Report to the Legislature

Quarterly Child Fatality Report

RCW 74.13.640

October - December 2009

Department of Social & Health Services
Children's Administration
PO Box 45040
Olympia, WA 98504-5040
(360) 902-7821
FAX: (360) 902-7848

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Children's Administration Quarterly Child Fatality Report

Executive Summary

This is the Quarterly Child Fatality Report for October through December 2009 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) The department of social and health services shall conduct a child fatality review in the event of an unexpected death of a minor in the state who is in the care of or receiving services described in chapter 74.13 RCW from the department or who has been in the care of or received services described in chapter 74.13 RCW from the department within one year preceding the minor's death.*
>
> *(2) Upon conclusion of a child fatality review required pursuant to subsection (1) of 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. Reports shall be distributed to the appropriate committees of the legislature, and the department shall create a public web site where all child fatality review reports required under this section shall be posted and maintained.*
>
> *(3) The department shall develop and implement procedures to carry out the requirements of subsections (1) and (2) of this section.*

This report summarizes information from 10 completed fatality reviews of fatalities that occurred in 2009. All were reviewed by a regional Child Fatality Review Team.

There was one Executive Child Fatality Review completed during the fourth quarter of 2009. All prior Executive Child Fatality Review reports are found on the DSHS website: http://www.dshs.wa.gov/ca/pubs/fatalityreports.asp.

The reviews in this quarterly report include fatalities from five of the six regions.

Region	Number of Reports
1	2
2	1
3	4
4	2
5	0
6	1
Total Fatalities Reviewed During 4th Quarter, 2009	10

Child Fatality Reviews are conducted when children die unexpectedly and their families had an open case or received services from the Children's Administration (CA) within 12 months of their death. Child Fatality Reviews consist 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 the identified issues. A review team can be as few as two individuals (in cases where the death is clearly accidental in nature), to a larger multi-disciplinary committee where the child's death may have been the result of abuse and/or neglect by a parent or guardian.

Executive Child Fatality Reviews (ECFR) have been conducted in cases where the child fatality is the result of apparent child abuse and neglect and CA had an open, active case at the time of the child's death. In the Executive Child Fatality Review, members of the review committee are individuals who have not had any involvement in the case and represent areas of expertise that are pertinent to the case. The review committee members may include legislators or representatives from the Office of the Family and Children's Ombudsman.

In June 2008, legislation passed (2SHB 6206) that expands the use of the Executive Child Fatality Review format to include this type of review for any child fatality that is the result of apparent abuse or neglect by the child's parent or caregiver and the child was in the care of the state or received any level of service in the previous year. Previously this type of review was conducted only on cases where the child died of abuse or neglect and the department had an open, active case at the time of the child's death.

The chart on the following page provides the number of fatalities reported to CA, and the number of reviews completed and pending for calendar year 2009. The number of pending reviews is subject to change if CA learns new information through reviewing the case. For example, CA may learn that the 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 2009			
Year	Total Fatalities Reported to Date Requiring a Review	Completed Fatality Reviews	Pending Fatality Reviews
2009	59	31	28

The numbering of the Child Fatality Reviews in this report begins with number 09-22. This indicates the fatality occurred in 2009 and is the twenty-second report completed during that calendar year. The number is assigned when the Child Fatality Review and report by the Child Protective Services Program Manager is completed.

The reviews contained in these Quarterly Child Fatality Reports are a summary of the actual report submitted by each region. These reports contain more detail and confidential identifying information that is not subject to disclosure.

Child Fatality Review #09-22
Region 1
Stevens County

This 16-year-old Hispanic male died from positional asphyxiation.

Case Overview
On the evening of May 2, 2009, this 16-year-old youth was out with friends. He was drinking alcohol and slept in a vehicle parked in front of a residence, along with a friend. On the morning of May 3, 2009 he was found deceased in the vehicle. He had vomited in the car. The Stevens County Coroner reported the youth died of positional asphyxiation due to intoxication. His blood alcohol level was .34 at autopsy.

The department did not have an open case on this family at the time of this youth's death. The department provided Family Reconciliation Services to the family and closed the case nine months prior to his death.

Referral History
On June 12, 2006 a DSHS employee reported to Child Protective Services (CPS) intake that the deceased youth's mother left her two-month-old infant and 11-year-old daughter in a vehicle with the motor running. The DSHS employee did not know how long the children were in the car. Upon investigation it was confirmed that the children were in the vehicle while the mother walked the deceased youth, then 14 years old, into a health clinic. The investigation was closed with unfounded findings of neglect.

On April 14, 2008, the deceased youth's mother called CPS intake requesting Family Reconciliation Services (FRS) for the deceased youth, then age 16, and her 12-year-old daughter. The deceased youth had refused to go to school and during an altercation with his mother he pushed her down leading to his arrest for assault. The deceased youth spent a night at a juvenile detention facility. The daughter was also missing school, and the mother sought assistance.

Due to the assault of his mother, the deceased youth was required to participate with the Juvenile Diversion program in Stevens County. He fulfilled the required 10 hours, eight of which was individual counseling and additional assessment time. He also completed a community service project and all involved believed that the deceased youth had reconciled his issues by the conclusion of his counseling sessions.

FRS services were offered to the family at the same time the deceased youth was participating in Diversion. The FRS social worker followed all requirements including the Global Appraisal of Individual Needs - Short Screener (GAIN-SS) for both teens and their mother. Phase two counseling began and after 1.5 hours of direct contact between the

family and the FRS provider, the case was closed by mutual consent. The FRS case was closed in July 2008.

Issues and Recommendations
Issue: The review committee did not identify any issues or recommendations regarding this case.

Recommendation: None

Child Fatality Review #09-23
Region 4
King County

This 16-year-old Caucasian female committed suicide.

Case Overview
On April 20, 2009, this 16-year-old youth was found dead in her bed at her family home. She was found by her mother in her basement bedroom around 10:00 p.m. The estimated time of death was around 3:00 a.m. She was last seen alive at about 10:00 p.m. on April 19, 2009 when she returned home and told her mother she was going to bed.

The mother left for work very early the next day and returned home about 5:30 p.m. She and the younger siblings thought the deceased youth was not home. At around 10:00 p.m. a friend of the deceased youth came to the home to show the mother a copy of the deceased youth's blog on My Space, which read, "This is my last blog. I'm sorry. I thought about this for 7 years. I shall remain 17 forever. But I love you guys okay. Bye."

The mother then checked her daughter's room and found her unresponsive and cool to the touch. King County Medical Examiner investigators found several very explicit notes written by the youth clearly stating her intention to commit suicide. They also found a Ziploc bag of miscellaneous pills (imipramine, ibuprofen, and acetaminophen).

The autopsy determined that the cause of death was a drug overdose. The manner of death is suicide. It was also noted that she had numerous scarring marks on her arms consistent with self-cutting.

The department did not have an open case on the family at the time of the youth's death. An intake screened for the Alternate Response System (ARS) was made to Child Protective Services (CPS) intake four months prior to the youth's death.

Referral History
On January 25, 2005, a relative called CPS intake alleging the deceased youth's mother was supposed to be home schooling her, but the child was receiving no school at all. The referrer cited similar concerns regarding the three other children in the home. This intake was screened for Alternate Response System. The matter was sent to a contracted ARS provider in Pierce County and later closed in March 2005.

On April 28, 2006, an acquaintance of the family called to report a statement made to her by the deceased youth's mother concerning possible sexual touching of the deceased youth's younger sister, then age six, by her father. There was a coordinated investigation that involved law enforcement, the Pierce County Child Advocacy Center, and CPS. This

intake was accepted for investigation of sexual abuse. There was no evidence found that the father abused the child, and the investigation was closed with an unfounded finding.

On January 30, 2008, a relative called CPS intake and reported the deceased youth's stepfather filed for divorce, and the mother was neglecting the medical needs of the children. The referrer cited a recent visit with the children. The children were sick with colds, and the mother did not provide any medication. The referrer also complained that the deceased youth used physical discipline when she cared for her younger siblings and the mother did not use booster seats for them when she drives. This intake was screened as Information Only.

On March 26, 2008, a social worker who was helping the parents through their divorce reported to CPS intake that the mother accused the deceased youth's stepfather of bruising their younger daughter's leg. She also accused him of observing the deceased youth while showering and exposing himself to her. The deceased youth's stepfather accused her mother of bruising the younger daughter's hands and striking the children with a metal spoon or wooden paddle. During the investigation, the deceased youth confirmed she made statements about wanting to commit suicide. However, she said it was more a sense of being overwhelmed and that she had people at school and church to talk to. This intake was accepted for investigation of physical abuse and sexual abuse. This investigation was closed with an unfounded finding.

