Report to the Legislature

Quarterly Child Fatality Report

RCW 74.13.640

January - March 2010

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Children's Administration Quarterly Child Fatality Report

Executive Summary

This is the Quarterly Child Fatality Report for January through March 2010 provided by the Department of Social and Health Services (DSHS) to the Washington State Legislature. RCW 74.13.640 requires DSHS to report on each child fatality review conducted by the department and provide a copy to the appropriate committees of the legislature:

> ***Child Fatality Review - Report***
>
> *(1) The department of social and health services shall conduct a child fatality review in the event of an unexpected death of a minor in the state who is in the care of or receiving services described in chapter 74.13 RCW from the department or who has been in the care of or received services described in chapter 74.13 RCW from the department within one year preceding the minor's death.*
>
> *(2) Upon conclusion of a child fatality review required pursuant to subsection (1) of this section, the department shall within one hundred eighty days following the fatality issue a report on the results of the review, unless an extension has been granted by the governor. Reports shall be distributed to the appropriate committees of the legislature, and the department shall create a public web site where all child fatality review reports required under this section shall be posted and maintained.*
>
> *(3) The department shall develop and implement procedures to carry out the requirements of subsections (1) and (2) of this section.*

This report summarizes information from 14 completed fatality reviews of fatalities that occurred in 2009. Thirteen of the child fatalities were reviewed by a regional Child Fatality Review Team.

There was one Executive Child Fatality Review completed during the first quarter of 2010. All prior Executive Child Fatality Review reports are found on the DSHS website: http://www.dshs.wa.gov/ca/pubs/fatalityreports.asp.

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

Region	Number of Reports
1	3
2	0
3	6
4	0
5	2
6	3
Total Fatalities Reviewed During 1st Quarter, 2010	14

Child Fatality Reviews are conducted when children die unexpectedly from any cause and manner 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 from a natural cause or accidental), to a larger multi-disciplinary committee where the child's death may have been the result of abuse and/or neglect by a parent or guardian.

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

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

The chart on the following page provides the number of fatalities reported to CA, and the number of reviews completed and pending for calendar year 2009. The number of pending reviews is subject to change if CA learns new information through reviewing the case. For example, CA may learn that the fatality was anticipated rather than unexpected, or there is additional CA history regarding the family under a different name or spelling.

Child Fatality Reviews for Calendar Year 2009			
Year	Total Fatalities Reported to Date Requiring a Review	Completed Fatality Reviews	Pending Fatality Reviews
2009	59	45	14

The numbering of the Child Fatality Reviews in this report begins with number 09-31. This indicates the fatality occurred in 2009 and is the thirty-first report completed during that calendar year. The number is assigned when the Child Fatality Review and report by the Child Protective Services Program Manager is completed.

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

Child Fatality Review #09-31
Region 3
Skagit County

This 16-year-old Native American female committed suicide.

Case Overview
On August 10, 2009, this youth's body was found late at night hanging from a rafter in the carport of the home of her boyfriend's grandmother. She and her boyfriend were staying at the home on and off. She left a suicide note. The youth's boyfriend discovered the note which caused him to search for her. The boyfriend's grandmother was home at the time of the incident. CPR was begun, but she was declared dead at the scene. The youth was four months pregnant at the time.

Children's Administration (CA) had an open dependency case on a younger sibling in this family at the time of the youth's death. CA social workers were not actively working with the deceased youth as she had moved out of the family home in September 2008 and was living with an adult brother. A few months prior to her death, she moved in with the grandmother of her boyfriend.

In November 2008, CA received a Child Protective Services intake (CPS) regarding a domestic violence (DV) incident in the home. The incident took place in the presence of the nine-year-old sister and a dependency petition was filed subsequent to the incident. CA social workers were working with the parents to address safety concerns in order to regain custody of their youngest daughter.

Intake History
On January 21, 2004, CPS intake received a report from staff at an elementary school alleging the deceased youth's sister, then five years old, had a bruise on her face that was believed to be from being hit by her mother. The intake was investigated and closed with an unfounded finding. Both the child and mother denied abuse when interviewed.

On August 24, 2007, law enforcement reported to CPS intake that the deceased youth, then 14 years old, was placed in protective custody. She had an altercation with her mother over her staying out too late. She told police she was afraid to return home. Her mother recently completed drug/alcohol treatment but was reported to be abusing prescription medication. The parents were constantly fighting. The officer believed the home situation too unstable for the deceased youth at that time. This investigation was closed with an inconclusive finding for negligent treatment or maltreatment.

The youth was placed with her adult brother. Social workers made multiple attempts to get the parents involved in chemical dependency treatment and urinalysis. The parents did not participate in services.

On August 27, 2007, the deceased youth's mother called CPS intake to request Family Preservation Services (FPS) services to assist with behavior issues with her oldest daughter, then 15 years old.

On September 13, 2007, the deceased youth's 15-year-old stepsister came to the Children's Administration office to report that her parents were using drugs in the presence of the children in the home. The assigned social worker attempted referrals to FPS and mental health. The youth's sister and parents were not cooperative with services. The stepsister eventually left the home and moved in with a relative. An intake was created and the report was screened in for investigation. This investigation was closed with an inconclusive finding for negligent treatment or maltreatment.

On June 16, 2008, CPS intake received a report that the deceased youth, then age 15, was temporarily detained to an inpatient mental health treatment after a recent suicide attempt. She had left a note at home and went to a bridge, apparently with the intent of jumping off. She was found by her stepfather at the railing of the bridge. He convinced her not to jump. The parents called 911. The parents reported she had an earlier suicide attempt. This intake was screened in for investigation.

The deceased youth told staff at the mental health treatment center that her parents abused prescription medication and had on occasion given her marijuana. She said that her 18-year-old boyfriend periodically lived in the family home and that they were sexually active. The parents denied allowing the boyfriend to live in their home.

On investigation, the investigating social worker found that the parents had been informed that the deceased youth was in need of mental health treatment, medication, and supervision due to her mental health issues. However, they did not follow through with meeting the child's mental health needs. The CPS investigation was completed with a founded finding for negligent treatment or maltreatment against the parents.

The deceased youth was released from the mental health facility to her maternal grandmother. A mental health professional created a self harm safety plan with the deceased youth. As part of the detention order, she was further court ordered to participate in counseling through December 2008. She complied with this court order. The youth eventually moved back to her parents' home.

A case remained open on the family under Family Voluntary Services. Services were provided to help the family avoid becoming homeless. The parents were taking the deceased youth to counseling and meeting with a psychiatrist. Family Preservation Services (FPS) was provided to the family at this time.

On June 17, 2008, a neighbor contacted CPS intake to report that the parents of the deceased youth were heavy drug users. The nine-year-old sister of the deceased youth

was still in the home. The referrer reported she had good hygiene. This intake was screened as information only.

On June 20, 2008, CPS intake was contacted by a staff member at a mental health counseling center where the deceased youth was in therapy. The referrer was concerned about safety and welfare of the deceased youth and her nine-year-old sister. It was alleged that the girls' basic needs were not being met due to the use of methamphetamine and alcohol by the parents. A staff member reported the mother appeared to be sedated or over medicated during a recent family meeting. The deceased youth told staff she did all the cooking, chores and sometimes had to get her little sister to school, as her parents are frequently unable due to drug use. This intake was screened for the Alternate Response System.

On July 9, 2008, CPS intake received a report from a doctor. There was a concern that no one was monitoring the deceased youth's medications after her recent suicide attempt in June 2008. The parents were unable to monitor appropriately as they were heavily involved in drugs/alcohol. The CPS investigation was closed with a founded finding for negligent treatment or maltreatment. The case was transferred to the Family Voluntary Services unit for monitoring of services. At that time, the deceased youth's 15-year-old sister moved in with her paternal grandparents.

In September 2008, the FPS provider working with the family reported the deceased youth ran away from her parents' home and went to the home of her adult brother. She never returned to live with her parents. She was attending school.

On November 20, 2008, CPS intake received a report from law enforcement. The deceased youth's parents were in a domestic violence incident in front of their nine-year-old daughter. The incident ended with a stabbing and attempted suicide by the mother. She was taken away by law enforcement to a hospital for a mental health evaluation. The deceased youth's stepfather left that evening with the children, but returned when his wife was released from the hospital. The deceased youth was living with her adult brother at the time of this incident.

On November 28, 2008 a dependency petition was filed on the nine-year-old because of the parents' history of non-compliance with services. A dependency petition was not filed on the deceased youth or her older sister as they were out of the parents' home for some time. The parents previously participated in FPS services but failed to be actively involved in changing behaviors. Both parents admitted their weakness as parents and have expressed a desire to change but neither has taken steps to achieve change.

The parents eventually participated in services and for the last few months prior to their daughter's death, were involved in treatment and provided clean urinalyses. During this time, the deceased youth had left her brother's house and was staying at the home of her

boyfriend's grandmother. She would occasionally stay with her parents for brief periods of time.

The record indicates that the day before the fatality the deceased youth was at her parents' home. The deceased youth's mother reported her daughter appeared happy in the days prior to her death. She re-filled a prescription for her mood stabilizing anti-depression medication, though she stopped taking this medication three days before her death out of concern for her unborn child. She did not talk to her therapist about this.

She got into an argument with them and returned to her boyfriend's grandmother's house, where she died on August 10, 2009.

Issues and Recommendations

Issue: After reviewing the record, the team agreed that there was likely not sufficient cause for a dependency petition to have been filed on the deceased youth at the time of the filing on her nine-year-old sister. However, it was also agreed that the circumstances of the older two girls should have been more clearly assessed and documented at the time.

Also, during the time of the dependency on the younger sister, while working with the parents in their services, the department did have information that the deceased youth was staying sometimes in the parents' home with her boyfriend, but again did not pursue this information to assess her situation, but proceeded only with the plan for the nine-year-old sister.

Recommendation: This issue should be addressed in the next training Region 3 does on "Lessons Learned" from child fatality reviews, or incorporated into other training in the region. The team believed that it would benefit social workers to have clarification of the extent of their responsibility toward children in the home other than the one(s) specifically identified as at-risk.

Issue: There was agreement in the team that the large number of workers assigned to this case at various times throughout the life of the case contributed to the family being viewed only in episodic fragments, and the whole picture of the situation was not clearly in focus until after the fatality.

Recommendation: There should be continuing emphasis in training on each worker assigned to a case thoroughly reviewing the whole history of the case.

Child Fatality Review #09-32
Region 6
Clallam County

This two-month-old Native American male died from cardiac arrest.

