RCW 74.13.640

Washington State Department of Social & Health Services

CA Children's Administration

Child Fatality Review

M.J.

March 2010
Date of Child's Birth

August 25, 2012
Date of Child's Death

December 20, 2012
Child Fatality Review Date

Committee Members:
Pat Shaw, Public Health Nurse, Program Manager with Clark County Public Health
Connie Head, Family Educator, Children's Home Society (Vancouver)
David Raines, Social Work Supervisor, Children's Administration, Region 3 South (Centralia)

Co-Facilitator/Committee Member:
Daphne Morrison, MSW, Clinical Supervisor-Homebuilders, Institute for Family Development

Facilitator:
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Executive Summary
On December 20, 2012, 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 2-year-old M.J. and her family. On August 25, 2012 M.J. died while in the care of her mother in Mesa, Arizona. The child was found unresponsive in a trailer with no working air conditioning in 100+ degree weather. Prior to the family moving to Arizona, M.J. was alleged to be a victim of neglect by her mother in Vancouver, Washington (2011).

A CFR is required under RCW 74.13.640(1)(a) because the child and her family received services by the department within a year of her death from alleged abuse or neglect. The CFR Committee was comprised of CA staff and community members with pertinent expertise from a variety of fields and systems, including public health nursing, parenting education, clinical social work, and child advocacy. None of the committee members had any previous direct involvement with the family. The Office of Family and Children's Ombudsman was invited to participate but was unable to attend.

Prior to the review each committee member received (1) a chronology of CA involvement with the family, (2) un-redacted case file documents relating to the CPS investigation in 2011, and (3) various Arizona media reports regarding the death of M.J.

During the course of the review the CA supervisor and social worker involved in the Washington state investigation in 2011 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 which are presented at the end of this report. There were no recommendations regarding policy, practice or service delivery.

Case Overview
The family first came to the attention of the Children's Administration in October 2011 when CPS investigated allegations of child maltreatment in the home made by a family acquaintance. The reported concerns included poor hygiene, inappropriate discipline, and leaving M.J. in a playpen for excessive amounts of time. Following an unannounced home visit, contact with the alleged victims and subject, contact with other residents of the home, a child safety assessment, and information provided by the child's primary

[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.

care physician, the allegations were determined to be unfounded[2] and the investigation was closed in November 2011.

At some unknown time after the Washington state CPS case closed, the family moved to Mesa, Arizona where on August 25, 2012 the mother called 911 to report her daughter unresponsive. When emergency responders arrived to the home they were unable to revive M.J. who was pronounced dead at the scene. The temperature in the trailer reportedly exceeded 100 degrees Fahrenheit. The mother told local police that the air conditioning unit had broken days before.

Responding officers initially found no evidence of physical abuse but both children in the home appeared malnourished and dehydrated and the mother was later arrested for child abuse based on the physical condition of the surviving child. At the time of the CFR no charging decisions had been made by the Maricopa County Attorney's Office regarding the death of M.J. as autopsy results were still pending.

Committee Discussion

Committee members reviewed and discussed the documented CA activities and decisions from the intake dated October 20, 2011 through case closure in November 2011. In an effort to evaluate the reasonableness of decisions made and actions taken by the department, the committee considered Washington law, CA policy, practice and system response, CA case documentation, and interview responses from CA staff that occurred during the review. No critical errors or significant practice issues were identified. Actions taken and decisions made appear to have been reasonable based on the information available at time of investigation.

The committee also reviewed and discussed numerous Arizona news articles that contained reported statements made by the mother and others after the fatality incident. These accounts suggest long term parental ambivalence[3] and depression that may have been active but undiscovered at the time of the CPS investigation in the state of Washington. While the committee acknowledged that such information retrospectively provided insight as to the nature of the parent-child relationship, the committee was unable to identify any clear failure on the part of the Vancouver CPS worker to uncover evidence of child safety issues or neglect.

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[2] "Unfounded" is defined as "the determination following an investigation by the department that available information indicates that, more likely than not, child abuse or neglect did not occur, or that there is insufficient evidence for the department to determine whether the alleged child abuse did or did not occur." RCW 26.44.020(24). "Founded" is defined as "the determination following an investigation by the Department that, based on available information, it is more likely than not that child abuse or neglect did occur." RCW 26.44.020(9).

[3] 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.

Findings

While the committee found that there were no apparent critical errors in terms of decisions and actions taken during the CPS investigation in 2011, the committee did find instances where additional social work activity may have been considered. However, the absence of these additional activities was found to have no reasonably discernible connection to the child's death. Thus the identified issues below serve as noted opportunities where improved practice may have been beneficial to the assessment of the family situation but were not found to be critical oversights that could have prevented the child fatality nearly a year later.

- The worker did not make contact with the referrer. Given the discrepancies between the referrer's and the parent's accounts regarding parenting practices, such additional inquiry with the referrer might have proven beneficial.
- When interviewed the CPS worker indicated that despite the mother's responses on the GAIN-SS[4] that indicated no depression, the worker suspected parental depression. The worker might have offered suggestions for local mental health or and/or counseling resources given her suspicions.

Recommendations

Upon review and discussion, the Child Fatality Review Committee forwards no recommendations.

Nondiscrimination Policy

The Department of Social and Health Services does not discriminate and provides equal access to its programs and services for all persons without regard to race, color, gender, religion, creed, marital status, national origin, sexual orientation, age, veteran's status or the presence of any physical, sensory or mental disability.

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[4] RCW 71.05.027 requires all DSHS Administrations to use the same screening tool for substance abuse, mental health and co-occurring disorders. The Global Assessment of Individual Needs – Short Screen (GAIN-SS) version 2.0.1 is the identified tool. The GAIN-SS is a screening tool to identify a need for further assessment to be completed by a community professional. The GAIN-SS does not identify service needs. The goal of the screen is to increase the number of people accurately identified as needing a mental health, substance abuse or co-occurring disorder assessment.