Report to the Legislature

Quarterly Child Fatality Report

RCW 74.13.640

April - June 2006

Department of Social & Health Services
Children's Administration
Division of Children and Family Services/Office of Risk Management
PO Box 45040
Olympia, WA 98504-5040
(360) 902-7718
Fax: (360) 902-7903

Children's Administration Child Fatality Report
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INTRODUCTION

This is the April – June 2006 Quarterly Child Fatality Report 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. This report summarizes the 14 reviews that were completed during the second quarter of 2006. Eleven of these cases were fatalities that occurred in 2004 and three were fatalities that occurred in 2005. All of these fatalities were reviewed by a regional Child Fatality Review Team.

Child Fatality Reviews are conducted when children die unexpectedly in a licensed facility or received services from the Children's Administration (CA) within 12 months of their death. Child Fatality Reviews consist of a review of the case file, identification of practice, policy or system issues, recommendations, and development of a work plan to address the identified issues. A review team can be as few as two individuals on cases where the death is clearly accidental in nature, to a larger multi-disciplinary committee where the child's death may be the result of abuse and/or neglect by a parent or guardian.

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

It is often many months following the death of a child before the fatality review is completed. This is due to Child Fatality Reviews requiring a multi-agency effort in gathering complete reports and findings. It is necessary to wait until all information is compiled in order to ensure a thorough review of the case, even when this means having an extended timeline for completion.

The chart below provides the number of fatalities reported to CA, and the number of reviews completed and pending for 2004-2006. The number of pending reviews is subject to change if CA learns new information through reviewing the case. For example, we may learn that the fatality was anticipated rather than unexpected, or there is additional CA history regarding the family under a different name or spelling.

Child Fatality Reviews for 2004 – 2006

Year	Total Fatalities Reported to Date	Completed Fatality Reviews	Pending Fatality Reviews
2004	63	63	0
2005	58	25	33
2006	26	0	26

The numbering for the Child Fatality Reviews in this report begins with #04-29. This indicates the fatality occurred in 2004 and is the 29th report completed for that year. The number is assigned when the Child Fatality Review and report by the CPS Program Manager is completed.

The reviews included in this quarterly report discuss fatalities that occurred in the following Regions:

Region 1 (1 report)
- 1 Spokane

Region 2 (0 report)

Region 3 (4 reports)
- 2 Everett
- 1 Day Care Center
- 1 Child Care Home

Region 4 (2 reports)
- 1 Division of Licensed Resources
- 1 Eastside

Region 5 (5 reports)
- 2 Day Care Center
- 3 Tacoma

Region 6 (2 reports)
- 2 Day Care Center

In addition to the quarterly Child Fatality Reviews, CA completed the 2003 Annual Child Fatality Report which provided statistical information on child fatalities that occurred throughout 2003. The next annual Child Fatality Report will be for the year 2004.

Child Fatality Review #04-29
Region 5
Tacoma Office

Case Overview

This two-month-old African American male died on August 27, 2004 due to Sudden Infant Death Syndrome (SIDS).

The decedent was in a day care home under the owner's supervision, and was placed on his stomach to sleep. The deceased child's mother gave permission for the child to sleep on his stomach. A day care assistant arrived at the day care and asked the owner how the children were doing. The day care owner went to check on the child, who had been sleeping for approximately an hour and a half, and found the infant unresponsive. Cardiopulmonary resuscitation (CPR) was initiated, and 911 was called. Paramedics arrived but were unable to revive the child, and he was transported to Mary Bridge Hospital where death was pronounced shortly after arrival.

There were no indications that the death was suspicious. The determination from the preliminary investigation by the medical investigator was that the death was consistent with SIDS. The referral was screened out per protocol of the Division of Licensing Resources/Child Protective Services (DLR/CPS). The information was referred to the Division of Child Care and Early Learning (DCCEL) as a non-CPS licensing complaint.

The licensing complaint investigation findings were valid for facility environment and for nurture/care. Although the deceased child's mother gave verbal permission to put the decedent on his stomach, state licensing requirements for documentation were not met by the provider.

The biological family of this child has not been previously involved with Children's Administration.

DLR/CPS had received several referrals regarding the provider. One referral was inconclusive for physical abuse. The other referral was screened out for licensing issues.

The biological mother of the deceased is active duty in the Army and is unmarried. She allegedly has had four children. Reportedly there is a nine-year-old child in the home (unconfirmed). In 2001 the mother gave birth to a set of twins, one of which died at three and a half months of age. The death was consistent with SIDS, and was listed as an undetermined cause and manner of death. The infant had been placed on his stomach for sleeping. That child fatality was reviewed by the Pierce County Community Child Death Review (CDR) team in 2002.

Issues and Recommendations

I. Practice Issue

A. Issue: The licensor's documented explanation regarding validation of the licensing complaint for "environment" was not clear and appeared questionable. Based on the licensor's documentation of having provided technical assistance to the child care provider regarding the set up of rooms at the home, speculation was that the "environment" issue was related to where infants were placed for sleeping at the day care. Furthermore, the fact that the child care provider failed to properly record the parent's permission to place the infant on his stomach for sleep reasonably could have merited a licensing complaint validation for reports and record keeping.

Recommendations: None

Action Taken: The licensor is no longer a Department of Social and Health Services (DSHS) employee and was not available to participate in the review. The licensing supervisor did participate and acknowledged that the validation findings should have been challenged at the supervisory review following the completion of the facility complaint investigation.

Comment: DCCEL continues to support improvements in licensor training with regards to completing complaint investigations, identifying licensing issues, specifying licensing complaint resolutions, and improving documentation standards. Many improvements in DCCEL practice expectations have occurred since the time of this fatality.

II. Contract Issue

A. Issue: The provider failed to follow Washington Administrative Code (WAC) requirements for documenting parental permission to place an infant in a sleep position other than on their back. While this violation was concerning, the failure to follow statutory and licensing requirements for "back to sleep" did not cause the child's death. The panel concurred with current medical research that sleep position of infants is a risk reduction issue and not a cause and effect in SIDS deaths. Therefore any conclusion of neglect would not be supportable for this fatality.

Recommendations: None. Requirements regarding sleep positions of infants while in licensed family home child care were in place at the time of this child's fatality.

Note: Modifications in the WAC specifications regarding infant sleep positions have occurred since the time of this fatality. The WAC revisions are currently more prescriptive regarding infant sleep requirements than were in effect at the time of this fatality.

B. Issue: The fatality review panel discussed the current training available to local child care providers regarding SIDS prevention.

Recommendation: While it was noted during the review process that day care providers receive SIDS prevention as part of the licensing process, DCCEL should consider initiating agency discussion surrounding additional training opportunities with child care providers on SIDS prevention.

C. Issue: There was some confusion as to whether the provider and child care staff were up to date on infant CPR and First Aid training. It now appears that they were.

Recommendation: None. The licensing requirements for child care providers to have current CPR and First Aid training were in place at the time of the child fatality.

Comment: There is currently no "tickler" system within DCCEL regarding expiring individual CPR or First Aid training certifications for day care providers and their staff. Keeping track of the current status of individual CPR and First Aid training would be difficult due to different CPR and First Aid training agencies having different lengths of certification. While the panel did not have any specific recommendation regarding this issue, it may be worthy of consideration for DCCEL to have further discussion on the matter.