Case Overview
On July 26, 2009 the deceased child stopped breathing while in his foster home. The foster mother called 911 and began performing CPR and used a defibrillator. The foster parent was trained on how to do infant CPR and use a defibrillator to shock his heart if necessary. The child was transported to the hospital and later pronounced dead.

The deceased child struggled with significant medical issues from the day of his birth. He was born with Timothy's Syndrome, a rare genetic disorder that resulted in webbed hands and feet and significant complications with the child's heart and kidneys. The deceased child was further diagnosed with Long QT Syndrome, which is also a rare congenital disorder of the heart's electrical activity. Long QT can result in sudden, uncontrollable and fatal heart rhythms (arrhythmia) in response to exercise or stress. The fatality rate in these cases is very high. This child was not expected to live past his fifth birthday. Due to his extreme medical issues, it was important that he was kept calm in a quiet environment.

The day after his birth, the child was airlifted from Olympic Memorial Hospital in Port Angeles to Seattle Children's Hospital Medical Center. The deceased child remained in Children's Hospital until June 30, 2009 when he was released to the foster home. The deceased child was in foster care for less than a month when he died.

Children's Administration (CA) had an open case on this child at the time of his death.

The deceased child was born to his teen mother in May 2009. The mother and her family struggled with issues related to parental substance abuse, neglectful home environment, domestic violence and truancy. At the time of his birth, the deceased child's mother was in foster care under a Child in Need of Supervision (CHINS) petition. The deceased child's father turned 18 after the birth of his son. He too spent time in foster care, but declined the option to sign himself back into care when he turned 18.

While the deceased child was in Children's Hospital, the department worked with his mother to provide her with a placement closer to the hospital so she could be with her baby as much as possible. Due to allegations of domestic violence between the mother and father, their contact was closely supervised.

Neither parent was able to fully care for their son and as a result of his extensive needs. The mother and child could not be placed together because the foster home could only

accommodate this child. Medical personnel stated that the deceased child needed to be placed in an environment free from stress or illness because of his risk of sudden death. A dependency petition was filed and the child was placed into foster care following his release from Children's Hospital.

Intake History on the Child's Family

On May 19, 2009, CPS intake received a report from law enforcement indicating the deceased child's mother, then 15 years old, was afraid to go home and worried about the safety of her unborn child. Police officers met her at a neighbor's home. She went there after her younger teen brother threatened to shoot her with a BB gun. The maternal grandmother arrived and police attempted unsuccessfully to reconcile the situation. The maternal grandmother had substance abuse issues and the home was dirty. Police put the teen in protective custody. The deceased child's mother was assisted in filing a CHINS petition. The intake was investigated and closed with an unfounded finding for negligent treatment or maltreatment. The family was provided counseling and Home Based Services to address the conflict in the home.

In May 2009, hospital staff reported the birth of the deceased child. Hospital staff reported he was born with "high risk" medical issues related to birth defects. The child was placed on a medical hold. The intake was accepted as a high risk intake. The child was transferred to Children's Hospital and remained hospitalized for one month.

On May 28, 2009, a new intake was created by social workers working with the deceased child's mother. The child was born with webbed fingers and toes and had a congenital heart defect and difficulty with his kidneys. He was air-lifted to Children's Hospital. The hospital social worker reported the deceased child's prognosis was not favorable. The child also was diagnosed with Long QT Syndrome. The hospital social worker stated that the child needed an environment where he is not startled or over-stimulated. Any indication of distress or illness must be responded to immediately.

The hospital social worker said the information about the home environment of the maternal grandmother suggested it was not a safe, stable environment for this child.

A dependency petition was filed on this child on June 2, 2009. The child was in Shelter Care status at the time of his death.

The assigned social worker completed a 30 Day Health and Safety visit two days prior to his death. He was gaining weight appropriately and was seen by his cardiologist one week prior to his death.

On July 26, 2009, the foster mother contacted the assigned social worker to report the child quit breathing in the morning. They called 911 and he was transported to the local hospital. He was pronounced dead later that day.

The foster home where this child was placed at the time of his death had eight intakes reported to CA between July 8, 2008 and July 26, 2009. The majority of the intakes involve licensing complaints with several of the complaints being from one parent of a child who was previously placed in this foster home. All of the referrals involving her child were investigated by licensing and were found to be not valid.

One licensing intake, dated March 5, 2009, was found to be valid. The foster mother transported a child to a visitation and took the child into the home. In doing so, she left two children, ages two years and seven months, in the car unattended. The foster mother worked with her foster care licensor to resolve this issue.

There was one prior investigation conducted by the Division of Licensed Resources/Child Protective Services (DLR/CPS) section. On July 13, 2009, it was reported to CA intake that the foster mother misplaced this child's defibrillator for two days and allowed a former foster child and her mother to be around the child for a few hours. The child's cardiologist was contacted during the investigation and noted it was not a concern that the defibrillator was missing if the caretakers knew CPR. The foster parents are trained in CPR and had specialized training to operate the defibrillator. The foster father cleaned the home and did not mention to his wife that he put away the defibrillator. The foster parents followed through with the child's medical plan.

Issues and Recommendations
Issue: The review team did not identify any issues or recommendations.

Recommendation: None

Child Fatality Review #09-33
Region 5
Kitsap County

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

Case Overview
On July 31, 2009, the mother of this nine-month-old child dropped him off with his father. The parents lived separately due to a No-Contact Order. The child's mother returned to the father's home later that day. The mother recalled that she and the father played with their son and about 8:00 p.m. they fed the infant and then put him down to sleep. The infant was in his car seat as there was no crib where they were staying. Both parents put him in a room upstairs and then went downstairs to watch a movie with the father's roommates.

At about 10:30 p.m. they went up to check on him and noticed that his arms were under the straps of the car seat and he was not breathing. They had not heard any noises. Witnesses interviewed separately confirmed the account provided by the parents. Emergency Response (911) was called and residents of the home were performing CPR when EMS arrived. Bremerton Police also responded. The infant was transported to the local hospital where he was declared deceased at 11:13 p.m.

The Kitsap County Coroner ruled the death to be accidental. The cause of death was asphyxiation related to head/neck position in the car seat. Toxicology results were negative.

The relationship between the child's parents included accusations of domestic violence and numerous law enforcement responses. A No-Contact Order was in place at the time of the child's death, but both parents were ignoring the order.

It is noted that there is no evidence that domestic violence played a role in the circumstances of the fatality incident.

Children's Administration (CA) did not have an open case on this family at the time of the child's death. Two weeks prior to the child's death, CA intake received a report from law enforcement that the parents argued over custody of their son and the mother was arrested for violating a No-Contact Order. This intake was screened as Information Only.

Intake History
On June 10, 2009, CPS intake received a report of a domestic violence incident between the parents of the deceased child. The child was in close proximity. The child's mother was arrested. The mother was later released from jail and moved in with a friend. A No-Contact Order was put in place. The intake was screened in for investigation. The

assigned social worker was unable to locate the parents or the child. The investigator was provided several possible addresses for the mother and the father. The investigator contacted the Kitsap County Jail and reviewed DSHS records for current addresses of the parents. Eventually a letter was sent to the mother's last known address. None of these attempts were successful. The CPS intake was closed without a finding.

On July 17, 2009, law enforcement contacted CPS intake to report the mother was arrested for violating the No-Contact Order. Law enforcement was called to the home as the parents were in a verbal dispute over custody of their son. Police officers determined the parents were living together. The mother was arrested for violating the No-Contact Order. This intake was screened as information only.

On August 1, 2009, CA intake received a report of the death of this nine-month-old infant. The child was at his father's home, where he lived with a friend. The mother visited the home and brought the child with her. The adults in the home watched a movie while the child slept strapped in his car seat. The parents checked on him around 10:30 p.m. and found him not breathing. The child slid down in the car sear and his throat was against the chest buckle. This intake was screened in for investigation by CPS. The investigation was closed with an unfounded finding for negligent treatment or maltreatment. The parents have no other children.

Issues and Recommendations

Issue: All three intakes involving the deceased child's family were reviewed. This included the June 2009 intake (screen in) taken by Central Intake (CI), a screen out taken by Bremerton intake regarding the mother's arrest for violation of a No-Contact Order (mid-July 2009), and the fatality notification in late July 2009. Upon review, final screening decisions were found to be reasonable and supportable. After the Child Fatality Review (CFR) the CI Program Manager was informed of the review committee's recognition of good intake practices.

Recommendation: None

Issue: The CPS investigation initiated six weeks prior to the accidental death of the deceased child was in process of being closed due to an inability to locate the family. While recognition was made to the numerous documented activities by the worker to locate mother, infant, and the father, the panel reached full consensus that additional efforts to locate the family could have been made per the Children's Administration "Guidelines for Reasonable Efforts to Locate Children and/or Parents" (07-19-05). The CPS investigator was not able to participate in the review. The supervisor was also unable to participate due to illness. Both received feedback post-review as to good practice and where practice might have been improved.

Recommendation: None

Comment: The CA "Guidelines for Reasonable Efforts to Locate Children and/or Parents" has been available to all CA staff on the CA intranet since statewide CA policy training in July 2005 regarding the 24/72 hour response standards. It is also known that the guidelines have been disseminated to the Bremerton CPS units on at least two occasions in 2009 as practice refreshers for investigators. In late December 2009 CA made it easier for CPS workers to find the guidelines by placing the "Protocol to locate children and parents" in the CPS Program section of the CA intranet (http://ca.dshs.wa.gov/intranet/sw/cps.asp).

Issue: The CPS worker who had previously failed to locate the family was assigned to investigate the child fatality event. In the course of meeting with the grieving parents, the worker inquired as to the prior allegations (including domestic violence) as well as to the circumstances surrounding the child's death. Both the mother and the father were interviewed together regarding the intimate partner violence, which is not consistent with recommended practice of interviewing partners separately. The worker might also have considered obtaining the police report for the domestic violence incident from May 2009 or obtain a copy of the No-Contact Order to review specific conditions.

Recommendation: None

Comment: A CA policy update (effective July 26, 2009) regarding "Domestic Violence and Co-Occurring Child Maltreatment Intake and CPS Investigative Policies" was posted on the Policy Update section of the CA intranet site in April 2009. This included guidelines for interviewing caretakers separately and an additional document titled "Key points from the Domestic Violence (DV) Guide." At the time of this child fatality report, the CA Practice Guide for Domestic Violence was in the final pre-publication stage with anticipated internet availability in early 2010.