On November 26, 2008, a social worker made a report to CPS intake after speaking with the deceased youth's nine-year-old sister and eight-year-old brother. They each made statements about the sister being bruised by the parents in separate incidents. The screening decision was initially Information Only, but based on the family history, it was screened in for investigation. This report was assigned to the contracted Early Family Support Services (EFSS) program. The exit summary received from the contractor stated that the family declined to participate in services. The mother and children were interviewed in the home. The mother explained the on-going family court issues and said they were working with the family court services social worker. The intake was screened for ARS.

On January 8, 2009, the deceased youth's mother called CPS intake to request Family Preservation Services (FPS). This is a contracted service, and the threshold for eligibility is that the children must be at substantial risk for out-of-home placement absent the service. The assigned worker attempted several times to reach the mother, without success. The worker was informed about the family's recent decision to decline services. She informed the family court worker that she was unable to reach the mother. The intake was accepted for Child Welfare Services.

On January 9, 2009, a relative reported to CPS the parents were in a custody dispute and the father received court documentation revealing a long history of abuse of their children by the mother. Most of the allegations were previously reported, except that the referrer also reported the mother had threatened to kill herself and the children in the past. She said she was going to kill them all and would swerve toward the cliffs while she was driving. The intake was screened for ARS. The ARS social worker made several attempts to contact the mother without success.

On April 21, 2009, CPS intake received notification of the death of this 16-year-old. The Medical Examiner reported the initial cause of death was a drug overdose. The intake was screened for ARS.

Issues and Recommendations
Issue: The deceased child had ten years of exposure to Domestic Violence (DV) and her three surviving siblings have experienced it their entire lives. Witnessing Domestic Violence is a known Adverse Childhood Experience (ACE) that increases the risk of teen suicide.

Recommendation: Communities should increase the capacity of mental health services to address the treatment needs of children who witness DV. In King County, Seattle Mental Health has received grant funds to increase services to this population.

Issue: The social worker assigned to the March 26, 2008 intake did a thorough job of documenting his contacts with the family and collateral professionals. Through his efforts, Children's Administration received a lengthy DV Assessment from the King County Family Court that provided a great deal of information about the batterer's pattern of abuse and the effects on the victim. He was careful to consult before contacting the batterer about the CPS investigation. His interview with the now deceased child revealed that she did have protective factors at that time and that her suicide was not imminent.

Recommendation: Reinforce the need for social workers to obtain collateral information when DV is an issue.

Issue: Children's Administration social workers should receive specific training on assessing teens for the risk of suicide, as well as other mental health crises.

Recommendation: The Program Manager and the Area Administrator will look for training resources that could be offered at no cost to the agency.

Child Fatality Review #09-24
Region 3
Snohomish County

This five-year-old Caucasian male died in a car accident.

Case Overview
On May 11, 2009, this five-year-old child was killed instantly when the car driven by his stepfather veered off the road and struck a tree. He was in the middle of the back seat riding in a booster seat restrained by a lap belt. When the impact happened, his head went forward and into the console in front of him, killing him almost instantly. His younger sister and stepfather survived with minimal injuries. The law enforcement investigation showed drugs or alcohol were not factors in this accident. The intake was assigned for contact with the family to assess their need for services at that time, but the family declined to be involved.

Children's Administration did not have an open case on this child or his family at the time of his death.

Intake History
On March 27, 2005, a report was made to Child Protective Services (CPS) intake alleging the deceased child's mother was a methamphetamine user and possibly a dealer. The caller stated that the mother had two small children, the deceased child, then age one, and his three-year-old sister. The referrer reported that the mother was extremely paranoid and her judgment was impaired by drug use. Her drug use also affected her care of the children.

The referrer said the mother was "paranoid" about germs and believed there were germs in the bathtub, so she bathed her children with baby wipes. The referrer said the children were very dirty and fearful of taking a bath.

It was further alleged that the mother put surveillance cameras on her doors and she pinched her daughter as discipline. The mother would leave the deceased child in his crib for hours at a time. This intake was screened in for investigation by CPS. The assigned worker engaged the mother in services to address her drug use and mental health issues. Intensive home based services were put in the home. The mother's commitment to these services wavered at times, but she eventually completed services and the case was closed. The CPS investigation was closed with an inconclusive finding.

On January 9, 2009, a former neighbor called CPS intake to report this family lived in a well-known drug-dealing house in Snohomish County. The caller believed that the deceased child's mother and stepfather were dealing drugs. The referrer reported she was aware of some domestic violence incidents between them a year prior. This intake was screened as Information Only.

Issues and Recommendations

Issue: In the January 9, 2009 intake, there were allegations of drug use by the parents, but there was no specific information documented about how that use was impacting the children. It was not clear whether that question was asked of the referrer.

Recommendation: The team believed that the best practice for intake staff in documenting a concern of parental drug use may be to document whether the question of the caller's perception of impact to the children had been asked. The team recommends that this topic be explored at the Region 3 Intake specialists' meeting.

Issue: In reviewing motor vehicle regulations for restraint of children of varying ages, this team agreed that the proper use and placement of the various restraint devices for children of varying ages and developmental levels is complicated. The team was unsure if all social workers in the office were completely conversant with best practice in the use of restraints.

Recommendation: The management of the Sky Valley office wishes to take this opportunity to raise awareness of best practice in the use of child restraints. The team recommends that the Sky Valley office proceed with plans by their Area Administrator to hold training for staff in the proper use and placement of restraint devices for all ages, and incorporate a segment on child safety restraint training in a parenting class scheduled to start soon in the Sky Valley office.

Child Fatality Review #09-25
Region 3
Snohomish County

This 15-year-old Caucasian female was hit by a vehicle and died.

Case Overview
On June 1, 2009, this youth's body was found along a trestle on U.S. Highway 2. She was walking along the highway late at night on May 30, 2009 when she was struck by a vehicle. The still-unidentified driver fled the scene. The law enforcement investigation is ongoing.

Children's Administration did not have an open case on this youth or her family at the time of her death.

Intake History
On March 15, 2001, school staff reported to Child Protective Services (CPS) intake that the deceased youth, then age 6, and her 10-year-old brother were left alone. The deceased child's father was reportedly out of the country. The person who stayed with the children did not properly supervise or care for them. The children appeared to be caring for themselves. This intake was screened in for investigation and closed with an inconclusive finding for negligent treatment or maltreatment.

On March 24, 2001, a neighbor reported to CPS intake that the deceased youth, then seven years old, was seen alone riding her scooter along a very busy street a half mile from her home. The referrer took the child home and talked to her 10-year-old brother who said he could not control her. Their father was at work. The father told the CPS investigator that he would look into childcare or get a live-in nanny to watch his daughter. This intake was screened in for investigation and closed with an inconclusive finding for negligent treatment or maltreatment.

On September 24, 2004, the deceased child's father contacted CPS intake to request assistance in filing an At-Risk Youth petition on his 15-year-old son. He reported that the boy was stealing, committing acts of vandalism, skipping school, and being rebellious at home, particularly with his stepmother. This intake was accepted for Family Reconciliation Services (FRS).

On March 24, 2006, school staff reported to CPS intake that the deceased youth, then age 12, disclosed ongoing physical altercations with her stepmother that had been going on for the previous four years. The counselor said there had been numerous neglect concerns since the family arrived in the district from another state several years prior. This intake was accepted for Family Reconciliation Services (FRS).

On June 30, 2006, law enforcement reported to CPS intake that the deceased youth, then age 12, was physically assaulted by her stepmother, who was attempting to discipline the child. This intake was screened in for investigation and closed with an inconclusive finding for negligent treatment or maltreatment.

On December 7, 2006, law enforcement reported to CPS intake that the deceased youth's father was hospitalized after attempting to kill himself. The older children, ages 16 and 18, were left in the home and the deceased youth, age 12, was left in the care of a neighbor until family members arrived. This intake was screened in for investigation and closed with an inconclusive finding for negligent treatment or maltreatment.

On January 19, 2007, school staff reported to CPS intake that the deceased youth's two older brothers, ages 16 and 18, were both involved in petty criminal activity that included weapons and violence. The referrer believes there is a lack of supervision in the home. This intake was screened as Information Only.

On January 26, 2007, a relative reported to CPS intake that the deceased youth's stepmother filed physical abuse charges against her father, and her father starting hitting his daughter. She also reported that once her stepmother stepped on her chest so hard that she had a hard time breathing. The youth gave no timeframe on this occurrence and there was no report of injuries. This intake was screened as Information Only.

On March 19, 2007, the deceased youth's father called CPS intake to request assistance with filing At-Risk Youth (ARY) petitions for his son and daughter (the deceased youth). This intake was accepted for Family Reconciliation Services (FRS). The deceased youth's father reported his 17-year-old son was out of control, had a long criminal history, and had been expelled from more than one high school. He reported the deceased youth, then 13 years old, had recently attempted suicide by taking caffeine pills. The children's stepmother had returned to the home. He said both had difficulties with their stepmother. He later filed the ARY petition only on his son. Counseling services were provided in the home.