Action Taken: The provider and assistants completed and updated their CPR and First Aid training immediately following the child death.

III. System Issue

A. Issue: The panel discussed the fact that providers have the responsibility to know the WACs and Minimum Licensing Requirements relating to their specific type of child care license. This requires providers to retain a large amount of information.

Recommendation: Currently there is on-going discussion within DCCEL as to improvements in organizing the vast amount of information that child care providers are required to know. This discussion has focused on possibly structuring licensing information by topics. DCCEL should continue to review this potential improvement.

Child Fatality Review #04-57
Region 3
Everett Office

Case Overview

This three-month-old Caucasian female died on January 27, 2004 due to unknown causes.

The mother said she checked on the infant at about 9:30 a.m. and found her lying on her back with her arms at her sides. The mother reported that she had bubbles in her nose. The mother said that when she went to wipe off the bubbles she realized the baby was dead and called 911. The mother said that she had arrived home from work the evening before at about 8:00 p.m. She did not go in to kiss the baby good-night at that time, as the father had told her that he had just put the baby down. The father had been caring for the baby while the mother was at work.

The medical examiner referred to this as a suspicious death. It was unknown at that time what part, if any, either parent had in the death. There is considerable history of abuse/neglect of their other children by these parents.

As teenagers, the mother and father were both under Alternative Residential Placement or At Risk Youth court orders due to runaway and chemical dependency issues. Both parents had at some time in their past been involved in inpatient treatment for the substance abuse, but neither completed treatment. They have reportedly been together since 1999, and married shortly thereafter when both were age 18.

This couple's first child was born in May 2000. He was two-months-old when the first CPS referral was received. Hospital staff called to say that the infant had to be hospitalized due to breathing problems. He ate poorly and had poor weight gain. The emergency staff that responded to the home said they observed considerable evidence of drug use in the home. Within a day of that referral the department also received a call from a neighbor saying the mother had to be hospitalized for alcohol poisoning. The referrer said there was considerable traffic in and out of the apartment and much alcohol and drug use.

The department proceeded with investigation of these referrals and filed a dependency petition shortly after these occurrences. At the shelter care hearing, the infant was ordered placed in the parents' care. A service plan was arranged with the parents and maternal grandparents that involved a public health nurse, substance abuse assessments for both parents, services for several instances of domestic violence, and mental health services. The parents did not follow through with this service plan, and additional causes for concern were identified. The case went back to court and in early September of 2000. The child was placed with the maternal grandparents. He was adopted by them in December of 2003.

By December of 2001, the parents had made minimal progress toward completion of services and establishing themselves as capable of parenting. Due to their continued use of drugs, primarily methamphetamine, it appeared unlikely that conditions would be remedied so the child could be returned to them. At that time, the department received another referral alleging the mother was pregnant again, and due next month. It was reported that she had last tested positive

for methamphetamine in May. It was also reported that the parents were anxious to give up their parental rights to their first child, as they planned to move out of state soon.

The assigned CPS social worker contacted the parents and informed them the department would need to be involved in assessing the safety of the baby when it arrived. The parents stated they understood that. However, they left the area within a few days. After attempts to locate the parents, the department was eventually notified that they were in California, and had given birth to another boy on June 15, 2002. Upon learning of the exact location, a CPS referral was made to that county. The department heard from California authorities that this infant had later appeared in the emergency room with broken bones. The authorities determined these injuries to be inconsistent with the parents' explanation. That child was removed from the parents by authorities in California, and California handled the case of that child through to the eventual adoption by the maternal great-grandparents.

In December of 2003, the adoption of the parent's first child was being finalized with the maternal grandparents. The maternal grandparents had maintained a very close relationship with the parents. The adoption social worker discussed with the grandparents the potential dangers of the parents attempting to raise another child, given the history with the two prior children. Despite having been warned of the dangers, the maternal grandparents did not notify CPS when the mother became pregnant with the decedent. CPS first learned of the birth of this child when the medical examiner reported her "suspicious" death at three-months-old in January of 2004.

This referral was assigned and investigated by CPS. The parents' affect was unusual, according to the investigator. The mother's story about the circumstances changed several times. The father was mostly silent and refused to speak with social worker. The autopsy did not show anything conclusive. The toxicology tests came back showing nothing in the baby's system that could have been the cause of death, and the manner of death remained "unexpected and undetermined."

The social worker had a conversation with the maternal grandparents and they stated that the parents come to visit with the oldest child usually about twice a month. The grandfather maintained that the visit was always supervised. He said he "did not take notice" if the mother was pregnant at the last visit, although at that time she would have been about eight months pregnant. The social worker stressed that should the parents expect another baby, the grandparents should call CPS so that there could be some monitoring to ensure parents learn good skills. The grandfather did not respond to that suggestion, and the social worker was left with the impression that he would not call.

Issues and Recommendations

I. Practice Issues

A. Issue: Referral date July 25, 2000 was not attached to the Investigative Risk Assessment that addressed the issues raised in the referral.

Recommendation: Follow policy in ensuring each high risk standard referral is related to an Investigative Risk Assessment.

B. Issue: There was a previous (1996) referral that alleged marijuana use by the maternal grandfather. There were also several references in the records to suggestions made by the parents over the years in this case that the maternal grandparents abused alcohol. Despite these cues, the adoption home study did not address the issue of substance use by the grandparents. The only place this issue was referenced in the adoptive home study was a standardized question of the applicants about their use of alcohol. The grandparents responded that their alcohol use was minimal, and that response was not questioned.

Recommendation: Adoption home studies for relatives should include a thorough review of the child's and parent's records for any indications of problem areas to be addressed prior to the adoption.

Child Fatality Review #04-58
Region 5
Tacoma Office

Case Overview

This four-month-old Caucasian female died on January 9, 2004 while in the care of a licensed child care provider.

According to the medical examiner, the cause of death is "death during infancy, no identifiable cause" and the manner is listed as "undetermined." The death is consistent with Sudden Infant Death Syndrome (SIDS).

Late in the afternoon of Friday, January 09, 2004, day care provider notified the Division of Child Care and Early Learning (DCCEL) licensor of the death. The infant had been attending the day care since January 5, 2004. The infant's father told the day care staff that the decedent had been spitting up all morning and he thought she might be teething (putting hands in her mouth quite a bit). The father left infant Tylenol and Mylecon drops for the child. The infant was given formula at approximately 8:00 a.m., and fifteen minutes later she began to heavily spit up. At 8:33 a.m., the infant was given the Tylenol. There were more episodes of spitting up and eventually the child took a one hour nap.

At about 1:00 p.m. the infant was fed again and she reportedly fell asleep while feeding. The baby was burped and put down in a playpen crib. The child was placed on her left side with a blanket behind her to prop her. The day care provider stated that she had been concerned about putting the baby on her back with all the spitting up. The child was seen around 2:30 p.m., still on her side and movement was observed. Between 3:00-3:15 p.m. the day care provider had noticed the infant had rolled onto her stomach and her right arm was very pale. The child was picked up and felt floppy and lifeless. The provider called out to her assistant to call 911. Rescue breathing and cardiopulmonary resuscitation (CPR) was initiated until emergency response arrived. The infant was taken to Mary Bridge Children's Hospital where she was pronounced dead.

