



Report to the Legislature

Quarterly Child Fatality Report

RCW 74.13.640

April - June 2008

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Executive Summary

This report contains an unusually high number of Child Fatality Reviews. CA staff in the six regions made a concerted effort to complete all outstanding Child Fatality Reviews by June 12, 2008 in order to comply with Chapter 211, Laws of 2008 (2SSB 6206) which requires completion of reviews within 180 days.

This is the Quarterly Child Fatality Report for April through June 2008 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 issue a report on the results of the review to the appropriate committees of the legislature and shall make copies of the report available to the public upon request.

(3) The department shall develop and implement procedures to carry out the requirements of subsections (1) and (2) of this section.

This report summarizes the information from 73 completed fatality reviews from fatalities that occurred in 2006, 2007, and 2008. All were reviewed by a regional Child Fatality Review Team.

The reviews included in this quarterly report discuss fatalities from all six regions.

Region	Number of Reports
1	2
2	10
3	16
4	5
5	24
6	16
Total Fatalities Reviewed During 2nd Quarter, 2008	73

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 others as determined by the Assistant Secretary.

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 below provides the number of fatalities reported to CA, and the number of reviews completed and pending for calendar year of 2006, 2007, and 2008. The number of pending reviews is subject to change if CA learns new information through reviewing the case. For example, we 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 Years 2006 / 2007 / 2008			
Year	Total Fatalities Reported to Date Requiring a Review	Completed Fatality Reviews	Pending Fatality Reviews
2006	62	62	0
2007	58	57	1
2008	32	1	31

The numbering of the Child Fatality Reviews in this report begins with number 06-45. This indicates the fatality occurred in 2006 and is the 45th report completed for 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 #06-45
Region 3
Mount Vernon Division of Children and Family Services

This one-month-old Caucasian male infant died due to positional asphyxiation.

Case Overview

This child's mother brought him to bed with her after feeding him at 2:00 am on June 23, 2006. The mother placed him in the crook of her arm to sleep. The child's father woke the mother at 8:00 a.m. and they discovered the child had stopped breathing and was cold. The parents called 911 and medics arrived but were unable to revive the child. It was later determined that his death was caused by his mother accidentally rolling over him while she slept. The mother was 18 years old at the time of her son's death. They resided in a licensed foster home. The mother's DCFS case was closed when she turned eighteen.

Referral History

There were no prior referrals alleging the deceased child was a victim of abuse or neglect by his parents. Both parents have extensive referral histories when they were children living with their parents.

The mother of the deceased infant was removed from her mother's care when she was three years old due to allegations of sexual abuse. She lived with her father and stepmother for some years. They were unable to cope with her worsening behaviors and she was placed in foster care. She eventually was placed in a guardianship with her last foster parent. When she turned 18 in April of 2006, just a month before the birth of her infant, the mother elected not to sign herself into a voluntary placement agreement with the department and remain with foster care funding. Instead, she terminated her foster care and made a private arrangement with her guardian to fund her care with her Supplemental Security Income (SSI) funds that she received because of her developmental disability and mental health issues.

The fatality occurred in a licensed foster home. There were 15 referrals on this foster parent prior to the fatality. All but one was screened out for investigation by the Division of Licensed Resources/Child Protective Services (DLR/CPS). The one DLR/CPS investigation was closed as unfounded for improper supervision.

This foster care license for this provider was closed on July 7, 2006 because the foster mother's fiancé had disqualifying crimes on his criminal background check and could not be added to the license.

Issues and Recommendations

Issue: There were several referrals on the foster parent in the past that did not rise to the level of CPS but did contain allegations of inappropriate discipline or other child safety related issues. These concerns were addressed by staff of the agency licensing the homes, often without interviewing the foster children directly or making other collateral contacts other than speaking with the foster parent.

Recommendation: The review recommends that foster children be interviewed by agency staff as a part of the licensing investigation when addressing allegations of inappropriate discipline or other issues directly related to child safety.

Child Fatality Review #06-46
Region 3
Division of Children and Family Services
Indian Child Welfare Unit

This three-month-old Native American female infant died of acute bronchial pneumonia.

Case Overview

The child's sixteen-year-old mother was placed by the Tribal Nation in the home of a relative. On November 21, 2006, the mother left for several hours one evening leaving her baby in the care of two teenage girls who also lived in the home. At one point one of these teenagers found the child not breathing. An ambulance was summoned and CPR was performed but was unsuccessful. There was no evidence at the scene that the death was suspicious. The cause of death after autopsy was determined to be acute pulmonary bronchial pneumonia due to a bacterial infection.

Referral History

There was one prior referral on this mother. Her baby (then 6 weeks old) was hospitalized to correct an intestinal birth defect. She developed an infection while in the hospital. Medical staff questioned the mother's ability to care for her infant. The mother had difficulty waking to the baby's cries and had to be repeatedly prompted to hold bottles upright to prevent the baby from swallowing air. There was also a concern that the mother was feeding the child enough formula for the infant to make adequate weight gain. This referral was not screened in for investigation.

At the time of the child's death, her mother was in the custody of the Tribal Nation. She had been in relative placement. There were four other children living in the home at the time; two other teenage girls who were also placed by the Tribe, and two biological children in the family. The mother and baby had been in the home for only two weeks prior to the death.

As a child, the mother and her siblings had considerable involvement with CPS. Her mother had ongoing issues with chemical dependency, incarceration, and domestic violence. There were some domestic violence issues with the children's father, and after their separation her mother was involved in an extremely violent relationship with another man, whom she later married.

The mother came into care in 2005, at age 13. She was in relative placement. She became pregnant and her aunt was unwilling to continue as her placement. In October of 2006, the mother and her baby moved in with her older sister. There were several supports in the home for the mother and infant. By two weeks, the situation had deteriorated. The mother was not happy there and her baby appeared to not be gaining weight. The baby was taken to a doctor,

but no concerns were noted. This information was presented to the Tribal Child Protection Team (CPT). It was discussed whether dependency needed to be filed on the infant. The CPT recommended keeping the infant with her mother without legal action, and recommended other supports for the mother, such as a parenting class. As of November 1, 2006 the mother and infant were looking better. The baby saw a doctor on October 30, 2006.

Issues and Recommendations

Issue: When infants are born to women who have dependent children or born to young women who are dependent themselves, there is currently no system in place in the Bellingham DCFS office to alert the unit supervisor of the birth and the need to assess the safety of the infant. In this case, although the assigned social worker did address the issue of the safety of the newborn with the Tribe, there is no documentation that the unit supervisor was aware of the birth and concurred with the decision.

Recommendation: The review team, including the Area Administrator of the Bellingham office agreed that such a system would be helpful in ensuring that these situations receive the attention they need. The office intends to direct its intake staff, when they receive information of a birth to a young woman who is dependent herself, or who has other children that are dependent, to document that according to policy and provide a written copy to the assigned worker and to the supervisor of that unit.

Child Fatality Review #06-47
Region 2
Toppenish Division of Children and Family Services

This 17-year-old Native American dependent youth died as a result of injuries suffered in an automobile accident on July 3, 2006.

Case Overview

On July 3, 2006, the youth was participating at a family gathering where alcohol was being consumed when he took his aunt's vehicle and drove off. It is not known if the child had permission to drive the vehicle on this date. Accompanied by another passenger in the car, the child collided into a tree bursting into flames killing both the child and the passenger. King County Medical Examiner's Office confirmed reports from the Washington State Patrol that indicated speed was a factor in the accident. It was unknown who was driving the vehicle at the time of the accident, the child or the accompanying passenger.

Referral History

The child's family has an extensive history with Children's Administration and the deceased youth's Tribe beginning in 1994. There were forty five referrals to CA intake prior to the child's death. The family's history includes several founded allegations of child abuse and neglect referencing sexual abuse of the young children by the mother's live-in paramours and severe substance abuse problems by varied caretakers including the child's mother. The mother's six children, including the child were initially placed out of the home in December 1997. All six children were placed in foster care for a short period and then transitioned to a relative placement with their maternal grandmother.

Once relative placement was established with the maternal grandmother, courtesy supervision was requested by the Toppenish DCFS Office of the King South DCFS Office. The mother's children were placed with her mother from 1997 to 2005. During this period, the maternal grandmother struggled raising the children who exhibited difficult to control behaviors that included oppositional defiance, sexual acting out and substance use/abuse. Extensive services were provided to all the children to support and advocate for placement stability. Intervention was provided by a local Tribe to assist in providing support services for the maternal grandmother and her grandchildren and repeated attempts to engage the mother into services. The mother's compliance with services during most of this time was very minimal and parenting skills were assessed to be minimal with a poor prognosis for improvement.

However, for a short period of time the mother did stay sober, maintain a job and housing. It was during this window of compliance and stability the Tribal Court ordered her children returned to her care on December 26, 2005. The children were placed on an in-

home dependency for approximately three months before the mother relapsed and began neglecting the children resulting in health and safety issues. The children were once again removed and placed with their maternal grandmother on March 10, 2006.

While in the care of his grandmother, the child and his siblings were offered services. Based on a previous assessment completed while the child was in the care of his grandmother in late 2005, the child was referred for drug and alcohol treatment. It was a Tribal chemical dependency professional who advocated for the child to enter an in-patient treatment program. Following a drug and alcohol re-assessment in June 2006 inpatient treatment was recommended as in the child's best interest. The child was reluctant to enter into inpatient treatment and stalled admission for several weeks. Unfortunately, he was never able to enter into treatment.

On July 3, 2006, the child was participating in a family gathering where alcohol was being consumed when he took his aunt's vehicle and drove off. It is not known if the child had permission to drive the vehicle. Accompanied by another passenger in the car, the child collided head on into a tree and burst into flames. Both the child and the passenger were killed as a result of massive head and internal injuries. On November 27, 2007, despite minimal compliance and in opposition to recommendations made by the Children's Administration, the Tribal Court dismissed the surviving sibling dependencies and returned all the children to their mother's care.

Issues and Recommendations

Issue: Funding sources for substance abuse treatment needs to be more readily available to state dependent youth.

Recommendation: The Area Manager for the Toppenish DCFS Office will dialogue at future regional management meetings for purposes of developing possible funding resources for said treatment. Parties to be included in such a dialogue shall include Regional Contracts Manager, Division of Alcohol and Substance Abuse representative and the Native American /DSHS Liaison.

Issue: Cases that require other DCFS offices to provide/oversee courtesy supervision need to be accepted and assigned to a social worker in a timely manner. According to the sending office, there was much difficulty in having this case accepted for courtesy supervision. It is recognized that this occurred prior to the policy being updated on providing courtesy supervision.

Recommendation: All regions shall adhere to the policy of accepting courtesy supervision cases and following through with visits and providing updates.

Issue: Better collaboration from Tribal Court in the decision making process regarding child safety and when to return children to their parents home is warranted and recommended.

Recommendation: Arrange a meeting with the youth's Tribe to discuss how to improve communication between DCFS and the Tribe as a means to ensure child health and safety. Create an arena for staff input. The Toppenish Area Manager will take lead and set up this dialogue.

The Toppenish DCFS office would benefit from having Attorney General representation other than a Tribal Court Prosecutor.

Child Fatality Review #06-48
Region 6
Kelso Division of Children and Family Services

This female infant died from medical complications following extreme premature birth.

Case Overview

The infant was born at an estimated 25 week gestation. Her mother had no prenatal care and claimed she did not know she was pregnant until about 3 days prior to the birth. On August 14, 2006, the infant was born in the toilet at her mother's home. An ambulance was called and the infant was transported to the emergency room at St. John's Hospital in Kelso. The child was hypothermic and was intubated when she arrived at the hospital. She was later transferred to Portland's Emanuel Hospital Neo-Natal Intensive Care unit (NICU).

The infant remained in the NICU at Emanuel until life support was removed at the request of the family. The infant passed away on August 17, 2006. The infant died as a result of complications from her extreme prematurity. A post mortem toxicology screen was positive for opiates. No autopsy was conducted on the baby given the severe medical problems that were the apparent cause of her death.

Referral History

This mother had 43 referrals made to the department since her first pregnancy as a teen mother in 1994. Of the 43 referrals, 18 were as information only and not investigated. Of the remaining referrals, 25 were screened in for investigation. The investigations resulted in nine referrals with founded findings and six that closed as inconclusive.

The referrals received regarding the mother's children include numerous allegations of physical and medical neglect, physical abuse, prenatal drug use, chronic unsanitary living conditions, lack of prenatal care, children being left unattended, and children having access to drug paraphernalia. Two of the mother's children were born in the toilet in her home. The most recent child later died after her premature birth into the toilet.

The mother gave birth to another child in May 2007. The department filed a dependency petition on this premature baby. The parental rights of the parents were terminated on this child. There are no children residing with this mother. All of her living children are either placed with relatives or in licensed foster care.

Issues and Recommendations

There were no issues or recommendations made by the review team. It was noted that the family has an extremely long history with the department. The department has placed all of the mother's children in relative or foster care. The department immediately secured legal authority over the placement of the now deceased infant to prevent the mother from removing her from the hospital. The extent of her medical problems precluded her from leaving the hospital. She was removed from life support and died.

The department has made attempts at providing appropriate services and resources to these parents to provide a safe environment for their children. The parents never engaged in services and refused to cooperate with the department.

Child Fatality Review #06-49
Region 6
Port Angeles Division of Children and Family Services

This Native American male infant died due to multiple congenital anomalies. The child was born at 32 weeks gestation. Drug use suspected during pregnancy may have contributed to the death of this infant.

Case Overview

On August 22, 2006, the mother delivered a male infant at 32 weeks gestation with extensive medical problems. The infant was transferred to Children's Hospital in Seattle. He later died as a result of multiple congenital anomalies. At birth the mother tested positive for cocaine and benzodiazepine. It was suspected that the drug use during pregnancy contributed to the death of the newborn.

The autopsy report identified the cause of death as multiple congenital anomalies and the manner of death as natural.

This family has a lengthy history of involvement with the department. Previous referrals involve allegations of neglect (no food in the home, dirty house, chronic lice), in addition to physical abuse allegations (bruises).

Many services have been offered to this family over the past several years between Tribal interventions and DCFS services. Those services have included: chemical dependency treatment, mental health services, Family Reconciliation Services, and parenting education.

Referral History

On May 11, 1992 allegations were made that a then 16-month-old sibling had bruising on her buttock and there was no food in house. CPS investigated with Tribal social services. Services were offered to the family. Allegations were determined to be inconclusive.

On August 14, 1992 a large bruise was seen on the lower back of a 19-month-old sibling. Bruising was also seen on the child's ankles. The child also had access to her paternal grandfather who is a registered sex offender. The mother obtained a restraining order on the grandfather. Prior investigation revealed the bruising to be Mongolian spots. The referral was screened as information only.

On February 1, 1993, a referral alleged the father was alone caring for his 4-year-old, 2-year-old and 14-month-old children while drinking heavily. He dropped the infant while intoxicated. The children were infested with head lice and scabies. CPS investigated along

with Tribal social services. Services were offered to the family. The allegations were determined to be inconclusive.

On April 5, 1994, it was alleged that the mother left her children (then aged 5, 3, and 2 years old) with a 14-year-old babysitter for two weeks with no money, food, or diapers. The children had severe diaper rash. The grandparents picked up the children before law enforcement and CPS arrived. The CPS investigation was closed as founded. The mother moved to avoid intervention.

On August 30, 1994, a referral alleged the mother was consistently drunk and was farming her children out to various caretakers. The mother did not check on them. One caretaker attempted suicide while the child was with her. The investigation was closed as inconclusive. The mother left the area.

On February 28, 1996, a referral alleged the mother's three young children (the aged 7, 5, and 4 years old) were found walking down the street. The children were picked up by their grandfather who is a registered sex offender. CPS and Tribal social services opened a case. The case closed as founded, and services were offered to the family.

On April 5, 1996, a referent saw a red mark on the five-year-old child's forearm and bloody nose. The child reported her father did it. The allegations were determined to be inconclusive.

On January 9, 1997 CA intake received a referral alleging the mother parties and drinks alcohol all the time and the father smokes marijuana. This occurs in front of the children. They have a big pile of beer cans in the back yard. The referral was screened as information only.

On August 15, 1997, the then seven and eight-year-old siblings cried and screamed about leaving daycare with their paternal grandfather. Then grandfather came to the center and yelled at the children that he was going to take them home later. The seven-year-old hid behind a staff person when he arrived. Staff did release the children to the grandfather. The grandfather is a convicted sex offender.

On September 25, 1997 a referral alleged the children had head lice and mother will not take care of it. The children are often out unsupervised playing in the neighborhood. The referral was screened as information only.

On May 7, 1999 a referral alleged the then eight-year-old sibling reported an incident when both parents were intoxicated and were fighting with knives. The child also said she does not get enough food at home. The child is always hungry and asking for more food school. The nine-year-old sibling denied the incident occurred. The referral was screened as information only.

On January 18, 2001, a referral alleged the then nine and ten-year-old siblings were being sexually assaulted by a 12-year-old cousin. The cousin and his mother were staying at the home. The boy's mom said the girls wanted "it." The mother kicked the woman and her 12-year-old son out and called police. The referral was screened as information only.

On September 24, 2001 a referral alleged the nine and ten-year-old girls had head lice. Dad was in jail and when that happens, the care of the girls deteriorates. The mother worked nights and slept days. The girls looked unkempt. They report the mother was drinking. The referral was screened as information only.

On June 17, 2006 law enforcement picked up the then 14-year-old sibling for panhandling and attempted to take her home. There was no parent home so the child was placed at the secure crisis residential center (SCRC). The mother later picked her up. The social worker was unsuccessful at making progress with the family. The Family Reconciliation Services (FRS) case closed without intervention.

Issues and Recommendations

There were no issues or recommendations made by the review team. The death of the child was due to multiple congenital anomalies due to preterm birth. The family has a lengthy history of involvement with the department. The office has worked closely with the Tribe and Tribal social services to ensure services and supports have been offered to this family. The parents have resisted services by the department.

Child Fatality Review #06-50
Region 6
Aberdeen Division of Children and Family Services

This four-month-old Caucasian infant died of Sudden Infant Death Syndrome.

Case Overview

On November 5, 2006, the Aberdeen Fire Department and Police Department unsuccessfully attempted life saving measures on a four-month-old found not breathing. The parents reported they fed the child around 6:00 a.m. They woke at approximately 9:20 a.m. and the child was not breathing.

On November 7, 2006 an autopsy was conducted and it was determined that the probable cause of death was Sudden Infant Death Syndrome.

Referral History

On October 26, 2006 a referral was made to CA intake alleging the mother gave birth to a premature child at the University of Washington Hospital. The urinalysis was negative. The mother has a history of using methamphetamines regularly and was recently asked to move from her home because of her drug use. The mother was reported to have "meth sores." This referral was information only

On November 9, 2006 a referral was made to document the death of this infant. A social worker saw the obituary of the three-month-old baby in the newspaper. Additional information was gathered. The infant had been sick for two days and the mother had not taken the child to the doctor. In addition, when the baby was found there was blood coming out of her nostrils. The autopsy was conducted and the cause of death was determined to be Sudden Infant Death Syndrome. However, there remained a question as to whether or not the parents medically neglected the child by not getting adequate medical care for her when she was ill. After investigation, the referral was closed as inconclusive.

On October 8, 2006, the infant was discharged to the care of her parents. The infant was sent home with numerous medical problems. She was seen by her doctor on October 16, 2006. The doctor noted she was growing properly and there were no medical concerns. She was supposed to return to see the doctor in one month; she died before her next appointment.

Prior to the birth of this infant, her father had been involved with the department as a youth. Numerous referrals were received on the father's family, primarily his siblings. One referral was received in 1997 by the paternal grandmother requesting an At Risk Youth Petition as

he was not attending school and had been stealing and using drugs. He was reported to be verbally aggressive with his mother and sisters.

Issues and Recommendations

Issue The first referral involving this family was received on October 23, 2006. The referral alleged the infant was born prematurely and that the mother had a history of drug use. Based on the allegations, the referral was screened as information only. There were no additional collateral calls conducted to learn more about the allegations in the first referral. Additional collaterals to the University of Washington hospital where the infant was may have provided additional information as to the concerns from the hospital staff about the lack of parent involvement and lack of visitations.

Recommendation: The supervisor will review with the intake staff the need to make collateral calls when referrals of this nature are received.

Child Fatality Review #06-51
Region 6
Vancouver Division of Children and Family Services

This six -year-old Caucasian child died of accidental overdose of prescription medication.

Case Overview

On June 28, 2006, medics were called to the home of a six-year-old found deceased by his parents. The medical examiner ruled the child died of an accidental overdose of his medications. The child's mother reported he had serious acting out problems including: raging, killing animals, setting fires, smearing feces, assaulting family members, and school personnel. The child had been diagnosed as bipolar and was taking four different medications.

In May 2006, the child's mother contacted the department wanting him placed in foster care as she was concerned for the safety of her then two-year-old daughter. The child had assaulted school staff earlier that day.

The child was later placed in a psychiatric ward at Providence Hospital for his aggressive behaviors. He assaulted his older sister and his mom on a frequent basis. The mother said the family was afraid of him and the family's focus has been on controlling his behavior. The mother believes the child was a victim of sexual abuse, although he had never disclosed being victimized.

On June 27, 2006, the mother brought the child home to spend the night with her after he was placed with his grandmother. He overdosed on his prescriptions that night. He was found deceased the next morning. The Family Preservation Services therapist worked with the family for two or three more sessions prior to the case being closed. The child's death was ruled as an accidental overdose.

Referral History

On July 31, 2001 a referral alleged sexual abuse of the eight-year-old sibling by her cousin. The mother was protective and did not allow any contact with the abuser. This referral was screened as information only.

On May 26, 2006 the mother contacted the department reporting her 6-year-old son has bipolar disorder that she wanted him placed in foster care. He had assaulted his teacher and had to be forcibly removed from the school. The mother said she had two younger children in the home and was concerned for their safety. The referral was assigned for child welfare services. The mother refused services offered.

On June 8, 2006, the mother called CA intake to report the child was acting out at home and was unsafe for his two sisters. He killed two pets, lit two fires, and smeared feces on the wall. He has assaulted all family members. The mother reported her child was sexually abused by a cousin. The referral was assigned for child welfare services. The parents agreed to services.

On June 9, 2006, CA received another referral with concerns about the child's aggressive behaviors. The child has a history of animal abuse and fire setting which seems directly related to sex abuse because it occurred during the time frame of abuse and the fire setting was in his grandmother's home which is where the abuse occurred. The child was diagnosed with post traumatic stress disorder, with sexualized behavior and sexualized talk. Referral was screened as low risk. The case was already open for services.

On July 6, 2006, a referral was made regarding the death of this child. A child protective services investigation was conducted to investigate possible neglect after medications were left within his reach. This investigation was closed as inconclusive. Law enforcement ruled the death as accidental.

Issues and Recommendations

Issue: No issues were identified at the review.

Recommendation: None

Child Fatality Review #06-52
Region 6
Kelso Division of Children and Family Services

This one-year-old Caucasian male died of accidental asphyxiation.

Case Overview

The deceased child and his three-year-old brother were in the care and custody of their paternal grandmother. The paternal grandmother reportedly lived in Vancouver, Washington, but stayed off and on with her paramour in Clackamas County Oregon. At the time of this child's death, the paternal grandmother was at her paramour's home in Oregon.

The child and brother were in the house watching cartoons. The deceased child was in a foldable playpen. The paternal grandmother reported that she placed the boys in a room where she could hear them. She stated that she then went outside to clean a refrigerator.

The paternal grandmother stated she was outside for only 10 minutes when she came back in to check on the boys. After confirming they were fine she went back outside to continue cleaning the refrigerator. Again, 10 minutes later, the paternal grandmother went back into the room to check on the boys and noticed that the child was lying on his stomach in the playpen and was not moving. The paternal grandmother reported to law enforcement that the child's head was at the end of the playpen and was under the mattress and that it appeared that his neck was broken due to it being bent over so far.

The paternal grandmother reported that she picked the child up and that he was purple in color and not breathing. The paternal grandmother yelled for her paramour, and took the child to the living room where she called 911 and her paramour began CPR.

CPR was performed on the child until the medics arrived, who continued the process on the way to the hospital. The child was pronounced dead at the hospital.

Referral History

Over the life of this family there were 25 referrals involving a variety of primary caregivers and alleged victims. The mother of the deceased child had both children when she was a teenager. As a teenager, she was actively using marijuana and methamphetamines and was on probation for a variety of offenses including minor in possession. Referrals regarding the mother of the deceased child alleged she was dealing drugs, prostitution to support a drug habit, not responding the baby's physical needs, propping a bottle up in the swing, driving the baby while under the influence, not following through with medical testing for the child, having drug paraphernalia around the baby and leaving the child with a known sex offender.

The father to both children was 19 at the time the oldest child was born. The father also has a lengthy history of involvement with the department, and involvement with substance

abuse. The father is alleged in referrals to have used the mother to deliver drugs for him on numerous occasions. The father was not actively involved in parenting his children at the time of the child's death, but did reside in Oregon and keep in regular contact with his mother, who was the primary caretaker of the children. The paternal grandmother obtained temporary custody of the children with the consent of the mother and father.

The father has reported to have recently completed treatment for his drug issues and has been sober.

The department attempted to work with the mother and her family to alleviate the risk to her and her children. The mother would initially agree to services and then take her children and go to Oregon where it was difficult for workers to engage her. Upon return she would again appear cooperative and initiate services, but failed to follow through.

The mother had a lot of family support. Her maternal grandmother was a steady source of support and kept the department and juvenile probation informed of all of the mother's issues and the risk to the children. These protective factors, combined with the mother's attempts to engage in services prevented the children from entering into care. In addition, the paternal grandmother stepped in and took over care and filed for custody of the children. This action alleviated the concerns over the mother's ability to care for the children properly. Since the time of this child's death, the mother gave birth to another baby, who is now in the state's care and custody.

Due to the fact that the fatality occurred in Oregon, the department was unable to obtain copies of the medical examiner's report and additional supporting medical information. The team was able to obtain a copy of the report from the Clackamas County Sheriff, which included the reports from the medical examiner that the death was accidental due to asphyxiation.

Issues and Recommendations

Issue: Provide clarification to the field on the requirements for screening in cases on child fatalities from other states when there is history within the previous 12 months. The referral for the death of this child was screened in for investigation, although the child was not physically residing in Washington, nor did the caretaker, although they had a physical address. This caused confusion at the onset of the case. However, the caretaker stated that she would not likely be returning to the Vancouver, Washington physical address with the exception of getting her belongings and moving. Screenings of fatalities from out-of-state cases where we have history are confusing. In this case a finding was made on a subject that had a physical address in Washington but was not residing in the state.

Recommendation: There needs to be a consistent message sent to the regions from HQ on how to screen cases where we are notified of out-of-state fatalities where we have had history in the previous 12 months. It is now clear that we need to conduct a fatality review, but supervisors are unclear as to the role of the office on screening in and assigning referrals.

Child Fatality Review #06-53
Region 5
Tacoma Division of Children and Family Services

This two-year-old Caucasian male died from blunt head trauma inflicted by his stepfather.

Case Overview

On February 20, 2006, the deceased child was taken to a local hospital with severe injuries to his brain, liver, and spleen. The parents' explanation for the injuries was not consistent with the severity of his injuries. The deceased child's stepfather was the sole caretaker when the child was injured. He was arrested, charged, and convicted of homicide by abuse. The allegation of physical abuse of the child by his stepfather was founded by the investigating CPS worker.

Referral History

On June 6, 2005, childcare staff reported the deceased child had a hairline fracture of his elbow. His mother had no explanation for the injury. The mother and stepfather told the doctor, "he just fell" to explain the injury to his elbow. The mother said he was injured at childcare. The deceased child also had a sprained ankle in May 2005. The childcare staff reported the mother would avoid medical treatment when they recommended he see a doctor for injuries. The mother said the stepfather wrestled with the deceased child and rolled over on him and sprained his ankle. Childcare staff reported the explanations for injuries changed frequently.

This referral was investigated by CPS. The child's doctor confirmed he saw the child for these injuries. The doctor noted no concerns about child maltreatment. An orthopedist confirmed the elbow fracture was consistent with accidental injury. The investigation was closed as unfounded for physical abuse.

On December 20, 2005, the deceased child's stepfather contacted the department claiming his biological children had been sexually abused. The stepfather alleged his children were being abused by their mother's boyfriend. This referral was screened as low risk CPS.

On November 19, 2005, the four-year-old stepbrother of the deceased was allegedly acting out sexually by inserting objects into his anus. The referent is the ex-wife of the stepfather. She is the mother of the four-year-old stepbrother. She reported the stepfather has a temper and a history of losing control. The referent said the mother and stepfather watch pornography in the living room in full view of the children. This referral was investigated by CPS and closed as unfounded.

Issues and Recommendations

Issue: Intake Referral of June 6, 2005 - The daycare provider called to report possible physical abuse of the then twenty-month-old deceased child. The child had been observed to be experiencing difficulty using his left arm, and the mother had been reluctant to take the child to be seen medically. The child had also recently experienced an ankle injury. While the child eventually received medical attention for both injuries, the daycare provider had concerns about the number and pattern of injuries the child was experiencing, the explanations being provided by the parents, and the child behaviors (e.g., increased clinginess). The daycare did not report any concerns for the other two children in the family who also had attended the daycare.

The information was accepted at intake for investigation by CPS and this screening decision appears to have been correct. The intake worker identified suspected physical abuse as the allegation. The referent also had neglect concerns regarding the parents delay in seeking medical care for the child in a timely manner. During the fatality review the intake worker indicated she had considered the concerns about possible neglect, as noted in the Basis for Risk section of the intake report, but did not feel the reported concerns were sufficient to meet the Washington Administrative Code (WAC) definition of neglect that was in place at the time of the referral. The consensus of the fatality review panel was that it would have been reasonable to include neglect as an allegation due to the concerns regarding delayed medical treatment, but that such omission had no significant impact on the investigative activities.

An additional intake issue discussed during the review related to the daycare provider having mentioned to the intake worker that the child's mother was blaming the daycare for injuries occurring to the child. While the intake worker might have considered generating a Division of Licensing/Child Protective Services (DLR/CPS) referral on the daycare based on the allegation made by the parent to the daycare provider, the fatality panel was unable to come to a clear consensus. At the time of the intake, there may not have been sufficient reasonable cause to believe that the daycare provider had caused injuries to the child. This issue surfaced again in review of the CPS investigators contact with the parents (see below) who reiterated their claim against the daycare provider.

Recommendation: None. It should be noted that legal definitions (RCW) and descriptions of what constitutes negligent treatment or maltreatment (WAC) have subsequently been revised (effective January 2007).

Action Taken: The intake worker who took the information from the daycare in June 2005 did participate in the fatality review and received feedback regarding her intake decisions.

Issue: The investigating social worker, who has many years of experience in CPS, appears to have met or exceeded most general practice expectations in place at the time of the

investigation in 2005. The worker's supervisor was also very experienced and had been a CPS supervisor for over twenty years. There were, however, several practice issues of varying degrees of concern and importance which were noted and discussed during the fatality review. Thus while overall the social work practice appeared to be very good, it was not without some criticism. Discussions during the review included recognition for excellent practice by the CPS worker as well as missed opportunities for best practice. The assigned social worker appears to have met policy and practice guidelines for face-to-face contact with the alleged victim, completing the Safety Assessment, and completion of the investigation. All documentation by the worker appears to have been recorded in a timely manner. The identified subjects of the investigation (the parents) were interviewed at the family residence and their responses to the allegations and concerns were documented. The worker did not appear to inquire as to the circumstances surrounding the stepfather having custody of his two biological children from a previous relationship. Additionally, the CPS worker did not appear to inquire as to any CPS history from other states. During the investigation of the child fatality (February 2006) it became known that the stepfather had some limited (not extensive) involvement with CPS in Texas when he reported concerns that his first wife's boyfriend had possibly physically abused his son.

During the investigative interview the deceased child's parents stated their belief that his arm injury had occurred at the daycare. In review it is believed that such an allegation may have been sufficient to have caused the CPS social worker to initiate a referral on the daycare. During the review the worker acknowledged she had not recognized the parents' claims against the daycare as sufficient to cause a DLR/CPS referral to be generated.

The worker documented that all children in the family were seen. Following best practice, the worker interviewed the oldest and most verbal child at school even though that child was not identified as an alleged victim. Interviews of non-victims are not required by law or CA policy.

Recommendation: CA has been in process of improving policy and practice expectations regarding response to suspicious injuries to young children. This has included efforts to develop guidelines for social workers as to under what circumstances hard copy medical records on children should be requested and obtained, and when to seek medical consultation with the state medical child abuse consultation network. It is recommended that CA continue to pursue improvement of such guidelines and continue to offer post-academy training for social workers on investigating reported injuries in young children that may be suspicious.

It is known that the Medical Child Abuse Consultation Network (MEDCON) physicians contracted to provide consultation to CA do conduct training for health care practitioners in the community (e.g., hospital staff and pediatricians). It is recommended that the MEDCONs include in such training a discussion on parents who may present well to

medical professionals but there may be a pattern of injuries with their child(ren) that merits more in-depth medical evaluation.

While training on conducting interviews with child victims has been required for CPS workers for many years, there has been a lack of training on interviewing caregivers and alleged subjects. In 2005-2006 no such training was available to social workers. At the time of this review it was believed that CA was considering such training, and it is recommended that CA continue to pursue this.

CA should continue to conduct Lessons Learned presentations around the state which offer useful considerations for social workers based on actual cases involving child abuse and neglect (CA/N) related child fatalities. The presentations should continue to include a focus on assessment of caretaker attachment and bonding and the need to improve social worker sensitivity to indicators of parental ambivalence. This includes hyper-vigilance to blended family situations in which there is a history of chaotic relationships, when there is a caregiver who has a role in toilet training a non-biologically related child, and when there is evidence of a child in the family receiving differential treatment (e.g., more harsh discipline) or maltreatment when compared to other siblings, half-siblings, or step-siblings.

Issue: The assigned investigating social worker contacted the daycare (referent), the primary care physician for the child, other medical professionals involved (e.g., Orthopedist), the Maternity Support Services (MSS) worker involved with the mother, law enforcement, and various relatives. At the time of the investigation the family was open for services with the local DSHS Community Services Office (CSO). Although there is no CA requirement for the CPS worker to contact the active CSO worker when there is a shared client, Region 5 CPS practice expectation is for the worker to make such contact. This did not occur. It remains speculative as to what, if any, difference such contact with the local CSO worker would have made in terms of risk assessment or case management.

As noted, the CPS worker did contact medical providers who had knowledge of the child and injury incidents. The worker did not request copies of medical records for the alleged victim. While there is no policy requirement to do so, consideration might have been made by the worker to obtain copies of deceased child's medical records and had them reviewed by the regional medical consultant with the Child Abuse Consultation Network for Washington State. However, the investigating social worker indicated during the review that the information provided verbally by involved medical professionals did not suggest a need for further medical consultation or need to obtain hard copies of the child's medical records. That is, the medical opinions did not indicate the injuries sustained by the child were intentional or the result of abuse. This would be consistent with CA current practices and procedures guidelines which states that the social worker considers utilizing a medical evaluation in cases where the reported, observable condition or the nature and severity of injury cannot be reasonably attributed to the claimed cause and a diagnostic finding would clarify assessment of risk [CA Practices and Procedures Manual].

At the time of the fatality review, even with additional information and post-fatality medical review of the medical records that would have been available in 2005, there was no substantive evidence that the injuries to the child in early 2005 were caused by physical abuse. Thus even if a review of the child's medical records would have occurred at that time with the regional child abuse medical expert (who participated on the fatality review panel), it appears unlikely that the results of such a review would have led to a different finding (unfounded) regarding the alleged abuse. It was recognized during the fatality review that despite a lack of medical evidence of non-accidental injuries, the CPS worker had considered a possible pattern of injuries as part of her risk assessment.

As noted above, the CPS worker interviewed the oldest child at school. During that interview, the seven-year-old child demonstrated with a punching motion how the deceased child was hit on one occasion by the stepfather. The boy also stated that his father did not like the deceased. In retrospect, these statements appear to be very significant, especially when combined with the MSS worker's later comment to the CPS worker that the stepfather appeared a little more cold towards the deceased child than to his own biological children. Additionally, daycare notes obtained post-fatality included a documented comment by the mother to the father that deceased child appeared fearful of him. Such observations and situations speak to concerns regarding parental ambivalence, a risk factor often present prior to serious injury cases and child abuse deaths. The CPS worker acknowledged during the review that she had not given as much consideration to these statements as she could have at the time, partially due to other sources of information (documented) that described a more positive parent-child relationship between the stepfather and the deceased child.

The intake report which initiated the investigation had included information that the daycare provider had a file of documented concerns regarding the deceased child. The CPS worker did not request a copy of the daycare notes which began in January 2005 and culminated in June 2005 when the daycare provider felt she had reasonable cause to believe that the deceased child was being abused and contacted CPS intake. The daycare provider had documented health concerns (e.g., rashes, pink eye), marks, bruises, and injuries involving the deceased child, as well as reluctance by the mother to seek medical services for the child. As noted above, the daycare notes also included documentation of an incident in which the mother remarked to the stepfather that the deceased child appeared fearful of him.

The overall impact that the daycare notes might have had on the investigation had they been obtained and reviewed by the investigator remains speculative. However, the fatality review panel concluded that a review of the daycare documents by the CPS worker, in conjunction with other information that the worker failed to give adequate weight to, impacted the workers assessed overall level of risk to the child. That is, failing to give exceptional weight to indicators of parental ambivalence towards the deceased child by his stepfather led to an under-assessment of risk to the child.

Recommendation: The investigating social worker was present during the review, and received both positive and critical feedback regarding the investigative and risk assessment activities. The worker acknowledged several oversights to best practice, including not having obtained the daycare records, not inquiring as to any CPS history in other states, failing to recognize the parents' claims against the daycare as sufficient to cause a referral to be made on the daycare provider, and not giving more weight to indicators of parental ambivalence by the non-biologically related caregiver towards the now deceased child. Additionally, the investigating social worker stated that with retrospection provided during the fatality review, her practice will include interviewing caregivers separately and inquiring with parents as to any witnesses who may be able to corroborate their account of events.

Note: Children's Administration changed to a different risk assessment model at the end of 2007. The current Structured Decision Making (SDM) assessment is an actuarial tool that reduces the likelihood of over or under assessment of risk as it is a more structured instrument. The SDM assessment does include a question on parental ambivalence although it is not scored at this time (i.e., it is a supplemental factor that will be tracked and statistically analyzed).

Issue: In review of the daycare records collected post-fatality, the review panel discussed whether or not the daycare provider had reasonable cause to believe that the deceased child was being abused or neglected earlier than reported. The daycare notes began in January 2005 and culminated in June 2005 with the daycare contacting CPS intake about concerns that he may be maltreated. The daycare provider had documented health concerns (e.g., rashes, pink eye), marks, bruises, and injuries involving the deceased child, as well as reluctance by the mother to seek medical services for the child. It also included an incident in which the mother remarked to the stepfather that the deceased child appeared fearful of him. The general consensus of the review panel was that the daycare could have contacted CPS intake earlier in 2005 although the daycare documentation of concerns before the contact with CPS intake may not have passed sufficiency for accepting the report for investigation.

During the investigation in June 2005 the parents indicated to the CPS investigator that they believed their child was injured at the daycare. Although in reflection of post-fatality case review there is sufficient reason to believe that the allegation against the daycare by the parent was probably without merit, the review panel concluded that the worker should still have generated a Division of Licensing Resources/Child Protection Services (DLR/CPS) referral. DLR/CPS is responsible for conducting investigations of child abuse and neglect alleged to have occurred in daycare facilities. As noted previously, the CPS worker acknowledged she had not recognized the parents' claims against the daycare as sufficient to cause a DLR/CPS referral to be generated.

Recommendations: Licensing and oversight of daycare providers are now under the Department of Early Learning (DEL). It is unknown as to the current content of DEL training curriculum regarding mandated reporting of child abuse and neglect, although such issues appear to be part of STARS training through DEL. DEL might consider requiring mandated reporting training for all daycare staff and licensees on a schedule similar to recertification for First Aid and CPR.

Actions Taken: Both the intake worker and the CPS worker involved with the June 2005 referral participated in the fatality review and received feedback regarding the issue of the parents claim against the daycare provider.

Community Mandated Reporting Training is now conducted twice a year in Pierce County by the Tacoma CPS intake supervisor. Daycare providers may attend these large group presentations as well as other mandated reporters. Notification of these presentations is now provided in advance to the local DEL office.

