Washington State Department of Social & Health Services

CA Children's Administration

Child Fatality Review

A.J.

March 2014
Date of Child's Birth

April 3, 2015
Date of Child's Death

August 13, 2015
Child Fatality Review Date

Committee Members
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RCW 74.13.640

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Executive Summary

On August 13, 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 1-year-old A.J. and her family.[2] On April 3, 2015, the child drowned in a bathtub at the family residence while in the care of her mother. One month prior to the fatality the Vancouver Division of Children and Family Services (DCFS) completed a Family Assessment Response (FAR) with the family.[3]

The CFR Committee was comprised of CA staff and community members with pertinent expertise from a variety of fields and systems, including public child welfare, public health nursing, parenting education, intensive family preservation services, 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. Available to Committee members at the time of the CFR were the parenting education records from a local community agency that had provided services to the family since July 2014. Clark County Medical Examiner's Office records regarding the child fatality (autopsy and ancillary studies) were formally requested in advance of the review but had not been received by the time the Committee convened.

During the course of the review the Vancouver DCFS Family Assessment Response (FAR) worker and his supervisor were interviewed. Following review of the case file documents, completion of the staff interviews, and discussion regarding department activities and decisions, the Committee made findings

[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] No criminal charges have been filed relating to the incident and therefore neither of the parent's names are identified. The name of the child is subject to privacy laws [Source: RCW 74.13.500(1)(a)].

[3] Family Assessment Response (FAR) is a Child Protective Services alternative response to investigations of low to moderate risk screened-in reports of child maltreatment. [Source: CA Practices and Procedures Guide 2332]

which are presented at the end of this report. The Committee forwarded no recommendations.

Case Overview

A.J. first came to the attention of CA on March 14, 2014, two months after her "RCW 13.50.100 [redacted]",[4] when a caller contacted CA intake with generalized concerns about the birth mother. Lacking any direct knowledge of the situation by the anonymous referrer or any specific allegations, the report was screened out at intake. In early June 2014, a social worker from a local hospital reported concerns that the parents may lack resources for meeting the needs of the infant who was due to be discharged from the hospital. Without specific allegations of abuse or neglect or imminent harm the report was screened out. It was reported at that time that the family had agreed to in-home services by a community health nurse.

On January 9, 2015, a parent educator from a local community agency working with the family reported concerns for the safety of an infant in the home. The mother reportedly was ignoring voiced concerns by the parent educator about leaving the infant on the couch unattended and concerns about a 4-foot boa constrictor roaming free in the residence. The mother had reported to the parent educator that the snake had previously constricted her (the mother's) neck but did not feel her infant was at risk. The intake was assigned for differential response and the parents agreed to FAR intervention.

The assigned FAR worker discussed with the parents the concerns as reported. The parents agreed to make sure they knew where the snake was at all times, keep it away from the child, and not leave the child unsupervised around the snake. Parents were cooperative and willing to make necessary changes to ensure the child's safety. Other issues of child safety were assessed (e.g., infant safe sleep) and the FAR worker confirmed that a parent educator with a community agency was still actively working with the family. FAR services were ended on March 11, 2015.

On April 4, 2015, CA intake received a report from local law enforcement that A.J. had drowned the day before. The mother had admitted to detectives that she had placed her 1-year-old daughter in the bathtub and stepped away to throw a dirty diaper in the trash. She then got distracted when getting onto the computer

[4] The term "micro preemie" is used in the medical field to refer to the smallest and youngest preterm babies who are born before 26 weeks gestation or weighing less than 1 pound, 12 ounces (800 grams).

and lost track of time. Ten minutes elapsed when the mother returned to the bathtub and found the child under water, not breathing, and lips having turned blue. The mother attempted CPR with no success and then called 911. Arriving medics continued to attempt resuscitation. The child was transported to a local hospital where she was pronounced dead.

A CPS investigation was initiated resulting in a founded finding regarding an allegation of negligent treatment on the part of A.J.'s mother.[5] According to Vancouver area media reports the Clark County Medical Examiner's Office ruled the drowning as an accidental death. At the time of the child fatality review it is believed that law enforcement had not charged the mother with any criminal offenses.

