Report to the Legislature

Quarterly Child Fatality Report

RCW 74.13.640

October – December 2010

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

Table of Contents

Children's Administration Quarterly Child Fatality Report

Executive Summary

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

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

This report summarizes information from 14 completed fatality reviews of fatalities that occurred in 2010. All 14 of the child fatalities were reviewed by a regional Child Fatality Review Team.

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

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

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

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

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

The chart on the following page provides the number of fatalities reported to CA, and the number of reviews completed and pending for calendar year 2010. The number of pending reviews is subject to change if CA learns new information through reviewing the

case. For example, CA may learn that the fatality was anticipated rather than unexpected, or there is additional CA history regarding the family under a different name or spelling.

Child Fatality Reviews for Calendar Year 2010			
Year	Total Fatalities Reported to Date Requiring a Review	Completed Fatality Reviews	Pending Fatality Reviews
2010	69	36	33

The numbering of the Child Fatality Reviews in this report begins with number 10-23. This indicates the fatality occurred in 2010 and is the twenty-third report completed during that calendar year. The number is assigned when the Child Fatality Review and report by the Child Protective Services Program Manager is completed.

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

Notable Findings

Based on the data collected and analyzed from the 14 deaths reviewed between October and December 2010, the following were notable findings:

- Children seven months or younger accounted for approximately 36% (5) of the 14 fatalities reviewed.
- Of the 14 child fatalities reviewed, 71% (10) were males and 29% (4) were females.
- Of the 14 child fatalities reviewed, 64% (9) of the children were white, 21% (3) were African American, 7% (1) were Native American and 7% (1) was Hispanic.
- Natural and accidental deaths, as classified by the medical examiner or coroner, accounted for approximately 57% (8) of the total deaths. The manner of death of the remaining cases was as follows: 21% (3) were the result of homicides, 14% (2) were due to unknown/undetermined causes, and 7% (1) were the result of suicide.
- One of the three child fatalities that were the result of homicide involved a 15-year-old, who was gang involved and his death was related to his gang involvement**.**
- In three infant deaths reviewed, unsafe sleep practices were noted; in two cases, the infants were co-sleeping with their parents and in one case, the infant was placed to sleep on her stomach in a bassinet with a poorly fitted foam mattress pad. Sudden Infant Death Syndrome (SIDS) was listed as the cause of one of these three deaths.

- Of the 14 child fatalities reviewed, all had prior contact with Children's Administration (CA). Forty-three percent (43%) of the child fatalities reviewed had between one and four prior intakes and 50% had between five and nine prior intakes.

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

Table 1.1

4th Quarter 2010, Child Fatalities by Age and Gender						
Age	**Number of Males**	**% of Males**	**Number of Females**	**% of Females**	**Age Totals**	**% of Total**
<1	2	20%	3	75%	5	36%
1-3 Years	2	20%	-	-	2	14%
4-6 Years	-	-	1	25%	1	7%
7-12 Years	3	30%	-	-	3	21%
13-16 Years	3	30%	-	-	3	21%
17-18 Years	-	-	-	-	-	-
Totals	10	100%	4	100%	14	100%

N=14 Total number of child fatalities for the quarter.

Table 1.2

4th Quarter 2010, Child Fatalities by Race	
Black or African American	3
Native American	1
Asian/Pacific Islander	-
Hispanic	1
White	9
Unknown	-
Totals*	**14**

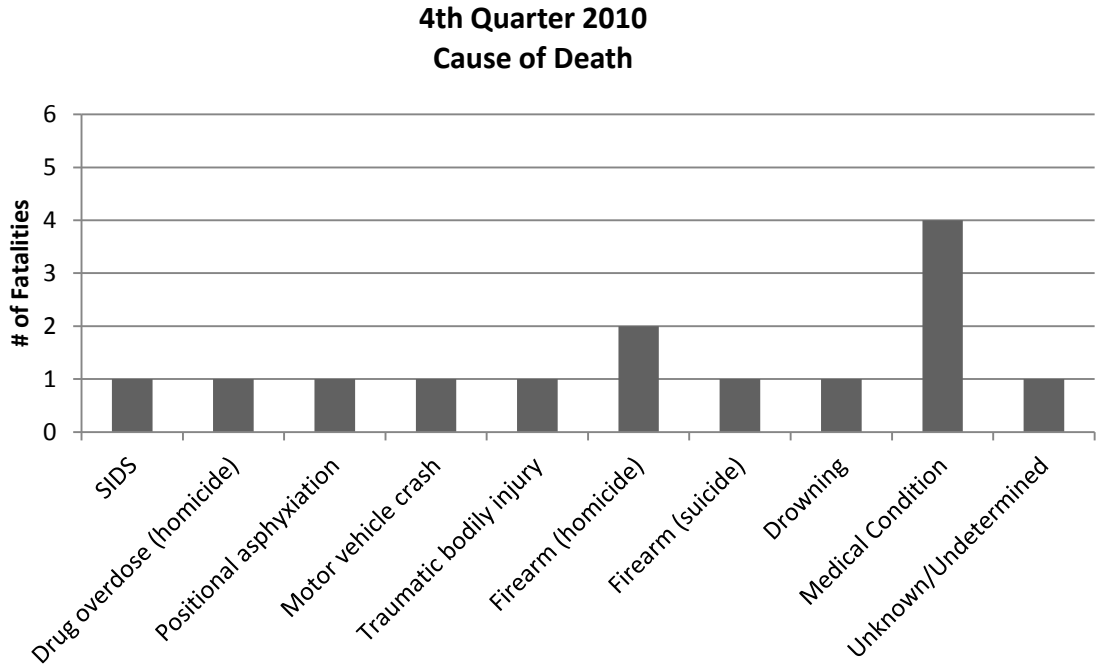
*Some children may be in more than one category.