Issue: It was reported that the four-year-old stepbrother of the deceased child was possibly sticking things in his anus. The biological mother of this child had just moved back from Texas. The child was in the care of his biological father and stepmother (biological mother of the deceased child). The father apparently had informed the school that his son had been acting out since his biological mother moved back to Washington, including wetting his pants and an incident whereby the child put his finger in his own anus. The stepmother was reported to work in an adult store and she and the father allegedly watched adult videos with the door to the children's room open. Additionally, concerns were reported that the father had recently threatened to hit his wife and infant daughter with a frying pan. Central Intake (CI) took the report and accepted it for investigation of sexual abuse by the stepfather of the deceased child and the mother.

The fatality review panel questioned the screening decision made by CI. There did not appear to be adequate reason to suspect the child was being sexually abused by either the biological father or the stepmother. Accepting a referral for investigation based on behavioral indicators of a child, per CA practice guidelines, usually requires more than a single indicator. While risk factors were identified at intake based on second-hand information provided by the friend of the biological mother who did not have physical custody of the child, the panel concluded the information did not meet sufficiency. The Tacoma intake supervisor, who reviews referrals for Tacoma CPS that are generated by CI, did not spot the deficiencies of the referral at secondary review.

Recommendations: None

Actions Taken: The Central Intake worker did not participate in the review. However, a CI supervisor was notified following the fatality review of the concerns that the referral should not have screened in for investigation.

The Tacoma intake supervisor was not able to participate in the review. Following the fatality review the Tacoma intake supervisor was briefed on the opinion of the review panel and agreed that the referral decision should have been questioned upon secondary review.

Currently Region 5 (including the Tacoma DCFS office) conducts daily intake consensus meetings at which time such referrals are routinely discussed.

Issue: The assigned social worker, whose experience had largely been in CWS rather than CPS, appears to have met policy and practice guidelines for face-to-face contact with the alleged victims, completing the Safety Assessment, and completion of the investigation. All documentation by the worker appears to have been recorded in a timely manner. Both the safety assessment decisions and the investigative findings (unfounded) appear to be correct. Following best practice, the CPS worker contacted the referent for additional information. The referent identified herself as a long time friend of the biological mother of the alleged victim (stepbrother of the deceased child) and stated she was helping her through the custody process. The referent confirmed that she had no direct knowledge about any sexualized behavior and that the boy's father was the one who had originally brought up the concerns. The referent stated knowledge of domestic violence between the stepfather and the victim's mother. It was later discovered that the victim's mother was sitting next to the referent when the call was made to intake and that she was the source of the information.

After numerous home visit attempts, the identified subjects of the investigation (the parents) were interviewed at the family residence. The stepfather indicated his concerns that the onset of his son's behaviors began when the biological mother moved to Washington. He maintained that during visits with the biological mother, the boy was left in the care of a woman (the referent) whose ex-boyfriend had molested children. He stated that he had consulted with the child's school (ECAP) about the child's behaviors (subsequently confirmed by the investigator). The CPS worker did not document any discussion regarding the possible exposure to the children in the home to adult sexual material (adult movies, sexual paraphernalia, etc.) nor the reported incident whereby the stepfather threatened to hit his wife and infant. The worker did inquire about the domestic violence history the stepfather had with his ex-wife, and he confirmed prior assaultive behavior and having done time in jail, and indicated he had participated in domestic violence (DV) treatment. The CPS worker did not seek verification of the stepfather's contention of having participated in DV treatment. When the worker inquired about any DV in the current relationship, the mother, in the presence of her husband, indicated there was no DV, stating she would leave her husband in an instance if such occurred.

The worker also inquired as to criminal history and was able to complete a Washington State criminal background check, but criminal data from Texas was not available at the time of investigation in 2006 [Adam Walsh law not yet in effect]. The investigator also

inquired as to substance abuse and child abuse history of the parents as children for risk assessment purposes. The CPS worker did not document any inquiry as to any CPS history from other states. During the initial home visit the worker saw documents in the possession of the stepfather regarding the circumstances surrounding his having custody of his two biological children. The social worker's narrative account of the home visit and parent interviews was detailed and extensive although the bulk of the documentation related to the interview with the stepfather and very little regarding his wife.

While most of the interview with the stepfather appeared to have been conducted without his wife (who arrived late into the home visit), she was interviewed only in the presence of her husband. In reviewing the social worker's narrative, it appeared to the review panel that the stepfather controlled much of the discussion.

The worker interviewed the alleged victim and the older sibling who was not identified as a victim. Neither child disclosed victimization of any type of abuse or neglect. Information from the ECAP and school staff did not indicate any concerns regarding the parents or the children, including any manifestation of sexualized behaviors by either child.

Prior to closing the CPS investigation, the stepfather made what appeared to be veiled sexual abuse allegations against his ex-wife and her boyfriend (see below). The CPS worker made a report to CPS intake based on the stepfather's statements. The CPS worker was assigned to look into those concerns and conducted a low risk intervention (not requiring a full CPS investigation).

The case was closed in early January 2006. The findings were unfounded for sexual abuse by the mother and stepfather. The findings appear to be supported by the investigative documentation. In reviewing the Investigative Risk Assessment the panel members agreed that the worker's assessment of the overall level of risk may have been rated too low. The areas of under-assessed risk included child vulnerability, DV history, CA/N as a child (stepfather), and familial stress.

Recommendations: As noted in a previous recommendation (see above), while training on conducting interviews with child victims has been required for CPS workers for many years, there has been a lack of training on interviewing caregivers and subjects. In 2005-2006 no such training was available to social workers. At the time of this review it was believed that CA was considering such training, and, as noted elsewhere in this report, it is recommended that CA continue to pursue such curriculum.

At the time of the child fatality review CA was already in process of developing guidelines for intake workers to inquire about any knowledge of domestic violence in the family they are reporting on with referents. It is recommended that CA continue with this plan.

It is also recommended that CA continue with the plan to develop state-wide guidelines for department social workers on how to interview caregivers and children about domestic violence in the home. This includes guidelines for interviewing partners separately when there are concerns regarding intimate partner violence.

Actions Taken: The investigating social worker was not able to be present during the review due to an emergency medical situation. However, she was briefly interviewed by the regional CPS Coordinator prior to the review. She did receive preliminary feedback regarding her investigative activities. The worker acknowledged at that time that she had not inquired as to any CPS involvement from other states and had not confirmed the stepfather's contention of having participated in a one year treatment program. At the time of the child fatality (post case closure) the worker had returned to a CWS case load.

Note: Children's Administration changed to a different risk assessment model at the end of 2007. The current Structured Decision Making (SDM) assessment is an actuarial tool that reduces the likelihood of over or under assessment of risk as it is a more structured instrument.

Issue: The stepfather contacted the CPS worker who was in process of closing her investigation of the prior referral. He indicated concerns that his two older sons may have been molested. His then seven-year-old biological son had indicated he had slept on the couch with his biological mother's boyfriend during a recent visit. The child was indicating anxiety about spending time at his mother's and said the boyfriend was nasty (unspecified). The stepfather indicated he had also contacted law enforcement (911) and someone spoke to the boy over the phone (unconfirmed). There did not appear to be any disclosure by the children of having been molested. In consultation with her supervisor, the CPS worker contacted CPS intake for a new referral that based on her conversation with the stepfather, was intended to be for information only. Later documentation (post intake) by the CPS worker shows she was still under the impression that the report had been taken as an information only referral.

The referral was processed by Tacoma CPS intake and accepted for a low risk intervention on an already open CPS case. The identified subject was the biological mother of the stepfather's children who were both identified as victims of negligent treatment or maltreatment. As in the prior referral, the deceased child was not identified as an alleged child victim or a child at risk.

While the father of the children seemed to be suggesting possible sexual abuse, the basis for accepting the referral appeared to be based on the biological mother letting one of the children sleep on the couch with the boyfriend during a visit. The report was not taken as a sexual abuse referral, and the biological mother's boyfriend was not identified by last name and was not identified as a subject. The referral was taken under the stepfather and the

mother's case number, as they were the primary caretakers of the children and had an open CPS case.

The child fatality review panel found the intake to be confusing. It is possible that sexual abuse as allegation was not identified under the belief that the biological mother's boyfriend was a third party and not a caregiver or person acting in loco parentis, although there was sufficient reason to believe the boyfriend was residing in the home. As the intake worker did not indicate any failure on the biological mother's part to protect her children from alleged sexual abuse, a more reasonable assumption may be that the intake worker concluded there was insufficient reason to believe that sexual abuse had occurred, which appears to be consistent with the CPS worker's narrative account of her conversation with the stepfather.

If the referral was indeed accepted on the basis that one of the boys slept on the couch with their mother's boyfriend, such fact would not be suggestive of physical neglect. The confusing nature of the referral and the decision to screen it in for low risk intervention did not appear to have any significant impact on the later child fatality.

Recommendations: Cases involving children who are allegedly abused or neglected by a non-custodial parent can be confusing. The current CA intake protocol is to assign such cases under the primary caregiver, usually the custodial parent. Yet the investigation primarily focuses on the alleged subject who is the non-custodial parent, and case notes and other documentation are retained under the custodial parent's case number. This becomes even more problematic when the custodial parent and the non-custodial parent reside in different counties. It is recommended that CA consider reviewing and revising how referrals get assigned, looking at allowing for cases to be created under non-custodial parents name even though the custodial parent may have an existing case file number.

Actions Taken: Neither the originating intake worker nor the Tacoma intake supervisor was available to participate in the fatality review. Following the review, the Tacoma intake supervisor was briefed on the discussion that occurred at the review regarding this intake. Currently Region 5 (including the Tacoma DCFS office) conducts daily intake consensus meetings at which time such referrals are routinely discussed

Issue: The CPS worker conducted a home visit (father, stepmother, and all four children present) just after Christmas 2005 (school was out for holiday break). The CPS worker interviewed the two children at the home but outside the presence of the caregivers. There were no disclosures of sexual abuse. Although not required by policy, the social worker and the stepfather and mother developed a safety plan (although the mother did not sign the safety plan). The agreement was to temporarily require only supervised visitation between the biological mother of the stepfather's children when the boys visited her, regardless of the presence of her boyfriend. During the home visit the stepfather detailed to the worker the on-going custodial issues with his ex-wife. The stepfather stated that he did

have difficulty believing his ex-wife's boyfriend would be so bonded with his sons. The stepfather as a self-example, stated that he had a hard time bonding with his stepson (the deceased child).

The CPS worker requested medical records for the stepfather's biological children which were received in late December. Both children were up-to-date on immunizations and well-child checks, and there were no noted concerns according to the social workers notation in review of the medical records.

The CPS worker was contacted by the stepfather's ex-wife who was upset at having been shown the CPS safety plan by the ex-husband. The CPS worker, as she had done with the stepfather suggested that his ex-wife seek relief in family court regarding visitation and other aspects of the parenting plan. The worker did not document any effort to obtain the full name of the ex-wife's boyfriend for addition to the CA data base.

As noted elsewhere in this report, the case was closed in early January 2006. After the case was closed by the worker (but still inactive to the CPS supervisor) the deceased child's mother contacted Central Intake wanting to speak to the CPS worker. She stated to the CI worker that the family was in crisis after her husband and his ex-wife apparently had a sexual encounter. The ex-wife was claiming her ex-husband had raped her. It is unclear as to what the mother was requesting other than to speak with the CPS worker that had been recently involved with the family. With the exception of requests for record disclosure by the stepfather and his ex-wife in early February 2006, it does not appear that there was any further contact by the family with CA until the child fatality notification on February 20, 2006.

Recommendations: None

Actions Taken: The investigating social worker was not able to be present during the review due to an emergency medical situation. At the time of the child fatality (post case closure) the worker had returned to a CWS case load.

Child Fatality Review #06-54
Region 5
Bremerton Division of Children and Family Services

This sixteen-year-old Caucasian female died from acute drug intoxication (ingestion of medications). Her death was classified as a suicide.

Case Overview

On May 2, 2006, the deceased youth was found unresponsive by her mother. The youth was recently dismissed from an eating disorder program in Utah. The youth shared a bed with her mother since returning from Utah. On May 1, 2006, the mother went to sleep about midnight and her daughter was awake. The mother awoke the next morning and found her daughter dead with a suicide note in hand.

Referral History

On March 21, 2006, a therapist reported the deceased youth's then 15-year-old sister disclosed past sexual abuse by her father. The sister disclosed that between the ages of six and eight she and her sisters were sexually abused by their father. This was previously reported in Idaho when the sister was in a psychiatric hospital. The sister stated her mother did not know of the abuse. The girls had not lived with their father since 1999. The therapist indicated the mother responded appropriately to the situation. The referral was accepted for a low risk intervention. Services were offered to the mother, but she declined. Law enforcement was notified.

On December 19, 2003, a teacher reported to Children's Administration (CA) intake that the deceased youth and her two sisters (then ages 11-14) were left home alone at night when the mother went to work in Seattle. It was alleged a nanny may have been staying at the house for a few hours at night. The referral was screened as information only.

Issues and Recommendations

Issue: On December 19, 2003, CPS intake received second-hand information that three children (ages 11-14) might be left at home in the evening while their mother was at work. In review of the intake report, there was little information regarding the maturity, functioning or capacities of the children. As the report was made by an educator, it would be reasonable to assume that such information was available at intake. It is noted that at the time of the report there was information that there may have been a nanny present during some of the evening hours. The report was taken as information only. The intake decision appears to have been reasonable.

Recommendation: No Recommendations

Comment: Since 2003 significant strides have been made in Region 5 and across the state in improving the information gathering process at intake including asking referents about both child and caretaker characteristics for risk assessment purposes. This effort continues in Region 5 with daily intake consensus and quarterly regional intake meetings in which such issues are routinely discussed.

Action Taken: The intake worker participated in the review and received feedback. The current Bremerton DCFS supervisor also participated in the review.

Issue: On March 21, 2006, a mental health professional reported a fifteen-year-old client was disclosing prior sexual abuse by her father. The teen also indicated that her older sister, the deceased youth, may have also been molested by the father who lived in California. The information apparently had been previously reported when the child was in in-patient psychiatric hospitalization in Idaho. It was not clear as to whether any incidents occurred in Washington State, although that may have been a possibility. Not having specific information regarding time frames and incident locations (jurisdiction) complicated the intake decision. Investigations of child abuse by CPS can only occur if such alleged incidents occurred in Washington State, and by law the incidents must be recent (RCW 74.13.031). This does not preclude law enforcement from conducting investigations on historical sexual abuse.

While there was reason to believe that the alleged sexual abuse was historical and not recent, initially the report was accepted for investigation. That decision was changed during intake consensus to a low risk referral, not requiring a full investigation or a finding to be made. The reason for the change in the intake decision was not clearly documented, although there was indication that the children were no longer having contact with their father and thus the risk was substantially lower than if there were current access by the alleged perpetrator.

The intake decision to screen-in the report was discussed during the review. Based on the apparent historical (not recent) nature of the alleged abuse, it would have been reasonable to contact the mother as a collateral contact during the intake process and then simply sending an information only report to law enforcement. It is believed that the decision to take the referral under the low-risk standard was an effort to err on the side of the child and make an inquiry as to the children's current safety. This was viewed as a reasonable and acceptable option to screening-out the report.

The mother was contacted by a CPS worker and she confirmed the child was receiving both therapy and psychiatric services. The mother declined any further services. Additionally, the intake information was sent to both local and California law enforcement jurisdictions where the alleged abuse may have occurred.

The case remained inactive pending closure when one of the other children in the family committed suicide six weeks later. The delay in closing the case was not deemed to have any significance related to the subsequent fatality incident.

Recommendation: As has been recommended in previous child fatality reviews, CA should provide better parameters for what constitutes recent acts as stipulated in RCW 74.13.031 which defines the limits of authority for DSHS to investigate child abuse and neglect. This issue as to what is considered recent has been an item of discussion at state-wide CPS Program Managers meetings and intake leads meetings over the past several years. The issue has yet to be resolved.

Action Taken: Region 5 currently has daily intake consensus meetings to discuss referral decisions, and has implemented an expectation that any changes made subsequent to the initial intake decision will be fully explained in a narrative text. The review panel included numerous individuals who currently participate in the daily intake Region 5 consensus meetings and the discussion served as a reminder of the importance of documenting decisions at intake.

Issue: After the death of the youth, CPS received calls from the child's father and an ex-therapist regarding concerns about the extensiveness of mental health problems and prescribed medications for the children in the family. Intake contacted school staff regarding the two surviving children in the home. The decision to screen out the reported suicide appears correct as there were no specific allegations regarding abuse or neglect. The second referral, after discussion by two Area Administrators, was also screened out (no allegations). However, the decision was made to send a referral to Early Intervention Program (EIP) for the medication concerns reported for the two remaining sisters.

Recommendation: No Recommendations

Action Taken: The Bremerton intake supervisor and Area Administrator participated in the review and both provided and received feedback regarding the intake decisions.

Child Fatality Review #06-55
Region 5
Tacoma Division of Children and Family Services

This two-year-old Guamanian female died from injuries sustained in a traffic accident.

Case Overview

On March 19, 2006, the deceased child was riding in a car with relatives when their vehicle was hit by a larger vehicle speeding through a red light. The driver of the other vehicle was driving with a suspended license, no registration, and no insurance. The collision scene investigator reported the deceased child was not properly restrained in the car.

The adults driving the vehicle did not comply with RCW 46.61.687 requiring a child safety seat restraint system for a person the age and weight of the deceased child. This law specifies that non-compliance with the law does not constitute negligence by a parent or legal guardian. The violation is not considered negligence. It is a traffic violation rather than a crime and cannot be used as evidence of negligence in any civil action.

The deceased child was placed with her maternal grandmother in July 2004. The grandmother was in the process of adopting the child.

Referral History

On January 20, 2004, hospital staff called Children's Administration (CA) intake and reported the mother gave birth to the deceased child; the child and mother tested positive for cocaine. The mother claimed she handled cocaine, but did not use it. The mother had three other children residing in California. The referral was accepted for CPS investigation and closed as founded. The mother's parental rights to the deceased child were eventually terminated.

Issues and Recommendations

Issue: None identified

Recommendation: No Recommendations

Child Fatality Review #06-56
Region 5
Tacoma Division of Children and Family Services

This four-year-old Caucasian female died of cardiac arrest.

Case Overview

On April 23, 2006, a hospital social worker reported to Children's Administration (CA) intake that the child suffered a seizure while in her father's care. The father thought his daughter was cold and had chills when she began shaking. He called 911 and assisted with the child's breathing until paramedics arrived. She was placed into the Pediatric Intensive Care Unit (PICU) at Mary Bridge. The child died later that day.

A pediatrician specializing in child abuse and neglect reviewed the medical information and found nothing in the medical records that would suggest child abuse or neglect (CA/N) was involved in the death of the child.

The cause of death was determined to be from a lack of oxygen to the brain following resuscitation from cardio-respiratory arrest. The cardio-respiratory arrest was caused by the seizure activity brought on by fever and bilateral pneumonia. The death was determined by the Pierce County Medical Examiner to be a natural death.

Referral History

On June 10, 2002, the deceased child, then seven months old, was taken to Mary Bridge hospital with bruising on her buttocks. The child had spent three days in the care of her father and paternal grandmother. Law enforcement was notified. Doctors report the bruising was old and they could not say who inflicted the injuries or when they occurred. The Child Protective Services (CPS) referral was screened in for investigation and closed as inconclusive.

On June 18, 2002, it was reported to Children's Administration (CA) intake that the father of the deceased child spanked and grabbed his stepson. The referral was screened as information only.

On October 8, 2002, the deceased child's mother reported the child's father was physically abusive toward the child. The referral was screened as information only.

On April 4, 2003, the deceased child's mother requested services from a CA social worker. She was pregnant at that time and admitted to using drugs. She said a urinalysis a week prior was positive for drugs. The mother reported she allowed her son to live with his father despite the father's violent history. The referral was screened as information only.

On September 12, 2003, the deceased child's mother gave birth and admitted past history of drug use. The mother told hospital staff that the child's father was abusive and controlling. The referral was screened as information only.

On October 16, 2003, a report was made to CA intake alleging a domestic violence incident between the deceased child's parents. The parents engaged in a "tug of war" with their newborn baby. The child was uninjured. It was also reported the father may have also hit the then 2-year-old child. The referral was accepted for investigation by CPS.

On December 18, 2003, CA intake received a report that the deceased child's mother was hiding herself and the child at a woman's shelter. The mother was not returning the deceased child to her father, the custodial parent. The mother alleged physical abuse of the child. The referral was screened as information only.

On December 18, 2003, CA intake received a report that the deceased child's mother slapped the child on her face and dragged her by the arm. This occurred at a shelter. The referral was screened as information only.

On July 31, 2005, the mother reported she took her daughters, including the deceased child, to be examined by a doctor, claiming the custodial father had molested the children. The exam was normal. A hospital social worker said the examining physician was concerned that the mother was manipulating for custody. The referral was screened as information only.

Issues and Recommendations

Issue: None identified.

Recommendation: None identified.

Child Fatality Review #06-57
Region 5
Bremerton Division of Children and Family Services

This 16-year-old Caucasian female committed suicide by hanging.

Case Overview

On December 1, 2006, the deceased youth was found hanging from a shower door rail by a belt. Her father had seen her 15 minutes earlier when the two had a discussion about her MySpace web page. She started to cry and went into the bathroom. The father forced open the bathroom door after not hearing any movement and found his daughter hanging. He called 911, medics arrived and performed CPR. Medics found the youth cool to the touch. She was transported to a local hospital where she was pronounced dead.

The deceased youth's parents said their daughter was depressed for some time. She had previous suicidal ideation by cutting herself with a razor blade. At the time of her death, the youth was in counseling and taking anti-depression medication.

Referral History

On December 2, 2006, a hospital social worker called Children's Administration (CA) intake reporting the suicide of the 16-year-old deceased youth. The youth hanged herself in the bathroom of her father's home. The youth went to live with her father in September 2006 after she disclosed sexual abuse by her mother's boyfriend. She had been to the hospital two weeks prior for anxiety and depression. At that time, she talked about wanting to die.

On September 25, 2006, school staff contacted CA intake as the deceased youth was seen with an ACE bandage on her left forearm. She reported she fell skateboarding and received eight stitches. She also said she got in a fist fight with her father and sustained a bruise on the upper part of her arm. She later said they were playing. The deceased youth did not seem upset. This referral was screened as information only.

On September 10, 2006, the deceased youth, then 16-years-old, alleged she was a victim of ongoing rape by her mother's boyfriend. The youth went to the police and disclosed the rape. She said her mother did not believe her. The youth was placed in her father's care. This referral was screened in for investigation by Child Protective Services (CPS) and closed with an inconclusive finding. The county prosecuting attorney declined to prosecute.

On April 28, 2006, a teacher reported to CA intake that the deceased youth was afraid of mother and father because they were verbally abusive to her. This referral was screened as information only.

Issues and Recommendations

Issue: On April 28, 2006, CPS received second-hand information from a school counselor that the deceased youth was in conflict with her mother and was staying with an aunt in Seattle. Reportedly the teen had complained of verbal abuse from her parents (who lived apart). There were no specific allegations as to child abuse or neglect and the report was taken as information only. The intake decision appears to be correct.

Recommendation: No Recommendation

Issue: Regarding the referral dated September 10, 2006. A Poulsbo detective reported that the deceased youth had stated she had been sexually abused by her mother's boyfriend who lived in Spokane but visited the home frequently. It was reported that the mother did not believe her daughter's allegations. Additional information from another source (third-hand information) was also called into CPS regarding the alleged sexual abuse and included an alleged incident of physical abuse by the mother's boyfriend. It is unknown why the physical abuse allegation was not also indicated on the intake report. The mother's failure to believe her daughter appears to have been taken as an indication of parental failure to protect and the mother was thus identified as a subject of neglect.

In review of the intake report it was not clear if there were any recent incidents or if the alleged abuse was historical (not current). It was known that the alleged subject had not been residing in the home for some time. While it might be argued that the mother's boyfriend could have been reasonably identified as a third party subject of sexual abuse, indication was that at the time of the referral he was still having occasional access to the child and the report was accepted for investigation.

The general consensus of the review panel was that the decision to accept the report for investigation of sexual abuse and negligent treatment/maltreatment was reasonable and correct.

Recommendation: No Recommendation

Comment: Since 2003 significant strides have been made in Region 5 and across the state in improving the information gathering process at intake including asking referents for clarifying information about timeframes for alleged incidents. This effort continues in Region 5 with daily intake consensus which occasionally results in sending back referrals to the originating intake worker for re-contact with a referent to get more specific information.

Action Taken: The intake worker did not participate in the review. However, the current Bremerton intake supervisor did participate in the review and contributed to the discussion regarding the need to continue to remind intake staff of the need to gather clarifying information at intake.

Issue: Regarding the referral dated September 10, 2006. Law enforcement and the Kitsap County Prosecutors Office conducted interviews of the alleged victim and her brother, as well as several others. The alleged subject denied the allegations and on advice of his attorney declined further contact. The CPS investigator interviewed the biological parents and gathered relevant information. A Safety Assessment and Safety Plan were completed, and the alleged victim went to stay with her father. School staff subsequently reported that the deceased youth had gotten a bruise on the arm stemming from a play fight with her dad. The child did not indicate abuse or fear of her father. That report was taken as information only on the already open CPS case. The worker maintained contact with the detective and the Prosecutor's Office which eventually decided there was insufficient evidence to prosecute. Both mother and daughter engaged in counseling and the CPS worker discussed Family Reconciliation Services (FRS) with the father prior to closing the case in mid-November 2006.

The CPS worker appeared to have met or exceeded policy requirements, such as timelines for documenting the victim interview, conducting a safety assessment, meeting documentation standards, and completing the investigation. The CPS worker also met or exceeded most practice expectations. Interviews with the child's caretakers were conducted. The investigative findings appear supported by documentation (unfounded for neglect by the mother and inconclusive as to sexual abuse by mother's boyfriend).

Minor criticisms were noted during the review, none of which were found to have significant impact on the child's suicide two weeks after case closure. One minor criticism was that the worker did not document the results of the sexual abuse exam. However, the worker did indicate that the results were included in the hard copy of the police report contained in the case file. Another deficit was the lack of consideration in the Risk Assessment regarding the child's mental health issues. There was sufficient information as to significant depression and recent suicide ideation. The social worker did give consideration as a protective factor to the fact that the child was receiving counseling and was prescribed medication at the time of case closure, but did not address the child's self-destructive risk behaviors in assessing the overall level of risk. This omission was found to have no obvious implication to the subsequent suicide event especially given the services the child was receiving at the time of case closure. It was noted during the review that the worker had discussed a number of issues with the child during a 30-day Health and Safety visit. Description of that discussion was documented, although it did not specifically describe any conversation about the significant mental health issues.

Recommendation: No recommendation.

Comment: Children's Administration changed to a different risk assessment model at the end of 2007. The current Structured Decision Making (SDM) assessment is an actuarial tool that reduces the likelihood of over or under assessment of risk as it is a more structured instrument.

Action Taken: The worker assigned to investigate the September 10th referral was not available to participate in the review. However, the worker was notified in advance of the probable issues that would be discussed during the review and was offered an opportunity to provide comments in writing which would be presented in her absence. Post review, the worker was provided with feedback regarding the overall excellent practice as well as the minor issues discussed above.

Issue: On December 2, 2006 Central Intake was notified by the local hospital of the suicide death of the youth. It was reported that the youth had been seeing a therapist and was on medication for depression. The report was taken as information only as there were no child abuse or neglect issues reported. The intake decision appears to be reasonable and correct.

Recommendation: No Recommendation

Child Fatality Review #06-58
Region 5
Tacoma Division of Children and Family Services

This 14-month-old African American male child died from methadone poisoning.

Case Overview

On August 6, 2006, the parents of the deceased child, then 14-months-old, dropped him and his three siblings off at a babysitter's residence around 2:00 in the afternoon. The 19-year-old babysitter lived with her mother. When the parents returned to pick up the children around 8:00 that evening, the mother found her son unresponsive with bloody foam around the mouth. The mother took the child and ran to the car. The parents drove immediately to a nearby local hospital. At the hospital the child was found to have no heart rate or respiration and resuscitation efforts were not successful. An investigation was initiated by law enforcement. The investigation uncovered the fact that the babysitter's mother had spilled her purse earlier that day and lost a methadone pill which she admitted was not from a prescription. The matter was turned over to the Prosecuting Attorney for charging decision. At this time, it is unknown as to the outcome. The law enforcement investigation cleared the parents of the deceased child of any suspicion. The autopsy revealed the child died from methadone poisoning. Given the fact that the death was the result of a felonious act (possession of a controlled substance), the death was ruled a homicide.

Referral History

On August 6, 2000, it was reported to Children's Administration (CA) intake that the mother was routinely homeless, depressed, used drugs, and had attempted suicide. The whereabouts of her children were unknown. The report was taken as information only.

On September 17, 2003, a medical professional called CA intake regarding the deceased child's mother failing to bring in her four-year-old child for an appointment for a black eye. The mother had made the appointment stating the child had been seen at a local emergency room (ER) and it was recommended that the child be seen again by her primary care physician. There was no record by any local ER that the child had been seen. Two days later the medical provider called back to report that the mother did bring in the child. The intake report does not indicate any concerns regarding non-accidental injury. This referral was screened as information only.

On May 22, 2006, law enforcement reported they had been to the home of the deceased child's mother who reported that her boyfriend (the father of the deceased child) had kicked her four-year-old child in the face. The child had a bruise on the side of his face. The mother told law enforcement that her boyfriend had assaulted her in the past and that he had possibly hit one of the children in the past as her children had unexplained bruises

after he had been with the children. Intake took the report as Third Party as the perpetrator of the abuse did not reside in the home.

Issues and Recommendations

Issue: A report made to CPS intake in 2000 was taken as "information only" as the whereabouts of the mother and her two children were apparently unknown (homeless). At that time the reported concerns were regarding parental instability (including mental health), drug use, and general care of her two children. It was not clear as to what active efforts, if any, were made at intake to locate the mother and children.

In December 2003 a medical professional called in concerns to CPS intake regarding the mother failing to bring in her four-year-old child for an appointment for a black eye to be examined. The mother had made the appointment stating the child had been seen at a local ER and it was recommended that the child be seen again by the PCP (primary care physician). There was no record by any local ER that the child had been seen. Two days later the medical provider called CPS intake back to report that the mother did bring in the child. The intake report does not indicate any concerns regarding non-accidental injury. The report was taken as information only.

The review panel discussed the lack of clarity in the 2003 referral. It was not clear if the medical professional initially suspected possible physical abuse due to the mother's story regarding the unconfirmed ER visit, or the concern rested on the mother and child not showing up for the appointment with the doctor. The notation by the intake worker regarding the follow-up call from the medical professional was also unclear and poorly written.

Neither of these reports on the mother was linked at intake to her CA history as child in the early 1990s which is documented in the Children's Administration Management Information System (CAMIS). In the CA data base the mother's birth date was clearly documented under her person identification number in CAMIS. Her children's names were identified in the 2000 and 2003 reports, and a simple search of state birth system (accessible to CA staff through the Department of Health) would have confirmed it was the same person. However, the mother received a different person identification number, thus being replicated in CAMIS.

None of the practice issues regarding the 2000 and 2003 referrals were found to have any significant impact on the child fatality event in 2006.

Recommendations: None

Comment: The current data system used by CA will be replaced in late 2008 by a new one (FamLink) and it anticipated that search and cross-referencing processes will be improved.

Action Taken: Region 5 intake workers are currently required to document active efforts to locate children and parents whose whereabouts are unknown at the time of the intake. This includes searching DSHS data bases, contacting the local CSO or child support enforcement, etc. Additionally, the expectation for clear documentation of information provided to intake workers has been emphasized at supervisory reviews, regional consensus, and quarterly regional intake meeting. A special intake focused Lessons Learned from R5 Fatality Reviews 2006-2007 is tentatively planned for September or October 2008 at which time active efforts to locate and clarity of documentation will be discussed.

Action Taken: The duplication of the mother's identity in CAMIS is in process of being corrected.

Issue: On May 22, 2006, the mother contacted law enforcement to report that her boyfriend had kicked her four-year-old in the face while babysitting the children. Law enforcement notified CPS via a mailed-in police report. The mother had also reported to law enforcement that there had been prior assaultive behavior on the part of the deceased child's father, including domestic violence and a past physical abuse incident involving one of the other children (unspecified time frame). The mother's boyfriend was the father of the youngest child only.

The report was recorded by CPS intake as a Third Party report. Although the father was caring for the children (babysitting) at the time of the incident, he was not apparently living in the home. WAC 388-15-013 authorizes child protection involvement when there is an allegation that a child has been abused or neglected "By a parent, legal custodian, or guardian of the child..." The father was not the parent of the child alleged to have been physically abused.

It is noted that the criteria used at intake to determine sufficiency for screening in a report of child abuse or neglect requires an affirmative to the question "Was the alleged perpetrator a caretaker of the child or acting in Loco Parentis; or is the parent negligent in protecting the child from further Child Abuse and Neglect?" Babysitters or relatives watching children, despite being temporary caretakers, are generally considered third parties unless a member of the household and providing either a fiduciary function or on-going supervision and care of the children. Given the significant relationship the father had to the family although not living in the home, the argument was raised during the review that the father might have been considered as acting in Loco Parentis. This was not the majority view. However, given that the mother, by her own admission to law enforcement, had left the children in the care of person whom she knew to be assaultive, an argument could have been made that she had demonstrated neglect. By statutory definition (RCW 26.44.020 and WAC 388-15-009), there must be circumstances of "clear and present danger" to the child's health, welfare, or safety. Applying such to the reported situation appears to be unsupportable in terms of screening in the report for neglect against the mother who was in fact reporting her boyfriend to law enforcement.

Recommendation: CA should make an effort to reconcile the narrow limits of statutory authority to provide child protection as found in WAC 388-25-013 with the more liberally applied sufficiency screen question used by CPS intake to determine a CPS response if the alleged abuse is reported to be perpetrated by a "caregiver" or person acting in Loco Parentis.

Issue: The mother has three distinct person identification numbers in Children's Administration Management Information System (CAMIS) reflecting the fact that she has been re-created in the data system twice (three total person identification numbers). This includes her original identification number as a child, a re-created identification number created in 2000, and a different identification number created in 2006.

When searching referral history under the mother's first person identification number in CAMIS, it shows referrals related to her as a child and referrals from 2006. It does not show a connection to referrals from 2000 and 2003. When searching the mother's second person identification number in CAMIS it shows no connection to her referral history as a child, no connection to the 2006 reports, but does list the 2000 and 2003 referrals. When searching the mother's third person identification, it shows no connection to any referrals, as a child or as an adult.

Recommendation: None

Comment: CA will be initiating a new data base system called FamLink in late 2008, and it will replace the current CAMIS system. It is anticipated that such data base entry problems will be reduced with FamLink.

Actions Taken: The benefits of searching the DOH birth certificate data base have been presented on several occasions at Region 5 Intake Meetings in the past two years by the regional CPS Program Manager. This issue will again be presented at the planned R5 "Lessons Learned from Child Fatalities 2006-2007" presentation scheduled for R5 intake workers in September or October 2008.

Actions Taken: The three person identification numbers for the mother are in process of being corrected (clerical). Any further CPS intake reports should show a connection to all referrals regarding the mother, as a child as well as a parent.

Child Fatality Review #06-59
Region 5
Bremerton Division of Children and Family Services

This two-month-old Caucasian female child died of Sudden Infant Death Syndrome (SIDS).

Case Overview

The mother of this two-month-old infant spent the night at a friend's home. The mother reported that she went to bed around 3:00 a.m. on the morning of October 11, 2006. She slept on the edge of a large mattress; she put her baby to sleep on a blanket on the floor, surrounded by pillows and stuffed animals. The mother awoke around 7:00 a.m. and checked on the baby. She appeared alive and healthy. Later that morning she awoke again to find her baby not breathing. The mother's friend called 911. They then drove to a nearby Urgent Care facility not waiting for emergency responders to arrive. The infant appeared to have been deceased prior to transport based on examination by the emergency room physician at Urgent Care.

Based on death scene investigation, law enforcement investigation, post mortem examination and toxicology studies, the forensic pathologist attributed the death to Sudden Infant Death Syndrome, and the manner of death was determined to be natural. The toxicology report showed no presence of drugs or alcohol in the infant's system. The child appeared normal and healthy. There were no indications of injury or trauma.

Referral History

On December 25, 2004, hospital staff reported to Children's Administration (CA) intake that the mother of the deceased child was admitted unconscious due to methamphetamine abuse. The child's grandmother reported the mother's drug use was out of control and she was unable to care for her two-month-old son (brother of the deceased child). This child was staying with his paternal grandmother. This referral was screened as information only.

On January 3, 2005, the paternal grandmother called to report that she still had the then two-month-old brother of the deceased child in her care. The child's mother had not seen him since December 10, 2004. The mother called to say she would pick him up, but never showed. The father was in jail on domestic violence charges. This referral was screened as information only.

On February 17, 2005, the paternal grandmother called to report the mother gave her three-month-old baby liquid Tylenol 3 times per day. It was also reported the mother was an intravenous methamphetamine user. The referent reported the baby is not being fed properly while in the mother's care. The referral was investigated by Child Protective Services (CPS) and closed as inconclusive. That child was removed from his mother's care due to neglect

and substance abuse. A dependency was established on this child. The mother attempted outpatient drug/alcohol treatment and was discharged for relapse and missed attendance. She failed to complete or comply with court ordered services. She relinquished her parental rights in April 2006. The child was adopted by his paternal grandmother.

On May 1, 2006, it was reported to CA intake that the deceased child's mother was pregnant and due in August 2006. She relinquished custody of her first child without completing any services. She was referred for inpatient treatment and did not complete a psychological evaluation. She completed an anger management assessment and was recommended for three months treatment, which she did not begin. This referral was screened as information only.

On August 21, 2006, hospital staff reported to intake that the mother gave birth to an infant girl (the deceased child). The baby was healthy at that time. The mother's urine drug screen was negative. The baby tested positive for opiates. The mother agreed to voluntarily place this child with the paternal grandmother. The case was staffed with a community-based Child Protection Team (CPT), and it was recommended to reunite mother and baby with extensive services and close monitoring. The referral was investigated by CPS and closed as unfounded.

On October 11, 2006, the death of this infant was reported to CA intake. This referral was screened as information only.

Issues and Recommendations

Issue: In May 2006 CPS intake was notified by a DCFS supervisor who had become aware that the mother was pregnant and due to deliver in three months. The mother was a known drug user and had a previous child removed through dependency action in 2005 with relinquishment occurring in April 2006. No children were currently in her care. The report was taken as "information only" per prenatal referral policy guidelines. There is evidence that the local hospital was provided with an alert letter requesting they contact CPS if and when the mother delivered.

Recommendations: None

Comment: The hospital alert letter sent in advance of delivery is deemed excellent practice. There is nothing to require such departmental action, and taking such proactive measure is commendable.

Issue: In August 2006, a Kitsap County hospital notified CPS that the mother had delivered the deceased child. There were no health concerns for the mother or newborn, and preliminary drug screen results showed negative for drugs. Although later tests showed the newborn tested positive for opiates, medications given to the mother prior to delivery may

have accounted for the positive drug screen. As there were no allegations, the report was accepted under "imminent harm" based on the mother's history of a recent relinquishment and prior non-compliance with court ordered services. On review the intake screening decision was deemed appropriate.

Response by CPS was immediate and both mother and newborn were seen at the hospital. The case was staffed and the decision was made for the child to be placed with a relative under a signed Voluntary Placement Agreement (VPA). Information was gathered from a variety of sources. The case had routine supervisory review. A courtesy home evaluation of the relative was requested by Pierce County, and this was done in a timely manner. Drug and alcohol testing was done on the mother and efforts to get a chemical dependency assessment were made but became complicated by the fact that the mother resided in Kitsap County but was temporarily staying near the relative's home in Pierce County so she could have contact with the infant and breastfeed.

A combined Child Protection Team (CPT) and Family Team Decision Making (FTDM) meeting was held. The decision was to return the infant to the mother who was living with her grandparents. The fact that the VPA was vacated as the child returned home was never documented in the CA data base although it was in social worker narratives.

The CPS worker appears to have met policy and practice guidelines. Documentation was excellent, and the number of contacts (medical providers, service providers, relatives) was commendable. The investigation/assessment was conducted in a timely manner and appropriately transferred to DCFS voluntary services with a service plan.

