Report to the Legislature

Quarterly Child Fatality Report

RCW 74.13.640

January – March 2011

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

Table of Contents

Children's Administration Quarterly Child Fatality Report

Executive Summary

This is the Quarterly Child Fatality Report for January through March 2011 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 20 completed child fatality reviews of fatalities that occurred in 2010. Seventeen of the child fatalities were reviewed by a regional Child Fatality Review Team and were not caused by child abuse or neglect, but as a result of accident or illness. In 2011, the child fatality statute was revised to require the department to post only reviews conducted in child deaths that resulted from child abuse or neglect. The reports from child fatality reviews from non-abuse or neglect related fatalities are not posted on the public website and are not included in this quarterly report. However, this report includes analysis of data from those reports.

Three reviews were completed by Executive Child Fatality Review Teams. Two of the Executive Child Fatality Reviews were facilitated by practice consultants from CA Headquarters and one was facilitated by a regional Child Protective Services Program Manager.

All prior Executive Child Fatality Review reports are found on the DSHS website: http://www.dshs.wa.gov/ca/pubs/fatalityreports.asp.

Child Fatality Reviews are conducted when children die unexpectedly from any cause and manner, and the child had an open case or received services from the Children's Administration (CA) within 12 months of his/her 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 (executive child fatality review) 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) are conducted in cases where the child fatality 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. 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.

The chart below provides the number of fatalities reported to CA, and the number of reviews completed and pending for calendar year 2010 and pending for calendar year 2011. 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.

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

Region	Number of Reports
1	1
2	3
3	3
4	5
5	2
6	6
Total Child Fatalities Reviewed During 1st Quarter, 2011	20

Child Fatality Reviews for Calendar Year 2010			
Year	Total Fatalities Reported to Date Requiring a Review	Completed Fatality Reviews	Pending Fatality Reviews
2010	69	57	12

Child Fatality Reviews for Calendar Year 2011			
Year	Total Fatalities Reported to Date Requiring a Review	Completed Fatality Reviews	Pending Fatality Reviews
2011	11	0	11

The numbering of the Child Fatality Reviews in this report begins with number 10-38. This indicates the fatality occurred in 2010 and is the thirty-eighth 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. Confidential and identifying information not subject to disclosure has been redacted.

Notable Findings

Based on the data collected and analyzed from the 20 deaths reviewed between January and March 2011, the following were notable findings:

- Three of the fatality reviews completed during the 1st quarter required an Executive Child Fatality Review (i.e., the child's death was caused by abuse or neglect).
- Of the three executive child fatality reviews, one fatality occurred when the case was open during a child protective services investigation.
- Children four months or younger accounted for approximately 20% (4) of the 20 fatalities reviewed.
- Of the 20 child fatalities reviewed, 55% (11) were males and 45% (9) were females.
- Of the 20 child fatalities reviewed, 55% (11) of the children were white, 20% (4) were identified as Asian/Pacific Islander, 15% (3) were Native American, and 12% (2) were Hispanic.
- Natural and accidental deaths, as classified by the medical examiner or coroner, accounted for approximately 60% (12) of the total deaths. The manner of death of the remaining cases was as follows: 15% (3) were the result of homicides, 10% (2) were due to unknown/undetermined causes, 10% (2) were the result of 3rd party homicide, and 5% (1) was the result of a suicide.

- The two 3rd party homicides involved two youth shot by a relative who was not in a primary caregiver role.
- In two of the three homicides, the children died from blunt force trauma. In the other homicide the child died from inflicted head trauma. The perpetrators were male caregivers and were the boyfriends of the children's mothers. The children were three and two years old.
- One fatality occurred in a licensed childcare facility.
- Of the 20 child fatalities reviewed, 19 had prior contact with Children's Administration (CA). One review was conducted on a child fatality that occurred at a licensed childcare facility with no prior history. Sixty-five percent (65%) of the child fatalities reviewed had between one and four prior intakes and 35% had between five and nineteen prior intakes.

Due to the small sample of cases reviewed, no statistical analysis was conducted to determine relationships between variables.

Table 1.1

1st Quarter 2011, Child Fatalities by Age and Gender						
Age	Number of Males	% of Males	Number of Females	% of Females	Age Totals	% of Total
<1	2	18%	2	22%	4	20%
1-3 Years	2	18%	2	22%	4	20%
4-6 Years	1	9%	1	11%	2	10%
7-12 Years	2	18%	-	-	2	10%
13-16 Years	3	28%	3	34%	6	30%
17-18 Years	1	9%	1	11%	2	10%
Totals	11	100%	9	100%	20	100%

N=20 Total number of child fatalities for the quarter.

Table 1.2

1st Quarter 2011, Child Fatalities by Race	
Black or African American	0
Native American	3
Asian/Pacific Islander	4
Hispanic	2
White	15
Unknown	-
Totals*	**24**

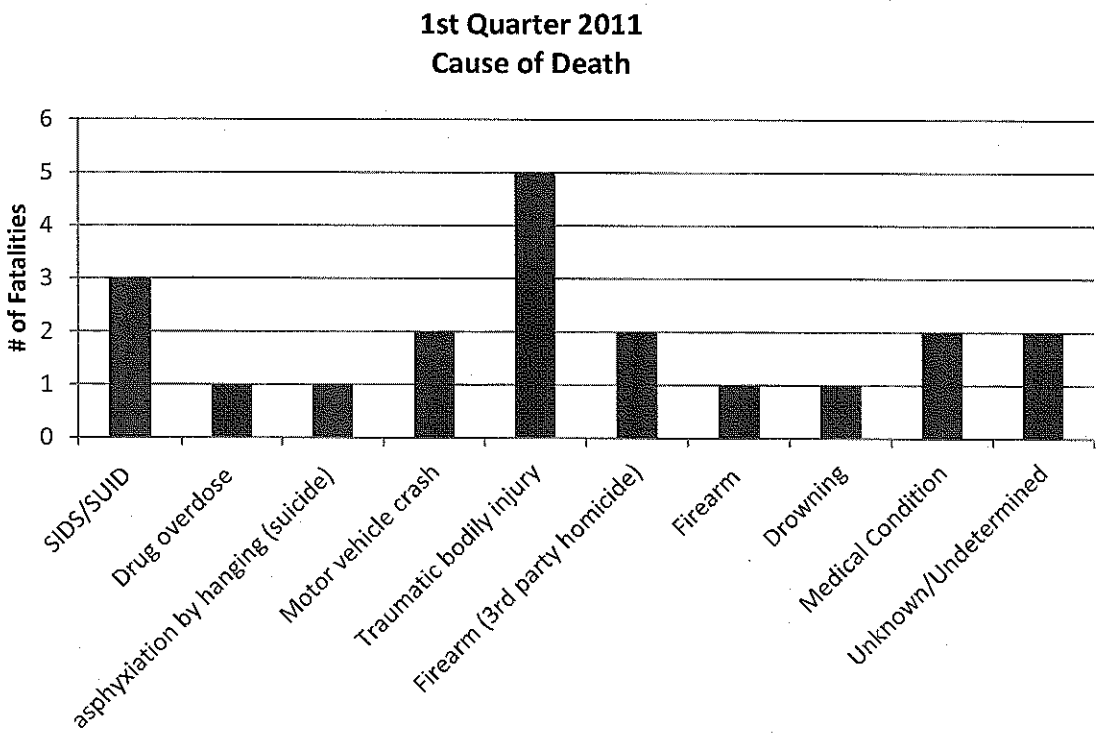
*Some children may be in more than one category.

Table 1.3

1st Quarter 2011, Child Fatalities by Manner of Death	
Accident	7
Homicide (3rd party)	2
Homicide by Abuse	3
Natural/Medical	5
Suicide	1
Unknown/Undetermined	2

N=20 Total number of child fatalities for the quarter.

Table 1.4



N=20 Total number of child fatalities for the quarter.

Table 1.5

1st Quarter 2011, Number of Reviewed Fatalities by Prior Intake						
Manner of Death	0 Prior Intakes	1-4 Prior Intakes	5-9 Prior Intakes	10-14 Prior Intakes	15-24 Prior Intakes	25+ Prior Intakes
Accident	-	3	4	-	-	-
Homicide (3rd party)	-	2	-	-	-	-
Homicide	-	2	1	-	-	-
Natural/Medical	1	3	1	-	-	-
Suicide	-	-	-	-	1	-
Unknown/ Undetermined	-	1	1	-	-	-

N=20 Total number of child fatalities for the quarter.

Summary of the Recommendations

Of the 20 child fatalities reviewed between January and March 2011, 15 (75%) had issues and recommendations identified during the child fatality review process. Issues and recommendations from fatality reviews impact policy, practice and systems associated with CA. At the conclusion of every case receiving full team review, the team decides whether any recommendations should result from the fatality review. In most instances where the death was categorized as being preventable, some recommendations were made.

Issues and recommendations that were cited during the child fatality reviews completed during the quarter fell into the following categories:

1st Quarter 2011, Issues & Recommendations	
Contract issues	2
Policy issues	4
Practice issues	24
Quality social work	0
System issues	10
Total	**40**

Issues and recommendations were made regarding thoroughness of casework in six cases. The issues identified involved conducting a thorough review of prior case history, interviewing all relevant participants during CPS investigations, and additional contacts made during the intake screening process. The recommendations made regarding the practice issues identified in the area of intake required attention at the local office level.

An issue identified in the area of social work practice specifically relating to the lack of timeliness in case file documentation was noted in two cases. Also noted in two cases were concerns regarding historical intakes that were found in the hard copy of the file but not in FamLink, the CA case management system. The intakes were not located because they were likely deleted in accordance with expungement requirements in statute. In two cases it was also noted that Child Protection Team (CPT) staffings were not held in a timely manner. These issues were addressed through training at the local level. Three cases identified caseload sizes as affecting the ability to complete work and close cases. Two of these three cases were addressed with recommendations at the regional and local level. One had no recommendation by the fatality review team.

Child Fatality Review #10-38
Region 6
Pacific County

This three-month-old Caucasian female born in April 2010 died from Sudden Unexplained Infant Death (SUID).

Case Overview

On July 28, 2010, the Pacific County Sheriff's office contacted the department after hours to report the three-month-old infant died earlier that evening. Her mother told law enforcement that the child had been sleeping in her bassinet. The mother checked on her later in the evening and found that she was not breathing. The mother called 911. Medics responded to the home. The child died before arriving at the hospital. The child appeared to have died at home as her skin was blue in color and rigor mortis was established when medics responded. Initially, the treating physician indicated the child's body showed signs of trauma. However, the autopsy noted no signs of trauma. The responding deputy was asked about this during the fatality review, and he indicated the trauma to which the physician referred was a nose bleed. The Coroner reported there was no evidence of abuse and/or neglect at the autopsy. The Coroner determined the cause of death was Sudden Unexplained Infant Death (SUID) although positional asphyxia could not be ruled out. The manner of death was natural/medical.

Children's Administration (CA) had an open case on the family at the time of the child's death. In April 2010, Child Protective Services (CPS) intake received a report soon after the birth of the three-month-old. The child was admitted to the intensive care unit at a Portland area hospital for a scalp hematoma and respiratory issues. The meconium test was positive for methamphetamine and amphetamines. The mother provided a urinalysis at the time of her daughter's birth which was negative for all substances. The case was open when the child died in July 2010.

Intake History

On April 6, 2010, a hospital social worker contacted Child Protective Services (CPS) intake to report the child was transported to Legacy Emmanuel Hospital in Portland shortly after her birth. The child had a hematoma on her scalp and had difficulty breathing. The meconium test was positive for methamphetamine and amphetamines; the mother's urinalysis was negative. The mother received no prenatal care. The intake was screened in for investigation, and a case was opened on the mother and her child. The mother received public health nurse visits, and the assigned social worker made several visits with the nurse. The family received assistance through the Women, Infants, and Children (WIC) program, and actively participated with the local "Early Steps to School Success Program," an early intervention program that included frequent home visits. The mother was referred to substance abuse treatment. She completed a substance abuse evaluation and was attempting to arrange for family to watch her child so that she could participate in treatment. This had not started before the child died.

The CPS investigation was closed with an unfounded finding for negligent treatment or maltreatment. On July 29, 2010, CPS intake received a report from law enforcement that the three-month-old was in distress at home and died before getting to the hospital. Law enforcement investigated the child's death. The intake was screened in for investigation and closed with an unfounded finding for negligent treatment or maltreatment.

Issues and Recommendations

Issue: There was an issue on this case related to documentation. When the department was notified of the death of the three-month-old, there was missing documentation that had not yet been entered into FamLink. The social worker was on annual leave when the child died. The social worker had case information in handwritten case notes, but had not input these notes into FamLink. This made review of the case record difficult and time consuming. This also delays the case being transferred to another social worker.

Recommendation: Policy has since been established with shortened timeframes for documentation. It is recommended that prior to any significant period of planned leave, supervisors review that important documentation on cases has been completed for that social worker. This is particularly critical for health and safety visits. This expectation has since been made explicit to supervisors within the Aberdeen/Long Beach/South Bend catchment area and will be discussed at the next regional supervisor's meeting.

Child Fatality Review #10-39
Region 5
Pierce County

This 16-year-old Caucasian male died from injuries after being hit by a train.

Case Overview
Shortly before 7:00 p.m. on August 1, 2010, this 16-year-old youth was standing on the northbound platform of the Puyallup Sounder Train Station with a friend. Both youth were beyond the well-marked yellow striped area that is designated to keep people a safe distance from approaching trains. As confirmed by video from the train's on-board camera, the 16-year-old was leaning over the platform edge and yelling at some other teens across the tracks as a passing Amtrak train approached at a speed estimated to be nearly 75 miles per hour. The train engineer sounded the train whistle, and the friend reportedly yelled for the 16-year-old to step back. The youth was struck in the head by the train causing him to flip through the air and hit a beam on the platform and then land on the platform. The youth died immediately from his injuries.

The Pierce County Medical Examiner determined the cause of death was from blunt force trauma and manner of death was classified as accidental. Toxicology results were negative, but the friend of the deceased youth admitted to police that earlier in the day they had been smoking K2, a legal herbal blend that has been synthetically altered to mimic THC (marijuana). It is known that K2 does not show up on toxicology tests.

Children's Administration (CA) had an open case on the family at the time of the youth's death. In June 2010, Child Protective Services (CPS) intake received a request from the youth's mother in filing an At-Risk Youth petition. The case was opened for Family Reconciliation Services (FRS) and was open when the youth died on August 1, 2010.

Intake History
On June 8, 2010, the mother of this 16-year-old contacted CPS intake to request Family Reconciliation Services in help filing an At-Risk Youth (ARY) petition. The mother reported her son was out control (i.e., he was drinking, had poor school attendance, possible gang involvement, and aggression at home). A FRS social worker met with the parents and the youth in mid-June and discussed various intervention and service options.

In May 2010, the family had moved from North Carolina to Washington State. In July the youth had violated his probation conditions from North Carolina and was charged in Pierce County for minor assault against his mother and for possession and consumption of alcohol. He was placed in detention. Information obtained from the youth's probation officer indicates that he began to show excellent improvement in his behaviors in July after his release from detention

Issues and Recommendations

Issue: Timelines by the worker were not met for entry of case notes and completion of the Voluntary Family Assessment. No contact was made with the youth or his parents in the month of July which is not consistent with expected practice [see CA Practices and Procedures Guide - Sections 3400 and 4420]. The failure to complete work requirements appear to reflect a pattern of work behavior by the individual social worker that may have been exacerbated by a significant increase in case assignments in March 2010.

Actions Taken: The FRS worker is currently employed in another DSHS administration and while willing to participate in the fatality review she was unable to do so due to a confirmed scheduling conflict. When interviewed by phone prior to the CFR, the worker acknowledged her failure to meet documentation timelines. The Pierce East Area Administrator for FRS has since transitioned to other duties (Pierce West) but did participate in the review and received feedback regarding the failure of timely documentation and completion of work.

Recommendation: None

Issue: Supervisory reviews were conducted and documented on this case. However, the supervisor at that time should have (1) been aware that the worker had not entered any case notes during the two months the case had been active, (2) directed the worker to complete required work, and (3) documented the discussion. It was noted during the review that the Pierce East FRS supervisor had assumed additional program responsibilities (EFFS oversight, FamLink related duties, and FRS program lead) which conceivably could have resulted in less time available for more intensive supervision.

Action Taken: The FRS supervisor left state service in August, moving to another state, and was not available to participate in the review. The current Pierce East FRS supervisor participated in the review and acknowledged supervisory responsibilities to document during monthly case conferences any directives to workers to complete work as required by policy.

Recommendation: None

Issue: Current CA policy has narrow limitations for denying requests from families seeking FRS [see CA Practices and Procedures Guide - Section 3200]. Given recent CA work force reductions, extensive state budgetary constraints (resource reductions), and prioritization of CA services (child safety), it may not be possible to serve as many families requesting FRS services as in the past while maintaining reasonably sustainable case loads.

Recommendation: (1) It is recommended that CA review current expectations for intervention and service delivery for the FRS program and consider revisions to policy that would allow for more flexibility in denying requests from families seeking FRS.

(2) It is recommended that FRS intake criteria be reviewed and discussed during upcoming Region 5 intake unit meetings. This should include a discussion on evaluating requests for services where there may be redundancy of services should CA become involved such as when a youth is already being served by juvenile probation. It is highly suggested that FRS program leads participate in such discussions with the intake units.