Child Fatality Review #09-34
Region 3
Whatcom County

This 16-year-old African American male died from a drug overdose.

Case Overview
On August 10, 2009, this youth died of a multiple drug overdose. He had traces of Ecstasy and benzodiazepines in his system when he died. Benzodiazepines are prescription drugs prescribed primarily to treat anxiety and insomnia. The father of the friend he was visiting is suspected of supplying the youth with the drugs, which he took willingly.

It was alleged the youth's mother told him to ask the friend's father for drugs as she would get drugs from him. The mother denied telling her son to buy drugs from this person, but admitted she would buy Vicodan from him to treat the pain from a neck injury.

Children's Administration (CA) did not have an open case on this family at the time of the youth's death. CA intake received an Information Only intake on the family 10 months prior to his death in August 2009.

Intake History
On September 27, 1994, Child Protective Services (CPS) intake received a report from a doctor following the birth of the mother's second child. Her doctor tested her for drugs and found evidence of a very high level of marijuana in her system prior to the delivery. The intake was screened as low risk and a referral was made for an Alternative Response System service, "First Steps," designed to assist new mothers who have some drug history. The mother did not cooperate with the service beyond the initial appointment.

On April 13, 2006, law enforcement contacted CPS intake regarding the deceased youth, then 13 years old. It was alleged that his mother had no idea he spent spring break week at his friend's house. The youth was found outside of a public building in Ferndale in the early morning hours and was questioned by law enforcement. He told police officers that his mother forgot to pick him up. He was dishonest with the police about that, according to information gathered in the investigation, but was never really able to state why. The deceased youth's mother and the mother of his friend had some miscommunication about how long the youth was supposed to be staying at the friend's home. When it was brought to the mother's attention that her son was out early in the morning hours, she picked him up from the friend's home. This intake was screened in for investigation by CPS and closed with an unfounded finding.

On October 22, 2006, CA intake received a report that the deceased youth's former stepfather (and father of his two younger half-siblings) called to say the youth's mother did not arrive to pick him up after getting off a ferry. It was also alleged the youth's mother smoked marijuana around him and that he did not attend school regularly. The intake was screened as Information Only.

On October 23, 2006, CA intake received a request from the youth's former stepfather to assist in filing a Child in Need of Services (CHINS) assessment, as he wished to have the youth live with him. The youth spoke with the intake worker and said he didn't like where he lived, or his school, and that he found a crack pipe that belonged to his mother. An appointment was arranged to complete the assessment, but the family did not appear for the appointment, and the case was closed.

On October 14, 2008, a relative called CA to report the deceased youth's brother was pushed to the ground by his mother's boyfriend and later had his shirt torn by his mother. The caller also alleged this child was unable to sleep in the bedroom he shared with his brother (the deceased youth) as "there was too much marijuana smoke in there." The deceased youth's brother lived with his mother and brother for a short time at the time this intake was received. The intake was screened as Information Only.

On October 17, 2009, a social worker made a CPS intake after being notified about the death of the deceased youth, who died of an apparent drug overdose. He was at the home of a friend when he died. The deceased youth's mother has an extensive drug history and reportedly had previously obtained drugs from the father of the friend. The deceased youth's two-year-old sister was still living with their mother at the time of his death. The intake was screened in for investigation.

During the investigation, the mother stated she knew her son was using marijuana but stated she had no knowledge of him using any other substances.

Law enforcement jointly investigated this incident with CPS. Law enforcement did not charge the mother with a crime. Police and CPS were in agreement that the mother was functioning fine with the two-year-old sister. The two-year-old sister appeared well cared for. She was dressed clean and appropriate. The mother was supervising the child at play when this worker arrived. The home was clean. The mother did not appear to be under the influence of any substances. The child's father lives in the home. There did not appear to be any safety concerns about the two-year-old sister. The CPS investigation was closed with an unfounded finding for negligent treatment or maltreatment.

Issues and Recommendations
Issue: None

Recommendation: None

Child Fatality Review #09-35
Region 1
Spokane County

This 16-year-old Caucasian female died from aspiration pneumonitis and pulmonary edema.

Case Overview
This youth and residents from her group home were on a camping trip in northern Idaho. The youth resided in a licensed home for children with developmental disabilities. On the morning of August 20, 2009, the youth was observed at 6:30 a.m. in her tent laughing. At 7:00 a.m. she was found in her tent not breathing and without a pulse. She was blue in color and unresponsive. Group home staff immediately called 911 and initiated CPR. They continued to do CPR until emergency medical technicians (EMTs) arrived. The youth was transported to Bonner General Hospital in Idaho where she was pronounced deceased at 8:07 a.m.

An autopsy was completed by the Spokane County Medical Examiner. The Bonner County Coroner determined the cause of death as aspiration pneumonitis and pulmonary edema. Aspiration pneumonitis is an acute lung injury after inhalation of vomited gastric contents. Aspiration pneumonitis can occur when patients have seizures. This youth had a history of seizures. The deceased youth was known to have an abnormality of chromosome 15 and related disorders. A Physician Advisory update has reported sudden, unexpected and unexplained deaths of seemingly healthy individuals with chromosome 15 abnormalities and related disorders.

The manner of death was determined to be natural.

Children's Administration (CA) had no recent prior history with this youth or her family. In 1998, the youth's mother requested foster care placement for her developmentally disabled daughter. She was unable to care for her daughter and had no other resources to assist her. The case was opened as a voluntary request for services. Eventually the youth was provided a residential placement for developmentally disabled children. She was never a dependent nor was she ever identified as a victim of child abuse or neglect. The family was referred to the Division of Developmental Disabilities (DDD) and in-home services were initiated. At the time of her death she was still residing in the group home. This group home is licensed by the state of Washington.

Intake History
On June 11, 2002, the deceased youth's mother met with Child Protective Services (CPS) to request placing her daughter, then four-years-old, in foster care. The child is developmentally delayed. The mother was parenting the child by herself and was overwhelmed. School programs were no longer available and she had no other relative support. Children's Administration staff coordinated services with the Division of

Developmental Disabilities (DDD) to arrange respite care for the mother. The intake was screened for Child Welfare Services and referred to DDD for follow up services.

On June 11, 2002, CPS intake was received from school staff who reported the deceased youth, then nine years old, had come to school with bruises. Several collateral contacts were made by Children's Administration with the youth's mother and the residential providers that cared for her Monday through Friday. The intake was screened low risk and closed.

The group home where this youth lived has been licensed with the state since August 1999. Since that time there have been 23 licensing complaints against this facility. Seven of the 23 licensing complaints were completed with a valid finding and compliance agreements were put in place to correct identified deficiencies.

One licensing complaint was completed with a valid finding for violations of health policies. This licensing complaint, received by CA intake on April 1, 2005, alleged a child at the group home was given the wrong medications by group home staff. The staff member who gave the wrong medications was ordered to re-take medication management training. This licensing complaint did not involve the deceased youth.

The deceased youth was the subject of two licensing complaints. On September 6, 2005, CPS intake received a report that the deceased youth, then 12 years old, went into the room of another group home resident and slapped him on the face. This resident retaliated by biting her on her face. They youth sustained a minor bite mark to her face. Group home staff took her to a hospital emergency room to have her injury examined by a doctor. The licensing complaint was completed with a not valid finding.

The second licensing complaint was reported after the youth died on the camping trip on August 20, 2009. The licensing complaint into the actions by group home staff in response to the youth's death was closed with a not valid finding.

There have been no prior reports of child fatalities in this facility.

There have been eight investigations conducted by the Division of Licensed Resources/Child Protective Services (DLR/CPS) section of this facility since 1999. None of the eight investigations were closed with a founded finding of abuse or neglect by group home staff. The deceased youth was not involved in any of the prior DLR/CPS investigations of this facility.

Issues and Recommendations
Issue: No issues identified by the fatality review team.

Recommendation: None

Child Fatality Review #09-36
Region 3
Snohomish County

This four-month-old Caucasian female died from unknown causes.

Case Overview
On August 17, 2009, the parents of this four-month-old infant fed her late at night and put her to sleep in bed with them. The child's mother awoke about 2:00 a.m. and found her daughter non-responsive. Emergency medical technicians responded immediately, but were unable to revive the child. She was pronounced dead at the home. An autopsy was conducted by the Snohomish County Medical Examiner. The medical examiner could not determine the cause and manner of death. Both the manner and cause of death are listed as undetermined.

The deceased child was born in April 2009, two and one-half months prematurely. She had many medical issues related to her premature birth and remained hospitalized until July 2009. At birth, she had a collapsed lung and cerebral hemorrhaging. Medical records show that at her discharge, she still had diagnoses of anemia, poor feeding, and was at-risk for respiratory virus. Both law enforcement and CPS investigated this child fatality. Neither agency was able to determine there had been any neglect of medical treatment for any of these issues and the child had been gaining weight satisfactorily until her death.

The Children's Administration (CA) did not have an open case on this child or her family at the time of her death. A child protective services (CPS) investigation was opened in 2008 and closed in October 2008. The investigation was closed with an unfounded finding for negligent treatment or maltreatment and physical abuse. The CPS case had been closed approximately 10 months prior to the child's death.

Intake History
On February 15, 2001, CPS intake received a report that an "older lady" was seen dragging the deceased child's four-year-old sister by the arm. There was also a report of yelling and screaming in the home. This intake was screened as information only.

On February 15, 2001, CPS intake received a report that the four-year-old sister of the deceased child was taken to a medical clinic by her mother with concerns that she may have been sexually abused while on an extended visit with relatives. The nurse practitioner who examined the child did not see signs of abuse and reported there appeared to be custody issues between the child's mother and a grandmother. This intake was screened as information only.

On March 25, 2002, CPS intake received a report that the five-year-old sister of the deceased child had visible pressure point bruising during a medical exam several months

prior. The deceased child's mother reported this occurred when she was living with her grandmother. The family had already moved out of the grandmother's home at the time of this intake. It was not reported at the time when bruising was visible. This intake was screened as Information Only.

On September 23, 2008, CPS intake received a report from a relative that the 11-year-old sister had bruises on her side, legs and back. The mother told the referrer these were from the child falling, but the referrer said the bruising was inconsistent with this story. The mother and her boyfriend (the deceased child's father) yell at each other in front of the children. This intake was screened in for investigation by CPS. During the investigation, the 11-year-old denied being hit and said the bruises came from a fall off a bicycle. The mother appeared depressed. The child's doctor and staff at her school reported no concerns about the child's well being. The CPS investigation was closed with an unfounded finding for negligent treatment or maltreatment and physical abuse.