On Monday, January 12, 2004 the day care provider called Child Protective Services (CPS) intake to file a report regarding the death, and the referral was assigned to the Division of Licensing Resources (DLR). The DLR/CPS supervisor contacted law enforcement on January 13, 2004 and received preliminary investigation findings that the death was not suspicious. On January 23, 2004, due to the absence of concerns for child abuse or neglect following the investigations by the medical examiner's office and local law enforcement, the referral was screened out for DLR/CPS and taken under Licensing Complaint (Non-CPS).

The investigation by the DCCEL licensor regarding licensing issues resulted in inconclusive decisions for facility environment, nurture/care, staff qualifications, and supervision. The facility complaint record was closed January 23, 2004.

All referrals related to the child care home, including those prior to the fatality incident, were reviewed. No issues surfaced with regard to prior intake decisions and investigations (DLR/CPS or licensing complaints). Additionally, it was noted during the fatality review that this child fatality case was one of several reviewed within DCCEL in 2005.

Issues and Recommendations

I. Practice Issue

A. Issue: The child care provider had propped the infant on her side for sleeping, fearing the child might choke if spitting up continued. The licensor indicated that the explanation appeared reasonable, but acknowledged limited awareness of current SIDS related research. Without documented parent permission, such decision by the provider violated the Washington Administrative Code (WAC) requirements in place at the time. The panel consensus was that the licensing decision based on the referral should have resulted in a finding of "valid" for "nurture/care" and "reports/record keeping."

Recommendations: None

Actions Taken: The licensor who investigated the fatality incident participated in the review and received feedback regarding the licensing complaint decisions. The licensing supervisor also was present during the review and acknowledged that the validation decision should have been challenged at the supervisory review following the completion of the facility complaint investigation.

Action Taken: SIDS related training has been scheduled for the next DCCEL licensors meeting in the Tacoma DCCEL office (May 2006).

Comment: DCCEL continues to support improvements in licensor training with regard to completing complaint investigations, identifying licensing issues, specifying licensing complaint resolutions, and improving documentation standards. Many improvements in DCCEL practice expectations have occurred since the time of this fatality.

II. Contract Issue

A. Issue: The provider failed to follow WAC requirements for documenting parental permission to place an infant in a sleep position other than on their back. While this violation was concerning, the failure to follow statutory and licensing requirements for "back to sleep" did not cause the child's death. The panel concurred with current medical research that sleep position of infants is a risk reduction issue and not a cause and effect in SIDS deaths. Therefore any conclusion of neglect would not be supportable for this fatality.

Recommendations: None. Requirements regarding sleep positions of infants while in licensed family home child care were in place at the time of this child's fatality.

Note: Modifications in the WAC specifications regarding infant sleep positions have occurred since the time of this fatality. The WAC revisions are currently more prescriptive regarding infant sleep requirements than were in effect at the time of this fatality.

B. The panel discussed the current training available to local child care providers regarding SIDS prevention.

Recommendation: Day care providers receive SIDS prevention information as part of the licensing orientation process, and the amount of information has increased over the last few years. It is recommended that DCCEL consider initiating agency discussion surrounding additional training opportunities with child care providers on SIDS prevention, including but not limited to orientation. Such additional training would also be available to child care licensors. It is recommended that SIDS related training include current medical research that does not generally support putting infants on their side or back even with concerns for spitting up, reflux, or choking.

C. Documentation obtained from the child care provider showed that the Child Care Enrollment form signed by the parent authorized the day care provider to give the child Children's Tylenol. A "Non-prescription Medication Authorization" was also signed by the deceased child's parent. The latter form specifically states that “medications shall be administered only as directed on the manufacturer’s label for the age or weight of the child.”

The issue of giving Infant Tylenol to infants under age six months was discussed during the review. The Public Health professional who participated in the review indicated that directions packaged with Infant Tylenol, as approved by the FDA, did not recommend the medication be given to very young infants without physician consultation.

Recommendations: None. Changes in WAC have occurred since the time of this fatality, and are currently more prescriptive regarding administration of medications in licensed child care homes and centers.

Comment: The issue of Infant Tylenol is covered in day care provider orientation provided locally by Public Health.

Action Taken: The Infant Tylenol issue has been scheduled for discussion at the next DCCEL licensors meeting in the Tacoma DCCEL office (May 2006).

Child Fatality Review #04-59
Region 3
Everett Office

Case Overview

This seven-year-old Filipino male, died on March 30, 2004 due to a car accident.

On March 30, 2004, around 2:20 a.m., an auto accident occurred in Poulsbo, Washington involving the father and his two sons, ages 13 and seven. They were on their way home after accompanying the father's girlfriend to the airport and waiting with her until midnight when she boarded a plane to the Philippines. The father had been drinking most of the evening. The older son stated that he had to wake his father up several times as he would fall asleep at the wheel and then he would start to drift off of the road. They stopped three times along the way because of this. The older son said that they came to a part of the road that had a turn in it but his father did not make the turn and went off the roadway and struck the guardrail.

As a result of the accident, the decedent, asleep in the back seat, was killed almost instantly. The older son was treated for facial injuries, and the father was treated for a broken leg, bruises, and cuts. The father was treated and arrested for vehicular homicide, as a breathalyzer showed he was intoxicated at the time of the accident (initial breathalyzer results of 1.8). The father pled guilty for one count of vehicular homicide and one count of child maltreatment. He was sentenced to 48 months in prison.

There was a Child Protective Services (CPS) finding against the father based on the fact that he was driving while intoxicated when the automobile accident occurred that killed his son and injured his other son.

The decedent was the youngest child of both parents who are of Filipino descent. The mother was originally from the Philippines and moved to the United States in 1981. The father was born in the United States. They were married in 1988. At the time of this child's death, the surviving children were two girls, ages 17 and 15, and one boy, age 13.

The parents of the children had been living separately off and on. The family had history with CPS in Everett and had an open case at the time of this incident. The most recent CPS referral on the family was received in January of 2004. The report at that time stated that the four children in the family were living alone without adequate facilities near Everett. The two children involved in this automobile accident had been sent to live with the father in Quilcene by law enforcement at the time that referral was received. The other two siblings went to live with friends in the Everett area.

Before the accident, there were ten CPS referrals. All of those referrals were handled by the Everett office, as the family was living in Mukilteo for most of the time that CPS was involved. The primary issues involved in these referrals were violence between the parents, violence alleged toward the children by their father, and neglect almost to the point of abandonment by their mother.

Services for domestic violence were being provided to the father by the Boeing company. The second daughter, age 14 at the time, was provided services by juvenile court under court action for truancy. The school had offered assistance with getting necessary glasses for her through Lions Club, but the family had not accepted this offer. The school counselor stated they had made other offers of assistance which had been refused. In her summary assessment of September 25, 2002, the social worker states she discussed the value of family counseling in this family's chaotic situation but the mother appeared unable to understand the helpfulness of this, and remained focused only on her more immediate needs.