Issue: The FRS worker was unfamiliar with working with military families and navigating military social services. Engagement with the family might have been improved had a worker familiar with military families been involved.

Recommendation: It is recommended that Region 5 develop a plan to improve the expertise of social work staff working with military families.

Child Fatality Review #10-40
Region 2
Yakima County

This five-year-old Native American female died from an inflammation of her heart muscle.

Case Overview
On August 2, 2010, the five-year-old child was being babysat by her 12-year old sister while their mother was at work. At 9:00 p.m. the five-year-old went to bed. The older sister told police that she checked on her at 10:00 p.m. and noticed she was having difficulty breathing. At 12:00 a.m., the sister noticed the five-year-old was not breathing and cool to the touch. She went next door to her aunt's home and got help. Police and emergency medical technicians were dispatched to the home where resuscitative efforts were attempted. The child was taken to Toppenish Hospital where she was pronounced deceased on August 3, 2010. The five-year-old had been ill days prior to her death.

On July 29, 2010, she was taken to the hospital by her parents to be treated for an allergic reaction to her medications. She was also treated for a cough, strep throat, and a bladder infection. The child's mother told police that she gave her daughter medication before she left for work on August 2, 2010. According to the Yakima County Coroner's office the past medical history of the five-year-old included a recent streptococcal pharyngitis (throat infection). The Coroner determined the cause of death was attributed to post streptococcal myocarditis (an inflammation of the heart muscle caused by a bacterial infection.) A postmortem examination also revealed the child had acute respiratory failure, active pharyngitis, active laryngitis, a skin rash and swollen lymph nodes. There was no evidence of abuse or neglect. The manner of death is classified as natural/medical.

Children's Administration (CA) had an open case on the family at the time of the child's death. In June 2010, Child Protective Services (CPS) intake received a report that the family home had no electricity and two children had head lice. The case was open when the child died in August 2010.

The family includes children ages 16, 12, and 8 years old.

Intake History
On December 6, 2007, a relative contacted Child Protective Services (CPS) intake to report another relative had contacted the referrer and said the children were not properly dressed for the weather. The referrer also reported that one of the children had head lice. It was also reported that there was excessive drinking in the home by the parents. This intake was screened as Information Only as there was no allegation of child abuse or neglect.

On January 31, 2008, a school nurse called CPS intake to report the eight-year-old sister of the now deceased child had head lice. The eight-year-old sister was six years old at the time of this report. The child had a wound on the back of her head. The referent reports the wound was approximately five inches wide. The wound was oozing, emitted a bad smell and was bleeding. The child told the nurse it hurt. The referent had contacted the parents to say the child needed to be taken to a doctor, but there didn't appear to be any action taken. The child reported her mother never cleaned her head. The intake was screened in for investigation and closed with an unfounded finding for negligent treatment or maltreatment. The department provided the family with medication to treat the lice infestation with the children. The assigned social worker met with the parents and confirmed they took the child to the doctor. The social worker made a follow up visit with the child one week after the intake and observed the wound was healing.

On July 24, 2008, a hospital nurse called CPS intake to report the eight-year-old sister of the now deceased child was brought to the emergency room with a severe case of head lice. The eight-year-old sister was six years old at the time of this report. The referrer reported the child had infected open sores and swollen lymph nodes. The referrer was concerned that it could turn into MRSA. The referrer stated the child's mother was questioned about how long the child had the lice and she reported she noticed them a couple of days prior. The child was treated at the hospital with lice treatment and antibiotics. The referrer was very concerned about the other children in the home who were 3, 14, and 10 years old at the time. The intake was screened in for investigation. The CPS investigation was completed with a founded finding for negligent treatment or maltreatment. The case was transferred to the Family Voluntary Services (FVS) unit for ongoing case management. The assigned social worker made a referral to Project Safe Care. Project Safe Care provides direct skill training to parents in child behavior management using planned activities training, home safety training, and teaching child health care skills to prevent child maltreatment. The family was also offered a Home Based Services voucher to purchase head lice medication and cleaning supplies.

On June 26, 2010, a neighbor reported to CPS intake concerns about the four children in the home. The power was shut off to the home. The two youngest girls (including the now deceased child) had severe head lice. The referrer reported the lice were visible on the children. The children attempted to hide their heads by wearing scarves and hoodies. The children range in ages from 16 to 5 years. The intake was screened in for investigation. The assigned social worker met with the family. The parents acknowledged the power was off, but was back on when the social worker made the initial visit to the home. The parents had already taken the children to the Indian Health Services clinic and had the children treated for lice. The case was staffed with the Local Indian Child Welfare Advisory Committee (LICWAC) and the social worker was preparing to close the case when the five-year-old child died on August 3, 2010.

The detective investigating the child's fatality reported to the assigned CPS social worker that there were no concerns about the home environment or the condition of the children at the time of the child's death. The home was well vented and cool.

The parents were provided a list of service agencies in the community. The social worker offered to assist the family with grief counseling. The family was accessing counseling through their church and received medical care through Indian Health Services. The family refused further assistance. The CPS investigation was closed with an unfounded finding for negligent treatment or maltreatment.

Issues and Recommendations
Issue: There was no intake generated by the field office as a result of the death of this child. Per policy, an intake should have been generated.

Recommendation: The Area Administrator for the Toppenish Division of Children and Family Services (DCFS) office will meet with the supervisors and review the policy in a supervisor meeting.

Issue: The fatality review team reviewed the case history and felt the two unfounded investigations completed on this family by CPS should have been founded based on the evidence suggesting more likely than not neglect occurred. There were observed wounds from lice infestation (that met the definitions of abuse and neglect) to the children by the assigned social workers/investigators.

Action Taken: The Regional Administrator will send the two investigations back to the appropriate supervisors to have the findings changed.

Recommendation: CPS investigation training for the Toppenish DCFS office will be completed by February 28, 2011 by a Children's Administration headquarters program consultant.

Issue: On two of the investigations completed on the family there were no subject interviews completed for the father. Per policy, interviews of all subjects need to be completed and documented.

Recommendation: CPS investigation training for the Toppenish DCFS office will be completed by February 28, 2011 by a Children's Administration headquarters practice consultant.

Child Fatality Review #10-41
Region 6
Grays Harbor County

This three-year-old Caucasian female died from unknown causes.

Case Overview
On August 4, 2010, Hoquiam Police reported that this three-year-old child was found deceased in her bed at 8:30 a.m. The parents had two other children in the home, ages 15 months and 3 years, who were placed in protective custody pending further investigation.

The mother told police that on August 3, 2010 the three-year-old child went to bed with her twin sister at approximately 8:00 p.m. The mother said the girls liked to sleep together in the bottom half of the bunk bed where they could look out the window. The mother reported she checked on the girls before she went to bed at approximately 8:30 p.m. On August 4, 2010, the twin sister woke up her mother and her mother's paramour. The mother reported it was unusual to have the three-year-old sleep late, but no one checked on her until approximately 11:00 a.m. when the mother's paramour went to wake her up for breakfast. She was found not breathing, and 911 was called. The child was declared deceased at the scene. The Coroner placed her death somewhere between 10:00 p.m. and midnight the night before. Although the mother reported her daughter had seizures in the past, the detective indicated her body position did not appear to be that of a child who died from a seizure. An autopsy was conducted; toxicology reports were negative. Positional asphyxia could not be ruled out, but the County Coroner could not determine cause and manner of death.

The Children's Administration (CA) did not have an open case on the family at the time of the child's death. In June 2010, Child Protective Services (CPS) intake received a report that the family home was dirty, the mother's paramour had been violent around the children and the 15-month-old had a bruise near her mouth. This intake was screened in for investigation and was closed on July 23, 2010. The child died on August 4, 2010.

Intake History
On January 4, 2007, a hospital social worker contacted CPS intake to report a nurse walked in to the mother's room after she gave birth to twin daughters and the father of the children had the mother in a choke hold. One child was released from the hospital the week prior to the intake being reported; the other was later released on January 6, 2007. The referrer speculated that the mother had mental health issues. The mother was working with a public health nurse and a medical social worker. The intake was screened as Information Only.

On November 13, 2009, a police officer contacted CPS intake to report an injury to the twin sister (who was two years old at the time of this report). The police officer reported the child had a "shiner" below her left eye. The parents were separated and the father

was babysitting at the time. The child reportedly told her father, "Mommy did it." Law enforcement could not interview the child due to her age. Police asked CPS to respond. The intake was screened in for investigation of physical abuse. The child's father and another relative had no concerns about the child in the mother's care. The investigator determined the child sustained an accidental injury and the case was closed with an unfounded finding for physical abuse.

On December 18, 2009, an anonymous referrer reported to CPS intake that the three-year-old twin sister of the now deceased child got felt pen marks on her face and mother scrubbed it off with an eraser (later determined to be a Magic Eraser sponge) resulting in bruising and scabs to child's face. The child was two years old at the time of this report. The intake was screened in for investigation of physical abuse and completed with an unfounded finding for physical abuse.

On March 8, 2010, a babysitter contacted CPS intake and reported that the mother dropped her three children at the babysitter's home. The infant sibling of the now deceased child had diaper rash and needed to be bathed. The intake was screened as Information Only as there was no allegation of child abuse or neglect.

On May 6, 2010, an anonymous referrer contacted CPS intake to report one of the three-year-old twin girls had a broken crib with no sheets, was very wet, and the home had dog feces on the floor and clothes. The children smeared feces on the walls; there were dirty diapers throughout the house and the house smelled like urine. The intake was screened in for investigation. The assigned social worker made an unannounced home visit and found the home to be safe and sanitary. The CPS investigation was closed with an unfounded finding for negligent treatment or maltreatment.

On June 7, 2010, a relative called CPS intake and reported that he received an email from a third party, indicating mother's live-in boyfriend was violent, and the girls did not want to be there. The referrer said the boyfriend may be sexually abusing the children, but provided no additional information. The intake was screened as Information Only as there was no allegation of child abuse or neglect.

On June 9, 2010, a relative called CPS intake and reported that he had helped the children's mother clean up her home, but he was unaware that there was an earlier CPS investigation. He felt the home was unsafe/unsanitary. The referrer indicated he heard that the mother's paramour was violent around the mother and the children, but was not specific. The referrer also reported that one of the three-year-old twins had a bruise inside her mouth which was earlier seen by a doctor. This bruise was visible three months prior to the intake report. The assigned social worker obtained the child's medical records and there was no record of the child being seen by a doctor for a bruise in her mouth. The intake was screened in for investigation and closed with an unfounded finding for negligent treatment or maltreatment.

The investigator made unannounced home visits on June 10, 2010 and June 21, 2010 and the home was in reasonable condition to leave the children in the home. The mother had supports and the children's father was also monitoring the situation. The children received medical attention. The case was reviewed at a Child Protection Team (CPT) staffing and the team recommended a Birth to 3 assessment, parenting classes, domestic violence classes for the mother, and a developmental assessment. The mother declined voluntary services. The case closed July 23, 2010, and the child died on August 4, 2010.

On August 4, 2010, law enforcement reported to CPS intake that the three-year-old was found deceased in her bed in the morning. The two surviving siblings were placed into protective custody pending investigation. The intake was screened in for investigation and completed with an unfounded finding for negligent treatment or maltreatment related to the death of the three-year-old. The intake also contained allegations related to the conditions of the home. The allegations pertaining to the condition of the home were founded.

The home was unsafe and unsanitary. There were cleaners and medications accessible to children. There were human feces on the floor and wall, dirty diapers throughout home, and piles of laundry throughout the house. The two surviving siblings were placed in relative care. Dependency petitions were filed on both girls. When the children were removed the 15-month-old had a severe diaper rash, both girls had poor hygiene, colds, sinus infections and conjunctivitis. A full skeletal survey was completed on both children at the time of removal and no injuries (old or new) were present. Toxicology screens on both children were negative.

Issues and Recommendations

Issue: The review team discussed whether use of the Structured Decision Making (SDM) tool was helpful on this case to identify risk. Some members of the review team felt the SDM tool was limited in its utility.

Recommendation: The department should continue to refine/revise the SDM tool and provide training to social work staff about use of the tool.

Issue: It was noted that the Aberdeen Division of Children and Family Services office had significant staff vacancies in the CPS unit and it had created difficulties for the supervisors and the social workers to manage vacancies. Otherwise, the social worker may have been able to make an additional visit to the home prior to reviewing it at CPT. The area administrator indicated she has reassigned some workload responsibilities to assist at times.

Recommendation: Although the review team identified this as an issue, no recommendation was made at this time.

Child Fatality Review #10-42
Region 6
Mason County

This six-year-old Caucasian male died from a gunshot wound.

Case Overview

On August 10, 2010, this six-year-old child was accidentally shot by his eight-year-old brother. The handgun belonged to their mother's live-in boyfriend. The child was airlifted to Harborview Medical Center after sustaining the gunshot wound to his head. Mason County Sheriffs report the children's mother was home with the children and they were watching a movie. The mother told law enforcement that she fell asleep and woke to the sound of the gunshot. She found her six-year-old son and called 911. The mother's boyfriend told police that the keys to the gun safe were kept on a key rack near the sink. This was accessible to the eight-year-old with little effort. Sheriff's deputies indicated that the gun was loaded. On August 12, 2010, the six-year-old died from his injuries. Doctors were unable to perform surgery to reduce the swelling in his brain due to risks and likelihood that he would not survive the surgery.

The eight-year-old brother was interviewed by a Child Protective Services (CPS) worker on August 10, 2010. He reported the gun was located in a gun cabinet, but the gun cabinet had been unlocked for several days. The eight-year-old said he thought the gun was unloaded, but a bullet remained in the chamber.

The Medical Examiner determined the child died from a gunshot wound. The manner of death is listed as accidental.

The Children's Administration (CA) did not have an open case on the family at the time of the child's death. In April and May 2010, Child Protective Services (CPS) intake received a report of physical abuse of the eight and six year old boys by their mother's paramour. These intakes were screened in for investigation and closed on June 9, 2010.

There are two other children in the home, the eight-year-old brother and a half sister 15 months old.

Intake History

On May 27, 2003, CPS intake received an anonymous report indicating the family home was dirty with piles of clothes on the floor and cat feces. The referrer reported the family had enough food and there were no reports of drug or alcohol abuse. The father of the child was working and the mother stayed at home with the child (the eight-year-old brother who was 20-months old at the time of this report). The intake was screened in for investigation. The CPS investigation was closed with an unfounded finding for negligent treatment or maltreatment.

On April 15, 2005, CPS intake received an anonymous report. The referrer heard from various relatives that the mother and father left their son (the eight-year-old brother) locked in his bedroom all day because they did not know how to manage his behavior. The mother heard him crying in his bedroom but did not respond. The father gave his son food while he was locked in his bedroom. The referrer also reported the parents left him sitting in front of the TV all day. The intake was screened as Information Only as there were no allegations of child abuse or neglect.

On January 25, 2006, an anonymous referrer reported to CPS intake that the children's mother locked her then four-year-old son in his bedroom for long periods of time. He pounded on the door until someone let him out to go to the bathroom. Sometimes he had accidents and wiped the feces on the walls in his room. The intake was screened in for investigation of negligent treatment or maltreatment. The CPS investigation was closed with an unfounded finding. The Department assisted the mother with getting her son into Headstart and provided her with information on parenting classes and family counseling.

On February 25, 2008, a mental health counselor contacted CPS intake and reported the eight-year-old brother (six years old at the time of this report) had multiple problems including a severe speech impediment and was not potty trained. His mother has not gotten him to appointments saying there are transportation problems. The referrer was concerned that the child's problems would get worse. The referrer said the child needed to have his teeth cleaned. The intake was screened as Information Only as there were no allegation of child abuse or neglect.

On September 15, 2009, a school counselor reported to CPS intake that the six-year-old (five years old at the time of this report) came to school with a burn mark on the left side of his neck. The burn is about 1 1/2" x 1/4". The child said that his older brother used the lighter from the hearth to burn him. He said that when he told his mom, his mom put his older brother in the corner. The referrer noted that the mother and her boyfriend both smoke. The referrer questioned the level of supervision in the home. The six-year-old wasn't wearing his glasses at school saying his glasses were broken. The intake was screened in for the Alternate Response System (ARS). A social worker contacted the mother. She reported her older son got the lighter off the hearth, lit the lighter and touched it to his younger brother's neck. The mother reported the lighter was moved. The social worker stressed the importance of supervising the children.

On October 31, 2009, a neighbor called CPS intake and reported that the eight-year-old brother (then seven years old) was slapped across the face by his mother and later she slammed him against a wall. The incident was observed with other children and an adult standing in an open door. The referrer reported that the child was told to dress for Halloween and go to neighbors' houses by himself. The referrer was not sure if the child sustained any injuries. The referrer reported she would call the police and ask for a welfare check. The intake was screened in for investigation of physical abuse and negligent treatment or maltreatment. Mason County Sheriff's deputies went to the home

and made a welfare check. The child was interviewed by the assigned social worker and denied an incident of physical abuse. The child had no injuries. The CPS investigation was closed with an unfounded finding.

On February 5, 2010, a school counselor reported to CPS intake that the eight-year-old brother was seen at school digging in garbage cans looking for food. The referrer talked to the child and asked him questions to determine if he had food to eat at home. The referrer believed there was food at home. The referrer was unsure why he was digging in the garbage. No other concerns were known other than the mother was unresponsive to the school. The intake was screened as Information Only as there was no allegation of child abuse or neglect.