On August 17, 2009, CPS intake received the report the child's death. This four-month-old was found deceased in the early morning hours in her parents' bed. Emergency personnel were called to the home, but attempts to revive her were unsuccessful. The intake was screened in for investigation by CPS. The parents were cooperative with the investigation. Law enforcement also investigated and determined this was an accidental death. The assigned social worker provided the parent with resources to access counseling to deal with grief and loss issues. The CPS investigation was closed with an unfounded finding for negligent treatment or maltreatment.

Issues and Recommendations

Issue: At the end of the September 2008 investigation, the Structured Decision Making (SDM) tool was used in this case with an outcome of "moderately high risk." According to Executive Order 9504 and Child Protection Team (CPT) policy, a "moderately high risk" designation involving a child six years and younger meets the criteria for a CPT staffing. However, the SDM tool produces more cases with this designation than can possibly be accommodated by the CPTs. With an awareness of this, statewide practice direction at the time the SDMs were being instituted nearly two years ago was that until there was a reconciling of the SDM policy with the CPT policy, social workers were to use the "old" risk assessment tool to determine if a case needed to be staffed by the CPT.

The issue now is that two years have elapsed since the SDM was instituted, and the issue has never been reconciled. Due to turnover among social workers, there are now many social workers investigating cases and completing SDMs that do not know anything about the "old" risk assessment tool, and therefore would have no idea about how to determine if a case that measures "moderately high" on the SDM should actually be evaluated to determine if a CPT staffing is necessary.

Recommendation: Consideration should be given to adjusting policy so that the Structured Decision Making policy is compatible with the Child Protection Team policy regarding the determination of when a high/moderately high risk case is to be staffed with the CPT.

Issue: The team believed that the Structured Decision Making (SDM) tool, which is used at the end of each investigation, was not utilized according to training in two of the investigations in this case.

Recommendation: The review team recommended a regional follow-up training in the use of the SDM, then yearly refresher training after that.

Child Fatality Review #09-37
Region 1
Spokane County

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

Case Overview
On September 16, 2009, this five-month-old infant was found not breathing in a crib while at the in-home child care she attended daily. The child care provider reported that she had placed the child on her back in the crib with her blanket. The child care providers reported that they checked on the child several times while she was napping and at one point the husband of the child care provider observed the child lying on her stomach and it appeared she was not breathing. He rolled her on to her side and observed vomit underneath her hand and face. He immediately called 911. The provider performed CPR until medics arrived. Law enforcement noted the crib was empty and the home was clean. The child was transported to a local hospital where she was pronounced dead.

Children's Administration (CA) has no history on the family of the deceased child. This child care provider was licensed with the Department of Early Learning (DEL) since August 2008.

Intake History of the Licensed Child Care Provider
On April 7, 2008, the DEL received a report that this child care provider was operating an unlicensed daycare. She was providing nanny care for two children in their home. The licensing complaint was closed as not valid.

On February 3, 2009, parents of a 15-month-old reported their daughter was picked up from the child care provider with a bruise and scratch to the side of her face near her eye. The child care provider refused to meet with the parents. The family stopped using this provider and made a report to Children's Administration (CA) intake. On February 20, 2009, the same parents reported that she also had a half inch wide linear bruise across the full width of her back.

DEL and DLR/CPS investigated these allegations. The child's father admitted that the injuries may have happened while the child was in the parents' care. The licensing complaint was closed as not valid and the DLR/CPS investigation was closed with an unfounded finding for physical abuse. The family of this child did not have any CPS history.

On March 27, 2009, a DEL supervisor reported a new intake on this provider. A parent recently reported to DEL that in December 2007, when the child care providers were not licensed, he was dropping his child off at the child care provider's home and observed a child, approximately four years old, sitting in the provider's car unattended. This parent

further reported that it was approximately 20 degrees outside, and the child was in the vehicle for at least 10 minutes. The parent said that later in the morning his wife went to the provider's home to pick up their child and she had to knock on the door for five minutes before the provider answered the door. This parent reported hearing her child crying hysterically the entire time she was knocking on the door. DLR screened the intake out for investigation as the child care provider was not licensed at the time of this alleged incident. DEL attempted several times to contact the family who made this report but were unsuccessful.

On April 30, 2009, a hospital social worker reported to Child Protective Services (CPS) intake that an eight-month-old infant was in the care of the child care provider and appeared to be in pain. The provider contacted the child's the mother around noon. The child care provider told the mother she did not need to come and pick up her child. The provider called the mother several hours later stating she needed come pick up the infant. The mother did pick up the infant and brought her to the emergency room. An MRI revealed the infant had bi-lateral femur fractures. There were no other injuries found. DLR accepted the intake for investigation of the child care provider. DCFS also accepted the intake for investigation of the birth family.

DEL suspended the child care provider's license. The provider appealed the summary suspension of her childcare license to the Office of Administrative Hearings. The suspension of her license was lifted by the administrative law judge and she re-opened her childcare on June 29, 2009.

On September 17, 2009, CPS intake received a police report of an incident that occurred on September 16, 2009. It was reported that this five-month-old infant was found not breathing in a crib while at the in-home child care she attended daily. The child care provider's husband reported he, and not his wife, put the child down for a nap. He told police he placed the infant on her side in the crib with her blanket. The infant was checked on several times while napping and at one point the provider's husband observed the infant lying on her stomach and appeared to not be breathing. He rolled the infant to her side and observed vomit underneath her hand and face. The child care providers immediately called 911.

DEL suspended the provider's child care license and DLR/CPS investigated the child care for negligent treatment. The Spokane County Medical Examiner conducted an autopsy and determined the infant's cause of death as sudden unexplained infant death.

DLR closed the investigation as unfounded. During the course of a DLR/CPS investigation, DLR found the provider did not report injuries she observed on a child's face and hand to CPS intake. DEL made valid determinations regarding these two failures to report. On January 6, 2010, DEL revoked this provider's license for failures to report and not following the licensing rules such as safe sleep requirements for children.

Issues and Recommendations
Issue: None identified.

Recommendation: None

Child Fatality Review #09-38
Region 6
Clark County

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

Case Overview
On September 3, 2009, this child's father awoke to get ready for work and took his infant daughter to sleep with her paternal grandmother at 4:00 a.m. The grandmother cares for the infant periodically when the child's father has to leave early for work. She cared for her granddaughter until she had to leave for work, at which time she took the baby to a babysitter.

At 4:00 a.m. the grandmother warmed a bottle for the child and fed her. The deceased child appeared alert and was smiling. She spit up and had her diaper changed and then went back to sleep. The grandmother reported her granddaughter was a bit fussy. The grandmother then went back to sleep with her granddaughter sleeping in the bed next to her. At 5:30 a.m. the grandmother was awakened by her alarm. She got out of bed at 6:00 a.m. and put pillows around her granddaughter to prevent her from rolling off the bed. The grandmother got ready for work and checked on the child at 7:15 a.m. and found she had rolled over and was on her stomach. The grandmother picked her up to put her in the car seat and she noticed she was "floppy."

The grandmother immediately rushed next door to the neighbor's house. This neighbor is a nurse. The nurse immediately began CPR and directed the grandmother to call 911. Emergency Medical Services (EMS) responded and transported the child to the hospital by ambulance. She was pronounced dead shortly upon arrival at the hospital.

Children's Administration (CA) had an open case on the family of the deceased child at the time of her death. The child was born in July 2009. At birth the child tested positive for amphetamines and methamphetamines. A case was opened on the mother shortly after the child was born. A service plan was developed and the child's mother was referred for services. She agreed to move into the home of the child's father and have no unsupervised contact with her daughter. The paternal grandmother would also be present. The mother initially stayed at the home, but left within a very short period of time. She has had no further contact with her child or the child's father. The child's father was in the process of establishing custody of his daughter at the time of her death.

Intake History
On February 6, 1997, Child Protective Services intake received a report from law enforcement. The intake alleged that the deceased child's mother had drug traffic in and out of her apartment all night long and that neighbors reported her baby, the deceased child's sister, was crying all night. It was reported that cleaning crews found empty

bottles of chemicals out back and it was suspected that the mother was manufacturing methamphetamines. The report further stated that they found empty hydrochloric acid bottles. The apartment was dirty and both the mother and baby smelled like urine. This referral was investigated and determined to be founded as to abandonment and neglect.

On March 22, 2006, school personnel contacted CPS intake with concerns about the deceased child's sister, then eight years old. The intake alleged the sister went to school late, hungry and tired. In addition, the report alleged that the mother and her children were homeless. The school attempted to engage the mother in services and scheduled a school conference. The intake was screened in for the Alternate Response System (ARS) and the assigned ARS worker made attempts to locate the mother, but due to being homeless, it was difficult. The children were finally located with their father. Alternative Response Services were put in place to provide support to the family. Another report was received on April 17, 2006, with similar allegations and lack of supervision. The ARS provider attempted to make contact with the mother on numerous occasions. The mother did not engage in services from the ARS provider and the case was ultimately closed.

On August 28, 2006, an intake was screened in alleging the mother was using methamphetamines and that she was injecting with needles. The referrer reported seeing the track marks on her arms. The referrer further reported there were drugs in needles and they were in the reach of the young children. This person also observed rotting food in the home. The mother was reportedly gone most of the time. It was also reported that various men, who are on drugs, were at the home watching the children. This intake was screened in for investigation and remained open for several months after more reports were made to CPS intake. This intake was eventually completed with an inconclusive finding for negligent treatment or maltreatment.

On September 11, 2006, CPS intake received another report alleging neglect of the deceased child's brother, then four years old. The referrer reported seeing this child outside unattended for long periods of time. It has been reported by neighbors that the previous week, this child was seen running in the street unsupervised and was seen with a butcher knife. The intake was screened in for the Alternate Response System (ARS).

On October 30, 2006, a friend of the mother reported to CPS intake that the mother reported to the referrer that she was pregnant. The referrer said the mother used methamphetamine every day. The referrer added the mother does meth in front of her 8- and 4-year-old children and left needles within their reach. The intake was screened in for the Alternate Response System (ARS). The mother told her DSHS social worker in November 2006 that she was not pregnant.

Repeated attempts were made to investigate the allegations and locate the mother and her children. The mother was transient and often moved from Olympia to Vancouver. The case was ultimately closed in January 2007 after repeated attempts were made to locate

and offer services to the mother and her older children. In February 2007, the paternal grandparents of the mother's two oldest children obtained guardianship. These two children remain in the care of grandparents. Neither of them have had any contact with their mother since February 2007.