Table 1.3

4th Quarter 2010, Child Fatalities by Manner of Death	
Accident	4
Homicide (3rd party)	3
Natural/Medical	4
Suicide	1
Unknown/Undetermined	2

N=14 Total number of child fatalities for the quarter.

Table 1.4



N=14 Total number of child fatalities for the quarter.

Table 1.5

4th Quarter 2010, Number of Reviewed Fatalities by Prior Intakes						
Manner of Death	**0 Prior Intakes**	**1-4 Prior Intakes**	**5-9 Prior Intakes**	**10-14 Prior Intakes**	**15-24 Prior Intakes**	**25+ Prior Intakes**
Accident	-	2	2	-	-	-
Homicide (3rd party)	-	1	2	-	-	-
Natural/Medical	-	1	2	1		-
Suicide	-	-	1	-	-	-
Unknown/ Undetermined	-	2	-	-	-	-

N=14 Total number of child fatalities for the quarter.

Summary of the Recommendations

Of the 14 child fatalities reviewed between October and December 2010, 9 (64%) had issues and recommendations identified during the child fatality review process. Issues and recommendations from fatality reviews impact policy, practice and systems associated with CA. At the conclusion of every case receiving full team review, the team decides whether any recommendations should result from the fatality review. In most instances where the death was categorized as being preventable, some recommendations were made.

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

4th Quarter 2010, Issues & Recommendations	
Contract issues	0
Policy issues	1
Practice issues	22
Quality social work	3
System issues	5
Total	**31**

Issues and recommendations were made regarding intake in four cases (29% of child deaths during the quarter). The issues identified all involved screening decisions. The recommendations made regarding the practice issues identified in the area of intake require attention at the local office level. For example, in one case, the Area Administrator instructed the CPS intake supervisors not to change screening decisions on intakes.

An issue identified in the area of social work practice specifically relating to the lack of timeliness in case file documentation was noted in three cases (21%). Also noted in two cases were concerns regarding historical intakes that were found in the hard copy of the file but not in FamLink, the CA case management system. The intakes were not located because they were likely deleted in accordance with expungement requirements in statute. A recommendation was made for further discussion at the CA Headquarters level as there was much discussion around the expungement time frames.

Child Fatality Review #10-23
Region 5
Kitsap County

Three-week-old Caucasian male died from undetermined causes. Children's Administration (CA) did not have an open case on the family of this child at the time of his death.

Case Overview
On April 26, 2010, the father of this three-week-old infant fed, burped, and held him while watching a movie in bed. The mattress was lying on the floor. The infant was cradled in the supine position in his father's left arm. The mother was also in the bed but was sleeping. It is believed that the father may have fallen asleep. Soon after, the mother awoke and noticed that the baby did not look right and was not breathing. The father called 911 and followed the dispatcher's instructions for CPR until aid arrived two minutes later. The family's residence was across the street from a fire station. The first responders found the infant unresponsive, no respiration or pulse and with cool, ashen skin. The infant was transported to Mary Bridge Children's Hospital where death was pronounced after unsuccessful resuscitation efforts.

A death scene investigation was conducted by local law enforcement, including interviews of both parents. The living environment was described as messy and cluttered, and heavy with cigarette smoke. A bassinette was observed at the residence but looked unused. Initially it was suspected that the infant may have died from accidental asphyxiation during bed sharing. However, both cause and manner of death were eventually ruled as "Undetermined" by the Kitsap County Coroner's Office. Post mortem blood toxicology and genetics testing were negative.

Children's Administration (CA) did not have an open case on the family of this child at the time of his death. An intake was received on April 5, 2010 after the birth of this infant and at discharge from the hospital. The hospital social worker called CPS intake with concerns that the young parents had apparently not been open with family members about the pregnancy and the mother did not have any prenatal care. The parents lived in the maternal grandmother's home. The child was born mildly premature (36-38 weeks gestation) and weighed over six pounds at birth. A toxicology screen at birth was negative. The intake was screened as Information Only as there were no allegations of abuse or neglect.