After the death of this child, the Guardian ad Litem appointed for his older brother gathered the following information through interviews of family and others involved:

“Both the mother and a long-term family friend reported that the father had a long history of alcohol and substance abuse. Both parents acknowledged that they had a difficult marriage from the very beginning. They blamed each other for their problems. Both parents claimed the other to have been physically, emotionally, financially and verbally abusive. The father claimed that the mother was very demanding and threatened him for money. He claimed that she spent lavishly on herself, friends, and gambling. The mother claimed that the father drank heavily, was involved with drugs and was violent with her and with the children. After their separation, she alleged that their children witnessed the father having sex with his cousin while they were at his house on a visitation. It appears the children witnessed their parents' screaming, name calling, and throwing of food and objects at each other and around the home for several years. During this time, the parents separated and reconciled several times, filed bankruptcy and filed and then dismissed restraining orders against each other. The father was employed as a machinist until terminated in 2003 for excessive absenteeism. The mother worked part-time and intermittently, often in security. It appears the father had left the home in Mukilteo permanently by September of 2002.

From September 2002 to January 2003 the mother and the children were living in the family home in Mukilteo, which was being foreclosed. Utilities were shut off. The mother was working in security at the airport then. She was leaving the children alone for many days at a time, often with no way to contact her in an emergency. In late January of 2004, the Mukilteo P.D. was called to the apartment to which the mother and children had moved after the foreclosure of their home. They called CPS to report that they had received a complaint of child neglect, had gone to the home and found the children to be "virtually living alone." The mother reportedly visited once a week or so, and the children had to find much of their own food. They had no way to reach their mother when needed. That night, law enforcement placed the two boys with their father in Quilcene, and the father agreed to an informal placement of the oldest daughter with her friend's family. The second daughter was not to be found. A home study was requested by Everett office to be done by the office near Quilcene, where the boys were then living. There was no documentation of staffing of the current case situation with that office. That office saw the home and it appeared to be appropriate. The boys were interviewed, and were pleased to be living with their father.

By March 30, 2004, the day of the accident, the mother had contacted the Everett office and made arrangements to meet with them. She had excuses for where she had been, and wanted her children returned to her. The accident occurred before that meeting took place."

Issues and Recommendations

I. Practice Issue

A. Issue: Two referrals showed a decision of "Referred to Alternative Response System" but there was no documentation in the file from which to determine what action had actually been taken on these referrals.

Recommendation: Follow policy of documentation of case activity. Practice in this area could be reviewed at an Intake meeting with the CPS supervisors and intake workers who work with Low Risk Response referrals.

B. Issue: The referral received in January 2004, had no Investigative Risk Assessment and therefore no findings made until January of 2006.

Recommendation: Follow policy for completing Safety Assessment and Investigative Risk Assessments timely. This was addressed with the social worker and the supervisor. Kids Come First refresher training occurred throughout the region and addressed completion of safety assessments and risk assessments. Regional Lessons Learned training is occurring currently in the region to address practice issues within the region.

C: Issue: In the fourth referral on this family one of the sisters reported physical abuse to the children by her father when he was drinking. She stated he also used drugs, and that he has threatened to kill the family. This met the Washington Administrative Code (WAC) standard and should have been screened in for investigation.

Recommendation: Follow policy in screening of referrals. Practice in this area was reviewed at Intake meeting with the CPS supervisors and intake workers.

D. Issue: A Service Episode Record (SER) on September 20, 2003 regarding one of the sisters states that a phone call had been received from the school counselor with allegations that "have been reported and are already being taken care of." There was no further text to give information describing the allegations.

Recommendation: Follow policy in documentation. The region recently had Risk Assessment refresher training which addressed case documentation.

E. Issue: A referral reported the children witnessed, while at their father's house for visitation, their father and his cousin "nude and involved in sexual activity." The risk tag on this referral was reduced from three to two. There is no documentation of any activity in response to this referral.

Recommendation: Follow policy in documentation of case activity. This issue was addressed with the social worker and the supervisor. Documentation of case activity was addressed in the refresher course of risk assessment and will be addressed in the Regional Lesson's Learned training currently occurring.

F. Issue: In November to December 2002, three high standard of investigation referrals were received. There were four victims identified in each of these referrals. Although there was documentation of four attempts to meet with the children face-to face, there is only documentation that one of the victims was actually seen, and that was in May of 2003. Documentation of supervisory review states the children were seen.

Recommendation: Follow policy in regard to documentation of face-to-face contact in investigation of referrals. This issue was addressed with the social worker and the supervisor. Documentation of case activity was addressed in the refresher course of risk assessment and will be addressed in the Regional Lesson's Learned training currently occurring.

II. Policy Issue

A. Issue: A referral in September 2002 was assigned for a high standard of investigation. There were four victims listed. However, the case was set aside for closure as unfounded after only one victim had been seen, and the subject was interviewed by phone. There is no documentation that a findings letter was sent on this investigation.

Recommendation: Follow policy for high standard of investigation. This issue was addressed with the social worker and the supervisor. Documentation of case activity was addressed in the refresher course of risk assessment and will be addressed in the Regional Lesson's Learned training currently occurring.

Child Fatality Review #04-60
Region 3
Daycare Licensing

Case Overview

On March 31, 2004, this three-month-old Filipino female died due to Sudden Infant Death Syndrome (SIDS).

The father brought his five-year-old son and his infant daughter to the day care home about 3:30 p.m. on March 31, 2004. The daycare provider stated she put the baby to bed on her stomach while she went into the downstairs day care area to make dinner for the other children. That was at approximately 5:45 p.m. The daycare provider said she could hear the baby crying for a while through the baby monitor, and the crying stopped after about fifteen minutes. She thought the baby fell asleep.

When the daycare provider next checked on the baby, she was cold to the touch. The daycare provider immediately started infant cardiopulmonary resuscitation (CPR), and 911 was called at 7:00 p.m. CPR was continued until paramedics arrived. They took over the CPR, and took the baby to the hospital, where she was pronounced dead. There were no indications that the death was suspicious. After autopsy and toxicology screens, it was determined that the cause of death was SIDS, and the manner of death was natural.

The daycare provider's son had previously been involved with law enforcement regarding an alleged incident of sexual impropriety with one of the daycare children.

The issues that arose after the death of the infant resulted in the closing of this daycare. The daycare provider will no longer be able to be licensed. The closure was effective June 28, 2005.

The parents of the baby were both employed at a local restaurant. They worked the swing shift. It is believed they had emigrated recently from the Philippines. They had been using the day care for about a month prior to the death of their infant. There was no previous Child Protective Services (CPS) history on this family.

Issues and Recommendation

I. Practice Issue

A. Issue: There is no documentation in the record that the daycare provider has participated in the required "STARS" training.

Recommendation: As a result of this issue, practice has changed in the way training of licensed daycare providers is documented in this region. When a provider completes training and receives a certificate, the provider will now ensure that it goes to the licensor, who will input directly into the training record.

Child Fatality Review #04-61
Region 3
Daycare Licensing

Case Overview

On June 11, 2004, this four-month-old Caucasian female died due to Sudden Infant Death Syndrome (SIDS) in a daycare home.

Her parents delivered her to the daycare in the morning of June 11, 2004. At about 11:00 a.m. that day, the day care provider put her down for a nap in the bedroom. She placed the child on her back in a portable playpen, and then closed the door to the bedroom. The day care provider reports that she checked on the infant about ten or fifteen minutes later. She found that she had "thrown up" and that her "hands were purple." The daycare provider started cardiopulmonary resuscitation (CPR) immediately and her assistant called 911. The baby was transported to Valley General Hospital where she was pronounced dead. The Snohomish County Sheriff's Office came to the home. According to the physician, there were no indications of abuse or neglect. It was later determined that the death was attributed to SIDS and the sheriff's office closed the case.

