Report to the Legislature

Quarterly Child Fatality Report

RCW 74.13.640

July - September 2007

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Children's Administration Quarterly Child Fatality Report

Introduction

This is the Quarterly Child Fatality Report for July through September 2007 provided by the Department of Social and Health Services (DSHS) to the Washington State Legislature. RCW 74.13.640 requires DSHS to report on each child fatality review conducted by the department and provide a copy to the appropriate committees of the legislature:

> *Child Fatality Review — Report*
>
> *(1) The department of social and health services shall conduct a child fatality review in the event of an unexpected death of a minor in the state who is in the care of or receiving services described in chapter 74.13 RCW from the department or who has been in the care of or received services described in chapter 74.13 RCW from the department within one year preceding the minor's death.*
>
> *(2) Upon conclusion of a child fatality review required pursuant to subsection (1) of this section, the department shall issue a report on the results of the review to the appropriate committees of the legislature and shall make copies of the report available to the public upon request.*
>
> *(3) The department shall develop and implement procedures to carry out the requirements of subsections (1) and (2) of this section.*

This report summarizes information from 5 completed child fatality reviews from fatalities that occurred in 2006. All were reviewed by a regional Child Fatality Review Team.

The reviews included in this quarterly report discuss fatalities from Regions 2, 3, and 4.

Region	Number of Reports
1	0
2	1
3	3
4	1
5	0
6	0
Total	**5**

Child Fatality Reviews are conducted when children die unexpectedly and their families had an open case or received services from the Children's Administration (CA) within 12 months of their death. Child Fatality Reviews consist of a review of the case file, identification of practice,

policy or system issues, recommendations, and, if applicable, development of a work plan to address the identified issues. A review team can be as few as two individuals in cases where the death is clearly accidental in nature, to a larger multi-disciplinary committee where the child's death may have been the result of abuse and/or neglect by a parent or guardian.

An Executive Child Fatality Review by policy is a special review convened by the Assistant Secretary for Children's Administration. The Executive Child Fatality Review may be requested when a dependent child dies as a result of abuse and/or neglect by their parent or caretaker, or a non-dependent child dies of abuse and/or neglect on an open, active case 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.

Many months often follow 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 the calendar year 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 that there is additional CA history regarding the family under a different name or spelling.

Child Fatality Reviews for Calendar Year 2005 – 2006			
Year	Total Fatalities Reported to Date Requiring a Review	Completed Fatality Reviews	Pending Fatality Reviews
2006	62	34	28
2007	55	0	55

The numbering for the Child Fatality Reviews in this report begins with the number 06-31. This indicates the fatality occurred in 2006 and is the 31st report completed for that calendar year. The number is assigned when the Child Fatality Review and report by the Child Protective Services Program Manager is completed.

Child Fatality Review #06-31
Region 3
Sky Valley DCFS

This 6-month-old Caucasian female died from undetermined causes that were consistent with Sudden Infant Death Syndrome (SIDS).

Case Overview

The mother and father of this six-month-old infant spent the night at the home of the father's parent on September 30, 2006. The infant, who slept between the parents on a mattress, was found unresponsive the following morning. Emergency services were called, but resuscitation efforts were unsuccessful. The medical examiner determined the manner of death "undetermined" and the cause "consistent with SIDS."

Referral History

On May 18, 2000, a report was made that the father and mother were driving drunk with a child in the car and that the mother had moved in with "a known methamphetamine user." The referral was investigated and closed as unfounded.

On December 14, 2003, a referral was made by the father of one of the mother's children. He alleged that the mother drank to the point of blackouts. Allegations were also made that older children in the home were assaulting the younger children. The referral was investigated for neglect and closed as unfounded.

On February 28, 2004, allegations were made that the 8-year-old son in the home was sexually assaulting a 3-year-old girl in the home. The mother was investigated for neglect; the case was closed as unfounded.

On March 11, 2004, the father of the three-year-old child alleged that she had five bruises on her upper and lower arm and what appeared to be bite marks. The referral was screened as information only.

On June 4, 2004, allegations were made by the father that the mother was drinking and using methamphetamines. The allegations were investigated and the case closed as unfounded.

On May 16, 2005, allegations were made that the mother was not providing antibiotics to a sick child in the home. Allegations included methamphetamine use by the mother and that the 4-year-old was constantly presenting with suspicious bruising. The referral was assigned to Alternative Response System.

On October 27, 2005, allegations were made that the 4-year-old had bruises on her forearms and that she had been burned. The referral was screened for Alternative Response System.