On May 31, 2007, the deceased youth's father called CPS intake to request assistance in filing an ARY petition on the deceased youth due to her rebelliousness and risky behaviors. This intake was accepted for Family Reconciliation Services (FRS). The father reported his daughter was sneaking out of the house and associating with drug users. More intensive in-home counseling was provided and the whole family initially engaged, but after a couple of weeks discontinued the counseling as the stepmother moved out again. The social worker sent a closing letter with a list of resources for the family.

On September 8, 2007, staff at an Assault and Abuse Center called CPS intake and reported the deceased youth was treated at the center after she was raped by a 16-year-old

acquaintance. This incident was reported to law enforcement. This intake was screened out as Third Party.

On September 20, 2007, the deceased youth reported to school personnel that her father was drinking again and that he sometimes got violent when he was drinking. The youth reported he hit her older brothers in the past. This intake was screened out as Information Only.

On September 29, 2007, CPS intake received a report that the deceased youth was picked up after being on the run. She was placed in a Crisis Residential Center. This intake was screened out as Information Only.

On November 16, 2007, staff at a juvenile detention facility, where the deceased youth was being held as a runway, contacted CPS intake after the deceased youth reported her father slapped her face every time she returned home. She reported no injuries. This intake was screened out as Information Only.

On January 7, 2008, a former neighbor called CPS intake to report concerns about the living conditions in the home of the deceased youth and her brothers. The referrer stated mildew in both of the bathrooms and in the kitchen. The caller also believed the deceased youth was being physically abused by her father. The deceased youth told the referrer of an incident in which her father choked her. This intake was accepted for investigation by CPS. The investigation revealed the home to be in adequate condition. The deceased youth was in counseling at the time. The CPS investigation was closed with an unfounded finding.

On January 14, 2008, staff at a shelter for homeless and at-risk youth reported to CPS intake that the deceased youth said her father had recently slapped her in the face leaving a red mark that lasted for about thirty minutes. This intake was screened out as Information Only.

On May 5, 2008, CPS intake received in a report from law enforcement that the deceased youth was raped a week prior. She reported she was given a "date rape" drug at a friend's apartment. This intake was screened out as a Third Party intake.

On May 7, 2008, the deceased youth’s father called CPS intake asking for additional assistance because his daughter was in violation of an At-Risk Youth (ARY) petition. He believed she needed mental health counseling. The intake was screened as Information Only as family counseling was provided through other court action on the youth.

On July 25, 2008, Secure Crisis Residential Center (SCRC) staff contacted CPS intake to report the deceased youth was placed there by police after she had been picked up as a runaway. The intake was accepted for FRS.

On July 26, 2008, SCRC staff reported the deceased youth disclosed that a boyfriend had other people beat her up on two different occasions a month prior. He also threatened her life and her family. There were no specifics in the disclosure other than the name of the boyfriend. The intake was screened as Information Only.

On September 11, 2008, a report was made to CPS intake that the deceased youth was arrested for trespassing at a Snohomish County transit station and taken to the juvenile center. She was continuing to violate a trespassing notice ordering her to stay off of that property. While in jail, she made vague allegations of being abused at home. She did not give any specific information. The intake was screened as Information Only.

On September 17, 2008, a report was made to CPS intake that the deceased youth was incarcerated at a juvenile center for violation of criminal probation. She disclosed being slapped and choked by her father some time (unclear when) in the past. She asked to return home and showed no fear of her father. Multiple services were attempted including court structure and in-home services. A Children's Administration social worker made phone contact with her father who denied physical abuse allegations and stated he has tried everything but nothing worked. He said that he was finished with attempts to help his daughter as she refused to be helped. He declined the offer of any further services. The intake was screened as low risk and assigned to the Alternate Response System (ARS).

Issues and Recommendations

Issue: The team noted that in the investigation of the June 30, 2006 intake there was brief contact with the deceased youth on two occasions but no documentation of a comprehensive interview occurring with her prior to the social worker meeting with the family as a whole.

Recommendation: ACTION TAKEN: In June 2009, policy training in Region 3 was provided emphasizing the policy requirement that an investigative interview must occur outside the presence of siblings and parents.

Issue: On March 24, 2006, the deceased youth called from her school with the school counselor, asking for services. This was treated as a Family Reconciliation Services (FRS) referral. It was assigned the same day but there is no documentation in the file of contact made until May 11, 2006, when the worker noted that she had called back to the school.

Recommendation: ACTION TAKEN: This information was given to the worker's current supervisor. In early 2009, the FRS program was restructured, establishing more specific time frames for response to situations such as this.

Child Fatality Review #09-26
Region 6
Thurston County

This 13-year-old Caucasian female drowned.

Case Overview
On December 1, 2008, this youth was reported missing after not returning home from school. She was 12-years-old at the time of her disappearance. Thurston County Sheriff deputies responded to a call of a citizen hearing screaming and located a three ring binder on a bridge over a canal with a suicide note written by a 12-year-old. The deputy had contact with the youth's father. He said he took her to school on December 1, 2008 and she was to meet a friend after school. The father checked with friends and was unable to locate his daughter. The father advised the deputy that his daughter had some behavioral issues, had run away before, and had written about suicide.

On June 1, 2009, the body of this 13-year-old youth was found in a canal just outside the Yelm city limits. She was 12-years-old at the time of her disappearance. The Thurston County Sheriff's Office and Thurston County Coroner arrived after the body was found. The Coroner said her body had been in the water for an extended period of time and determined the youth drowned. An autopsy was held on June 4, 2009, and the manner of death is listed as undetermined.

Children's Administration did not have an open case with this family at the time of this youth's death.

Intake History
On September 3, 2002, a relative reported to Child Protective Services (CPS) intake that the deceased youth's brother, then three years old, would occasionally soil his pants. In response, the father and stepmother would wrap his soiled pants around his neck. The referrer reported the boy was very upset by this. This intake was screened in for the Alternate Response Services (ARS) and contact was made with the parents.

On July 19, 2005, a social service professional reported to CPS intake that the deceased youth, then nine years old, inappropriately touched a three-year-old cousin while visiting relatives in Oregon. The three-year-old was examined by a doctor. The medical exam revealed scratches to the inside of the labia near the vagina. This intake was screened out as Information Only as the incident occurred in Oregon and was investigated by social service agencies and law enforcement in Oregon.

On July 21, 2005, a social worker from the state of Oregon reported to CPS intake that the deceased youth, then nine years old, sexually assaulted a three-year-old cousin while visiting with relatives in Oregon. Doctors who examined the three-year-old reported her

injury was aggressive and bordered on sexual assault. When the deceased youth was questioned by relatives in Oregon, she said that she was touched sexually by her brother, but that the touching didn't happen as much anymore. The referrer said the youth's mother was not protective, and the father may not be aware that his daughter was back in Washington. The deceased youth was temporarily staying with her mother and her three-year-old brother.

The referrer reported the deceased youth's brothers, ages 11 and 6, live with their father. Oregon CPS recommended that the allegations of the deceased youth being sexually molested by her brother be investigated by CPS and that the deceased youth be assessed and treated. Oregon CPS also recommended that a safety and supervision plan be discussed with the parents. This intake was screened as Low Risk. Contact was made with the father and stepmother and safety planning was discussed.

On July 22, 2005, another intake was created on the incident originally reported on July 19, 2005. This intake was created because the deceased youth, then nine years old, also spent time at her mother's home. A three-year-old child also lived in the mother's home. The intake was screened in for investigation. The investigation was not completed as the assigned social worker was unable to locate the mother. The address provided to the intake worker was incorrect.

On December 13, 2005, the deceased youth's stepmother contacted CPS intake to report her 12-year-old daughter, the deceased youth's stepsister, had run away twice since September 2005 and would be gone for two to three days. She would reportedly go to her friend's house. This intake was accepted for Family Reconciliation Services (FRS).

On December 13, 2007, a mental health professional contacted CPS intake to report the 12-year-old stepsister of the deceased youth had a history of abdominal pain related to a traumatic event. This child implied that when she was six-years-old, she was sexually abused. The child reported "something sexual" happened with three individuals who were older than her. She reported the abuse did not include intercourse. The child was encouraged to see a therapist. The referrer reported there was no indication that it was a family member. This intake was screened out as a Third Party report.

On October 12, 2008, the deceased youth contacted CPS intake. She said she ran away from home on October 6, 2008. She said she ran from her father's home where she has been living for about one year. Prior to this she was living with her mother but moved in with her father because her stepfather tormented her.