As there were no indications of child abuse and neglect, no safety plan was necessary. However, the provider asked the other parents to pick up their children and she closed for a week, at her request.

This provider became licensed for day care in her home in November 2001. She had previous experience in day care, and worked for the local school district. In February 2002, her allowed capacity for children was increased to nine children, with four under the age of two. The capacity was increased again to twelve children in February 2003. There were no deficiencies noted in the monitoring visit, and she and her assistant appeared to be giving excellent care to the children in her home. There were no previous referrals on the birth family or on the day care home.

The four-month-old infant had been coming to this day care only for about a week prior to her death. On the day of the infant's death, the daycare provider stated that the biological mother had reported to her that the baby had not had a bowel movement in the last twelve or thirteen days. The previous evening the biological mother stated that she had given the baby a suppository and the mother "felt it had worked." When the baby was pronounced dead at the hospital the physician stated he saw no indications of child abuse/neglect. Law enforcement responded to the scene when the baby was taken to the hospital. The Division of Child Care and Early Learning (DCCEL) licensor and supervisor made a home visit on June 14, 2004. They determined that the daycare provider was within her allowed number of children in the home at the time of the incident, and nothing was found amiss.

Issues and Recommendations

No issues or recommendations were identified.

Child Fatality Review #04-62
Region 5
Tacoma Office

Case Overview

This 15-year-old Caucasian male died on February 22, 2004 due to hanging.

His older brother (age 18) came home and found the decedent hanging by a vinyl covered cable in the family garage. Although transported by Emergency Medical Services (EMS) to Mary Bridge Children's Health Center, the child appears to have been dead on scene. The mother was apparently out of town at the time. The boy's father lives in another county.

It is assumed that the deceased's sister was also living at the mother's residence, but this was not confirmed.

The family had never had a Child Protective Services (CPS) investigation of child abuse or neglect. There had been two information only referrals and two Family Reconciliation Services (FRS) referrals. The latter two referrals were in 2003 and involved a counseling intervention and aiding the child's parent in filing an At Risk Youth (ARY) petition.

Many of the services sought by the family were external to the Division of Children and Family Services (DCFS). The mother had counseling services prior to DCFS involvement. Both parents had made attempts to get the decedent into services (e.g., drug/alcohol treatment, mental health). The school was involved as well, including contact by the school psychologist with his mother. His mother had made appointments and taken off work numerous times to take her son to drug and alcohol inpatient treatment, mental health counseling, and medication management appointments. The decedent would run the night before the appointments to ensure avoiding them. He appears to have resisted nearly all forms of help.

FRS Phase II in-home services were provided between June and July of 2003, consisting of 12 hours (seven sessions) of parental, individual, and family counseling at the home involving multiple combinations of all family members. Both parents appeared motivated and actively participated as did the children. The final Phase II meeting involved an individual session with the decedent, and primarily focused on anger management issues. In late 2003, the FRS worker discussed the ARY petition process with the parents following two Secured Crisis Residential Center (S-CRC) episodes.

According to information obtained post-fatality from the Regional Support Network (RSN), the decedent had crisis intervention services and Family Assessment Stabilization Team (FAST) involvement between September 2003 and January 2004. During that time he had three suicide attempts, seventy-seven contacts with professionals, one emergency room visit, and one Crisis Triage response.

Both of the parents and all the children have related a history of chaotic family lifestyle, including substance abuse (father), domestic violence, and conflicting parenting styles. The

decedent's father allegedly would threaten suicide at times when he had been drinking. The decedent's mother reports intergenerational suicide issues on her side of the family. Her mother had several attempted suicides and her mother's mother actually died of suicide.

In January 2000 and in December 2003, the mother's therapist contacted CPS intake and reported second-hand information regarding incidents between the decedent's sister and the non-custodial father. The parents were in the process of divorcing. The children frequently visited their father who tended to have somewhat harsh disciplinary techniques. Both reports were taken as information only.

In mid-December 2003, the decedent's father contacted DCFS requesting help in filing an ARY petition on the decedent who was in runaway status. He was said to be depressed and suicidal and had previously been hospitalized for overdosing on pot and alcohol. The mother later provided information that the school psychologist had been concerned after reports of the decedent telling his friends "goodbye." The request was accepted by FRS.

That day, the decedent was picked up by law enforcement and transported to a Secured Crisis Residential Center (S-CRC). After three parent-child conferences he was discharged to his father. Within the week he was taken by law enforcement back to the S-CRC after an altercation with his father. The decedent was court ordered by a Kitsap County Commissioner to be released and the department was ordered to pursue a Child In Need of Services (CHINS) petition. Phase I (in home contact) meeting did occur with the mother, but the decedent refused to get out of bed. The mother indicated she was pursuing the ARY petition (filed in mid-January with dispositional plan filed February 4, 2004). The mother requested a change in curfew in mid-February but the Juvenile Court refused the request based on the decedent's promise to comply with the original court ordered curfew.

On February 22, 2004, DCFS was given notification by the Pierce County Medical Examiner's Office of the suicide.

Following the death, the FRS worker informed the prior Phase II provider of the suicide. FRS contacted the S-CRC to inform them of the decedent's death, as he had been placed there on two different occasions. The social worker from the hospital contacted the FRS social worker and informed her of the status of the family. It appears that the family was handling the loss in appropriate ways and referrals were made for grief counseling. The FRS worker contacted the mother to offer condolences. The mother had support from professionals and the community. The funeral was held on Saturday, February 28, 2004, and both FRS and Phase II workers attended.

Issues and Recommendations

No issues or recommendations were identified.

Child Fatality Review #04-63
Region 6
Child Care Home

Case Overview

This nine-month-old Caucasian male died on August 8, 2004 due to Sudden Infant Death Syndrome (SIDS).

The child stopped breathing while at daycare. The daycare provider performed cardiopulmonary resuscitation (CPR) until emergency medical services arrived. The decedent was transported to Mary Bridge Hospital. While at the hospital a head computed tomography scan was performed which was unremarkable for injury or bleeding, however, he developed multiple complications from his initial presentation. A second head CT revealed acute severe hydrocephalus with infracted cerebellum and multiple large infarcts bilaterally and diffusely throughout the cerebellum, both frontal and parietal areas, as well as midbrain (fluid on the brand and infarcts throughout the brain) and a large cephalohemotoma (blood clot on the brain). The determination was made that the most likely cause of this injury was a non-accidental injury.

Life support was withdrawn. The hospital's discharge/death summary states that the most likely cause of injury was a non-accidental injury which most likely occurred while this child was at the daycare and the cause of death was anoxic encephalopathy (brain damage from insufficient oxygen). An autopsy was performed and the cause of death "is ascribed to anoxic encephalopathy, secondary to unexplained respiratory arrest." Thurston County Sheriff's Department investigated the death and concluded that his death was not caused by criminal action.

The family of the deceased child has no prior history with the department. The decedent and his brother have been seen by their medical providers on a regular basis and no concerns have been noted. The extended family, both maternal and paternal relatives, are a strong resource for the surviving sibling and his mother. The licensed provider had one previous referral which was a licensing only referral which alleged that the daycare provider was fraudulently caring for subsidy children registered for care at another day care facility. This referral was found to be invalid.

