

Child Fatality Review #08-53
Region 5
Pierce County

This 13-year-old African American male committed suicide.

Case Overview

On September 18, 2008, this 13-year-old youth fatally shot himself in the head with his father's pistol. The incident occurred at the family residence and family members were home at the time of the incident. Family members called 911. Emergency medics and law enforcement went to the home and transported the youth to a local hospital emergency room. He was resuscitated several times. Ultimately he was declared dead. The gun used was reportedly stored separately from the bullets. The family could describe no behavioral indicators of suicide or any precipitating event that would indicate their son intended to harm himself. The child did not leave a suicide note. The death was declared a suicide by the Pierce County Medical Examiner.

Referral History

On April 9, 2002, staff at a local hospital called CPS intake to report a gunshot wound to the ear of the then three-year-old sister of the deceased youth. Law enforcement responded to the report of an accidental gun shot wound. The father had purchased two guns out of concern for possible assault of his wife and children. He told police he purchased the guns for protection. The deceased youth's mother kept her .22 caliber gun in her pocket. When she returned from the store she put her jacket, with the gun in the pocket, on the back of a chair. She left the room and shortly thereafter, heard a gunshot. She found her daughter with a gunshot wound to her ear. Law enforcement described the mother as distraught about the injury to her daughter. Law enforcement said the child's injury was not life threatening. She was sent to a local hospital for reconstructive surgery of her ear. The child was not placed in protective custody. This referral was screened in for investigation and closed with a founded finding for negligent treatment or maltreatment.

On July 15, 2008, a juvenile probation officer reported to CPS intake that the deceased youth reported a typical form of punishment in his home was to be hit in the stomach. He added that he is hit hard enough to double over. The deceased youth said he expected to be hit for misbehaving. The child had no visible injuries. The father denied hitting his son. The family was offered Family Reconciliation Services (FRS), but declined the service. This referral was screened in for investigation and closed with an unfounded finding for physical abuse.

On November 24, 2008, law enforcement contacted CPS intake to report the suicide of this 13-year-old youth by a self-inflicted gunshot wound. Law enforcement reported this incident occurred on September 18, 2008. Law enforcement reported no concerns about abuse or neglect based on their investigation of the incident. This referral was screened out for investigation.

Issues and Recommendations

Issue: Intake referrals dated April 9, 2002 and July 15, 2008: The report to CPS in 2002 regarding a three-year-old girl being seen at a local emergency room for a non-life threatening accidental gunshot wound to the ear was initially designated for CPS investigation (non-emergent response). Two days later the intake was "downgraded" by a CPS Supervisor and designated for alternative intervention and sent to the Alternative Response System (ARS), apparently based on the referent having referred to the incident as being accidental and on the fact that local law enforcement had already become involved. Four days later, upon further review and consensus building, the intake was re-screened for a CPS investigation. The original decision at intake appears to have been correct, as supported by the fact that the report was later re-screened for a high standard investigation. The delay in correct assignment caused a delay in contact with the alleged child and her parents. However, contact with victim was still within 10 working days of the date of the referral which was CA policy at the time. Policy regarding face-to-face contact with alleged victims was revised in April 2005 and now requires such contact to be within 24 hours (for emergent response intakes) or 72 hours (non-emergent response intakes).

The physical abuse intake six years later (July 2008) was screened in for investigation. The review panel agreed with the intake decision for assignment to CPS for investigation based on the child's statement to a mandated reporter of having been punched in the stomach by his father.

Recommendation: None. Current Children's Administration policy and practice is less flexible than in 2002 as to the ability of CPS supervisors to "downgrade" intakes without shared decision making.

Issue: Investigation of the July 2008 referral [prior to fatality incident in September 2008]: Overall the CPS worker appears to have met basic practice expectations for conducting investigations. Timeframe requirements were generally met for both investigative activities and documentation. There were no significant deficits noted regarding practice. Minor practice deficits and noted areas for improved practice (e.g., best practice) were discussed during the child fatality review and are included below as documentation of the discussion.

Given that all children in the family were home schooled, interviewing options were limited. An attempted unannounced home visit was conducted within 24 hours of the intake. The family was not at home likely due to the mother having just given birth. The worker was not able to make another attempt within the 72 hour policy requirements, and an extension for face-to-face contact was granted. The CPS investigator was able to contact the father by phone and address the allegations. This occurred several days before interviewing the child. Normally best practice is to interview the alleged victim before or soon after interviewing subjects/caretakers when possible.

The CPS investigator interviewed the alleged victim at the family home. The social worker's documentation did not indicate if the interview was conducted outside the

purview of the parents. However, during the child fatality review, the worker recalled that she had interviewed the boy privately at the home. While the Global Appraisal of Individual Needs-Short Screener (GAIN-SS) was available to use with the deceased youth there were no indications of substance abuse or mental health issues which might have suggested the need to administer the GAIN screening tool to the child. It is unknown as to how the youth would have answered questions regarding mental health or suicidal ideation at that time.

The CPS investigator was in process of interviewing the deceased youth's mother (outside the presence of the husband), when the youth's father interrupted the interview. It is unknown if the interruption was unintended or intended. The worker was not able to specifically address with the mother the concerns about her husband's alleged physical abuse to their son, although the mother did speak to her concerns about her son and his running away.

The worker did not conduct any sibling interviews. While policy only requires interviews be conducted with identified victims, best practice suggests that, where possible, interviews of siblings also occur. There were several siblings in the home (ages 7, 10, 14) who might have been interviewed regarding the allegations of physical abuse to their brother.

Although the previous CPS involvement (2002) involved a firearm injury to a child in the family, the worker did not inquire as to the current (2008) status of any guns in the home. In a pre-review interview the worker admitted that such inquiry had not crossed her mind during her investigation. The panel was divided as to whether or not it would be reasonably expected for the worker to have inquired as to guns currently in the home, given that the prior gun incident occurred six years prior. It was noted that information gathered by law enforcement during its fatality investigation in September 2008 indicated that the parents had attempted reasonable safe firearm storage in the home prior to their son's suicide and there was no evidence of usual behavioral indicators of suicidal ideation.

When interviewed during the child fatality review, the CPS worker indicated that there were cultural, religious, and family values issues that appeared to create barriers to routine investigative process. This included indicators of patriarchal control in the family, isolation of the family (no relatives in the area, minimal neighborhood/community involvement, home schooled children), and limited services available to the family which would accommodate the family's religious beliefs.

Recommendation: None.

Action Taken: Pierce East Area Administrator will attempt to schedule for summer 2009 training similar to the "CPS Summer Series Training" held in Region 5 in 2008. The training will function as both a re-fresher for veteran workers and new training for inexperienced workers. Topics would include practice considerations for conducting CPS investigations, serious injuries and child abuse, and interviewing subjects.

Action Taken: The CPS supervisor participated in the child fatality review and acknowledged areas in the worker's practice that could be improved. The CPS supervisor will discuss with the CPS investigator, as part of normal clinical supervision, strategies and resources available for dealing with cultural and religious issues that may present barriers to fulfilling investigative expectations.

Action Taken: The worker participated in the review process, and received feedback regarding good practice as well as areas where practice could be improved.