On April 21, 2010, school counselor reported to CPS intake that the eight-year-old brother told the referrer that his mother's boyfriend gave him a bloody nose. The child said his mother's boyfriend accused him of being disrespectful and hit him hard with a pillow. This caused him to hit the wall and he got the bloody nose. The referrer reported there were no marks on the child. The child said his mother went to the neighbor's house and called the police. The referrer asked the child if his mother's boyfriend had ever hurt him before, the child said that one time when he wouldn't get up, he took him by the legs and slammed him into the couch and floor. The social worker spoke with the officer who responded to the call and said this was a family matter. No arrests were made or citations issued. The intake was screened in for investigation and closed with an unfounded finding for physical abuse.

On May 5, 2010, a relative reported to CPS intake that another child visiting the family home reported that the mother's live-in boyfriend "hit the boys all the time when they were bad." The child also recounted an incident in which the boyfriend threw a pillow at the eight-year-old resulting in a nose bleed. The intake was screened in for investigation and investigated in conjunction with the April 21 intake. The investigations were closed with an unfounded finding for physical abuse.

On August 10, 2010, a Mason County Sheriff's Deputy called CPS intake and reported that the six-year-old child was shot in the head by his eight-year-old brother. The children found a handgun owned by their mother's boyfriend. The six-year-old was airlifted to Harborview Medical Center. He died on August 12, 2010. The intake was screened in for investigation of negligent treatment or maltreatment. The CPS case was completed with a founded finding due to the keys to the gun safe being easily accessible to the children. All firearms were removed from the home. A case remained open in the Family Voluntary Services unit. The parents of the eight-year-old son placed him in the care of his paternal grandfather. Family Preservation Services was offered to the family. The eight-year-old brother began seeing mental health professionals.

Issues and Recommendations

Issue: The child fatality review team did not find areas of concern during the review of this case.

Recommendation: None

Child Fatality Review #10-43
Region 3
Snohomish County

This 15-year-old Caucasian male committed suicide.

Case Overview
On August 15, 2010, the Snohomish County Medical Examiner reported the death of this 15-year-old youth. The Medical Examiner stated that on the evening of August 14, 2010, the youth's 17-year-old sister found him "hanging in the garage." The youth had wrapped an extension cord around his neck tied to a garage door track. The youth was transported to Seattle Children's Hospital and was pronounced dead on the morning of August 15, 2010. The Medical Examiner reported that it appeared that the youth had committed suicide. He lived with his mother and his sister. The mother reported that her son had a history of depression and a prior suicide attempt. The Medical Examiner had no concerns of child abuse or neglect.

The Medical Examiner determined the cause of death was asphyxiation by hanging. The manner of death is suicide.

The Children's Administration (CA) did not have an open case on the family at the time of the youth's death. In March 2010, Child Protective Services (CPS) intake received a report that the mother was reporting an adult male, not a family member, had raped her children. This intake was screened as Third Party and referred to law enforcement.

There was one other child in the home, a 17-year-old sister.

Intake History
On December 28, 1995, CPS intake received a report from a medical professional that the 15-year-old (a 15 month old child at the time of this report) was seen at a hospital with a fractured arm. The intake was screened in for investigation. The CPS investigation was closed with an unfounded finding for physical abuse.

On February 7, 2007, CPS intake received information from a CA social worker. The social worker met with an older sister of the 15-year-old youth. The sister reported that her brother (12-years-old at the time of this report) was in detention for truancy. The youth's 17-year-old sister had a warrant for truancy. The tribal police had gone to the home to investigate the assault of the adult sister in the home. Tribal police reported being at the home many times for drug and criminal activity. The police told the referrer that the father has a history of violence and sex offenses. The intake was screened in for investigation of negligent treatment or maltreatment. The investigation was completed with a founded finding.

Dependency petitions were filed on the 15-year-old and his sister. In-home dependencies were established in March 2007 due to lack of supervision, failure to protect and continued drug and criminal activity in the family home. The case remained open under the dependency action. The court dismissed the dependency on May 10, 2007. The case remained open in the Family Voluntary Services (FVS) unit following the dismissal of the dependency. The family was provided Functional Family Therapy. The FVS case was closed in July 2007.

On April 8, 2007, the youth's mother reported to CPS intake her son (then age 12) was having sex with his adult babysitter. The mother reported she would not allow this babysitter to be around her son any longer. The intake was screened as Third Party abuse and referred to law enforcement.

On November 20, 2007, a juvenile detention staff contacted CPS intake and reported that the 15-year-old and his 17-year-old sister (they were 13 and 14 years old at the time of this report) were arrested on warrants and placed in detention. The 15-year-old had a large amount of cash and drugs on him. The referrer had concerns that the 15-year-old may be running drugs for the family. The intake was screened as Information Only.

On July 4, 2008, an anonymous referrer called in to CPS intake to report that the 15-year-old and his 17-year-old sister (13 and 14 years old at the time of this report) were both using methamphetamine in their home with mother's knowledge. The referrer stated the teens were possibly dealing and manufacturing drugs. The referrer also stated the mother was abusive and an alcoholic. The children were not attending school. The intake was screened in for investigation. The allegations of negligent treatment were inconclusive on September 29, 2008. Both children were on probation at the time and substance abuse monitoring and treatment were being provided and supervised by probation. The case was closed in October 2008.

On April 16, 2009, Tribal Police contacted CPS intake and reported that the 17-year-old sister of the now deceased youth was not being supervised by her mother. The youth was 15-years-old at the time of this report. The mother was not following through with the At-Risk Youth court orders. The youth was found walking the streets at 2:00 a.m. Later she was at her boyfriend's house when police raided the house and found a methamphetamine lab. This intake screened in for investigation and completed with a founded finding for negligent treatment or maltreatment.

The assigned social worker met with the mother who reported her daughter continually left home without the mother's permission. The youth was on probation. The probation officer reported the mother was not reporting her daughter as a runway. The youth was on the run while the CPS investigation was open. It was reported she was staying with a 30-year-old male. The mother acknowledged that her daughter would periodically appear at home for a brief period and leave. The CPS investigation was closed with a founded finding as the mother failed to call in her daughter as a runaway.

On June 19, 2009, a staff member from the Department of Corrections reported to CPS intake that the 15-year-old youth stole items from stores with his father. The father was incarcerated at the time of this report. The child was living with his mother. The intake was screened for the Alternate Response System (ARS).

On July 31, 2009 a mental health counselor contacted CPS intake and reported that the mother reported her daughter (then 16 years old) was a chronic runaway and was living with an adult male in his 30s. The mother reported he was a methamphetamine addict and dealer. The mother also reported he shot out the windows of her car. This intake was screened in for investigation of negligent treatment or maltreatment. The mother had filed a runaway report with the Washington State Patrol and the Tribal Police. The youth had an active warrant for her arrest. The social worker contacted the youth's probation officer. The probation officer acknowledged that there was a warrant for the youth's arrest, though her whereabouts were unknown. The social worker spoke with an Everett Police Officer about the allegations. Everett Police acknowledged there was a warrant for the arrest of the 30 year old male. The social worker closed the case after being unable to locate the youth; she was on the run. The CPS investigation was closed as unfounded.

On September 9, 2009, a relative reported to CPS intake concerns that the 15-year-old youth and his half brother, 33 years old, were actively using methamphetamine. The relative reported that the half-brother and the youth's father supplied him with methamphetamine and alcohol. The referrer stated that the youth's mother overdosed three days prior on sleep medication and alcohol and was taken to the hospital. The referrer stated the youth's father has taught him how to steal. The father was recently in jail but was released. The referrer believed that the father and half brother were manufacturing methamphetamine in the home. The referrer has talked to the mother about the safety of the children but she didn't listen. There were reports of domestic violence in the home. The intake was screened in for investigation. The assigned social worker made an unannounced home visit and found no evidence of methamphetamine use or manufacture. The mother reported she accidentally mixed sleeping pills and alcohol resulting in her going to the hospital. The mother was accessing mental health and drug/alcohol services from Tribal Family Services. The supervisory closing case note indicates the allegations were unfounded. The investigative assessment was closed without a finding due to the social worker being unable to locate the alleged victim of the investigation.

On March 11, 2010, a staff member at Echo Glen Children's Center called CPS intake and reported that the 17-year-old sister (then 16 years old) was caught using methamphetamine while at Echo Glen. She reported that she received the methamphetamine from her father, who has sneaked it into the facility during his visit on March 8, 2010. The youth disclosed that her father has a history of providing her and her friends with illegal drugs. The incident was reported to the King County Sheriff's Department. The 17-year-old was interviewed and reported she lied about her father

providing her methamphetamine. She reported it was her boyfriend who supplied the methamphetamine. The 17-year-old remained in Echo Glen. Unsuccessful attempts were made to locate and interview the father. The mother was offered services but declined because she was already seeing a counselor. The investigation was closed without a finding due to the social worker being unable to locate the subject (the father) of the investigation.

On March 12, 2010, an anonymous referrer contacted CPS intake and reported that the mother reported that an adult male was raping her children. This was the same male in his 30s with whom the 17-year-old daughter was involved. The referrer said the mother was very incoherent and sounded intoxicated. The intake was screened as Third Party and was referred to law enforcement.

On August 15, 2010, the Snohomish County Medical Examiner called CPS intake and reported the death of this 15-year-old youth. The Medical Examiner reported that it appeared the youth committed suicide. He lived with his mother and 17-year-old sister. The referrer stated that on the evening of August 14, 2010, the sister found her brother "hanging in the garage." The child was transported to Children's Hospital and was pronounced dead on the morning of August 15, 2010. The mother told the Medical Examiner that her son had a history of depression and a prior suicide attempt. The intake was screened as Information Only.

Issues and Recommendations

Issue: Two of the most recent CPS investigations in 2009 and 2010 were closed on the Investigative Risk Assessments as "No Finding-Unable to Locate."

Recommendation: This topic will be addressed at the next CPS Supervisors meeting in March 2011. CPS Supervisors will be retrained on following the Diligent Search Guidelines for Reasonable Efforts to Locate Children and/or Parents. When CPS Supervisors approve a case for closure and notice the case is being closed as "No Finding-Unable to Locate," they shall ensure that the social worker has followed the diligent search protocol on locating children and parents.

Issue: It appeared to be unclear as to whether Children's Administration or the Tribe had jurisdiction regarding this case. There was a communication issue regarding tribes not immediately knowing about information only/screened out intakes involving tribal families.

Recommendation: When Region 3 CPS Supervisors are reviewing a CPS screened out intake involving a tribal family, they should communicate with the tribal case manager to ensure the intake should still screen out. The Smokey Point Area Administrator will address this topic at the next all staff meeting in February 2011 as well as with the tribe. This topic will also be addressed at the next CPS Supervisors' meeting in March 2011.

Issue: Several workers were assigned to this case over the years. There appeared to be an issue in which new workers on this case didn't review the complete case history and see the "whole picture." Also a CPS worker faxed a request form to Texas to obtain CPS history there however no follow up was made and Children's Administration never received this family's CPS history in Texas.

Recommendation: At the next all staff meeting in February 2011, the Smokey Point Area Administrator will retrain staff to review the entire case at the time of assignment and if applicable, out of state CPS history. This will also be discussed at the next CPS Supervisors' meeting in March 2011.

Issue: The dismissal of dependency of the three children occurred on May 10, 2007. Concern is that the social worker's declaration regarding the dismissal of dependency for the 15-year-old and his sister cannot be located in the hard file. When the determination and decision was made to dismiss the dependency on these children, a CPT staffing was not held even though there were significant risks regarding this family.

Recommendation: The Regional Safety Program Manager will discuss with the Area Administrators the protocol for conducting CPT staffings prior to returning children home when there are indicators of high risk. The Area Administrators will retrain their Children's Administration staff on this protocol by April 2011.

Child Fatality Review #10-44
Region 6
Clallam County

This 13-year-old Caucasian female died from Acute Methadone Intoxication.

Case Overview
On August 26, 2010, the 13-year-old youth was camping with her mother. Her mother was a caregiver for an adult male in his 60s, who was also present on this camping trip. The mother and 13-year-old went to bed between 8:30 and 9:00 p.m. in the same tent. Clallam County Sheriff's deputies reported that prior to going to bed, the mother and the adult male smoked marijuana. The youth reportedly did not consume any alcohol or marijuana but told her mother that she used methamphetamine a few days prior. The youth suffered from mild asthma but was not taking medication for this ailment.

At around 6:30 a.m. on August 27, 2010, the adult male got out of bed to use the bathroom. He and the youth had been sleeping on the same mattress. The mother slept on her own mattress which was next to the other mattress. After the male adult left the tent, the mother moved to the mattress where her daughter was sleeping and laid down next to her. The mother told law enforcement that her daughter was warm at that time. At about 9:00 a.m. the mother tried to wake up her daughter but found her unresponsive and not breathing. The mother called 911.

Law enforcement arrived on the scene and found the 13-year-old deceased with rigor mortis setting in. The youth had started to turn blue. Law enforcement reported the youth was naked when the deputy found her. The mother told law enforcement that her daughter regularly slept nude. Her body was warm to the touch on the side that the mother was laying next to her but was cold to the touch on the opposite side of her body.

Law enforcement investigated the youth's death and obtained a toxicology screen. The toxicology screen revealed the youth had ingested a lethal dose of methadone. The toxicology screen also found traces of methamphetamine and marijuana. The autopsy revealed no evidence of any sexual activity the night of the youth's death. Law enforcement found medication at the campsite including a prescription for methadone issued to the adult male. The Clallam County Coroner has ruled this youth's death accidental due to acute methadone intoxication.

Children's Administration (CA) did not have an open case on the family at the time of the youth's death. In February 2010, Child Protective Services (CPS) intake received a report that the mother's boyfriend had sexually abused the 13-year-old. This intake was investigated and closed with an unfounded finding in April 2010.

Intake History

On June 13, 1996, a doctor contacted Child Protective Services (CPS) intake and reported that the mother of the 13-year-old was 17 weeks pregnant and did not receive regular prenatal care. The doctor conducted a toxicology screen on the mother which was positive for amphetamines, methamphetamine, marijuana and codeine. All levels were high. This intake was screened in for Alternate Intervention. A referral was made to the First Steps Program.

On June 21, 1999, a staff member at a transitional housing facility reported to CPS intake that the mother was nursing her daughter (who was 2½ years old at the time of this report) and had a dirty urinalysis. On June 8, 1999, the mother tested positive for methamphetamine and marijuana. On June 16, 1999, she tested positive for methamphetamine. The intake was screened in for investigation. The child's father obtained temporary custody of his daughter. Staff at the transitional housing facility arranged for the mother to complete a drug/alcohol evaluation. The mother entered inpatient treatment on June 28, 1999. The investigation was closed with a founded finding for physical abuse.

On December 14, 2001, a police officer reported to CPS intake that the mother had reported her daughter missing (the child was four years old at the time of this report). She said she left her daughter in care of a friend. The mother told the police officer that she returned later and found her friend unconscious in the living room and her daughter was missing. The friend told police that the child's father picked her up. Police reported the house was a mess, dirty dishes, dirty clothes, and a mattress on the floor with no bedding. There was a syringe on top of the refrigerator. The father had temporary custody of his daughter in 1999. At some point prior to 2001, the child moved back with her mother. The intake was screened in for investigation. The CPS investigation was completed with a founded finding for negligent treatment or maltreatment. The case was closed after the father successfully petitioned the court to become the custodial parent of his daughter.

On December 17, 2001, a police officer reported to CPS intake that the mother was arrested for several shoplifting incidents that occurred several weeks prior to the intake report. The mother used her daughter, then four years old, as a distraction while she stole items from different stores. The child was in her father's care from an incident occurring three days prior in which her mother left her with an unfit caregiver. The intake was screened in for investigation. The CPS investigation was completed with an inconclusive finding for negligent treatment or maltreatment.

On March 23, 2006, the mother of the child reported to CPS intake that she saw what appeared to be finger marks on her daughter's arms. The mother reported these marks were fading. The mother reported she was not the custodial parent. The child was seen by the school nurse and no report was made to CPS intake. According to the referrer, the

child made no report of how she got the finger marks. The intake was screened as Information Only as there was no report of child abuse or neglect.

On February 1, 2007, the mother of the child reported to CPS intake that she had a visit with her daughter who reported being afraid of her father's new girlfriend. The mother said the child had lice in her hair and that her daughter was hit by the father's former girlfriend. There was no report of any injury or current abuse. The intake was screened as Information Only as there was no report of child abuse or neglect.

On May 6, 2008, CPS intake received a report from the Clallam County Sheriff who reported the 13-year-old youth (11-years-old at the time of this report) had disclosed that she was molested by her older half brother who was 18 years old at the time of this report. The 13-year-old told the investigating officer that she informed her father of the abuse, but he did not believe her and allowed her to be alone with her half brother following her disclosure. Law enforcement placed the youth in protective custody. The girl's mother had filed for a Protection Order and was awarded temporary custody. Counseling was arranged for the 13-year-old. The intake was screened in for investigation and completed with a founded finding on the father for negligent treatment or maltreatment.

