Report to the Legislature

Quarterly Child Fatality Report

RCW 74.13.640

January - March 2008

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Children's Administration Quarterly Child Fatality Report

Executive Summary

This is the Quarterly Child Fatality Report for January through March 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 2 completed fatality reviews from fatalities that occurred in 2006 and 2007. All were reviewed by a regional Child Fatality Review Team.

The reviews included in this quarterly report discuss fatalities from Regions 2 and 4.

Region	Number of Reports
1	0
2	1
3	0
4	1
5	0
6	0
Total Fatalities Reviewed During 1st Quarter, 2008	**2**

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.

An Executive Child Fatality Review by policy is a special review convened by the Assistant Secretary for Children's Administration. The Executive Child Fatality Review may be requested when a dependent child dies as a result of abuse and/or neglect by their parent or caretaker, or a non-dependent child dies of abuse and/or neglect on an open, active case, when Children's Administration (CA) has had an open case or provided services to the family or child from the within 12 months of the fatality, or in a licensed facility. In the Executive Child Fatality Review, members of the review committee are individuals who did not have any involvement in the case and represent areas of expertise that are pertinent to the case. Committee members may include legislators or others as determined by the Assistant Secretary.

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	44	18
2007	54	1	53
2008	12	0	12

The numbering of the Child Fatality Reviews in this report begins with number 06-44. This indicates the fatality occurred in 2006 and is the 44th 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.

Recommendations made by the child fatality review team are included in this report verbatim.

Child Fatality Review #06-44
Region 2
Yakima Division of Children and Family Services (DCFS)

This two week old Caucasian infant died of a severe lung condition due in part to being born 11 weeks premature. The infant's mother tested positive marijuana at the time of her birth.

Case Overview

The parents are migrant farm workers who moved from California to Washington for work. While in Washington, the mother required an emergency caesarean section and delivered her baby 11 weeks premature. The infant had a severe lung condition as a result of premature birth. The mother tested positive for marijuana while in the hospital. The mother agreed to participate in a drug/alcohol assessment.

The infant was taken to University of Washington hospital and the parents went to Seattle to be with their daughter. They stayed in Seattle until their daughter died on July 16, 2006. The parents moved to Montana directly from Seattle without returning to Yakima. The mother did not participate in a drug/alcohol assessment nor engaged in any other services. The mother reported she had a son who was staying with relatives in Idaho. The DCFS case was closed as the family moved out of state.

Referral History

There was one prior referral on the family. This referral was called in to CA intake shortly after the mother delivered her baby. On July 3, 2006, Children's Administration (CA) intake was notified by a hospital social worker that the mother gave birth to the deceased child 11 weeks premature. She also tested positive for marijuana. No toxicology results were available on the infant. Doctors requested CPS involvement with this family. The family recently came to the Yakima area from Redding, California to pick fruit. There was no other known history. This referral was accepted for investigation by Child Protective Services (CPS) and closed as unfounded.

Issues and Recommendations

Issue: No issues were identified by the review team.

Recommendation: None.

Child Fatality Review #07-01
Region 4
Region 4 ICW

This sixteen-year-old Native American youth died of accidental overdose.

Case Overview

The youth was arrested by the Seattle Police Department on January 19, 2007 on a warrant stemming from drug charges. In the holding area at detention, he began convulsing. He was taken to Harborview and died on January 21, 2007. The King County Medical Examiner ruled the cause of death as anoxic encephalopathy (brain damage related to lack of oxygen) due to cocaine and alcohol intoxication. The youth swallowed a plastic bag of cocaine. The manner of death is accidental.

Referral History

The family has extensive history with the department. DCFS case files contain extensive documentation about social workers' effort to help the family. Services were provided to the family, including Family Reconciliation Services (FRS), Family Preservation Services (FPS), individual and family counseling, multiple placements and independent living. Both boys have behavior problems, and most placements ended because of their ejection due to non-compliance or running away. Both had substance abuse and anger management problems, and both have come in contact with the criminal justice system.

On December 8, 2000, a referral alleged the decedent's sibling, then age twelve, told a public librarian he had been kicked out of the home, was being beaten by his father and expressed fear of returning home. Seattle Police Department (SPD) responded, took him home and spoke with the parents, who said they were in counseling. The referral screened for Child Protective Services (CPS), low risk.

On February 6, 2002, a referral to Children's Administration (CA) intake alleged the, then fourteen year old brother of the deceased, who claimed he was physically abused by the mother three years prior. This referral screened for CPS, low risk.

On November 7, 2002 the youth's mother called the department asking for services as her then sixteen year old son was refusing to attend school, was defiant and had violent/destructive behavior. This referral was screened for Family Reconciliation Services (FRS).