Intake History
On April 5, 2010, a hospital social worker contacted Child Protective Services (CPS) intake to report concerns about the parents of a newborn infant. The parents did not inform extended family members about the pregnancy. The mother did not have any prenatal care and while at the hospital the parents had slept through their newborn's crying.

Hospital staff offered the parents public health nurse services. The parents declined this service. This intake was screened as Information Only as there were no allegations of abuse or neglect.

Issues and Recommendations
Issue: None identified.

Recommendation: None

Child Fatality Review #10-24
Region 4
King County

This seven-month-old African American female died from a respiratory complication. Children's Administration (CA) had an open case on the family at the time of the infant's death.

Case Overview
On May 14, 2010, the seven-month-old medically fragile infant died at her home. She was in the care of her mother. Her mother was changing and cleaning her daughter's trachea tube and the child turned blue. This was a normal occurrence during tube maintenance. The mother replaced the tube and increased the child's oxygen supply but she did not start breathing again. The mother gave her infant daughter CPR and called 911. The seven-month-old was pronounced dead at the scene by paramedics.

The child was born three months premature and had chronic lung disease. The child had a trachea tube for breathing and also had a feeding tube. The trachea tube required regular maintenance. On February 18, 2010, the infant had stopped breathing and had to be hospitalized.

The mother tested positive for amphetamines during pregnancy and the child tested positive for opiates and benzodiazepine at birth.

The King County Medical Examiner conducted an autopsy. The medical examiner determined the cause of death to be bronchiopulmonary dysplasia, a respiratory complication of premature birth. The manner of death is natural/medical.

Children's Administration (CA) had an open case on the family at the time of the infant's death. A case was opened in October 2009 after the child's birth. The child was born at 27 weeks gestation. The infant had several serious health problems. She remained hospitalized since birth until April 8, 2010. A dependency petition was filed in January 2010. The department recommended to the court that the child be placed in out-of-home care. The court ruled that the child was to be placed with her mother when discharged from the hospital. The child was in Shelter Care status when she died.

The mother has two other children in her care; sons 12 and 15 years of age.

Intake History
The family history includes 12 reports to Children's Administration. The reports span a seven year period from February 2002 to February 2009. Five of the reports were made several years prior to the birth of the seven-month-old infant and allege abuse or neglect of the two older brothers. The five reports include two investigations of physical abuse.

One was closed with an unfounded finding and the other was closed with an inconclusive finding. Two reports were referred to the Alternate Response System (ARS). One of the two ARS intakes alleged a nine-year-old was outside and his clothes were not appropriate for the cold temperatures. The other ARS intake alleged the 12-year-old was not being given his ADHD medications and was having behavior issues at school.

Another intake was screened as Information Only. This intake alleged that the 12-year-old was locked outside the home. He stayed with a neighbor until his mother returned home. This intake was not investigated by Child Protective Services (CPS) as there was no allegation of child abuse or neglect.

On January 3, 2008, a school counselor reported to CPS intake the 10-year-old in the home was being beaten and bullied by his 12-year-old brother. The mother did not intervene when this occurred. It was also reported that the mother's live-in boyfriend was intoxicated every night. The 10-year-old also told the school counselor that there was minimal food in the home.

This intake was screened in for investigation. The CPS investigation was completed with an unfounded finding for negligent treatment or maltreatment. The case remained opened as the mother agreed to a voluntary services contract which includes following up with the 12-year-old's mental health needs and the family participated in Family Preservation Services (FPS). The case was closed in August 2008.

On March 3, 2008, a school nurse reported to CPS intake the 10-year-old complained of a toothache in February 2008. The nurse gave the mother a referral for an emergency appointment for a dentist. The mother didn't take the child to this appointment. The school principal also talked to the mother about getting the child to the dentist. The intake was screened as Information Only. The case was still open from the January 2008 intake. The assigned social worker addressed the concerns with the mother. The mother took both her 10 and 12 year old sons to a dentist.

On September 19, 2008, a neighbor reported to CPS intake that mother sends her sons (then ages 10 and 13 years old) to the neighbors to wait for the bus. She locked them out of the house and didn't feed them breakfast. The referrer said the boys got breakfast at school. The intake was screened as Information Only as the allegations did not allege abuse or neglect.

On May 4, 2009, a school nurse called CPS intake to report the mother's youngest son (then 11 years old) lost a tooth two weeks prior. The tooth appeared infected. The child came back to the nurse reporting that his mouth hurt. The school contacted the mother and she said she would take him to the dentist. The child returned days later and said his mother never took him to the dentist. The intake was screened in for investigation. The assigned social worker met with the mother about her son's dental needs. The social

worker followed up with the child and he stated he was treated by a dentist and that his tooth pain was gone. The CPS case was closed with an unfounded finding for negligent treatment or maltreatment.