On August 27, 2009, a juvenile probation officer called CPS intake and reported that a youth on her caseload was friends with the 13-year-old. The referrer reported it was disclosed to her that the 13-year-old was threatening suicide because she was raped by her grandfather and other male family members. The intake was screened as Information Only as the allegations alleged third party abuse. The allegations of sexual abuse by family members were investigated by law enforcement and adjudicated.

On February 23, 2010, a staff person from a domestic violence sexual assault advocacy center called CPS intake and reported that the 13-year-old youth told her mother that her mother's boyfriend had raped her during the past year. The youth told her mother that the last incident of abuse occurred on February 15, 2010. The mother brought her daughter to the clinic on February 19, 2010 and she was interviewed by a Clallam County Sheriff's deputy on that day. The sexual assault clinic assisted the mother in obtaining a temporary Protection Order. The referrer reported the mother was very supportive of her daughter and was extremely distressed over her disclosure. The mother and daughter went to a shelter for victims of domestic violence in Jefferson County. The intake was screened in for investigation of sexual abuse and the case was referred to the Port Townsend Division of Children and Family Services office. Law enforcement investigated the allegations and made no arrest and filed no charges. The CPS investigation was completed and closed with an unfounded finding for sexual abuse.

On August 27, 2010, a Clallam County Sheriff's deputy reported to CPS intake the death of this 13-year-old girl. Law enforcement reported the mother is a caregiver to an adult male in his 60s. The mother, the adult male, and her daughter were on a camping trip. At 6:00

a.m., the mother moved to where her daughter was sleeping and laid next her. The mother told law enforcement that she believed her daughter was alive at that time because she was warm to the touch. At 9:00 a.m. the mother tried to wake her daughter but she was unresponsive.

The death of the youth was investigated by law enforcement. The lab that completed the toxicology report indicated the youth ingested approximately 10 methadone tablets.

The adult male cared for by the youth's mother was taking prescribed methadone. Both he and the youth's mother told law enforcement that they caught the 13-year-old going through his bedroom looking for his methadone. A friend of the youth told police that he saw the adult male give the 13-year-old methadone. The adult male admitted to police that he gave her one methadone tablet once or twice because the youth complained of back pain. The law enforcement investigation is ongoing. The CPS investigation was closed with an unfounded finding for negligent treatment or maltreatment by the mother. The department offered grief counseling to the mother. She declined the offer.

Issues and Recommendations

Issue: The investigation of the February 23, 2010 intake initially came into the Port Angeles office. The case assignment was transferred to the Port Townsend office when the mother and daughter went to live in a shelter in Port Townsend. The case was assigned to a CFWS social worker rather than a CPS social worker due to staff shortage at the time of the intake.

Recommendation: A shelter is not a permanent housing arrangement. The case could have remained in the Port Angeles office with a request for courtesy interview with the child in Port Townsend. The Area Administrator will discuss this with both the Port Angeles and Port Townsend supervisor.

Issue: Finding all of the history on this family was made difficult by the search feature in FamLink. While all of the history was eventually found by the reviewer of this case prior to the fatality review meeting, it took several hours to complete the search in FamLink.

Recommendation: The team did not have a recommendation for this issue.

Issue: In February 2010, when the Port Townsend office received this case from the Port Angeles office they did not connect the father's history with the child. Had they done so they would have known that the 13-year-old had previously been a victim of sexual abuse by her half brother.

Recommendation: Conduct more thorough and complete history checks on all cases received in the Port Townsend office.

Issue: The Port Townsend office closed out the case after the mother and her daughter moved out the shelter and moved back to Clallam County. The review team felt that the case should have been transferred back to the Port Angeles office where services could have been provided to the mother and daughter.

Recommendation: The supervisor of the Port Townsend office participated in the review and acknowledged that they should have transferred the case back to Port Angeles for follow up with the mother and daughter. She will ensure that this does not happen in the future.

Child Fatality Review #10-45
Region 4
King County

This two-month-old Caucasian male born in June 2010 died from undetermined causes.

Case Overview

On August 29, 2010, the King County Medical Examiner reported to Child Protective Services (CPS) intake the death of this two-month-old infant. The Medical Examiner reported the child's death was being investigated as a Sudden Infant Death (SIDS) or Sudden Unexpected Infant Death. Two days after his death, the paternal grandfather called the Medical Examiner and reported that he had additional information. His mother (the paternal great-grandmother to the two-month-old) had observed, and photographed, the baby in his car seat in the bedroom, with a pillow placed on top of him. This was the morning of the date of child's death. The child's mother was sleeping in the same room. The great grandmother woke the child's mother and told her to take care of her son.

The child was born 10 weeks premature and remained in the hospital for six weeks after his birth.

The Medical Examiner reported this information to the King County Sheriff's Office. A Special Assault Detective was assigned. Family members and collaterals were interviewed. The parents refused to take polygraph exams upon advice of their attorney. The detective reported that the child's death was suspicious, but there was no further information to warrant any legal action. Law enforcement reported the investigation will remain open and inactive pending additional information. The Medical Examiner certified the cause and manner of death as undetermined.

Children's Administration (CA) did not have an open case on the family at the time of the child's death. In July 2010, CPS intake received a report that the child was due to be discharged from the hospital after being born prematurely. Hospital staff had concerns about the parents' bonding with their son. This intake was screened as a Risk Only and a case was opened. The case was closed on August 17, 2010.

Intake History

On July 16, 2010, a hospital social worker contacted CPS intake and reported that the child was ready to be discharged from the hospital. Hospital staff had concerns about lack of visitation with the baby and bonding. The child had been in the Intensive Care Unit. He was born approximately 10 weeks premature. The parents had no other children. The parents were living with the paternal grandparents. The child was due to be discharged from the hospital, but the parents delayed discharge for two days.

The parents had sporadic visits with their son in the hospital and would go weeks without visiting. The parents were confronted about the lack of visitation and they began to visit more regularly. Their visits would last less than one hour. This intake was screened in as Risk Only. The hospital staff referred the mother to the Women, Infant, and Children (WIC) program, Maternity Support Services, and Public Health Nurse (PHN). The parents obtained medical coverage for their son. The social worker arranged for the family to receive items from Westside Baby. Westside Baby is a community based organization that provides essential items such as diapers, clothing, toys and equipment to families in need. The social worker closed the case on August 17, 2010.

On August 29, 2010, the King County Medical Examiner's Office contacted CPS intake and reported that this two-month-old child had died. The Medical Examiner investigated the child's death as a Sudden Infant Death Syndrome (SIDS). The Medical Examiner did not have any additional information at the time of the child's death. The intake was screened as Information Only.

Issues and Recommendations

Issue: The hospital released the infant to his parents before making a report to CPS. A more effective choice would have been to make the report to CPS while the child was still a patient in the hospital. This would have given the assigned worker a better opportunity to meet with the parents, observe the child, and collaborate with the hospital staff. Had this been done, there would have been a clear service plan, which likely would have included a PHN assigned to the family via the Early Intervention Program. The assigned social worker, who specializes in referrals from hospitals, will follow up with the referring hospital about this issue.

Recommendation: The team did not have a recommendation for this issue.

Child Fatality Review #10-46
Region 3
Island County

This three-month-old Caucasian female born in May 2010 died from Sudden Infant Death Syndrome (SIDS).

Case Overview
On September 14, 2010, the licensed childcare provider of this three-month-old infant put her down for a nap in a car seat in a back bedroom of her home. Approximately one hour later, the provider went to wake the child from her nap and noticed that the child had pulled her blanket up to her face. The childcare provider told law enforcement that she moved the blanket and the child had spittle coming from her mouth and appeared to not be breathing. The provider grabbed the car seat with the three-month-old in it, brought it to the living room and called 911. The childcare provider immediately administered CPR. She reported there was a lot of mucus coming from the baby's nose and mouth so the provider turned her to her side several times to clear her airway. The provider's husband was notified at work of the incident and he immediately returned home and assisted with CPR on until medics arrived. The medics attempted to revive the baby at the scene but were unsuccessful. The baby was transported to Whidbey General Hospital.

The Island County Coroner determined the cause of death was Sudden Infant Death Syndrome. The manner is listed as natural.

Children's Administration (CA) has no prior history on the family of this three-month-old infant. This childcare provider has been licensed since June 2009. There is one prior licensing complaint from June 2009 reporting the provider's home needed minor repairs and the appropriate permits. Children's Administration has a Service Level Agreement with the Department of Early Learning (DEL) that CA will conduct child fatality reviews of fatalities that occur in licensed childcare facilities. DEL staff members were present and participated in this child fatality review.

Intake History
On June 5, 2009, the childcare provider contacted the childcare licensor and reported the county had not granted a permit to use the garage as living space and the stairs on the back deck did not have a handrail. This report was screened as a licensing complaint. The complaint was closed with a valid licensing finding.

On September 14, 2010, an Island County Sheriff's deputy reported to Child Protective Services (CPS) intake the death of the three-month-old infant at the home of a licensed in-home daycare provider. The provider put the child down for a nap and when she went to wake the child the child was not breathing. The child was pronounced dead at the scene. The intake was screened for a Division of Licensed Resources/Child Protective

Services (DLR/CPS) investigation and a childcare licensing complaint. The DLR/CPS investigation was closed with an unfounded finding for negligent treatment or maltreatment. The licensing complaint was deemed valid as the provider was overcapacity.

Issues and Recommendations

Issue: The team agreed that there is a lack of ongoing safe sleeping education and SIDS awareness for DEL in home daycare and daycare center providers.

Recommendation: The fatality review team recommended that DEL ensure their website includes information about safe sleeping and SIDS awareness. They also recommended that the DEL newsletter provide this information to providers. The DEL Northwest Area Service Manager will meet with local residential and referral agencies to discuss having them train daycare providers on the topic of safe sleeping and SIDS awareness.

Child Fatality Review #10-47
Region 4
King County

This 17-year-old Asian female died from a gunshot wound.

Case Overview
On September 23, 2010, Seattle Police responded to reports of gunshots being fired at a family home. At around 1:30 p.m., a grandmother took two handguns and began shooting at family members, killing her two granddaughters, ages 17 and 14 years old. The father of these two teenagers was also shot and killed. The grandmother then committed suicide.

The children's mother was also shot but survived. A 16-year-old brother and 6-year-old sister escaped from the home and were unharmed.

The King County Medical Examiner determined that this 17-year-old died from a gunshot wound. The manner of death is third party homicide.

Children's Administration (CA) did not have an open case on this family when the shooting occurred. On October 16, 2009, the department received an intake alleging the children had chronic lice issues and needed dental care. A younger sibling was not attending school. The intake was screened for the Alternate Response System and was closed in December 2009.

Intake History
There are three prior reports made to Child Protective Services (CPS) intake regarding four eldest children of this mother. All four are now adults. There were two reports to CPS intake made in 1991 alleging sexual abuse of one of the children. The child's father was arrested following these reports. In 2003, the four oldest children were in the custody of their grandparents. Two of the children moved back in with their mother. The intake alleged the mother told her daughter (then 16 years old) to get out of the house. The report alleged this 16-year-old was living on the street and had no money. The intake was investigated by CPS and closed with an unfounded finding for negligent treatment or maltreatment.

On October 16, 2009, CPS intake received a report from a doctor who reported the mother may be exhausted and was neglecting her children. She had five children in her care at the time, ages 16, 15, 12, 10, and 6 years old. The children had had lice since June 2009. The children needed dental care and the 10-year-old was not attending school. The intake was screened in for Alternate Intervention and sent to an Early Family Support Services (EFSS) provider. The EFSS provider (a public health nurse) closed her case in December 2009 after several unsuccessful attempts to contact the family.

Issues and Recommendations

Issue: The assigned public health nurse did not have contact with the referring doctor.

Recommendation: The contracted EFSS provider will ensure that public health nurses assigned for EFSS cases will make contact with the person who reported the concern to CPS.

Child Fatality Review #10-48
Region 4
King County

This 14-year-old Asian female died from a gunshot wound.

Case Overview
On September 23, 2010, Seattle Police responded to reports of gunshots being fired at a family home. At around 1:30 p.m., a grandmother took two handguns and began shooting at family members, killing her two granddaughters, ages 14 and 17 years old. The father of these two teenagers was also shot and killed. The grandmother then committed suicide.

The children's mother was also shot but survived. A 16-year-old brother and 6-year-old sister escaped from the home and were unharmed.

The King County Medical Examiner determined that this 17-year-old died from a gunshot wound. The manner of death is third party homicide.

Children's Administration (CA) did not have an open case on this family when the shooting occurred. On October 16, 2009, the department received an intake alleging the children had chronic lice issues and needed dental care. A younger sibling was not attending school. The intake was screened for the Alternate Response System and was closed in December 2009.

Intake History
There are three prior reports made to Child Protective Services (CPS) intake regarding four eldest children of this mother. All four are now adults. There were two reports to CPS intake made in 1991 alleging sexual abuse of one of the children. The child's father was arrested following these reports. In 2003, the four oldest children were in the custody of their grandparents. Two of the children moved back in with their mother. The intake alleged the mother told her daughter (then 16 years old) to get out of the house. The report alleged this 16-year-old was living on the street and had no money. The intake was investigated by CPS and closed with an unfounded finding for negligent treatment or maltreatment.

On October 16, 2009, CPS intake received a report from a doctor who reported the mother may be exhausted and was neglecting her children. She had five children in her care at the time ages 16, 15, 12, 10, and 6 years old. The children had had lice since June. The children needed dental care and the 10-year-old was not attending school. The intake was screened in for Alternate Intervention and sent to an Early Family Support Services (EFSS) provider. The EFSS provider (a public health nurse) closed her case in December 2009 after several unsuccessful attempts to contact the family.

Issues and Recommendations

Issue: The assigned public health nurse did not have contact with the referring doctor.

Recommendation: The contracted EFSS provider will ensure that public health nurses assigned for EFSS cases will make contact with the person who reported the concern to CPS.

Child Fatality Review #10-49
Region 6
Lewis County

This 17-year-old Caucasian male died from injuries sustained in a car accident.

Case Overview
On September 26, 2010, this 17-year-old youth was a passenger in a vehicle with three other male teens in rural Thurston County near Olympia. The 17-year-old was seriously injured in the vehicle collision when the driver lost control and the vehicle went off the road hitting several trees. He was airlifted to Harborview Medical Center where he died on September 26, 2010.

The King County Medical Examiner reported the youth died from blunt force injury, including skull fracture, subarachnoid hematoma and cerebral contusion. The manner of death is accidental. The medical examiner who reported this death did not indicate that there was any suspicion of neglect contributing to this incident. The 17-year-old driver of the vehicle was later arrested for suspicion of vehicular homicide. Police report the accident was alcohol related.

Children's Administration (CA) did not have an open case on this family when the accident occurred. In April 2010, the youth's mother contacted Child Protective Service (CPS) intake requesting assistance with filing an At-Risk Youth Petition as she was having difficulty with her 13-year-old daughter. The department accepted this FRS intake and provided services to the family

Intake History
The department received eight intakes on this family prior to the death of this 17-year-old. The first seven intakes were received between March 1993 and April 1997. Three of the seven intakes have investigations with one receiving a founded finding of abuse and neglect.

This family first came in contact with the department in 1993 when an intake was received regarding the mother's alleged drug use. The case was opened and referred for services through First Steps in Thurston County. Children's Administration received an intake in May 1995 and opened a case to investigate allegations of negligent treatment or maltreatment. It was reported that the mother allegedly allowed a registered sex offender to have contact with her son (who was approximately two years old at the time). The department received four intakes from March 7, 1996 to November 22, 1996 regarding possible sexual abuse of the 17-year-old (then three years old). There was one final intake on the mother in 1997 indicating she could benefit from the Early Intervention Program to help her with parenting skills and support.

The department became involved with the mother and her son in May 1995; it appears that the department stayed involved with the family until November 1997 when the case was closed. This included the filing of a dependency petition in January 1996. The youth was made dependent and was briefly placed with his grandmother. The case record indicates the mother participated in substance abuse treatment and parenting classes and made significant changes in her life during this period of time. The dependency was dismissed in November 1997.

On April 2, 2010, the mother of the 17-year-old youth contacted Child Protective Service (CPS) intake to request assistance in filing an At-Risk Youth Petition for her 13-year-old daughter. The mother reported she had been defiant and disrespectful with everyone. The intake was screened in for Family Reconciliation Services (FRS). The department provided FRS services to the family and both the mother and daughter participated in a Strengthening Families class. The At-Risk Youth Petition was not filed, and the case was subsequently closed in June 2010.

On September 26, 2010, the King County Medical Examiner contacted CPS intake and reported the death of the 17-year-old in a rollover car accident. Following the accident, he was transported to Harborview Medical Center where he died from head injuries. The intake was screened out for investigation as there was no allegation of abuse or neglect.

Issues and Recommendations

Issue: This case was a FRS case. When asked about the completion of the family assessment, the worker indicated that she did not complete a full family assessment on this family as the mother did not move forward with filing an At-Risk Youth Petition. Services were however provided to the family. CA Policy 3330 reads that the social worker must meet with the family to complete the family assessment, which includes the following components: FRS supplemental, youth assessment and household assessment. The social worker and supervisor stated that the family assessment in FamLink is difficult to complete and it has not been their practice to enter the Family Assessments into FamLink.