On July 10, 2009 two referrals were received regarding the birth of the deceased child. One was screened out due to being screened in for the wrong location. Ultimately both intakes had the same allegations and were screened in as Risk Only intakes. The referrer reported that a baby was born positive for amphetamines and methamphetamines. The mother declined drug screens throughout prenatal care. She was reportedly living in an apartment by herself. A service plan was developed and the mother was referred to services. This service plan required the mother to live in the home of the child's father and have no unsupervised contact with her daughter.

On September 3, 2009, a risk only intake was received from the hospital that the deceased child was brought to the hospital by ambulance and was pronounced dead shortly after arrival. The referral stated that the baby had been positive for methamphetamine at birth and had been sleeping in the same bed with the grandmother prior to the death.

Issues and Recommendations

Issue: Throughout this case there was a pattern of staff not conducting thorough risk assessments, either informally or formally through the use of existing tools (i.e. SDM).

Recommendation: The Region office will work with CA Headquarters staff to coordinate and schedule training for staff on risk assessment throughout the life of the case, including the use of formal tools available in FamLink (i.e. SDM).

Child Fatality Review #09-39
Region 6
Clallam County

This seven-month-old Caucasian male died from Sudden Infant Death Syndrome (SIDS).

Case Overview
On September 15, 2009, the mother of this seven-month-old infant arrived at the in-home child care provider's home to pick him up. The child care provider's husband went to retrieve the child from a crib where he was napping. The child was found lying somewhat on his side and stomach at the center of the crib, covered with a blanket. When the child care provider's husband removed the blanket he noticed that the child's skin was bluish in color and he was not breathing. The child care provider said the child was warm, but non-responsive and limp. The provider's husband took the child to the living room and the child care provider called 911. The provider's husband performed CPR with instructions from dispatch and assistance from his wife. Medics responded to the home, continued CPR and transported the child to Olympic Medical Center where his death was ultimately declared. The King County Medical Examiner conducted the autopsy and reported the child died of natural causes with the cause of death determined to be SIDS.

Children's Administration (CA) has no history on the family of the deceased child. This child care provider had been licensed with the Department of Early Learning (DEL) since June 2008.

Intake History of the Licensed Child Care Provider
On September 15, 2009, Child Protective Services (CPS) intake received a report of the death of this child while in the care of his in-home child care provider. A detective with the Clallam County Sheriffs office reported responding to a 911 call of an infant who wasn't breathing. Medics responded and found the child non-responsive and immediately transported the child to the hospital where he was later pronounced dead.

The detective reported the child arrived at the child care provider's home with a dry cough. The child care provider checked on him after hearing him cough and found him rolled up in his blanket and he moved around but remained asleep. Approximately 15 minutes later his mother came to pick him up. The provider's husband went to get the child from the crib and found him blue. They immediately started CPR and called 911. The detective reported there were no immediate or obvious concerns with the crib in which the child was sleeping. The intake was screened in for investigation by the Division of Licensed Resources/Child Protective Services (DLR/CPS). The investigation was completed with an unfounded finding for negligent treatment or maltreatment. The licensing complaint on this report was completed with a not valid finding.

Issues and Recommendations

Issue: It was noted during the review that both the DEL Licensor and the DLR/CPS Investigator conducted exceptional social work practice during this investigation. Both showed compassion to both the mother of the deceased child and the child care provider and her husband.

Recommendation: No recommendation. During the review the Deputy Regional Administrator thanked them for their excellent documentation and good practice in this case.

Child Fatality Review #09-40
Region 3
Skagit County

This two-month-old Native American female died from viral pneumonitis.

Case Overview
On September 15, 2009, the mother of the deceased child reportedly gave her and her twin sister medication called "Kolik" at 11:30 a.m. The mother then went to sleep. The children's father came home to wake the mother to take her and the twins to a doctor appointment. The father woke the mother and went to get the babies ready. He noticed that the deceased child was not breathing right. The mother called 911 at 12:24 p.m., and both parents performed CPR. Fire department personnel arrived at 12:31 p.m. and took over CPR. Police arrived a few minutes later, and the child was rushed to the hospital where she was pronounced dead. The surviving twin sister also had breathing issues, but these did not turn out to be serious.

Police and hospital staff reported that Kolik is not an approved drug in the United States but is available in Canada. The mother got the medication from the grandmother. The doctor who treated the deceased child in the emergency room reported the colic medication did not contribute to the death of the child. There was a rash on the infant's neck, but there were no obvious signs of trauma.

A chest x-ray was taken of the surviving twin. She had old healing rib fractures. Law enforcement was notified of these injuries.

Children's Administration (CA) had an open case on the family of the deceased child at the time of her death. At the time of this child's death, the mother had a 16-month-old and four-year-old at home in her care. These children had previously been removed from the care of the parents in March 2009 on dependency actions and were placed in out-of-home care. In July 2009, the deceased child and her twin sister were born and the decision was made for the newborn twins to remain in their mother's care living at home. The siblings were returned to their mother's care on an in-home dependency in July 2009.

Intake History
On February 15, 2007, Child Protective Services intake received a report that the deceased child's mother took her oldest child, then two years old, from the family home and left him with another family. There were reports of a lot of drinking going on at the home where this child was left. Tribal law enforcement and social services picked him up and placed him overnight in a "safe house." The child's father was told where his son was located. He picked him up from the safe house and took him home. The father did not bring the child in to meet with tribal social workers and could not be located. This intake was screened out for investigation.

On February 24, 2007, Child Protective Services intake received a report from tribal social services that the deceased child's mother had neglected to take her prescribed mental health medication. She could become violent when she was off her medications. This included yelling and getting into physical fights. The referrer stated the mother is developmentally delayed and was abusing alcohol, cocaine, and marijuana. The referrer did not think the mother provided a stable home for her two-year-old son. The mother would leave him for days at a time with friends believed to be drug users. He was also left with his Godmother. There was no action taken by Children's Administration (CA) on this intake as the Tribe intended to keep jurisdiction of the case.

On May 29, 2007, a report was made to CPS intake that the deceased child's mother was seen yelling obscenities at her two-year-old son child outside the home. The neighbors said they were afraid of the mother. The mother was taking medication to control anger outbursts. The week prior she was throwing things inside the house. The mother reportedly had a drug problem. There was no action taken by CA on this intake as the Tribe intended to maintain jurisdiction of the case.

On August 31, 2007, a report to CPS intake indicated that the deceased child's brother, then age two, was in the care of his biological father. The father was passed out and when he woke up he could not find the child. The father called family members who looked for the child for about two hours and finally found him asleep under a coffee table.

The house was very dirty. The child was covered with flea bites. The child's mother could not be located. The deceased child's brother was placed in protective custody by tribal police and placed in the care of his aunt just for the night, as she was not able to continue to care for him. At this time the Tribe asked CA to take custody and to file a dependency petition in state court, which was done. The CPS investigation resulted in a founded finding for negligent treatment or maltreatment.

For the next nine months, the deceased child's brother lived in foster care. The deceased child's mother became involved in court ordered services including drug treatment, random urinalyses, counseling, and a parenting assessment. The CA social worker worked closely with the tribal social workers.

In May 2008, the deceased child's mother gave birth to a daughter. This child's father is also the biological father of the deceased child and her twin sister. CA social workers filed a dependency petition on this child immediately after her birth partly due to concern about her father's history. There were allegations that the deceased child's father had assaulted his ex-wife. He had a founded CPS complaint and criminal history, including assault. This newborn was not removed from her parents' care at that time. The court approved a service plan on the father that required him to participate in services before he could live in the home with the deceased child's mother and sister.

The deceased child's brother was returned to the care of their mother in October 2008. She had recently moved into a three bedroom home in tribal housing on the reservation. The deceased child's father was in and out of the home at various times during this period. Sometimes his presence in the home was in accord with the state and tribal plan, and he sometimes lived there despite it.

On December 30, 2008, CPS intake received a report that the deceased child's brother, then age four, was seen with two bruises that the referrer believed were caused by the mother's boyfriend (father to the deceased child). The brother had a quarter inch bruise on the right side of his neck and a one and half inch bruise on the middle of his spine. The brother told the referrer that his mother's boyfriend caused the bruises. This intake was screened in for investigation and completed with an unfounded finding for physical abuse.

On March 12, 2009, CPS intake received a report regarding the deceased child's older brother and sister. Both were state dependents living with mother on an in-home dependency. The parents agreed to a safety plan in which the father of the sister was not to be in the home. A community member reported that a week prior, the mother and father were seen together. The father hit the older brother hard enough to knock him to the ground. Both the mother and father were seen slapping the older daughter and son. The community member observed that both children have bruises that she believed were from the incident last week. This intake was screened in for investigation and completed with an unfounded finding for physical abuse.

After this intake was received on the family, the case was staffed with the Tribal Child Protection Team (CPT). The situation appeared to deteriorate. The CPS social worker investigating the March 2009 intake was unable to locate the family. The court was notified and ordered that the children be picked up when located and placed in custody. This occurred in late March 2009. The family was located staying with a relative in the southwestern part of the state. The children were eventually returned to their mother about a month later. The mother was instructed to obtain a restraining order against her boyfriend and return to her services. There were concerns this restraining order was not being adhered to. At this time the mother reported she was pregnant by her boyfriend (the deceased child's father).

On April 27, 2009, CPS intake received a report that the deceased child's brother disclosed his mother hit his sister. The brother also reported he was hit by his mother's boyfriend. The intake was screened as information only. The children were placed in foster care at the time of this report. The intake worker thought this incident occurred prior to their removal the mother's home.

On June 10, 2009, CPS intake received a report from a Tribal Indian Child Welfare (ICW) social worker that several months prior, the deceased child's brother had a black

eye. The mother told a service provider that he was injured while jumping on a trampoline. The explanation appeared plausible to the service provider. The intake was screened as information only.

In July 2009, CPS intake received noticed that the deceased child and her twin sister were born. Hospital staff expressed concern that the mother did not appear to be bonding with her newborn infants.

The older two children were placed in foster care on a voluntary placement agreement while their mother was hospitalized and recuperating. At the Family Team Decision Making (FTDM) meeting to plan for the children, the decision was made to leave the twins in the home with an extensive safety plan and to return the two older children.

The infants were discharged to the mother's care and lost weight (approximately five ounces). The Tribe sent a public health nurse to the home to address the concerns about the weight loss of the infants.