CFR Committee Discussion

Committee members reviewed and discussed the CA documentation and the additional verbal accounts presented by the CA staff who were interviewed during the review. The Committee considered relevant CA practice and procedural standards for intervention and service response.

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 worker 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 FAR worker and supervisor who were involved.[6]

Thus the Committee discussed whether the worker, in the process of conducting safety and family assessments, sufficiently gathered, probed, and understood the family members individually and collectively. Such discussions were important in evaluating whether the services offered by CA were the most appropriate to meet the needs of the family.

[5] "Founded" means the determination that, following an investigation by the department, based on available information: it is more likely than not that child abuse or neglect did occur. [Source: RCW 26.44.020]

[6] 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.

The Committee briefly discussed both the workload and caseload[7] of the worker at the time of his FAR assignment as well as his breadth of experience working for Children's Administration for 20 years. This included consideration of the fact that the worker, after 7 years as an intake worker, had relatively recently rejoined field work following implementation of FAR in the Vancouver DCFS office in October 2014. The purpose of such discussion was to apply a context for the Committee's concerns that the supervisor may have overestimated the worker's skill level based upon previous field experience at a time in which the Vancouver office developed high caseloads in FAR as a result of the transition to the new response system. The Committee was provided information that, following an internal review of A.J.'s death and routine review of other cases, the Vancouver DCFS office utilized a Regional Safety Practice Consultant to work with Vancouver workers to improve practice in the Structured Decision Making® (SDM)[8] and Family Assessments.

The Committee also briefly discussed the service delivery by a local community agency that had worked with the family since July 2014, which predated involvement by the Children's Administration that began in January 2015. Although the agency providing services to the family is a contracted provider for CA, its engagement with the family was not through the department. Thus, any Committee considerations regarding that service delivery is deemed outside the scope and purpose of this review.

Findings

The Committee found no apparent critical errors in terms of decisions and actions taken by CA. 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.

[7] 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]

[8] The Structured Decision Making® (SDM) Risk Assessment is an evidence-based actuarial tool from the Children's Research Center (CRC) that was implemented by Washington state Children's Administration in October 2007. It is one source of information for CPS workers and supervisors consider when making the decision to provide ongoing services to families.

Lack of Curiosity

The FAR worker appeared to primarily focus on the incident involving the lack of supervision of the infant around the boa constrictor. The worker did document general aspects of child safety in the home (e.g., safe sleep practices by the parents), the home environment (cleanliness of the residence), and parent cooperation. These appeared to have been given great weight by the worker in his assessment which reflected possible confirmatory bias.[9] Such appeared to result in a general lack of curiosity about more global aspects of the family which led to missed opportunities to gather comprehensive information about the family to assess child safety and the family's needs and strengths as required in RCW 26.44.260 Family Assessment Response.

Collateral Contacts

The Committee found that there were missed opportunities for additional collaterals by the FAR worker including contacting the referrer, the Primary Care Physician, the Public Health Nurse who had previously engaged the family, and relatives. The Committee found what little information was gathered by the worker largely came from the mother's accounts, without significant probing or seeking corroboration. This was particularly evident in the lack of information sought by CA workers regarding the mother's mental health situation.

Lack of Adequate Collaboration

Although brief phone contact was made by the worker with the community agency that had been providing parent education services to the family since July 2014, requesting records from that agency would have been helpful for assessment purposes, particularly in improving the accuracy of the SDM®. The records obtained post-fatality from the community agency revealed numerous documented indicators of possible parental ambivalence on the part of child's mother.[10]

Recommendations

The Committee forwards no recommendation.

[9] Confirmation biases are effects in selective collection of evidence and information processing that explain how people search through available information, interpret that information, and hence reach conclusions. Studies of social judgment provide evidence that people tend to overweight positive confirmatory evidence or underweight negative disconfirmatory evidence.

[10] Parental ambivalence relates to the nurturing and affectionate aspects of a parent/child relationship. It is often identifiable by behavioral or verbal indicators that suggest contradictory attitudes toward the relationship, incompatible expectations and mixed emotions, and self-doubt regarding being able to handle a parent/caretaker role.