Recommendation: The social worker will complete the required components in the Family Assessment as outlined in the CA policy in future cases assigned to her. The social worker supervisor will review the policy guidelines with staff and monitor their compliance with this policy. This will be accomplished by March 15, 2011.

Issue: This FRS case was opened on April 2, 2010 and closed on June 8, 2010. CA Policy 3400 states: For all FRS cases that are expected to remain open 60 days or longer, the FRS social worker must comply with the monthly health and safety visit requirement outlined in the Practices and Procedures Chapter 4000 Section 4420. The social worker conducted one health and safety visit during the time that this case was open. She documented this visit in case notes, however it was not documented as a health and safety visit. The supervisor noted in her monthly case notes that the worker had completed her health

and safety visit. Per the policy the worker should have seen the child for a health and safety visit per chapter 4000 section 4420 twice during the time the case was open.

Recommendation: The Area Administrator will review Policy 3400 with the supervisor and social workers as well as Chapter 4000 section 4420 regarding health and safety visits. This will be accomplished by March 15, 2011.

Issue: This family had a history with the department back to 1993 when the 17-year-old youth was an infant. There is converted information in FamLink regarding the previous history with this family including historical information about a founded finding of abuse and neglect and a dependency on the youth. When the paper case file was requested for preparation of the fatality review the only file that was produced was the current case file from the April 2010 FRS intake. The office was unaware that there was a previous case file on this family. It was discovered that the paper case file was destroyed on August 1, 2004 and on August 31, 2007.

The process for records destruction in 2004 and 2007 was for a list to be sent to clerical staff in the field offices from records retention indicating records were slated to be destroyed, the field office was to review the list and indicate to records retention if the records should not be destroyed. It is unclear what the procedure was in the Centralia office at the time these records were destroyed. The person who was the CPS supervisor at the time the records were destroyed was asked what the procedure was when she was the supervisor in the Centralia office. She indicated that she was unaware that there was a procedure and was never talked to by clerical staff regarding the destruction of records.

The current CPS and Child Family Welfare Services (CFWS) supervisors were asked if they knew what the procedure was regarding the destruction of records. They indicated that they were not aware of what the procedures were for destruction of case records. There has recently been a change to the process of sending records to records retention. The Area Administrator indicated that she and all of the other Area Administrators in Region 6 received an email on December 20, 2010 informing them that they could now send boxes of files for imaging to the DSHS Management and Operations Document Imaging System (MODIS). There has been little information communicated out to the field offices regarding MODIS except for the email the Area Administrator received on December 20, 2010.

In November 2010, identified staff from each region received training on the MODIS system from CA Headquarters' staff. There was training for the staff in the field offices who will be scanning and sending records to MODIS. There has been no training for supervisors or managers regarding MODIS and how it interfaces with FamLink. Each region identified a lead staff responsible for providing training and ongoing technical assistance on MODIS to staff in the regions.

Recommendation: The Area Administrator will review current policy and procedure regarding MODIS and update procedures in both of her offices. This will occur in April 2011.

Relevant Headquarters staff will provide training and communicate out to all social worker supervisors, Area Administrators and program staff regarding the MODIS system and rules around its use.

Issue: The history of this family was in FamLink. The social worker who was assigned this case in April to work with the mother and her daughter was unaware that there was a history on this family. The Prior Involvement Tab on the intake clearly shows that there was history on this family; however the history was very old with the department's last involvement with this family in 1997 and was as to the 17-year-old and his mother.

The social worker indicated that she would like more information on how to search properly in FamLink so that she doesn't miss history in future cases assigned to her.

Recommendation: The Area Administrator and supervisor will review with staff the Web Based Training on Search. This training can be located in the Knowledge Web in FamLink. This will occur by March 15, 2011.

Child Fatality Review #10-50
Region 4
King County

This 22-month-old Pacific Islander female died after being hit by a car.

Case Overview
On September 25, 2010, this 22-month-old toddler opened a door at her grandmother's home and walked up to the road at 7:30 p.m. She walked onto the road and was struck by a southbound vehicle and was killed. Simultaneously, her aunt was driving along the road and saw her niece about to enter the road. The aunt got out of her car in an attempt to get the child off the road and was struck by another vehicle and was critically injured. The grandmother was caring for her grandchildren while the mother was in the process of moving. She had just given the 22-month-old a snack, and the child was watching TV while the grandmother gave her three-year-old grandson a bath. The 22-month-old managed to open a door and went outside without her grandmother's knowledge. The family reported she was not known to be able to open the front door.

The King County Medical Examiner determined that this 22-month-old died from injuries after being hit by a car. The manner of death is accidental.

Children's Administration (CA) did not have an open case on this family when the child was hit by the car. On May 2, 2010, the department received an intake alleging the three-year-old brother of the 22-month-old was found wandering away from home with no supervision. He was in his father's care when he wandered away from home. This intake was investigated by Child Protective Services (CPS) and closed in August 2010.

Intake History
On May 2, 2010, law enforcement contacted CPS intake to report a police officer had taken a male child, approximately three years old, into protective custody. The boy was found alone in a laundromat in Seattle at 9:15 a.m. The officer reported the child knew his first name but not his last name and could not identify where he lived. A Region 4 afterhours field response worker met with the officer and took the three-year-old to a foster home. Later that afternoon, the worker learned that the father had come to the police station inquiring about his son who was missing. Later the mother came to the police station.

The parents explained that the child stayed with the father on the weekends. The father got up to go to church and told his 15-year-old brother to watch his son. The 15-year-old went back to sleep. At some point while the teen slept, the three-year-old woke and left the house. When the teen woke up, he noticed that his three-year-old nephew was not there and assumed the child had gone to church with his father. It was not until the father returned home from church that he learned that his son was missing.

The field response worker met with the mother at her home and made a decision to return the three-year-old to her care that day. The intake was screened in for investigation of negligent treatment or maltreatment and was assigned to a CPS social worker.

The assigned social worker met with the parents and reviewed the incident in detail. A Safety Plan was written with the parents indicating that the mother would not leave her son unsupervised and that she would not leave him with the father until the CPS worker approved. The worker and parents also created a Family Action Plan in which the father would use a logbook at his home to communicate about his son's whereabouts and who is supervising. The father also agreed to install a deadbolt on the door to his home that was higher than the child could reach by May 7, 2010.

This case was closed on August 11, 2010, and the investigation was unfounded for negligent treatment or maltreatment.

On September 26, 2010, the King County Medical Examiner contacted CPS intake to report this 22-month-old child was struck by a car in front of her grandmother's home. The child's mother and her children were moving into the grandmother's home in Kent. The home is located near a busy highway. The mother had gone to move more belongings. The grandmother gave the 22-month-old a snack while she was watching TV. The grandmother then gave the three-year-old brother a bath. The 22-month-old managed to open a door and went outside. The driveway gate was open because the child's mother was driving back and forth. The child wandered onto the highway and was struck by a car and killed. The child's aunt was also hit by a car and critically injured while trying to get her niece out of the road.

The intake was screened in for investigation of negligent treatment or maltreatment. The death was ruled an accident, and the CPS investigation was unfounded. The case was transferred to Family Voluntary Services (FVS) to offer grief and loss resources but the family declined, and the case was closed.

Issues and Recommendations

Issue: The team did not have any recommendations concerning practice, policy or system issues.

Recommendation: None

Child Fatality Review #10-51
Region 5
Pierce County

This 16-year-old Hispanic female died from aspiration pneumonia.

Case Overview

In the evening hours of September 24, 2010, this 16-year-old youth and a female friend attended a party in Tacoma. The adult male hosting the party reportedly did not know the youth, but was aware she was a minor. Witnesses indicate she consumed a large quantity of liquor, vomited, and fell asleep on the living room floor. An adult male who also lived at the residence arrived in the early hours of September 25, 2010 and called 911 after finding the youth unresponsive. Law enforcement officers arrived at approximately 3:00 a.m. Tacoma Fire Department and a Medic One unit were already on scene performing resuscitation. The youth was transported to Mary Bridge Hospital where she was eventually stabilized but remained in critical condition, having suffered a severe anoxic brain injury (lack of oxygen to the brain). The youth's blood alcohol level was .27 and there were initial concerns that she had been sexually assaulted. Subsequent expert medical opinion (Child Abuse Intervention Department - Mary Bridge Children's Hospital) and post mortem examination by the Pierce County Medical Examiner's Office found no evidence of any recent sexual assault.

In the afternoon of September 27, 2010, the 16-year-old was taken off life support and passed away.

The Pierce County Medical Examiner determined the cause of death to be from "aspiration pneumonia with alcohol toxication a contributory factor." The manner of death was determined as natural.

Children's Administration (CA) had an open case on this family when the youth died. In May 2010, the youth's mother contacted intake requesting assistance with filing an At-Risk Youth Petition as she was having difficulty with her 16-year-old daughter. The department accepted this Family Reconciliation Services (FRS) intake and initiated Family Reconciliation Services to the family. The assigned FRS worker completed a family assessment and offered to assist the mother with filing an At-Risk Youth petition. The FRS social worker also discussed with the mother about making a referral for her daughter to see a chemical dependency counselor. The youth refused to participate in this service. The mother was provided with a package of information about community resources to address some of her daughter's out of control behavior. The case was open when the youth died in September 2010.

Intake History

On September 25, 2010, the mother of the 16-year-old youth contacted Child Protective Service (CPS) intake to request assistance in filing an At-Risk Youth Petition for her 16-

year-old daughter. The mother reported that her daughter was skipping school, failing classes, frequently not coming home, drinking, and running with an older "bad crowd." The intake was assigned to an FRS social worker who contacted the mother within 24 hours of the intake. During the initial meeting with the youth and parent, the option of an At-Risk Youth (ARY) petition was discussed. The mother expressed reluctance to be involved with any legal system process. The social worker reviewed a list of local community resources with the parent and child and encouraged the mother to reconsider the ARY option. In July 2010, the mother told the FRS worker that her daughter was sent to live with her father. The FRS supervisor documented during a monthly case staffing that the case was ready for closure. There was no further contact with the family until after the fatality event in September.

On September 25, 2010, a staff member at Mary Bridge Children's Hospital contacted CPS intake and reported the 16-year-old was found unresponsive at a Tacoma residence where she had attended a party at which alcohol was provided. Emergency responders were able to resuscitate the youth and she was transported to a local hospital where she was placed on life support. Two days later the youth was removed from life support and died from "aspiration pneumonia with alcohol toxication a contributory factor." The FRS case had not yet been processed for closure. The assigned FRS social worker contacted the family to help them connect with community support services. The intake was screened out for investigation as there was no allegation of abuse or neglect.

Issues and Recommendations

Issue: Family Reconciliation Services were initiated in May 2010 and consisted of one meeting with the parent and youth (in May) and two follow-up phone contacts with the mother (in July) at which time the youth went to live with her father. The FRS case reasonably should have been closed following assessment and brief intervention per CA Practice and Procedures Guide [Chapter 3000]. The worker was directed to close the case by the Pierce East FRS supervisor prior to the supervisor leaving state service in August 2010. However, the case remained opened without further social work activity until the fatality incident in late September 2010.

All social worker documentation was entered post fatality in late September. In addition to the failure to meet expected timeframes for case note entry, the worker did not administer the GAIN-SS to the youth, and did not complete the Family Assessment/Family Engagement Tool in a timely manner. The failure to complete work appeared to reflect a pattern of work behavior by the individual worker that may have been exacerbated by a significant increase in case assignments earlier in the year.

Action Taken: The FRS worker left Children's Administration in November 2010 and is currently employed in another DSHS administration. She was interviewed by the fatality review panel and acknowledged she had not followed the documented supervisory directive in August to close the case. The worker indicated she had at that time a

significant backlog of cases that inhibited her ability to complete documentation within expected timeframes.

The region will develop transition and support plans unique to the circumstances of the unit and that in all instances a worker will know who to go to for direction, guidance, new assignments and case closures. This will vary based on the amount of time the supervisory position is vacant. If the supervisor position is vacant for a significant period of time, the region will ensure the unit has closer supervision. In all instances, each worker in the unit will be assigned to another supervisor pending hiring of a new supervisor for the unit

Recommendation: None

Child Fatality Review #10-52
Region 6
Clark County

This 15-year-old Caucasian male died from injuries sustained in a truck accident.

Case Overview
On September 28, 2010, this 15-year-old youth died when the truck he was a passenger in rolled over. The youth was pronounced dead at the scene. There were two other teens in the truck, one of which was the driver. None of the teens had drivers permits or were licensed drivers. They had taken the vehicle without permission. Speed was determined to be the contributing factor in the accident, and the driver lost control of the truck while negotiating a curve in the road.

The County Coroner reported the cause of death was motor vehicle accident. The manner of death is accidental.

Children's Administration (CA) had an open case on this family when the motor vehicle accident occurred. In May 2010, the youth's relative guardian contacted Child Protective Service (CPS) intake to request assistance with the youth's out of control and combative behaviors. The case was opened for Family Reconciliation Services (FRS) and services were offered to the family.

Intake History
On May 19, 2010, the relative guardian of the 15-year-old youth contacted Child Protective Service (CPS) intake to request assistance with the 15-year-old youth in their truck. He was caught with drugs at school and had been out of control and combative at home. The referrer didn't think her family could keep him safe given his issues. The referrer stated he was verbally abusive and attempted to run away. The referrer was told to call the police if he was getting out of control. The intake was screened in for Family Reconciliation Services (FRS). The family was in counseling and the FRS social worker referred them to community resources for a drug and alcohol evaluation. The FRS worker notified the family to call again if they needed any additional supports or resources. The staff did not hear from the family again until it was discovered that the youth had died in an automobile accident. The FRS worker reached out to the family and offered supportive services to them in dealing with the death of their nephew. The case was closed at that time.

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

Recommendation: None

Child Fatality Review #10-53
Region 4
King County

This four-month-old Asian male born in May 2010 died from Sudden Infant Death Syndrome (SIDS).

Case Overview
On September 25, 2010, the mother of this four-month-old child put him down for a nap around 12:00 p.m. Approximately one hour later she went to check on him and found him unresponsive. Police and medics arrived at the home but were unable to revive the child. He was pronounced dead at 1:30 p.m. There was no report of concerns related to the death of this four-month-old.

The King County Medical Examiner conducted an autopsy and determined the cause of death to be SIDS. The manner of death is natural.

Children's Administration (CA) did not have an open case on this family when the child died. In May 2010, hospital staff contacted the Child Protective Service (CPS) intake to report the birth of this child and that his mother had very little prenatal care. The baby was born healthy and a toxicology screen done on the newborn was negative for drugs and alcohol. The intake was screened as Information Only as there was no allegation of abuse or neglect.

The family also includes two siblings ages 18, and 10 years old.

Intake History
On June 11, 2003, a police officer contacted Child Protective Service (CPS) intake to report the 10-year-old sibling (then three years old) was found wandering the streets unsupervised. The child said his mother was asleep. He appeared to have dressed himself. The child showed the officer where he lived and the officer responded to the home. The officer estimated the child was outside his mother's presence for approximately one hour. The officer chose not to place the child in protective custody. The home was clean and there was adequate food. The parents installed a chain lock on the front door as a safety measure to prevent their son from opening the door. The intake was screened in for investigation of negligent treatment or maltreatment and closed with an inconclusive finding.

On May 11, 2010 a hospital social worker called CPS intake to report the four-month-old had recently been born. He was full term and with good birth weight. The mother reported she did not have prenatal care until one week prior to delivery. She also stated that she drank alcohol twice during her pregnancy. The mother and infant both tested negative for alcohol and substances. The intake was screened out as information only.

On September 25, 2010, the King County Medical Examiner contacted CPS intake to report the death of this four-month-old child. The referrer reported the mother put him down for a nap and found him unresponsive when she went to check on him approximately one hour later. There were no reports of concerns or allegations of abuse or neglect related to this child's death. The intake was screened as Information Only.

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

Recommendation: None

Children's Administration

Executive Child Fatality Review

B.M. Case

Date of Birth: 02/ /2008
Date of Death: 08/25/2010
Date of Review: 01/06/2011

Committee Members
Tim Abbey, Area Administrator, Division of Children and Family Services (DCFS), Region 1
Adam Diaz, Chief, Toppenish Police Department
Deborah O'Neil, Program Manager, Department of Early Learning
Travis Hansen, Licensing Supervisor, Department of Early Learning
Geri Phillips, Social Worker 4, Supervisor Intake, DCFS, Region 1
Roy Simms, MD, Child Protective Services (CPS) Medical Consultant, Children's Administration, Region 2

Observers
Ernie Gowen, Area Administrator, DCFS, Region 2
Mary Meinig, Director, Office of the Family and Children's Ombudsman
Robert Rodriquez, CPS Program Manager, DCFS, Region 2

Facilitator
Marilee Roberts, Practice Consultant, Field Operations, Children's Administration

Table of Contents

Executive Summary

On August 25, 2010, Children's Administration (CA) accepted an intake from Toppenish Police Department (TPD) reporting the death of 2½ -year old B.M. The referent reported they responded to Toppenish Community Hospital after receiving a call from emergency room staff regarding a child's death. It was reported the child's mother's boyfriend, Juan Balverde Lopez,[1] brought the child to the hospital where the mother was a patient. Mr. Balverde was caring for the child while the child's mother was hospitalized.