The only noted practice error noted during the review involved the likelihood that the child should have been considered for Native American (NA) heritage. While the intake worker had indicated no Native American heritage, the earlier referral acknowledged possible tribal affiliations and the case with the prior child was assigned to the Indian Child Welfare (ICW) unit. Determination of ICW status is critical in placement decisions. The law does not allow a VPA to be taken for a child of Native American ancestry if less than 10 days old, and, if older, the VPA must be presented in court prior to implementation. The CPS worker could not account for how the possible Native American status was missed. The possible illegal nature of the VPA situation was not found to have any significance to the subsequent SIDS death of this child

Recommendations: None

Comment: Training on Indian Child Welfare laws and practices is required for all CA social work staff, and offered many times a year throughout all six regions of CA. Intake workers are required to inquire as to Native American status for every referral, and CA practice guidelines clearly state that such inquiry should be made throughout the life of a case, and especially at case transfer.

Action Taken: The worker participated in the review and received feedback regarding her practice. She acknowledged the error regarding the VPA on an infant of possible Native American heritage, but could not account for how the error occurred as it was contrary to her general practice. She also was recognized for her good work which was apparent upon review.

Action Taken: A "Lessons Learned" presentation is planned for the Bremerton DCFS All-Staff meeting in September or October 2008. At that time practice issues surfacing during recent child fatality reviews conducted in the Bremerton office, including this review, will be presented and discussed. The presentation will include general practice issues that surfaced during reviews whether or not directly related to a child fatality investigation. This will include a reminder to social work staff as to VPA requirements for Native American children and as to reducing simple data input errors such as failing to document vacated VPA or expired protective custody actions.

Child Fatality Review #06-60
Region 5
Tacoma Division of Children and Family Services

This one-month-old Caucasian male died from positional asphyxiation.

Case Overview

On November 9, 2006, Lakewood Police reported to Children's Administration intake the death of this one-month-old infant. The child's father called 911 after he had come home around 11:30 a.m. that morning and found the child's mother lying on top of her son on a mattress that was on the floor. The baby was blue, not breathing, and was rigid. The child was pronounced dead shortly after medics arrived to the family home.

The autopsy revealed the infant was adequately nourished and healthy. There were no marks or signs of injury, and toxicology results were negative for drugs. The cause of death was entered as suffocation by overlaying (evidence of co-sleeping) and the manner determined to be accidental. Law enforcement initiated a court-ordered blood test on the mother at the time of the incident and the results returned in late December 2006 showed she had been positive for cocaine. The mother's drug intoxication may have contributed to the child's death. The mother has a criminal history of prostitution, drug possession, and assault. The father had no substantive criminal history, although did have an outstanding misdemeanor warrant at the time of the fatality. Both parents were arrested on outstanding warrants.

Referral History

On August 30, 2004, the mother's, then four-year-old, son was found wandering in a motel parking lot. When the mother finally arrived on the scene she appeared under the influence of drugs. The child was placed into protective custody and Child Protective Services (CPS) was notified. A dependency petition was filed and the child has remained in care. The referral was investigated by CPS and closed as founded. The father completed all court ordered services and this child was returned to his care.

The mother still had an open, active dependency case regarding this child at the time of her infant son's death. However, the department had no contact with the mother in over a year. She had discontinued contact with Juvenile Court, had not maintained compliance with court ordered services, nor had she visited her son in over a year. Her whereabouts had become unknown. The mother delivered the deceased child at home, which may have been an attempt to avoid losing custody of this child. The department had no knowledge of the mother being pregnant or giving birth to the deceased child prior to the notification of the child fatality.

Issues and Recommendations

Issue: None identified

Recommendation: No Recommendations



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Child Fatality Review #07-02
Region 3
Everett Division of Children and Family Services

This two-month old infant died of natural causes. The cause of death was listed as both unexplained and undetermined.

Case Overview

The mother and her three young children were staying at a motel in Marysville. When they awoke the morning of May 14, 2007 they found the two month old child unresponsive, and called 911. The infant was taken to a hospital by ambulance, and was declared dead at 8:15 a.m. There were no obvious signs of trauma to the infant. An autopsy later could find no apparent cause of death, and the toxicology screen was negative for substances. The official cause of death was listed as both "unexplained" and "undetermined." The manner was listed as "natural."

Referral History

There was one prior referral on this mother. Her baby (then 6 weeks old) was hospitalized to correct an intestinal birth defect. She developed an infection while in the hospital. Medical staff questioned the mother's ability to care for her infant. The mother had difficulty waking to the baby's cries and had to be repeatedly prompted to hold bottles upright to prevent the baby from swallowing air. There was also a concern that the mother was not feeding the child enough formula for the infant to make adequate weight gain. This referral was not screened in for investigation.

At the time of the child's death, her mother was in the custody of the Tribal Nation. She had been in relative placement. There were four other children living in the home at the time. Two other teen girls who were also placed by the Tribe, and two biological children in the family. The mother and baby had been in the home for only two weeks prior to the death.

As a child, the mother and her siblings had considerable involvement with CPS. Her mother had ongoing issues with chemical dependency, incarceration, and domestic violence. There were some domestic violence issues with the children's father, and after their separation her mother was involved in an extremely violent relationship with another man, whom she later married.

The mother came into care in 2005, at her age 13. She was in relative placement. She got pregnant and her aunt was unwilling to continue as her placement. In October of 2006, the mother and her baby moved in with her older sister. There were several supports in the home for the mother and infant. By two weeks, the situation had deteriorated. The mother was not happy there and her baby appeared to not be gaining weight. The baby was taken to a doctor, but no concerns were noted. This information was presented to the Tribal Child Protection Team (CPT). It was discussed whether dependency needed to be filed on the infant. The CPT recommended keeping the infant with her mother without legal action, and

recommended other supports for the mother, such as a parenting class. As of November 1, 2006 the mother and infant were looking better. The baby saw a doctor on October 30, 2006.

Issues and Recommendations

Issue: There was considerable activity on this case in both in CPS and in the Temporary Assistance for Needy Families (TANF) case. Different agencies within DSHS had different pieces of information about the family. It appears that improved coordination among those agencies would have resulted in an improved assessment of the family's total functioning.

Recommendation: The feasibility of granting some access for social workers to "ACES on-line" and the "Document Managing System" be explored by regional management.

Issue: One of the referrals in this case was assigned in the Lynnwood catchment area in error. Although that fact was realized early on in the investigation, there were difficulties encountered when transfer of the case was attempted. This had some affect on the handling of the case when it eventually got to the correct office.

Recommendation: The review team recommends that the regional transfer policy for CPS and Family Voluntary Service cases be updated as necessary to include written expectations for timeframes and that this policy be discussed at the upcoming regional meeting of CPS and Family Voluntary Services supervisors.

Issue: In the documentation on services provided in response to referral dated May 24, 2005, there was considerable discussion of compliance with services, but no documentation that the original allegation that screened the referral in, was specifically addressed with the mother, or with collaterals.

Recommendation: Action Taken: The Regional Safety Program Manager will be incorporating this issue into regional trainings on safety planning.

Issue: The social worker assigned to the last referral prior to the death did not input the case activity notes and closing assessment until more than a year after she received and began work on the referral. As a result, it was not clear if all of the activity was captured in that documentation. The delay in writing the report was caused by the movement of the worker to another position prior to her closing out/transferring her cases.

Recommendation: The team recommends that a region-wide protocol be instituted concerning the transfer of case-carrying social workers from one assignment to another within the region. The protocol should address the disposition of the workload that the social worker is leaving. Written expectations for case transfers and closures should be completed prior to the social worker's leaving.

Issue: The fact that a prior infant death had occurred in this family was not noted in the most recent referral prior to the last death. The review team believes our information

system would be improved if that information could be automatically brought forward into each new referral in a case.

Recommendation: ACTION TAKEN: This information was forwarded to the regional FAMLINK lead for consideration in the new information system.

Child Fatality Review # 07-03
Region 2
Richland Division of Children and Family Services

This two-year-old Caucasian male child died as a result of accidental drowning in an irrigation pond on the family property.

Case Overview

A missing child report was received by Benton County Sheriff's Office from this child's guardian on April 27, 2007. After an extensive search was conducted by Benton County Deputies and Yakima Search and Rescue Team members, the child's body was found in an irrigation pond on the property near the family home. The Division of Children and Family Services Richland office was notified of the child's death by Benton County Sheriff's office on May 1, 2007.

Referral History

This family is a blended family which includes the child's paternal aunt and uncle. In addition to the identified child four other children reside with the care takers. This child was placed in the care of his paternal aunt and uncle following the death of his mother from an overdose of illicit substances and the conviction and subsequent incarceration of his biological father for sexually abusing his four-year-old sister. Third Party Guardianship of this child was awarded to the paternal aunt and uncle by Benton County Superior Court in late 2006.

The Child Protective Services history affiliated with this family prior to this child's death includes three information only referrals, only one in which either parent was identified as a subject. The only referral in which either parent was listed as a subject was in August 1999. An information only referral regarding the physical condition of the home was received; however the referent did not indicate there were significant issues which could affect the health or safety of the children in the home. However, a social worker did visit the home and recommended the family clean the area, however did not note any hazardous issues. The referral was not assigned for investigation.

The May 1, 2007 referral referencing this child's death was accepted for investigation and worked in collaboration with Benton County Sheriff's Office. The assigned social worker interviewed the relative guardians in their home in addition to making several trips to see the property and gain an understanding as to the circumstances of the child's death. The social worker addressed several external safety hazards with the family and made recommendations to the family to alleviate excessive clutter and safety hazards. During the home visits the guardian's also acknowledged the cluttered appearance of the inside of their home. Due to circumstances around this child's death and funeral arrangements they

had not been home to restore order. They stated the home is generally picked up and clear of hazards.

During an in depth interview with the guardians regarding the events leading up to discovering the child's body in the irrigation pond behind the home was described. The aunt stated the child was up early, around 7:30 a.m. as he in all likelihood heard his uncle leave for work. She stated she put him down for a nap around 9:30 a.m. which was customary in their home. She stated she works nights and once the older children are off to school; she and the youngest two children (one being the child in question) would lie down and take an early morning nap. When asked if the front door had been locked or secured prior to the family taking a nap, she stated it was not and added both children can unlock the door lock and the dead bolt even if they were locked.

The guardians stated it is their understanding when the child awoke from his nap he wandered outside into the field where the horses were grazing and could have possibly fallen or been nudged by a horse or one of the family's dog into the irrigation pond where he was found. The uncle stated when he arrived home from work at approximately 11 a.m. for lunch he noted the child was missing and began looking for him. As a member of the Yakima Search and Rescue Team the uncle was familiar with search procedures. The child's body was found by Deputies shortly after 1 p.m. in the irrigation pond not far from their family dwelling. The County Coroner ruled the child's death as accidental drowning.

Family Preservation Services were offered to the family for purposes of dealing with their grief and assisting the family in explaining the child's death to their children. They later declined services. However, given the circumstances around the child's death and hazards noted externally a safety plan was developed to remove potential hazards and to increase door security and supervision of the surviving children. The family was cooperative in the plan development and secured additional locks for the only door used for entering and exiting the home.

Issues and Recommendations

No issues or recommendations were identified at this time. Participants in the fatality review noted the incident was a tragic accident.

Child Fatality Review #07-04
Region 2
Yakima Division of Children and Family Services

This two-hour-old Caucasian male child passed away shortly after birth. The cause of death was determined due to premature birth and exposure to illicit substances.

Case Overview

On August 22, 2007, the mother delivered a premature infant boy who was only able to survive for approximately two hours. The mother notified hospital staff she was four or five months pregnant, had received no prenatal care to date and was in pain caused by cramping and bleeding. The mother tested positive for amphetamines, methamphetamine, opiates, benzodiazapines, marijuana, and anti-depressants. The mother refused medical treatment despite having come to the hospital.

Referral History

The mother has extensive history with Children's Administration (CA); both as a child victim and as a parent. In total there are twenty-five referrals in which the mother is affiliated either as a victim or as a subject parent/care giver.

The mother grew up in the foster care system having been placed multiple times. She was diagnosed with conduct disorder at an early age and was physically violent. She ran from placement often and eventually aged out of the system.

To date, the mother has had five live births. In regards to her abuse/neglect history as a parent, the mother is associated with fifteen reports of abuse or neglect. Of those fifteen she is the identified subject in nine referrals with six of those referrals assigned for investigation. Findings include three founded for physical neglect and two inconclusive.

The mother does not have custody of any of her children at this time. The most recent child was born on August 22, 2007 and passed away two hours after delivery.

A DCFS social worker interviewed the mother while she was still in the hospital and shortly after the infant's death. She told the social worker that "the allegations did not matter since the child was deceased." She refused to speak further and according to the social worker observations showed no remorse regarding her newborn's death.

Nurses reported the mother refused to take any medications to slow down her labor knowing if the child was born that day he would not survive. When the hospital social worker attempted to talk with her about this she swore at her and kicked her out of her room. The mother told hospital staff her life style would kill the baby anyway. She

obtained no prenatal care and actively used drugs during her pregnancy, testing positive for six different drugs the day prior to the child's delivery.

A variety of services have been offered to the mother over the years since she has been an adult but most have been refused. Services offered included mental health services, substance abuse treatment and parenting classes. The department has also found it difficult to track her whereabouts as she does not maintain any type of residence for long periods of time. Social workers have attempted to engage her, especially after delivering her last two children, but she has not cooperated and has failed to provide an accurate address and phone information as a means to avoid contact with the department.

Issues and Recommendations

There were no issues or recommendations identified by this review team.

Child Fatality Review #07-05
Region 6
Vancouver Division of Children and Family Services

This one-month-old Caucasian child died from positional asphyxiation.

Case Overview

On September 26, 2007, the parents of this one-month-old infant found him limp with blood coming from his mouth. The infant slept with his parents, both of whom consumed a considerable amount of alcohol the night before. The child's mother had been drinking throughout the day, and then proceeded to go with a friend to a local bar. The father was home watching the child and reported he drank several beers prior to bed. The father reported he fed the child at approximately 11:00 p.m. and laid him on the bed beside a sibling. The father reported laying the child on his back.

No other signs of trauma were noted.

The mother had custody of two other children from a prior marriage, a 5-year-old male and 7-year-old female. Both were placed with their biological father following the death of their sibling.

The father of the deceased child had a conviction for Malicious Mischief 3, Domestic Violence. There was a no contact order issued, protecting the child's mother. The father left the area and did not cooperate with the investigation.

The mother and siblings were offered services through the department to deal with their grief. The mother was offered services to deal with substance abuse and domestic violence issues.

The department was able to secure the law enforcement reports which summarize the investigation and findings. Included in the law enforcement reports was information from the medical examiner. The medical examiner would not release any records for purposes of the fatality review citing legislation that prohibits him from providing the documents. The nature and cause of the death were obtained from the law enforcement reports.

Referral History

On June 11, 2003, a referral alleged the sibling of the deceased infant came to childcare with blisters on his head and bruises on his body. He had bruise marks on his legs and bite or burn marks on his back. A child protective services investigation was conducted on these allegations and closed as unfounded.

On February 15, 2007, it was reported to Children's Administration (CA) intake that the, then five-year-old, sibling of the deceased child was cross-eyed and has very poor vision. The parents were following the treatment plan to address these issues. The parents were not keeping doctor appointments and not following through with recommended surgery for this condition. School personnel report the child was unable to learn without glasses. This referral was not screened in for investigation. This information was screened in for alternate response.

Issues and Recommendations

Issue: No issues were identified at the review.

Recommendation: None

Child Fatality Review #07-06
Region 6
Vancouver Division of Children and Family Services

This twelve-year-old Caucasian youth died from cancer.

Case Overview

This youth had a kidney transplant when he was four-years-old. He had chronic medical problems throughout his life. In early August of 2007, he was diagnosed with lymphoma, a type of cancer which is frequently seen in transplant patients. He died from cancer shortly after the diagnosis.

The youth was born with congenital renal defects and went through a kidney transplant at the age of four. Referrals to Children's Administration (CA) intake indicated his parents were unable to meet his special needs. He required daily care and close monitoring including a restricted diet, the forcing of fluids and the administration of a number of medications for the kidney condition for normal growth and development to occur. His mother was unable to provide the care that he needed due to phobias and problems with alcohol abuse. His father was not available. The youth was diagnosed with Reactive Attachment Disorder, Fetal Alcohol Syndrome and pervasive developmental delays.

After many attempts to work with the youth's parents, with no success, their parental rights were terminated. Shortly after his placement in the dependency guardianship, his cancer was diagnosed. The cancer spread rapidly and in a short period of time he was on life support. The youth died on September 10, 2007.

Referral History

The youth has been in foster care or a dependency guardianship since September 1998. He was in a dependency guardianship when he died. There were six referrals on this family prior to the youth's placement. The referrals allege medical neglect of they youth and physical neglect of he and his siblings. The biological mother had ongoing struggles with drugs and alcohol that impacted her ability to parent her children and provide the medical care the youth needed. The referrals involving the family also include allegations of domestic violence and mental health issues.

On April 15, 1992, it was alleged that the deceased child's biological mother abused prescription medication while pregnant and was in no condition to parent her two children. This referral was screened as low risk Child Protective Services (CPS).

On June 18, 1992, it was alleged that the deceased child's biological mother abused a tranquilizer when she was five months pregnant. This referral was screened as low risk CPS

On July 27, 1994, the mother reported to CA intake her husband was physically abusive of her and threatened her children. The mother reported seeing a therapist for agoraphobia. The father told the children she was a drug addict. This referral was screened as information only.

On July 21, 1998, it was reported that the mother left her medically fragile three-year-old with his teen sister for several days. The sister did not know how to care for her brother. The mother improperly gave medications to the boy when she was intoxicated. There was ongoing domestic violence in the home. The mother was not getting regular medical care for this child. The mother threatened to kill herself in front of he children. This referral was investigated by CPS.

On August 20, 1998, medical staff reported concern for the care of the medically fragile child with mother as sole caretaker. Their concern is mom's ability to care for this medically fragile child as he requires extreme care. The mother continued to give him foods against doctor's advice. The child required a kidney transplant, the mother was a viable donor, but refused to be a donor. Hospital staff did not believe mother is capable of providing dialysis. The mother frequently missed doctor visits. The mother left caretaking responsibilities to a fourteen-year-old sibling in the home. This referral was investigated by CPS and closed as founded for medical neglect.

Issues and Recommendations

Issue: No issues were identified by the review team.

Recommendation: In review of the file it was not clear to what extent a relative search was conducted to look for the child's extended family to continue to provide connection to him, even if they were not available for placement. This practice has been improved throughout the region in the past few years, and has been clarified in policy. Region 6 is hiring a relative search specialist who will be able to support relative searches in these difficult cases.

Child Fatality Review #07-07
Region 6
Kelso Division of Children and Family Services

This fifteen-year-old Caucasian female died in an automobile accident.

Case Overview

On January 9, 2007, the deceased youth and a group of friends left school and went to the home of a fifteen-year-old classmate. This fifteen-year-old male classmate found the keys to his parent's car. The group of teens went for a ride. The fifteen-year-old male drove the car and lost control resulting in an accident. The car slammed into a tree and flipped over. The deceased youth was the only passenger in the vehicle not buckled in. She was pronounced dead on the scene. The autopsy revealed she suffered a broken neck and fractured skull. Several other passengers were seriously injured in the accident; one was left a quadriplegic.

Referral History

This deceased youth was in the custody of her paternal grandparents at the time of her death. There were referrals to the department in 1992 and 1993 alleging neglect of the youth and her siblings by their biological mother. These referrals alleged substance abuse and ensuing neglect. The grandparents eventually obtained custody of the deceased youth.

On December 29, 2006, the grandparents contacted the department seeking help filing an At Risk Youth petition. They reported the granddaughter had become disrespectful, skipped school, and regularly sneaked out of the home. The referral was screened for Family Reconciliation Services (FRS). The grandmother declined this service.

On March 5, 1996, it was alleged that the paternal grandfather was physically abusing one of his children. The referral was screened for Child Protective Services (CPS). The investigation was completed and the result was an unfounded finding.

On February 29, 1996, it was alleged the paternal grandmother gave her son valium. The referral was screened for CPS. Social workers attempted contact with the caregivers and complete the investigation. These attempts were unsuccessful. The findings were inconclusive.

On November 15, 1995, a referral was made to Children's Administration (CA) intake alleging physical abuse of the biological children of the paternal grandparents. The referral was screened for CPS. There was no response from the caregivers and the investigation was unable to be completed. The finding was inconclusive.

On June 9, 1995, the paternal grandmother contacted CA intake and reported her husband was sexually abusing the children in their home. The allegation was that the grandmother knew of the abuse and left the children with a known offender. The referral was screened for CPS and investigated. The investigation was completed and the finding was unfounded.

Issues and Recommendations

Issue: None identified

Recommendation: None identified

Child Fatality Review #07-08
Region 1
Spokane Division of Children and Family Services

This fourteen-year-old Caucasian male died after being struck by a car.

Case Overview

On November 23, 2007, the deceased youth was a pedestrian crossing a road at approximately midnight when he was struck by a car in a hit-and-run accident. The driver fled the scene and was later apprehended by law enforcement.

Referral History

On September 4, 2007, the youth was placed in protective custody after he choked his mother's boyfriend. The youth has a history of violence toward family members. This referral was screened in for Family Reconciliation Services.

On November 29, 2006, Children's Administration (CA) intake received a referral alleging the youth went to school with broken blood vessels on his neck from his sister choking him. The referral was screened as information only.

On April 27, 2006, the father reported the seventeen-year-old sister was stabbed by the deceased child. Law enforcement responded to the home. The referral was screened as information only.

On February 7, 2006, school reported the deceased child had poor attendance. He arrived at school on this day with a bloody lip and a bruise from his sister. The mother was rarely home. The referral was screened as information only.

On May 17, 2005, the mother requested Family Reconciliation Services as her daughter (sister of the deceased child) was defiant and assaultive. This referral was screened in for Family Reconciliation Services.

On February 13, 2002, the deceased child reported his mother hit him with a belt. The referral was screened as low risk Child Protective Services (CPS).

On March 23, 2001, the deceased child reported his mother hit him with a belt on his neck and ribs. The referral was screened in for investigation by CPS. The investigation was closed as unfounded for physical abuse.

On February 12, 2001, concerns that the deceased child, then eight years old, and his siblings, then eleven and ten years old, were home alone after school until 5:30 p.m. for

approximately one month. The mother was not employed at that time. The referral was screened as low risk CPS.

On October 9, 2000, the deceased child reported his father slapped him and his siblings during court-ordered visits. There were no documented injuries. The referral was screened as information only.

On September 16, 2000, it was reported that the deceased child, then seven years old, was held down by his siblings while their mother hit him with a hockey stick. There were no documented injuries. The referral was screened as information only.

Issues and Recommendations

Issue: Three consecutive referrals dated February 7, 2006, April 27, 2006, and November 27, 2006 were screened as Information Only reports. All three referrals included significant violence between siblings that resulted in injuries.

Recommendation: According to intake sufficiency screening, the panel believes that each of these referrals should have been accepted for investigations of negligent treatment due to lack of supervision by the mother

Issue: The Family Reconciliation Services social worker only had the family's home phone to contact the mother for services when she requested services on May 17, 2005.

Recommendation: The panel recommends that intake social workers ask for alternate contact numbers when a request is made for Family Reconciliation Services to assist with direct contact with the requestor of the service.

Issue: Collateral contact was not made with the state of California to assess if there was abuse or neglect issues when the children lived in California.

Recommendation: When families move to Washington from other states and there are allegations of abuse or neglect the social worker should attempt to gather information from the other state to assist with risk assessment for the children involved.

Child Fatality Review #07-09
Region 3
Lynnwood Division of Children and Family Services

This newborn Caucasian male died one hour after birth from fetal lung immaturity.

Case Overview

This infant was born prematurely at 23 weeks gestation, due to membrane rupture. His mother tested positive for methamphetamine twice before he was born and again at the time of his birth. No autopsy was performed.

This family has history with the department. The deceased child's father has three other children from a prior relationship who were dependents of the state for several years. The issues involved in that dependency action were physical abuse, domestic violence, and sexual abuse.

By 2005, the department had received information of domestic violence between the parents and physical abuse of one of the children. In 2007, the department received a call from a hospital social worker reporting the mother went into premature labor. In the hospital she tested positive for both marijuana and methamphetamine. The deceased child was delivered two weeks later and a Child Protective Services (CPS) referral was screened in based on risk to the other two children due to the mother's drug use. The department filed dependency petitions on the five-year-old and nineteen-month-old children still in the home.

Referral History

On July 24, 2007, the department received a call from a medical examiner who reported the mother gave birth to a boy at twenty-three weeks gestation. He passed away within a half hour of the birth. The mother tested positive for methamphetamine at the birth, and on two occasions previously in the month. The medical examiner did not believe the infant's death was caused by the methamphetamine use. The medical examiner was concerned for the care of the two other young children in the home because of the mother's drug use. This referral was screened in for investigation by CPS and closed as inconclusive.

On July 13, 2007, the hospital called the department reporting the mother had gone into labor at twenty-one weeks into her pregnancy. The mother tested positive for both marijuana and methamphetamine. She self reported she used marijuana regularly for past fourteen years, but denied use of methamphetamine. This referral was screened as information only.

On September 12, 2006, Children's Administration (CA) intake was notified that the mother was hitting her then four-year-old daughter leaving bruises on her face. It was alleged the

mother abuses methamphetamine and smokes marijuana even though she is nursing her baby. The referral was investigated by CPS and closed as unfounded.

On February 2, 2005, it was reported that there had been two recent domestic violence incidents between the parents of the deceased child. One incident resulted in the mother being injured and taken to the hospital. The child was not injured in either of those incidents. The referral was screened as low risk CPS.

On July 30, 2002, law enforcement contacted the department to report the mother was arrested on an outstanding felony warrant for assaulting a police officer. Her infant was with her in a car seat and not properly belted. The infant was released to the mother's roommate. The referral was screened as information only.

Issues and Recommendations

Issue: In the first referral that was assigned for a full investigation, there was no documentation that collateral contacts were made as needed or that service needs were adequately explored.

Recommendation: The Family Assessment section of the new client information system (FamLink) coming to Children's Administration in December 2008 will address these issues and ensure service needs are identified, addressed, and documented as a part of the case assessment.

Issue: In the July 13, 2007 referral, CPS was called because the mother was first thought to be going into labor and tested positive for methamphetamine. There was no documentation in that report that the intake worker had asked questions at the time to assess the possible affect of the drug usage on the mother's two children at home. The review team was also unable to find documentation that that the July 13, 2007 referral was sent to First Steps program, as described in policy.

Recommendation: These items have been set on the agenda of the regional intake specialists meeting. At that meeting, one of the members of this review team will address these issues, along with other areas of the prenatal policy that prescribes actions on referrals such as these.

Child Fatality Review #07-10
Region 3
Smokey Point Division of Children and Family Services

This three-month-old Caucasian male's death was determined a natural death affiliated with Sudden Infant Death Syndrome (SIDS). There were no signs of trauma or abuse noted following the autopsy.

Case Overview

On June 21, 2007, the King County Medical Examiner's Office reported to Children's Administration (CA) that the decedent was found not breathing and non-responsive in the family home on June 20, 2007. An autopsy was conducted on June 21, 2007 noting the child died as a result of natural causes affiliated with Sudden Infant Death Syndrome.

Referral History

Children's Administration's first contact with this family was in February 2006 regarding their first child. The child's physician contacted Child Protective Services (CPS) reporting the five-month-old child had not gained any weight in the previous two months, and had gone from the 50th percentile to the 5th percentile in weight. The physician believed his parents were not fully appreciative of the seriousness of this situation as they failed to respond to his office's attempts to contact them. He feared the child's life was at risk if the parents were not more responsive to the medical issues. The child was born with a genetic medical disorder, Syndactyly which is fingers and toes being fused together. Surgery would be required to resolve the issue.

This referral was assigned for investigation and services to support and motivate the parents to ensure the child received follow up medical care and monitoring were initiated. The family was referred for services and Family Preservation Services was placed in the home to work with the parents helping them to understand the seriousness of the child's condition and how they could most effectively work with their medical providers. This case was closed as moderately high risk after four months of services for the family along with consultation with the Child Protection Team and the development of an aftercare plan with the family.

In April 2007, a neighbor of the family called Child Protective Services regarding concerns for their now second child, the decedent. The decedent was born with similar genetic issues as his older sibling. The referent expressed concerns regarding the condition of the home and that the decedent's mother did not feed her children properly. The referral was assigned for investigation and follow up. A home visit revealed the family lived with some clutter, but there were no safety or health hazards in the home. It was observed both

children appeared sufficiently well cared for at the time. Contact with the children's physician was made in which it was noted there were no concerns for neglect or abuse.

Shortly after this referral was made the family re-located to another community, however, Public Health Nurse Services continued in the home reporting they were doing well. It was just two weeks after reports from the Public Health Nurse were received the decedent's death was reported.

Issues and Recommendations

No issues or recommendations were identified at this time.

Child Fatality Review #07-11
Region 3
Lynnwood Division of Children and Family Services

This 15-year-old Caucasian male died as a result of accidental drowning after falling through the ice on a lake.

Case Overview

On January 17, 2007, local news reported the accidental drowning of a 15-year-old on January 16, 2007. The decedent and his friends were on the ice when he and one other friend fell through a patch of thin ice. Neighbors responded to the cries for help and were successful in rescuing the friend. Divers recovered the youth's body later that evening and an autopsy was performed. The primary cause of death was listed as asphyxia, the secondary was fresh water drowning. The manner of death was listed as accidental. A Child Protective Services (CPS) social worker noted the news report and that the family had most recently been involved with Family Reconciliation Services (FRS) in January 2006.

Referral History

This family first came to the attention of Children's Administration (CA) in November of 1992. The decedent was nineteen-months-old at the time and his mother, a single parent, was recovering from surgery. A request for childcare services was made as the maternal grandmother could no longer care for the child pending his mother's recovery. The family agreed to two weeks of childcare assistance and opted for no other services. The referral was determined information only and closed once childcare payment was completed.

In February 1996, a report was received that the decedent's mother had left him unsupervised in the food court of a shopping mall while she continued to shop. The decedent was four years of age at the time. The referent remained with the child until his mother returned approximately 30 minutes later. An investigation followed resulting in an unfounded finding.

In November of 1996, Children's Administration received an information only report regarding decedent's mother having been involved in a domestic violence relationship. The referral does not indicate any child was witness to or involved in any altercation.

In August 2000, it was reported the decedent's parents were involved in a heated custody dispute. Attempts to reconcile their relationship were not successful and resulted in accusations by both parties of their subsequent inefficiencies as parents. The referral was assigned for investigation referencing the claims against one another; an interview with the decedent confirmed his parents do fight, but he felt safe with both of them. A safety plan

was developed to ensure child's health and safety and a restraining order was in place between the parents with custody being granted to the decedent's mother. Findings were noted as unfounded for negligent treatment.

In May 2001, Child Protective Services received a report alleging the decedent's mother had been drinking and driving with her son in the car. The decedent's mother told the CPS investigator this was a retaliatory report by the decedent's father's girlfriend for placing a restraining order on them and limiting contact with the decedent. When interviewed the decedent told the investigator he did not recall his mother drinking and driving and did not fear for his safety when driving with his mother. The case was closed shortly thereafter and no services were deemed necessary.

In November of 2005, a report was received in regards to the decedent threatening to run away and hurt his mother. He was placed in a Secure Crisis Residential Center (SCRC) for the evening. While at the SCRC the decedent discussed taking part in high risk activities, including fighting, street racing, and drinking. After a family meeting and an offer of services to include court intervention, he returned home with Family Reconciliation Services (FRS) Phase 2 counseling in place. A few weeks later, however, he was again held in the SCRC similar issues. At this time a petition to the court on a At-Risk-Youth petition, a legal action which could set expectations for the decedent, such as school attendance, etc. and consequences if these were not met, such as brief incarceration was implemented. The case record for this family closed as the mother's petition was granted and the family had completed the counseling sessions. FRS services had ended with several referrals to other services for the family and for the decedent including drug and alcohol counseling. The prognosis from the counseling sessions was somewhat guarded. Concerns noted were the decedent's unrealistic assumptions about life, himself, his goals, and his glorification of illegal, violent, and risky behavior.

In January 2006, the decedent's mother requested Family Reconciliation Services following an incident with her son and his placement back once again in the SCRC. Anger issues, physically assaultive behavior and running away were presenting issues. Services were once again provided including support in filing an At Risk Youth Petition. At case closure, the family's prognosis by the providing counseling agency was listed as 'guarded.' One year later, the decedent accidentally drowned.

Issues and Recommendations

In reviewing the available DCFS case file documentation and post-fatality information gathered from other sources, no violations of policy, procedure, or practices surfaced that would suggest actions taken or not taken by the department contributed to this child's death. No recommendations were identified by the review team.

Child Fatality Review #07-12
Region 3
Bellingham Division of Children and Family Services

A seventeen-year-old Caucasian male was killed after being ejected when the stolen vehicle he was driving crashed. The manner of death was listed as accidental.

Case Overview

On October 22, 2007, the Bellingham Herald newspaper reported the decedent was killed in an automobile accident on October 21, 2007. The decedent was driving a stolen truck and failed to negotiate a turn on a road. He was thrown from the truck and died at the scene. At the time of death, the decedent was living with his maternal grandmother who had custody of him since 1993.

Referral History

The decedent's family had been involved with Child Protective Services (CPS) when the decedent was very young. The first contact the decedent's mother had with Children's Administration (CA) was in June 1991 regarding allegations of neglect, primarily supervision issues when the decedent was approximately 14 months old and found wandering in the street. It was later learned the decedent's mother was sleeping and had enlisted the decedent's older sibling, then not quite four years of age, to supervise his younger sibling. In September 1991, a similar report of failure to supervise children was made regarding an older sibling.

Additional referral information indicates the decedent's mother had difficulty parenting the decedent and his older brother due to long standing drug issues. As a result a change of custody was effected between the decedent's mother and his maternal grandmother when he was three years of age. He had been in the care of his maternal grandmother since 1993 and had only occasional contact with his mother and his half sister, who was born when the decedent was eleven.

While in the care of his maternal grandmother, the decedent was not involved with Children's Administration until January 2006 when the decedent disclosed to a psychologist that he had admitted to his mother and grandmother that he fondled his four-year-old sister. He stated this had only occurred on one occasion. The incident occurred when the decedent's mother, boyfriend and his sister were visiting at his grandmother's home. As a result of the disclosure the family was referred to services for both the victim and the decedent and that no unsupervised contact between the decedent and his sister was permitted. The case was closed after confirming law enforcement and counseling services were involved. There was no other contact with this family until the accident resulting in the decedent's death.

Issues and Recommendations

When reviewing the case history and the circumstances surrounding this child fatality, the review team did not identify any significant issues or make any recommendations.

Child Fatality Review #07-13
Region 3
Everett Division of Children and Family Services

This 21-month-old Caucasian male likely died from hyperthermia (high body temperature). The manner of death was listed as undetermined.

Case Overview

The Snohomish County Medical Examiner reported on October 30, 2007, this 21-month-old child was found dead, wrapped in multiple blankets, in his home. At the time of this initial call, the referent stated there was little to suggest an intentional act or negligence on the part of the parents that contributed to this child's death. In March of 2008, the department learned from the Medical Examiner's office that the death had been caused by hyperthermia - the child's body temperature rose too high. His mother's live-in boyfriend put him to bed the night before he was found. The boyfriend rolled the deceased child into several blankets, securing his arms and legs so that he was unable to get up, and propped a bottle of milk in his mouth. The child was found deceased by his mother in the morning. The primary cause of death was listed as probable hyperthermia, and the secondary was "enwrapment in bedding for the purpose of restraint." The manner was listed as "undetermined".

Referral History

On March 31, 2008, Children's Administration (CA) intake received information that the primary cause of death of the deceased child was listed as probable hyperthermia with a secondary cause listed as "enwrapment in bedding for the purpose of restraint." The finding suggested child abuse/neglect may have been a contributing factor in this death. This referral was accepted for investigation by Child Protective Services (CPS). The investigation has not concluded.

On October 31, 2007, the medical examiner called to say that the deceased child was found deceased in his home, wrapped in multiple blankets, by his mother on October 20, 2007. The medical examiner said there was no suspicion of child abuse or neglect. An autopsy has not been completed. This was an information only referral.

On March 23, 2007, the public health nurse contacted the department to report that the deceased child's mother was assaulted by his father. The child was not present at the time. The mother obtained a restraining order. This was an information only referral.

On October 1, 2006, an anonymous caller reported the deceased child's mother, then sixteen years old, was using methamphetamine supplied by her mother. The deceased child's mother left the child, then nine months old, in the care of his maternal grandmother. The

grandmother was contacted and denied the allegations. She reported the mother was doing a good job parenting. This referral was screened as low risk CPS.

On April 18, 2006, hospital staff reported the deceased child's parents were involved in a domestic violence episode. The parents engaged in a "tug of war" with their son, then two months old. The child's father was arrested. This was an information only referral.

On February 7, 2006, hospital staff called to report the deceased child, then two weeks old, was diagnosed with hemophilia. The maternal grandmother called the hospital and related concerns about the child's father's violent behaviors. Given the child's health, the caller was concerned that he could die if he were to be hit just one time, and believed him to be at great risk of harm. The referral was screened in for CPS and closed with an inconclusive finding. When the case was closed, the mother had obtained a restraining order against the father.

On January 27, 2006, hospital staff reported the birth of the now deceased child. Hospital staff expressed concern about the infant's father who was very agitated, disruptive, and possibly on drugs. The mother appeared appropriate and had family support. This was an information only referral.

On July 20, 2005, the public health nurse reported the deceased child's mother, then fifteen years old and pregnant, was hit on the face by her boyfriend causing a swollen lip. This referral was screened as third party.

Issues and Recommendations

Issue: None identified.

Recommendation: None identified.

Child Fatality Review #07-14
Region 3
Mount Vernon Division of Children and Family Services

This five-week-old Caucasian female passed away in the family home. Following an autopsy the infant's death was ruled a result of Sudden Infant Death Syndrome.

Case Overview

On September 23, 2007, the Skagit County Coroner reported that a five-week-old female child was found deceased that morning. The decedent was last seen alive at approximately 4:30 a.m. after being breast fed by her mother. The deceased child's mother reported they were co-sleeping on a two seat couch. The deceased child was on the inside and the mother was on the outside facing the child. After breast feeding they both went back to sleep. When the mother awoke, she found the deceased child non-responsive. The mother attempted cardio pulmonary resuscitation and called 911. The Skagit County Coroner's Office completed an autopsy and is ruling the death as Sudden Infant Death Syndrome (SIDS) from natural causes. When asked a question about the possibility of the infant having been suffocated due to the position she was in, the referent stated that could be a possibility that cannot be ruled in or out.

Referral History

In January 2005, Child Protective Services (CPS) received the first of three Information Only referrals regarding the decedent's mother. The January 2005 referral referenced the deceased child's mother pregnant at age nineteen (19) and reportedly actively using illicit substances including methamphetamine on a daily basis. The referent stated the mother had self reported the substance abuse to her during emergency room visit. She reported having been involved with drugs for at least the last two years.

Four months later in April 2005, an information only referral was received from another medical provider regarding the failure of the deceased child's mother to obtain consistent prenatal care and concerns regarding continued substance abuse. In addition, the referent believed this to be a high risk pregnancy, medically. In August 2005, a third information only referral was received when the deceased child's mother delivered her first child. The hospital social worker had evidently made a plan with the decedent's mother that following the delivery she would be going to her paternal grandmother's home to stay. It was later learned this did not happen and it was unknown where the deceased child's mother had gone with her first child. This referral was not assigned for investigation.

In May 2006, a referral was received regarding allegations of negligent treatment perpetrated by the deceased child's mother in reference to her first child who was 10 months old at the time. The law enforcement officer had arrested the mother on

outstanding warrants and when visiting the home noticed the child had 21 stitches in her head and eye. The mother stated the stitches were the result of being bitten by a dog approximately two weeks prior. The officer also noted broken glass and other hazardous conditions in the home. This referral was assigned for investigation. As a result of this referral, services were initiated in the home including a public health nurse as well as recommendations for substance abuse treatment as the deceased child's mother had tested positive for methamphetamine. After several weeks of attempting to work with voluntary services a decision was made to file a dependency petition and seek removal of the child due to evidence the decedent's mother was not complying with services and was actively using methamphetamines. The child was found with inappropriate caretakers in an environment that law enforcement described as inappropriate as registered sex offenders were present and violence, cockfighting, and methamphetamine use by residents was occurring.