The deceased youth stated she was physically abused by her biological brothers, ages 15 and nine. The deceased youth told intake she was afraid to go home as her father was unable to protect her. She told her father of the abusive treatment, and he told them to stop, but the abuse continued.

The deceased youth reported two months prior, her brothers tied her to a tree with duct tape. They also beat her with sticks. She said she had a broken nose and scars on her legs. She said she did not get medical attention. She reported her older brother would chase her and bash her head against a wall. Her brothers would pull her hair so hard she fell out of a chair. They also beat her with broomsticks on the back and stomach.

This intake was screened in for investigation. The local office later changed the screening decision to a Third Party report. The deceased youth was not living in the family home at the time of the intake. The youth was advised to consider filing a Child In Need of Services (CHINS) petition. This information was forwarded to law enforcement.

On October 16, 2008, the deceased youth's stepmother contacted CPS intake to request help with filing an At-Risk Youth (ARY) petition on her daughter. This child, the deceased youth's stepsister, reportedly used marijuana, opiates, and Ecstasy. She would be gone for a weekend without permission. She was defiant, stole her mother's property, and skipped school. Her school filed a truancy petition. This intake was accepted for Family Reconciliation Services (FRS). The stepmother reported she worked through the issues with her daughter and was no longer interested in FRS. FRS is a voluntary service. The case was closed.

On October 28, 2008, a probation officer reported to CPS intake that a 14-year-old boy raped the deceased youth, then 12 years old, in her father's unlocked motor home. The deceased youth reported this boy put handcuffs on her and then forced himself on her. The deceased youth shared this information with the referrer while they were discussing an At-Risk Youth petition. She also reported that two to three months prior she had sexual relations with a man who was 18 or 19 years of age. This intake was screened out as a Third Party report and forwarded to law enforcement.

On February 25, 2009, a relative reported that the deceased youth's father asked his son to do some chores, but the boy refused and went to his room. The father followed him to the room and punched the teen on his head two times. The father also punched a hole in a wall. The father suffered cuts on his fist from punching the teen and the wall. The referrer did not know if the teen suffered any injuries from this incident. The referrer also mentioned that the deceased youth, now 13 years old, had been missing since December. This intake was screened in for investigation and closed out as unfounded for physical abuse. The investigation revealed it was the boy's uncle, and not the father, who was the subject of the report.

Issues and Recommendations

Issue: The review team felt that the screening decisions on two intakes were inappropriately changed by the local office.

When reviewing the intakes received on this family, two intakes stood out for the review team. One intake dated July 21, 2005, alleged the deceased youth was molested by an older brother. This report came from the State of Oregon after they received an intake alleging the deceased youth sexually abused a younger cousin. It was unclear if the youth's father was aware of the alleged sexual abuse by her brother. The intake was originally screened in by Central Intake and sent to the local office. The intake worker made a call to the father's home, talked with the stepmother who was unaware of the allegation and asked what she needed to do. A safety plan was discussed. After this contact with the stepmother the intake was screened down to ARS. No contact was made with the father or the children.

The second intake dated October 12, 2008, called in by the deceased youth and the person with whom she was staying. The youth stated her brothers were abusive to her and her father was unable to protect her. She was afraid to go home. The intake was originally screened in by Central Intake and sent to the local office. Upon receipt of the intake in the local office, the intake supervisor reviewed it with the area administrator and made the decision to change the screening decision to Third Party and made a referral to law enforcement.

The review team felt that both of these intakes were appropriately screened when initially called into Central Intake.

Recommendation: With the transition to FamLink, intakes can no longer be screened down or out once completed by intake. The region has addressed the issue of screening decisions through quarterly consensus building meetings. In addition to consensus building, the region is moving forward with a plan to review the intake decisions in this office and all offices in the region. A review team, led by the deputy regional administrator, will conduct random reviews of intakes in offices throughout the region. This team will assess if intake screening decisions are appropriate. This plan will also emphasize the importance of assessing risk to teen populations.

Issue: The Global Appraisal of Individual Needs - Short Screener (GAIN-SS) was completed on the stepmother and her daughter by the FRS worker in October 2008. There was no documentation in the case file showing that a referral was made to the designated mental health professional or substance abuse provider. If there are two or more yes answers on the GAIN-SS, a referral is required.

Recommendation: On October 21, 2009, an all staff meeting was held in the Tumwater Division of Children and Family Services office. A plan was developed to streamline the process of referrals to mental health and substance abuse providers so that all the social workers are utilizing the same process of reporting.

If the client/parent or child (age 13 and older) produces a "yes" on two or more of the questions in the mental health or drug/alcohol domains and signs the form, the social

worker will call the community provider to process the referral with the client being present when the call is made. The social worker will then document the referral and enter a case note in FamLink.

All staff were asked to revisit the GAINS-SS policy to refresh themselves on the requirements.

Issue: The intake investigated in February 2009 showed that the Structured Decision Making (SDM) tool was completed at the close of the case rather than at the beginning of the case. The SDM is meant to guide decisions of whether to provide services and the intensity of those services to the family.

Recommendation: The social worker who investigated the case participated in the review and indicated that because the allegations turned out to be unfounded, he did not complete the SDM in the beginning of the case. The team reviewing the case reviewed the appropriate timelines for completing the SDM and the benefits of completing it at the beginning of the case. The expectation that the SDM document is completed at the beginning of the case was communicated to the social worker and the supervisor verbally during this review and in writing following the review. A communication has been sent to all social workers in this region regarding this expectation.

Child Fatality Review #09-27
Region 1
Spokane County

This nine-month-old Caucasian female died from Sudden Unexplained Infant Death (SUID).

Case Overview
This child was a dependent of the state with an open case at the time of her death. She died while in a foster home licensed and supervised by Children's Administration.

On July 9, 2009, the foster mother for this child contacted the child's social worker to report the child was found deceased in her crib in the morning. Law enforcement and the Medical Examiner's office conducted a death scene investigation. The Medical Examiner concluded the child died from Sudden Unexplained Infant Death.

The child was born with a positive toxicology screen at birth. She demonstrated withdrawal symptoms while still in the hospital and was administered morphine. She remained hospitalized for three weeks after she was born. She was discharged from the hospital and immediately placed in foster care. The assigned CPS investigator filed a dependency petition three days after she was born.

The child was seen regularly at the foster home by the assigned social worker. By April 2009, she was weaned off medications used to control withdrawal symptoms. The deceased child had reflux and poor feedings according to foster parents. Days prior to her death, she was assessed to be in the fifth percentile for growth. This growth percentile was consistent since her birth. The deceased child received appropriate medical care and medical consultations throughout her foster care placement.

Intake History of Child's Parents
On January 10, 2005, the deceased child's mother contacted Child Protective Services (CPS) intake to report she was pregnant and due within the month. She reported she was about to enter an inpatient drug/alcohol treatment facility. She was already in another in-patient treatment facility. The intake was screened in for investigation.

On January 23, 2005, a nurse from Ellensburg area hospital contacted CPS intake and reported the deceased child's mother left court-ordered chemical dependency treatment in Everett. She was riding in a bus headed toward eastern Washington when she went into labor. An ambulance took her to Ellensburg, where she gave birth by caesarian section.

The nurse was concerned about the mother's mental health and her ability to care for the newborn infant. The mother did not interact with the baby and did not want to feed him. Hospital staff placed an administrative hold on this infant.

The mother reportedly had a history of methamphetamine use and was diagnosed with paranoid schizophrenia. She had another child, then age seven, who lived with the maternal grandmother. The grandmother was awarded third party custody of this child shortly after the child was born. He has been in his grandmother's care his entire life. No report was made to Children's Administration alleging abuse or neglect of this child.

On January 24, 2005, the deceased child's mother was arrested on outstanding warrants and booked into jail. A CPS worker spoke with the mother who acknowledged prior in-patient treatments, admissions into mental health facilities, and that she spent time in prison.

A CPS social worker met with the mother who signed a Voluntary Placement Agreement (VPA) for her newborn son, the deceased child's stepbrother. This child was briefly placed in foster care. The mother asked that the maternal grandmother or the baby's father be considered for placement. The maternal grandmother had legal custody of this child's older brother.

The grandmother came to Ellensburg from Spokane. The placement with the grandmother was approved by the assigned supervisor. The infant was placed with his maternal grandmother on January 26, 2005. The worker assumed the maternal grandmother would file for third party custody of this second child. The CPS investigations were completed with unfounded findings.

On April 14, 2005, a different supervisor conducted a quality assurance review of this case and had concerns that the case was not staffed with a Child Protection Team (CPT) prior to the grandmother taking the infant. The grandmother was contacted on April 21, 2005 and reported that her daughter (the deceased child's mother) got married in March 2005. The grandmother said she returned the second child to the mother and her new husband who is the child's father. The grandmother did not file for third party custody of this child.