On December 21, 2005, allegations were made that the father, referred to above, was in a violent relationship with a girlfriend and that the children were in danger. The girlfriend went to an emergency room with injuries, and the father was arrested. The mother agreed to no unsupervised contact between the father and child, and the investigation was closed as founded for physical abuse and neglect by the father.

On August 21, 2006, a referral alleged that the father was being allowed unsupervised contact with the 6-year-old. The referral was screened as information only.

Issues and Recommendations

Issue: Neither of these referrals was closed with the Investigative Risk Assessment until April 2005. Policy at that time was that cases would be closed with the Investigative Risk Assessment within 90 days from the date of the referral.

Recommendation: This issue was discussed with the supervisor and area administrator of the unit involved. The social worker involved in the investigation of these two referrals was out of the office on emergency sick leave for an extended period, and was unable to write the report to close her investigation until her return.

Child Fatality Review #06-32
Region 2
Yakima DLR & DCFS

This 16-year-old Mexican-American male died from a gunshot wound.

Case Overview

On June 9, 2006, this 16-year-old dependent youth was shot in the back while on an outing with other residents from the Positive Directions group home in Yakima. The boys had been visiting a park when a group of five youths, which appeared as a gang, walked into the park and threw rocks at the group home youths. The counselor told the boys to get into a van. The boys began running to the van when one of the five, from the presumed gang, drew a firearm and shot the decedent in the back. Police were called, and CPR was administered. Emergency medical technicians were unable to resuscitate. The manner of death was third-party homicide.

Referral History

The decedent and his siblings first came into care in October 2001, because of mother's inability to care for them. The children were placed with an aunt and uncle for a year and a half, and a dependency guardianship was entered in May 2003. The relatives vacated the guardianship on the decedent because of school problems. The child was then placed with an adult sibling until September 2005 when he ran away. After a failed foster home placement, the child was placed at the Positive Directions group home. Other placements were explored, but relatives would not accept placement, and the mother was not an option due to her developmental delays. Meetings with the relatives and social workers concluded that Positive Directions was the best placement option.

The Positive Directions group home had four prior referrals in the past ten years that were accepted for CPS investigations for neglectful supervision. Three of the four referrals related to altercations between teens in the home. The fourth referral alleged that medication was not adequately locked and that a child tried to overdose on Ibuprofen. All were closed unfounded.

Issues and Recommendations

Issue: Social workers need current, up-to-date training on gang activity/culture.

Recommendation: Continue collaboration and cross training between law enforcement and Child Protective Services in all areas where there is overlap - to include trainings related to gang culture. Consult with the regional training coordinator for possible related training topics.

Issue: Current ordinances in the city of Yakima related to gang activity are inadequate.

Recommendation: Send a letter from Children's Administration's Regional Administrator to the Yakima City Council advocating for stricter ordinances on gang activity. The area administrator will speak to the regional administrator regarding this recommendation.

Issue: It is important to identify specific gang affiliation of a youth prior to out of home placement to prevent a possible danger to children and adults in the home/facility.

Recommendation: The area administrator will direct his supervisors to identify gang affiliation whenever possible prior to a child being placed in a foster home or any other licensed facility. This will help with overall safety by preventing rival gang members in the same facility.

Issue: Foster parents and group care providers are in need of critical incident training.

Recommendation: The Division of Licensed Resources area administrator will explore the possibility of offering training for foster parents and group care providers on how to deal with critical incidents.

Child Fatality Review #06-33
Region 4
Kent – King South

This 8-month-old African-American female died of Sudden Infant Death Syndrome (SIDS).

Case Overview

On October 12, 2006, the King County medical examiner responded to the scene of what was reported as a deceased infant who was with her mother at the Godmother's home. The mother fed the infant at 5:30 a.m. and the godmother found her unresponsive at noon. The family called 911 and CPR was administered but resuscitation efforts were unsuccessful. The medical examiner found the cause of death SIDS and the manner of death was natural.

Referral History

The mother of the decedent was sixteen-years-old when she gave birth to her daughter. The mother has had involvement with Division of Children and Family Services (DCFS) on multiple occasions as a child. There were eleven referrals to Children's Administration: one was accepted for CPS investigation, six for Family Reconciliation Services (FRS), and three were screened out as either information only or third-party. The mother has a history with King County Juvenile Court for drug-related offenses.

On May 24, 1996, a referral was made to CA that alleged the decedent's grandmother's boyfriend may have pushed the then six-year-old mother. It was unclear whether this was intentional or a result of play, but she was injured. There is no Service Episode Record (SER) or finding for this investigation.