On November 8, 2002 the deceased youth (then thirteen years old) contacted the department requesting to stay at a youth care shelter. He reported his mother's boyfriend had beaten him for the past eight years. He disclosed other family violence. The family was living in a homeless shelter. This referral was screened for CPS, low risk.

On November 12, 2002, SPD broke up a physical fight between the mother and her children. Three of the children and the mother had injuries. The referral was screened for CPS and investigated. The investigation was unfounded for neglect.

A referral dated November 21, 2002 was reported to CA intake. The assigned FRS social worker reported a number of violent incidents between the siblings as well as the mother. This referral was screened for CPS and assigned for investigation. There were also neglect concerns. This was investigated and unfounded.

On February 25, 2003, the mother called requesting an assessment for the, then fourteen year old, sibling of the deceased. The mother wanted to apply for a Child In Need of Services (CHINS) petition. She reported he was out of control, assaultive, angry, and refused to go to school. This referral was screened for Family Reconciliation Services (FRS).

On October 22, 2003, the youth's mother requested the department complete a family assessment in order to file a CHINS petition on her daughter. She refused to attend school and was physically abusive to her mother. The referral was screened in for FRS

On April 9, 2004, a probation officer from King County Juvenile Court reported the youth was in detention for stealing a car. The court ordered the youth placed in DCFS care and evaluated. The referral was screened for Child Welfare Services (CWS).

On September 3, 2004, a police officer reported that he had picked up the youth, then age fifteen. The youth told the officer his mother had recently moved and he did not know the address. This referral was assigned to FRS.

On October 22, 2004, a juvenile probation officer reported that the decedent's seventeen year old brother was placed in detention for possession of rock cocaine. This referral was screened for CWS.

On December 1, 2004, a juvenile probation officer reported the youth had been in detention for a gun charge. The probation officer was requesting DCFS place the youth. The youth's aunts and the mother refused to take him. This screened was screened for CWS.

On December 7, 2004, a juvenile probation officer reported the decedent's brother was in detention. A judge ordered CA assess him for placement and report back. This referral was screened for CWS.

On January 25, 2005, a juvenile probation officer reported the youth ran away from his mother's home on January 18, 2005. He was picked up by police and charged with drug possession. He was released to DSHS custody. This referral was screened for CWS.

On March 8, 2005, a juvenile probation officer reported that the decedent's brother was to be released from detention on March 11, 2005. The mother moved and did not leave a forwarding address. She did not return his phone calls. The probation officer was advising CA that the child may need to placement if the mother did not respond. The referral was screened for CWS.

On March 9, 2005, a juvenile probation officer (P.O.) reported from King County Juvenile Court reported the youth was to released from detention on March 17, and the P.O. is unable to reach the mother. The referral was screened for CWS.

On March 10, 2005, a juvenile probation officer reported the youth's mother did not want to pick him up from detention and was willing to sign a Voluntary Placement Agreement. The referral was screened for CWS.

On May 8, 2006, the youth called to request filing a CHINS petition. He was living at a youth shelter working with a chemical dependency counselor, a drug court advocate and a probation officer. The referral reads the youth had been out of his family home for four years. This referral was assigned to FRS. The FRS case was closed on June 22, 2006. Contact was made with the youth's tribe in Montana about case planning. The tribal social worker reported the Tribe had no intention of intervening in the case. The Tribe was involved in case planning.

On June 29, 2006, the decedent's fifteen year old sister was picked up by police as a runaway. This is the last report concerning this family before the youth died on January 21, 2007. This referral was assigned to FRS. The DCFS case on the sister was open at the time of her brother's death. The case on the deceased youth was closed at the time of his death.

Issues and Recommendations

Issue: Closer collaboration with Juvenile Court. The youth received services at Juvenile Court, including probation and detention, as well as services through DCFS. Both the King County Service Integration Initiative and the working agreement between Region 4 DCFS and the juvenile court emphasize the need to work together when we share clients.

Recommendation: When working with juvenile court and other agencies with clients in common, invite them to shared planning meetings.

Issue: Identification of substance abuse problems. The youth's substance abuse problems were severe and started at a very young age. According to probation however, he did receive extensive treatment, but did not maintain sobriety.

Recommendation: Follow the new (2007) practice and policy of screening adolescents for mental health and substance abuse problems, with the Global Appraisal of Individual Needs - Short Screener (GAIN-SS) tool. Use outstationed chemical dependency professionals (CDPs) for consultation, screening and referral.

Issue: Chronicity as this family had multiple referrals for all major programs.

Recommendation: Use more shared planning and case review tools to help get the best assessment of service needs for the family.