The grandmother explained that she returned this child to his parents because his mother had completed chemical dependency treatment, was taking her medications, and was meeting regularly with a therapist. The grandmother said she had no concerns about the child's welfare with his father.

A social worker contacted the deceased child's mother and her husband. They reported that they and the baby were doing well and moved to Tennessee. The social worker had the child's father agree to a verbal safety plan that he would be the primary caretaker of the child, he would ensure the child have all needed medical care, immunizations and well-child exams, he would utilize licensed daycare or relatives to baby-sit as needed, and he would not leave the child in the mother's care if she was mentally unstable. The father agreed to this safety plan, although he did not sign or return a copy of the plan.

On May 24, 2005, a social worker contacted Children's Services in Tennessee and made a report to CPS intake regarding the mental health issues of the deceased child's mother.

On July 14, 2005, this case was again staffed with a CPT. The CPT wanted follow up that the deceased child's oldest stepbrother was still in the maternal grandmother's care and a report be made in Tennessee because the parents didn't sign and return the safety plan.

The open case was closed on July 18, 2005.

Between July 2005 and September 2008, the maternal grandmother traveled to Tennessee and picked up the child and returned to Washington State. The deceased child's stepbrother was later taken in by relatives, who were awarded third party custody of this child. He is still in their care. His mother has minimal contact with him.

On September 23, 2008, a social service professional called CPS intake to report the mother was again pregnant, homeless, did not receive pre-natal care, and had a long history of methamphetamine use. She was diagnosed with paranoid schizophrenia. The other children of the mother are in the care of relatives. This intake was screened as Information Only because the child had not yet been born.

On October 20, 2008, hospital staff contacted CPS intake to report the birth of the deceased child. She was born weighing 4 pounds 8 ounces. The hospital social worker reported the mother had poor nutrition during the pregnancy. She was referred to First Steps; however, the nurse assigned was unable to make contact with her. The mother was homeless and did not have a plan at discharge for where she and her newborn daughter would live or how she would care for her. The mother told the hospital social worker she had two other children that were in the custody of relatives. She was no longer with the father of her second child with whom she moved to Tennessee. This intake was screened in for investigation.

On October 21, 2008, the CPS investigator interviewed the mother and the deceased child's alleged father. The mother appeared to be mentally unstable and unable to care for a child. The father disclosed he was a Level 3 registered sex offender with an extensive criminal history. He also reported he used methamphetamine, cocaine and alcohol.

The CPS investigator filed a dependency petition on October 23, 2008. The deceased child tested positive for marijuana at birth. The mother had a negative urinalysis at the same time.

On October 24, 2008 the deceased child demonstrated withdrawal symptoms while still in the hospital and was administered morphine. She remained at Deaconess Hospital until her discharge to foster care on November 14, 2008.

The CPS investigator discussed the dependency action with the parents. The father testified in court that he was unable to parent a child and did not want to participate in the dependency process. The deceased child was found dependent on October 27, 2008.

The foster home where the deceased child passed away was the only placement for her following her discharge from the hospital. She was completely weaned off morphine but was prescribed Phenobarbital. She still had some stiffness and jitters.

The CPS investigation of the intake reported on October 20, 2008, was concluded with a founded finding of negligent treatment. The remaining months, prior to the deceased child's death, there was very little contact or participation by either her mother or alleged father.

On July 8, 2009, the foster mother contacted the department to report the death of this child.

The foster home where this child was placed at the time of her death has been licensed with the state since November 2003. The home has been the subject of one Division of Licensed Resources /CPS investigation reported to CA intake in June 2006. The intake alleged the foster parents neglected the dental health of a former foster child. The investigation was closed with an unfounded finding. Medical professionals told the CPS investigator that the foster parents did an exceptional job in caring for the child and had no concerns that dental issues were the result of neglect while in foster care.

Issues and Recommendations

Issue*:* Back in 2005, the second child born to this mother and was informally placed by the department with his maternal grandmother. This grandmother had the oldest sibling in her care on a third party custody order and it was assumed that she would also file for third party custody on the second child. She did not and later returned the child to his parents' care. There was no indication that the child's father presented a risk to him. However, this placement had no legal structure to ensure the child's safety.

Recommendation*:* None

Action Taken: A special review of cases in this unit resulted in additional case activity that included a Child Protection Team staffing and referral to Tennessee CPS to ensure the safety of the child.

Action Taken: The CA Field Operations staff and the Regional CPS Program Managers met with an Assistant Attorney General to discuss informal placements. The Office of Program and Practice Improvement is working on developing policy and/or procedures to guide staff when working with families that make their own decisions about informal placements of children.

Issue: Following the birth of the mother's second and third children there were no shared decisions making processes utilized regarding placement of these children.

Recommendation: Shared decision making staffings (e.g., CPT, Family Team Decision Meeting, Administrative staffings) are required under specific circumstances and should be utilized regarding the possible placement of children in out of home care.

Issue: There was little documentation to support the determination of decisions related to licensed provider actions and outcomes of the Division of Licensed Resources' (DLR) complaint investigations.

Recommendation: The committee recommends DLR licensors include supporting documentation for detailing the information used to determine provider actions.

Recommendation: The review committee also recommends additional training to licensed care providers to include issues related to SIDS, safe sleep, drug affected infants, etc. The committee would like Children's Administration to explore the development and implementation of a training which focuses on care for special needs infants for licensed care providers.

The DLR Regional Administrator, Licensing Supervisor, and Foster Care Licensor all participated in the fatality review. The recommendations made by the committee were sent to the DLR Administrator and Deputy Administrator for consideration and implementation.

Child Fatality Review #09-28
Region 4
King County

This eight-month-old Caucasian male died from brain damage due to lack of oxygen.

Case Overview
On June 14, 2009, a detective with the Snohomish County Sheriff's Office reported the death of this eight-month-old child. The family lived in King County and was visiting the maternal grandmother in Snohomish County at the time of the child's death. The detective reported he died between the hours of 2:00 a.m. and 9:00 a.m. The child's mother stated that she placed him alone on a regular twin bed at her mother's home. He was last known alive at 2:00 a.m. At 9:00 a.m. she found him face down on the floor, with a white trash bag next to him. He had a candy substance on his face and the substance was also in the bottom of the bag.

During the autopsy, the Snohomish County Medical Examiner found unexplained injuries around the child's head and eye. The Medical Examiner also found multiple scalpular hemorrhaging behind the right ear, the top of the head and the left scalp. The Medical Examiner did not conclude that the injuries were inflicted.

The Medical Examiner ruled the cause of death was hypoxic encephalopathy (brain damage due to lack of oxygen) and the manner of death is undetermined.

Children's Administration did not have an open case on this child or family at the time of his death.

Intake History
On August 20 2008, a doctor contacted Child Protective Services (CPS) intake regarding the possible sexual abuse of a child by the deceased child's father. This child, then two years old, and his mother were temporarily living with the deceased child's family. The concerns were that this child's behavior had become sexualized and that the deceased child's father is a registered sex offender.

This intake was screened in for investigation. The deceased child's parents had a two-year-old child of their own also living in the home. The assigned worker made collateral contacts to law enforcement. The assigned social worker met with the children, the deceased child's mother and father. The father's offense was not recent and did not involve children. He had no restrictions on contacts with children. This CPS investigation was closed with an unfounded finding.

On October 11, 2008, CPS intake received a report that the deceased child was recently born. The referrer expressed concern for this newborn, and for the safety of all the

newborns at that hospital, since the deceased child's father is a registered sex offender. The referrer expressed concern that he would molest the children in the hospital. This intake was screened as Information Only.

On June 14, 2009 and June 16, 2009, CPS intake received separate reports of this child's death. The second report was made by the Medical Examiner and included more detailed information. This intake was screened in for investigation of negligent treatment or maltreatment and physical abuse. The Medical Examiner conducted an autopsy and found "multiple scalpular hemorrhaging" behind the right ear, top of head and left scalp. He reported that the injuries looked recent. The Medical Examiner did not conclude that the injuries were inflicted. Law enforcement completed their investigation and determined the death was accidental. The CPS investigation was closed with an unfounded finding for negligent treatment or maltreatment and physical abuse.

Issues and Recommendations
Issue: There are multiple unanswered questions about the circumstances of this infant's death.

Recommendation: The Region 4 CPS Program Manager and the Infant Death Investigation Specialist through the Northwest Infant Survival Alliance (NISA) are working to schedule a special review with the Snohomish County Medical Examiner's Office, to include CPS from the King South (Kent) office and the Snohomish County Sheriff. If there are new allegations that warrant additional investigation, Children's Administration will take appropriate action.