On May 21, 1998, staff from an elementary school reported that the mother (nine-years-old at that time) touched another girl on her "private parts" on the playground. The referral was screened as third party.

On January 07, 2000, a CPS worker in Florida reported domestic violence between the grandmother and her boyfriend. He struck her in the face and was arrested. Florida CPS determined that the mother was safe, closed the case, and the family returned to Washington.

On May 07, 2002, the grandmother requested assistance in filing an At-Risk-Youth (ARY) petition with Juvenile Court. The mother of the decedent was twelve-years-old but had begun staying out all night, was sexually active, and had been present at a drug bust. Both agreed to participate in contracted FRS counseling with the Ruth Dykeman Center. Services were engaged until the case was closed on June 24, 2002.

On March 24, 2003, CA received two referrals at the grandmother's request for an ARY petition. The mother was failing in school, has been suspended, ran away multiple times, and had two diversions for theft and graffiti. The family was in counseling. The assigned social worker

provided the grandmother a family assessment form required for an ARY petition. The case was closed on April 17, 2003.

On September 29, 2003, the grandmother again requested help with an ARY petition. She claimed that the mother was caught distributing crack cocaine, and was assaultive and rebellious. The family did not follow through with additional services, and the case was closed on October 22, 2003.

On January 02, 2004, Planned Parenthood reported that the decedent's then 14-year-old mother was involved in a sexual relationship with a 23-year old male. The referral was screened as third-party. No documentation was found to indicate that this report was forwarded to law enforcement.

On May 16, 2006, a Public Health Nurse (PHN) reported that she had just seen the decedent at the grandmother's home and that the mother, who had left the residence while the PHN was present, may have been substance impaired. The referral was screened as information only because the baby was safe with the grandmother.

On June 27, 2006, the grandmother again called for Family Reconciliation Services (FRS) services for the mother. Two weeks prior the mother took the decedent to a drug house where she was selling Ecstasy. The grandmother indicated interest in a third-party custody change. This referral was never assigned to a social worker.

Issues and Recommendations

Issue: The referral on June 27, 2006, did not get assigned to an FRS worker due to an error by the supervisor, who no longer worked for the agency. It should have been screened for CPS, not FRS. The report of the mother taking the decedent to a drug house is an allegation of negligent treatment/maltreatment.

Recommendation: Review of the referral screening decision occurred with the intake unit and supervisor.

Issue: Several risk factors were identified for SIDS such as smoking before and after the decedent's birth. The child was premature, born at 33 weeks gestation and weighing just four pounds. A neonatal intensive care unit was necessary before her release. The mother used the prone sleep position for the decedent, and the infant slept in adult beds with soft bedding. During the death scene investigation it was noted that the decedent was in full rigor and there was evidence of alcohol use by the adults who were present.

The mother sought prenatal care through the Public Health Department, and she did receive safe sleep information from the PHN.

Recommendation: Children's Administration should team with the Public Health Department to develop effective ways of informing families about SIDS risk factors.

Issue: The PHN assigned to the mother should have referred her to the Nurse Family Partnership Program, a more intensive intervention managed by Public Health. It is for first-time teen mothers, in the first 26 weeks of gestation. A PHN will work with mother and child until the child is two years of age.

Recommendation: Public Health Seattle-King County will follow up with the assigned PHN.

Issue: The mother did not receive a bereavement support referral from Public Health.

Recommendation: Public Health Seattle-King County will follow up with the assigned PHN.

Child Fatality Review #06-34
Region 3
Everett DCFS office

This 3-month-old Caucasian female died from causes consistent with Sudden Infant Death Syndrome (SIDS).

Case Overview

This 10-week-old infant died on December 6, 2006, while sleeping prone on a pillow in the bed next to her mother. The mother had lived in a chemical dependency inpatient program since the child's birth in September. The mother reported that the child had been fussy the night before, so she placed her on her stomach on a pillow next to the bed and patted her on the back until both went to sleep. The infant was not breathing when she awoke the next morning.

The manner of this death was listed by the Medical Examiner's office as "undetermined" and the cause was determined as "consistent with SIDS."

Referral History

The first referral on the mother was received in April 2005. A physician from Providence Hospital notified law enforcement that she brought her one-month-old son to the emergency room but had refused recommended blood tests. She later took the one-month-old to another hospital for the tests, and the referral was not assigned for investigation.