B.M.'s mother told law enforcement officials Mr. Balverde contacted her the previous evening and told her B.M. was complaining of a stomach ache and not feeling well. She added he told her he had been roughhousing with his siblings and one of them had jumped on his stomach. She stated she told Mr. Balverde to wait until the morning to see how he was feeling. The mother reported Mr. Balverde had told her he took B.M. to bed with him that evening and at 5 a.m. he had crawled into bed with his sister, age 7. Mr. Balverde reported he found the child the next morning unconscious and his feet were purple in color. Mr. Balverde then proceeded to drive the child, along with his two siblings (ages 7 and 4), to the Toppenish hospital.[2] He left B.M. in the car in the emergency bay at the hospital and went to the mother's room to tell her of his concerns for B.M. The child's mother immediately went to her child and carried him into the emergency room where he was pronounced dead by hospital staff.

B.M. presented in the emergency room with multiple bruises and contusions. Given the injuries the Yakima County Coroner requested an autopsy to determine the cause and manner of death. The autopsy was completed on August 26, 2010 and noted *"cause of death: acute laceration of the small bowel and acute intra-abdominal hemorrhage due to blunt impact injuries to the abdomen; manner: homicide."*

After receiving the intake information regarding B.M.'s death, CA collaborated with the Toppenish and Sunnyside Police Departments in initiating an investigation into the fatality. During the course of the investigation, Mr. Balverde admitted to striking B.M. on at least one occasion. A witness in the home told investigating officials Mr. Balverde had hit B.M. multiple times the previous evening. Mr. Balverde was subsequently arrested and charged with murder in the 2nd degree.

In January 2011, CA convened an Executive Child Fatality Review[3] (ECFR). Given the departmental history referencing this family, including interventions in the 12 months prior to

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[1] The full name of Mr. Juan Balverde Lopez (aka Mr. Balverde) is being used in this report as he has been charged in connection to the incident and his name is a part of the public record.

[2] Family was residing in Sunnyside at the time of the fatality.

[3] 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.

this child's death, CA convened the review team pursuant to RCW 74.13.640[4]. The committee met to review the decisions, policy, practice and service delivery in this family's case.

The family's Child Protective Services (CPS) history began in 2008 and includes six previous intakes prior to B.M.'s death. Three intakes were accepted for investigation and identified B.M.'s mother as the subject of physical neglect and/or physical abuse; one was accepted as a low risk intake, and two intakes were screened out. The record reflects intakes investigated prior to the fatality resulted in unfounded findings and did not result in the initiation of services to the family or court intervention.

Committee members included a diverse group of CA staff, a medical professional, law enforcement, the Office of the Family and Children's Ombudsman, and the Department of Early Learning. Review committee members had no involvement with the B.M case. Team members were provided case documents consisting of family history/chronology[5] including all intake information, Yakima County Coroner's report, and child care records.[6]

During the course of the review team members discussed screening decisions on intakes received prior to the child's death, accessibility of historical information in FamLink,[7] diversity in staff roles and responsibilities related to intake and investigations within CA, and communications between CA and referring parties. In addition, the review team addressed issues related to medical follow up for children known to CA and the moral responsibility of citizens to report child abuse or neglect.

Following review of the case histories, child care records and discussion, the review committee made findings and recommendations which are detailed at the end of this report.

Case Overview

The review team was provided with CA case information for three families; the deceased child's mother's case, the deceased child's father's case and Mr. Balverde's case. Intakes referencing the families were reviewed in regards to service decisions and interventions, system issues, and policy implications.

B.M.'s Mother's History

The deceased child's mother's CPS history as a parent began in 2008. CA has received a total of six intakes prior to B.M.'s death in August 2010. Of the six prior intakes, three were accepted for investigation and identified the child's mother as a subject of physical neglect or physical abuse, one was accepted as a low risk/alternative response intake, and two intakes were screened out.

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[4] RCW 74.13.640

[5] Case history information was available for all the following families: deceased child's mother, father (separate case) and Mr. Balverde's case history affiliated with the mothers of his two children.

[6] The autopsy and the police report were not available at the time of review due to pending legal charges. The review team stated the availability of these reports would have been helpful in their review of this child's death.

7 Children's Administration's Management Information System.

In the summer of 2008, CA received two separate intakes alleging neglect/negligent treatment to B.M.'s siblings. In June 2008 it was alleged B.M.'s mother was driving while under the influence of substances with children in the car, living conditions posed a safety and health risk to the children in her care, and inadequate supervision resulted in injuries to her children. In July 2008 it was alleged B.M.'s mother was not providing adequate supervision for her children resulting in one child suffering an injury to his foot requiring stitches. CA assigned both intakes for investigation. CA conducted several home visits, interviewed the children's child care provider, obtained medical records, and contacted law enforcement and family members for additional information. In addition, the children's mother submitted to urinalysis on two separate occasions. Both investigations resulted in unfounded findings with no post investigation services provided.

In March 2009, CA received a report referencing possible burn marks on the thighs and fingers of B.M. who was 13 months of age at the time. The referent (family friend requesting anonymity) was unaware if the mother had taken the child to a doctor. This intake was screened in as low risk and an alternative response resulted in a letter being sent to the mother notifying her of the intake and services in the community she could access. No other services were provided.

In July 2010, CA received two intakes referencing B.M.'s family from the child's child care provider. Both intakes alleged injuries to B.M. and an older sibling, age 4.

- The July 14, 2010 intake noted B.M. presented with a black eye. The referent stated the mother's boyfriend had dropped the child off and said he had fallen off the bed and injured his eye. When making the report to CA the referent was asked by CA intake staff to contact the mother and confirm the explanation. The referent did as asked and reported back to CA the mother said the child had fallen off the bed. CA did not get the name of the boyfriend and screened out this intake.
- The July 27, 2010 intake noted bruises to both B.M. and his older brother. Again, the referent (same referent from the July 14, 2010 intake) stated the mother's boyfriend dropped the children off and stated the children did not appear fearful of the boyfriend. The referent stated the mother said the child had fallen off the bed. CA did not obtain the name of the boyfriend from the referent at the time of this intake. The intake was screened out.

RCW 13.50.100

Mr. Balverde's Case History

Mr. Balverde (Lopez) is affiliated with five intakes received by CA. Information available to CA indicates he is the father of two children, ages 4 and 2, by two different women.

This intake notes that Mr. Balverde was arrested for assault in the 4th degree, domestic violence, for the same incident that led to the referral. This intake was screened out. RCW 13.50.100

The fourth intake in August 2010 references Mr. Balverde's role in the death of B.M.

August 2010 Fatality

In August 2010, CA received a report that B.M. had been transported by the child's mother's boyfriend to the Toppenish Community Hospital and was deceased. Information provided by medical staff and law enforcement noted significant bruising to B.M. and an autopsy would be conducted to determine cause of death. The intake identified Mr. Balverde as the subject of physical abuse and neglect/negligent treatment and B.M.'s mother as a subject of neglect/negligent treatment.

The Sunnyside Police Department's photographs taken at the hospital showed that B.M. had a large bruise on his forehead, a left black eye, a large mark running down from his forehead to his cheek, a purple bruise above his navel and a purple bruise in the middle of his back. An autopsy was completed on August 26, 2010 by the Yakima County Coroner's office and the preliminary results of the autopsy listed *"cause of death: acute laceration of the small bowel and acute intra abdominal hemorrhage due to blunt impact injuries to the abdomen; manner of death: homicide."*

During the course of the investigation into B.M.'s death CPS and law enforcement conducted interviews with several people including family members[8] living in the home with Mr. Balverde. B.M.'s sister disclosed Mr. Blaverde had punched B.M. in the stomach the previous evening and then he later fell off the bed and hit his head. When she awoke the next morning she knew B.M. was dead. She stated Mr. Balverde made her 'pinky promise' she should say she had jumped on B.M. When interviewed by detectives, Mr. Balverde admitted to striking B.M. one time. Mr. Balverde has been charged with murder in the 2nd degree.[9]

As a result of B.M.'s death his siblings were placed into protective custody by law enforcement on August 25, 2010 and placed in the care of B.M.'s father and his partner. Mr. Balverde's

[8] Mr. Balverde shared a home with his father, three siblings, his own daughter and the deceased child's mother and two siblings.

[9] Mr. Balverde remains incarcerated at this time pending completion of legal proceedings.

daughter, who was living in the home, was also placed in protective custody on August 25, 2010 and placed in foster care. CPS investigative findings resulted in founded findings for physical abuse and neglect/negligent treatment for Mr. Balverde and founded findings for neglect/negligent treatment for the child's mother.

Findings by the Review Team

Intake Decisions

The review team discussed the screening decisions related to intakes involving B.M.'s family in March 2009 and July 2010. Findings include the following:

- Alternative Response System[10] (ARS): ARS services were intended to improve family cohesiveness, prevent re-referrals of the family, and improve the health and safety of children. Contracted providers, such as public health nurses followed up with families when an intake had been screened as ARS or low risk. However, in October 2008 budget impacts in Region 2 limited contracted providers ability to follow up with families and confirm medical care was accessed. The review team found limitations to ARS resources impacts CA's ability to ensure a family has followed through with accessing any recommended services, including medical care, unless an intake is screened in for further investigation.
- In the July 14, 2010 intake, CA requested the referent seek an explanation for the injury from the parent. The review team found when additional information, such as medical status of a child or cause of an injury, would assist in making an intake decision it is the responsibility of CA staff and not the referent to obtain this information.
- Information provided in the July 2010 intakes referencing the deceased child and his sibling suggested further inquiry at intake was recommended. Documenting the name of the mother's boyfriend and retrieving historical person and case information could have provided additional information when making intake decisions. The review team discussed CA's management information system, FamLink. FamLink provides limited person or case history information up front and requires staff to conduct time intensive research to ensure an adequate assessment of a family's history is obtained and applied to any decision making.[11] This limits CA's ability to obtain a quality assessment of a person's CPS history at intake. The review team found the intake decision on July 14, 2010, given its limited information may not have warranted further inquiry, however the July 27, 2010 intake coupled with the family's history supported assignment for investigation.
- The review team found CA best practices include asking the referent if they would like a call back regarding CA's decisions or actions on the information provided. The review team found calling back the referent in regards to the July 2010 intakes involving B.M. may have elicited additional information and would have notified the referent of any intervention by CA. Child care information reviewed post fatality indicated B.M.

[10] ARS services included Early Family Support Services and Early Intervention Programs.

[11] A review of Mr. Balverde's history in FamLink revealed the November 2008 intake referencing his arrest for assault 4, domestic violence is documented in the system. However the intake is not connected to his person or case information affecting CA intake staff from retrieving historical information efficiently.

continued to present with bruises in early/mid August 2010 and should have resulted in a call to CA. The review team found when call backs to referents are completed the referent may provide additional information or make subsequent calls of concern. Call backs to referents elicit support from referents and the community in reporting child abuse and neglect.

Roles and Responsibilities

The team discussed roles and responsibilities of persons involved in ensuring the health and safety of children. Findings regarding roles and responsibilities are as follows:

- The review team asserted child health and safety is the collective responsibility of all CA staff regardless of role and responsibility. The review team discussed when intake staff make inquiries from referents about child abuse and neglect their primary role is one of active listener and recorder. CPS intake staff receive and assess available information to make intake screening decisions. Whereas the CPS investigator is responsible to conduct investigations seeking facts about the family's current situation as a means to assess for impending dangers or threats to child health or safety. The review team found intake staff in July 2010 in the office was staffed by a CPS investigator who had not been afforded the opportunity to attend intake training and may not have had a clear understanding of the intake role and its duties.
- CA currently does not have statutory authority to access autopsy results through the course of an investigation or for purposes of a fatality review on cases that CA was involved within 12 months of a child's death. The review team found that limited access to the autopsy report was a barrier in discussing medical issues during the course of the review.
- The Revised Code of Washington 26.44.030[12] defines the duties and authority for those persons who are mandated to report when they have reasonable cause to believe that a child has suffered from abuse or neglect. The law defines the roles of professionals and practitioners who are mandated to report. The review team found given the nature of this child's injuries, others in the home knew of this child's distress but failed to report concerns.

Recommendations

Intake Decisions

- CA's Central Case Review Team in consultation with CPS Program Managers have developed a tool for the purpose of reviewing intake decisions. It is recommended the Central Case Review Team pilot the new review tool in the Sunnyside CA office in 2011.
- FamLink Historical Information Access: CA's continued efforts in merging case and person information in FamLink will support efficient retrieval of case/family history to

[12] RCW 26.44.030

support effective decision making. Also, CA might consider including abuse/neglect[13] type in the *Prior Involvement* section of the intake.

Roles and Responsibilities

- The review team found that given the complexity of positions within Children's Administration, it suggests staff should clearly understand the varied roles and responsibilities of each position in the event they are asked to fill in or assume other duties for a time. CA should give consideration to ensuring all staff are cross trained and aware of the varied roles and responsibilities within CA. This is especially critical in smaller offices where staff perform multiple roles and functions or are asked to fill in during staff shortages and emergencies.
- The review committee recommends an addition to RCW 68.50.105[14] to allow release of an autopsy report to CA when a child's death is the result of alleged abuse or neglect.
- No one residing in the child's home falls within the category of those who are mandated to report; therefore they did not have a legal duty to report, absent serious abuse[15]. Nevertheless, the review team found that, given the nature of this child's injuries, others in the home knew of the child's distress but did not report concerns. Therefore the review team recommends that consideration be given to amending RCW 26.44.030 to include *any person* who has reasonable cause to believe or suspect a child has suffered from *any abuse or neglect* shall make a report.

[13] Physical abuse, Neglect/Negligent Treatment, Physical Neglect and Sexual Abuse.
[14] RCW 68.50.105
[15] RCW 26.44.030 defines... "severe abuse means any of the following: Any single act of abuse that causes physical trauma of sufficient severity that, if left untreated, could cause death; any single act of sexual abuse that causes significant bleeding, deep bruising, or significant external or internal swelling; or more than one act of physical abuse, each of which causes bleeding, deep bruising, significant external or internal swelling, bone fracture, or unconsciousness.

Children's Administration
Executive Child Fatality Review
Isayah Casch

January 7, 2011

Committee Members

- Craig Davis, Detective, Everett Police Department
- Frances T. Chalmers, M.D.
- Deborah Brown, Certified Chemical Dependency Professional, Snohomish County Human Services
- Mary Meinig, MSW, Director Ombudsman, Office of the Family and Children's Ombudsman
- Yen Lawlor, MEd, Deputy Regional Administrator, Region 3, Children's Administration
- Rhoda Ramirez, MSW, Child Protective Services Supervisor, Children's Administration
- Natalie Green, MSW, Area Administrator, Children's Administration

Facilitator

- Toni Sebastian, MSW

Observers

- Cristina Limpens, MSW
- Kara Rozeboom, MSW

Table of Contents

Executive Summary

On September 19, 2010, Children's Administration (CA) accepted an intake from Harborview Medical Center reporting the death of seven-year-old Isayah Casch, following a roll-over accident of a car driven by his mother, Kortnie Casch. The caller reported that Ms. Casch appeared intoxicated and that two blood draws had been completed; one by Providence Hospital and one by Harborview at the request of the Snohomish County Sheriff. The caller reported further that Isayah's half-siblings, [redacted] and [redacted] had been in the car and were admitted for observation and treatment of minor injuries. The caller noted that hospital staff were concerned about the children's unsanitary and dirty appearance. [redacted] and [redacted] were placed with their paternal grandfather and his wife following their release from the hospital [redacted]

After an investigation by Snohomish County Sheriff of the accident leading to Isayah's death, the case was referred to the Snohomish County prosecutor. Charges against Ms.Casch are pending.

The family's history with CA began in February 2003 and includes four previous investigations in 2003, 2006, 2007, and July 2010. The investigations were based on allegations against Ms. Casch of driving while under the influence with her children in the car, [redacted] neglect of her children, and alcohol abuse. The investigations in 2003 and 2006 were closed on inconclusive findings. The investigation in 2007 was closed without a finding [redacted] The investigation begun in July 2010 was ongoing at the time of Isayah's death and was subsequently closed as unfounded in October 2010.

On January 7, 2011, CA convened a multi-disciplinary committee to review the decisions, policy, practice, and service delivery in this family's case.[1] The committee, including CA staff who had no direct connection to the case, represented disciplines associated with this case. Documents available to the committee included: chronology of the case prepared for the review, Snohomish County Sheriff's investigation of the September 18, 2010 accident, CA case records, Ms. Casch's childhood records from Georgia, Isayah's autopsy report, the CA policy on child protective services (CPS) investigations, and RCW and WAC

[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.

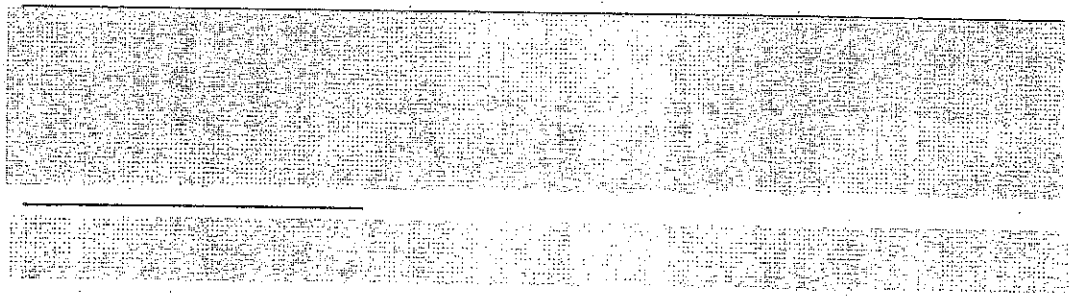
chapters on CPS activities including the definitions of child abuse and neglect. In addition, the supervisor on the case at the time of Isayah's death was interviewed by the committee. The social worker on the case was not available for interview.