On August 27, 2009, CPS intake received a third hand report that the deceased child's mother slapped her then 15-month-old daughter. There was no reported injury to the child and the intake was screened out for investigation.

In August 2009, the safety plan put in place after the birth of the deceased child became jeopardized. The safety plan included support persons, identified at the FTDM, to be in the home regularly to check on the children. Some of the identified support persons were no longer available to check on the children and mother shortly after the children were returned home. The mother had missed two scheduled doctor appointments for her children.

In August 18, 2009, the case was staffed with the Tribal ICW program with concerns about missing a doctor appointment and establishing a dependency on the deceased child's older sister. The recommendation was made to build in more supports to see the children, including welfare checks by tribal police.

On August 20, 2009, the infants were weighed at a doctor appointment. The deceased child had gained two pounds and 15 ounces since birth.

On September 15, 2009, CA received a report that the deceased child had passed away.

The intake alleged at 11:30 a.m. the deceased child's mother gave her and her twin sister a medication called "Kolik" and then all three went to sleep. The deceased child's father came home to take the children to a doctor appointment. He found the deceased child breathing erratically. He woke the mother and they attempted CPR until medics arrived. She was taken to a local hospital where she was pronounced dead.

An intake was screened in for investigation on the deceased child's death and assigned to CPS. An autopsy was performed by the coroner's office, with the cause of death listed as "probable viral pneumonitis." The manner of death is listed as "natural." The toxicology report does not indicate the presence of any illegal drug or an improper amount of legal medications.

There was also a finding of a healed left clavicle fracture. The CPS investigator gathered this report, along with other medical records on the twins, and sent them to a medical consultant at Children's Hospital, who works with abuse and neglect cases. He reviewed all of the medical records, including x-rays of the twin sister, who had a medical evaluation and full skeletal survey after the death of her twin sister.

The surviving siblings were placed into foster care, where they remain. The deceased child's funeral was held four days later. On the night of the funeral, the deceased child's mother took an overdose of prescription antidepressants and/or sedatives and passed away.

The medical consultant determined from the records that both infants had some evidence of healing fractures, not related to any birth injury. The deceased child had evidence of clavicle, tibia and rib fractures, while the surviving twin's skeletal survey showed "right lateral rib fractures." The medical consultant believed it highly unlikely that "given the mild nature of her symptoms, lack of fever, lack of respiratory distress, that the pulmonary changes noted at autopsy are actually the cause of her death."

The medical consultant concluded that the autopsy did not reveal any obvious cause or manner of death. This consultant's report, along with all the medical records and autopsy report were provided to the tribal law enforcement. That agency's response to the information is not known at this time. The CPS investigation into the allegation of abuse was closed with a founded finding.

Issues and Recommendations

Issue: There were two CPS intakes, on April 27, 2009 and on August 27, 2009, that the team believed should have screened in for investigation, given the history in this case.

Recommendation: The team recommends that these two referrals be reviewed with the Intake supervisor.

Issue: When it became apparent in August of 2009 that the twins were losing weight and medical appointments were not being kept, the social worker should have requested medical evaluations, including exploring the possibility of skeletal surveys, on all of the children in this family.

Recommendation: Social workers should be trained to strongly recommend a full medical evaluation; including exploring with the medical provider the possibility of a full skeletal survey, when there has been a series of unexplained injuries to a child, particularly a non-verbal child. A combination of other risk factors such as those that existed in this case raises the risk significantly. The team recommends that this issue be raised in the next "Lessons Learned" or other such training in the region.

Issue: The team found that there was uncertainty with the social worker and supervisor working with Indian Child Welfare about the appropriate responses when there was a difference of opinion regarding the direction of the case between the state worker and the Tribe, particularly when child safety is the concern.

Recommendation: The team has heard concerns that training on the issues of ICW conflict resolution protocol may not be clear in Academy training, post Academy ICW training, supervisors' trainings, and possibly other ICW trainings. The team recommends that training Academy curriculum be reviewed to ensure that the protocol for addressing conflict resolution issues is clear.

Issue: The team found that in this case there was also a certain lack of clarity about the process for resolving issues with Assistant Attorneys General about when legal action should be taken.

Recommendation: The team recommends that the office continue with its program of having an Assistant Attorney General at monthly trainings, focusing at least one of the trainings on the filing of dependency petitions. Specifically, how to initiate the dependency filing process, what background information should be provided in the dependency petition, what to do if there is a conflict over the filing of dependency.

Issue: There was an appreciable amount of case activity reported by one social worker/supervisor that was not documented in the case notes.

Recommendation: Continue emphasis in office trainings on thorough documentation of all significant case activity.

Issue: Risk to these children should have been apparent to the social worker and supervisor at least a month prior to the death of the infant, as the safety plan dissolved and the monitoring faded away, and should have been more aggressively addressed.

Recommendation: Increased training is needed on the development and monitoring of effective safety plans.

The team recommends that Region 3 continue with their plan to develop a training curriculum for developing effective safety plans within the structure of Solution Based Casework, with particular emphasis on chemical dependency issues.

The team also recommends that the region continue with their plans to train social workers and supervisors on the framing of questions to providers doing assessments. The plan is to have workers identify the specific safety threats that are the concern when they request assessments, with the goal of having the assessment and later progress reports refer back to that safety issue.

Issue: A social worker 1 was assigned the case and as social worker 1s cannot actually carry a case, the supervisor was assigned to the case, with the social worker 1 carrying out the supervisor's directives. That meant that this case did not have the benefit of a second level of clinical supervision, as other cases do. In a second level perspective on a case, some things become apparent that are not seen by the worker directly involved.

Recommendation: If social worker 1s are utilized and the supervisor is actually the one carrying the case, arrangements should be made with the Area Administrator to do a monthly "100% review" of those cases to ensure that they have clinical supervision.

Issue: The review team was not able to locate evidence of the proper notification to the Muckleshoot Tribe when the state filed dependency on the deceased child's older sister. Her alleged father is an enrolled member of the Muckleshoot Tribe. The team also was not able to locate documentation in the file that the Muckleshoot Tribe had been invited to FTDMs or other case staffings.

Recommendation: The team recommends that all staff working with ICW cases be reminded of this requirement.

Child Fatality Review #09-41
Region 1
Spokane County

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

Case Overview
On September 20, 2009, the deceased child's mother awoke and found her daughter not breathing. The mother and infant were co-sleeping at the time. The mother called 911 and the infant was transported to the hospital where she was declared deceased. The Spokane County Medical Examiner has determined the death to be sudden unexplained infant death. The manner of death is ruled natural/medical.

Children's Administration (CA) had an open case on the family of the deceased child at the time of her death. The case was opened in August 2009 after the deceased child was born and she was going through drug withdrawal. Her mother tested positive for methadone, cocaine and opiates during her pregnancy. The deceased child was discharged to her parents' care after spending a week in the hospital. A service plan was developed with the parents who agreed to chemical dependency assessments, First Steps Nursing program, Parent Child Assistance Program (PCAP) and the Women, Infant and Children (WIC) program. Both parents were providing random urinalysis.

Intake History
On October 3, 1994, Child Protective Services (CPS) intake received a report that police were called to the family home when the deceased child's mother was damaging the home of her mother and siblings. The police were called and tried to calm the deceased child's mother. She was reportedly holding her four-month-old daughter at the time. This intake was screened as information only.

On August 17, 1995, CPS received an intake alleging that the deceased child's mother, then 16 years old, was arrested for assaulting her one-year-old daughter. The social worker made home visits and offered a service plan to the mother including drug/alcohol monitoring. On August 29, 1995, the mother tested positive for marijuana. Shortly after, the mother reportedly left the state.

The social worker continued to try to contact the mother and her child for several months. The mother refused services or any interventions. The child's maternal grandmother was providing most of the care for her. This intake was screened in for investigation and closed in December 1995 with a founded finding for physical abuse.

On September 29, 2000, CPS intake received a report of a domestic violence incident between the deceased child's mother and another relative, who allegedly had a knife. The

deceased child's older sister told a staff member at her school about the domestic violence incident. The referrer also reported concerns for the deceased child's older sister due to excessive absences from school. The investigative assessment indicates the investigation was completed with an inconclusive finding and there was no imminent risk to the child since the maternal grandmother was the primary caretaker for the child.

On November 30, 2001, a school staff member reported to CPS intake that the deceased child's older sister said she was afraid to go home because her 19-year-old cousin was slapping her. The intake was screened as low risk. The family was referred to the School Project, a low risk contracted intervention. The school counselor also reported additional information that the deceased child's mother was pregnant.

On February 1, 2002, CPS intake received a report that the deceased child's mother allegedly hit her oldest daughter with a belt on her shoulders and back and kicked her in the arm and left bruises. The child said she was hit daily with belt buckles, shoes, a vacuum hose and her mom's hands and feet. The school reported there was a six-week-old infant, also in the home. The school's family resource specialist tried to work with the family but the risk appeared to be increasing. CPS intake accepted an investigation for physical abuse.

The investigating social worker was unable to locate the child. The mother was contacted and she reported her daughter had been sick. The mother was instructed to take her daughter to a doctor. The child was seen by a doctor on February 6, 2002, who reported the child had no concerning marks or bruises.

The mother denied hitting her child and denied drug and alcohol use. She agreed to work with the resource specialist through the School Project. The investigation was closed with an inconclusive finding.

On November 19, 2007, CPS intake was called by school personnel to report the deceased child's older sister reported being hit, kicked, and punched by her mother. There were no injuries at the time. The intake was screened as information only.

On August 13, 2009, CPS intake received a report from a hospital social worker that the deceased child was born and the hospital placed a hold on the baby. The infant was in the intensive care unit for drug withdrawal. The mother tested positive for methadone, cocaine and opiates during her pregnancy. The intake was accepted for investigation for negligent treatment. The mother had two other children in her home at the time, a 15-year-old daughter and a seven-year-old son.

CA opened a case on the family. A service plan was developed in anticipation of the deceased child's discharge from the hospital on August 21, 2009. Both parents agreed to

chemical dependency assessments, First Steps Nursing program, PCAP and WIC. Both parents had been providing random urinalysis, which were negative.
On August 24, 2009, the deceased child was seen by her primary care physician who noted she was a well baby. The mother brought the child in to the doctor two times in early September.

