Children's Administration

Child Fatality Review

A.S.

September 2004
Date of Child's Birth

January 30, 2012
Date of Child's Death

June 27, 2012
Child Fatality Review Date

Committee Members:
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Mary Anne Boyce, R.N., Public Health Nurse Early Intervention Program, Snohomish Health District
Renea Wardlaw, Detective, Everett Police Department
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Executive Summary

On June 27, 2012, Children's Administration (CA) convened a Child Fatality Review[1] (CFR) to review the Department's practice and service delivery to a 7-year-old boy, A.S., and his family prior to the death of the child on January 30, 2012. On the day of his death, the child's father brought the deceased A.S. to a hospital. The cause of death was not known at that time, and believed to be related to the child's medical conditions. The Snohomish County Medical Examiner later determined that the child died as the result of salicylate[2] overdose, with the manner of death then ruled "accidental, homicide, or undetermined." The family did not have an open case with Children's Administration at the time of the child's death, but ten months earlier, in February 2011, dependency actions on both A.S. and his older sibling were dismissed by the Snohomish County Juvenile Court.

The CFR Committee included CA staff and community members selected from diverse disciplines with relevant expertise, including representatives from the law enforcement, parenting instruction, social work, developmental disabilities, and public health. Committee members had no previous direct involvement with the case, although most were aware of the fatality incident through various media reports. Prior to the review each Committee member received a summarized chronology of CA's involvement with the family, relevant case file materials (intakes, case notes, safety and risk assessments, CPS investigative reports) and service exit summaries.

Additional sources of information and resource materials were available to the Committee at the time of the review. These included (1) additional case-related documents such as medical and developmental screening records, legal documents relating to the prior dependency action, case staffing/shared planning meeting documents, and various reports regarding the parents, (2) CA practice guides relating to Child Protective Services (CPS) investigations and assessment of risk and safety, (3) copies of state laws and CA policies relevant to the review. CA staff involved with the case were made available for interviews by the Committee, but were not called.

Following review of the case file documents and discussion regarding Department activities and decisions, the Committee made findings which are detailed 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 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 deceased child's life or death. 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] Salicylates can be found in numerous prescription medications, hundreds of over-the-counter medications including aspirin, and many topical products containing methyl salicylate (oil of wintergreen) which are highly toxic when ingested by young children.

Case Overview RCW 74.13.505

In early 2008 CPS was contacted with allegations of neglect – that the parents were failing to provide supervision sufficient to meet the needs of the two developmentally disabled children in the home. The allegations were not substantiated by the CPS investigation. Although the risk assessment completed on the family indicated moderate high risk, the family declined services, and the case was closed in June of 2008.

No further reports were received until March 2010 when law enforcement contacted CPS requesting placement for A.S. and his sibling due to gross neglect. The condition of the family home was found to be uninhabitable, posing a significant health risk to the two special needs children. The Department initiated dependency actions on both children based on the neglect. The parents remediated the condition of the home and in June the children were court ordered to return home, but remained in the legal custody of the Department. The parents completed numerous services, made additional progress in improving safety, and successfully completed Family Preservation Services (FPS). The dependency was dismissed in February 2011 and the case was closed.

Ten months later on January 30, 2012, 7-year-old A.S. died. A CPS investigation was initiated in collaboration with local law enforcement. The cause and manner of death initially was thought to be related to medical issues and the county Medical Examiner (ME) concluded that the circumstances of the death did not warrant a full autopsy. Shortly after cremation, toxicology results revealed that A.S. died as a result of a salicylate overdose. The manner of death was then ruled "accidental, homicide, or undetermined" by the county ME. It is unknown as to how the child came to have a lethal dose of salicylate in his system, and no criminal charges have been filed. The CPS investigation resulted in a finding of "founded for neglect" as to both parents in the death of their son. The Department filed a dependency action on the older sibling and the child was placed in CA custody; the sibling is placed in relative foster care.

Committee Discussion:

Committee members reviewed and discussed the documented CA activities and decisions from the early involvement (2006-2008) to the more recent pre-fatality involvement (2010-2011) with the family. Review of the post-fatality social work activities was limited primarily to the CPS fatality investigation. Committee discussions focused on CA policy, practice, and system

[5] The names of the parents are not being used in this report as neither has been charged in connection to the fatality incident.

response to the family in an effort to evaluate the reasonableness of decisions made and actions taken by CA. Actions taken by non-CA agencies were briefly discussed, but considered outside the scope of this review in terms of generating any findings or recommendations.

No significant CA policy issues were identified during the Committee discussions. In terms of demonstrated practice, the social work generally appeared to be of good quality and was well documented during the 2010-2011 involvement with the family. The Committee found no critical errors, and all substantive decisions made and actions taken during CA involvement appeared to be reasonable and supportable. However, the Committee found instances where additional actions could have been considered. These noted opportunities for improved practice are detailed below.

Findings:

Earlier involvement with CA (2006-2008)

- The Committee found a possibility that the earlier CPS investigation results, assessments, family engagement activities, and case closure decisions may have been influenced by worker bias. The parents were described as cooperative, educated, employed, and as presenting well. The Committee found that workers may have viewed the parents as more capable of meeting the needs of their two severely developmentally disabled children than was actually the case. This might explain how the risk assessments completed in 2006-2007 appeared to underestimate risk and overestimate family strengths. A more accurate assessment (moderate high risk) was completed in 2008 using the newly implemented Structured Decision Making[4] (SDM).
- The engagement with the family in 2006 to 2008 appears to have been somewhat limited. This may be because the social workers believed the parents were capable of meeting the children's needs, as noted above. The Committee found several windows of opportunity where workers might have been more proactive, if not more assertive, with the parents in connecting the family with services. These might have included referrals to Infant Toddler Early Intervention Program (Birth to Three), Children with Special Health Care Needs, Public Health for Nursing Child Assessment Satellite Training (NCAST), and/or Project SafeCare. Whether these services would have been accepted by the parents or how they might have impacted the family is unknown. The Committee believed that the family likely would have benefited from more active engagement strategies from CA.

CA services 2010-2011

- Less than three months after being removed from his parents' care due to the uninhabitable conditions of the home, A.S. was court ordered to return home. While the condition of the family residence may have been remediated, the Committee questioned whether there had been sufficient time to assess the capacity of the parents to sustain intensive supervision and safety. A more gradual transition process may have been

[4] 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.

helpful in providing time for in-home observations to evaluate parenting prior to a full return home. A court transcript was not available for review by the Committee, so the basis of the return home decision is not clear. However, CA case documents show that the case worker neither expected nor supported the court's decision to return home of the children in June 2010. Many services (e.g., psychological evaluations/parenting assessments, reunification assessment, multi-discipline team staffing) normally completed before transitioning a child home occurred well after the children were returned.

- The Committee found the Department's support to dismiss the dependency in February 2011 to be reasonable given the demonstrated progress made by the family. However, given reported concerns by the child's guardian ad litem[5] shortly before the final court hearing, an alternative reasonable option would have been to ask the court for a short delay in the dismissal of the dependency.

Recommendations:

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

[5] A GAL is an individual appointed by the court to represent the best interests of a child. See RCW 13.34.