Child Fatality Review #09-29
Region 3
Snohomish County

This 16-year-old Caucasian male died from traumatic bodily injury.

Case Overview
On June 17, 2009, this 16-year-old youth was beaten and stabbed to death by five teenagers in downtown Sultan during a late night altercation. The incident was caught on video surveillance. The footage showed the teens approaching the deceased youth in the middle of the street, stabbing him several times in the torso and then repeatedly pummeling and kicking him in the head.

The youth was taken to a Seattle hospital where he died of the wounds later that day. The assailants were teens identified as members of a local gang. Two of them are brothers of the deceased youth's girlfriend. All of the assailants were arrested the next day. The deceased youth was believed to have had an argument with two of the attackers earlier in the evening.

Children's Administration did not have an open case on this youth or family at the time of his death. Children's Administration most recent open case with the family was closed in July 2008.

Intake History
The family of this youth has extensive history with Children's Administration beginning in 1993. At that time, his eight-year-old stepsister alleged her stepfather (the deceased youth's father) sexually molested both her and a stepbrother. The deceased youth's father was eventually found guilty and incarcerated. He later escaped and fled to Mexico, and never returned.

From December 1993 to March 1996, there were several reports of the mother's neglect of her three children due to drug and alcohol abuse. The department became involved with the family and attempted to keep the children at home with services, including chemical dependency treatment, use of the mental health/case management services, Children's Hospitalization Alternative Program (CHAP) in home, and childcare. This kept the family together safely until the deceased youth was approximately four-years-old, when the mother's drug/alcohol issues resurfaced, and the three children were placed in a voluntary arrangement with their maternal grandmother for three months. By the time the deceased youth was five-years-old, his mother was doing well with her sobriety and was continuing in therapy. The children were returned home.

In February 1998, the situation deteriorated with the mother again using drugs. She became physically assaultive toward her children. All three children were again removed and

dependency petitions were filed in March 1998. By this time, the older children had severe behavioral issues. The deceased youth was placed in foster care and then with relatives, where he remained until early 2004. His siblings returned to the home before him. After their return, the mother contacted the department for assistance with their behavior issues. The department accepted several intakes for Family Reconciliation Services (FRS) and offered Family Preservation Services to address the issues within the family.

In 2004, the deceased youth's older brother, then 15, was incarcerated for criminal gang-involved behavior. His sister was 19 and living on her own, struggling with her own children and chemical dependency issues. The deceased youth's mother regained her sobriety and was doing well. The dependency on the deceased youth was dismissed in June 2004.

On January 30, 2004, a mental health practitioner contacted Child Protective Services (CPS) intake to report that she had been told by the family that the deceased youth called law enforcement to the house to say that his mother had kicked and pushed him. Law enforcement reported no concerns about the youth's safety but there was apparently an altercation. This intake was accepted for investigation and closed with an unfounded finding for physical abuse. The youth was in his mother's care on an in-home dependency at this time. The dependency was eventually dismissed in June 2004.

On November 23, 2004, the deceased youth's mother called CPS intake requesting assistance in filing an At-Risk Youth (ARY) petition with the court. She wanted the court to establish and enforce rules and consequences for her son's (the deceased youth) behavior. The intake was accepted, and the mother was contacted. The case was closed after the mother did not respond to requests for contact to discuss the ARY petition.

On January 3, 2005, a relative contacted CPS intake alleging that drug use by the deceased youth's mother was affecting the behavior of the deceased youth, then 12 years old. The relative reported the mother and son are very closely bonded, and he became anxious and acted out when she used drugs. This intake was screened in for investigation and closed with an inconclusive finding for negligent treatment or maltreatment.

On September 29, 2005, staff with the Department of Corrections called CPS intake and reported the mother's drug involvement took her away from the home and caused her to neglect her son, the deceased youth. This intake was screened in for investigation. A case was opened to address the neglect concerns. The mother was to return to drug/alcohol treatment and submit to random urinalysis. The mother's new husband, who was clean and sober, would be the primary caregiver for the deceased youth. The CPS investigation was closed with a founded finding.

On February 3, 2006, CPS intake was contacted with a report that the deceased youth disclosed his mother left the house a day and a half prior and was using drugs again. It was

unknown what level of supervision there was in the home at the time. Although the referral was incorrectly coded as “Information Only,” this intake was investigated and resulted in a second dependency petition being filed on the deceased youth. He was placed in relative care with an aunt.

For a time this relative placement worked well, however, the deceased youth’s behaviors began to escalate. He was increasingly attracted to the “gang” lifestyle and his constant running eventually meant that he needed a more structured environment. His social worker placed him in Crisis Residential Centers and group homes from October 2006 to August 2007. He did very well in these facilities and in August 2007 was returned to the home of his aunt, with Intensive Family Preservation Services in the home to help with the transition. When his gang involvement and persistent running behavior continued, the aunt declined to have him return. He was in several placements for the next month or so, constantly running.

On September 18, 2006, CPS intake received a report that the deceased youth had run from his placement with his maternal aunt after an altercation on a school bus. He was later picked up and placed at the Crisis Residential Center. He was a dependent youth at the time. This intake was screened as Information Only.

The deceased youth and his mother maintained a close bond while he was out of her care. The mother’s chemical dependency prevented him from being with her. In March 2008, the mother had regained her sobriety and was doing well enough for her son to be able to return to her care under an in-home dependency. After his return, the department's plan was to monitor the placement at home for the next six months and close the case if all was going well. Before that could happen, the youth was incarcerated for prior criminal activities.

On March 13, 2008, the deceased youth’s mother called CPS intake to ask for an At-Risk Youth (ARY) petition for her son. She reported he was engaging in at-risk behaviors, including gang and drug involvement. The referral was taken as information only as the legal system does not allow for an ARY petition while there is a dependency on the child at the same time. Family Preservation Services were provided in the home to assist the mother.

In July 2008, the deceased youth was sent to a juvenile detention facility and was released in April 2009. The mother visited her son at the facility as often as allowed. The dependency was dismissed while the youth was incarcerated. The mother was in full compliance with all court ordered services. When the youth was released he went to live with his mother once again. He was living with her for two months after his release. In June 2009 he went to Sultan to visit his girlfriend and was killed.

Issues and Recommendations

The team did not note any policy, practice or systems issues in their review of this case that would have affected the outcome. Every resource reasonably available was utilized in the effort for a good outcome for this youth.

Child Fatality Review #09-30
Region 3
Snohomish County

This nine-day-old Native American female died from complications of a premature birth.

Case Overview
On June 12, 2009, this infant was born in a Tri-Cities area hospital at 30 weeks gestation. She was later transferred to Children's Hospital in Seattle. This infant was in the Neonatal Intensive Care Unit at a local hospital since birth until her condition worsened on June 20, 2009, and she was transferred to Children's Hospital.

On June 21, 2009, she died of a perforated bowel. The cause of her death was listed as necrotizing enterocolitis, a condition related to her prematurity. Necrotizing enterocolitis is an inflammatory disease occurring in the intestines of premature infants. This child's mother was a resident at an inpatient drug treatment facility when she went into labor.

The mother failed to access any prenatal care and was reported to be using drugs during this pregnancy.

Children's Administration had an open case on this family at the time of her death. The mother has three older children. All three were born drug affected and were removed from her care at birth. These children are dependents of the state and in foster care. This mother never had any of these children in her care.

Intake History
On June 25, 2006, Child Protective Services intake received a report from hospital staff that the deceased child's mother gave birth to a baby boy. It was reported that both the mother and infant tested positive for cocaine. This child was born three months premature. The mother had no prenatal care during the pregnancy. The CPS intake on this incident was screened in for investigation of negligent treatment or maltreatment. The investigation was completed with a founded finding.

A dependency petition was filed while the baby remained in the hospital for medical issues. This child later went to a Pediatric Interim Care (PIC) facility to treat symptoms related to prematurity and fetal drug exposure.

The mother left the area and this child was placed in relative care when he was released from the medical facility. The mother was offered services to address the identified risks to her newborn. Chemical dependency evaluations and treatment were offered in addition to random urinalysis. A psychological evaluation with a parenting assessment was also offered to this mother.

The mother frequently went long periods of time with no contact with her social worker. Despite being provided bus passes, she never met with any service providers nor did she attend visits with her child. By May 2007, she had yet to engage in any of the services offered. At that time, her child was transitioned to a relative/tribal home recruited for him by the tribal ICW worker in Tacoma. It was intended as a possible permanent home.

In April 2007, it was learned that the mother was again pregnant. The case remained open from the dependency on the first child. On May 11, 2007, the second child was born, also premature. The mother disclosed at the hospital that she had no prenatal care during this pregnancy and that she had used crack cocaine the previous day.

