children's Administration
Victoria Wagner, Executive Director, Youth Suicide Prevention Program
Jennifer Gaddis, MSW, Quality Practice Specialist Region 3 North, Children's Administration
Robert Welch, MSW, MHP, LSWAIC, CDPT, Behavioral Health Specialist, MDC

Facilitator
Libby Stewart, Critical Incident Review Specialist, Children's Administration

Executive Summary

On June 23, 2016, 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 14 year old J.J. and his family.[2] The child will be referenced by his initials, J.J., in this report.

On January 26, 2016, J.J. was brought to a local hospital with a gunshot wound to his head. He was pronounced brain dead. J.J. and a couple of friends were allegedly under the influence, obtained a gun and engaged in Russian roulette. J.J. was shot in the head. The shooting did not occur at J.J.'s house.

At the time of his death, J.J. lived with his mother, stepfather, younger half-brother and older sister. In October of 2015, CA had closed a family assessment response assessment regarding allegations of neglect.[3] As part of the investigation by CA regarding J.J.'s death, it was determined that J.J.'s younger brother was at imminent risk and was removed from his parents' home. Both parents were founded for negligent treatment or maltreatment as to J.J. and the younger sibling. J.J.'s older sister had turned 18 and was therefore not under the jurisdiction of CA or the juvenile court.

The review Committee included members selected from diverse disciplines within the community with relevant expertise including the Office of the Family and Children's Ombuds, a youth suicide prevention expert, co-occurring treatment provider, a program manager with CA who specialized in integration of mental health and chemical dependency services and a quality practice specialist with CA. Neither CA staff nor any other Committee members had previous involvement with this family.

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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 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 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] J.J.'s family members are not named in this report because they have 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. [Source: 74.13.500(1)(a)]

[3] Family Assessment Response (FAR) is a Child Protective Services (CPS) alternative response to an investigation of a screened-in allegation of child abuse or neglect. FAR focuses on child safety along with the integrity and preservation of the family when lower risk allegations of child maltreatment have been reported. [Source: CA Practices and Procedures Guild 2332. Family Assessment Response]

Prior to the review, each Committee member received a case chronology, 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 review. These included relevant state laws and CA policies.

The Committee interviewed the assigned CPS supervisor and area administrator. The area administrator had no involvement in the case prior to the fatality. The assigned FAR worker and her supervisor no longer work for CA.

Family Case Summary

The first CA intake regarding this family was received on May 3, 2000. The allegations were for RCW 13.50.100 and the investigation findings were inconclusive. A second intake was received in June 2012 and was screened out. In April 2015, an intake was received alleging RCW 13.50.100 by the mother. Less than a month later, another intake was received following the lack of RCW 13.50.100 by J.J.'s RCW 13.50.100. Both intakes were screened out.

In October 2015, an intake was received stating the RCW 13.50.100 in the home had disclosed that J.J. had been arrested and uses drugs. This child disclosed observing the mother and possibly the RCW 13.50.100 hitting J.J. The RCW 13.50.100 also made a RCW 13.50.100 statement during his disclosure and stated he thinks about RCW 13.50.100 a lot. He spoke about using a RCW 13.50.100 and he does cool tricks with the RCW 13.50.100. This intake was assigned for a FAR assessment.

During the FAR assessment, the FAR worker documented speaking with the mother, J.J. and the younger sibling. During the initial interview with the youngest child, he disclosed that he thinks about RCW 13.50.100 every day, has seen RCW 13.50.100 at his home and their mother helps the older sibling or sibling's friend get RCW 13.50.100. The mother's response to the suicidal statements was RCW 13.50.100. She stated he only made the statements because he heard J.J. say it. The mother refused to allow the FAR worker entrance into the home and would not give permission for her to speak with the oldest sibling. The mother refused to continue with the FAR assessment process and stated she understood the refusal may result in the assessment changing to a CPS investigation. The FAR worker staffed the case with a CPS supervisor. The determination was to close the case at that time without further investigation. The date of closure was October 25, 2015.

On January 26, 2106, CA received an intake regarding J.J.'s fatal shooting. This intake was assigned for a CPS investigation. The investigation concluded with a

founded finding as to the mother and stepfather for negligent treatment or maltreatment.

Committee Discussion

For purposes of this review, the Committee focused on case activity prior to the fatality. The CPS investigation regarding the fatality was briefly discussed. The Committee noted that the local school district had provided appropriate interventions regarding the RCW 13.50.100 of the younger sibling.