Issues and Recommendations

I. System Issue

A. Issue: The provider needs training regarding SIDS.

Recommendation: This training is to be developed by the regional day care staff and provided to day care centers, day care homes, and family home licensors.

Child Fatality Review #04-64
Region 6
Child Care Home

Case Overview

This 11-month-old Caucasian male died on April 22, 2004 due to Sudden Infant Death Syndrome (SIDS).

The daycare provider reports checking on the child and could not wake him. She immediately called 911. Skamania County Sheriff's Deputies investigated. At the time of the investigation by law enforcement, the child was believed to have died from SIDS. An autopsy was performed and confirmed this. Skamania County Coroner signed the death certificate indicating SIDS as the cause of death. The law enforcement investigation was closed. There have been no prior referrals on the in home daycare.

Children's Administration did not have a history on the deceased child's family.

No evidence of history of complaints on this in home day care provider. On January 26, 2004, there was documented technical assistance to this (and other) providers regarding SIDS prevention. A Compliance Agreement was issued on January 14, 2002 for this provider to incorporate SIDS prevention guidelines into policies and procedures. Upon notification of the child's death, the licensor immediately notified the Regional Manager and reported incident to Child Protective Services (CPS) intake. A Summary Suspension was delivered to the provider on April 30, 2004 at approximately 5:30 p.m. The provider was issued a probationary license for six months beginning May 19, 2004. She worked with the licensor to gain knowledge about caring for infants, and more specifically SIDS issues. She was fully licensed November 19, 2004.

Issues and Recommendations

I. System

A. Issue: In Home Day Care SIDS death.

Recommendation: The Division of Child Care and Early Learning (DCCEL) has recommended that they provide a regional training regarding SIDS awareness for Day Care Center and Family Home Licensors. This training is to be developed by the DCCEL Region 5 and 6 staff.

Child Fatality Review #04-65
Region 5
Tacoma Office

Case Overview

This 11-year-old Caucasian male died due to a mega colon impaction on May 12, 2004.

This child was one of triplets born prematurely. He had some special needs (delays and mild mental retardation have been indicated in the case file documentation) and was receiving medical assistance under "categorical needy-home services." He and his siblings were residing with their maternal grandmother since the death of their biological mother.

The cause of death of this child was determined to be "Complications of colitis; Mega colon; fecal impaction; chronic constipation; Gastroesopphagitis." The manner of death has been listed as "Natural." There was no indication that any of the other children were at serious and immediate risk of harm.

The biological father of the triplets has never been involved with the children, and his whereabouts are unknown.

Following the death of his mother in November 2003, the decedent and his siblings were in the care of their maternal grandmother, who has never had allegations of abuse. Six months later the decedent died. CPS received notification from the local medical examiner's office of the death of this triplet. The grandmother indicated he had had flu symptoms (multiple vomiting episodes), and she had spoken to a health care provider. She found him unresponsive, and emergency services were contacted and responded.

The grandmother had assumed care and custody of the triplets as well as an older sibling after their mother died in November 2003. Children's Administration was not involved at that time.

This family first came to the attention of Children's Administration in 1995. Children's Administration documentation from the 1995 CPS intervention is unclear as to what services were offered to the family. In 1998, the CPS worker documented effort to help with locating housing resources for the family. Additionally, the mother was referred to the local Family Support Center (FSC) where there would be access to community services, parenting support, parenting classes, etc. In 2002, Alternative Response System (ARS) services were initiated, but the ARS worker was unable to engage the family due to mother's refusal of services.

The circumstances of the decedent's demise were reviewed by the local Child Death Review (CDR) team in October 2004. Both CPS and the Division of Developmental Disabilities (DDD) had representation at the CDR.

There have been no further reports involving these children or the grandmother since the notification of the child's death.

Issues and Recommendations

There were no issues or recommendations identified by the review panel.

Child Fatality Review #04-66
Region 5
Tacoma Office

Case Overview

This two-year-old African American female died on July 30, 2004 due to blunt trauma to the head.

In June 2004, the mother of the decedent, asked the father to care for the decedent and her sister while she found new housing. The father of the decedent had occasional visitation with both girls. In early July the mother tried to contact the father, but was unsuccessful. She reports that she contacted law enforcement with concerns that the father was purposely not returning the children, but was told that since she had given permission she needed to seek legal advice to get her children back. She eventually was contacted by the father on August 1, 2004. After asking about the return of her children, the father then informed the mother that the decedent had died.

On July 30, 2004, the father and his girlfriend called 911 reporting that a young child in their care had stopped breathing. Paramedics responded to the residence and found the decedent unresponsive and lacking body warmth. Furthermore, the first responders noted extensive multiple bruising on the child, and observed the adults at the home to be without normal emotions usually found in such crisis situations. The child was transported to Mary Bridge Children's Hospital (MBCH) where death was declared. The examining physician, after finding extensive indicators of non-accidental injuries, determined the death to be suspicious for child abuse.

The father (non-custodial parent) and his girlfriend told detectives that the decedent had been left in the care of a babysitter while they had gone camping. Subsequent to their return from camping, they reportedly observed the decedent not eating and vomiting, and eventually the child stopped breathing. Detectives later determined that the story was fabricated.

An autopsy conducted by the Pierce County Medical Examiner concluded that the child's death was caused by blunt trauma to the head. There were no broken bones or skull fractures, but severe damage to the brain was found. The time from injury to death would have been three to four hours, which placed the child in the care of the father and his girlfriend. Multiple bodily bruises were found, and the child was severely dehydrated at death.

Within days of this child's death, the father and his girlfriend were booked into the Pierce County Jail on homicide charges. In 2005, the girlfriend was given 18 years in prison, and the father was sentenced to 50 years for the homicide by abuse of this child.

The mother of the deceased child did not have Children's Administration services in the four years prior to the fatality. While the caretakers responsible for the child’s death had had recent Child Protective Services (CPS) involvement, the deceased child was not involved as she did not reside in the home of the father and his girlfriend in early 2004. The department had no

knowledge of the decedent being in the temporary care of her father and his girlfriend in June and July 2004 until after the fatality incident.

The older sister is a half-sibling of the deceased child by virtue of sharing the same mother.

At the time of her half-sister's death, the older sister was also staying at the residence of the father and girlfriend, neither of whom were biologically related to her. Following the death, the surviving sibling was returned to her mother's care, but eventually was placed in relative care under a dependency action. She remains in out-of-home care.

The history of five Division of Children and Family Services (DCFS) referrals, includes those for the mother, the father and his girlfriend. Prior to the fatality referral, the decedent was never identified in any of the referrals.

Alternate Response System (ARS) attempted to contact the deceased child's mother in 2000, but was unsuccessful. There is no indication that any services or referral to services were provided during the CPS investigation that occurred in August 2000. CPS had no further contact with the mother between late 2000 and the death of her daughter in July 2004.

Subsequent to the premature delivery of triplets, of which only one child survived, the father and his girlfriend were offered Parenting Partnership Program services through the hospital. That program included nurse and social work services. The parents declined. The girlfriend was receiving Temporary Assistance to Needy Families (TANF)–WorkFirst services at that time.