Given its limited purpose, a Child Fatality Review by CA should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. Review is generally limited to documents in the possession of or obtained by the Department of Social and Health Services (DSHS) or its contracted service providers and the committee 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 committee has no subpoena power or authority to compel attendance and generally will only hear from DSHS employees and service providers. The committee 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 enquiry 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.

During the course of the review, committee members discussed concerns regarding the possible impact social worker inexperience has on thorough risk assessment and service delivery. The committee members also discussed concerns regarding the impact of recent funding cuts which eliminated the regional placement of chemical dependency professionals in local offices to assist social workers with home visits, consultation, and intervention with families where substance abuse is alleged to have placed children at risk.

Though the committee found that the practice on the case, up and until Isayah's death, was reasonable per CA policy, RCW, and WAC, there were concerns related to the inexperience of the assigned social worker, unnecessary delay in staffing the case with a child protection team (CPT), and the unavailability of professional chemical dependency providers for case consultation. Further discussion of this case by the committee and findings and recommendations made by the committee are detailed at the end of the report.

Case Overview



[redacted]

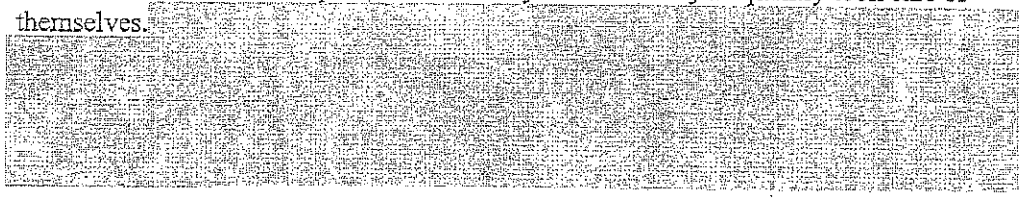
In December 2002, when Ms. Casch was 17 years old, she moved to Washington state with her seven-week old son, Isayah; [redacted]

Ms. Casch's history with the department began the following year in February 2003 with an anonymous caller reporting that Ms. Casch drove with children in her car while under the influence of alcohol and pain medication. The caller reported that Ms. Casch mixed alcohol and pain medications that were supplied by Mr. F. The caller reported that they had contacted law enforcement several times about Ms. Casch. [redacted] CA sent the intake report to law enforcement and a CPS case was opened for investigation. The finding was inconclusive and the case was closed in September 2003. No services were offered. [redacted]

[redacted]

An anonymous caller contacted the department on July 27, 2010 to report that Ms. Casch was driving while intoxicated everyday with her children in the car. The caller reported that Ms. Casch began drinking early in the morning and drank throughout the day until she

passed out. The home was reported to be in poor condition with empty alcohol bottles in view. The children were reported to be "filthy" and that they frequently took care of themselves.



The case was opened for investigation and assigned to a social worker. The social worker made two attempts to visit the home. The door was not answered on the first visit. On the second visit, the worker attempted to interview Isayah. Ms. Casch and the paternal grandfather were present during the interview. [redacted] and [redacted] were also at home. The home was cluttered, extremely dirty inside and outside, with clothes and dirty dishes lying around the home. The home was noted to have an unpleasant odor. When interviewed, both parents denied using substances and that Ms. Casch had driven the car with the children while intoxicated. Ms. Casch submitted to a urinalysis test and results were negative. Services were offered to Ms. Casch which she declined. On August 23, 2010, the social worker prepared the transfer/closing summary. The supervisor requested follow-up work prior to closure including obtaining medical records for the children, criminal history checks on the parents, and contact with Isayah's school. The case remained open pending a CPT staffing. In October 2010 the investigation was closed. The allegations of neglect were unfounded based on clean random urinalysis from Ms. Casch, Ms. Casch and Mr. F.s' denial of using alcohol while driving, and Isayah making no report that his mother had driven him while drinking.

In the early morning hours of September 19, 2010, Harborview Medical Center contacted the department to report the accident leading to Isayah's death. Later during the day, Ms. F. called the department to report she had heard about the car accident the night before and that she had been the person to call in the July 2010 report.

Committee Discussion

Practice

Given the facts of the case at the time of the accident, the committee concluded that the CPS investigation and actions of the social worker and supervisor were reasonable per CA policy and the laws and code governing CPS investigations. The committee noted that, despite the history on the case indicating Ms. Casch was a long-term user of drugs and alcohol, there were never any allegations of physical harm to the children. Concerns about the conditions in the home or neglect of the children were not raised until July 2010. Ms. Casch, Mr. F., and Ms. F appeared to have ongoing conflict. Mr. F.'s ex-wife made several of the reports to the department including reports about Ms. Casch's use of alcohol and driving with children in the car.

The committee noted that the supervisor provided the necessary oversight on the case when the social worker staffed the case for closure. The supervisor stated she and the worker were both concerned about the allegations of Ms. Casch's substance use. Rather than close the case, the supervisor requested that the case be staffed by a CPT and that the parents be invited to the staffing with the goal of engaging the parents in services. The supervisor also directed the social worker to gather additional information that would be considered standard in any investigation. This included:

- Checking with the children's pediatrician to assess their physical health and development.
- Completing a criminal history check.
- Contacting Isayah's school for information about interactions with the family, his attendance and academic status.

During her interview with the committee, the supervisor commented that solution-based strategies of engaging the family were used in practice and that the CPT staffing held some promise of having the family better understand the concerns and possibly agree to services. The office had a two-month backlog of cases to be staffed with the CPT, and this case was put on the waiting list for October 2010. While it may be more convenient to staff a case with the local office team, this delay was of concern to the committee. There is no policy in place requiring that a case be staffed with the local office CPT.

Social Worker Experience

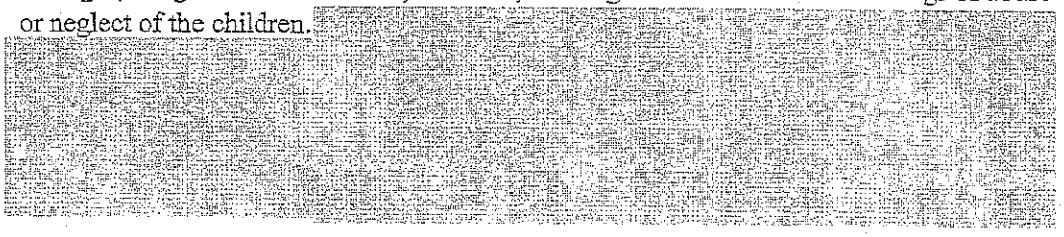
The social worker assigned to the case had four plus months experience working in CPS and had no field experience prior. The worker had completed the required academy training. Despite the consensus that the supervisor acted as an appropriate safety net for the social worker's inexperience, the committee discussed the value of experience and knowledge of practice and how those factors influence the social worker's interaction with the family, their skills of engagement, recognition of risk factors, and assessment of safety. The casework appeared to focus on Ms. Casch as an individual rather than on the family as a whole. Reports of her mental health history did not appear to be considered. Mr. F was never fully assessed for substance abuse or for his participation and condoning of Ms. Casch's use of substances while parenting the children. The paternal grandfather, who lived next door, had frequent contact with the family, provided care for the children, likely had knowledge of the parents' use of substances and their parenting of the children. Conflict between [redacted] and Ms. Casch appear to have provided a distraction from the concerns about Ms. Casch and the impact of her substance abuse on the younger children. This focus on the dynamic of adolescent conflict with caregivers appeared to become the primary focus of the early reports that also alleged Ms. Casch was driving under the influence of substances.

Historically, the CPS program has the highest rate of staff turnover in CA and, likely the highest rate of new or inexperienced workers. The committee had a discussion of how CA

manages this difficult reality and how the department can compensate for the lack of knowledge and experience in CPS without relying completely on supervisors who may not have a great deal of practice and management experience. The committee made recommendations that provide possible strategies on overcoming high staff turnover and inexperience in CPS.

Chemical Dependency

Of the four reports received by the department regarding Ms. Casch between 2003 and 2010, three indicated that she drove vehicles under the influence of alcohol and drugs with her children in the car. Ms. Casch had no criminal record of driving under the influence. When the case was open in October 2006, a drug and alcohol evaluation may have been helpful in determining Ms. Casch's substance use. This case, like so many the department manages, alleged substance abuse, however, investigations resulted in no findings of abuse or neglect of the children.



Reports that allege serious substance abuse without accompanying direct impacts to children are challenging for the department. Options include testing the client who is alleged to have used substances, offering voluntary services to the caregiver and family, determination if the department has information sufficient for filing a dependency, or if the family refuses services, closing the case.

During the July 2010 home visit, when the social worker was attempting to interview Isayah, Ms. Casch and the paternal grandfather were present. Ms. Casch was disruptive, interfering with the interview. The paternal grandfather appeared to condone Ms. Casch's behavior and did not intervene. The committee recognizes that interacting with a person who is using or addicted to drugs or alcohol can be an intimidating and frightening encounter. For those social workers who do not have experience with substance using or addicted clients, this type of behavior may result in backing off or avoiding continued contact with those clients. The social worker understood there were underlying concerns about substance abuse but may not have known how best to respond to Ms. Casch's behavior.

Having certified chemical dependency professionals (CDPs) available for home visits, consultation, and intervention provides the expertise that can support child welfare social workers in their investigations and case management responsibilities. The value of these CDPs was recognized when the department, in partnership with the Division of Alcohol and Substance Abuse (DASA), placed CDPs in CA offices within each region to assist

social workers when working with clients impacted by substance abuse or addictions. As a result of budget reductions the CDP program was reduced. In 2008 in Region 3, the CDPs were reduced to one to cover the entire region. This CDP placement was cut in December 2010.

The committee questioned whether or not alcohol use is regarded differently by the department than abuse of illegal drugs or prescription medications. The CDP on the committee noted that there has been a significant increase in heroin and prescription drug abuse in the last five years. The absence of chemical dependency experts in an agency that sees the majority of its caregivers using substances to some degree creates a void of educated and experienced professionals who can assist CA social workers in understanding and assessing chemical dependency.

In this case, the urinalysis run on Ms. Casch did not include analysis of ethyl glucuronide (ETG) in the urine.[3] ETG analysis is a more expensive test but is more accurate in determining alcohol consumption. While ETG analysis continues to be requested by CA social workers, budget considerations are resulting in fewer tests of this type. Consultation with CDPs can result in recommendations about drug and alcohol testing and may provide CA social workers with better opportunities for information gathering, intervention, and engagement with those clients who have a lengthy substance abuse history.

Findings and Recommendations

Findings

1. The committee found that the delay in staffing the case with a CPT was unnecessary as CPTs exist in other offices and the case could have been staffed by another team.

2. The committee found that the practice on the case, up and until Isayah's death, was reasonable per CA policy, RCW, and WAC. Given her four month's on the job, the social worker did an adequate job. The social worker did not see the whole picture and focused primarily on Ms. Casch. She did not appear to consider the need for additional work on this case and was prepared to close the case after the home visit. The supervisor addressed the direction the case was headed and requested additional information be gathered and further consideration given to address the substance abuse of the parents.

3. The lack of available CDPs to social worker for consultation, intervention, and planning on cases involving substance abusing clients presents a significant void in expertise that CA must find ways to fill. Having CDPs out-stationed in local offices is best; one CDP for an entire region is not practical or realistic.

[3] An ETG urinalysis provides a definitive indicator that alcohol has been ingested about 80 hours prior to the test. A urinalysis that does not include ETG analysis may show alcohol consumption only within a few hours prior to the test, depending on the amount of alcohol consumed.

4. Department policy does not require regular visits to a home when the case is open for CPS investigation. This case was open for two and a half months. One attempted visit and one achieved visit was made in an effort to complete face-to-face contact with the children.

Recommendations.

1. Region 3 should ensure that social workers and supervisors are aware that cases can be staffed with CPTs in any office and do not have to wait for an opening in their own office.

2. CA should consider new social workers as "in training status" for up to 90 days minimum and should consider implementing the following training and mentoring strategies:
   - Partner "in training" social workers with experienced, mentor social workers.
   - "In training" social workers will not be assigned cases for 45 days. If assigned cases prior, the "in training" social worker should be assigned as a secondary with the mentor social worker as the primary social worker assigned to the case.
   - If staffing resources do not allow for partnering, "in training" social worker has daily supervision with assigned supervisor.
   - CA should develop a checklist of case "types" to ensure "in training" social worker has exposure to and experience with a variety of cases while in training, to include:
     - Newborn victim cases
     - Non-verbal victim cases
     - Adolescent victim cases
     - Substance abusing and addicted caregivers
     - Mentally ill caregivers
     - Physical abuse
     - Sexual abuse
     - Negligent treatment or maltreatment
     - Chronic maltreatment

3. Snohomish County providers of services for chemically dependent clients have begun monthly meetings to address budget cuts, reduction in resources, and how to maximize existing resources. This meeting has recently been joined by Region 3, Everett office management. The additional goal is to improve and increase communication about working with chemically dependent clients.
   - The department should consider working with local county providers and setting up similar network meetings around the state.
   - The department should conduct a survey to identify social workers currently employed by the department who are also CDPs. These staff could be utilized as local "experts" and assist social workers, particularly those less experienced, with cases involving chemically dependent clients.

4. The department should implement a visitation requirement for families who have open CPS cases longer than 30 days. Similar to dependent children, children who are open to CPS should be seen every 30 days.

Children's Administration

Executive Child Fatality Review

Santiago Twohearts

January 19, 2011

Committee Members:
Donald Ashley, MD, Regional Medical Consultant, Dept. of Social and Health Services
Brent Borg, Area Administrator, Children's Administration, Region 1
Chauntelle Bryant, Legal Advocate, YWCA, Spokane
Nancy Foll, Director, Kids First Child Advocacy Center, Colville
Dwayne Johnson, Detective, Colville Police Department
Robert Palmer, CPS Program Consultant, Children's Administration, Region 5
Marilee Roberts, Practice Consultant, Children's Administration
Daryl Toulou, Regional Manager, Office of Indian Policy, DSHS
Jill Volke, Community Corrections Officer, Department of Corrections, Spokane

Observers:
Mary Meinig, Director, Office of the Family and Children's Ombudsman
Rachel Pigott, Ombudsman, Office of the Family and Children's Ombudsman

Invitee:
Thomasine Iron, Representative for the Standing Rock Sioux Tribe[1]

Facilitator:
Nicole LaBelle, Regional Programs Administrator, Children's Administration

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[1] The Standing Rock Sioux Tribe identified a representative to participate on the review committee. However due to unforeseen circumstances was unable to participate the day of the review.

Table of Contents

RCW 74.13.500

RCW 13.50.100

Executive Summary

On September 29, 2010, Children's Administration (CA) Central Intake (CI) received an intake that a child [redacted], 4-years-old, had been injured and another child, S.T., 13-months-old, had died. The referent, [redacted]'s father, stated he saw this information had been reported on the local news and was concerned for his son, [redacted]. The referent stated he called law enforcement and learned his son, [redacted], was currently with [redacted]'s mother.

CI contacted Spokane Police Department (SPD) and received limited information until receiving hard copies of preliminary police reports. The police confirmed that S.T. had suffered injuries indicative of non-accidental trauma and was pronounced dead at a local hospital. SPD contacted James Cooley[2] as a person of interest, and he was later arrested and charged with first degree murder. S.T.'s older sibling, [redacted] presented with non life threatening injuries and law enforcement left him in the care of his mother. [redacted]'s father located and obtained [redacted] from his mother.

[redacted] CA agreed [redacted] should remain in his father's care.

[redacted]'s statements revealed he had witnessed the death of his half-brother, S.T.

On September 29, 2010 a detective conducted an interview with James Cooley regarding the death of S.T. During the interview on September 29, 2010, Mr. Cooley admitted responsibility for the fatal injuries to S.T. and injuries to another child in a previous incident. Law enforcement reported that Mr. Cooley had also been a person of interest in another criminal child abuse investigation which caused serious injuries to a 6-month-old infant, [redacted] In May 2010 [redacted] was hospitalized when he suffered serious injuries from what appeared to be shaking and assault.[3]

Following S.T.'s death, the Spokane County Medical Examiner's office conducted an autopsy and determined S.T.'s cause of death: *non-accidental head trauma with contributing factor, liver lacerations* and the manner of death: *homicide*.

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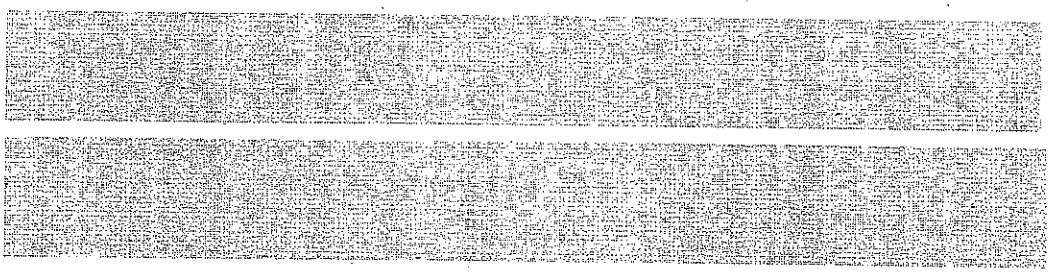
[2] The full name of James Cooley is being used in this report as he has been charged in connection to the incident and his name is part of the public record.