The deceased child's mother then engaged in services including random urinalyses and a substance abuse assessment which assessed her as not substance abuse dependent. Following compliance and progress in services the decedent's mother subsequently began living in the home with her grandmother and her child. Included in services was substance abuse education and domestic violence counseling. The dependency referencing this first child was dismissed in June 2007, and the case was closed. At the time of the dismissal of the dependency, the mother was expecting her second child, the deceased child.

This case was not active at the time of the child's death and her birth was not known until the department received word of her death in September 2007. This generated a low risk referral. The decedent's father was not listed on the birth certificate, nor noted in any DSHS records.

At the time of the Child Fatality Review it was learned the deceased child's mother is again pregnant and due to deliver in October 2008. An information only referral was generated in May 2008 as a result of this new information.

Issues and Recommendations

Issue: The review team noted the referral reporting the birth of the first child in August 2005 should have been screened in for investigation given the high risk factors affiliated with this mother.

Recommendation: As a result it was recommended cases similar to this situation be discussed at the next Regional Intake Specialist meeting and screening of said referrals will note known history.

Issue: The review team also noted a significant lapse in time occurred between when the referral for a chemical dependency assessment was made in May 2006 and when it was

actually completed. The review team noted a misunderstanding in regard to the amount and nature of information to be conveyed to the evaluator as a means to effectively complete the evaluation.

Recommendation: As a result it was recommended a workgroup convene to develop a standard on what information will be included in a referral from Children's Administration (CA) for chemical dependency evaluations.

Issue: The Child Protection Team (CPT) concurred with the decision to return the mother's first child to her care. However, it was noted by the review team that none of the professionals attending the meeting were involved directly with this case, other than CA; nor were there any reports sent on behalf of these agencies/professionals.

Recommendation: It is recommended when social workers present cases to the CPT they are encouraged to invite professionals involved in the case. If they are unable to attend the meeting in person, a report for the CPT should be provided.

Child Fatality Review #07-15
Region 3
Mount Vernon Division of Children and Family Services

This sixteen-month-old child died of intentional carbon monoxide poisoning.

Case Overview

On November 8, 2007, the mother and her sixteen-month-old child were found dead in their home in Anacortes. The mother ignited a container of charcoal briquettes in a very small enclosed room. It was determined that carbon monoxide intoxication was the cause of death for both. The deaths were determined to be a homicide and suicide.

The deceased child's father was a subject of the referral regarding the fatality. Child Protective Services (CPS) investigated the allegation that he was negligent in leaving his child alone in the care of her mother. This referral was screened in based on history of a prior referral in 2007 raising concerns about the mother's mental health status and her ability to safely care for the deceased child.

Referral History

On April 20, 2007, the deceased child's mother had taken her daughter in the family car and disappeared without word to anyone. Four days later they were found living in the car on a service road in an isolated area. They had little food and were dehydrated. They were hospitalized and the father allowed the deceased child to remain in the hospital for several hours with her mother, causing some concern among hospital staff. A CPS referral was investigated and closed with an inconclusive finding.

Issues and Recommendations

Issue: In the prior referral on the family, the deceased child's mother was the only subject identified in the referral. This was despite concerns being voiced by the hospital about the father leaving the child at the hospital in the care of her mother, with her mother's mental health issues making questionable her ability to appropriately supervise.

Recommendation: The topic of identification of subjects in referrals will be revisited and clarified at the next meeting of Region 3 intake specialists.

Child Fatality Review #07-16
Region 5
Tacoma Division of Children and Family Services

This nine-month-old Caucasian female was found unresponsive in her crib in the family home. She was later pronounced dead by emergency medical personnel who responded to the scene.

Case Overview

On September 11, 2007 it was reported to Children's Administration (CA) by the Pierce County Medical Examiner's Office (PCMEO) that a 10-month-old child had passed away in her parental home. It was reported by the deceased child's mother that she put the infant in her crib around 11:00 p.m. with a bottle; placing the baby on her back with pillows and stuffed animals around her. At approximately 2:30 a.m. the mother found the child on her stomach not breathing and non-responsive. The mother called 911. Emergency Medical Services (EMS) found the baby with lividity and rigor with death being pronounced at the scene.

Law enforcement and the Medical Examiner's office reported the apartment was unkempt and messy but acceptable. Risk factors known to be common to Sudden Infant Death Syndrome were present; such as smoking (outside), a crib with pillows and stuffed animals, bottle-propping and a medical history noting child was delivered by cesarean section. The investigating detective noted both parents appeared to be low functioning however did not suspect deception by the adults as to the circumstances surrounding the death.

The Medical Examiner found no indication of trauma although the child was found to have focal bronchiolitis (acute infection of the bronchial tubes), but otherwise appeared healthy. The cause of death was determined to be Sudden Unexplained Infant Death, and the manner of death was classified as undetermined.

Referral History

The mother's family of origin was well known to Child Protective Services (CPS) with numerous referrals between June 1989 and December 1992 when the mother was a child. The concerns were for low level neglect and one possible incident of minor physical abuse. Several times it was reported the mother, as a child, was on medication for Attention Deficit Hyperactivity Disorder. It is known Children's Home Society was involved with the mother's family in the early 1990s.

One referral had been received by Children's Administration referencing the deceased child's mother as a parent/care provider. In late January 2007, CPS was contacted by an

anonymous referent who reported that the while visiting at another residence the mother was observed to run up and down the stairs with her infant baby (then three months of age) in her arms. In addition to the concern voiced by the anonymous referent that the mother could trip and fall, it was also reported the mother had summer clothes on the baby and it was winter. It is not clear whether or not the infant was being taken outside without warm covering. The report was taken as information only as there were no allegations meeting the Washington Administrative Code (WAC) definition for child maltreatment. Additionally, as noted, the referent was anonymous and per RCW 26.44.030 the circumstances alleged would not meet the criteria for accepting an anonymous referral for investigation.

Eight months later in September 2007, CPS received notification (per protocol) from the Pierce County Medical Examiner's Office (PCMEO) of the death of the ten-month-old. At the time of notification there were no suspicious circumstances indicated although the PCMEO investigator noted risks including the mother was unsure as to who was the father of the deceased child and both the live-in boyfriend and mother presented with developmental delays. The mother's low mental functioning was confirmed by a mandated reporter from the community who also contacted CPS following the death. The fatality notification report was taken by Central Intake (CI) and received additional review at the Tacoma DCFS office, and remained as an information only report.

Issues and Recommendations

There were no issues or recommendations made by the fatality review team.

A Region 5 Area Administrator and the Region 5 CPS Coordinator reviewed the Children's Administration (CA) history involving this family. In review of that history and the information obtained about the circumstances surrounding the child's death, no significant issues were identified which would benefit further review. While the death of the child was unexpected, it was considered to be a SIDS type death with no apparent suspicions that child abuse or neglect contributed to her death.

Child Fatality Review #07-17
Region 3
Lynnwood Division of Children and Family Services

This sixteen-year-old youth died of bilateral pneumonia and acute methadone intoxication.

Case Overview

On May 3, 2007, the sixteen-year-old youth was found unresponsive by his grandmother, with whom he was living. The youth was deceased by the time medics arrived. There were no obvious signs of trauma. The autopsy revealed the youth died from pneumonia and methadone intoxication.

Referral History

On October 21, 1997, Children's Administration (CA) intake received a report by an anonymous referent alleging the deceased child's mother was addicted to heroin, her children were exposed to needles lying around and left unsupervised with a man was sexually abusing them. The referral was screened in for CPS and closed as unfounded.

On February 20, 1998, it was alleged the deceased child, then seven years old, went to school with a large bruise on the left side of his face and eye. He said his mother slapped him with an open hand. The deceased child and his, then two-year-old brother were placed in protective custody and a dependency petition was filed. They were placed with their grandmother by court order. The investigation was closed as founded for physical abuse.

On July 2, 1999, a referral was made alleging the deceased child's mother was pregnant. She was in drug/alcohol treatment and a urinalysis (UA) came back positive for cocaine. She gave birth to a girl on September 27, 1999. A dependency petition was filed on behalf of this newborn. The mother was allowed to keep the baby with her as she was in an inpatient treatment program. The deceased child and his brother were still in out-of-home placement with their grandmother. The CPS referral was screened in for investigation and closed as founded.

On January 4, 2005, the mother contacted the department requesting childcare for two of her children. She was starting chemotherapy. This is accepted for Child Welfare Services.

On October 30, 2005, it was alleged that the mother and her boyfriend were using drugs thereby putting the children in harm's way. It was reported drug deals were made in the driveway of the family home. There was no information that the children were present during drug transactions or use. This referral was screened as information only.

On September 15, 2006, an anonymous referent called CA intake alleging the mother's three children should be removed and blamed the mother's boyfriend for neighborhood thefts. This referral was screened as information only.

On October 3, 2006, the maternal grandmother reported the deceased child's brother and sister had been staying with her for the past three weeks, by arrangement with the mother. The grandmother added the mother, father, and another couple live together and all are active heroin users. This referral was screened as information only

On January 5, 2007, a hospital social worker reported that the deceased child, then fifteen years old, was admitted to the rehabilitation unit for a brain injury from an auto collision that occurred December 21 2006. His mother left no way to contact her. The grandparents said the mother was a heavy heroin user, and that the boyfriend was involving the deceased child in criminal activity. This referral was screened in for investigation by CPS. The investigating social worker was unable to locate the mother. She did return to the hospital and authorized the grandparents to act in her absence. The deceased child was released to his grandparents. The investigative finding was inconclusive.

On January 23, 2007, law enforcement contacted CA intake to report an auto accident involving the deceased child's mother. She was arrested for Driving Under the Influence (DUI), reckless driving, and giving a false statement. Her three children were not present, but it raised concern about her ability to care for them. The referral was screened as information only

Issues and Recommendations

Issue: When CA received the report of the deceased child's death, there was no inquiry about the safety of the surviving siblings. According to information from the Snohomish County Medical Examiner's review, the youth died from a methadone overdose. The pill he took came from a bottle he found in his grandmother's bathrobe. It was a 100 milligram pill. He also had a pill in his wallet, as well as ethanol in his blood.

This raises questions about the grandmother's use of methadone. Was it legally prescribed? If so, for what purpose? Is she also abusing substances? Is she still caring for the surviving siblings?

Recommendation: CA will request the law enforcement incident report (request made May 16, 2008). The last assigned worker will make a new report to Intake about the safety of these children (new report made May 16, 2008).

Issue: Screening decisions on referrals dated October 30, 2005, September 15, 2006, and January 23, 2007 were information only. However, given the extensive history of substance abuse, these might have been screened in.

Recommendation: CA will review these referrals at a future statewide meeting of CPS Program Managers and Intake Leads, for consensus. (Request made May 20, 2008 to place these on the agenda for the June 2008 meeting)

Issue: Reporting and information sharing between agencies when children die unexpectedly.

Recommendation: CA should work with law enforcement, medical examiners, coroners, and death investigators to establish statewide standards for sharing information on child deaths. The information received by CA when this child died unexpectedly was insufficient to make an informed decision as to whether that fatality should screen in for a CPS investigation.

Child Fatality Review #07-18
Region 4
Kent Division of Children and Family Services

This sixteen-year-old youth died in a pedestrian/vehicle accident.

Case Overview

On September 10, 2007, the sixteen-year-old youth was hit by a dump truck while he was riding a skate board through an intersection. The driver did not see the youth and did not fully stop at the intersection. The driver was charged with negligent driving.

Referral History

On January 24, 2007, it was reported to Children's Administration (CA) intake that the deceased youth's mother was in a pain management program and she disclosed that she relied on her, then eleven-year-old, daughter to manage her medications for her. The referral was screened in for investigation by CPS. During the investigation the mother and daughter denied that this occurred. At that time, the deceased youth was in an inpatient treatment facility and refused contact with the CPS worker. The investigation was closed as unfounded.

On February 23, 2007, a school administrator called Children's Administration (CA) intake to report that friends of the family said the mother was drug-involved, erratic, and not meeting the basic needs of the children. The referral was screened low risk.

On March 4, 2007, the deceased youth told a mental health counselor that his father shoved him into a wall two weeks prior, but made no mention of marks or injuries. This referral was screened as information only.

On March 19, 2007, the twelve-year-old sister of the deceased youth called to report her father threatened to ground her for a month; he drinks alcohol nightly and won't allow her to have a lock on her door. This referral was screened information only

On March 20, 2007, the deceased youth's mother called to report that she thought his sister was in grave danger living with her father due to his alcohol abuse and an arrest for DUI with her in the car. The mother also said the sister was very frightened of her father, and he would not allow her privacy. The referral was accepted for investigation. There was no evidence of child maltreatment found in the investigation. The investigation was as unfounded.

On March 22, 2007 it was reported to CA intake allegations the deceased youth's father made against the mother during a court hearing regarding custody of the children. He alleged

the mother has an extensive substance abuse history and she may have contributed to the deceased youth's own substance abuse problems. The referral was accepted for investigation and closed as inconclusive.

Issues and Recommendations

Issue: The team did not identify a specific policy, practice or system issue. The referrals were properly screened and investigated. The father took responsibility and was awarded temporary custody of the children in family court. The mother was ordered to have no contact with the children until she completed substance abuse treatment. The deceased youth completed thirty-nine days of inpatient treatment, and began outpatient treatment after that.

Recommendation: The team did not identify a specific recommendation, except to point out the dangers of skateboarding in front of a dump truck. Driver error may have contributed (i.e., obeying traffic laws and driving safely can also reduce risk).

Child Fatality Review #07-19
Region 4
King Central Division of Children and Family Services

This sixteen-year-old African American youth drowned during a church camp outing.

Case Overview

The deceased youth had been in a dependency guardianship since April 2000 and was living in a licensed foster home at the time of his death. The deceased youth died on August 4, 2007 in a drowning accident at a church camp. The deceased youth was a counselor at the church camp at the time of the accident. According to the Okanogan County Coroner there were no suspicious circumstances surrounding the death. The deceased youth was under water for 20-30 minutes and there was no indication of foul play.

Referral History

The referral history is on the foster home where the deceased youth was placed at the time of his death.

On March 15, 1999, it was reported to Children's Administration (CA) intake that the deceased youth and his sister reported their foster father punished them with a belt. The referral was accepted for investigation by the Division of Licensed Resources/Child Protective Services (DLR/CPS) and closed as unfounded.

On March 15, 2001, the deceased youth and his sister told their social worker they were sexually abused by two older cousins who babysat them five years prior when they lived with their grandparents. This referral was screened as third party and referred to law enforcement.

On February 19, 2002, the foster parents did not report that they had a nanny from South Africa living in their home. The referral was screened as a licensing complaint (Non-CPS) and closed as valid. The foster parents signed a compliance agreement.

On May 14, 2007, the aunt of the deceased youth reported that the foster parents were emotionally abusive to the deceased youth. The deceased youth was considering leaving the home because of this. The referral was screened as a licensing complaint (Non-CPS) and closed as not valid.

Issues and Recommendations

Issue: Two social workers participated in this review, one had carried the case when the children were younger, and had helped with the transition from the guardianship with the

elderly grandparents to the foster parent guardianship. The other was the most recently assigned worker. Both social workers provided excellent service to the children and guardians, helping to ensure a smooth transition and facilitating communication. The current worker has continued her work with the caregivers and the surviving sibling.

Recommendation: None

Issue: Many Washington state parks have defined swim areas in lakes, but do not have life guards. Typically there is a beach, an area defined by buoys, and a sloping entry to the water that becomes deeper. A defined area implies a safe area, but without life guards, a person can drown just as easily as in an unmarked area.

Recommendation: The state should consider funding for life guards at all state park swimming areas.

Issue: There was no autopsy. Based on the scene investigation and external examination, the authorities decided to sign a death certificate. This occurred in a rural county where the prosecutor is also the coroner. In a county with a medical examiner, there would have been an autopsy.

Recommendation: The state should consider reviewing standards for when autopsies are necessary and provide rural counties with the necessary resources.

Child Fatality Review #07-20
Region 4
Division of Children and Family Services
Indian Child Welfare Office

This seven-day-old Native American infant died from an overwhelming infection (sepsis).

Case Overview

The mother gave birth to twins born on July 16, 2007 at 29 weeks gestation. She admits to intravenous (IV) methamphetamine use three to four times a month during her pregnancy. She also had no prenatal care. The deceased child weighed two pounds ten ounces at birth. The mother was in inpatient drug/alcohol treatment, but left before her treatment was completed. At the time of the infant's death, the mother had an open case with a Tribal Indian Child Welfare (ICW) program regarding her other six children. The infant never left the hospital and died one week after his birth. He died of an overwhelming infection. His twin survived and is dependent in relative placement.

Referral History

On May 27, 1998, an aunt who was caring for the, then two-year-old, brother of the deceased child called Children's Administration (CA) with concerns the mother would attempt to take him from her care. This referral was screened as information only.

On September 23, 2004, a school counselor reported the deceased child's brother, then eight years old, missed six straight days of school. School staff were unable to make contact with the family. This referral was screened as information only.

On October 4, 2004, a school counselor called CA intake to report the deceased child's then eight-year-old brother had not been to school the entire school year. His mother did call on September 24, 2007 and said she was withdrawing him, but was going to enroll him at another school. This referral is screened as information only.

On November 30, 2005, an elementary school principal called CA intake about the deceased child's, then six-year-old brother. The boy did not start attending school until November 28, 2007. He did not have a coat, lunch or supplies. He is deaf with academic and developmental delays. The referral was screened as information only.

On October 11, 2006, a Tribal housing employee reported substance abuse by the deceased child's parents. The referral also alleged the parents left their children alone, engaged in domestic violence, and refused to submit to urinalysis (UAs). The children had sporadic school attendance. The referral was screened in for investigation. The mother was in jail

during much of the investigation. The father tested positive for methamphetamine and cocaine. This investigation was closed as founded.

On October 25, 2006, an employee of the Tribal housing reported that law enforcement found a teenage runaway at the family home who may have gotten high on drugs there. This referral screened in as information only

On November 2, 2006, school staff reported concerns about the seven-year-old brother of the deceased child. He is deaf and has special needs. He was rarely in attendance. When he came to school he was hungry, dirty and smelled. The family was not using American Sign Language so he had no communication in the home. He had no language, he cannot talk, use sign language, nor can he hear. The only sign language he received was at school and he was rarely present. The investigation found that the mother was absent, the father was abusing drugs, and the children were being neglected. At the time of the investigation, all of the children were found dirty, without socks, shoes, or adequate clothing. The children were placed in protective custody in relative placement. Tribal authorities filed dependency petitions in tribal court. The investigation was founded for neglect.

On July 16, 2007, a Tribal social worker called to report the mother gave birth to twins at 29 weeks gestation. She had no prenatal care and had a positive drug test during pregnancy. The mother admitted to intravenous methamphetamine use during her pregnancy. One of the twins died seven days later. The referral was screened in for investigation by CPS and closed as founded.

Issues and Recommendations

Issue: The CA social workers conducted thorough investigations, assessed risk appropriately, and coordinated all case-related activities with Tribal Indian Child Welfare. This case is a good example of State-Tribal child welfare partnership.

Recommendation: None

Issue: Screening referrals on families living on Indian reservations. The November 30, 2005 referral was screened information only. It was the third referral from a school about children in this family not attending. This time, the seven-year-old child did not have a lunch or any supplies, and the school discovered he was deaf with academic and developmental delays. The Tribal ICW worker who participated in this review explained that reports of reservation children in dirty clothes, with lice and/or missing school are red flags for parental substance abuse problems.

Recommendation: Children's Administration should review this referral at the June 2008 CPS Program Manager's and Intake Leads meeting and discuss whether this and similar

reports on reservation families should be sufficient for investigation. The request to have this on the agenda was made on May 24, 2008.

Issue: This mother's drug of choice was crystal methamphetamine. Records confirm that while she used during pregnancy, she still received some health care and drug treatment. By her report she did not use alcohol, known to be the most harmful substance to the fetus. She also reported that she stopped using several weeks before the twin's premature birth.

Recommendation: All agencies who serve pregnant and parenting women should continue to make them the highest priority for treatment, and to do everything to engage them in treatment.

Child Fatality Review #07-21
Region 3
Everett Division of Children and Family Services

This three-month-old Caucasian male died from causes consistent with Sudden Infant Death Syndrome (SIDS).

Case Overview

The deceased child was born on May 6, 2007 drug affected and withdrawing from methadone. The mother received no prenatal care. Dependency was then filed on this child and his siblings on May 16, 2007. They were placed with their maternal grandmother. On August 3, 2007 the child was staying with his paternal great aunt. At 5:00 a.m. she checked on him and found him unresponsive and not breathing. He was rushed to the hospital and remained non-responsive. He was kept alive on life support. His prognosis was very poor due to the length of time he had been lacking oxygen to the brain. There were no signs of trauma on his body. He died on August 9, 2007. The cause of death was determined to be hypoxic, ischemic encephalopathy, due to interrupted SIDS.

Referral History

The referral history is on the maternal grandmother's home where the deceased child was placed at the time of his death.

On July 10, 1991, it was reported to Children's Administration (CA) intake that the maternal grandmother was having difficulty with her biological teen child. It was also reported the grandmother was separating from her abusive husband. The referral was screened as information only.

On May 15, 1993, the then teenaged daughter of the grandmother was arrested following a domestic violence incident in the home. The grandmother was offered services. There was no report of child abuse or neglect. The grandmother accepted Family Reconciliation Services (FRS). This referral was accepted for FRS.

On February 5, 2007, a daycare provider called reporting the then three-year-old brother of the deceased child, came to the daycare with red marks on his thighs, saying that his brother had hit him. These siblings were in the care of the maternal grandmother at the time. The maternal grandmother explained that he had been at another relative's home for the weekend and it occurred there. This referral was screened as information only.

On August 7, 2007, the Pediatric Interim Care (PIC) manager reported past concerns about the maternal grandmother. The deceased child had been in the PIC facility after his birth to complete his withdrawal from prenatal drug exposure. On June 27, 2007, the maternal

grandmother reported the deceased child was fine after his release from the PIC facility. On July 31, 2007, the grandmother report to PIC staff that the baby was having problem with formula and was cramping. The PIC worker advised grandmother to contact the baby's doctor. PIC staff attempted to schedule a follow up home visit, but the grandmother said she was too busy. On August 1, 2007, two PIC workers made an unannounced home visit. The grandmother refused to allow the PIC workers access to her home, reporting that the baby was with her sister-in-law. The PIC worker notified the social worker of that situation. The deceased child was admitted to the hospital on August 3, 2007, due to interrupted SIDS and died six days later. This referral was screened in for investigation by CPS and closed as unfounded.

Issues and Recommendations

Issue: At the time these children were placed with the maternal grandmother, the process for conducting background checks on relative caretakers to be approved as placement resources was somewhat confusing to most social workers.

Recommendation:

Action Taken: Since the time of this fatality, there has been clear policy implemented for background checks for relative and other persons with whom children are placed. This policy came in July 2007 with the Adam Walsh legislation. The policy was strengthened and clarified in April 2008 by the implementation of a standard background check administrative waiver process statewide.

Issue: When an infant is released from the Kent Pediatric Interim Care facility and placed in a home in the Everett area there appeared to be a lack of clarity about the roles each program would have with the home in which the child was placed. There was some confusion in this case as to the process for accessing the services of the Everett Pediatric Infant Care Program.

Recommendation:

Action Taken: Since this incident, Children's Administration (CA) headquarters has brought together CA staff and representatives of the three Pediatric Interim Care programs in the state and begun the process of developing an inter-regional protocol for PIC-involved cases that involve more than one region.

Issue: When the decision was made to place the deceased child and his siblings in the maternal grandmother's home, it was known that there were currently other grandchildren placed there by the department. There is no documentation in the record that any collaboration occurred between the social workers of these two separate cases on how this new placement would impact all. A Family Team Decision Meeting (FTDM) was not held

at the time of this placement, as the office at that time had only one FTDM facilitator and many more cases needing the meetings.

Recommendation:

Action Taken: Since this time, the region has had additional funding to hire another FTDM coordinator, and each placement or change of placement now has an FTDM staffing. There is also now an office protocol that directs that both social workers attend the FTDM when children from two cases are being placed with the same relative.

Child Fatality Review #07-22
Region 3
Department of Early Learning (DEL-Licensing)
Children's Administration Division of Licensed Resources (DLR-CPS Investigation)

This newborn infant died of a congenital adrenal gland defect.

Case Overview

The father of this one-day old infant drove him to the home of his mother (the child's paternal grandmother) who is a licensed childcare provider. The grandmother noted the child appeared yellow and did not feel right. She attempted to take his pulse, but was unable to detect a heartbeat. She started CPR and called 911. The infant was rushed to the hospital. He could not be revived. The baby very likely died while the father was driving him to the grandmother's home. The medical examiner determined the child died from Congenital Adrenal Hyperplasia, a condition present, although undetected, at his birth.

A domestic violence protection order between the parents of the deceased child was in place at the time of his death. The father has two convictions for domestic violence. The mother has one conviction for domestic violence. There are no prior referrals of child abuse or neglect on the parents of this infant.

Referral History

The referral history is on the in-home childcare of the paternal grandmother where the infant died.

On October 29, 1991, Children's Administration (CA) intake received a report from a former child in the grandmother's childcare facility. She said she was disciplined at the facility by being made to take off all her clothes in front of the other children. Another time she remembered that she had to take off her clothes and stand outside on the porch. She remembered the weather was cold and she had to stay there a long time. This referral was screened as a licensing complaint.

On December 2, 1994, the biological son of the paternal grandmother disclosed his father slapped him hard enough to knock him down and then kicked him in the stomach. He was twelve-years-old at the time. It was also alleged that the father was emotionally abusive telling his son he was no good. This referral was screened for CPS and closed as unfounded.

On July 13, 1998, the biological father of the deceased child, then a twelve-year-old boy, reported bruising on his back near his kidneys from his older brother kicking him. The older brother was sixteen-years-old. It was alleged he was violent, drank and took drugs, and that their mother (the paternal grandmother of the deceased child) did not protect her younger son

or the daycare children from her teen son's anger. This referral was screened for investigation by the Division of Licensed Resources, Child Protective Services (DLR/CPS) and closed as unfounded.

On July 20, 1998, it was reported to CA intake that the father of the deceased infant, then a twelve-year-old boy, said his sixteen-year-old brother kicked him in the groin. The caller said there were bruises still all over the twelve-year-old's body. It was alleged that the mother (the paternal grandmother of the deceased child) did not protect him. This referral was screened in for investigation by Child Protective Services and closed as inconclusive.

On July 20, 1998, it was reported the then sixteen-year-old son of the childcare provider was a paid employee at his mother's childcare facility. He was alleged to be violent and had severely kicked his brother (the father of the deceased child). This referral was screened for investigation by DLR/CPS and closed as unfounded.

On October 29, 2001, CA intake received a report that a staff person working at the grandmother's childcare facility had her own children removed from her care. This employee allegedly has two founded findings for neglect of her children. This person was no longer employed there when the licensor arrived at the childcare home. This referral was screened as a licensing complaint.

On May 9, 2007, CA intake received a report of the infant's fatality. The day after he was born, he and his mother were released from the hospital. The child's father drove him to his mother's home and it appeared the child was dead when they arrived. The paternal grandmother began CPR, but the infant was non responsive. The paramedics were called and they were unable to save the baby. There was no evidence of trauma to the infant. At the close of the investigation, both parents of the infant were barred from contact with the daycare children due to their criminal backgrounds. This referral was screened for investigation by DLR/CPS and closed as unfounded.

Issues and Recommendations

Issue: None identified

Recommendation: There are no official recommendations from the review team. The team did concur, however, with the Department of Early Learning's plan to monitor this facility by home visits at least every three months. The goal is to ensure that neither the father nor the mother is present when daycare children are there, due to their criminal histories.

Child Fatality Review #07-23
Region 6
Vancouver Division of Children and Family Services

This fourteen-year-old Caucasian female overdosed on medications given to her by her mother. Her death is ruled a homicide.

Case Overview

The deceased youth and her mother were found dead inside their home. Law enforcement investigated and ruled the deaths a suicide and a murder by acute intoxication. Both mother and daughter overdosed on prescription medications. The mother had been a licensed foster parent. The Division of Licensed Resources (DLR) twice initiated legal action to revoke the mother's foster care license due to her unwillingness to comply with standards set in the Minimum Licensing Requirements. The foster care license was closed ten months prior to her death.

Referral History

On October 23, 2003, it was reported to Children's Administration (CA) intake by law enforcement that the deceased youth had been inappropriately touched by another child on the playground of at her elementary school. Law enforcement reported all children were eight or nine years of age, therefore, no crime had been committed. This referral was screened as information only.

On January 5, 2005, a former foster child placed in the mother's home reported emotional abuse by her foster mother (the mother of the deceased youth). The foster child said she did not feel emotionally safe or supported by the mother. The mother yelled at the child, went through her personal journals, and listened in on her phone conversations. The referral was screened as a licensing complaint and closed as valid.

On May 30, 2005, law enforcement removed a teen foster child from the mother's foster home as the teenager was out of control. The officer reported concerns about the cleanliness of the home. He reported there was garbage everywhere in the home and everything was dirty. The officer recommended the teenager not return until a licensor or social worker inspected the home. This referral was investigated by the Division of Licensed Resources, Child Protective Services (DLR/CPS) and closed as inconclusive. The licensing complaint was closed as valid.

On July 25, 2005, the deceased youth's mother reported that her, then twelve-year-old daughter, was inappropriately touched on several occasions by a religious teacher at her church. The incidents occurred in Oregon. This referral was screened as information only and forwarded to law enforcement in Oregon.

Issues and Recommendations

Issue: One of the mother's references in the licensing process raised concerns regarding the mother's ability to be a foster parent. This reference happened to be a neighbor and was the only reference that raised red flags. As a result of this reference others were obtained by the licensor. In discussing how references are obtained it was stated that three references are required. Guidelines regarding references indicate that only one of the three references can be a family member. There are no other guidelines on this topic. Is it appropriate or within the department's ability to talk with references that have not been submitted to the department by the potential foster parent?

Recommendation: DLR should look at their process of obtaining references from potential foster parents and the possibility of talking with neighbors, church members, and employers.

Issue: One of the supervisors documented that he would not place children in this home and stated that the children his unit services were not well served by the mother.

Recommendation: When supervisors have concerns about foster homes and their ability to care for certain age groups or behaviors, a face to face discussion should occur between the supervisor and licensing staff.

Issue: During the course of this review the licensor stated that he did not want to license this home yet the license was issued. It was discussed that after the psychological evaluation was completed with the recommendation that the home be licensed for only one child, the department felt like they had no other choice but to license the home rather than deny and go through a possible fair hearing.

Recommendation: Include this issue in the lessons learned review that is being conducted by Risk Management.

Child Fatality Review #07-24
Region 3
Division of Licensed Resources

This nine-year-old Caucasian male died from cardiopulmonary arrest.

Case Overview

This child was medically fragile. He was born with several congenital birth defects affecting his stomach, esophagus, intestines, and heart. He also had a skin disorder. Both his biological parents are developmentally delayed and were unable to provide for his many needs. He was placed in out of home care immediately after his birth and moved to his guardians' home in late 1999 and remained there until his death.

The child's death certificate reads this medically fragile child died from cardiopulmonary arrest, massive aspiration, and gastrointestinal disorders. He was hospitalized as his lungs filled with fluid. He was released December 24, 2007. On December 31, 2007, he collapsed unexpectedly. His guardian foster parent began CPR and called 911, but he was unable to be revived. He was declared dead at the hospital. The deceased child received 80-100 hours of skilled nursing care per month in the foster home and received multiple medications daily.

Referral History

The referral history is on the foster home where the deceased youth was placed at the time of his death.

On May 29, 2001, Children's Administration (CA) intake received a report regarding concerns that the deceased child's foster parent/guardians were being overburdened and overextended with the special needs children in their home. It was alleged one child had poor hygiene and another developmentally delayed child was supervising the younger children in the home. The referral was accepted for investigation by the Division of Licensed Resources/Child Protective Services (DLR/CPS) and closed as unfounded.

On June 1, 2001, a child in this foster home reported she did not want to return to the foster home. She is 17-years-old and has cerebral palsy. The child alleges being put to bed at 6:30 p.m. until 4:00 a.m., and is left in feces and urine soaked diapers. She said she is left in bed all day Saturdays. There were five special needs children in this home; two of them require total care. The foster mother was overwhelmed. The referral was accepted for investigation by DLR/CPS and closed as unfounded.

On August 23, 2001, it was reported to CA intake that the foster mother flicked water at the deceased child, then four-years-old, to stop him from hitting his three-year-old foster

brother. The foster mother met with a behavioral specialist to learn better ways to deal with the child. This referral was screened as a licensing complaint.

On April 1, 2002, a DCFS social worker observed a red mark on the forehead and a small bruise on the right cheek, of an eleven-month-old foster child placed in the foster home. The referral was accepted for investigation by DLR/CPS and closed as unfounded.

On April 25, 2002, it was alleged a five-year-old foster child attempted sexual contact with another child in her current foster home. This child reported she observed this behavior when she was in a prior foster home (where the deceased child was placed in a guardianship). The referral was accepted for investigation by DLR/CPS and closed as unfounded.

On December 31, 2007, it was reported to Children's Administration (CA) intake the death of the nine-year-old child. The medical examiner reported no signs of abuse and he died a natural death. The child had a chromosome defect and extensive medical history. The referral was screened as information only.

Issues and Recommendations

Issue: When this child suddenly died, the foster family and the agency encountered significant problems in finalizing his funeral arrangements. His body remained in the funeral home for two to three weeks because the mortuary was not able to act on the wishes/direction of the foster parents, even though they had guardianship of the boy. This added considerably to the family's distress. The guardianship agreement did not specifically address who was to have decision-making authority in the event of his death, even though the child was considered medically fragile from birth. The mortuary believed they needed permission from the biological parents, so nothing could be done until the parents could be located out of state, which took considerable time as they had not been heard from for several years.

Recommendation: The team recommends that the region's Area Administrators, in their regularly scheduled meeting with the Assistant Attorneys General, look at the feasibility of addressing the issue of final arrangements in guardianship agreements, particularly with medically fragile children.

Child Fatality Review #07-25
Region 6
Shelton Division of Children and Family Services

This nine-month-old Caucasian female asphyxiated on the straps of an infant car seat.

Case Overview

On October 2, 2007 the deceased child's mother and a friend were moving items from her car to another car leaving her children strapped into their car seats. Witnesses report the mother was never far from the vehicle during this process. The mother later checked on her nine-month-old daughter and noticed she was hanging from the seat belt. The mother removed her from the car seat and called for help. CPR was initiated and medics were called. The child was transported to the hospital and was pronounced dead.

The law enforcement investigation revealed that the car seat was facing forward in the back seat. The car seat tipped backwards due to being inappropriately placed in the vehicle. It appeared the child was trying to get out of the seat and got tangled in the restraints. She was strangled by the seat belt. The law enforcement investigation determined that the death was an accident and no criminal charges would be filed. An autopsy was completed and the cause of death was determined to be asphyxia secondary to neck compression from the car seat strap.

Referral History

On May 3, 2001, a hospital social worker contacted Children's Administration (CA) intake and reported the mother was late in entering prenatal care and reportedly smoked marijuana early in her pregnancy. The mother said this occurred before she knew she was pregnant. This referral was screened as information only.

On March 10, 2003, a domestic violence (DV) advocate reported the mother has had an ongoing DV relationship with the father of her oldest child. The father hits the mother in front of the child who is almost two-years-old. The referral was screened as information only.

On March 22, 2006, it was alleged the mother's home was called a few times and a child answered the phone and hung up. Child Protective Services (CPS) intake called the home and a person that sounded like a child hung up. A welfare check was done by law enforcement and an adult was found in the home. This referral was screened as information only.

On October 16, 2006, it was reported to CA intake that the mother was pregnant and she and the unborn child's father smoke marijuana in front of the other children. It was also alleged

that when the parents go out they leave the five-year-old half-brother of the deceased child to watch the one-year-old. This referral was screened as low risk.

On August 30, 2007, law enforcement contacted CA intake after an act of domestic violence against the mother by the deceased child's father. The father hit and kicked the mother. He then threw a rock at the van window while she was driving away and the rock broke the back window. One of the children was hit with the broken glass. The father also threatened to kill the mother. The father was charged with Assault in the Fourth Degree, Felony DV Harassment, Reckless Endangerment DV and Malicious Mischief Second Degree DV. CPS social workers contacted the mother. She reported she obtained a Restraining Order against the father. This referral was screened as low risk.

On October 2, 2007, Children's Administration (CA) intake received a report that this nine-month-old child died after she strangled on her car seat straps. The referral was investigated by Child Protective Services (CPS) and closed as founded for neglect.

Issues and Recommendations

Issue: The Shelton office was required to come into compliance with the expectations of the CPS/Child Welfare Services (CWS) redesign. A plan had been developed by the office as to how they would comply with the redesign expectations. In review of this case the participants in the review stated that the office had not implemented the redesign plan and the CPS workers were carrying voluntary service cases.

Recommendation: It is recommended that the Shelton office review their redesign plan and come into compliance with the expectations of the plan.

Issue: There were several items in the Structured Decision Making (SDM) tool that were not scored accurately based on case documentation.

Recommendation: It is recommended that the CPS staff in the Shelton office be retrained on the SDM tool.

Issue: The referral dated August 30, 2007 was screened as a low risk referral. The screening of this referral is questionable given the allegations. It does not appear through this review that there was a response to this referral.

Recommendation: There is a new Intake/CPS Supervisor in the Shelton office. It is recommended that the new supervisor review all low risk referrals for accuracy of screening.

Child Fatality Review #07-26
Region 6
Kelso Division of Children and Family Services

This 16-year-old Caucasian female died of an acute rejection of her transplanted organs.

Case Overview

On December 26, 2007, the deceased youth was shopping with a friend when she suddenly collapsed. Paramedics were called and efforts were made to revive her. She died soon after her collapse. The deceased youth had an extensive medical history, including a heart transplant at the age of three and a kidney transplant at the age of twelve. For the majority of her life the youth resided with her mother and various relatives. Her mother started abusing illegal drugs and the youth was sent to her adult sister's home. In June 2007, she entered into foster care when no other family members were available to care for her. Relatives reported she had become increasingly defiant and out of control. She was also drinking alcohol and skipping school. She refused to take her medications. The deceased youth resided in the same foster home from June 2007 to her death in December 2007.

Referral History:

The referral history is on the foster home where the deceased youth was placed at the time of his death.

On March 24, 2001, a referral was made to Children's Administration (CA) intake alleging two foster children physically assaulting each other. The foster mother was in the room but had her back to the children. There were no injuries and or marks. This referral was screened out for investigation.

On March 11, 2003, a former foster child had bruising near her hip. She reported she fell down. The referral was screened as a licensing complaint.

On June 19, 2003, it was alleged a former foster child left the foster home not being allowed to take her belongings. It was also alleged the foster mother gave her medication to sleep in violation of the minimum licensing requirements. The child also reported the foster mother inappropriately shared information about her. The referral was screened as a licensing complaint.

On July 15, 2003, it was reported that a former foster child in this home cut herself with a knife and burned herself with a lighter. This referral was accepted for investigation by the Division of Licensed Resources/Child Protective Services (DLR/CPS) with concerns about the level of supervision in the home. The investigation was closed as unfounded.

On November 23, 2004, a school counselor reported to CA intake that a former foster child said she was pushed down a flight of stairs by a relative of the foster mother. This referral was accepted for investigation by DLR/CPS and closed as unfounded.

On December 27, 2007, CA intake received a report that the deceased youth died as a result of an acute rejection of her transplanted organs. This referral was screened as information only.

Issues and Recommendations

Issue: None identified.

Recommendation: In reviewing this case file it is noteworthy to document that this file was well organized. This youth had a significant amount of medical issues and the worker diligently gathered the medical information to learn more about how to assist this youth in having her needs met. The documentation was thorough and easy to follow. The social worker in this case worked closely with this youth to maintain family and community connections for her, and collaborated with medical providers to ensure that the medical needs were met.

Child Fatality Review #07-27
Region 6
Vancouver Division of Children and Family Services

This 18-month-old child died of an accidental drug overdose.

Case Overview

On April 24, 2007, a relative of this 18-month-old child contacted a Vancouver DCFS social worker to report the child died on March 19, 2007 while placed with his grandmother in Oregon. The social worker contacted law enforcement and CPS in Oregon and confirmed that the child had died and the death was investigated. The grandmother dropped her prescribed medications on the floor and missed picking up all the pills. The child found the medications and ingested them. The medications were identified as Methadone and Loxapine. The death was ruled as an accident and Oregon CPS provided services to the family. The Vancouver case was closed in October 2006.