Following CPS involvement in January 2004, the father and his girlfriend were offered medical education specific to their child's special medical needs, and participation was documented by medical providers. The child received medical services (physical therapy, Kids Screen Assessment, etc.) and was referred for developmental disabilities services. The child was temporarily placed in a Pediatric Interim Care foster home. The mother was referred to the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), and did participate.

The father and his girlfriend were given drug and alcohol tests early in the CPS intervention in January 2004. During the time one of the children was in foster care, home studies were conducted by DCFS and the court appointed guardian ad litem (GAL). Family Preservation Services (FPS) were offered and accepted by this couple. Prior to reunification of this child with her parents, a community Child Protection Team staffing occurred.

There is no known child abuse/neglect history of the father as a child.

Some information is known about the girlfriend as a child. An information only report was taken in December of 1991, regarding her father’s drinking and driving and being involved in an accident with children in the car during visitation. Later that month a request by law enforcement was made to Family Reconciliation Services (FRS) for placement of the girlfriend when she was 14-years-old and refusing to go home. She went to a drug and alcohol treatment program but ran away. The case was closed in April of 1992.

The mother of the deceased child, has a history of child abuse and neglect as a child. Her family of origin has documented CPS history starting in 1988 and ending in 1993. Primary issues involved lack of parental supervision and control, general neglect, substantive school absences by all the children in the family, and a pattern of the children running away at an early age. This is consistent with what the mother reported to a CPS worker in 2000 – that she had been essentially on her own since age thirteen, with her father being an abusive alcoholic and her mother a drug user. She also reported having been sexually assaulted as a child while in her mother's home. Two of her brothers and her father have significant criminal arrest/conviction histories. The mother herself was arrested as a juvenile for theft (1992), assault (1995), and for possession of stolen property (1996). In 1997 (as an adult), she was cited and arrested for possession of marijuana and booked on several charges relating to driving without a license and drug offenses. Similar arrests continued between 1998 and 2000.

Issues and Recommendations

No issues and recommendations were identified by the review panel.

Child Fatality Review #05-23
Region 4
Division of Licensed Resources

Case Overview

This 12-year-old Native American female died on September 28, 2005 due to accidental suffocation.

On September 28, 2005, the decedent came home from school and went upstairs to her bedroom. Ten minutes later, family members found her unresponsive, with a karate belt tied around her neck and the other end tied to the bed frame. She may have been experimenting with the "choking game" - partial restriction of the airway followed by sudden release causing euphoria. A field worker was dispatched to the residence.

This investigator asked the guardian to agree to the following: All of the children supervised at all times and any ropes, belts, or any other item that could be used to choke a child be placed in a locked space in the home. The guardian agreed to this plan.

In the biological family of the decedent, six children have the same mother. Three of whom are now deceased. One brother died from Sudden Infant Death Syndrome (SIDS) on November 15, 1991. A sister died July 4, 1997 from complications of a near-drowning incident. The two older children have the same father. The four younger children have the same father.

This is a chronically referring family with substance abuse, domestic violence, sexual abuse, neglect, and caretaker impairment as major risk factors. The safety of the children made placement necessary because the birth parents were not protective. The guardian became the legal guardian of three of the children through family court Third Party Custody proceedings. Prior to family court action, the Division of Children and Family Services (DCFS) had established dependency through Juvenile Court in 1994.

The guardian has been a foster parent since 1994. During that time there has been 18 facility complaints. Several of these complaints were incidents that did not occur in her home. Due to Case and Management Information System (CAMIS) programming issues the referrals were entered as under the guardian's name, when in reality the incidents involved the birth parents of some of the children the guardian has had in her care.

However, there have been critical incidents that have occurred in the home of the guardian. On July 2, 1997, the 15-month-old sibling to the decedent was found unresponsive in the swimming pool at the guardian’s home. The 15-month-old died two days later from bronchopneumonia and anoxic encephalopathy (brain injury from lack of oxygen). This fatality was ruled an accident by the King County Medical Examiner. The Division of Licensed Resources (DLR) concluded that the incident was unfounded for neglect by the foster mother. At the same time, DLR found the complaint was valid for licensing issues. Children's Administration completed a fatality review in December, 1997.

Subsequent to the younger sibling's death but preceding the death of the decedent, there were several reports that were screened for licensing issues or investigated by DLR but unfounded. These included a report that the guardian had an assistant that was mistreating children in her care, and an incident involving a 15-year-old male foster child who may have been sexually aggressive toward others. He moved to Alaska soon afterward.

The medical examiner ruled this death an accident. The investigation by DLR/CPS was unfounded for negligent treatment/maltreatment. The subsequent allegations of physical abuse of the decedent and three other children in the guardian's care were inconclusive.

As a result of the investigation, numerous licensing violations unrelated to the death of the decedent were found. The foster mother has agreed that she will not renew her license when it expires in April 2006. DCFS is working to find other families for the foster children that remain in her home. She will continue to be a third party guardian for the rest of the children in this family.

Issues and Recommendations

I. System Issue

A. Issue: Caregiver and community lack of awareness of the "choking game."

Recommendation: *All caregivers and parents should try to keep as informed as possible about dangerous "fads" such as the choking game. Communicate with children and youth about such activities and the dangers involved.*

Child Fatality Review #05-24
Region 4
Bellevue Office

Case Overview

This 14-year-old Caucasian male died on October 19, 2005 due to a car accident.

On October 18, the decedent was a passenger in a Ford sedan, wearing a seat belt in the back seat. He was riding with two acquaintances. The driver was turning left and was struck broadside by a van. The driver of the sedan and the front seat passenger survived, as did the driver of the van. Per the King County Medical Examiner, the cause of death includes blunt force injury to the head and trunk. The manner of death is accidental.

This family has a history of twelve referrals preceding this child's death, beginning April 21, 1995 through October 3, 2005. This included nine Child Protective Services (CPS) referrals. Four were accepted for investigation and all were unfounded. There was one CPS report screened for Alternate Response Services (ARS). The other referrals were information only or not investigated due to no allegations of abuse. The family also made two requests for Child Welfare Services (CWS) and one for Family Reconciliation Services (FRS).

All the referrals, except the most recent one, focused on the decedent's two older brothers. The record describes involvement with the Interagency Staffing Team (IST) for mental health services, including an older brother's placement at Children's Hospital in-patient psychiatric unit and in-home group care provided by Friends of Youth. The family also received Intensive Family Preservation Services (IFPS) with Grayson Associates in 1997.

The October 3, 2005 referral is a request for a family assessment as part of an At-Risk-Youth petition the mother wanted to file on the decedent. She reported that he had run away about four times that year, and was skipping school. She suspected he was drug involved. The assigned FRS worker met with the mother on October 10 and had telephone contact with her on October 12 concerning the family assessment. The mother indicated the decedent had since started coming home on time and staying there. She did not actually file the petition.

Issues and Recommendations

No issues or recommendations were identified in the review process.

Child Fatality Review #05-25
Region 1
Spokane Office

Case Overview

This seven-year-old Caucasian male died in the home of his adoptive mother on January 13, 2005 due to "severe dehydration" as reported by the medical examiner. He weighed 28 pounds, significantly below the fifth percentile for children his age at the time of his death.