A dependency was filed on this child and she was placed in the same relative home as her older half brother. At this time the mother had not made herself available for services nor had she requested a visit with either child. She had not completed a chemical dependency assessment or treatment. Again, random urinalysis was offered to the mother. The mother was also offered assistance getting into a detoxification facility. She did not show for the scheduled appointment.

In July 2008, the mother appeared in court and relinquished her parental rights to both children and later the Tribe assumed jurisdiction of the children's dependencies after the children became legally free as to their fathers as well. Children's Administration closed the cases on the two oldest children at that time.

On April 14, 2008, CPS intake received another report that the deceased child's mother gave birth to a third child. This child was also born premature (at 33 weeks) and was placed in the Neonatal Intensive Care Unit due to the prematurity. The mother did not contact her previously assigned social worker during this pregnancy. The hospital reported she had very little prenatal care.

The mother entered the hospital directly from the Snohomish jail. The baby tested positive for drugs. However, the mother claimed she had been in jail since February 20, 2008 and was clean and sober while incarcerated.

The alleged father was a registered level three sex offender. This time the mother said she was interested in services with a goal of being able to parent this child. A dependency was filed on this child also and later established. He was placed in the same home with his siblings. The mother was again offered chemical dependency evaluations and treatment, random urinalysis, psychological and parenting evaluations, and supervised visitation with her child.

The mother continued to no-show for scheduled visits offered with her child.

In May 2008, the mother began participating in chemical dependency treatment and appeared to be clean and sober. However, by September 2008, the mother was no longer in compliance with court ordered services and still was not visiting her child. She continued a pattern of not contacting her social worker for several months. Social workers would attempt to contact the mother, but she moved frequently and left no way to contact her.

In November and December 2008, the mother failed to show for two scheduled drug/alcohol assessments.

The mother again became pregnant. In March 2009, she reported to her social worker that she had been in jail.

In May 2009, she was participating in intensive outpatient treatment and had a bed date to enter a residential treatment in eastern Washington. Her social worker reminded her that she had other services she needed to complete once she successfully completed inpatient treatment. She was in this inpatient treatment facility when she went into labor.

On June 9, 2009, CPS intake was notified that deceased child's mother went into labor and was hospitalized. The mother reported using drugs throughout the pregnancy and had very little prenatal care. She delivered the child on June 12, 2009. The hospital placed an administrative hold on this child. This intake was screened as Information Only.

The mother was in residential treatment when she gave birth to the deceased child. She also was born premature weighing just three pounds. Despite her having come from the treatment facility, the mother reported to the hospital that her last drug use (Oxycontin) was just two weeks prior. The deceased child's condition deteriorated and by June 20, 2009, had to be moved to Children's Hospital in Seattle, where she died of a perforated bowel, a condition which is frequently a risk with premature infants.

Issues and Recommendations

Issue: The pediatrician member of this review team pointed out that perforated bowel/necrotizing enterocolitis is a condition for which premature babies are at risk. Each of the mother's babies was born premature, with drug use, and little to no prenatal care with each pregnancy. Appropriate prenatal care would have reduced the risk of prematurity and therefore the risk of death from this condition.

The team considered that this pattern could indeed continue with additional pregnancies. The Tribal representative who participated in the child fatality review agreed to initiate conversations with the mother regarding family planning, in an attempt to intervene in this pattern.

Recommendation: None

Issue: In reviewing the file, the team found several indications that the mother was developmentally delayed and quite possibly was functionally illiterate. The review team questioned how much of a barrier this had been to her accessing services.

Recommendation: None

Action Taken: The social worker and supervisor agreed to include a request of the psychologist completing the mother's upcoming psychological assessment to evaluate whether her cognition and developmental abilities impact her participation in court ordered services.

Children's Administration

Executive Child Fatality Review

R. E. Case

Date of Birth: 01[redacted]/2007
Date of Death: 07/03/2009
Date of Review: 11/20/2009

Committee Members:
Debbie Fenske, Area Administrator, Division of Children & Family Services (DCFS), Region 1
Debbie O'Neil, Assistant Service Area Manager, Department of Early Learning, Eastern Washington
Rory Schilling, Social Work Supervisor, DCFS, Region 2 (Walla Walla Office)
Roy Simms, MD, Regional Medical Consultant, Region 2

Observers:
Sheri Hart, Social Worker 3, Division of Licensed Resources (DLR), Children's Administration
Rachel Pigott, Special Projects and Data Base Coordinator Office of the Family and Children's Ombudsman
Robert Rodriquez, Child Protective Services Program Manager, DCFS, Region 2
Rocio Romo-Burkhardt, Licensing Supervisor, Department of Early Learning, Yakima
Jennifer Triggs, Social Work Supervisor, DLR, Children's Administration

Facilitator:
Marilee Roberts, Practice Consultant, Office of Risk Management, Children's Administration

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Executive Summary

On July 3, 2009, Children's Administration (CA) Central Intake (CI) accepted an intake from Grandview Police Department reporting the death of 2½-year old R.E. The referent stated that they responded to R.E.'s family home along with Emergency Medical Technicians (EMT) after receiving a 911 call. They found R.E. non-responsive, not breathing and cold to the touch. EMTs transported the child to Sunnyside Community Hospital where he was pronounced dead shortly after arrival in the emergency room. Law enforcement and medical staff reported R.E. presented with suspicious bruising to the right side of his head. Based on a preliminary assessment as reported by law enforcement, R.E. died in what appeared as suspicious circumstances and an investigation followed. CA did not have an open case on this family at the time of R.E.'s death,

The Thurston County Medical Examiner conducted an autopsy at the request of the Yakima County Coroner. Information from the Division of Licensed Resources/Child Protective Services investigation indicated R.E. had a history of a fall from a bicycle at an unlicensed child care home and suffered a brief illness prior to his death. Autopsy results noted recent hemorrhage of the duodenum. However, the cause of the hemorrhage was undetectable at autopsy and could have resulted from blunt impact injury such as falling off a bicycle. The Medical Examiner found no evidence of lethal head trauma despite the contusion on R.E.'s forehead. The autopsy determined *cause of death as acute peritonitis; manner as undetermined.*

Information provided by the referent said R.E. had been attending child care in an unlicensed home on a regular basis prior to his death. The referent reported R.E. had fallen off a bicycle and became ill while at child care two days before his death. Therefore, in conjunction with Division of Children and Family Services (DCFS) Child Protective Services (CPS) and law enforcement, investigations by the Department of Early Learning[1] (DEL) and the Division of Licensed Resources Child Protective Services[2] (DLR/CPS) were also conducted.

A review of the family's history with CA notes six previous intakes prior to the R.E's death. Family composition at the time of the intakes included R.E.'s mother, father and two siblings ages 15 and 8. Three intakes alleging physical abuse and neglect (supervision) screened as low risk resulting in either a low risk letter being sent to the family or a referral to an Early Family Support Services (EFSS[3]) program. Three other intakes include two identified as Third Party reports referred to law enforcement and one intake screened as information only.

The record reflects no intakes were screened at a level requiring a high standard child protective services (CPS) investigation or face to face interview with the children or the

[1] Department of Early Learning has authority over child care facilities.
[2] Division of Licensed Resources child protective services investigates allegations of child abuse and neglect in licensed and unlicensed child care facilities.
[3] EFSS is a voluntary service offered to families when an intake meets the criteria for alternate intervention.

family. In addition, no intakes received referencing this family's history identified the deceased child as an alleged victim of child abuse or neglect.

In May 2009 CA did refer the family to services (Early Family Support Services) following receipt of an intake referencing sibling conflict and parental supervision. Though the case was closed to CA at the time of R.E.'s death services were being offered in the home by a contracted provider. The contracting agency notifies CA of any service intervention, their outcomes and recommendations for future service need. A written exit summary was provided to CA and is included in the family's case file.

In November 2009, Children's Administration (CA) convened an Executive Child Fatality Review[4] (ECFR) committee to review the practice and service delivery in the case involving R.E and his family.

Committee members included a diverse group of CA staff representing several regions and programs. Review committee members[5] had no involvement in the R.E. case. Team members were provided case documents consisting of family history/chronology including all intake information, police report, a summary of the autopsy results prepared by Dr. Roy Simms, CA Region 2 Medical Consultant, and the medical examiner and coroner's information and findings. In addition, the social work supervisor overseeing the fatality investigation was available for questions by review team members.

During the course of the review team members discussed screening decisions on previous intakes received, service delivery parameters and effectiveness affiliated with the EFSS program, and departmental (Children's Administration and the Department of Early Learning) expectations regarding knowledge of and intervention in unlicensed child care facilities.

Following review of the documents, case history and consultation with the social work supervisor the review committee made findings and recommendations which are detailed at the end of this report.