All Committee members acknowledged seeing an increase of reported suicide amongst youth. Suicide is now the second leading cause of death among young people across the country.[4] There was a substantive discussion regarding what CA can do to assess for suicidal ideation of youth understanding the scope of CA's duties, the lack of tools and minimal training in this area for CA staff and what possibilities exist to make change within the agency.

CA removed the GAIN-SS tool from CPS investigations.[5] The expectation for staff was to incorporate that tool's questions into the gathering questions and assessment process. However, the Committee believes this is not occurring on a regular basis. The GAIN-SS tool was never utilized by FAR staff. This discussion resulted in the recommendations listed at the end of this report.

The discussions also included how CA assesses substance related issues for youth, the determination not to change the case from FAR to CPS, the lack of tools and the lack of timely and available community mental health providers. There was some discussion as to the length of time legislatively allowed for a FAR assessment to remain open. The statute states a FAR assessment should close after 45 days. An extension may be added for up to 90 days. The Committee noted that this timeframe is possibly a barrier to the idea of a FAR/CPS worker assessing child safety, building a relationship with a family through engagement and ameliorating the identified issues within a family.

[4] Source: Public News Service

[5] The five-minute Global Appraisal of Individual Needs-Short Screener (GAIN-SS) is primarily designed for three things. First, it serves as a screener in general populations to quickly and accurately identify clients who would be flagged as having one or more behavioral health disorders on the GAIN-I, suggesting the need for referral to some part of the behavioral health treatment system. It also rules out those who would not be identified as having behavioral health disorders. Second, it serves as an easy-to-use quality assurance tool across diverse field-assessment systems for staff with minimal training or direct supervision. Third, it serves as a periodic measure of change over time in behavioral health. It is designed for self- or staff-administration with paper and pen, on a computer, or on the web. It can be easily converted to a scannable form or incorporated into existing instrument batteries or systems. [Source: GAIN Coordinating Center]]

During the discussion of whether the case should have changed from FAR to investigations, the Committee noted it may not have changed the outcome of that intake assessment. However, based on the fact that the FAR assessment could have been more thorough, and in light of the mother's refusal to complete it, knowing it would move to a CPS investigation process, it would have been appropriate to change the case to an investigation to more adequately assess the children's safety.

It was clear from the documentation, that this family was not easily engaged. The mother was not willing to allow the FAR worker into the home and was at times hostile. The Committee acknowledged this was a barrier to a full assessment but noted other strategies may have been utilized to conduct a full assessment of the safety and well-being of the children in the home.

The Committee noted the struggles for the Pierce West office at the time of closure of the FAR assessment. The office was settling into a new area administrator, turnover was high and there were significant morale issues. Based on the employee interviews, it appeared the FAR worker's supervisor was not readily available to her and therefore the expected clinical supervision was not provided. Also, at this same time FAR staff were required to carry ongoing child and family welfare services cases due to the high number of vacancies.

Findings

The Committee did not find any critical errors that directly correlated with the fatality. However, the Committee identified areas where practice could improve. The FAR assessment was not as comprehensive as it could have been. Without a more comprehensive assessment, the determination to not send the case to investigation appeared to be flawed. Some areas of the assessment that were not completed included the parents' RCW 13.50.100 and how it may or may not have impacted the children's safety. In that same thought, J.J. admitted to drug use which should have led to a further assessment of his use and possible treatment needs. More in-depth collaterals could have also assisted in assessing the safety of J.J. and his siblings. The collaterals could have included the maternal grandmother, J.J.'s father and RCW 13.50.100 he stepfather, who lived in the home, was never interviewed. The Committee noted that a stronger approach would have been appropriate regarding the interview to assess the safety and well-being of J.J.'s older sister.

The Committee believed the use of a Family Team Decision Making (FTDM)[6] meeting would likely have assisted in engagement and assessment of this family.

Recommendations

CA has removed the mandatory usage of the GAIN-SS tool in CPS assessments. The expectation was that staff would incorporate the areas of mental health (to include suicidal ideation) and chemical dependency use in their assessment process. The Committee recommends CA provide training for case carrying staff on how to incorporate those questions into their contact with families, including youth. CA should consider making this training mandatory.

It should be noted that prior to this review, the office was working with the regional practice consultation team to provide trainings to staff regarding assessments, how to ask the difficult questions and incorporation of the GAIN-SS questions into the gathering questions.

CA should incorporate into the direct questioning of teen and adult clients as to whether or not they have thought of committing suicide within the last 30 days.

[6] Family Team Decision Making (FTDM) meetings bring people together who are involved in the family to make critical decisions regarding the removal of child(ren) from their home, changes in out-of-home placement and reunification or placement into a permanent home. [Source: CA Practices and Procedures Guide 1720. Family Team Decision Making Meetings]