Referral History

On September 13, 1995, Children's Administration (CA) intake received a referral alleging the deceased child's sister, then six-years-old, disclosed she was inappropriately touched by a male cousin. This incident happened when the family was visiting relatives in Oregon. This referral was screened out for investigation and sent to law enforcement in Oregon.

On July 12, 2002, it was alleged that the deceased child's mother lived with a known drug dealer. It was also alleged that she and her paramour cooked crack cocaine in the home with the children present. This referral was screened in as low risk and no investigation was conducted.

A referral was received on October 3, 2002, from an anonymous caller stating the mother was smoking crack in front of her one-year-old and four-year-old children. The referral was screened as information only.

On September 11, 2005, a referral was received alleging the mother gave birth to the deceased child on September 10, 2005, and he tested positive for cocaine. The mother admitted that she smoked marijuana, but denied using cocaine. The mother maintains she walked through a room where others were smoking cocaine. The referral was investigated by CPS and closed as inconclusive.

On December 29, 2005, the deceased child's father reported concerns of drug use and neglect by the mother. The father said the mother spends all her money to buy cocaine. The mother's home was reported to be very cluttered. The referral was screened as information only.

Issues and Recommendations

Issue: None identified

Recommendation: None identified

Child Fatality Review #07-28
Region 6
Centralia Division of Children and Family Services

This two-month-old child died from causes consistent with Sudden Infant Death Syndrome (SIDS).

Case Overview

On February 23, 2007, law enforcement responded to a 911 call that a two-month-old baby was found not breathing and CPR was in progress. The child was transported to Providence Hospital where he was later pronounced dead.

The maternal grandfather had come to the family home after he received a call from the deceased child's five-year-old brother. The mother had not picked him up as planned and he contacted his grandfather. The grandfather went to the mother's home and repeatedly knocked on the door. He entered the residence after the mother did not respond. He found the baby lying face down on the couch in some blankets. The baby was pale. The mother awoke, picked up the baby and started patting him on the back, unaware he was not breathing. The grandfather grabbed the baby and began CPR. The mother called 911. It is believed the mother was crashing from methamphetamine use earlier that day and was unaware that her baby had died.

The five-year-old sibling brother was placed into protective custody pending the results of the law enforcement and CPS investigations. The coroner's office determined SIDS as the cause of death.

Referral History

On October 22, 2001, Children's Administration (CA) intake received a referral alleging the mother, then pregnant with the sibling of the deceased child, was at the hospital and was experiencing an abruption of the placenta which doctors felt was a result of her drug use. Drug tests on the mother were positive for amphetamines. The referral was screened as information only.

On February 22, 2006, it was alleged the deceased child's mother and her boyfriend were using drugs. The referent expressed concern over the four-year-old brother of the deceased child who was in the home at the time. The referral was screened as information only.

On October 11, 2006, CA intake received a referral alleging the mother was smoking methamphetamines while she was pregnant. The referral further alleged the mother was not keeping prenatal appointments. The referral was screened as information only.

On February 23, 2007, it was reported the mother was crashing from methamphetamines and her infant son died. This referral was screened in for investigation by CPS and closed with an inconclusive finding for physical neglect.

Issues and Recommendations

Issue: Law enforcement in the Lewis County area has worked closely with CPS in the past to provide an expedited response to situations involving child abuse and neglect. In this situation the law enforcement agency contacted CPS directly and a worker responded to the case before a referral was generated. The worker responded on February 23, 2007, and the referral was generated on February 25, 2007. The electronic version of the referral was later changed to reflect the date of February 23rd.

Recommendation: The Centralia DCFS Office needs to work with local law enforcement to solidify the local law enforcement protocol and update if necessary to ensure response to cases goes through the intake process prior to a worker being dispatched.

Child Fatality Review #07-29
Region 6
Division of Licensed Resources

This five-year-old medically fragile Caucasian child died after he choked on his own vomit.

Case Overview

On January 14, 2007, law enforcement reported this five-year-old child was found deceased in the foster home where he lived. The foster parents found him in his bed unconscious and not breathing. They called 911. Medics arrived but were unable to revive him. It appeared he had been dead for some time. There were no suspicions or concerns of abuse or neglect due to the ongoing health problems of this young boy. The child had multiple congenital anomalies and had been medically fragile since birth. The death was expected to occur at some point when he was young. The initial prognosis was that he would not survive past his first birthday. The official cause of death was ruled as asphyxiation from aspirating on vomit.

Referral History

The referral history is on the foster home where the deceased child was placed at the time of his death.

On September 7, 1995, it was reported to Children's Administration (CA) intake that a former foster child who was wheelchair bound had bruises on his arms and marks that were scabbed over. It was alleged the foster parents were not providing good supervision. It was also alleged that the child had poor hygiene. The referral was accepted for investigation by the Child Protective Services and closed as unfounded.

On October 14, 1995, the foster mother contacted the department to report the death of a two-year-old medically fragile foster child in her foster home. The foster mother states she was bathing the child in an infant bathtub. She acknowledged she was distracted by other children who were fighting and left the child unattended for a minute to attend to the other children. She returned and found the child had slipped under water. The foster mother reported the child was very disabled did not easily move. The foster mother believes the child had a seizure and her face slipped into the water. The referral was accepted for investigation by the Child Protective Services and closed as unfounded.

On January 28, 1997, it was reported to CA intake that two former foster children engaged in inappropriate sexual contact with each other at this foster home. The referral was screened as a licensing complaint.

On February 28, 1999, it was reported that a former foster child sustained a black eye while he was placed in this foster home. There was no allegation of child abuse or neglect. The referral was screened as a licensing complaint.

On January 28, 2000, it was reported to CA intake that a former foster child did not receive appropriate medical attention for her asthma and ear infections. The referral was accepted for investigation by the Division of Licensed Resources/Child Protective Services (DLR/CPS) and closed as unfounded.

On May 1, 2001, it was reported to CA by a nurse that an 11-month-old foster child died on the car ride to a doctor's office. The child was being transported by the foster mother. The foster mother told the doctor the child was sick and she would be transporting her to his clinic. By the time the foster mother arrived at the hospital, the child had died. According to the several physicians, this child's health was extremely fragile since birth due to a unique syndrome resulting in dramatic growth failure. No autopsy was conducted. The referral was screened as a licensing complaint.

On July 16, 2002, it was reported to CA intake that a former foster child did not receive appropriate medical attention for her asthma and ear infections. The referral was accepted for investigation by the Division of Licensed Resources/Child Protective Services (DLR/CPS) and closed as unfounded.

On December 28, 2005, the foster mother reported that a former foster son became angry with her foster daughter and choked her. There were no marks or bruises on either child. The referral was screened as a licensing complaint.

On January 14, 2007, law enforcement contacted CA intake and reported the death of the five-year-old special needs foster child. His death was expected due to his health concerns. Law enforcement did not have any suspicions and/or concerns of child abuse or neglect.

Issues and Recommendations

Issue: The funeral home waited for approximately a week and a half to process the child's body as they were awaiting a down payment on the services they were to provide.

Recommendation: This issue has been remedied since the review. The Regional Office has created a streamlined process for processing payments for funeral expenses and the Area Administrators have been informed on how to do this. It will be expected that the CPS Program Manager and Business Manager continue to inform new Area Administrators of this process and upon a fatality of a dependent child, contact the AA to remind them of the process and assist in streamlining where possible.

Issue: This case was very medically involved and the social worker did not understand many of the anomalies present for this child, and had to rely on the foster parent and medical providers to determine what services he needed. Supporting medically fragile children on caseloads is very difficult and time consuming.

Recommendation: Medically fragile children in care should be identified to the priority level in offices in order to receive a Passport Nurse and evaluation. In addition, staff who carry these types of cases need to be reminded and encouraged to utilize the Region 6 medical consultant to review the cases where there are multiple medical problems.

Issue: This case was transferred throughout the life of the case due to the various workers involved, from investigation to voluntary services to ongoing services. Although a case transfer summary was completed to assist in the transfer, the worker initiating the transfer did not tell the receiving worker that this child was terminally ill. When the receiving worker obtained the case they were aware of the multiple developmental issues, but were not aware that he was not expected to live.

Recommendation: The local office should consider identifying a practice to support a better transfer of knowledge in cases involving medically fragile children. Due to the complexities of the case, regardless of whether or not the child is terminally ill, there are numerous medical needs that need to be shared with the new worker to ensure services are continued and streamlined in a way that best supports the child's needs.

Child Fatality Review #07-30
Region 4
Division of Children and Family Services
Indian Child Welfare Office

This three-month-old Native American female died from Sudden Unexpected Infant Death (SUID).

Case Overview

The infant's mother placed her face-down on a couch. She laid down on the couch next to the infant. A comforter covered both of them. The grandmother returned from the store and noticed the infant was face down. She checked on her, saw she was not breathing, and woke the mother. The medical examiner determined the cause of death to be Sudden Unexpected Infant Death, (SUID), and cause undetermined. The manner of death is undetermined.

Referral History

There are over 50 reports to Children's Administration (CA) associated with the mother, including the time that she was a minor. She was a victim of child maltreatment and lived in foster care. As a minor, the mother was convicted of Assault in the Second Degree and committed to a Juvenile Rehabilitation Administration (JRA) facility. As an adult, she has a felony assault in 2003 and served time for that offense. There are 27 reports that list her as the primary caretaker.

On July 19, 1993, law enforcement reported the mother with a bottle while she was holding her baby. This referral was screened as third party.

On January 23, 1995, the King County Medical Examiner reported that an infant (brother to the deceased child) died from Sudden Infant Death Syndrome (SIDS) at age 22 days. The mother and this child shared a bed together. The case was open for services at that time in the Seattle North DCFS office. According to the autopsy report there was no evidence of trauma to the child. This referral was screened information only.

On June 28, 1996, the deceased child's mother called from a JRA facility where she was incarcerated and wanted her daughter (sibling of the deceased child) placed in foster care. She said the child was living with a relative who was not allowing contact between the child and the mother. This referral is screened for Child Welfare Services (CWS).

On December 4, 1997, law enforcement reported that a person witnessed the mother striking her then four-year-old daughter for spilling juice. The referral was screened in for investigation and closed as inconclusive.

On July 22, 1998, it was reported to CA intake the mother and her children lived in a home that was physically unsafe, and the adults smoke marijuana in front of the children. The referral was screened in for investigation by Child Protective Services (CPS) and closed as inconclusive.

On December 22, 2000, CA intake received a report from school staff alleging the deceased child's mother dropped off her then six-year-old daughter at school and a cloud of marijuana smoke was seen exiting her mother's car when the child opened the door. The child seemed intoxicated. The referral was screened in for investigation and closed as inconclusive.

On January 3, 2001, law enforcement reported the deceased child's mother and her boyfriend were arrested on a narcotics charge. No children were present at the time. This referral was screened as information only

On January 4, 2001, law enforcement reported a domestic violence (DV) incident between the deceased child's mother and her boyfriend. The boyfriend reportedly beat her, using his closed fists, a towel bar ripped off the wall, a hammer, an axe, and a saw. He also bit her and doused her with caustic chemicals. Two of her children were present at that time. The referral was screened in for investigation and closed as inconclusive.

On January 17, 2001, school staff where the mother's six-year-old daughter attended made a home visit following the January 4th DV incident. The mother had not yet sent her daughter back to school since the New Years holiday. She planned to move out of state. This referral was screened information only.

On February 2, 2001, a school counselor reported the mother's then six-year-old daughter missed a lot of school. The mother said she no longer lived with her. There was no explanation why the change of placement. This referral was screened as information only.

On September 7, 2001, CA intake received a report that a three-year-old child living at the mother's residence was hit by a car. The child walked behind a neighbor's truck while the neighbor was backing out of the driveway. The child was not hurt. There was some suspicion about drug activity in the home. The referral was screened in for investigation and closed as inconclusive.

On October 16, 2001, law enforcement reported the mother was seen yelling at, and hitting, her then three-year-old son. There were no injuries on the child. The referral was screened in for investigation and closed as inconclusive.

On March 8, 2002, CA intake received a referral alleging physical abuse of the then seven-year-old sister of the deceased child by their mother. This referral was accepted for investigation and closed as unfounded.

On April 8, 2002, hospital staff reported the mother gave birth to a boy (brother to the deceased child) on April 7, 2002. CA had an open case at that time. This referral was screened as information only.

On August 15, 2002, childcare staff reported that mom was gone and dad was sleeping when the van arrived to pick up 3-year-old and 23-month-old siblings of the deceased child. There was an open case at that time. This referral was screened as low risk.

On September 24, 2002, childcare staff reported the then four-year-old sister of the deceased child said her mother hits her; there were no marks or other information to confirm this allegation. This referral was screened as information only.

On November 22, 2002, the deceased child's mother and siblings moved in to a homeless shelter. The mother was angry and made inappropriate statements to her children. This referral was accepted for investigation and closed as unfounded.

On February 4, 2003, a teacher reported the deceased child's nine-year-old sister was selling candy at school. This referral was screened as information only.

On April 22, 2003, law enforcement reported to CA intake they put the four siblings of the deceased child into protective custody. The mother left them in the care of the maternal grandmother. She said she could no longer care for them. This referral was accepted for investigation and closed as founded. CA filed dependency petitions on the children. The mother's parental rights were terminated in 2006.

On July 9, 2003, a CA social worker reported a relative claimed that the then five-year-old sister of the deceased child made a statement about being sexually abused when visiting at her father's home. Law enforcement was notified. This referral was screened as low risk.

On September 21, 2003, a relative caregiver was concerned about the 10-year-old sister's behavior as she was disrespectful and defiant. The relative wanted her removed from her home. This referral was screened information only.

On May 14, 2006, the deceased child's then 10-year-old sister was placed at the Secure Crisis Residential Center (SCRC) after law enforcement picked her up for running away from her foster placement. She reported that three years ago, her mother used to hit her with objects. This referral was screened as information only.

On August 21, 2007, staff at a youth shelter called to report the then 14-year-old sister of the deceased child was admitted into the facility. The referral was screened in for Family Reconciliation Services (FRS); the case was open to Child Welfare Services (CWS) at that time.

On August 21, 2007, CA intake received a referral with concerns about the deceased child, then 2-months-old. It was alleged the infant did not look healthy. The mother was using cocaine and breast feeding the baby. The mother allegedly sells the infant's WIC and food stamps. The referent was concerned the infant was not getting enough to eat. The mother avoided the doctor, afraid they would find drugs in the infant's system. It was also alleged there were large number of drug traffic in and out of the home. The mother did not have custody of any of her other children at that time. The referent reported there were guns in the home. The mother left the deceased child with strangers and other people at the house to go out and use drugs. This referral was screened in for investigation and closed as unfounded.

On August 27 2007, CA intake received a referral alleging the mother was in a cocaine induced coma, while the deceased child cried for four or five hours. The baby was in the same diaper for two days. Law enforcement was called but she would not answer the door. It was also alleged the infant was failure to thrive. The infant's eyes were yellow. The mother reportedly had outstanding warrants related to drug issues. This referral was screened in for investigation and closed as unfounded.

Issues and Recommendations

Issue: In 1995, the mother had another child die, this one from SIDS. Region 4 wrote a summary report of deaths that occurred in 1995. One of the team's recommendations was that Children's Administration develop a much stronger response to chronic neglect. It was not until 2007 that the chronic neglect legislation went into effect. This law allows CA to file for dependency based on patterns of neglect, not incidents.

Recommendation: New referrals on a mother with history such as hers should result in an immediate review to determine the best case plan.

Issue: The mother had one positive urinalysis (UA) for cocaine, but the case plan did not change.

Recommendation: With this mother's chronic history of substance abuse, filing a dependency petition (but not asking for removal) would have been an appropriate response.

Issue: Services continued with the visiting post-partum Public Health Nurse (PHN), but a referral to the Early Intervention Program (EIP) was not made.

Recommendation: EIP is a longer-term and more intensive nursing intervention, specifically for families referred by CPS. This is the best choice for families with newborns and preschool age children, or families with any child with a chronic health condition.

Issue: Safe Sleep Environment. The mother did receive safe sleep information from the visiting nurse. She had a portable crib and was using it. However, when the mother and her infant moved from Seattle to Auburn, she was not using safe sleep practices, as witnessed by the death scene investigation. She told one investigator that all of her babies had slept on their stomachs without a problem.

Recommendation: There needs to be a much clearer, more effective message to parents of newborns about sleep safety. Especially to a mother who had already lost an infant to SIDS, with a history of chronic substance abuse. In this case, the mother co-slept with her infant on a couch (a soft sleep surface), and the baby was placed on her stomach (against advice to reduce the risk of infant death).

Child Fatality Review #07-31
Region 4
King West Division of Children and Family Services

This newborn female infant died of natural causes.

Case Overview

The deceased infant was born full term on December 13, 2007 and in no distress. She decompensated suddenly and died eight hours later. The infant tested positive for opiates. The mother had no prenatal care. No autopsy was performed.

The mother gave birth to another drug-affected infant in 2006. The child's father has custody of this child.

Referral History

On September 14, 2006, hospital staff reported the mother gave birth to a female infant. The infant tested positive for opiates and benzodiazepine. The opiates could have come from the epidural injection during delivery. Benzodiazepine came from the mother's illicit drug use. The infant was jittery and not feeding. The mother had no prenatal care. The infant remained hospitalized for some time. The father eventually obtained custody. The mother was granted supervised visits. Children's Administration (CA) social workers visited to the father's home to assure her safety. The mother did not engage in services. The Child Protective Services (CPS) referral was investigated and closed with a founded finding.

On December 13, 2007, hospital staff reported the mother gave birth to a full term female infant (the deceased child). The baby died eight hours after birth. She tested positive for opiates. The deceased child was not in distress at birth, but decompensated suddenly. The mother had no prenatal care. The mother's 15-month-old daughter is in her father's care. No referrals have been received regarding the father and this child. He is the father of the deceased child. The mother was a victim of abuse and neglect as a child. Her mother was addicted to drugs. The CPS referral was investigated and closed with an inconclusive finding.

Issues and Recommendations

Issue: It appears that the case was transferred from CPS investigations to the voluntary services unit without completing the safety assessment, safety plan, structured decision-making (SDM) risk assessment and findings in regard to the referral dated December 13, 2007.

Recommendation: The CPS worker and supervisor will complete these items.

Issue: Lack of prenatal care. The deceased child was her mother's second drug-exposed infant. The mother did not participate in treatment, or seek prenatal care, per her own report to the hospital. Pregnant and parenting women are the highest priority for chemical dependency treatment programs. Had she sought care, treatment and medical care would have been readily available to her.

Recommendation: All agencies that have contact with pregnant women should strongly encourage them to participate in prenatal medical care, and chemical dependency treatment if applicable.

Child Fatality Review #07-32
Region 1
Spokane Division of Children and Family Services

This 17-month-old Caucasian male child died from swelling of the brain due to overheating and dehydration.

Case Overview

On November 10, 2007, a 17-month-old male child was taken to a Spokane area hospital unconscious. He had non-accidental injuries consistent with shaken baby syndrome. He had no bone fractures or evidence of prior injury. The deceased child was a dependent child in relative care at the time of his death.

The deceased child was awake and fussy in the early morning of November 10, 2007. He was put to sleep on a queen bed in a sleeping bag. He was regularly checked on and appeared to be healthy and sleeping. The relative adults left the home in the afternoon. They left the deceased child and two other children in the care of 14-year-old and 16-year-old cousins. In the early afternoon, the child was found breathing erratically, sweaty, unresponsive, and with a high temperature. The teen babysitters sought help from an adult neighbor. The deceased child's aunt and uncle were summoned home.

After attempting to treat medical issues themselves, the relatives transported the child to the hospital. The child stopped breathing; CPR stabilized him and he was transported to another hospital. Medical staff noted the child had retinal hemorrhaging, often indicative of shaken baby syndrome. A Child Abuse Consultation was completed by a medical expert who found the child did not have additional indicators of abuse and determined the child's injuries were more likely the result of hyperthermia and extensive CPR. The child was pronounced dead on November 12, 2007.

Law enforcement determined there was no criminal offense. The deceased child's sister was allowed to remain in the relatives' care. After hours CPS social workers met with the sister and relatives and determined there were no imminent safety issues at that time.

The medical examiner ruled the child died of lack of oxygen to and swelling of the brain due to overheating and dehydration.

Referral History

There were no prior referrals on the relative home where the deceased child was placed at the time of his death.

There were two prior referrals regarding the deceased child's mother.

On October 11, 2005, a doctor contacted Children's Administration (CA) intake with concerns about the mother's, then one-month-old, daughter. The doctor diagnosed the infant as failure to thrive. The doctor reported the infant lost weight during her first month of life. The baby had thrush and a severe diaper rash. The family did not show up for follow-up doctor appointments. The CPS referral was investigated and closed with an inconclusive finding.

On August 6, 2007, a neighbor reported to CA intake that the two-year-old sister of the deceased child was found wandering in the street at 5:30 a.m. wearing only her underwear. The neighbor said this was not the first time the child was left unsupervised or wandered away. It was also reported the mother was seen shaking the child and yelling in her face. The home was a health hazard and that the family who lived in the home was arrested for manufacturing methamphetamine. All adults living in the home appeared as though they were using methamphetamine and/or were drug involved. The neighbor also reported there were four or five children in the home, including the deceased child, and they were always left unsupervised. CPS and law enforcement investigated the allegations. The deceased child and his sister were placed in protective custody and placed with relatives. A dependency petition was filed on the children's behalf. The CPS investigation was closed with a founded finding.

Issues and Recommendations

Issue: The social worker did not follow the policy for relative home study to include criminal background checks for all adults living in the residence.

Recommendation: Criminal background checks and the full relative home study were initiated after the child's death.

Child Fatality Review #07-33
Region 5
Tacoma Division of Children and Family Services

This two-month-old African American female died from undetermined causes.

Case Overview

On October 22, 2007, the mother and the deceased child were residing at a YWCA Shelter. The mother was feeding the infant when she appeared to choke and sneeze. The mother got help from the YWCA staff and CPR was administered. Medics arrived and transported the infant to Mary Bridge Children's Hospital. The infant was pronounced dead ten minutes after arriving at the hospital. Children's Administration (CA) had an open case with this family. The child was in her mother's care on an in-home dependency.

The final determination of cause of death according to the Pierce County Medical Examiner was unexpected death associated with sickle cell trait. The manner was listed as undetermined.

Referral History

On May 21, 1996, CA intake received a referral reporting that the mother, then 16-years-old, had just given birth. Hospital staff were concerned for her anger problems and poor coping skills. The report had no specific allegations of abuse or neglect. The mother had prenatal care. Service providers and relative support were in place. The referral was screened as information only.

On September 1, 1996, the deceased child's mother left her four-month-old infant in the care of friends three months prior and never returned. The infant was sick and taken to a hospital. Hospital staff called CA and law enforcement. The infant was placed in protective custody. The Child Protective Services (CPS) referral was screened in for investigation and closed as founded. The mother's parental rights to this child were terminated.

Issues and Recommendations

Issue: None identified

Recommendation: No Recommendations

Child Fatality Review #07-34
Region 3
Smokey Point Division of Children and Family Services

This 10-month-old Native American male died from a Sudden Unexplained and Undetermined Infant Death (SUUID).

Case Overview

On December 11, 2007, the Snohomish County Medical Examiner called CPS intake to report the death of this 10-month-old child. The baby's father reported he put the child to sleep in his crib just before midnight on December 10, 2007. Around 2:00 a.m., the father went to check on the child and he was non-responsive. Medics were called but were unable to revive the baby. They found nothing suspicious. The baby had a cold the previous week. The Medical Examiner determined the manner of death "Undetermined" and the cause was listed as "Sudden unexplained and undetermined infant death." The deceased child was not known to Children's Administration (CA) prior to his death. The child's mother was also unknown to CA. The father has two children with a prior partner. That family has prior history with the department.

Referral History

On July 24, 2005, CA intake was called by law enforcement when they responded to a call at the father's home he shared with a previous partner. The father's girlfriend was found lying in the yard naked, bloodied, and unconscious. The father was found unconscious in the living room and their children were asleep. Both parents had very high blood alcohol levels. The children were taken into protective custody. The referral was accepted for investigation by Child Protective Services (CPS) and closed as founded for negligent treatment. The children became dependents of the state. The children's mother actively participated in services and the children were returned to her care.

On July 17, 2004, a neighbor reported to Children's Administration (CA) intake that the father's children from a prior relationship were often wandering the neighborhood unsupervised while their mother was at work at the casino and their father was caring for them. The referral was accepted for investigation and closed as unfounded.

On February 2, 2002, law enforcement reported they took custody of the two children of the father and his former girlfriend. Police had been at the residence regarding a domestic disturbance. Police found the girlfriend intoxicated. The father is a registered sex offender and had warrants for his arrest. The referral was accepted for investigation by Child Protective Services and closed as founded.

Issues and Recommendations

Issue: None identified.

Recommendation: No Recommendations

Child Fatality Review #07-35
Region 3
Everett Division of Children and Family Services

This 10-month-old Caucasian male died from acute methadone intoxication.

Case Overview

The deceased child and his brother were placed with their maternal grandmother. The mother and her boyfriend took the children from the maternal grandmother's home for an unauthorized weekend visit. During the visit, the mother left them for several hours with a teenaged cousin in a motel room. The mother returned early in the morning and slept. Around 11 a.m. the mother awoke and found the ten-month-old non-responsive. She attempted to initiate CPR, and called 911. The child was cold and blue when paramedics arrived. An autopsy determined the cause of death to be acute methadone intoxication. The medical examiner determined that the child likely ingested a methadone tablet two to six hours before his death. The medical examiner stated the amount prescribed to an adult could be enough methadone to be fatal to a small child. It remains unclear where the child obtained the methadone.

From the time of the first CPS referral, this family was provided with numerous services. A team of social service agencies worked with the mother to support her in stabilizing her family's situation and safely raising her children. The mother received help with parenting skills, housing, and provided Family Preservation Services (FPS). Despite all the services through several agencies, reports of neglect continued. DCFS social workers removed the children in May 2007 when the mother left the child alone in their apartment and the two-year-old brother was found wandering the apartment complex, crying. A dependency petition was filed, and the children were both placed with their maternal grandmother.

Referral History

On November 3, 2006, the deceased child, then 30-days-old, was taken by his father after a domestic violence incident with the child's mother. Despite a protection order in place, the mother invited the father into her apartment. He became intoxicated and hit her on the face. When the mother attempted to call the police, the father grabbed the deceased child and left through a ground floor window. He jumped two high fences with the baby and disappeared. The mother later found the father and baby at a friend's home. He gave the baby to her. She took the baby to a hospital for examination. He was found to have no injuries from the event, but was held for several days for a respiratory problem. He was released to his mother and they went into a domestic violence shelter. The referral was accepted for investigation by Child Protective Services (CPS) and closed as inconclusive.

On November 17, 2006, the mother reported to her pediatrician, that her infant son (the deceased child) turned blue and stopped breathing, but started again. She did not call 911 or a doctor. The child had sleep apnea. She did not give the child his medication for three days. The mother was told the medication was crucial and he may die without it. She was referred for a blood test and the medication was called into a pharmacy. A clinic nurse called mother later in the day found she had not taken the deceased child in for blood test nor picked up the medication. The doctor reported these concerns to Children's Administration (CA) intake. The referral was accepted for investigation by CPS and closed as inconclusive.

On April 22, 2007, medical staff reported the deceased child, then six-months-old, had diarrhea for three to four days and was dehydrated. The mother said she was taking him to the hospital, but delayed several days before finally doing so. The referral was accepted for investigation by CPS and closed as unfounded.

On April 23, 2007, it was reported to CA intake that the mother left the deceased child, then six-months-old, in a bath that had about two inches of water in it. The mother also delayed in taking the deceased child to the doctor after she was told to for ongoing diarrhea. The referral was accepted for investigation by CPS and closed as unfounded.

On May 16, 2007, law enforcement reported the police were dispatched to the family home on May 20, 2007 and found the children (then seven-months and two-years-old) left alone in the apartment by their mother. The children were placed into protective custody. The DCFS social worker was aware of this situation and had filed a dependency petition on May 10, 2007. The children were placed with the maternal grandmother. This referral was screened as information only.

On August 29, 2007, the deceased child's maternal grandmother, with whom he and his brother were placed, called CPS to report that her 10-month-old grandson died. The mother took the children from the grandmother's home the night before to a motel. Medics attended to the child but he had passed away. The referral was accepted for investigation by CPS and closed as founded as to the mother and grandmother.

Issues and Recommendations

Issue: The referral was received on May 16, 2007 alleged the mother's two-year-old son was found wandering the apartment complex late at night, crying and wearing only a diaper. The six-month-old was found alone in the apartment. It was determined by law enforcement that the mother had left the children alone and they were placed in protective custody. The department proceeded with the filing of a dependency petition. The review team agreed this referral contained a clear allegation and should have had a separate investigation and finding. However, it was screened as "information only" and not assigned for investigation.

Issues and Recommendations

Action Taken: Since this review, the process for assessment of referrals taken by the county's centralized intake unit has been modified so that the CPS supervisors in each office will be viewing all of the referrals taken for their offices. The prior practice was for the individual CPS offices to review only those referrals that were screened in for investigation.

Issue: After the death of the child, a CPS investigation determined that the maternal grandmother, with whom the children were placed, had been allowing the mother to take the children for unauthorized visits, contrary to the court order. The team agreed that relatives with whom dependent children are placed are frequently conflicted about their relationships with the natural parents and their obligations to cooperate with the department and courts in protecting the children.

Recommendation: The team agreed that family with whom dependent children are placed could benefit from additional supports. The team recommends that the region form an ad hoc workgroup to explore possibilities for increased support to relative placements. The team recognizes this as a very complex issue that would benefit from the brainstorming of a workgroup consisting of social workers, relative caretakers, and others.

Child Fatality Review #07-36
Region 2
Toppenish Division of Children and Family Services

This two-year-old medically fragile Native American female died from a heart attack.

Case Overview

On December 21, 2007, this two-year-old child died in her sleep. The child was medically fragile and diagnosed with congenital hydrocephaly (an abnormal buildup of spinal fluid in the brain). The child also suffered from developmental delays, a seizure disorder and chronic feeding issues. The county coroner and Tribal Police Chief determined an autopsy was not necessary due the extent of the child's medical issues. The county coroner determined the child died of a heart attack.

Referral History

The referral history is on the maternal grandparents (where the deceased child was placed at the time of her death) and on the child's mother.

On June 8, 1995, the deceased child's grandparents were caring for a nephew. It was alleged the grandmother yelled at him, pulled his ears leaving scars, and hit him with a beaded belt. The referral was screened as information only.

On September 25, 1995, the nephew living with the grandparents came to school with multiple bruises. He had several bruises on his chest and back. His face is swollen and bruised on the left and right black eye. His left ear was bruised. The boy stated that he was wrestling with his cousin. The case was closed with no finding of abuse.

On February 1, 2005, the deceased child's mother was arrested after she got into car accident. She was driving under the influence and had outstanding warrants for her arrest. The mother had her two children, ages three-years-old and four-months-old, in the car with no safety restraints. The children were placed in protective custody and placed with relatives. This referral was investigated by Child Protective Services (CPS) and closed as founded for neglect.

On December 13, 2005, Children's Administration (CA) intake received a report regarding the deceased child. She was born on December 10, 2005 with hydrocephalus. The mother had limited prenatal care. She was instructed to make arraignments to deliver the baby in Seattle, which she failed to do. The parents were non-compliant with a service plan. Their two older children were still in out-of-home care. This referral was investigated by CPS and closed as founded for neglect.

On April 10, 2006, a doctor called CA requesting DCFS intervention as the deceased child was scheduled to be discharged from the hospital. The doctor expressed concern that she would not be safe to discharge to parents unless they participated in training to care for her special needs. Both parents were non-compliant with medical training. The deceased child was hospitalized since her birth on December 10, 2005. A dependency petition was filed in Tribal Court; the court denied out of home placement. The child remained in her parents' care on an In-Home Dependency. This referral was investigated by CPS and closed as founded for neglect.

On June 19, 2006, the deceased child was released from Children's Hospital at the end of April 2006. She was discharged to her parents. She was hospitalized on June 17, 2006 for a fever and put on antibiotics. Her gastric tube (G-tube) was pulled out and was becoming infected. She lost a lot of weight. The parents were not giving her prescribed medications. She was ready for discharge and medical professionals were not comfortable discharging her to the parents. There was concern that her G-tube would get infected and fail to function. The G-tube was her life line. This referral was investigated by CPS and closed as founded for neglect.

On June 30, 2006, the deceased child's mother was admitted to the hospital due to abdominal pains. She had acute renal failure and liver failure. She was also positive for cocaine and opiates. The mother was referred for a psychological evaluation. Medical professionals reported the mother was not able to care for her medically fragile baby (the deceased child) due to her substance abuse. It was reported the mother had previously tested positive for opiates. A dependency petition was filed in Tribal Court on the child on July 7, 2006. She was placed with her maternal grandparents. This referral was investigated by CPS and closed as founded for neglect.

On October 11, 2006, it was reported to CA intake that the grandmother caring for the deceased child said many times she did not want to care for the child. The grandfather provided all the care. The grandmother was overwhelmed but refused respite care. There were concerns that the grandmother did not take the child to her medical appointments. The deceased child missed three appointments for feeding evaluations. The grandmother was not home for dietician visits or home therapy appointments. There were concerns that the grandmother gave the child more Tylenol than needed. This referral was investigated by CPS and closed as inconclusive.

On September 11, 2007, it was reported to CA intake that the grandparents withheld food from the deceased child because it was difficult to administer. The child's sodium levels dropped dangerously low and she began to have seizures. The grandparents did not consult with medical providers before withholding food. It was reported the deceased child was only receiving water through her G-tube for three to four days which likely caused her increase in seizure activity. This referral was investigated by CPS and closed as unfounded.

On December 21, 2007 it was reported that the deceased child was found dead in the home of her grandparents. It was determined by the County Coroner that the child died of a heart attack. Her brother and sister remained in the grandparents under a guardianship through Tribal Court.

Issues and Recommendations

Issue: The overall concern was that there appeared to be a lack of communication, collaboration, and consistency between Children's Administration, medical staff, family, and other professionals involved with the deceased child and her family/caregivers.

Recommendation: All entities involved with a family need to come together to discuss extent of involvement and services being provided. This can be done with current practice of Family Team Decision Meetings, Multiple Disciplinary Team meetings, and or staffings. Such staffings will be beneficial in discussing the child's up to date condition, progress, concerns, and develop appropriate Safety Plans/Service Plans with clear and concise needs identified to be met by all parties.

Issue: There is a lack of an outside entity to represent a dependent child's needs in Tribal Court.

Recommendation: It was identified that DCFS continue discussing the need for a GAL in Tribal Court with Tribal Court Administrators.

Child Fatality Review #07-37
Region 2
Yakima Division of Children and Family Services

This 17-year-old Caucasian male committed suicide.

Case Overview

On December 4, 2007, the deceased youth was found by his father in a bedroom closet. The youth had hung himself while at his father's home in Idaho. The deceased youth sustained life-threatening injuries from this suicide attempt and received medical treatment at a Boise, Idaho area hospital. He died on December 5, 2007.

Children's Administration received many referrals on the youth's family since 1991. Most of the referrals recount drug use by the mother and her boyfriend. There were referrals regarding the deceased youth and his brother's drug use, running away, and truancy issues. Many services were offered to the family, including: Family Preservation Services (FPS), Intensive Family Preservation Services (IFPS), At Risk Youth Petitions (ARY), drug/alcohol assessment, probationary services, and parenting classes. Despite these services, the family did not stabilize. The department filed a dependency petitions for both the deceased youth and his brother on May 6, 2004. The deceased youth was in multiple placements, including group care to address his drug addiction. The youth either sabotaged or ran away from placements. He had been in group care and inpatient drug/alcohol treatment on two occasions. He last ran away from group care on June 14, 2007 and was not located until the time of his death.

The deceased youth's biological father admitted knowing where his son was located, but refused to give his whereabouts or confirm his physical address. The father reported his son would remain hidden until he turned eighteen. Attempts to locate the father's home address were unsuccessful.

Referral History

On February 15, 2002, CA received a report that the deceased youth refused to go to school. The deceased youth does not listen to his mother and is disrespectful. He abuses methamphetamine and marijuana. He had a date for inpatient drug/alcohol treatment in May 2002. This referral was screened for Family Reconciliation Services (FRS).

On February 22, 2002, it was alleged the mother's paramour attempted to get the deceased youth to go to school. The paramour grabbed the youth by the earring. This started a fight. The paramour grabbed the youth by the neck and necklace causing welts to the youth's neck. Law enforcement was called and intervened. The youth was taken to juvenile

detention. The deceased youth ran away three days later. This referral was screened as low risk Child Protective Services (CPS).

On August 7, 2002, the deceased youth and his younger brother reported their mother threatened to beat them with a bat. The boys reported their mother's paramour hits them. The deceased youth's brother said he was hit by the paramour on August 1, 2002. The mother's paramour hit him three times on the back and twice on the buttocks. There were no bruises or injuries to the brother. The deceased youth was hit sometime during the week. Social workers went to the home and found no signs of injury to the children. The paramour denied drug use or threats with a bat. This referral was accepted for investigation by CPS and closed as unfounded.

On August 12, 2002, a neighbor reported to CA intake that the deceased youth and his younger brother (then ages 10 and nine) were seen fighting. The deceased youth beat up his brother. The neighbor said they saw this often and the deceased youth would punch his brother on the face with a fist. The brother said his mother didn't do anything to stop it. The neighbor saw blood coming from the wrist of the younger child from an injury inflicted by the deceased youth. The neighbor said the parents use drugs and give drugs to the children. Law enforcement was notified. This referral was accepted for investigation by CPS and closed as unfounded.

On August 31, 2002, law enforcement reported to CA intake requesting placement for the deceased youth and his brother. The brother told law enforcement he ran away from home because he was beaten. The police officer did not believe that the boy was beaten. He was concerned that the mother never called to file a run report. The mother eventually picked up her son. Police believed her explanation. The two boys had a history of running away. This referral was screened as information only.

On September 4, 2002, the deceased youth's mother called CA intake to request help filing an At Risk Youth (ARY) petition. The deceased youth refused to go to school and was smoking marijuana. This referral was accepted for FRS.

On September 8, 2002, the deceased youth, then 12-years-old, was placed in a Crisis Residential Center (CRC) by police after being picked up on a run. The youth said he would run away again if returned home. The deceased youth was released to his mother later that day promising to go to school. This referral was accepted for FRS.

On December 16, 2002, the deceased youth's mother called CA intake to request help filing an ARY petition. She reported her son did not attend school, had criminal charges pending, was involved with drugs, and was a chronic runaway. This referral was accepted for FRS.

On January 1, 2003, the county sheriff's department responded to a domestic violence incident and observed that the deceased youth, then 12-years-old, was extremely intoxicated. He was out of control and damaging property. The deceased youth got drunk at a friend's house. The youth said his mother and boyfriend smoke marijuana in front of him. He also said his mother hits him on a regular basis. This referral was accepted for FRS.

On June 23, 2003, the deceased youth's mother reportedly gave the teens who supervised her children beer and marijuana so that they will stay and babysit for her. The mother also reportedly gave beer and marijuana to other minors. The home was full of garbage and filthy. A referral was sent to law enforcement. This referral was accepted for investigation by CPS and closed as inconclusive.

On October 2, 2003, the mother of the deceased youth brought him to a detox facility because she thought he was using drugs. At the time, he was taking prescribed medication. The mother forgot to bring his medication. This referral was screened as information only.

On October 2, 2003, the deceased youth's mother reported he was out-of-control. He was physically and verbally abusive to all other family members. She stated he is in counseling and wants to file an At Risk Youth petition. This referral was accepted for FRS.

On October 3, 2003, the deceased youth's mother reported he was out of control. He was physically and verbally abusive to other family members. Law enforcement was contacted. The deceased youth was taken into a crisis residential center for possible methamphetamine use. This referral was screened as information only.

On January 20, 2004, it was reported to CA intake that the deceased youth started to use methamphetamine. The referent said the younger brother has a history of following his older brother's substance use and will possibly start to use drugs. It was also alleged the mother goes to her boyfriend's house and leaves the children alone. This referral was screened in for Alternate Response.

On January 29, 2004, CA intake received a report that the mother's boyfriend was not to be in the home. He kicked the children out of the home to smoke crack. The deceased youth smoked crack with him. School staff reported the deceased youth's younger brother missed 70-80% of school due to chronic vomiting. The mother delayed getting help for her son's stomach problems. The brother reported getting hit daily by the deceased youth. The mother was rarely home to supervise. A therapist working with the family reported the brother had marijuana in his system and the deceased youth was using methamphetamine. The therapist provided therapy to the family for three to four months. This referral was screened in for investigation by CPS and closed as inconclusive.