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[4] Given its limited purpose, a Child Fatality Review by Children's Administration should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. A review is generally limited to documents in the possession of or obtained by DSHS or its contracted service providers and the panel may be precluded from receiving some documents that may be relevant to the issues in a case because of federal or state confidentiality laws and regulations. A review panel has no subpoena power or authority to compel attendance and generally will only hear from DSHS employees and service providers. The panel may 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 take personnel action or recommend such action against DSHS employees or other individuals.

[5] A member of law enforcement was included in the review team, but was unable to attend the review due to an emergency.

Case Overview

The review committee reviewed all six CPS intakes referencing this family and the screening decisions made. The following is a brief description of each intake and action taken by CA.

Intake 1

Intake 2

Intake 3

Intake 4

[6]Alternative Response Services (ARS) at the time of this intake. Program is now entitled Early Family Support Service (EFSS). **RCW 74.13.500**

Intake 5

[redacted]

Intake 6

On May 12, 2009 an *intake was screened in for Early Family Support Services* following allegations by R.E.'s brother (now age 8 years) his sister (now age 15 years) continue to pinch and hit him causing injury. Information was reported in the past and the referent is concerned that the older siblings are dishonest to their parents about their interactions. The referent further reported R.E.'s brother spends a great deal of time at his grandmother's home who has expressed concern about his behaviors. It has been reported he is defiant and having disciplinary problems at school. Upon referral to EFSS CA policy requires closure of the case while a contracted EFSS provider engages the family in services to address issues related to the allegations.

The EFSS provider documented initial contact (June 2009) and screening with the family to discuss services; however, were unable to maintain contact with the family citing scheduling issues with R.E.'s mother. An EFSS exit summary received on July 10, 2009 indicates given the circumstances at the time, R.E.'s death on July 3, 2009, the family refused services. The EFSS case was closed.

Intake 7

The next CPS contact with the family was on July 3, 2009 reporting R.E.'s death. Law enforcement and EMTs responded to the family home and found R.E. in the home with his father, an older sibling, her son and two friends of the older sibling. R.E. was unconscious, not breathing and cold to the touch. EMTs transported R.E. to Sunnyside Community Hospital. Upon admission the referent stated emergency room personnel noted several bruises on R.E. including a contusion to the right side of his forehead. Despite attempts to resuscitate R.E. he was pronounced dead shortly after arriving at the hospital. An autopsy was scheduled for the following Monday (July 6, 2009) to determine cause and manner of death. The initial child abuse and neglect allegations referencing the parents were listed as: *Neglect and Negligent Treatment regarding R.E.'s mother and Physical Abuse regarding his father.*

During the course of the investigation investigators learned R.E. was attending child care in an unlicensed facility.[6] Investigators were told R.E. had suffered a fall off a tricycle while in child care on July 1, 2009. It was believed the fall was the cause of the bruising to his forehead. The child care provider said she notified the parents of the incident and recommended they seek medical care. On the following day, July 2, 2009, while at child care R.E. became ill, began vomiting and running a fever. Again, the child care provider recommended to the parents that R.E. should see the family's primary care physician. The child care provider told investigators R.E.'s father deferred such decisions to the child's mother.

On July 3, 2009, R.E. was dropped off at child care by R.E.'s mother who told the provider he did not sleep well the previous evening and continued to present with discomfort, vomiting, and fever. As the day progressed the unlicensed child care provider stated she attempted to reach R.E.'s mother on several occasions to inform her of R.E.'s condition, gain permission to medicate R.E., and again recommend he see a physician. The provider told investigators R.E.'s mother expressed concern regarding the time it would take to bring R.E. to the doctor and the cost of medical care.[7] R.E. was picked up at child care at approximately 4:40 p.m. on July 3, 2009 and arrived home at 5:00 p.m..

While at home the family was unsuccessful in getting R.E. to eat or drink without vomiting. Shortly after arriving home he lost consciousness. Emergency personnel arrived at approximately 5:35 p.m. and resuscitation efforts began, however were unsuccessful. Final autopsy (including toxicology) report received on October 5, 2009 indicates *cause of death: acute peritonitis; manner: undetermined.*

Law enforcement did not place the other children in the home into protective custody at the time of initial contact on July 3, 2009. However, it was recommended by both law enforcement and CPS the children stay with their maternal grandmother (background clearances were completed and clear) until the investigation was completed.

Conclusions of Death Investigation

CPS investigative findings regarding the July 3, 2009 intake are as follows:
R.E.'s Mother - Neglect/Negligent Treatment - Founded
R.E.'s Father - Physical Abuse - Unfounded
Neglect/Negligent Treatment[8]- Founded

Review team members agreed with the founded findings in the July 2009 death of R.E. Review of medical information and autopsy/coroner's reports indicated R.E.'s death was potentially preventable if the infection had been recognized and treated by a physician. The

[7] Division of Licensed Resources CPS intake was generated and assigned for investigation. DLR/CPS investigated findings regarding negligent treatment on the part of the unlicensed child care provider was deemed *unfounded.* Department of Early Learning initiated their own investigation into the operation of an unlicensed child care provider.
[8] Records indicate the family's Medicaid was current for the month of July 2009.
[9] Allegation of neglect/negligent treatment was added post intake during the investigation phase based on evidence gathered during course of the investigation.

parents' delay in seeking medical care and the progression of R.E.'s illness necessitated contacting a physician and constituted neglect.

The review team members discussed screening decisions on intakes prior to the July 3, 2009 death report. Although no intake identified R.E. as a victim of abuse and neglect, review team members did indicate screening decisions on intakes received on September 21, 2007, December 9, 2007 and May 12, 2009 should have screened in for investigation based on information at time of intake and history.

Issues related to unlicensed child care providers and what intervention is required were discussed by committee members. In this particular case both the DLR/CPS and Department of Early Learning (DEL) initiated investigations into the death of R.E.

The DLR/CPS investigation focused on issues related to child abuse and neglect by an unlicensed child care provider. Specifically allegations of neglect[9] and failure to report abuse/neglect on behalf of the unlicensed provider were made. Investigation findings were *unfounded* based on the following:

- The Washington State child abuse and neglect mandated reporting law (RCW 26.44.030) does not reference or require unlicensed child care providers as mandated reporters.
- Evidence obtained via witness statements supported information that the child care provider attempted on several occasions to encourage both parents to seek medical care for R.E.
- The child care provider requested her daughter, who worked with R.E.'s mother, to speak with her face to face and emphasize the need to obtain medical care for R.E.
- The child care provider sought and received parental permission prior to administering any medication to R.E.

Oversight of unlicensed child care facilities is conducted by DEL. When an unlicensed facility is identified, as in this case, DEL contacts the provider regarding licensing expectations and follows up with a cease and desist letter[10] until such time the provider is licensed. Only if the child care provider continues to provide unlicensed care after receiving a cease and desist letter and DEL has knowledge of continued care does DEL take further action; up to and including referral for prosecution or civil penalty.

Findings and Recommendations

The committee made the following findings and recommendations based on information provided by the social work supervisor overseeing the investigation, review of the case records, department policy and procedures, Revised Code of Washington (RCW), and Washington Administrative Code (WAC).

[10] Neglect/Negligent Treatment for failing to report child's illness and concerns regarding parents lack of follow through in seeking medical care.
[11] A cease and desist letter was forwarded to the provider in accordance with RCW 43.215.340, WAC 170-296-0430 and WAC 170-296-0110.

Findings

- Intakes 2, 4 and 6, received on September 21, 2007, December 9, 2008, and May 12, 2009 should have screened in for either an investigation or a referral to an EFSS program service.
- CA practice and procedures[11] requires creating a case file and opening a case when referred to EFSS. However, policy does not require CA to provide oversight of services or evaluation of their effectiveness. Unless the EFSS provider has assessed an increase in risk and contacted CA recommending further intervention. An exit summary of services is the only notification CA will receive regarding status of the family.

Recommendations

- Every referral, regardless of the screening decision, should include a review of the referral history of the family including both screened in and screened out referrals. The consideration of family history supports more accurate screening decisions. This report and recommendations should be reviewed with the Intake Units that screened the intakes on this family.
- The review committee identified recent legislation (HB 2106) which will establish a 'performance based contracting' system for all CA contracted service providers by January 1, 2011. In the event the EFSS[12] program is restored, EFSS program performance and evaluation will be required. Developing a method to assess the inherent value of EFSS services through evidence based practice[13] data can assist in noting a reduction in risk and/or show a decrease in recidivism rates is essential in evaluating the program's long term value and effectiveness in supporting child health and safety.

12 CA Practice and Procedures Chapter 2332
13 EFSS program services were discontinued in October 2009 in Region 2 due to budget constraints.
[14] Contract revisions for EFSS in July 2009 included the use of Evidence Based Practices for evaluation purposes.