On September 8, 2009, CPS intake received an anonymous report that the deceased child's older sister had a black eye and bruises, allegedly the result of physical abuse by her mother. The assigned CPS social worker met with the child who reported that she and a cousin had an altercation and that her mother did not cause the black eye or the bruises. This intake was screened in for investigation and closed with an unfounded finding for physical abuse.

On September 9, 2009, a public health nurse (PHN) made a home visit and saw both parents and the deceased child. The deceased child's father appeared engaged, the home environment looked good and the mother was appropriate in her handling and care of her child.

On September 17, 2009, the assigned social worker went to the family home to meet with the parents and see the child. A visitor to the home said the family had taken the child to her doctor appointment.

On September 20, 2009, CA intake was notified of the death of this child while co-sleeping with her mother. The mother said she drank one beer before going to sleep with her daughter. The mother was asked to submit to a urinalysis. On September 21, 2009, she completed the urinalysis which was positive for alcohol. The urinalysis results indicated excessive drinking the night before or drinking the same morning of the urinalysis. The deceased child's father was not in the home during the time his daughter died. He came to the home after she died and appeared very intoxicated to law enforcement.

One month after the child died, the social worker received copies of police reports for incidents that occurred while she was in her parents' care. A report from August 28, 2009 documents the mother's DUI arrest. It was also reported she tried to run over the deceased child's father. Another incident dated September 12, 2009 describes a domestic violence altercation between the deceased child's parents. The father was arrested for domestic violence, 4th degree assault and obstructing an officer.

Dependency petitions were filed on the two surviving siblings of the deceased child and they were placed in out-of-home care because of ongoing safety concerns. The Child Welfare Services case was assigned a worker who specifically carries Indian Child Welfare cases. The mother identified herself as a descendant of a Canadian Band of Cree. The worker contacted the Tribe and was told that the mother is not affiliated with the Tribe.

Issues and Recommendations

Issue: The September 29, 2000 investigation and risk assessment do not have supporting documentation including supervisory reviews. Two case notes were created more than three months after the intake was accepted for investigation. There is no documentation of any shared decision making prior to the case closure.

Recommendation: The review committee is aware that the assigned worker at the time is no longer employed with Children's Administration. Policy currently exists regarding investigative requirements as well as documentation expectations.

Issue: Shared decision making was not utilized when the deceased child was released to her parents' care from the hospital hold on August 21, 2009.

Recommendation: Social workers should not make placement decisions in isolation and can utilize Child Protection Teams, Family Team Decision making process as well as supervisory staffing. Current policy exists to address shared decision making.

Child Fatality Review #09-42
Region 3
Snohomish County

This 19-month-old Caucasian male drowned while bathing.

Case Overview
On September 29, 2009, the mother of the deceased child was bathing this 19-month-old at the family home. She walked out of the room for a few minutes and came back and found the child to be unresponsive. The mother and father called 911 and the child was brought to the emergency room of a local hospital where he was declared deceased. The child had some physical disabilities and developmental delays. He was tube fed and delayed in both growth and brain development.

An autopsy was completed and the cause of death was determined to be drowning. The manner of death was accidental.

Children's Administration (CA) did not have an open case on the family of the deceased child at the time of his death. The deceased child's mother was a licensed in-home child care provider with the Department of Early Learning (DEL). She had been a licensed child care provider since November 2008.

Intake History
On September 30, 2009, CPS intake received a report from the Snohomish County Medical Examiner reporting on the death of this child the previous night. The initial cause of death was fresh water drowning. The Medical Examiner said the child died in an infant tub in the family home when the mother left the room for a few minutes. The parents called 911 and the child was declared dead at the hospital. The Mountlake Terrace Police Department chose not pursue an investigation citing no evidence that a crime had been committed. The intake was screened in for investigation by the Division of Licensed Resources/Child Protective Services (DLR/CPS) section. The investigation was concluded with a founded finding. DEL has revoked the mother's child care license.

Issues and Recommendations
Issue: The team discussed the licensing history and post fatality activity, but there were no issues or recommendations identified.

Recommendation: None

Child Fatality Review #09-43
Region 3
Skagit County

This seven-month-old Native American male died from positional asphyxiation.

Case Overview
On October 6, 2009, the deceased child's parents reported that their seven-month-old infant son woke up hungry around midnight. The mother fed him and put him to bed, lying between his father and her. The mother reported she and the child's father had consumed alcohol the night before, but did not believe they were intoxicated when they went to bed.

The mother told the Coroner that she woke up at 4:35 a.m. and discovered the father lying on top of the baby. The baby was not breathing and they started CPR immediately. Emergency Medical Technicians (EMTs) were called but the child could not be revived. The Skagit County Coroner determined the death to be from positional asphyxiation. The manner of death is accidental.

Children's Administration (CA) did not have an open case on the family of the deceased child at the time of his death. The deceased child's father has three children from a prior marriage. CA received a report in May 2009 that the father was negligent in his supervision of his eight-year-old son from his prior marriage. CA opened a case at the time and closed it in June 2009, three months prior to the deceased child's death.

Intake History
On September 27, 2004, CPS intake received a report from a mental health counselor who was seeing two child clients, ages four and two. The parents were divorcing as the mother alleged the father is an alcoholic and there were on-going domestic violence issues. The mother also reported the father treated the older child unfairly. The children are older half-brothers to the deceased child. The father in this intake is also the deceased child's father. The intake was screened for the Alternate Response System (ARS).

On May 4, 2009, CPS intake received a report of concerns about the deceased child's father's treatment of his oldest son. While the children were on visitation with their father, he allowed them to play with BB guns and paintball guns. The eight-year-old older brother was hit with a paintball leaving a dollar sized bruise on his stomach. It was also alleged that the father consistently treated the eight-year-old unfairly. The intake was accepted for investigation and closed with an unfounded finding for negligent treatment or maltreatment.

Issues and Recommendations

Issue: The first CPS intake on the family in 2004 screened in at a low level of risk and was designated for an Alternate Response. The response was considerably delayed. There was also no documentation in the record that this intake was sent to the Tribe, as required by agreement.

Recommendation: ACTION TAKEN: Since this time, Intake in Region 3 has designated one person to ensure that intakes are sent to the appropriate law enforcement agencies and tribes as needed. This has considerably reduced the number of errors in the sending of reports.

Children's Administration

Executive Child Fatality Review

Orlando Potts

November 23, 2006
Child's Date of Birth

July 28, 2009
Child's Date of Death

December 2, 2009
Date of Fatality Review

Committee Members
*Roland Bautista, Sgt., Pierce County Sheriff's Department
*Lori Van Slyke, MSW, Crisis Social Worker Mary Bridge Children's Hospital
*Ann Eft, Director, Pierce County Commission Against Domestic Violence
*Linda Miner, Family Support Partnership Program Coordinator, Tacoma-Pierce County Health Department
*Lawrence Cross Sr., SGM Retired, MSW, U.S. Army Warrior Program Soldier and Family Advocate (Armed Forces Services Corporation)

Medical Consultant to the Committee
*Michelle Terry, M.D.

Observers
*Mary Meinig, MSW, Director of the Office of the Family and Children's Ombudsman
*Tonya Fox, MSW Practicum Student, Children and Family Services Region 5

Facilitator
*Bob Palmer, Regional Child Fatality Program Consultant, Children's Administration

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Executive Summary

On December 2, 2009, Children's Administration (CA) convened an Executive Child Fatality Review[1] committee to examine practice and service delivery in the Kitsap County fatality case involving two-year-old Orlando Potts. CA received a low risk intake on June 24, 2009. This intake was screened by CA for Alternate Intervention with a contracted provider for Early Family Support Services (EFSS) and was still active at the time of Orlando's death.

Committee membership consisted of a diverse group of individuals from outside Kitsap County, representing the fields of law enforcement (LE), domestic violence (DV), military advocacy, medical social work, and community family services. Four of the five members had no prior knowledge of the case, and none had any direct involvement with case.

The incident initiating this review occurred on July 27, 2009, when a hospital social worker from Harrison Medical Center (Kitsap County) notified Child Protective Services (CPS) of the impending death of a young child from suspicious injuries. The child was subsequently transported to Mary Bridge Children's Hospital (MBCH) in Pierce County where brain death was assessed. Medical intervention was discontinued and Orlando Potts died within minutes of life support removal on the evening of July 28, 2009. Cause of death was determined to be from blunt force trauma, and manner of death declared a homicide. Jimmie Joseph Wright III[2], the cohabitating fiancé of the deceased child's mother, was the only adult caretaker present in the residence at the time of the incident. Mr. Wright has been charged with second-degree murder.

Prior to the fatality the Potts family involvement with CA consisted of one low risk case[3] assigned in June 2009 for Alternate Intervention by a contracted provider for Early

[1] Given its limited purpose, a Child Fatality Review by Children's Administration should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. A review is generally limited to documents in the possession of or obtained by DSHS or its contracted service providers and the panel may be precluded from receiving some documents that may be relevant to the issues in a case because of federal or state confidentiality laws and regulations. A review panel has no subpoena power or authority to compel attendance and generally will only hear from DSHS employees and service providers. The panel may not hear the points of view of a child's parents and relatives, or those of other individuals associated with a deceased child's life or fatality. A Child Fatality Review is not intended to be a fact-finding or forensic inquiry or to replace or supersede investigations by courts, law enforcement agencies, medical examiners or other entities with legal responsibility to investigate or review some or all of the circumstances of a child's death. Nor is it the function or purpose of a Child Fatality Review to take personnel action or recommend such action against DSHS employees or other individuals.

[2] The full name of Jimmie Joseph Wright III is being used in this report as he has been charged in connection with the death of Orlando Potts and his name is part of the public record.

[3] "Low to Moderately Low Risk Cases means cases where the primary concerns are issues of neglectful social, environmental, parenting practices that have not yet resulted in serious injury, developmental delays or other significant problems for the at-risk child" [DSHS Central Contracted Services 2045XS Early Family Support Services – Client Service Contract 6-1-09].

Family Support Services (EFSS)[4]. The identified clients were the mother (S.P.), her son Orlando Potts, and a younger sibling (T.P.). The EFSS case was still active at the time of the fatality and more detail can be found in the Case Overview section of this report. There had also been recent CA involvement with Jimmie Joseph Wright III, his estranged wife T.H.W., and their three children (J.A.W., J.J.W., and J.L.W.). None of the Wright family history involved allegations of physical abuse (see Case Overview).

Prior to meeting, review committee members were provided a summary of the EFSS intervention provided to the Potts family, two newspaper reports regarding the fatality incident, and detailed chronologies for both the Potts and the Wright families. A large portion of the information contained in the two family chronologies was obtained post-fatality from a variety of sources outside DSHS/CA (e.g., Naval Hospital, Naval Housing, local law enforcement).