The second referral received concerning this family was in June 2005. Law enforcement was called to the home regarding the mother's then 18-month-old daughter and her three-month-old son. They were unable to wake the mother who was in the bedroom with her daughter. Her son was in a child swing in the living room in front of the television. The mother was unresponsive for some time and officers eventually entered the house on behalf of the infant. The house was in such disarray as to be deemed a health hazard by law enforcement. The children were taken into protective custody until the mother's rights were terminated in 2007.

The third referral was received the day after the above referral. The relative caregiver of the children reported bruising to the 18-month-old in the vaginal area. An examination at the sexual assault clinic was inconclusive.

On February 15, 2006, the public assistance office made a referral indicating the mother was pregnant and due in September, and she had a history of drug abuse. The referral was screened as information only and the case was referred to "First Steps."

On September 19, 2006, CPS received a referral about the mother's impending delivery. She had been in substance abuse inpatient treatment for the past month. That referral was assigned for investigation.

Recommendations

Issue: This review team believed that the second referral in June 2005 was not adequately addressed in the Investigative Risk Assessment. The assessment on the referral that led to placement of the two older children is founded as to the mother, but no victim is listed.

Recommendation: The social worker writing this assessment no longer works for the agency. The issue was addressed with the worker's former supervisor.

Issue: The closing Investigative Risk Assessment indicated risk level as moderately low, although the children were removed from the home.

Recommendation: The rating of moderately low was apparently documented in error and may be attributed to a flaw in the computer system used to document the assessment. This entire system is currently in the process of being replaced with a new system.

Summary of Review: In reviewing the available Division of Children and Family Services case file documentation and post-fatality information gathered from other sources, no violations of policy, procedure, or practices surfaced to suggest actions taken or not taken by the department contributed to this child fatality.

Child Fatality Review #06-35
Region 3
Olympia DLR Facility Investigations

This 17-month-old Caucasian male died from accidental asphyxiation.

Case Overview

On November 11, 2006, this toddler choked to death in the foster home where he had been placed. The foster mother noticed the child turning purple a few moments after she gave him a "power bar" for lunch. The foster mother called 911, and the first responders administered CPR. Efforts to resuscitate by the foster parent and emergency medical technicians were unsuccessful. It was later determined that the child had aspirated a chunk of the power bar.

Referral History

Most referrals on the biological family pertained to other children. The department filed a dependency petition and removed the two children in December 2000, because the mother was encouraging a sexual relationship between her 12-year-old son and a 15-year-old girl. The other referrals, 1999 and 2000, were allegations of neglect. One was founded due to hazards in the home.

In May 2005, an "information only" referral alleged that the mother failed to obtain prenatal care and a second "information only" referral was made when the decedent was born, with concerns noted about prior history with the other children. The second referral in 2005 alleged neglect, which was founded, and the child was removed from the home.

Licensing:
One referral was made as to the foster family in 1998 that alleged unsafe conditions in the home. The investigation was closed unfounded.

One month after the home was licensed a second referral was made in February 2006. The caller alleged a dirty and cluttered home. The referral was screened to licensing since no abuse or neglect allegations were made. Licensing concluded "valid" for licensing facility violations because "safety hazards, clutter and trash were observed in all areas of the home" at the time of the CPS investigation, which occurred one month later.

The final referral was made when the fatality occurred. CPS found the home to be unkempt and somewhat dirty. An investigation of the foster home was completed and concluded as founded for neglect on the foster parents because the was child was not an appropriate age to be fed a power bar. The foster home license was revoked by the Division of Licensed Resources.

Recommendations:

Issue: According to licensing regulations, an "administrative approval" must be given to allow the placement of any child in a facility when such would exceed the number of children the

home is licensed for, or the ages or gender of children are different than the license allows. In this situation, the administrative approval process was not completed for the placement of the youngest child in the home, who was outside the age range of the license. The process involved in completing administrative approvals of this kind was determined by this team to be cumbersome.

Recommendation: The team recommends that a regional work group be convened to attempt to simplify or expedite the process involved.

Issue: The application for a foster home license for this family was received in the Division of Licensed Resources on June 12, 2005. The license was actually granted on February 14, 2006. Ninety days has been identified as the goal for completing the licensing process.

Recommendation: None. This issue was addressed with the licensing social worker and their supervisor.

Issue: The referral received on October 9, 2006, contained allegations about the condition of the foster home. It was assigned as a "licensing only" complaint for assessment by the licensor. As of the date of this review, the only documented activity on this complaint was a phone contact with the referrer.

Recommendation: None. This issue was addressed with the social worker and their supervisor. Since this incident, the Division of Licensed Resources has begun work on addressing/clarifying the issue of time frames for these "licensing-only" referrals to ensure timely follow-up.