On February 19, 2004, it was reported the deceased youth's younger brother was beaten by a much older teen. The brother said his mother was present and did not intervene. The brother had bruising and a puncture wound near his temple. There were also concerns of the mother's sobriety. This referral was screened in for investigation by CPS and closed as inconclusive.

On March 1, 2004, the mother reported to a therapist that her babysitter was giving bipolar medications to children in the neighborhood, including her son (brother of the deceased youth). Law enforcement was notified. This referral was screened as a third party report.

On April 2, 2004, the mother contacted CA intake requesting help filing an At Risk Youth petition. She reported the deceased youth was in trouble for drug/alcohol use and theft. He was on probation. This referral was accepted for Child Welfare Services (CWS).

On May 10, 2004, school staff reported the brother of the deceased youth was expelled from school. The mother was required to respond to a letter from the school to get him re-enrolled. The mother had failed to communicate with the school or respond to the letter. The brother was home from school for a month due to lack of follow through by his mother. The deceased youth had sporadic school attendance as well. The department was awaiting placement in group care to meet the boys' needs. This referral was screened as information only.

On February 25, 2005, the mother contacted CA intake to report she was court ordered to request an At Risk Youth petition or a Child in Need of Services (CHINS) petition so that the deceased youth could remain in treatment. This referral was accepted for FRS.

On May 3, 2006, the brother of the deceased youth was admitted into a Secure Crisis Residential Center after being picked up as a runaway. He reported being ignored by his parents, but denied any form of physical abuse. This referral was accepted for FRS.

On December 14, 2006, the brother of the deceased youth disclosed his father punched him twice on the face with a closed fist. The boy reported this happened on December 1, 2006. The boy had no marks or injuries. This referral was screened as information only.

On April 12, 2007, the mother contacted CA to request assistance with At Risk Youth petition. This referral was accepted for FRS.

On May 29, 2007, the brother of the deceased youth was arrested after being caught breaking into a car. He was placed in a Secure Crisis Residential Center. This referral was accepted for FRS.

On October 22, 2007, the deceased youth's brother disclosed that his father molested him. He did not give any more details. The deceased youth was known to be with the father in Idaho. His address was unknown. The youth's mother was unsure if her son made up the allegations. The brother had been on the run. He had not seen his father in two to three years. This report was forwarded to law enforcement. This referral was screened as information only.

Issues and Recommendations

Issue: This family was still in need of services, even after the death of the youth. The brother has attempted suicide and has been hospitalized.

Recommendation: Generate a referral of imminent risk on the brother and continue to assist the family with services.

Issue: All indications were that the biological father was harboring the youth in the state of Idaho. Social workers' attempts to secure a physical address of youth's biological father were unsuccessful.

Recommendation: Regional protocols in locating runaway youth known to reside outside the state should be established. The CPS program manager will take the lead in obtaining feedback from Regional staff for a written proposal to be submitted to the Regional Administrator.

Child Fatality Review #07-38
Region 2
Richland Division of Children and Family Services

This five-year-old Caucasian female died from a fatal head injury.

Case Overview

On August 25, 2007, the relative caretakers of the deceased child reported she slipped and hit her head on the bathtub. The child sustained a skull fracture and subdural hematoma. She was airlifted to Spokane area hospital for further evaluation. She was placed in a pediatric intensive care unit as doctors considered surgery to treat the bleeding in her brain. The child died on August 30, 2007.

The deceased child and her sister came into state custody February 1, 2006 after reports of their mother using cocaine. The children were placed with a maternal aunt and uncle. After the mother failed several attempts at in-patient treatment, the department filed a dependency petition. They remained in relative care until the child's death. When the child was initially hospitalized, her 18-month-old sister was placed in protective custody

The aunt admitted leaving the 5-year-old the deceased child and her 18-month-old sister unsupervised in the bathroom where the fatal injury occurred. The aunt said she put the 18-month-old in the bath tub and went to the kitchen. She reported the deceased child was not in the bathtub. She heard the deceased child cry and returned to the bathroom and found her in the tub. The aunt reports she did not observe the incident. By her own account, she left the 18-month-old in the bathtub unattended. The medical findings were staffed with CPS medical consultants Dr. Ken Feldman and Dr. Deborah Harper. They reported that the explanation of the injury was consistent with the injury. There remained concern about bruises on the child's body that appeared in multiple stages of healing. The CPS investigation was closed as founded as to the aunt for leaving the young child unattended. The finding as to the deceased child was inconclusive. The 18-month-old sibling was moved to a new relative placement following her sister's death.

Referral History

The referral history is on the relatives where the children were placed at the time of the child's death.

On February 25, 1991, it was alleged the aunt put her biological child at risk by being with a drug involved individual. Additional information also sent from the State of California informing Washington State that the aunt had been incarcerated and her children placed in care due to a narcotics raid on her home. This referral was screened for low risk Child Protective Services (CPS).

On August 1, 1992, it was reported to CA intake that the aunt left her son and daughter in the care of a relative who was unable to provide proper care. This referral was screened as low risk Child Protective Services (CPS).

Issues and Recommendations

Issue: The department did not adequately respond to Background Check Central Unit (BCCU) information which listed criminal convictions that would have disqualified the family from placement consideration. Once the department received the relative's criminal history, CA staff did not adequately respond to the relative's inaccurate response to the question inquiring about any known convictions.

Recommendation: All information received from a criminal background inquiry must be thoroughly evaluated. This field office successfully completed a review of all open relative placements to assure all home studies and background inquiries were completed and appropriate.

Issue: There was an incomplete assessment of relative home environment at the time children were placed.

Recommendation: This field office successfully completed a thorough review of all open relative placements to assure all home studies and background inquiries were completed and appropriate.

Issue: Initially, the surviving sibling that was also in the home at the time of the injury was not identified as a victim.

Recommendation: Risk assessment on all children in the home needs to be completed.

Child Fatality Review #07-39
Region 2
Richland Division of Children and Family Services

This seven-year-old Caucasian male died following an allergic reaction to medication.

Case Overview

The King County Medical Examiner reported the deceased child was pronounced dead on July 18, 2007. The cause of death was an allergic reaction to antibiotics.

The deceased child was living with his paternal grandparents at the time of his death. He moved in with his grandparents during an on-going divorce and custody dispute between his parents. His father reported there was a restraining order barring him from unsupervised contact with his son. There was no proof that such an order existed.

The deceased child and his then two-year-old stepbrother had been removed from their mother's care after the stepbrother sustained a fractured arm caused by neglect. The deceased child's father obtained custody of him, although he lived with his grandparents.

The deceased child's mother and husband were offered services related to their substance abuse. The mother accepted and completed drug/alcohol treatment. She was offered and accepted Family Preservation Services (FPS). Her husband aborted treatment twice. This family was offered childcare services and ongoing counseling prior to the child's death but refused.

Referral History

On November 5, 2003, it was reported to Children's Administration (CA) intake that the deceased child's mother took him, when he was four-years-old, with her to purchase drugs. This referral was screened accepted for investigation by Child Protective Services (CPS) and closed as founded.

On November 25, 2003, the deceased child's stepfather called intake and reported the child's mother left the home at 10:00 p.m. the previous night and didn't return. He suspected she was with drug dealers. He reported she used marijuana and associated with people who used methamphetamines and cocaine. This referral was screened as information only.

On September 9, 2004, it was reported to Children's Administration (CA) intake the deceased child, then four-years-old, was found wandering residential streets. This referral was screened accepted for investigation by Child Protective Services (CPS) and closed as founded.

On September 27, 2005, it was reported by medical professionals that the deceased child's two-year-old brother sustained a fractured arm. The parents reported he fell off a bed. A doctor reported an injury of this type is not usually the result of an accidental trauma. The doctor added DCFS should consider the possibility of intentional trauma. This referral was screened accepted for investigation by CPS. The children were removed from the parent's care. The investigation was closed as founded.

On November 23, 2005, it was reported the deceased child's stepfather lifted him up from the neck and held him against the wall. This referral was screened as low risk CPS.

On November 28, 2005, the deceased child's stepfather called intake to report drug use by the deceased child's mother. This referral was screened information only.

On March 27, 2006, it was reported the mother's home was cluttered and had an odor of marijuana. This referral was screened information only.

On April 27, 2006, it was reported to CA intake that the mother's home had an odor of marijuana. This referral was screened as low risk CPS.

On May 4, 2006, it was reported the deceased child, then five-years-old, was left alone in the home for a short period of time by his biological father. This referral was screened as low risk CPS.

On August 17, 2006, it was reported the deceased child's legs were bound with duct tape by his stepfather. This referral was screened accepted for investigation by CPS and closed as unfounded.

Issues and Recommendations

Issue: None identified

Recommendation: None identified

Child Fatality Review #07-40
Region 2
Richland Division of Children and Family Services

This three-month-old Chicano female died from Sudden Infant Death Syndrome (SIDS).

Case Overview

On May 13, 2007, this three-month-old infant was found deceased by her mother. The mother had a party at her home that day. The mother was intoxicated. Later that night, the mother put the infant in bed with her. Around 2:00 a.m. the mother found the infant pale, limp, and not breathing. Medics were called and CPR was performed. The infant was transported to the hospital. Medical professionals were unable to revive her. There were no obvious injuries to the deceased infant found at initial contact or during autopsy. It was suspected that the mother rolled over her baby while they both slept. The mother denied drinking, but police reported she smelled of intoxicants. The Benton County Coroner ruled the cause of death as Sudden Infant Death Syndrome (SIDS) and the manner of death as natural. Despite the coroner's ruling that the deceased infant's death as SIDS, DCFS has concerns that the mother was intoxicated when she slept with her baby. It is uncertain if the mother contributed to or could have prevented her daughter's death. Law enforcement closed their case with no charges against the mother as the infant's death was ruled SIDS.

Referral History

On February 26, 2006, hospital staff reported to Children's Administration (CA) intake that the deceased infant's mother was admitted to a hospital on May 25, 2007. She was given a urinalysis (UA) which came back positive for marijuana and barbiturates. The referral was screened as information only.

On April 1, 2007, it was reported the deceased infant's mother was at a party and was very intoxicated. The mother left her baby (then four-weeks-old) in her baby seat all night while she was partying. The referral was screened as information only.

On May 14, 2007, Kennewick Police Department reported they went to the mother's home where the deceased infant (then three-months-old) was found not breathing. Law enforcement reported the mother and her roommate had a barbeque the evening before and the mother was intoxicated. The mother put her baby in bed with her and woke several hours later to find her pale, limp, and not breathing. This referral was investigated by Child Protective Services (CPS) and closed as inconclusive.

Issues and Recommendations

Issue: None identified.

Recommendation: No Recommendations

Child Fatality Review #07-41
Region 2
Richland Division of Children and Family Services

This 13-year-old Caucasian female died by homicide. The cause of death is stabbing.

Case Overview

This 13-year-old female was stabbed to death on December 19, 2007. Her mother was murdered at the same time. Both were allegedly stabbed to death by a sixteen-year-old dependent of the state of Washington. The dependent youth was arrested and charged with their murders. He ran away from foster care on November 27, 2007 and was reportedly staying at the deceased child's family home for approximately two weeks prior to the deaths. On the night of the murders the deceased child, her mother, brother, and the dependent youth were all drinking alcohol. The deceased child's brother was charged as an accessory to the murders of his sister and mother.

Referral History

On February 6, 2003, school staff reported to Children's Administration intake that the brother of the deceased child told a little girl at school that he was going to "sperminate" her. He later asked her if she wanted him to put a caterpillar up her vagina. He also made other inappropriate sexual comments to children. This boy came to school smelling of urine and often had to use clothes out of the lost and found. He has Attention Deficit Hyperactivity Disorder (ADHD) but his mother refused to consent to medication. The referral was screened as information only.

On February 28, 2003, school staff reported the deceased child's brother begged other children for food. He received free lunches that ran out and then began receiving emergency lunches which have now run out too. His mother refused to pay for lunches or give him money. This referral was screened for Alternate Response (ARS).

On January 2, 2006, school staff reported to CA intake that neither the deceased child nor her brother attend school. The deceased child went to work with her mother. Her brother stayed home to clean. The children's mother kept 19 dogs and 15 cats in the home. There were animal feces everywhere and the home was too much for the brother to clean. The mother kept a freezer on the front porch full of dead animals. It was also alleged the mother was verbally abusive to the brother. This referral was investigated by Child Protective Services (CPS) and monitored to address verbal abuse and home cleanliness issues. The case was closed as inconclusive.

On June 26, 2006, it was reported to CA intake that the home was filthy. It was reported the mother used child support to buy more animals. The children were being home schooled, but

were not getting an education. The home and property are said to be unlivable due to the animal feces and garbage. The landlord was trying to move the family out of the home. This referral was investigated by Child Protective Services (CPS) and closed as unfounded.

On November 16, 2007, it was reported to CA intake that the father of the deceased child and her brother was physically abusive. The brother was under the age of four. As a form of discipline, the father hit the brother with a leash resulting in red welts on his bottom that went through his diaper. The father has not had contact with the children in 12 years. The family did not know where he lived.

On December 20, 2007, law enforcement reported a double homicide at the family home. The victims were the deceased child and her mother. The brother of the deceased child was initially detained as a material witness by law enforcement. The suspect in the murder is a 16-year-old state dependant child. He had been on the run since November 27, 2007. This referral was screened as information only.

Issues and Recommendations

Issue: Benton/Franklin County practice and/or policy does not permit the secured transportation of juveniles apprehended on civil warrants. This creates a safety issue for both client and staff. On a previous runaway status and after being apprehended, the dependent youth jumped out of a moving vehicle while being transported back to detention by a Children's Administration volunteer.

Recommendation: Unsuccessful attempts were made to resolve this issue on a local and regional level. The next step will be for the Children's Administration Region 2 Regional Administrator to bring this issue forward as an agenda item at a future management team meeting for possible change in law or policy.

Child Fatality Review #07-42
Region 6
Vancouver Division of Children and Family Services

This four-year-old Caucasian male died following a near-drowning in a swimming pool.

Case Overview

On August 26, 2007, law enforcement reported this four-year-old was pulled from a swimming pool at the apartment complex where his family lived. Witnesses reported the mother's boyfriend was holding the child under water for 10 to 30 seconds. The pool was not heated. When law enforcement arrived on the scene the child was not breathing and was cold to the touch. According to witnesses, the four-year-old was alive when the family left the pool. The detective said the child vomited fluids and licorice at home and then aspirated on his own fluids. The medical staff called to the family home stated the child's condition was a result of the aspirated vomit. He was placed on life support and was pronounced brain dead. He survived one additional day and was pronounced dead on August 27, 2007.

Law enforcement investigated this incident. The official cause of death was ruled as hypothermia. However, there was initial speculation that it was a combination of swimming in the cold pool and being forced to take cold baths as a result of soiling his underwear. Law enforcement learned that the mother's boyfriend was teaching the boy to swim days prior to his death. The swimming lessons included throwing him into the deep end of the pool repeatedly and pulling him out by his hair. Witnesses reported the child could not swim and that he would repeatedly vomit. He had blue lips and was unstable on his feet. These symptoms of hypothermia did not stop the mother's boyfriend from continuing with his swimming lessons.

The child's body temperature continued to decline over several days. He became more ill until his collapse on August 26, 2007. The mother's boyfriend admitted pulling the child's hair out of his head, but stated it happened when he pulled him out of the pool. The boyfriend denies responsibility for the child's death. He is still under investigation for this death, and although not yet charged, the prosecutor is considering manslaughter charges for the death of this child.

Referral History

On January 17, 2003, a relative reported the three-year-old stepbrother was frequently locked in his room, often for the entire day. The referent reported seeing mother's boyfriend beat the child with a belt. He has scars on his lower back which appear to be the result of a beating. The home smelled of urine. This referral was investigated by CPS and closed as unfounded.

On June 6, 2003, an apartment manager discovered that the children were frequently locked in their bedroom for hours at a time. The children's bedroom had feces on the wall. The three-year-old step-brother of the deceased child had a hand-sized bruise on his arm which appeared to be grab marks. The three-year-old sibling was found down the road unattended. He asked people for food. The children all appear thin. The apartment was filthy. Law enforcement was notified. This referral was investigated by Child Protective Services (CPS) and closed as unfounded.

On June 14, 2003, the deceased child's three-year-old stepbrother was brought to a Vancouver-area hospital by his grandmother for seizures. The grandmother told hospital staff the child had significant CPS history. Hospital staff called CA intake to determine if there was any reason to not release the child to his mother. The referral was screened as information only.

On October 25, 2003, a relative reported to Children's Administration (CA) intake that the children were not fed, they are emaciated, and there was rarely food in the home. It was reported the children were locked in their room and left there. The referent reported the children are not bathed and do not have any weather appropriate clothing. It was reported the mother's live-in boyfriend punched the three-year-old stepbrother of the deceased child. The mother and boyfriend had substance abuse problems. This referral was investigated by Child Protective Services (CPS) and closed as unfounded.

On September 20, 2004, the then the three-year-old stepsister of the deceased child told her grandfather that her mother's boyfriend played with her private areas and put his fingers inside her and hurt her. The grandfather said this was reported to law enforcement. The grandfather also reported that the five-year-old stepbrother had bruises all over his chest, back, and arms. The child said his mother's boyfriend hit him with his hand and closed fist. Services were offered and refused. The department found no basis for court action. This referral was investigated by CPS and closed as inconclusive.

On September 12, 2006, law enforcement contacted CA intake to report the deceased child and his two-year-old sister were taken into protective custody. The officer reported the mother was not appropriately supervising the children. The deceased child had two black eyes and an old scar on the top of his head that appeared as though it could be from a burn. The parents worked with the department to comply with the case plan. In June of 2007, the social worker staffed the case with the Child Protection Team (CPT). The CPT team recommended reunification and the worker began planning for a return home. The children were in foster care for nine months and were reunited with their parents. The two stepsiblings were living with their father at the time of this action. This referral was investigated by CPS and closed as inconclusive.

On August 26, 2007, a referral involving the fatality of the deceased child was input by CA intake. The two-year-old sister was removed from the family home and placed in relative

care following this referral. The assigned social worker reported the investigation would be founded.

Issues and Recommendations

Issue: The social worker in this case did not work with the husband to the biological mother to assess the need for services and provide those services prior to the return home of the children. At the time this case was open and active, there was no legal authority for the department to require services for caregivers who are not a party to the case. In practice, services to caregivers who are not legally a party to the case can be offered on a voluntary basis. This did not happen in this case. There is no information in the case file or through the fatality review process that the court and CPT were informed of the husband's history and involvement in the case.

Recommendation: Since this time, Sirita's law has been enacted and requires the department to assess all caregivers for services and make recommendations as appropriate. The workers are expected to inform the court if the caregivers do not comply with the service. The implementation of this policy will have an impact on these types of situations.

Issue: Although the reunification assessment was completed within the proper timelines prior to reunification, there was a disconnect in the level of risk and the recommendation for reunification.

Recommendation: The Regional CPS Program Managers will provide CFWS units in the Vancouver office additional training on utilizing the risk assessment process throughout the life of the case, emphasizing the connection between the level of risk and reunification.

Issue: This case was transferred from one worker to another without the workers having an opportunity to meet and staff the case together at transfer.

Recommendation: The Vancouver office will explore the feasibility to meet and review cases at the case transfer.

Issue: The in-home dependency policy requires two in-home visits per month for children birth to 5 years for the first 120 days of placement back in the home. If this policy were followed, there would have been at least three home visits with the deceased child and his sister in their home after they were reunified. There was only one.

Recommendation: CFWS Supervisors in the Vancouver office need to review the in-home dependency policy with all workers.

Child Fatality Review #07-43
Region 6
Olympia Division of Children and Family Services

This two-month-old Caucasian male child died of Sudden Infant Death Syndrome (SIDS).

Case Overview

This two-month-old infant died on May 19, 2007. An anonymous referrer notified the department of the death on May 20, 2007. The referrer stated that they had been told the baby died of SIDS, but that the referent did not believe it and thought that the child's mother had something to do with the death. Police reports indicate that on May 19, 2007 law enforcement and fire department personnel were dispatched to a home where a two-month-old baby was not breathing. The deceased child's mother reported she had been at her friend's home to watch movies for the evening and fell asleep around 10:30 p.m. after feeding the child. She reported she woke up to find him not breathing and blood coming out of his nose. The County Coroner determined the cause of death to be SIDS.

Referral History

There were no prior referrals on the mother of the deceased child as a parent. There are numerous referrals regarding the mother living her mother and siblings. The mother of the deceased child was a teenage mother and continued to live in her mother's home. This extended family moved to the state of Washington from Utah just prior to the birth of the deceased child. The department has received allegations of drug use, lack of prenatal care, unsuitable living environment, neglect and exploitation. In addition, there was one referral requesting Family Reconciliation Services (FRS) for the mother and her sister. All of the referrals, with the exception of the referral involving the death of the child, were screened as information only.

On May 20, 2007, an anonymous referent called CA intake to report the death of this two-month-old child. The referent did not believe the child died of natural causes and suspected the mother contributed to the child's death. The referent suspected the mother may have rolled over on the child while she slept. This referral was accepted for investigation by Child Protective Services (CPS) and closed as unfounded.

Issues and Recommendations

Issue: None identified

Recommendation - None

Child Fatality Review #07-44
Region 5
Bremerton Division of Children and Family Services

This two-month-old Caucasian male child died from positional asphyxiation.

Case Overview

On October 4, 2007, the deceased child's mother and her two-month old son went to sleep with the baby in the mother's bed. They spent the night at the home of the mother's sister. The mother positioned the baby next to the wall so he would not fall out. The mother said she fed and changed him between 2:00 and 3:00 a.m. Around 7:00 a.m. on October 5, 2007 she awoke and found her baby quiet and started changing his diaper. She realized he was not breathing. The mother's sister reported to detectives that she awoke to her sister's screams about the baby not breathing. The sister is a nursing assistant and began CPR and then called 911. Medics arrived and determined the child was deceased.

Following an autopsy and secondary studies (toxicologic and pediatric screening), and based on death scene investigation, the death of the child was attributed to asphyxia caused by suffocation or smothering as a result of overlying while bed sharing. The manner of death remains classified as an accidental death.

Referral History

On July 10, 2003, the Navy Police Department reported to Children's Administration (CA) intake that they responded to an emergency at the family home as the mother had a diabetic seizure. When the police arrived they observed the home to be filthy with old food lying around. A referral was made to the health department for an inspection to see if the home was a health hazard. The referral was investigated by Child Protective Services (CPS) and closed as founded. Services to the family were provided by the Navy and the Housing Authority.

On November 3, 2003, a social worker with the Department of the Navy reported to CA intake concerns about the 12-month-old in the home (the sister of the deceased child). The referent reported this infant did not smile or respond to interaction. Based on the infant's inability to play or interact, the referent presumed that the mother was not playing or interacting with this infant. The home was very unsanitary and dangerous. The mother's church cleaned it. However, three to four weeks later the home was back to being unclean. The mother appeared to be unable to care for the infant. She was unwilling to accept direction from medical professionals. The father was active in the Navy and had returned home. The referral was investigated by Child Protective Services (CPS) and closed as founded. This child was voluntarily placed with her paternal grandparents.

On November 3, 2003, a social worker with the Department of the Navy went to the family home. The social worker found the door open. The social worker noticed the house was filthy with food everywhere, knives on the floor, and baby bottles on the floor. The mother was pregnant at the time. The referral was investigated by Child Protective Services (CPS) and closed as unfounded.

On August 17, 2007, the deceased child's mother brought him into the hospital because he had jaundice. The mother moved from Montana due to the father's mental health issues and domestic violence. The father was suicidal, paranoid, and threatened to harm mother and child. The father was discharged from the military due to his mental health issues. There was an open CPS case in Montana at the time of the baby's birth. The main reason the case was opened was because of mother's mental health issues, but later found the house to be a mess. The referral was investigated by Child Protective Services (CPS) and closed as unfounded.

On October 5, 2007, the Deputy Coroner called to report the child fatality. The coroner stated that initial indication is that the mother inadvertently slept on her child. The mother had an open case with the department. She had completed a drug and alcohol assessment, was starting outpatient drug treatment, had a mental health appointment scheduled, and was attending parenting class at the time of her child's death. This referral was screened as information only.

Issues and Recommendations

Issue: On August 17, 2007, a hospital social worker reported the mother brought in her 16-day-old son to be seen for jaundice. There was concern as the mother had recently come from Montana where there had been an open CPS case. The mother and infant son were reportedly living with her mother. It was reported that the mother had three other children who were no longer in her care. The referral was accepted for assessment of "imminent harm" as there were no current allegations of abuse or neglect occurring in Washington State. In review, the decision to accept the report for assignment to CPS was deemed appropriate given the overall history and the recent CPS in Montana.

The CPS investigator met or exceeded CA policy requirements and fully met most practice expectations. In review, the work was found to be overall very good. The field response occurred on the same day as the referral. Documentation of the initial home visit and interview with the mother was concise. Most documentation was made in a timely manner, and supervisory reviews were routinely conducted and documented. A Safety Assessment was immediately completed. The service plan developed appears to have targeted significant risk factors (mental health, substance abuse, health care for the child, parenting) and engagement in services was in early stages when the infant died.

A minor criticism regarding social work practice was noted during the fatality review. The worker did not appear to have inquired with the mother as to the circumstances surrounding her other children being in the care and custody of others.

Recommendation: None

Action Taken: The CPS investigator participated in the review and received feedback regarding his overall very good practice.

Action Taken: A "Lessons Learned" presentation is planned for the Bremerton DCFS All-Staff meeting in September or October 2008. At that time practice issues surfacing during recent child fatality reviews conducted in the Bremerton office, including this review, will be presented and discussed. This will include a discussion on inquiring with a parent who does not have care or custody of their other children as to the circumstances of such situation.

Child Fatality Review #07-45
Region 5
Tacoma Division of Children and Family Services

This 17-year -old Caucasian male child died from a gunshot wound.

Case Overview

On June 14, 2007, local law enforcement notified CPS intake of an apparent homicide of this 17-year-old male. The deceased youth was sleeping in a travel trailer when his father shot him in the chest. The father stated that he was cleaning his gun when the teen was accidentally shot. No cleaning supplies were found at the scene. The teen was pronounced dead at the scene and the father has been charged with murder in the second degree, manslaughter in the first degree, and unlawful possession of a firearm. The father was not allowed possession of a firearm due to a prior conviction for domestic violence. The father is awaiting trial.

Referral History

On March 17, 1995, a neighbor to the family reported to Children's Administration (CA) intake that a person named "Jeff" was sexually abusing his children. Upon conducting a visit to the address given the CPS worker found none of the names provided to intake matched with the names of the family found at the residence. The referral was investigated by Child Protective Services (CPS) and closed as unfounded.

On September 4, 1996, the deceased child's mother reported that an eight-year-old neighbor girl was sexually inappropriate with her then 6-year-old son (the deceased child). This referral was screened as third party.

On September 23, 2001, the deceased child's mother reported the father was physically abusing the children while he and his brother visited him. The deceased child had bruising from a spanking by his father. The referral was investigated by CPS and closed as founded. The mother obtained a Protection Order.

On August 23, 2006, the deceased child's mother reported the father physically abused her son and refused to give the boy ADHD and bi-polar medications. The alleged victim (the brother of the deceased child) was living with his father at the time. The boy denied abuse and he returned to his mother's care. This referral was investigated by CPS and closed as inconclusive.

On June 14, 2007, law enforcement contacted CA intake to report the father shot and killed his 17-year-old son, who was living with his father at the time. The referral was investigated by CPS and closed as founded.

Issues and Recommendations

Issue: In August 2006, the mother contacted CPS intake to report that her 14-year-old son (brother of the deceased child) had recently been physically abused by his father, who lived elsewhere. The boy now was residing with his father, and the mother reported that the boy was allowed by his father to smoke marijuana and the father was refusing to give the boy his medications for ADHD and bi-polar. The referral was accepted at intake for investigation of physical abuse and neglect by the father of his son. This screening decision appears appropriate.

The CPS worker appears to have met CA policy and practice expectations. Documentation was, however, sometimes outside policy timeframes in terms of entry into the CA data base. In-person contact with the alleged victim was within 24 hours of the referral. The alleged victim was reluctant to speak with the CPS worker, but did state that his mother was trying to get him to come back to live with her, and he preferred to live with his father. Several attempts were made to interview the alleged subject, (the deceased child's biological father) even when he had moved back in with his estranged wife. The case was closed in a timely manner in October 2006 with the allegations determined to be inconclusive. Based on the information that was documented by the worker, the finding appears to be reasonable.

However, some deficits were noted during the fatality review. The worker might have considered contact with the boy's school which is deemed a routine and expected practice for CPS investigators. There was no attempt to interview the older sibling, (the deceased child), or the mother who was the originating referent. It is speculative as to whether having interviewed the sibling and the mother would have resulted in a different finding. The assessed overall level of risk (moderate low) appears to be slightly under-assessed given the history and other information known about the family.

Recommendation: None

Comment: CA has recently adopted a new risk assessment model called Structured Decision Making. Because it is actuarial-based, the likelihood of under-estimating risk is reduced from that of the previous risk assessment tool

Issue: On June 14, 2007, CPS was notified of the homicide death of this 17-year-old on his birthday. The boy's father was believed to have shot and killed his son, and was arrested. There was information of another child, believed to be the 2-year-old daughter of the father's girlfriend, at the home during the shooting incident. The child was allowed by law enforcement to go with relatives and was not identified as a victim.

The CPS investigation was conducted by a social worker assigned to the Pierce County Child Advocacy Center (CAC). The investigative activities and documentation were found

to be of excellent quality. Required duties and timeframes were met, and narrative documentation in the Service Episode Record (SER) was very detailed. The exception was completion of the investigation which was delayed due to the on-going criminal investigation. There was superb collaboration with law enforcement and continuous efforts to gather information.

Several days into the investigation it was reported that the father's girlfriend was at the residence at the time of the shooting, and had taken off, leaving her daughter at the home. Consideration was made by the social worker in consultation with a CPS supervisor as to whether a separate referral for neglect should be made on the girlfriend. The decision was made not to do so. In review, it would have been reasonable to generate a referral on the girlfriend for investigation of negligent treatment of her daughter.

Recommendation: None

Action Taken: The CPS investigator and her supervisor participated in the review and received feedback regarding the high quality investigation and documentation.

Child Fatality Review #07-46
Region 5
Tacoma Division of Children and Family Services

This three-month-old Cambodian male died from blunt force trauma to his abdomen inflicted by his father. His death was ruled a homicide.

Case Overview

On July 25, 2007, the Pierce County Medical Examiner's Office called to report the death of this three-month-old male. Earlier that day he was taken to the hospital in respiratory distress. A police detective reported that three ribs were broken, there were lacerations to the baby's stomach and liver, and there was a possible healing fracture. There was evidence of multiple blows to the stomach and blunt force trauma. The deceased child's sister was placed into care. The father remained at large and reportedly had contact with the mother threatening to kill her and kidnap his daughter. Due to the danger, as well as the mother's further admissions, a dependency petition filed and shelter care status was granted on the sister.

On the day the child sustained his fatal injuries, the mother reported she and her husband argued and at one point the father took the deceased child into the bathroom for a bath. The mother reported she tried to open the bathroom door but it was locked. She heard the baby crying for about 15 minutes in the bathroom and later heard him cry for about 20 minutes once his father put him to bed. She checked on the baby and noticed the baby's stomach was swollen. The baby was having difficulty breathing. The father admitted hitting his son. The mother attempted to take the baby to a doctor, but the father prevented her from doing so. She eventually alerted a neighbor to call 911 and medics arrived.

The father fled and was eventually apprehended in Stockton, California. He admitted he punched the baby in the stomach three times. He said that the baby cried after the first punch, but not after the other two. He then turned and spanked the baby three to five times as hard as he could. Detectives learned that the parents remained in contact while he was on the run and the mother said she wanted to have more babies with him. The mother later told the court social worker that it would be best if her daughter lived with relatives as she could not choose between her daughter and her husband. The deceased child's sister is currently in relative care with her grandmother and this is a likely permanent placement for her.

Referral History

On June 2, 2006, Children's Administration (CA) intake received allegations from an emergency room (ER) physician as well as a primary care physician that then 8-month-old sister of the deceased child had injuries that, though consistent with the mother's report, were concerning. The doctors were especially concerned that the mother did not immediately

follow through with their directives. In addition, the ER doctor was concerned about an abrasion on the child's ear that he did not believe was consistent with the fall as described by the parent.

After being seen in the emergency room, the child was seen by the child abuse medical consultant. The medical consultant did not take issue with the abrasion on the ear, saying that it could have occurred during the fall. This referral was investigated by Child Protective Services (CPS) and closed as unfounded.

On July 26, 2007, CA intake received report of the fatality of the three-month-old due to a lacerated liver and rib fractures. This referral was investigated by Child Protective Services (CPS) and closed as founded.

Issues and Recommendations

Issue: In review of the investigative activities, the assigned CPS worker appears to have met basic policy and practice expectations in effect at the time of his investigation. Face-to-face contact with the child and parents was timely, medical report was obtained, and collateral contact with the Child Advocacy Center (CAC) was made. The investigation was closed in a timely manner, and documentation was entered within prescribed timeframe policy.

However, the reviewed practice was not without some noted areas where improved practice could have been done. The worker did not take the opportunity to contact the Primary Care Physician (PCP) to access medical history of the child. It would also have been reasonable to have added the father as a subject for the allegations reported for the mother. The father was unquestionably a caretaker of his daughter, and any allegations regarding possible physical abuse to neglect to the child would include the father as a possible subject. Finally, consideration might have been made to interview the parents separately in order to fully assess what may have been occurring in the home at the time of the injury to the child.

Recommendation: None

Action Taken: A "Lessons Learned from Child Fatalities 2006-2007" presentation is planned for the Tacoma CPS units in September/October 2008. At that time practice issues surfacing during recent child fatality reviews conducted in the Tacoma office, including this review, will be presented and discussed. This will include discussions regarding contacting known PCPs on cases involving young children and when possible interviewing parents separately. A separate training for social workers on interviewing subjects and caretakers is scheduled for the summer of 2008 in Region 5. In conjunction with CA Program Manager staff, refresher training for conducting CPS investigations is also scheduled for 2008.

Action Taken: The social worker was present during the review and acknowledged that with the benefit of hindsight, his practice would be different than practiced at the time.

Issue: In review of the practice throughout the fatality investigation by supervisors, after hours staff, and the assigned investigator, excellent work was evident. Every precaution was used to keep the sister safe while continuing to gather information regarding the circumstances surrounding the death of this three-month-old.

Recommendation: None

Action Taken: The worker who conducted the fatality investigation now works for the local Child Advocacy Center and was not able to participate in the review. The CPS supervisor did participate in the review and received feedback regarding the excellent work evidenced in the case file by the prior worker and himself.

Child Fatality Review #07-47
Region 5
Tacoma Division of Children and Family Services

This 19-month-old Mexican male child died of acute bronchopneumonia complicating lymphocytic myocarditis of probable viral origin.

Case Overview

On the evening of December 2, 2007, the Children's Administration (CA) received a call from a St. Clare Hospital nurse. The referent stated that Christopher Cruz-Lugos had passed away from unknown circumstances. CA received additional information from law enforcement and a Medical Investigator with the Pierce County Medical Examiner's Office.

It was reported that the child had been ill for about a week, with bronchitis and a fever. The child was seen by a doctor on November 27, 2007 and the child was prescribed antibiotics and medicine. As the illness continued to worsen, the mother brought the child into the Emergency Room (ER) at St. Clare Hospital where he died within an hour of admission.

The Medical Investigator and law enforcement went to the home and found the conditions to be clean and well stocked with food.

Following an autopsy and ancillary studies, the cause of death was declared as acute bronchopneumonia complicating lymphocytic myocarditis of probably viral origin.

Referral History

On November 16, 2007, the mother's estranged husband reported finding their 1-year-old son (deceased child) alone. The alleged incident had occurred a month prior to the husband's call to CPS. The husband stated that at that time he remained with the child until his estranged wife arrived home. When she returned home, the mother was reportedly intoxicated. The allegation of neglect or maltreatment was inconclusive.

On December 2, 2007, St. Clare Hospital called to report this child passed away from unknown circumstances.

Issues and Recommendations

Issue: Regarding referral dated November 16, 2007, CA received information from the father of the deceased child that a month prior he had gone to his estranged wife's apartment and found the child unsupervised. He stated he stayed with his son until the mother arrived home. When the mother arrived home, according to the father, she was

intoxicated. The father's reason for waiting a month to contact CPS was not documented, and it is unknown if the question was asked by the Central Intake (CI) worker. It is speculated that the parents may be undocumented residents and as such may be hesitant to contact authorities such as CPS or law enforcement.

Initially this referral was screened out by CI as information only, but was later screened in for investigation due to the child's age and the reported lack of supervision. The screening decision was changed during the daily Region 5 intake consensus meeting. The decision to change the original decision appears to have been appropriate.

Recommendation: None

Action Taken: Both the Tacoma Intake Supervisor and CPS Area Administrator participated in the review and received feedback regarding the better decision by the Region 5 daily intake consensus group to change the decision from screen-out to accepting for investigation.

Action Taken: A special intake focused "Lessons Learned from Region 5 Fatality Reviews 2006-2007" is tentatively planned for September or October 2008. At that time intake practice issues surfacing during recent child fatality reviews, including this review, will be presented and discussed. Both good practice and questionable practice will be presented as learning opportunities

Issue: Initial contact with both the alleged victim and subject was made by a Spanish speaking CPS worker the same day as the intake. The mother denied ever leaving her son alone and stated that she sometimes goes to the store for about a half hour leaving her son with a roommate, an unrelated adult male. The child appeared in good health and the investigator noted that mother and child interacted comfortably. The home was observed to be clean and there was adequate food available for the child. The investigator learned that the mother was receiving food stamps and was enrolled in WIC services.

Three days later another home visit occurred, again with a Spanish speaking CPS worker. The worker noted her observations of the child and again discussed the allegations. A review of the documentation shows that the assigned worker met expected practice in questioning the subject regarding risk factors such as history of abuse and neglect as a child, domestic violence history, and drug and alcohol use. The worker received the name and phone number of the mother's roommate and the name and address of the child's primary care physician. The worker contacted the mother's roommate who could not verify whether or not the child had ever been left alone. The roommate did say that the mother was sometimes gone 4 to 5 hours and that he was uncomfortable being responsible for the child. The CPS worker also spoke with the father who provided additional details of the incident whereby he had found his child unsupervised. The worker instructed the father that should there ever be another such incident, to contact law enforcement immediately.

The Investigative Assessment was completed on November 28, 2007 with a finding of "inconclusive" regarding the allegation of negligent treatment.

While policy requirements appeared to have been met (face-to-face contact, Safety Assessment, documentation timely, investigation completed timely), a number of practice deficits were noted during the review. It was clear that both parents were Spanish speaking. The case file was not identified as Limited English Proficiency (LEP) at intake or after contact with the parents by CPS. LEP identification is required by policy and practice guidelines. Additionally, although the assigned CPS worker was bi-lingual (Spanish and English), she is not state certified for interpretation. Although on the surface it would appear unnecessary to use a contracted interpreter when the assigned worker is fluent in the family's preferred language, consideration could have been made to do so. The lack of certification can potentially be problematic if a case goes to court and a worker testifies that they are not a state certified interpreter and relied on their own perceived level of fluency to interview a parent.

Another practice issue involved the missed opportunity to contact the child's primary care physician (PCP). Although provided with the name of the PCP, the worker did not contact the doctor. Best practice would suggest such contact should be routine on any investigation involving a young child, regardless of the nature of the reported allegations. The worker had noted that the 18-month-old was crawling and pulling himself up but not yet walking. The worker had an opportunity to contact the child's doctor to discuss the child's development and general health.

The third practice issue involved the apparent failure to reconcile different accounts of supervision of the child. The social worker heard from the mother's roommate that he was extremely uncomfortable watching the child. He said that he did not know how to change a diaper and did not know how to entertain such a young child. The roommate also stated to the CPS investigator that the mother was sometimes gone for 4 to 5 hours at a time and he had not known how to reach her. The worker did not confront the mother about the inconsistencies between her accounts of leaving the child with the roommate and the roommate's version and his admitted discomfort with that responsibility. When coupled with the father's statements regarding the incident whereby he had found the child alone at the mother's residence, a finding of founded for neglect could arguably have been made. Additionally, the level of assessed risk may have been under-assessed in that the mother appeared to be leaving her child with an adult roommate who admittedly was ambivalent about the child and had little knowledge of how to care for a child.