Available to committee members at the time of the Executive Child Fatality Review were un-redacted copies of the CPS files for the Potts and Wright cases. A listing of the specific set of documents can be found in the Addendum section of this report. Additionally, a considerable array of reference materials were made available to committee members, including DSHS and CA publications regarding policy and practice, several Washington State laws relating to child abuse and authorized response by CPS, published articles on domestic violence (in general and with regard to spousal abuse in the military), articles on non-accidental head trauma, and internet source materials regarding the Navy Family Advocacy Program, the Institute of Family Development (IFD), and the National Safe Kids Organization. A listing of the reference materials can be found in the Addendum section of this report.

Personnel from IFD, the contracted EFSS provider, were available for interview but the panel declined as the documentation appeared sufficient. Additionally, CA social workers involved with the Potts and the Wright cases case were available for interview but were not called to appear.

Following review of the CA case file documents, the additional information regarding the Potts and the Wright families from non-CA sources, and discussion of CA policy, practice, and procedures, the review committee made one recommendation which is presented at the end of this report.

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[4] EFSS was previously known as Alternative Response Services (ARS). The EFSS contractor provides direct services to families and/or links families to community resources to accomplish the following goals for families: (1) reduce risk of abuse or neglect of children in the home; (2) enhance parenting skills, family and personal self-sufficiency, and family functioning; (3) reduce stress on the family; (4) reduce the likelihood of additional referrals to CPS; and (5) enhance the health status of families and linkages to health services [DSHS Central Contracted Services 2045XS Early Family Support Services – Client Service Contract 6-1-09].

Case Overview

RCW 74.13.500

Wright Family:
Prior to her marriage to Jimmie Joseph Wright III,

RCW 74.13.500

Mr. Wright was deployed by the U.S. Navy a large portion of that time. Mr. Wright and his wife subsequently had three children (November 2004, January 2006, and April 2007), all born in the state of Washington.

RCW 74.13.500

there were no further concerns reported to CPS until December 2008 when CA intake was notified by Bremerton Police of a domestic dispute call that resulted in both parents being arrested for violations of mutual No Contact Orders (NCO).

RCW 74.13.500

In February 2009 Bremerton Police responded to a complaint by Mr. Wright that his estranged wife had again violated the NCO,
The three Wright children remained in the care of their father.

The Wright family case was in process of case closure at the time of the fatality to Orlando Potts while in the care of Jimmie Joseph Wright III. Following that fatality, the three Wright children who had been in the care of their father were placed into protective custody and dependency actions initiated

RCW 74.13.500

Potts Family:
On June 24, 2009, the Bremerton Naval Hospital made a referral to CPS regarding possible parental delay in seeking medical intervention for a laceration on the leg of two year old Orlando Potts. While the wound was not significant in terms of required medical intervention or threat to the child's health, the possibility that lack of supervision by his mother had resulted in the injury was noted at CPS intake. The report was taken for

Alternate Intervention (low risk) and sent to the Early Family Support Services (EFSS) contracted provider for Kitsap County. The identified clients were S.P. and her two children.

Attempted contact by the EFSS provider was made within three days of the intake, but unbeknownst to the interventionist the client had moved. Persistent efforts to contact the family were successful, resulting in a home visit being conducted on July 14, 2009.

Three days after the EFSS home visit, Orlando was seen at Harrison Medical Center following a reported fall from playground equipment. No referral to CPS was made. Medical records obtained (and reviewed by CA Regional Medical Consultant) show there were no injuries upon medical examination and no report was made to CPS. When interviewed following the later fatality incident, S.P. revealed that her son had actually fallen out a window during nap time (observed by a neighbor) and she had lied about the fall due to fear that the incident would jeopardize her custody situation with her estranged husband.

A second home visit by the EFSS therapist was conducted on July 21, 2009. Present were S.P. and her two children. The fiancé (Jimmie Wright) was present at the home but he did not participate in the session. Mr. Wright's three biological children were also present at the home that day. S.P. expressed concern about how her estranged husband might react to her seeking custody and a NCO, although she did not indicate fear of physical violence. The EFSS therapist and the mother discussed safety issues and available community resources. The EFSS provider was not informed as to Orlando having been seen at the ER following a fall. A third home visit was scheduled for July 28, 2009.

On July 27, 2009, CPS received a report from Harrison Medical Center of the impending death of a young child from suspicious injuries. The attending ER physician and other medical professionals involved concluded that the injuries were not consistent with the explanation of the child having fallen backwards on a coffee table or some other object. Jimmie Joseph Wright III, the cohabitating fiancé of the deceased child's mother, was the only adult caretaker present in the residence at the time of the incident. The child was subsequently transported to Mary Bridge Children's Hospital (MBCH) where brain death was determined. Medical intervention was discontinued and Orlando Potts died within minutes of life support removal on the evening of July 28, 2009. Cause of death was determined to be from blunt force trauma, and manner of death declared a homicide. Mr. Wright is currently charged with second-degree murder and remains incarcerated pending trial. Although the criminal case has not been concluded, the CPS investigation resulted in a finding of founded for child maltreatment by Mr. Wright.

Immediately following his brother's death, sibling T.P. was taken into protective custody by law enforcement and placed in out-of-home care by CPS. A dependency petition was filed in Pierce County Juvenile Court

RCW 74.13.500

RCW 74.13.500

Findings and Recommendations

The committee made the following finding and recommendation based on review of CA case records including contracted provider documents, department policy and protocol, and records obtained from sources outside CA.

Finding

Overall the EFSS provider for the Potts family appeared to have met service requirements as described in the current DSHS Central Contracted Services EFSS County Program Agreement and EFSS Client Service Contract. However, a review of the EFSS documentation, including therapist notes, suggested that some aspects of the discussion and intervention around domestic violence issues involving the mother and her estranged husband (who was not involved with the fatality incident), could have been improved.

Recommendation

The current DSHS Central Contracted Services EFSS County Program Agreement and EFSS Client Service Contract require CA to provide mandatory EFSS training for all direct EFSS service staff. It is recommended that the contract be amended to specifically require domestic violence training for all EFSS direct service staff, through CA if available, or as acquired by the provider agency from community sources.

Addendum

Case file documents available at review

Potts Family

EFSS documentation from contracted provider [Institute for Family Development]
Post-fatality CPS records (from the July 2009 fatality incident through October post-fatality activities)

Results of various assessments (provided by CA post-fatality)

- Regarding the biological father: DV assessment, Parenting Assessment, Family Assessment/Homebuilders Intervention
- Regarding the biological mother: 2 Psychological evaluations

Law enforcement documents

- Initial police report regarding the fatality incident [additional documentation from law enforcement was not available due to on-going criminal prosecution]

Medical records - Orlando Potts [pre-reviewed by the committee medical consultant]

- Two pre-fatality Emergency Room visits
- Critical care records following the fatality incident

Medical records - Miscellaneous

- Pre-fatality and post-fatality medical records regarding sibling T.P.
- Pre-fatality medical notes (Navy) regarding mother S.P. (2008 pregnancy)

Navy documents (pre-fatality records)

- DV/Family Advocacy
- Naval Housing
- Psychiatric services summary for S.P.
- Naval Hospital records (S.P. 2008 - family advocacy)

Wright Family RCW 74.13.500

CPS records 2008-2009 (Jimmie Joseph Wright III and spouse)
Law enforcement documents [pre-fatality] involving responses to violations of NCO between Jimmie Joseph Wright and his estranged wife

Reference Materials Available at Review

Washington State/DSHS/CA Publications

- Children's Administration Practice Guide to Intake and Investigative Assessment (Draft 4; 2009)
- CA Practice & Procedures Guide Section 2332: Alternate Intervention
- CA Structured Decision Making Procedures Manual® (2007)

- CA Policy Summary - Co-occurring Domestic Violence and Child Maltreatment (July 2009)
- CA Key Points from the Domestic Violence (DV) Practice Guide (April 2009)
- Protecting the Abused & Neglected Child: A Guide for Mandated Reporters In Recognizing & Reporting Child Abuse & Neglect (DSHS 22-163 Rev /09)
- WAC 388-15-009: What is child abuse or neglect?
- WAC 388-15-020: How does CPS respond to reports of alleged child abuse or neglect?
- WAC 388-15-005: What definitions apply to these rules?
- Comparison of Court Orders for Washington State (prepared by the Washington State Coalition Against Domestic Violence)
- Memorandum of Understanding (MOU) between Navy Region Northwest and Washington State Department of Social and Health Services regarding child abuse and neglect involving military personnel (August 2009)
- DSHS Central Contracted Services 2046CS Early Family Support Services (EFSS County Program Agreement 6-2-09)
- DSHS Central Contracted Services 2045XS Early Family Support Services (EFSS Client Service Contract 6-1-09)

Articles

- Synopsis of Army family study of the rate of spousal abuse to child abuse and neglect (article originally published November 2000 issue of Child Abuse and Neglect).
- *Should childhood exposure of adult domestic violence be defined as child maltreatment under the law?* Jeffrey L. Edleson (2004).
- *The Battered Mother in the Child Protective Services Caseload: Developing an Appropriate Response*. Evan Stark (2001) - Originally developed for class action lawsuit Nicholson v. Williams et al.
- Synopsis of facts emerging from the National Survey of Children's Exposure to Violence (2008; published 2009 NatSCEV).
- *Tin Ear Syndrome: Rotational Acceleration in Pediatric Head Injuries* (Hanigan, Peterson & Njus, Pediatrics Vol. 80 No. 5 November 1987)

Miscellaneous

- 2001 Memo from Deputy Secretary of Defense Paul Wolfowitz regarding Domestic Violence in the Department of Defense.
- List of common acronyms used by Children's Administration

Internet Materials

- www.usmilitary.about.com
  - Navy Family Support
  - Military Domestic Problems - Part IV Family Violence

- www.Fapmip.defense.gov
  - Department of Defense Family Advocacy Program
- The Navy Fleet and Family Support Center www.nffsp.org
  - Family Advocacy Program
- Institute for Family Development web site - program materials www.institutefamily.org
- Abusive Head Trauma (Reviewed by Elaine Cabinum-Foeller, MD for Kids Health Organization www.kidshealth.org
- National SAFE KIDS Campaign - statistics/incident rates regarding childhood injuries from falls (including window falls). www.usa.safekids.org