[3] Mr. Cooley has been charged with felony assault referencing A.G.'s injuries and murder in the 2nd degree for S.T.'s death.

CA history referencing S.T. and his family includes two prior intakes. The intakes received in April 2008 and December 2009 referenced issues related to domestic violence. Both intakes were screened out for investigation as there was no indication the children living in the home at the time were present or affected by the alleged incidents.



In January 2011, CA convened an Executive Child Fatality Review[4] committee to review the case practice and decisions regarding 13-month-old child, S.T. and his family. The fatality review members included CA staff and community members who had no involvement in the case. S.T. was eligible for enrollment as a member to the Standing Rock Sioux tribe. His father is an enrolled member. Tribal representatives were invited to participate in the January review.

Committee members received documents including a case summary of the CPS history of the deceased child's family. In addition, committee members were provided information from two other cases in which Mr. Cooley was involved and a copy of a critical incident briefing paper referencing the fatality, dated October 5, 2010. Complete case records of all three families were available to the committee for review and were referenced during the fatality review meeting.

The review committee addressed issues related to intake practice and procedures, investigative policies and practice related to information gathering and documentation and training of CPS social workers.

Case Overview

The review committee was provided case information regarding three families as a means to gain an understanding of the events leading up to S.T.'s death and to review CA's

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

practice and delivery of services to the respective families. A search of FamLink[5] revealed that Mr. Cooley's connection with three different families all included allegations of physical abuse, neglect and domestic violence.

Family #1 – S.T.'s Family

The review committee discussed the screening decision for the April 2008 intake at length. The screening decision was based on factors that included: no specific allegations of child abuse and/or neglect, no previous CPS history for the family, and the child appeared to be in good health with no injuries. The review committee agreed that based on the information provided at the time of the intake, the "information only" screening decision was appropriate.

The committee did note that although a collateral contact was made to law enforcement regarding this intake the full name of the man who had contacted the referent was not known or obtained. The disposition of the incident was not obtained from law enforcement and a police report was not requested. As a result, the review committee discussed the documentation completed by intake when collateral contacts are made. The committee encourages as near-verbatim documentation as possible to explain/support the intake screening decision and response time.

Additionally, questions specific to domestic violence and safety in the home were not reflected in the intake report. CA has since implemented a universal domestic violence screening question[6] at the point of intake, beginning in February 2009.

On December 7, 2009 CA intake received a written police report dated December 4, 2009 (09-40124). S.T.'s mother and father were involved in a domestic violence incident. Reports stated S.T.'s father hit S.T.'s mother multiple times in the head with his fists and choked her. S.T.'s father admitted to law enforcement that he had hit the child's mother

[5] CA's Management Information System

[6] *"Has anyone used or threatened to use physical force against an adult in the home?"* The universal screening question is used to help the intake worker identify if DV is an issue. It is not used for sufficiency screening because DV, in and of itself, is not child abuse or neglect. (RCW 26.44.020 (13). Intake workers must screen all intakes for DV to assess whether a child is in clear and present danger from DV. If the universal screening question is answered yes, then intake workers: Complete the remaining DV questions in FamLink. Ask who did what to whom and document in the Additional Risk Factors section.

in the head, chest, and face. S.T.'s mother had marks on her neck and her face was swelling. The whereabouts of the children was not documented in the police report.

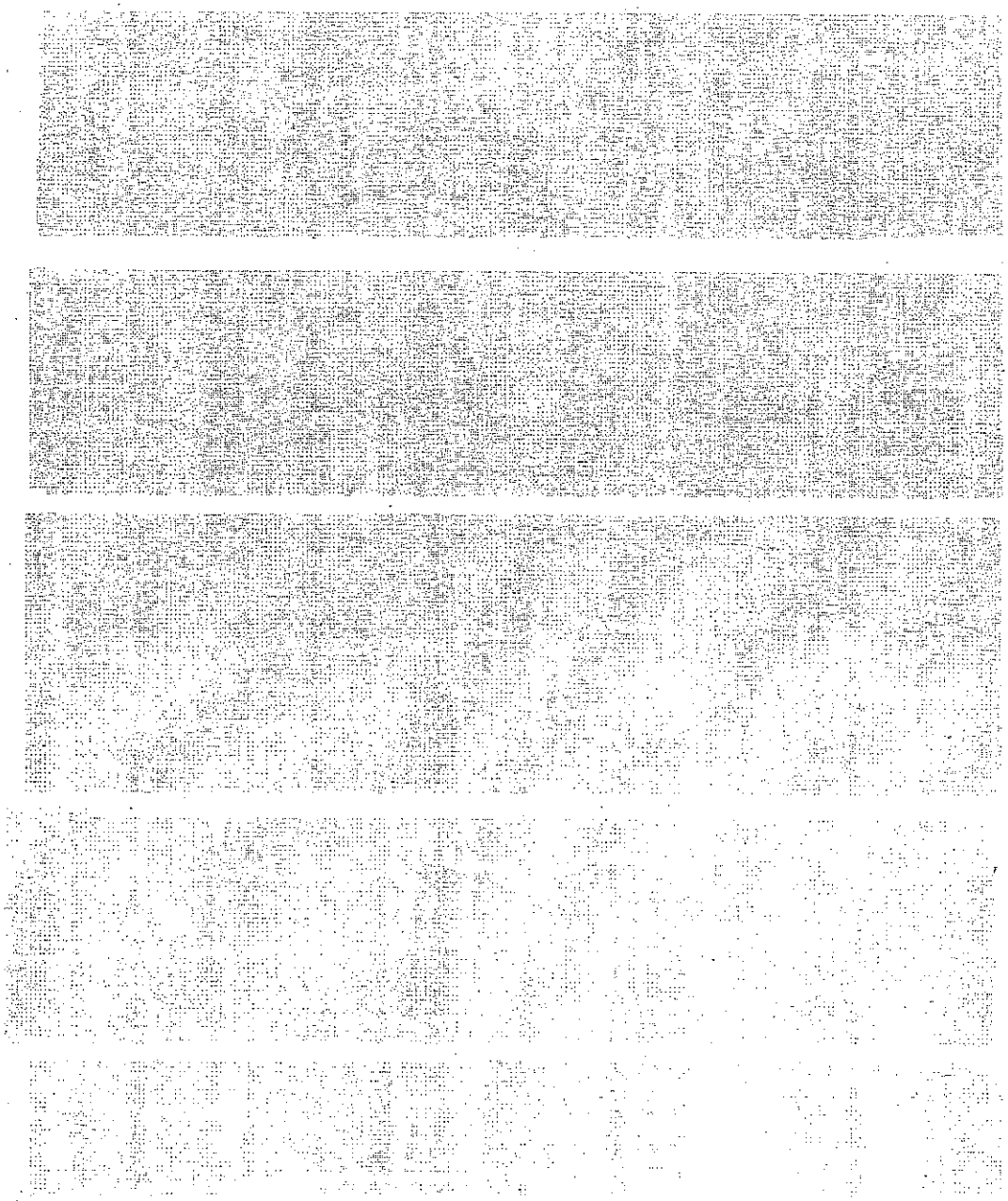
The intake was screened as information only. The committee agreed that based upon the information known at the time, the screening decision was accurate.

The committee commented that even with the domestic violence screening question being asked, the use of language in the documentation is an important factor. Domestic violence is not between two people but rather domestic violence is committed by a perpetrator against a victim. The December 7, 2009 intake identified that S.T.'s mother had been choked during the domestic violence incident. The word "strangulation" is preferred as it denotes the true violence of the action.

The next intake received by CA referencing S.T. and his family is the fatality intake received on September 29, 2010. CPS intake received a call from the father of the deceased child's sibling stating that he saw on the local news that his son, [redacted], had been injured and another child, S.T. had died. Intake called law enforcement and learned that the paramour of S.T.'s mother was arrested and was being charged with first degree murder in the death of S.T. [redacted] was left in the care of his mother by law enforcement and the referent was concerned for his safety. The committee noted that CPS had not been contacted by law enforcement, the hospital or any of the first responders regarding the fatal incident.

Family # 2

[redacted]



The committee discussed the value of utilizing Multi-Disciplinary Teams (MDTs) when multiple systems are involved with individuals related to critical incidents. In this particular case, a warrant was filed by county corrections for Mr. Cooley's arrest from Kitsap County on May 5, 2010 related to his activities involving another woman and his children. May 5, 2010 was the same date , presented at Sacred Heart Hospital with critical injuries in Spokane. The committee identified the possibility that had the systems

involved with Mr. Cooley staffed their respective information Mr. Cooley may have been arrested on the warrant prior to S.T.'s death.

[redacted]

The review committee identified the inability to add or modify the alleged subjects in the intakes as a potential barrier to history searches on specific individuals. FamLink allows for additional subjects to be added to the investigative assessment tool but does not automatically link that individual to the case. This may contribute to time intensive history searches on individuals since each investigative risk assessment tool needs to be opened and reviewed for subject findings.

Family # 3

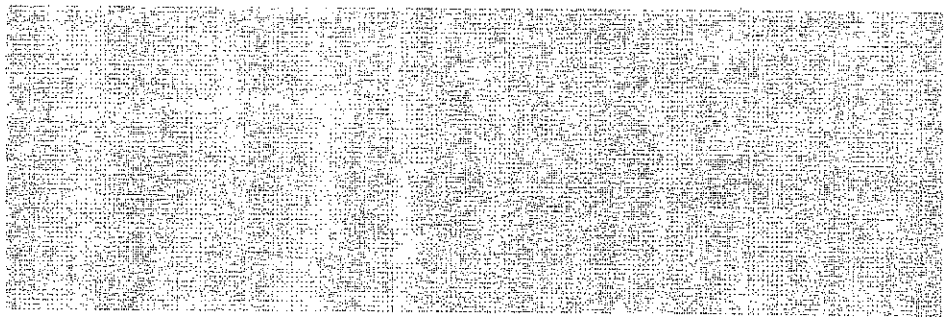
[redacted]

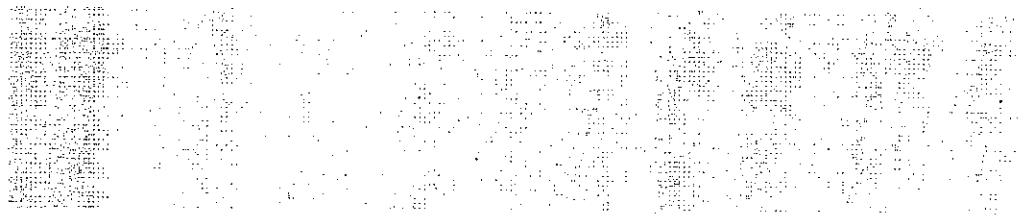
The committee had concerns that a referent was directed to call law enforcement instead of CA intake contacting law enforcement. As a result there was no verification that law enforcement was actually called by the referent.

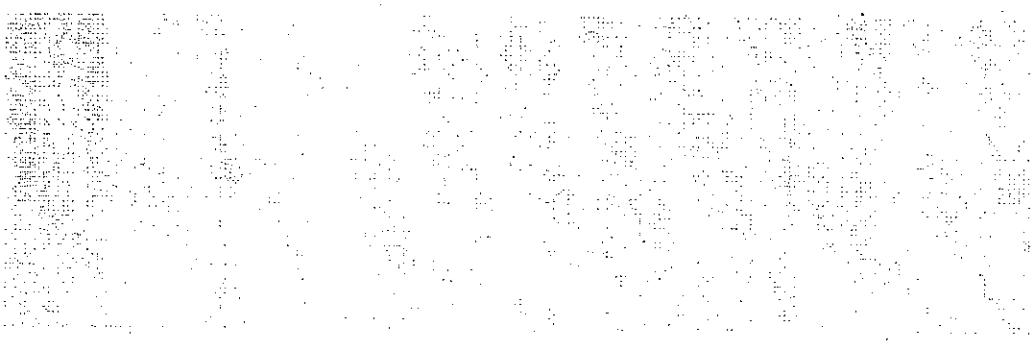
[redacted]

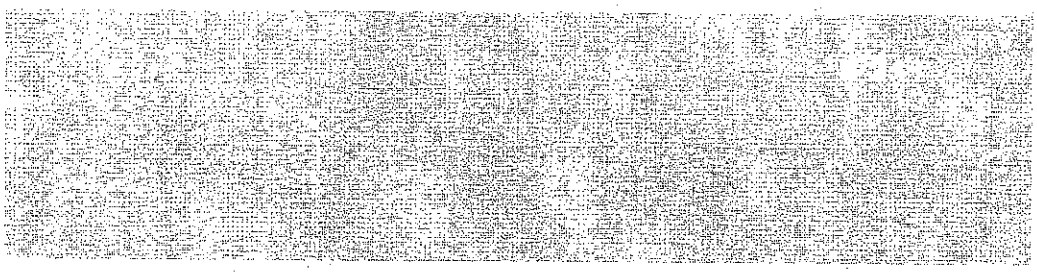
RCW 74.13.500

RCW 13.50.100









Findings and Recommendations

The committee made the following findings and recommendations based on review of the case records, department policy and procedures, Revised Code of Washington (RCW), Washington Administrative Code (WAC), and medical documents.

Findings

- The committee found that CPS was not contacted by law enforcement, the hospital or any of the first responders to the fatal incident involving S.T. Many of these individuals are mandated reporters in Washington State.

- The investigation from the June 3, 2010 intake regarding Mr. Cooley's daughter does not include an interview with the babysitter of the children. This individual was identified as an eye witness to the circumstances of how the child's arm was broken.

Recommendations

- The review committee recommends Children's Administration develop procedures for obtaining and maintaining police reports on both screened in and screened out intakes. Information should include full names of participants in the incident and law enforcement's disposition of the incident. The information should be documented in FamLink and police reports uploaded into FamLink.

- When speaking with collateral contacts at the point of intake, particularly law enforcement, Children's Administration staff should request details about the case and document those details near-verbatim. The police report number, full names of all parties involved and the name of the officer or individual providing the information should also be obtained and documented.

- Children's Administration should develop domestic violence curriculum and provide domestic violence training to accompany the *"Social Worker's Practice Guide to Domestic Violence."*[7] The training should include local community

[7] The "Social Worker's Practice Guide to Domestic Violence" was published by Children's Administration in February 2010 and disseminated to all case carrying social workers and their supervisors. CA developed this practice guide to provide direction to social workers working with families experiencing domestic violence. While varying definitions for "domestic violence" appear within Washington statute, it is important to note that this guide addresses best practices for working with families experiencing domestic violence occurring between intimate partners. The guide focuses on the knowledge and skills needed by all

resources involved with domestic violence, as well as, information regarding the judicial system and issues related to "No Contact Orders". Many "No Contact Orders" restrict contact with the adult victim but allow for unsupervised visitation between the adult perpetrator and their children. The training should be made available to social work staff on an annual basis.

- Children's Administration should consider initiating the development of a Domestic Violence and Child Maltreatment coordinated response guideline for local communities similar to that of King County, WA. Primary participants should include the judicial officers and other program staff in criminal and civil courts; law enforcement agencies; the Office of the Prosecuting Attorney; the Washington State Attorney General; Public Defender Agencies; and the Washington State Department of Social and Health Services, Children's Administration.
- The committee found CA best practices include asking the referent if they would like a call back regarding CA's decisions or actions on the information provided. The committee suggested that when call backs to referents are completed the referent may provide additional information or make subsequent calls of concern. Call backs to referents elicit support from referents and the community in reporting child abuse and neglect.
- Mandated reporters identified in RCW 26.44.030[8] should be required to review the Department of Social and Health Services mandated reporter training materials on an annual basis.

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workers, not solely DV specialists. The guide reflects new insights in effective child welfare responses, so it is relevant for both experienced and new workers.

[8] When any practitioner, county coroner or medical examiner, law enforcement officer, professional school personnel, registered or licensed nurse, social service counselor, psychologist, pharmacist, employee of the department of early learning, licensed or certified child care providers or their employees, employee of the department, juvenile probation officer, placement and liaison specialist, responsible living skills program staff, HOPE center staff, or state family and children's ombudsman or any volunteer in the ombudsman's office has reasonable cause to believe that a child has suffered abuse or neglect, he or she shall report such incident, or cause a report to be made, to the proper law enforcement agency or to the department as provided in RCW 26.44.040.

(b) When any person, in his or her official supervisory capacity with a nonprofit or for-profit organization, has reasonable cause to believe that a child has suffered abuse or neglect caused by a person over whom he or she regularly exercises supervisory authority, he or she shall report such incident, or cause a report to be made, to the proper law enforcement agency, provided that the person alleged to have caused the abuse or neglect is employed by, contracted by, or volunteers with the organization and coaches, trains, educates, or counsels a child or children or regularly has unsupervised access to a child or children as part of the employment, contract, or voluntary service. No one shall be required to report under this section when he or she obtains the information solely as a result of a privileged communication as provided in RCW 5.60.060.

Nothing in this subsection (1)(b) shall limit a person's duty to report under (a) of this subsection.