None of the identified areas where practice could have been improved were determined to have had any significant impact on the circumstances of the child's death from acute viral bronchopneumonia a week after the case was closed. Medical records obtained post-fatality clearly show that the child had been seen by his PCP due to illness in the week prior to the child's demise, and had been receiving treatment (antibiotics and medications).

Recommendation: None

Action Taken: A "Lessons Learned from Child Fatalities 2006-2007" presentation is planned for the Tacoma CPS units in September/October 2008. At that time practice issues surfacing during recent child fatality reviews conducted in the Tacoma office, including this review, will be presented and discussed. This will include contacting known PCPs on cases involving young children, the need to assess caretaker ambivalence towards a child, and how to approach a parent when their statements conflict with other information gathered. Additionally, training for social workers on interviewing subjects and caretakers is scheduled for the summer of 2008 in Region 5. In conjunction with CA Program Manager staff, refresher trainings for conducting CPS investigations and for Safety Assessment/Safety Planning are also scheduled for 2008.

Action Taken: The CPS worker participated in the fatality review and received feedback regarding her CPS investigative activities. She reported that she was a recent hire to Washington State, having worked in California where CPS investigation practice was different. She acknowledged where she could improve practice such as routinely contacting primary care physicians on cases involving young children and inquiring as to general health and development. She acknowledged not having the case file tagged as LEP. The worker indicated an interest in becoming state-certified as a Spanish interpreter and was given directions as to how she can obtain such certification.

Issue: Regarding CA's response to the December 2, 2007 law enforcement call to Children's Administration Central Intake (CI) to report the death of 18-month-old Christopher Cruz-Lugos, the cause of death was initially unknown. A detective called CI a short time after the initial call to report that Christopher had been ill and had been under a doctor's care days before the death. There were no apparent concerns regarding abuse or neglect regarding the child fatality. The referral was taken as information only. Upon review, the screening decision appears appropriate.

As the case was still active with CPS, the worker obtained the child's medical records and documented continued contact with law enforcement and the Medical Examiners Office until the final cause and manner of death was obtained several months after the death.

Recommendation: None

Comment: Given the fact that preliminary results regarding the circumstances of the child's death indicated a non-suspicious death, and there were no other children in the home, the case might have been closed soon after the death was reported. However, the decision was made to keep the case open until all available information was obtained. That decision was commendable and reinforces the integrity of the CPS investigation results.

Child Fatality Review #07-48
Region 5
Bremerton Division of Children and Family Services

This two-month-old Native American child died of Sudden Unexplained Undetermined Infant Death.

Case Overview

On the morning of May 18, 2007, Kitsap County Central Communication received a 911 call from the mother who reported not being able to wake her 2-month-old infant. On arrival emergency responders found the infant limp, no pulse, asystolic, and grayish yet warm. Life support was initiated and the decision was made to transport to the local hospital although the child was likely deceased on scene.

The mother reports having attended a barbecue the evening before, including having consumed numerous beers. She went to bed late, sleeping on a mattress with her infant on one side, she on the other, and her 18-month old son at the foot area of the mattress. A niece was also at the home and had slept on the floor. The mother's other 5-year-old child was on a visit with his biological father.

The mother maintains she fed the baby around 3:00 a.m. and then awoke again around 10:00 a.m. to find the baby unresponsive. The mother admitted to law enforcement that she had drank "a little" the night before, and agreed to a breathalyzer test. She tested just under .04 which would be under any legal level for intoxication. However, it has been estimated that the time she quit drinking that night and went to sleep she may have had an alcohol level of .22.

Given some inconsistencies in statements and perceived reluctance to be fully honest, law enforcement and the coroners office expressed several concerns relating to possible contribution of neglect to the death of the infant. This included the possibility of overdose of over-the-counter medicine not appropriate for an infant and the possibility that the mother may have been intoxicated and rolled over on the child during co-sleeping. The eventual conclusion by the County Coroner was that the child died from Sudden Unexpected, Unexplained Death in Infancy, Cause Unknown.

There was no substantive forensic evidence that either overlaying or age inappropriate medicine contributed to the infant's death.

Referral History

On January 5, 2003, a referrer reported concerns for the young mother and her ability to meet the needs of her one-year-old child. The referrer had concerns regarding supervision,

parenting, and general care. The referral was sent to an Alternative Response System (ARS) provider. The April 2003 termination summary from the ARS provider noted, "All Services Completed: The mother and child were residing with the child's maternal grandmother at the time of ARS contact. The child appeared healthy and well cared for, and mother maintained allegations were retaliatory. ARS worked on safe environment including safety checklist, age appropriate expectations, the need to follow through when child had medical needs, and accessing local resources for housing.

On February 19, 2004, a referrer reported concerns that a Level 1 registered sex offender (RSO) may be living with the mother and her child. The mother reportedly left her son to be watched by the RSO. The mother reportedly is pregnant with the RSO's child. The whereabouts of the mother and child were unknown at the time of the referral to CPS intake. This referral was screened Information Only.

On March 12, 2004, a referrer reported the mother was using drugs and was 5 months pregnant. The referrer also reported that sometime in the past the two-year-old child's maternal grandmother hit him in the face and knocked him down (unspecified as to when this may have occurred). This referral was screened as Information Only.

On December 6, 2005, a Community Corrections Officer notified CPS that a Level 1 RSO has been approved to be in the home and can be around his infant son as well as the son of his girlfriend (mother of deceased child).

On July 24, 2006, a referral was received on the RSO's sister regarding general neglect in the home. Also living in the home were the RSO, his infant son, the mother of the deceased child and her four-year-old son. This referral was screened as Information Only.

On August 18, 2006, a referral was received reporting that the father of mother's oldest child was not returning that child from a visit. No parenting plan or custody order has been involved. Law enforcement responded but did not intercede. This referral was screened as Information Only.

On September 1, 2006, a hospital social worker reported that the then nine-month-old sibling of the deceased child was brought to Harrison Medical Center by ambulance with the mother because he was observed to have eaten one 5 mg Klonopin tablet that day. The tablet was left on a nightstand in the mother's bedroom. The referrer states the child appears to be fine but sleepy and will remain overnight for observation. The referral was screened as moderate low risk. A worker went to the home rather than merely contacting the parent by phone or mail.

On April 23, 2007, CA's Central Intake received a call from a Bremerton police officer regarding the three children of the mother. Law enforcement responded to a domestic disturbance at the home. The caretakers were determined to be too intoxicated to care for

the children, and the father was arrested for the DV incident. Law enforcement turned the children over to a relative and requested CPS involvement. This referral was screened in for an investigation and resulted in a founded finding for neglect.

On May 4, 2007, a mandated reporter called to report that an RSO was around the children. This information was well documented in the CA data base and the RSO was not prohibited from being around his children. This referral was screened as Information Only.

On May 18, 2007, CA received the report that the child died. There were initial concerns that the mother's drinking may have played a role in the child's death. The cause and manner of death was determined to be sudden unexpected, unexplained death during infancy.

Issues and Recommendations

Intake Issues: All CPS intakes involving this family were reviewed during the fatality review process. This included referrals screened out as information only reports (2003-2005). A number of issues surfaced that were viewed as either clear deficits in practice or examples where improved practice would be advised.

On a number of occasions an intake worker appeared to have failed to conduct adequate search in the CA data base regarding prior history resulting in inaccurate information regarding history. This included an apparent disregard to search the CA data base for prior history of the fathers of the children.

There was duplication of the mother due to misspelling of her child's name, which could have been prevented had a simple search of the Department of Health birth certificate data base been conducted and the correct spelling been confirmed.

On one occasion a referent who called intake appeared not to know the whereabouts of the mother and children. There was no documentation of any effort on the part of the intake worker to search available data bases or contact other agencies (such as the welfare office) to try to locate the family.

There were several instances where information regarding possible abuse or neglect was vague, such as a referent stating that one of the children had a severe diaper rash "a while back." There were missed opportunities to ask clarifying questions or to document that such questions were asked.

On one occasion a referral involved concerns about neglect occurring in a multiple family household. Although the referral identified the mother and her partner and their children as members of the household, the referral was taken only on the other parent, a relative of the mother's partner. A referral should have been generated on the mother as the allegations

also involved her children in terms of health and safety concerns. That particular referral in July 2006 alleged lack of supervision of children around a swimming pool as well as other health and safety concerns. It was screened out due to having been called in anonymously and determined at intake to not meet the statutory criteria that must exist in order for an anonymous referral to be accepted for investigation (see RCW 26.44.030). In review, the information as documented at intake may have been sufficient to screen in the report for investigation

Recommendation: None

Comment: CA will be initiating a new data base system called FamLink in late 2008, and it will replace the current CAMIS system. It is anticipated that search and cross-referencing processes will be improved and accessibility to prior CA history for families will be easier for intake workers with the implementation of FamLink.

Action Taken: A special intake focused "Lessons Learned from Region 5 Fatality Reviews 2006-2007" is planned for September or October 2008. At that time intake practice issues surfacing during recent child fatality reviews, including this review, will be presented and discussed.

Action Taken: The duplication of the mother's name in the current CA data base (CAMIS) has been corrected.

Action Taken: An intake worker involved with several of the family's referrals participated in the review as did her current supervisor. Feedback was provided and the intake worker acknowledged where improvements in her practice could be made.

Investigation of April 23, 2007 referral

After midnight on April 23, 2007 the Bremerton Police contacted Central Intake regarding a response made to the residence of the mother and her partner for a domestic violence situation. All adults were found to be too intoxicated to care for the children and consideration was being made for protective custody of the children. Law enforcement had contact with a relative who was willing to have the children stay with her temporarily. The officers were notified by Central Intake that the relative in question had CPS history, including an in-home dependency in the process of dismissal. Law enforcement officers made the decision not to initiate protective custody anyway and allow the children to go with the relative.

The CPS response was immediate (same day). Policy requirements were met for face-to-face contact with the alleged victims and for the Safety Assessment. Initial efforts to engage the mother in services was initiated, including drug testing, a chemical dependency assessment appointment, and obtaining housing for the mother and her children. The father

was in jail and was interviewed by the social worker. Efforts to identify Native American heritage was made. Documentation was found to have been made in timely manner. Overall the CPS investigator met policy requirements. The CPS worker had phone contact with the mother just two days before the death of the 2-month-old from Sudden Unexpected, Unexplained Death in Infancy, as the case was still active in preparation for on-going service provision.

The investigation was not without some criticism. There was no documentation of any interview with the relative who picked up the children from law enforcement. The oldest child was seen (as were the younger children) but not interviewed. Although the oldest child was only five-years-old, an attempt to interview him should have been made. While the interview of mother's partner was well documented, the interview of the mother was not, and there was not a clear picture of what took place when the CPS worker interviewed her. While there were services and resources provided the mother, there was no documentation that domestic violence resources were provided. The Safety Assessment showed no serious and immediate concerns, but in review of the information provided by law enforcement at intake, there is an argument that such level of concerns existed and a Safety Plan should have been developed.

Recommendation: None

Action Taken: A "Lessons Learned from Child Fatalities 2006-2007" presentation is planned for the Bremerton DCFS All-Staff meeting in September or October 2008. At that time practice issues surfacing during recent child fatality reviews conducted in the Bremerton office, including this review, will be presented and discussed. That presentation will not only include issues specific to circumstances of a child's death, but also general social work practice issues that surfaced during the reviews.

Action Taken: With the purpose to improve social work practice, a multitude of training opportunities are scheduled to occur in Region 5 CA in the summer and fall of 2008. This includes a presentation on interviewing subjects. While training on conducting child interviews has been required for CPS workers for many years, there has been a lack of training for CA social workers on conducting adult interviews. CA has recently increased the availability of such training state-wide and training for social workers on interviewing subjects and caretakers is scheduled for the summer of 2008 in Region 5. Additionally, in conjunction with CA Program Manager staff, refresher trainings for conducting CPS investigations and for Safety Assessment/Safety Planning are also scheduled for 2008.

Action Taken: The CPS worker participated in the review as did her current supervisor. Feedback was provided as to both evidence of good practice and areas which need improvement. The worker acknowledged deficit areas of practice identified during the panel review.

Child Fatality Review #07-49
Region 5
Bremerton Division of Children and Family Services

This eight-year-old Filipino female child died in a house fire. The official cause of death is asphyxiation.

Case Overview

On March 2007, at 3:00 a.m. a passing cab driver called 911 to report smoke coming out of house. The cab driver helped the mother and a 3-year-old child get out of the home. The heat was too intense to rescue the older child, the eight-year-old deceased child. By the time emergency fire responders were on scene, the home was fully involved in fire.

The body of the deceased child was later recovered from one of the bedrooms in the single-story home. The mother suffered serious burns when she had tried to re-enter the home to rescue the child. She and the surviving 3-year-old son were both hospitalized with serious injuries. According to the Kitsap County Fire Marshal the probable cause of the fire was unattended candles burning in the living room. Additionally, the home had no working smoke detectors. The autopsy revealed that the child died of asphyxia secondary to inhalation of toxic combustible materials. The manner of death was classified as accidental.

Referral History

On July 10, 2002, law enforcement reported to Children's Administration (CA) intake that a neighbor complained the mother pushed and hit her child. Law enforcement responded to the home and took statements. No further law enforcement involvement was deemed necessary. This referral was screened as information only.

On November 9, 2002, CA intake received a report that the deceased child, then four-years-old, was sexually abused by the adult son of a person who babysat her. This referral was sent to law enforcement and screened as third party.

On September 20, 2006, a neighbor reported the mother left her 2-year-old son alone for 15 minutes when she went to meet her daughter returning from school. There was a fire in the fireplace at the time. The neighbor reported the family lived in a risky neighborhood for children (i.e., several registered sex offenders and a mentally ill person in the immediate area). The report was accepted for investigation regarding the supervision concerns. The referral was investigated by CPS and closed as inconclusive. The mother admitted leaving her 2-year-old alone for 15 minutes, but said she was within line-of-sight of the home at all times.

Issues and Recommendations

Issue: On September 20, 2006, CPS received a call regarding the mother having left her 2-year-old son alone in the home for fifteen minutes while going up the street to meet her older child coming home from school. The referent indicated that the fireplace was lit at the time and the residence was very old and substandard in terms of fire protection (e.g., no firewalls or drywall). The neighbor also suspected that the mother had left the children alone on other occasions, but had no proof. Additional concerns were that there was domestic violence between the mother and her boyfriend, and that there was physical discipline occurring in the home.

The assigned CPS investigator appeared to have met most required policy and practice expectations for investigative and assessment activities and for documentation. A home visit was conducted with face-to-face contact with the alleged victim. The parent was interviewed regarding the allegation. She stated that she had gone down the street to meet her daughter coming home from school, but was within sight of the house at all times. Additionally, the CPS worker followed best practice by inquiring with the parent as to domestic violence (confirmed), substance abuse (none), mental health (depression), criminal history (forgery), child abuse as a child (indicated), medical care, and other areas used in assessing risk. No apparent safety or health hazards were observed in the home. During the review the question was raised as to social worker responsibility to assess concerns about the substandard structural problems (lack of firewalls or drywall protection). The consensus of the panel was that expecting social workers to assess homes for substandard structural problems is not reasonable, recognizing that a large number of DCFS clients reside in older, pre-code homes. However, best practice would include inquiry as to working smoke detectors if the referral involved any fire-related concerns.

The worker interviewed the older child at school regarding supervision, domestic violence in the home, and discipline. The child indicated that an aunt babysat when mother went out, but stated that her mother did sometimes leave the brother sleeping at home when coming to pick her up from school. Additionally the 8-year-old stated she would sometimes be left home alone when her mother went to the store.

While the general social work practice was good, it is not without some criticism. The worker did not seek information regarding the mother's boyfriend. Although he did not appear to be living at the home and mother indicated she was seeking a restraining order against him, best practice would have been to get the full name and birth date of this individual and have this information entered into the Case and Management Information System (CAMIS) and cross-referenced for any prior history with the department. The CPS worker did not confront the mother with conflicting information as to how frequently she had left the toddler in the home while walking to meet the other child getting home from school or as to leaving the oldest child alone on other occasions. The worker indicated that

she had felt uncomfortable with a situation that would have pitted the child's statements against the mother. While the worker did make a collateral contact with a family friend (no concerns), the worker might have considered contacting the original referent, contacting the older child's school, and requesting from local law enforcement any reports regarding responses to the home (including DV calls to the home).

At case closure in November 2006 the investigative finding was inconclusive as to neglect. On the surface this appears to be a reasonable finding given that the investigator was unable to determine whether or not the mother was within sight of the home at the time she allegedly left the toddler in the house asleep. However, the oldest child's statements when interviewed appeared to indicate other recent incidents when the younger sibling was left home alone and sleeping when mother walked to meet the older child coming home from school. Had additional inquiries been made as suggested above, a finding of founded may have been supportable, although this is speculative.

It is recognized that the circumstances involving the later house fire did not involve lack of supervision of the children, and none of the identified deficits in practice appear to have any perceptible consequence to the circumstances surrounding the older child's death in March 2007.

Recommendations: None

Comment: The lack of training for social workers regarding interviewing subjects and caretakers has been identified in previous child fatality review recommendations. CA has recently made available such training state-wide and training for social workers on interviewing subjects and caretakers is scheduled for the summer of 2008 in the Bremerton office.

Action Taken: A Lessons Learned presentation is planned for the Bremerton DCFS All-Staff meeting in September 2008. At that time practice issues surfacing during recent child fatality reviews conducted in the Bremerton office, including this review, will be presented and discussed. This will range from discussions on simple data input errors to more substantive practice issues such as lack of sufficient collateral contacts, failing to seek available records from other agencies even on investigations not involving high risk allegations, and failing to obtain sufficient information regarding adults who have contact with the children involved on an open DCFS case. To the last issue, the Bremerton DCFS Area Administrator, subsequent to this review, sent an office-wide email best-practice reminder to social workers.

Action Taken: It is known that following this fire death the local fire district that responded to the house fire canvassed the neighborhood and installed working smoke detectors in many homes in similar condition as that of the home which burned down. The fact that many local fire districts often have smoke detectors available to families and will

install such devices free to families will be presented at the Lessons Learned presentation planned for September 2008 in the Bremerton DCFS office. Additionally, the Bremerton Area Administrator has conveyed to the CPS supervisors that home-based funds may be used to purchase smoke detectors or batteries for families on open cases.

Action Taken: The investigating CPS worker was not available to participate in the fatality review. However, the worker was provided with an opportunity to comment on practice issues prior to the review, and these were shared with panel review members in her absence. The worker was provided feedback following the review. The prior supervisor of the worker is no longer in the Bremerton DCFS office and was not able to participate. However, he was contacted prior to the review and presented an opportunity to comment on the practice issues likely to be discussed during the review. No comments were received.

Child Fatality Review #07-50
Region 5
Tacoma Division of Children and Family Services

This 13-year-old Caucasian male child died acute peritonitis.

Case Overview

On September 29, 2007, the deceased child's mother noticed his abdomen was rigid. The 13-year-old was having flu-like symptoms for several days, but refused to be seen by a doctor. The mother took him to a clinic and on the way he vomited on himself. The child asked to go home and clean up before heading back to the clinic, to which the mother agreed. The child and his mother went to the clinic, where the ill teen was left in the car as she checked-in at the clinic reception. When she went back to take him into the clinic she found him unconscious with no apparent heart beat. Emergency Medical Services (911) was called by the mother and she began CPR. When EMS arrived the boy was taken to a hospital where he was revived. He was transferred to Mary Bridge Children's Hospital where initial exam showed massive bleeding in his abdomen of an unknown cause. Surgery was required. The child appeared to have suffered septic shock from a ruptured bowel that was likely punctured by adhesions from the appendix which was rupturing. Medical records were reviewed by Region 5 Children's Administration (CA) medical child abuse consultant. She concluded that the family did not appear to be medically neglectful. Such a medical condition is very difficult to diagnose and has similar symptoms as seen in the flu, which is what the family thought the child had for several days. The cause of death was acute peritonitis as a consequence of appendicitis and the manner of death was determined by the medical examiner to be natural.

Referral History

In January 2003, Child Protective Services was contacted by a Community Services Office (CSO) worker concerned that the mother was allowing the father to watch the children while she worked. There was some concern that he was not capable of caring for the children. The children ages ranged from age nine years to 16 months. A year later it was reported to CPS that the mother was observed screaming profanities at the children and the father was heard making a drug deal over the phone. Empty cold medicine boxes were observed at the residence, and neighbors suspected methamphetamine manufacturing. The children were often seen with bruises and had poor school attendance. The information received was sent to local law enforcement. The referrals were screened as information only.

In June 2004, three reports were called into CPS intake regarding the children being smacked with an open hand (no known bruises), yelled at constantly, appeared unkempt, smelly, thin, and often asked neighbors for food. The report was accepted and deferred to

Alternate Response Services (ARS). The assigned ARS worker confirmed the concerns during her home visit and speculated there was methamphetamine manufacturing and use at the home. Law enforcement did go out to the home and found some materials on the property that could be used for methamphetamine manufacturing, but not sufficient for any arrests. ARS worked briefly with the family until they moved. The case was closed in August 2004.

In May 2005, CPS received two related referrals. There were concerns that the family was homeless living with another family. The children had complained of having no food. The children reportedly were running around the parking lot of the apartment complex. A neighbor reported having called law enforcement for a welfare check on the children, but law enforcement refused. The information was taken as information only.

In March 2006, CA intake was contacted by school personnel reporting poor school attendance for the oldest child. The Becca Bill had been initiated. This referral was screened as information only.

In January 2007, several reports were made to CPS by the children's schools (poor hygiene, school absences, behind on immunizations). A school nurse had gone to the residence and reported a strong animal urine stench. The referent did not go into the home or observe any physical indicators of methamphetamine manufacturing. Another reported concern was that 5-year-old sister of the deceased child said she gets hit by her brothers and her dad. No specifics as to what being "hit" meant and there were no injuries or bruises seen on the child. The child was reported to come to school with dirty clothes and poor hygiene. These referrals were screened as information only.

In March 2007, school staff reported that 7-year-old brother of the deceased child had a bruised eye and the child stated he did not know how it happened. Additionally, the 5-year-old sister told a teacher that the mother was afraid to drive the family car so the deceased child, then 13-years-old, drove. The children often came to school dirty and smelly. The report was accepted for investigation. Interviews were conducted with the children and the parents (alleged subjects), and information gathered suggested that the brother had received the injury while play fighting with his sibling. The father indicated that the deceased child was allowed to drive the car with his mother in the parking lot. At the home visit by the CPS worker the home was found to be very dirty, cluttered, and with some physical hazards (e.g., exposed wiring). Improvements were made at the home and consideration was to move the case to Alternative Response Services for services. The allegations were determined to be unfounded by the investigating CPS worker.

While the case was still open in June 2007 with CPS, a report was received by CPS intake in late June that the younger children may have been left to be supervised by some (unknown) 12-year-old who was an inappropriate caretaker. It was also reported that the house was again dirty, smelled of urine/ammonia, and there was a firearm in home (it was

not known if the gun was secured). The brother had reportedly shot the gun out the window hitting a person in a vehicle (law enforcement later indicated having no such reported incident). The brother and the deceased child reportedly had smoked marijuana in front of their mother. The information was accepted for investigation. The younger children went to stay with the paternal grandmother while the home environment was cleaned up. Services were initiated including FAST (Family Assessment and Stabilization Team) which provided family counseling, help finding daycare, help with the family move to a new apartment, and working with the family and school on improving school attendance. DCFS provided home-based service funds (clothing for the children, bus passes). The allegations were determined to be inconclusive by the investigating CPS worker.

The case remained open when another report was received by CPS regarding the deceased child driving a car at the new apartment complex parking lot. Additionally, it was reported drug use by the older boys and the mother having the older siblings to watch the younger ones when she was at work. The report was accepted for investigation. The mother and the older siblings denied that the deceased child drove the car. The youngest child was staying with the paternal grandmother. The FAST worker was contacted and indicated that the family was doing well and was stable. The investigation concluded after the child death and closed as unfounded.

On September 29, 2007, the deceased child was hospitalized with flu-like symptoms for several days. The mother had taken the boy to the doctor, but while in the parking lot he fell into unconsciousness. There were concerns of possible delay in seeking medical care on the part of the parent, but medical assessment post-fatality did not support the allegation. The child died from septic shock post-surgery, related to a rupture bowel likely to have occurred from a rupturing appendix. The CPS investigation was closed as unfounded.

Issues and Recommendations

Issue: None identified

Recommendations: None identified

Child Fatality Review #07-51
Region 5
Tacoma Division of Children and Family Services

This two-month-old Caucasian male child died of unknown causes.

Case Overview

On March 22, 2007, the father of this two-month old fell asleep on a sofa with the child in his arms. When he awoke a few hours later, the father found his infant son unresponsive. Medics were called to the home and transported the child the local emergency room where death was pronounced upon arrival. At the time of the incident there were no obvious signs of abuse or neglect. At post-mortem examination, the child was found to have had prior broken ribs. Both law enforcement and CPS initiated full investigations. The final determination made by the Pierce County Medical Examiner was of “death during infancy - no identifiable cause” and the manner of death was listed as “undetermined.” Although the child and subsequently a twin sibling were found to have been victims of physical abuse, the noted injuries to the deceased upon autopsy were not determined to have caused the death.

Referral History

On March 13, 2007 Children’s Administration (CA) intake received a report from a Maternity Support Services (MSS) worker about the general care of the twins (including the deceased child) by their parents. A relative told the MSS worker that the children are missing doctor appointments and the father has mental health issues. The MSS worker had last been to the home on February 26, 2007 and the children looked fine and the home appeared clean and safe. This referral was screened as information only.

On March 22, 2007, CPS was notified of the death of this two-month-old infant. The autopsy on this child showed that he had suffered prior suspicious injuries (broken ribs). Investigations by both law enforcement and CPS were initiated and information surfaced regarding a multitude of risk factors that resulted in the surviving siblings being placed into protective custody. The surviving siblings were examined (including a full skeletal survey) and prior injuries were also found on the twin of the deceased. Dependency actions were initiated and the children currently remain in out-of-home care. The parents have had another child that was born a year after the child’s death. That child is in out-of-home care as well. The CPS investigation was closed as founded.

Issues and Recommendations

Issue: One week before the death of the two-month old information was received by CPS intake (Tacoma) from a Maternity Support Services (MSS) worker. The referent was

reporting both first-hand and second-hand information regarding the family. It was reported that the infant twins had respiratory problems and the parents had missed some appointments. The father was reported to have some emotional issues according to a relative, but no specifics were given. It was known that the mother had a history of substance abuse which was likely the basis for MSS involvement. The relative had reported that the one-year-old child in the home was often up and about while the parents slept.

The MSS worker reported at intake that she had been to the home about two weeks prior and the children looked fine and the home was clean and safe. A relative was at the home helping out the family at the time. The report was taken as information only. The decision to screen out the referral appears to have been based on the fact that the children had recently been seen by the MSS worker and they appeared fine and the plan was for on-going MSS involvement. There were no prior CPS reports. The father had Family Reconciliation Services (FRS) involvement as child, although this was not identified by the intake worker during the person search of CAMIS. It is unknown as to why that history was not identified at intake.

An argument could be made that there was sufficient information for the referral to be accepted low risk and possibly sent to Alternative Response Services (ARS) for services, although the family was already receiving MSS services. Such argument to accept the report for an alternate intervention would be based on the reported lack of supervision for the one-year-old child and the missed medical appointments. The lack of specific information regarding the supervision may have played a role in the screening decision (screen out). At intake contact information for the relative was not provided, so there was no opportunity for a collateral contact to that person. It is unknown if the missed doctor appointments were for routine check-ups or necessary appointments specific to the respiratory problems. CPS had received no reported concerns from any medical providers. The intake worker did receive the name of the pediatrician but did not do a collateral call with that medical provider. It is possible that additional information might have resulted in a different screening decision.

Recommendations: None

Action Taken: A special intake focused "Lessons Learned from Region 5 Fatality Reviews 2006-2007" is tentatively planned for September or October 2008 at which time the issue about contacting medical care providers will again be discussed and emphasized as a best practice expectation for any referral involving young children.

Issue: On March 22, 2007, CPS intake was notified of the unexpected death of this child. Such notification to CPS of deceased children is routine and is part of an agreement with the Pierce County Medical Examiner's Office (PCMEO). There was no apparent indication of abuse or neglect, though co-sleeping on a couch was indicated.

Given no indications of abuse or neglect, the report was initially pended and then taken as information following collateral contacts and in consultation with the regional CPS Program Manager. On March 27, 2007 the MSS worker reported that a relative had related to the MSS worker a recent incident involving domestic violence in the home and that the father was making suicidal and homicidal statements. Within a day CPS intake was also notified that the autopsy results showed the infant had evidence of healing broken ribs. Based on the new information, the original fatality notification referral was changed to accepted and a CPS investigation for both referrals was initiated by a special CPS investigator assigned to the local Child Advocacy Center (CAC). The surviving twin was examined and also found to have had healing broken ribs. The two children in the home were removed and dependency action was initiated. Those children remain in out-of-home care.

A review of the fatality investigation documentation showed the assigned worker met expected practice and policy expectations. There was excellent collaboration by the CPS investigator with law enforcement, medical provider, and the regional Medical Child Abuse Consultant, and this was documented. Allegations of abuse and neglect against the parents were founded. However, it should be noted that the cause of death for this child was determined as death during infancy, no identifiable cause and the manner as undetermined. While there is evidence the infant had been abused prior to his demise, the death was not determined to be related to the injuries found post mortem.

Recommendation: None

Action Taken: The CPS investigator currently works for the CAC and is no longer a CA employee. She was invited to attend the review but was not able to attend. The individual who was her supervisor at the time of the CPS investigation did participate in the review and received the feedback at review.

Child Fatality Review #07-52
Region 5
Tacoma Division of Children and Family Services

This seven-week-old Caucasian child was found deceased in his parents' home at 12:30 p.m. on October 10, 2007. The cause of death is Sudden Unexpected Infant Death (SUID) and manner of death is undetermined.

Case Overview

Around 12:30 P.M. on October 10, 2007, the then seven-week-old deceased child was found deceased at the mobile home where he lived with his parents and a two-year-old sibling. The parents reportedly had gone to bed late the previous evening. The infant had been placed on his stomach on the couch where the mother also slept. Reportedly the infant had last been seen alive around 5:30 a.m. that morning.

A relative came to the residence and, when unable to wake anyone, he entered the home. It was at that time he noticed the infant next to the sleeping mother. The infant's face was against the couch back. As the baby did not look right, 911 was called. CPR was attempted by responding emergency medical services. At that time the child was removed for transport to the hospital although it is likely that the child was already deceased. Death was declared at the local hospital.

Subsequent to post mortem exam and ancillary studies, the cause of death was determined to be Sudden Unexpected Infant Death (SUID), noting co-sleeping. Manner of death is listed as undetermined.

Referral History

On May 25, 2006, it was reported that the mother left the deceased child's older sibling (then 12-months-old), unattended on the porch in his walker and he fell off the porch. The mother reportedly did not seek medical treatment due to fear of the department. The referrer also stated that the child has had a black eye for three months. The referral was accepted for a CPS investigation and was unfounded for physical abuse and inconclusive for neglect or maltreatment. During this investigation, the mother was offered parenting classes and urinalyses (UAs). Bus tokens were provided to assist the mother with transportation. CPS confirmed that the child was receiving medical care and contacted the primary care physician (PCP). The mother also received a referral to complete her GED and she was a recipient of Temporary Assistance for Needy Families (TANF) services prior to her involvement with CPS.

Following the death of her child, the mother was referred for UAs, parenting classes, and a drug and alcohol assessment. Her UAs were at times positive for methamphetamines and

at other times positive for marijuana. She completed the drug and alcohol assessment and was enrolled in an outpatient treatment program. The mother was also referred for a mental health assessment and mental health counseling, as well as bereavement counseling. Public health nurse services and Family Preservation Services (FPS) were also utilized.

Court involvement became necessary in March 2008 and services through Juvenile Court are now in place.

Issues and Recommendations

Issue: Regarding the investigation of the May 25, 2006 referral: In May 2006 CPS intake received a report from an anonymous caller that the deceased child's sibling, then one-year-old, had what appeared to be a chronic black eye situation. The report was assigned for investigation and contact with the mother and child was within the policy requirements at that time. Multiple and frequent contact with the family was documented, including home visits. More than one contact with the child's doctor was made by the worker. During the panel review, it was noted that although contact had been made with the primary care physician, there was opportunity for additional collateral contacts. This would have included consideration to seek consultation with the regional CA Child Abuse Medical Consultant. But overall the work appeared to meet acceptable standards for investigation.

As there had been only one pre-fatality referral involving this family, the review was limited to a single investigation that closed out 11 months prior to the SIDS death of another child. Only minor practice issues were identified and there was no apparent connection of the perceived deficits with the SIDS death almost a year later.

Action Taken: A "Lessons Learned from Child Fatalities 2006-2007" presentation is planned for the Tacoma CPS units in September/October 2008. At that time practice issues surfacing during recent child fatality reviews conducted in the Tacoma office, including this review, will be presented and discussed. This will include discussion regarding situations whereby consultation can or should occur with the regional CA Child Abuse Medical Consultant. In conjunction with CA Program Manager staff, a separate refresher training for conducting CPS investigations is also scheduled for 2008.

Child Fatality Review #07-53
Region 5
Tacoma Division of Children and Family Services and
Division of Licensed Resources

This two-year-old Native American/Mexican male child died as a result of an accidental drowning in the family's above ground swimming pool.

Case Overview

This home was a licensed private agency foster home. In placement in the home at the time of the incident were six children; the four biological children of the family (including the decedent) and two relative children placed in the home.

On September 14, 2007, Child Protective Services was notified by law enforcement that a two-year-old male child had been found in the family's swimming pool and was non-responsive; not breathing and had no heart rate. Per law enforcement the decedent's mother had a friend and her children over for lunch. While the lunch was being prepared by the decedent's mother and her friend, the children were outside playing. When the children were called in for lunch the decedent's mother noticed he was missing. The child's mother searched the yard and found the child floating face down in the pool. Upon arrival of the paramedics Cardio Pulmonary Resuscitation was initiated and the child was transported to Good Samaritan Hospital where he was pronounced dead shortly after his arrival.

Referral History

Prior to the report of the drowning regarding the decedent, this family had not been reported regarding any concerns related to child abuse or neglect. In addition there is no history of licensing complaints noted.

On the day of the fatality (September 14, 2007), the decedent's father was not at home. The decedent's mother and her biological children were at the home, as were two relative children placed in the home. An adult female and her three children were also at the home. All of the children had been outdoors playing while the decedent's mother and her friend were alternately making lunch and checking on the children. The decedent's mother became involved in a phone call for approximately 10 minutes and when she got off the phone the children were called in for lunch. Upon noticing the decedent was missing she ran to the yard and looked all around. She did not immediately check the pool as the decedent had an historical reluctance to be in the water. It was when she finally checked the pool that she found her child floating face down.

The pool was eighteen (18) feet in diameter with a water depth of approximately two (2) feet; the pool was housed inside a fence. The pool faced no windows and thus could not be

seen unless from outside the building. The pool was left uncovered. The pool ladder, normally removed and placed over the fence when the pool was not in use, had been left in the pool. It was known the decedent enjoyed sitting on the ladder and watching what was going on in the pool, but had to be coaxed into the water according to his mother. The decedent's mother reported the decedent was tall enough, that once in the pool, his head remained above the water level.

When the child was discovered he was wearing heavy sweat pants, a sweat shirt, and a diaper which when soaked with water was determined to have great weight. It is believed the child may have hit his face on the ladder before going under. Law enforcement, following their preliminary investigation activities, declined to pursue the matter as did the Medical Examiner and both determined the death to be accidental drowning.

Given this was a licensed foster home with a relative placement, the Division of Licensed Resources/Child Protective Services (DLR/CPS) conducted an investigation into the incident. The investigation resulted in founded finding for negligent treatment by the decedent's mother in the drowning death of her son. DLR/CPS requested the relative children placed in the home be removed and placed elsewhere. These children have not returned.

The investigation further determined the family had not abided by foster licensing requirements in regard to the swimming pool. Multiple licensing violations involving the installation of the pool were found to contribute to the fatality. As a result, valid licensing infractions were found in regard to supervision, overcapacity, nurture/care, failure to report (other people in the home), character, and facility environment. Revocation of the foster home license was recommended based on the CPS founded finding and valid licensing infractions.

Issues and Recommendations/Actions

Issue: Given the fact that there were no prior complaints (including licensing complaints) involving this family, the review focused on the circumstances surrounding the drowning death of a biological child in home that was licensed specifically for two relative children.

Documentation from the private licensing agency (Total Unity Family Services) shows the family had been notified of requirements regarding safety of foster children around bodies of water (WAC 388-148-170) after the parents had told the licensor they had a pool (not installed). The parents were told if they put up a pool the licensor needed to know, and a safety plan would be required as well as a pool cover. The licensor was never informed that the pool had been put up, and had not seen a pool during the last visit to the home.

Overall the DLR/CPS investigation and the activities by the licensor following the fatality incident appear to meet policy and practice expectations. Good collaboration between

DLR/CPS, Office of Foster Care Licensing (OFCL), and the private agency worker was evidenced and documented. Although, following the fatality there appears to have been a miscommunication between the private agency and the OFCL licensor as to a staffing. Response to the field was immediate following the notification of the drowning, and efforts to collaborate with law enforcement were made and documented.

The DLR/CPS investigation was not without some acknowledged practice concerns. Some Service Episode Reports (SERs) were entered well outside policy timeframes. DLR/CPS did not confirm with the person the mother was talking to on the phone just prior to the drowning as to how long that phone call had taken. The DLR investigator's interview of the adult witness to the incident was not done until four months after the drowning. The investigation was not completed until well beyond the 45 day requirement for DLR/CPS, which in turn held up the licensing complaint investigation by the foster home licensor. During the review it was presented the investigating social worker was in an automobile accident during the time of the investigation and was only able to return to work half time, although still carrying a full caseload.

Recommendations/Actions: The DLR/CPS investigator and his supervisor participated in the review and received the feedback regarding the investigative practice. The worker acknowledged the practice deficits/concerns discussed during the review, indicating that such was not his normal practice, noting the reduced work hours due to the automobile injuries.

Issue: In consultation with an Assistant Attorney General, the DLR/CPS investigator made a finding of founded against the mother for the drowning death of her biological son. The review panel discussed the fact that had the referral not involved a licensed foster home, the case would likely not have been investigated by Division of Children and Family Services (DCFS) CPS let alone founded for neglect given the reported circumstances and lack of history of reported concerns. Additionally, the question was raised as to whether, as written, the intake actually met sufficiency for accepting for investigation. Although tragic, the information provided about the circumstances of the drowning did not clearly implicate the mother as having been reckless in her supervision (see RCW 9A.36.050) or had shown a serious disregard such that it created a clear and present danger (see WAC 388-15-009).

Neither RCW nor WAC differentiate the legal definitions of abuse and neglect for licensed and non-licensed persons. The basis for the finding of founded appears to be based on the principle that there is a higher standard of care required for licensed foster parents. While this standard of care principle may apply to licensing expectations, the legal definitions of child abuse and neglect do not appear to reflect that same application of principle.

Recommendation/Action: Consideration might be made by CA to reconcile this issue. It is known that the Office of Family and Children Ombudsman (OFCO) has noted this separate standard for findings in DLR/CPS cases and DCFS/CPS.

Child Fatality Review # 07-54
Region 5
Tacoma Division of Children and Family Services and
Division of Licensed Resources

This four-month old African American male child's death was determined as Sudden Unexplained Infant Death (SUID); manner undetermined following post mortem exam and ancillary studies.

Case Overview

On October 09, 2007, staff members of a Tacoma licensed childcare center reported the death of a four-month-old child while in their care. The child had stopped breathing and despite resuscitation efforts died. Childcare staff initiated Cardio Pulmonary Resuscitation (CPR) following 911 contact and prior to paramedic arrival. Medics transported the infant to Mary Bridge Children's Hospital where the child was pronounced dead.

Facility staff reported the infant had arrived at 8:05 a.m. on October 9, 2007 and had been fed several times throughout the day, the last time around 2:30 p.m. The infant had slept from 9:00 a.m. to noon, and again between 1:30 p.m. and 2:30 p.m. in the afternoon. Reportedly the child was checked for a diaper change around 4:00 p.m. and offered a bottle but became "fussy." One of the childcare staff placed the child in a crib but he did not sleep until rocked by another staff person. Once asleep the child was placed on his back in the crib where he was later found unresponsive with fluid seeping from his nose.