The decedent was born on January 13, 1998. He was placed in foster care on April 5, 1998 due to concerns of neglect by his biological mother. His biological father is a registered sex offender. Although the department had concerns about the decedent's biological mother's drug use, the decedent's birth records indicate that he did not have drugs in his system at birth. He was placed in his adoptive mother's home on May 29, 1998, after a brief stay in another foster home.

The decedent's medical records indicate that he weighed 16 pounds on July 7, 1998, in the 50th percentile for children his age. His biological mother relinquished her parental rights on December 3, 1998. She agreed to an open adoption with his adoptive mother. He was adopted on April 10, 2000.

Children's Administration Division of Licensed Resources Child Abuse and Neglect Section (DLR/CPS) investigated the circumstances surrounding the decedent's death in conjunction with Stevens County Sheriff's office.

In the eleven months since the decedent's death, there have been six new referrals alleging physical abuse, negligent or maltreatment of other children who were placed in the adoptive home prior to the decedent's death. Several of the decedent's adopted and foster siblings have reported that the adoptive mother and her daughter physically abused them and withheld food and water from them. These referrals were generated both by Department of Social and Health Services (DSHS) staff and providers upon learning of new allegations of abuse and neglect in the course of the investigation following the decedent's death.

For a copy of the full report and case history please review the fatality report at:

http://www1.dshs.wa.gov/pdf/MR/DELEON-ECFR-Feb-2006.pdf

Issues and Recommendations

Fatality Review Process

Recommendations:

1. *This report should be made available and disseminated to department employees and stakeholders connected to this case. The report should be made easily accessible to others who are interested in this case.*
2. *The committee requests that the department provide a response to committee regarding the recommendations in this report.*

Information Management and Retrieval

Findings:

- DSHS record retention policies compromise social workers' access to accurate history of cases.

- Each state agency is required by statute to establish a policy regarding retention and destruction of records. Current DSHS policy requires that CA retain the records of founded child abuse and neglect investigations for six years after a case is closed. The adoptive mother's founded records from 1988 were not available when she was licensed in 1996. In this case, if there had been adequate knowledge of a record in 1988 pertaining to the adoptive mother's children and her involvement with Stevens County Sheriff's Department and CA, she would not have been eligible for a foster care license per **WAC 388-148-0035 (4):**
  What personal characteristics do I need to provide care to children? *If you are requesting a license, certification, or a position as an employee, volunteer, intern, or contractor in a foster home, group care facility, staffed residential home, or child-placing agency you must have the following specific personal characteristics: (4) You must not have been found to have committed abuse or neglect of a child of vulnerable adult, unless the department determines that you do not pose a risk to a child's safety, well being, and long-term stability.*

- Social workers' capacity to thoroughly investigate may have been compromised by their inability to access pertinent information which was kept in other data base systems such as JUVIS (Juvenile Court Information System), Courtlink (U.S. District Court and state court information), SCOMIS (Superior Court Management Information System) and NCIC (National Crime Information Center).

- Lack of uniformity with the way information was referenced in the CAMIS and GUI databases interfered with the efficacy of the investigation. Lack of integrated case numbers and information resulted in misinterpretation of information regarding the involvement of the adoptive mother and her sons in the system in 1988. The application of CA's background check process is inconsistent and lacks uniformity.

There is a discrepancy in training made available to staff who review CAMIS records for licensing applicants.

Recommendations:

1. *The department should extend the timeline regarding retention of records on founded child abuse and neglect investigations. The department should review their current retention schedule to determine an appropriate extension of the time period.*
2. *The department should address ways to provide CA staff access to the JUVIS, SCOMIS, Courtlink and NCIC systems.*
3. *The department should integrate the CAMIS/GUI systems in order to provide more efficient and complete information gathering.*
4. *Establish a clear and consistent procedure for more thorough background investigation. Adequate training should be provided to staff performing this task.*
5. *The department should require a consistent application of case number assignment statewide.*

Information Sharing and Collaboration

Findings:

- Service providers, including the school district and medical community, were operating from different sets of information. Relying exclusively on self reports by the adoptive mother, little or no verification of facts was confirmed.

- The adoptive mother failed to report a number of decedent's injuries in a timely manner.

- The adoptive mother failed to inform her licensor that she adopted an infant from a source unknown to the department.

- The adoptive mother failed to report previous involvement with the department on her original and subsequent licensing documents.

- The decedent was seen by multiple medical providers for physical and psychological health care amongst whom there was no sharing of information.

- There were discrepancies in reporting incidents to service providers by the adoptive mother. When these discrepancies were discovered, there was no mechanism to resolve them.

  For example, the adoptive mother reported to the school that the medical provider had recommended restriction of the decedent's fluids and caloric intake. In the process of the investigation, it was determined that the doctor made no such recommendation. The school indicated to the committee that they felt there was no mechanism by which to confirm this with the doctor.

Recommendations:

1. *CA should research the concept of "health care management"[2] in order to develop a practice standard to facilitate the open exchange of information with all providers. Each service provider should have access to multiple sources of information to avoid triangulation and miscommunication.*
2. *CA should explore the use of the Foster Care Medical Home Model as described in Fostering Health: Health Care for Children and adolescents in Foster Care.*
3. *CA should request legislation to change RCW 68.50.105 to allow CA access to reports and records of autopsies or post mortems.*

Training

Findings:

- CA did not recognize the sophistication with which the adoptive mother was managing information.

- Confirmatory bias was prevalent throughout the case. Professionals from all systems locked into early opinions based on information the adoptive mother reported, and disregarded information contrary to their initial impressions.

- Information regarding reported diagnoses with no factual base perpetuated erroneous beliefs about the decedent's behaviors. The record contained statements made about diagnoses that were not supported by source documents. Behavioral observations of the decedent by educators disputed reports supplied by the adoptive mother.

- There were indications of parental ambivalence by the adoptive mother which included repeated utterance of denigrating statements made about the decedent and the other children in the home.

- There was a pattern of events in which not one individual incident substantiated a level of verified child abuse and/or neglect. In the aggregate, these gave rise to an elevated risk that should have resulted in further action from the department.

- Environmental failure to thrive was apparent. Emotional and nutritional neglect resulting in poor growth is difficult to recognize, even by trained professionals.

Recommendations:

1. *CA staff should continue to emphasize training to recognize its own confirmatory bias as well as confirmatory bias evident in the assessments of other professionals.*
2. *CA should continue to provide training in critical thinking.*
3. *The department should provide an opportunity for community partners to participate in CA training.*
4. *The department should incorporate training on parental ambivalence and pattern recognition in cases of child abuse and/or neglect on a regular basis.*
5. *The department should develop a chronicity review protocol to include DLR/CPS and adoption workers.*

6. *CA staff should be trained in the use of the department's proposed health management model to assist with communication among professionals.*

Practice Issues

Findings:

- Children should not have been interviewed in the presence of the alleged perpetrator.
- Independent licensing investigations should have followed the CPS investigation when the allegation was unfounded.
- The child's statements disclosing abuse were ignored.
- Mandatory reporters did not recognize signs of abuse or neglect and, therefore, did not make reports to the department.
- There was insufficient collaboration and information sharing amongst service providers and the department.

Recommendations:

Some of these findings are already addressed in CA policy. Although the committee did not have any recommendations regarding these findings, they believed they had a significant impact on this case.