Referral History

The family of the decedent does not present with any child abuse or neglect history with Children's Administration. This review is in regard to the childcare facility where the decedent was found.

The entire referral history involving the childcare center was reviewed, including reports taken after the death but before the fatality review was conducted. The referral history largely involved licensing complaints made against the center which is licensed for eighty-five (85) children. Although there were minor issues identified for some of the intakes and licensing complaint investigations, there were no patterns of practice deficits, and nothing prompting consideration for any recommendations or needed actions. Practice issues identified as to the Division of Licensed Resources/Child Protective Services (DLR/CPS) fatality did not appear to reflect any generalized practice or policy deficits for DLR/CPS.

This facility was licensed March 11, 1993, noting the owner had four locations in Pierce County. Since that time there have been nineteen (19) referrals received in regard to this

location with various allegations, most being licensing only referrals, and six being assigned to DLR/CPS for investigation of child abuse and/or neglect. The other locations for this agency had a total of eighteen (18) referrals, four of which were assigned for investigation by DLR/CPS. No pattern is noted in regard to any of the allegations.

Referencing this location the first referral was received in 1996 and alleged the childcare owner sexually abused her own children twenty (20) years prior; the referent was concerned about the childcare children. This licensing complaint was closed as not valid. The only referral received in 1997 alleged physical abuse by an employee of the center and was assigned to DLR/CPS for investigation. The allegations were founded in regard to physical abuse by the staff member and unfounded as to physical neglect on the part of the childcare center. The individual who was named as the subject resigned their position prior to the conclusion of the investigation. The investigating licensor found discipline issues and other violations to be valid, with supervision and failure to report violations as inconclusive. A compliance agreement was developed and signed with the owner and monitored by DLR.

In 1998 a referral alleged a teacher was spanking children. This licensing complaint was closed as not valid. A second referral received in 1998 alleged sex abuse by a staff member. Per the referent's statement, the alleged child victim was a recent victim of sexual abuse elsewhere. DLR/CPS investigated the complaint with an unfounded finding while DLR licensor closed the complaint as not valid. In 2000 a licensing complaint was received alleging inappropriate responses to a child by a staff person. Following an investigation regarding discipline issues the licensor had the center sign a compliance agreement in regard to supervision, however, did not find any valid issues related to excessive discipline. A second licensing complaint in 2000 was inconclusive for discipline and a compliance agreement was signed.

Two referrals were received in 2002 alleging staff record keeping was inappropriate. The referrals were received from non-custodial parents wanting records to which they did not have permissible access resulting in no valid complaint. Three other referrals were received the same year. A DLR/CPS investigation was unfounded for neglect, lack of supervision and the attached licensing complaint was not valid, though a compliance agreement was signed. One licensing complaint was not valid in regard to staff qualifications (staff person yelling at the children) and one alleging inappropriate discipline were found invalid. Three referrals were received in 2004, all licensing complaints. Two were from the same parent, the first in regard to nurture/care and was not valid, and later the parent alleged that the director of the childcare breached confidentiality which was inconclusive and a compliance agreement was signed in regard to "gossip". No reports were received in 2005 or 2006.

A person who worked near the childcare reported in 2007 teachers yelling at the children. The licensor made several clandestine visits to areas surrounding the childcare playground and did not hear anything inappropriate. The complaint was closed as not valid.

On October 9, 2007 the decedent was found non-responsive in the crib where he had been laid approximately forty-five (45) minutes before. During the investigation staff were interviewed separately and reported the same sequence of events prior to finding him with blood coming from his nose and non-responsive. CPR was administered and Emergency Medical Technicians (EMT) responded. The child was pronounced dead upon arrival at the hospital.

On October 10, 2007 a parent reported possible physical abuse of an infant in the childcare center. A parent reported observing a staff person in the infant room swaddle a child and toss the child onto the crib mattress where the child bounced. DLR/CPS investigated both of these referrals concurrently as the infant classroom was named specifically in both.

There were no licensing infractions found as a result of the fatality investigation nor were there any findings related to the concurrent DLR/CPS investigation received on October 10, 2007. The swaddling was deemed appropriate and witnesses stated the staff member did not toss the infant on the crib, nor did the baby bounce. The child's death was determined as Sudden Unexplained Infant Death, manner undetermined.

Issues and Recommendations/Actions

Issue: The childcare licensor's documentation and activities appear to meet or exceed the policy and practice expectations for DEL. The worker made an effort to gather information regarding the circumstances surrounding the fatality incident, and to work collaboratively with DLR/CPS which had initiated a facility investigation. This included a collaborative site visit with DLR/CPS. Documentation met standards for quality and timeframe entry requirements. The DEL licensors work with the childcare provider was supportive while meeting the investigative needs.

Recommendation: For risk management purposes, the Department of Early Learning (DEL) should consider developing a child fatality review process separate from that conducted by The Department of Social and Health Services, Children's Administration.

Action Taken: The DEL childcare licensor participated in the review as did the Assistant Field Manager for DEL, who was the supervisor at the time of the incident. Both received feedback regarding the good work.

Issue: The Division of Licensed Resources Child Protective Services (DLR/CPS) investigator appears to have met most policy and practice expectations. Field response was immediate and collaborations were documented (law enforcement, hospital, Medical

Examiner, CA Child Abuse Medical Consultant, and childcare licensor). The DLR/CPS case remained open more than the 45 day requirement, but this was due to waiting for the final cause and manner of death to be determined by the Medical Examiner.

The investigation was not without some criticism. The investigator had opportunities for additional collateral contacts with other childcare staff not directly involved, and did not appear to interview one of the witnesses present at the time of the incident. Given the determined cause and manner of death, the deficits noted during the review do not appear to have any significance regarding the findings (unfounded).

Recommendation/Action: The DLR/CPS investigator participated in the child fatality review and received feedback regarding his practice and social worker activities. During the review it was presented that the worker was only working half time at the time of the investigation due to having been in an automobile accident, although maintaining a full caseload. Thus missed timeframes for data entry and other omissions in practice occurred. The worker acknowledged the deficits in practice as identified, noting that such errors were not reflective of his general practice.

General Recommendation/Comment:

The entire referral history involving the childcare center was reviewed, including reports taken after the SUID death but before the fatality review was conducted. The referral history largely involved licensing complaints made against the center which is licensed for 85 children. Although there were minor issues identified for some of the intakes and licensing complaint investigations, there were no patterns of practice deficits, and nothing prompting consideration for any recommendations or needed actions. Practice issues identified as to the DLR/CPS fatality did not appear to reflect any generalized practice or policy deficits for DLR/CPS.

Child Fatality Review #07-55
Region 5
Tacoma Division of Children and Family Services

This five-month old Caucasian female child's death was determined as Sudden Unexplained Infant Death (SUID); manner undetermined following post mortem exam and ancillary studies.

Case Overview

On May 8, 2007, Child Protective Services (CPS) received notification from the Pierce County Medical Examiner's Office (PCMEO) regarding the death of an infant the previous day. Given the location of the death on Fort Lewis, a military Criminal Investigation Division (CID) had initiated an investigation. Intake noted there was an active CPS case on the family initiated in April 2007.

The deceased child's mother reported to officials she fed her daughter early on the morning of May 8, 2007 and placed her down to sleep in a crib with a foam wedge which reportedly was used for a medical condition (esophageal problems). The mother reported she returned approximately 1.5 hours later and found the infant non-responsive with a small piece of plastic covering the her mouth. A friend with whom the decedent's mother lived called 911 and the infant was transported to Madigan Army Hospital following emergency response to the residence.

The child was pronounced dead at Madigan Hospital. An autopsy and ancillary studies were done and the cause of death was determined to be Sudden Unexpected, Unexplained Death in Infancy. The manner of death was classified as undetermined.

Referral History

The first referral referencing the decedent's mother was in August 2002. A CPS referral was received alleging medical neglect by the decedent's boyfriend (who allegedly was to have smoked marijuana in the presence of the asthmatic child) and physical neglect/failure to protect by the child's mother. The infant was placed into out of home care on October 9, 2002 and a dependency was established to the mother in November 2002. Neither the decedent's mother nor her father followed through with services. The dependency in regard to this child was dismissed March 8, 2005 at which time the maternal grandmother had obtained third party guardianship.

A second child was born to the mother in February 2006. In May 2006 a referral was received in regard to the biological father's care of the child. The father and the child were living with the maternal grandmother at the time. No allegations were made as to the

decedent's mother who did not appear to have much of a parental role with the child other than visits. Allegations as to the father were unfounded.

The now deceased child was born in December 2006. In April 2007 she was admitted to the hospital for breathing issues and difficulty keeping food down. CPS intake was notified by an out-of-state relative with concern the decedent's mother was not keeping appointments for a child with a medical condition. Investigation into the allegations noted several missed doctor appointments, however, the decedent's mother indicated an appointment had been re-scheduled for the following day. The decedent's mother was involved in services including mental health services, and a maternity support program. Contacts with several service providers indicated no concerns in regard to child abuse or neglect by her mother.

On May 8, 2007, the Medical Examiner's Office reported the death of the five-month-old child. Per the Medical Examiner, the mother reported she had fed the baby early in the morning and placed her back in her crib to sleep. An hour and a half later when she checked on the infant she was non-responsive and had a piece of plastic over her mouth. It was assumed the plastic came from a special wedge on which the baby slept.

As a precaution pending the outcome of the investigation the CPS social worker contacted the maternal grandparent and father of the decedent's other siblings. Both care providers signed safety plans stating there was to be no unsupervised contact between the children and their mother pending completion of the CID and CPS investigations. Interviews with the woman residing with the decedent and her mother at the time of death told investigators she did not see plastic on the child's mouth and believed the child to have been dead longer than the mother reported.

The final report from the Medical Examiner in coordination with law enforcement noted the infant's death was due to sudden unexpected, unexplained death in infancy and the manner of death was undetermined. No criminal charges were filed.

Issues and Recommendations/Actions

Issue: In April 2007 a referral was received stating the decedent had been hospitalized for breathing issues and inability to keep food down. The referent, who was an out-of-state relative, alleged the mother had not followed through with doctor appointments for the child. The report was accepted for investigation and the intake screening decision appeared reasonable. The initial face-to-face contact with the infant and mother was done in a timely manner. The worker addressed the allegation with the subject who acknowledged having missed some appointments but stated that an appointment had been re-scheduled. Soon after the worker went on annual leave. Shortly after returning from leave, notification regarding the infant's death was received.

The worker appears to have relied on the mother's accounts of the missed appointments and her contention that an appointment had been re-scheduled. The assigned social worker did not contact the primary care physician (PCP) to gather medical information on the child or to confirm the missed appointments, which were both central to the allegations. While it is acknowledged the worker went on annual leave shortly after initiating the investigation, and may have planned to make such contact with the doctor at a later point in the investigation, the review panel identified medical contacts as a priority activity that should occur immediately when possible.

Less critical practice errors were also identified during the review. The worker documented the mother had indicated she had two other children who were not in her care and custody. The worker did not appear to inquire further. The worker did not identify service providers by their roles. The mother had reportedly been working with a program called Step by Step. It was not clear as to what this program provided, and only in preparation for the review was Step by Step identified as a maternity support program. While the assigned social worker documented contact with the service provider at Step by Step she did not identify the person's role. Again, it was only much later that this person was identified as a dietician.

Contact information for a counselor was provided to the CPS worker by the mother, but that person was never identified in notes or contacted. During the review the worker acknowledged that she had been unaware of the any prior CA history for the mother and had not looked through the referral history attached to every CPS intake. The worker indicated she had relied on a statement in the intake that noted there were no priors with the additional caretaker involved in the home. The intake worker had noted extensive CA history for the mother as a child, but appears to have failed to identify a referral on the mother as a subject in 2002.

Recommendation/Action: A "Lessons Learned from Child Fatalities 2006-2007" presentation is planned for the Tacoma CPS units in September-October 2008. At that time practice issues surfacing during recent child fatality reviews conducted in the Tacoma office, including this review, will be presented and discussed. This will include a general discussion on making collateral contacts, as well as special emphasis on contacting medical providers in cases that involve young children. It will also include discussion in regard to documentation and the importance of listing first and last names and identifying the role of individuals identified in Service Episode Records (SERs). The importance of reviewing case history prior to initiating an investigation will also be highlighted in the "Lessons Learned" presentation.

Issue: Following the notification of the child fatality, the case was re-assigned to a new worker. The fatality investigation was initiated in a timely manner and the assigned worker moved quickly to put in place a safety plan for the deceased child's older half-siblings even though they had been in the care and custody of relatives for years. Attempts to work

with the military investigator (CID) were documented, but information flow appears to have been slow. The investigation appears to have been hampered by the difficulty in locating the mother who had been removed from the military base housing. The assigned worker never met with the mother in person. In review, the investigative activities appear minimal and sparse. The worker had apparently not understood he assumed the investigation of the pre-fatality referral as well as the fatality referral. There did not appear to be any significant collaboration between the previous worker and the newly assigned worker. After mid-June 2007 the case appears to have gone inactive and remained open until the fatality review 2008. Supervisory reviews stopped in June 2007 until an entry made by the supervisor in February 2008. The worker stated he did not think he could close the case until the fatality review took place. The regional CPS Coordinator maintained he had informed the worker before the end of 2008 the case could be closed. The investigative assessment and findings for both investigations had still not been completed at the time of the fatality review in 2008.

Recommendation/Action: Both social workers participated in the review and were given feedback regarding their respective CPS investigative activities. Both acknowledged the identified practice issues and agreed where better practice could have been demonstrated. The supervisor who supervised both workers back in 2007 also attended the review and participated in the discussions. The social worker responsible for completion of the Investigative Assessment was directed to complete work and close the case.

Child Fatality Review #07-56
Region 5
Tacoma Division of Children and Family Services

This seven-month-old female child was found not breathing and non-responsive in the family home. Following the Medical Examiner's report the death was listed as "death during infancy; no identifiable cause", manner of death is undetermined.

Case Overview

On January 29, 2007, Tacoma Police Department contacted Child Protective Services to report the death of a seven-month-old child in the family home. The infant was said to have been found deceased by the mother. Per law enforcement reports, the mother had placed the infant in an infant "bouncy chair" the night before. The child had been ill for several days with a runny nose and diarrhea. Upon discovery of the child the father performed Cardio Pulmonary Resuscitation prior to the arrival of emergency medical services (EMS). EMS transported the infant to the hospital where the child was pronounced dead. The police reported the deceased infant was found with a bleeding diaper rash and a small bruise on the forehead which may have occurred during resuscitation efforts.

The medical examiner indicated on the death certificate the cause of death as "death during infancy; no identifiable cause." The manner of death is listed as "undetermined".

Referral History

This family consists of two adults and four children, including the deceased child. The Child Protective Services (CPS) history began in August 2000 regarding concerns for neglect and physical abuse of the oldest child, then a year old, by the decedent's mother. Reported concerns included failing to provide basic needs (feeding, nurturance, medical), hitting the child, and the mother's substance use. Five unannounced home visits were conducted during the investigation. Drug use was confirmed by urinalysis, however, the mother failed to make her appointment for a chemical dependency assessment. Following completion of the investigation findings for this referral were listed as unfounded in November 2000.

In April 2001 a relative living with the decedent's family reported the decedent's mother had taken off, possibly on a drug spree. She reportedly had been gone for five days, leaving her then 18-month-old child at the residence with the relative. The report was taken as information only. A year later in April 2002 a referral was received regarding alcohol use by decedent's mother during pregnancy. At the time of the referral the mother was receiving medical care (OB Access), community health nurse services, and mental health counseling. The report was taken as information only as the situation did not meet the

prenatal substance abuse criteria. Two months later (October 2002) she delivered her son at Tacoma General Hospital who reported no concerns to CPS intake.

In early 2003 the decedent's mother was alleged to have been physically abusive to her then 3-year-old son. The child reportedly had a hand-shaped bruise on his back which someone at a birthday party had photographed. Unable to obtain the photograph and no indication of the injury at time of investigation, the CPS investigator was unable to prove the allegation of physical abuse. The mother's drug test results were negative for drugs and the children's physician indicated no concerns for their health or welfare. The case was closed June 2003 with an unfounded finding.

During August-September 2004 three reports were made to CPS regarding concerns for neglect and abuse (accepted) and drug use (information only). Law enforcement was also briefly involved. Concerns included lack of food in the home, the parent sleeping all day and partying all night, lack of supervision, drug use/drug selling in the home, and a possible cigarette burn on one of the children. Allegations were found to be inconclusive and the case was closed January 2005 with the agreement the two children in the home would reside with relatives. A month later the decedent's mother gave birth to another child with no concerns reported to CPS.

It was not until a year and a half later (June 2006) CPS received a report from a hospital social worker reporting the decedent's mother had given premature birth to a child, the now deceased child. At the time of the report, it was not known whether a toxicology screen had been done on the child at delivery. The mother did not appear to have had any prenatal care. Given no allegations, the report was taken as Information Only.

The referral received January 29, 2007, reporting the fatality of the seven-month-old infant was assigned for investigation due to a physical injury reported to the face of the child and the reported severe diaper rash. Conditions of the home alleged significant neglect issues and was noted to include dog feces on the floor, filthy carpet, a crib full of clothes, sink overflowing with dishes, limited food in cabinets, limited food in refrigerator, dining table with food remnants, and garbage in carpeted areas.

During the course of the investigation it was determined the decedent had a severe bleeding diaper rash with dried feces. Both parents admitted to have used drugs the previous evening; two hits of crack were reported. The decedent was noted to have had a blood alcohol level of .03 from an unknown source. While there is evidence of diaper rash and elevated blood alcohol level, the cause of death is undetermined. The injury to the head was later determined to have been caused by a valve mask used during resuscitation efforts.

During the course of the investigation an initial safety plan was implemented regarding the surviving siblings. The three children were initially placed with relatives under a Voluntary

Placement Agreement (VPA). However, in April 2007 all three children were made dependents of the state of Washington and are placed with a relative who plans to adopt the children.

Issues and Recommendations

Issue: Within the year prior to the fatality referral in January 2007 there had been one information only referral at the time of the deceased child's premature birth in June of 2006. All other referrals on the family occurred between 2000 and 2004. It was apparent to the panel review members that CA policy and practice guidelines involving the intake process have changed significantly since 2004. Thus discussion on practice issues identified for the 2000-2004 intakes was tempered by the fact that CA practice expectations were different at the time those referrals were processed.

All intake screening decisions for the 2000-2004 referrals appeared to be reasonable. The only referral decision that was questionable occurred back in 2001 when a relative contacted CPS alleging the decedent's mother had asked the relative to watch her son and had not returned in the week since. It was not clear as to what the arrangement had been between the mother and the relative regarding "watching" the child. It was not clear if the situation was one of abandonment. It was also not clear if the relative was indicating an unwillingness to continue caring for the child. Clarifying questions by the intake worker may have changed the screening decision. The intake worker did document the relative was advised to file for temporary custody, but in and of itself this advice was viewed by the review panel as being of little help without some suggestions to the relative of how to go about such a process.

An additional minor criticism was from a referral in 2000 that indicated there was a live-in boyfriend in the home. The intake worker did not appear to inquire as to the name of the live-in boyfriend who would be considered a member of the household and a caretaker.

Recommendation: Region 5 DCFS in collaboration with Pierce County Superior Court has now developed a guide for helping relatives or other interested parties work with a Family Court liaison to pursue third party custody and guardianships. This guide is available to all social workers as well as intake workers.

In addition, as the review panel discussed the recurring issue of intake workers not asking clarifying questions, it was suggested that a desk top resource guide with suggested clarifying questions be developed for intake workers with "templates" designed for a multitude of categories. This might include templates for asking clarifying questions when there is a reported injury to a child, when there are concerns for lack of general medical care of a child, for reported domestic violence situations where children may be present, for when a child has been left to be watched by a relative and the parent has not returned to retrieve the child, etc. The Tacoma intake supervisor offered to begin developing such a

resource/desk guide, and will contact other regional intake leads across the state regarding such a project.

Issue: There were three CPS investigation assignments prior to the January 2007 child fatality; one in 2000, one in 2003, and one in 2004 (involving two referrals). It was apparent to panel review members CA policy and practice had changed significantly since 2004. Timeframe requirements for initiating investigations and making face-to-face contact with alleged victims have been narrowed to 24 hour (emergent) and 72 hour (non-emergent) response times. The expectation that supervisory reviews will be conducted on every active case on a monthly basis has now been established. The risk assessment model used in Washington State has since changed to an actuarial model (Structured Decision Making tool) which significantly reduces the likelihood of under-estimation of associated risk for future child abuse and neglect. Thus discussion on case work deficits identified for the 2000-2004 investigations was tempered by the fact that CA practice expectations were different at the time those investigations took place.

However, there were some recurring practice issues identified during the review that were worthy of both discussion and note. For all three investigations the opportunity to contact the children's medical provider to obtain general medical/health care information was missed, although each involved at least one very young child. There was no evidence any of the three CPS workers had offered Public Health Nurse Services to the family, although such referrals would have addressed identified risk factors. Indicators of parental ambivalence were either missed or dismissed by each worker. Persistent drug use by the adult caretakers was apparent. While some efforts to engage the caretakers in drug and alcohol services were documented, the social workers appeared stymied by client resistance and did not appear to factor the resistance to services/treatment in the risk assessments.

Recommendation: As noted, there have been many recent policies, practice, and program changes in CA designed to improve safety and service provision. In 2007 CA contracted to have out-stationed Chemical Dependency Professionals (CDPs) in every region. There are currently three CDPs out-stationed in the Tacoma DCFS office. Duties of these CDPs include consultation with social workers on drug and alcohol issues in the families they work with, providing support to social workers in scheduling parents in need of chemical dependency assessments and to track progress of service delivery, to work collaboratively with the Community Services Offices (CSO) and their CDPs when there are clients in common, and to attempt active engagement with resistant drug using clients when requested by a social worker. There is evidence that such efforts have resulted in improved assessment, treatment, and general engagement rates with drug using Division of Children and Family Services clients. Additionally, special Client Engagement training is now offered twice a year in Region 5, and all social worker staff are strongly encouraged to attend this training within the first year of taking a social work position. Finally, since 2006 CA has developed a state-wide Lessons Learned presentation that is offered annually

in all six regions. A critical part of the presentation focuses on recognizing parental ambivalence and giving such indications great weight in assessing both safety and risk. The new risk assessment tool (SDM) includes a question regarding this factor.

A Lessons Learned from Child Fatalities 2006-2007 presentation is planned for the Tacoma CPS units in September/October 2008. At that time practice issues surfacing during recent child fatality reviews conducted in the Tacoma office, including this review, will be presented and discussed. This will include contacting primary care physicians on cases involving young children and recognizing signs of parental ambivalence towards a child.

Child Fatality Review #07-57
Region 5
Tacoma Division of Children and Family Services

This four-month old African American female infant died as a result of hyperthermia and radiant burns. Manner of death was undetermined.

Case Overview

On June 15, 2007, it was reported to Child Protective Services (CPS) this four-month-old infant was reportedly placed by her parents in front of a heater to sleep at the motel where the family had been residing. The family had a history of frequent moves and unstable housing and had been staying at this location for two days. Per the Medical Examiner (ME) probable cause of death was likely from hyperthermia (heat exhaustion). The parents admitted to using drugs the evening prior to the death where they maintained they had last seen the child alive around 3:30 a.m. that morning.

Subsequent to the initial notification of the death, CPS received information from law enforcement regarding radiant burn marks on the deceased child (no pattern burns), suggesting the infant had been left too close to the wall heater. Criminal charges were not pursued as the circumstances appeared more likely the result of inattention rather than reckless in nature.

Referral History

This family had four referrals (2002-2007) prior to the death of their daughter. Three of the referrals alleged neglect and one was taken as information only (prenatal drug use). Following the fatality referral, two additional reports were called into CPS intake.

In February 2002 Des Moines Police (King County) responded to a domestic dispute where the decedent's mother was arrested. Apparently the mother had left her then 16-month-old child with a neighbor who had agreed to watch the child. The mother had indicated she would return within an hour, but did not. The mother returned approximately two hours later (after midnight) and no one at the home responded to her knocking. The mother waited until morning and when she went to pick up her child the neighbor gave the mother conflicting stories as to the child's whereabouts. Officers, responding to the disturbance by the mother as she attempted to break into the neighbors' house to look for the child, assessed the neighbor as being an inappropriate caregiver (allegedly having mental health issues and a seizure disorder). The neighbor was unable to handle the child and gave him to a friend. The child changed caretakers several times before ending up with maternal grandfather's girlfriend. The report was accepted for investigation of physical neglect.

The subsequent investigation resulted in an 'unfounded' finding for neglect with the overall level of risk was assessed as low. A safety plan (not requiring CPS monitoring) was created with the mother and the grandfather who had previously petitioned the court for temporary non-parental custody of the child in 2001. The case was closed in March 2002 after the maternal grandparent was granted legal custody of this child.

Three years later, in September 2005, CPS received information the mother had delivered a baby and both had tested positive for marijuana. The baby weighed approximately 9 lbs at birth. The report was taken Information Only.

The mother again tested positive for marijuana when delivering the deceased child in February 2007. CPS intake was contacted and in addition to a positive drug test, it was reported the family's toddler had a scratch and a small bruise. The child's mother was not sure about the source of the bruise. She indicated the older child had not seen a doctor in the last year and was behind on his immunizations. The mother told the hospital she had had no prenatal care. The hospital social worker was concerned the mother and father would not follow-up with routine medical appointments for the newborn. Based on this information the report was screened in for investigation of possible neglect. Both announced and unannounced home visits were conducted during the CPS investigation. No serious and immediate safety issues were assessed. Urinalysis testing confirmed drug use by the parents. Prior to case closure, contact with the medical provider indicated no health concerns for either the infant or the sibling. The case was closed April 2007, unfounded for child maltreatment, moderately low risk.

In May 2007 a person watching the children reported that the decedent (at three-months of age) had a bad diaper rash and peeling skin and the parents had not provided diapers when they left the child. The child was later seen in the same diaper. The referent also alleged the children had recently been left alone for several hours in the motel room and the older sibling had fallen out of the motel room window (ground floor). The report was accepted for investigation of neglect. A CPS worker went to the residence and did not observe diaper rash, peeling skin, or scratches alleged to be on the children. The investigation finding was 'unfounded.'

The referral referencing the fatality was received on June 15, 2007, and included allegations of negligent treatment. During the course of the investigation into the infant's death the parents admitted to having placed the child in the car seat to sleep and put the car seat next to the heater in their motel room. The child was found deceased at 9:50 a.m. the following morning with radiant burns. Parents admitted to the use of drugs the evening before. Father used marijuana and mother used non-prescribed valium. Investigation into the allegations against the parents related to neglect regarding their child's death was 'founded.'

Four days following the infant's death on June 19, 2007 another referral was made alleging the surviving sibling had been hit in the stomach and on the head and had cigarette burns on his neck. It was unclear as to when such events had allegedly occurred. This referral was assigned a low risk tag and referred to an alternative response system. CPS social worker closed the fatality investigation and the subsequent June 19, 2007 referral and submitted to the CPS Supervisor for review. While awaiting final review by the CPS Supervisor another report of neglect was received by CPS on November 2, 2007.

Allegations in a November 30, 2007 referral noted the parents were using crack and marijuana in the presence of their surviving son. Allegations included the home was dirty, dishes stacked, dirty laundry about the house, and vomit on the floor. Despite repeated efforts to locate the family the social worker was unable to find them or see the child until June 2008. The family had apparently been homeless and been moving from place to place for several months. The child was seen recently and appeared healthy and the parents stated he has been seeing his primary care physician regularly. This case remains active.

Due to concerns about the circumstances surrounding the death of the infant and the safety of the 21-month-old sibling, CPS has initiated and developed a Safety Plan with the family. As part of the Safety Plan, a maternal aunt agreed to have the surviving sibling temporarily stay with her and not allow unsupervised contact with the parents. Although the parents refused to sign the Safety Plan, they did agree to the plan. Services such as Public Health Nurse, daycare for the surviving sibling, resources for locating suitable housing, and drug testing have been offered.

Issues and Recommendations

During this review good social work practice was commended and areas to improve on recognized. Some of the general areas needing improvement were engagement of the parents in services, and improving intake referrals and documentation. The difficulty in this case was when information was reported by referents it did not match up with what was being viewed by the social worker, thereby resulting in unfounded findings. Also, a general recommendation would be to engage clients in services, especially when drugs or alcohol is involved.

Issue: On February 17, 2007, CPS received a referral from a local hospital. While at the hospital delivering a baby girl (healthy, but mother testing positive for marijuana), the mother's toddler came to visit and was observed to have a bruise and scratch on his face. When asked about the injury to her older child, the mother indicated she did not know how he had gotten injured. The report was accepted for investigation.

The assigned CPS worker made contact four days later (extension for face-to-face granted by supervisor) with the mother, father, and the two children. The injury to the child was addressed with the parents who indicated they did not know how their son had gotten the

small bruise and scratch. The area of injury and type of injury would be consistent with accidental injury common with toddlers. Observation of the parent-child interactions was documented as appearing appropriate. The newborn was asleep but appeared fine. The worker discussed concerns for drug use, and the parents agreed to take drug tests (both tested positive).

The worker was provided with the name of the children's doctor and contact was made with the medical provider a month into the investigation. The worker confirmed the child had been seen for immunization and the infant had an appointment for late April. There was no documentation regarding general medical/health information for either child, although the worker did document the medical provider did not have any reportable concerns.

The family was receiving assistance through the department but no contact was made with the Community Services Office worker. Ethnic identity was asked and both parents indicated Native American ancestry. There is no documentation in the file to show that a Tribal search was initiated. Although information in the referral clearly shows mother had another child residing with a maternal relative, the worker appears to have not made any inquiry as to circumstances of this child no longer being in her care. While the parents continued to test positive for drugs or no-showed for requested drug tests, there was no documentation of referrals being made for substance abuse assessment or resources provided to the parents for chemical dependency services in the community.

The investigation was conducted in a timely manner, and the investigative findings (unfounded) appear to be supportable. The case was closed in mid-April 2007.

Recommendations/Actions: A "Lessons Learned from Child Fatalities 2006-2007" presentation is planned for the Tacoma CPS units in September-October 2008. At that time practice issues surfacing during recent child fatality reviews conducted in the Tacoma office, including this review, will be presented and discussed. This will include a general discussion on making collateral contacts such as with the CSO when there are shared clients, obtaining information regarding the general medical/health of especially young children on a case load, and inquiring with parents about the circumstances for which their other children are no longer under their care and custody.

Issue: On May 17, 2007, CPS received a report the 3-month-old infant had a bad diaper rash, with peeling skin and caked feces in folds of skin. Additionally, it was reported the children had been left in the motel room while the parents were upstairs celebrating a birthday. Other instances of leaving the children alone in the motel room were reported to have occurred in the past. The report was accepted for investigation, and the intake decision appears correct.

The assigned CPS worker conducted face-to-face contact within 24 hours. The social worker documented having observed the infant being changed during the home visit, and she did not observe any diaper rash or peeling skin. The diaper supply was found to be adequate. The toddler was observed to be very active, pulling out a dresser and trying to climb. The father denied the child had fallen out the first floor window, stating he had actually caught the boy trying to climb out after his mother who was leaving for work. The parents denied leaving the children unattended. The parents provided names of people who watch the children when both parents are at work. There is no documentation that any of the individuals identified were contacted by the worker except the person who had watched the children the day before. Although the investigation was still in the early stages, best practice would have included contact with the children's medical provider fairly soon into the investigation.

No other activity was documented until after the notification of the infant's death on June 15, 2007 approximately 30 days later.

Recommendations/Actions: A "Lessons Learned from Child Fatalities 2006-2007" presentation is planned for the Tacoma CPS units in September-October 2008. At that time practice issues surfacing during recent child fatality reviews conducted in the Tacoma office, including this review, will be presented and discussed. This will include a general discussion on making collateral contacts, contacting the referent, and seeking information from medical providers as to the general medical/health of especially young children on a case load as a routine expected practice.

Issue: On June 15, 2007, Central Intake received notification from the Pierce County Medical Examiners Office (PCMEO) of the death of the four-month-old infant. The infant had been found non-responsive in the morning after having been put down to sleep in a car seat on the floor of a motel room. The referral was assigned for investigation. The worker appears to have met most policy and basic practice expectations regarding conducting a CPS investigation. Face-to-face contact was made with the parents and the surviving sibling the same day as the report was taken. Law enforcement was already on scene, and collaboration was initiated at that point.

The Safety Assessment indicated safety issues were such that the surviving sibling needed to be out of the home. Under a Safety Plan (SP) the child went to stay with a relative. Utilizing relatives as short-term placement resources is encouraged, but any placement developed by Children's Administration (CA) should afford the relative with structure and support needed to adequately protect and care for the child, even on a short term basis. The use of an unenforceable agreement such as a SP to protect the child is questionable and does not provide CA with required legal authority for placement.

The worker requested medical records for the older sibling following an additional referral (post fatality) in which there were allegations the child may have recently been physically

abuse, including a burn. However, there was no similar request for the medical records of the deceased child. There was continued effort to obtain information from law enforcement until the criminal investigation ended without charges.

It is not clear as to the basis for a finding of founded for neglect in the pre-fatality referral dated May 2007. It is believed to be a clerical error as neither parent was founded as a subject for the allegations in the May referral. However, the finding of founded for neglect as to the infant and the circumstances surrounding her death appear supportable. The leaving of the child too close to the heater for a long period of time, resulting in hyperthermia, may have been unintentional. However, the parents' actions created a substantial risk of injury to the child and thus the finding meets the definition of negligent treatment (WAC 388-15-009).

The case was closed in early November 2007 by the worker and sent for supervisory review for closure. The Structure Decision Making assessment indicated a risk level not requiring consideration for keeping the case open for services. However, given the continued drug use by both caretakers, instability of the family living situation, and continued concerns from others about the care of the surviving sibling, best practice would have been for the worker to present the case to her supervisor for consideration of an override decision and transferring the case to voluntary services rather than closure.

Recommendations/Actions: On May 20, 2008 a Regional Expectation memo was issued by the Region 5 Regional Administrator regarding voluntary placements and clarifying informal relative placement issues. The memo states in situations where it is believed child safety can only be assured by having the child leave the home; there are three options open to social workers: a signed Voluntary Placement Agreement (VPA), Protective Custody, or court order.

Issue: Although not a focus in the fatality review, an anonymous referral subsequent to the fatality was received at Central Intake (CI) on November 30, 2007. The referral was changed from information only to accept for investigation (moderate high) on December 3, 2007 and then sent to the Tacoma field office. During the fatality review it was noted CI does not begin counting the 72-hour face to face requirement until the referral has been sent to the field. The 72-hour face to face requirement for field response time begins at the time the referral is created, not from when it is completed and sent out by CI. So when there is a delay in making the intake decision, it becomes problematic for field offices as such situations are then identified for data collection purposes as having failed to meet the 72-hour face to face requirement.

Recommendations/Actions: It is believed that this issue is being addressed by CA and Central Intake. It is recommended that effort to address this issue continues until resolution is attained.

Child Fatality Review #07-58
Region 4
King West Division of Children and Family Services (DCFS)

This two-month-old African American child died from Sudden Infant Death Syndrome (SIDS).

Case Overview

On October 22, 2007, the King County Medical Examiner reported the child's death to Children's Administration Intake. The official cause of death listed for this two-month-old infant is SIDS. Deputies from the King County Sheriff's department also investigated. The police detective reported the deceased child, his mother, father, and 16-month-old sister were all sleeping in the same bed when the child was found deceased around 4:30 a.m. The mother was 18-years-old at the time of her son's death. The father was 17-years-old and a state dependent. The deceased child's mother had no prior referral history as a parent, prior to the death of her son. The mother is listed as the daughter of a former foster parent. The deceased child's father was on a Child Welfare Services (CWS) caseload at the time of his son's death. He has a history of over ten years of dependency legal actions in which the state placed him in out-of-home care and established legal jurisdiction. He was on probation for assault, had substance abuse issues (marijuana) and had difficulty making progress in school. His foster mother worked with him and was a major source of structure and support.

The investigating detective reported there was no evidence of foul play as far as the infant's fatality. The mother's 15-month-old child was temporarily with her father. When he heard about the fatality he came and got his child. There was no indication there was any risk to this child.

Referral History

On October 22, 2007, CA intake received the report of the death of this two-month-old infant. The assigned Child Protective Services (CPS) social worker made multiple attempts to contact the family, but was unsuccessful. There was no finding and the case was closed as Unable to Locate the Family. According to the King County Sheriff's Office (KCSO), the apartment complex where the mother lived has a lot of gang activity.

The death of this infant also resulted in a licensing complaint concerning the father's foster mother. A Division of Licensed Resources (DLR) licenser concluded the complaint was not valid for nurture and care issues. The licenser found that the foster mother was very attentive to the father's needs. The foster mother did her best to set limits with him, and would always contact his social worker when she found that he had left during the night. He did not have the permission of the social worker or foster parent to spend the night with his girlfriend.

On February 10, 2008, the deceased child's mother was at a Seattle area hospital being treated for injuries sustained in a DV incident. The mother said this incident occurred in front of her daughter. The referral was assigned for investigation to the same office and worker that had been assigned the referral in October. Again the worker closed the investigation without a finding, noting that he was unable to locate the family.

Issues and Recommendations

Issue: The social worker assigned to the father has been very supportive to him, both before and after the death of his son. She has worked closely with the foster parent to provide appropriate structure and services.

Recommendation: None

Issue: Incomplete investigations. The investigations were assigned to a different office (per the regional plan at that time), but they were not completed and no findings were entered.

Recommendation: The program manager will follow up with the supervisor and worker to review the investigations. (Request for meeting was made on June 9, 2008)

Issue: The mother of the deceased child has been receiving intensive Public Health Nursing services since she became pregnant with her first child. This includes an in-home visit by the nurse, every two weeks. The program is called the "Nurse-Family Partnership" (NFP) and is available to first-time mothers who are under age eighteen. Services continue until the child is age two. The mother also used Public Health for the deceased child's health care needs. He was doing well and had gained weight appropriately.

The NFP nurse did note the sleeping arrangements during a home visit and did provide safe sleep information to the parents. The nurse has continued to provide grief support to the parents.

Recommendation: Wherever this program is available, social workers should refer pregnant teens.



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Child Fatality Review #08-01
Region 2
Richland Division of Children and Family Services (DCFS)

This eight-year-old medically fragile Caucasian male died from liver failure.

Case Overview

The deceased child was admitted to the hospital on January 15, 2008. He was lethargic and vomiting. He aspirated on his vomit. He remained hospitalized for several days. While in the hospital, his liver functions suddenly declined. The doctors treating the child indicated an infection may be the source of his liver failure. The child died on January 28, 2008. The cause of death is listed as liver failure. The child had a history of multiple admissions into the pediatric intensive care unit. The deceased child was medically fragile. He had severe cerebral palsy, a seizure disorder, and frequent pneumonia brought on by vomit aspirations. The child's doctor reported the child was born missing part of his brain. Just prior to his death, the child had pneumonia and was being treated on an outpatient basis. The doctor had no concerns that the child was neglected by his parents. A public health nurse who worked with the family reported she had absolutely no concern about the level of care provided to the child.

Referral History

On March 23, 2001, a social worker with the Division of Developmental Disabilities (DDD) expressed concern that the deceased child's parents gave him water, causing him to have seizures. The parents were previously instructed not to give him water. The referent reported the parents were following through with all other services and needs to child. The referral was screened as information only.

On October 23, 2002, the deceased child needed seizure medication and mother told medical professionals that she did not feel child had a seizure disorder. It was alleged the child's medical needs were not being met. The referral was screened in for investigation by Child Protective Services (CPS) and closed as inconclusive.

On January 7, 2008, a nurse working in the home reported she observed the seven-year-old sister of the deceased child drink beer with the consent of her parents. She assumed that the deceased child was given alcohol through his G-tube. The referral was screened in for investigation by CPS and closed as unfounded.

Issues and Recommendations

Issue: Regarding the referral dated January 7, 2008, the home health care nurse observed the alleged abuse on January 4th; the referral was not made to Children's Administration

until January 7th. The health care agency admitted that their staff should have reported concerns of alleged child abuse and neglect (CA/N) earlier to intake. Mandatory reporting laws need to be followed when CA/N is suspected.

Recommendation: Clarification of mandatory reporting laws were provided to all review members. The home health care agency will contact their local Children's Administration office for a CPS presentation for their staff.