On October 18, 2009, a hospital social worker called CPS intake to report the birth of the now deceased child. The child was born at 27 weeks gestation and tested positive for benzodiazepines and opiates. The referrer reported the hospital determined that the positive toxicology screen was from the mother's prescribed medications. The mother was also hospitalized, but left against medical advice. The referrer stated that the mother appeared to be going through withdrawal but did not specify what was causing the withdrawal symptoms. The intake was screened in for Risk Only. A case was opened on the family.

The infant remained hospitalized. On January 13, 2010, the assigned social worker filed a dependency petition on this infant. The parents did not follow through with requests for random urinalysis; the child had serious and high risk medical issues that needed close attention by her parents. The child needed to be transferred to Pediatric Interim Care Center (PICC) for further monitoring. Doctors were concerned that the parents did not spend a lot of time with their daughter while she was hospitalized and they did not understand all of the needs of this medically fragile child. This required the parents to sign her into care to be transferred to PICC. The parents initially agreed, but later refused indicating that they wanted to take their daughter home. The social worker filed the dependency petition at this time.

The child was discharged from the hospital on April 8, 2010. The department recommended to the court that she be placed in out-of-home care. The court ruled that the child was to be placed with her mother when discharged from the hospital. A contracted Family Preservation Services (FPS) provider was in place when she was discharged.

The mother received training on feeding as well as care for her trachea tube and oxygen management.

The social worker made multiple home visits and had collateral contacts with all of the health care professionals involved. In-home nursing services for 16 hours per day were provided. The mother demonstrated the ability to provide competent care for her daughter, as affirmed by the in-home nurse.

On May 15 2010 a report to CPS intake documented the death of this seven-month-old infant. She died at home. Her mother was following the care protocol for cleaning the breathing tube, but the infant turned blue and did not respond to her oxygen flow. The mother called 911 and began resuscitation until the first responders arrived. The infant could not be revived. The CPS intake was screened in for investigation of negligent

treatment or maltreatment. The investigation was unfounded and the workers focused on providing the family support and resources. The mother was offered grief counseling. She was also provided a list of resources to deal with grief and loss.

Issues and Recommendations

Issue: The social workers made an appropriate decision to file a dependency petition and to oppose placement of the infant with her mother. This was based on the family's pattern of neglect concerning the older brothers, the mother's suspected substance abuse, and the infant's very fragile medical condition due to prematurity.

Recommendation: None

Issue: The social worker was able to find the best possible FPS resource - a therapist who had a child with similar medical needs, who also had experience working in a hospital setting.

Recommendation: None

Issue: Engagement with resistant clients. This mother would not engage with Children's Administration social workers. She would selectively engage with FPS and health care professionals.

Recommendation: Continue to improve client engagement through Solution-Based Casework and other techniques.

Issue: The court ordered that the infant be reunited with her mother, over the objections of Children's Administration. The court was influenced by evidence that the mother had demonstrated a level of competency necessary to care for her daughter, and that a nurse would also be present 16 hours per day.

Recommendation: Region 4 plans to have training/discussions with the court about safety planning.

Child Fatality Review #10-25
Region 2
Yakima County

This fourteen-month-old Caucasian male died from respiratory arrest prior to cardiac arrest. Children's Administration (CA) did not have an open case on the family at the time of this child's death.

Case Overview
On May 26, 2010, Toppenish Police and emergency technicians were dispatched to the home of a grandmother who was caring for her twin grandsons, then 14 months old. The grandmother reported that she was temporarily caring for her grandsons while the family was moving. On May 25, 2010, at 9:00 p.m. she placed her grandsons in a playpen in a back room of her home. Police report that the room contained cans of gasoline and cleaning solvents approximately 10 feet away from where the children were sleeping. The grandmother told police that she checked on her grandsons around noon the following day (May 26, 2010). She found that one of her grandsons was deceased when she checked on them. The other twin appeared unharmed.

Police officers placed the surviving twin into protective custody. The surviving twin was taken to an area hospital for observation. He was mildly dehydrated but otherwise in good health.

Police arrested the grandmother on suspicion of manslaughter charges.

After the initial autopsy, the Yakima County Coroner determined the cause of death was related to the child's known heart condition. The cause of death was originally listed as respiratory arrest prior to cardiac arrest. The grandmother was released from police custody following the initial autopsy results.

On July 13, 2010, the Yakima County Coroner reported to the assigned social worker that the toxicology results had come back and that the child had a blood concentration of opiates (specifically morphine) in his system of .31 mg/L. The coroner reported .2 mg/L is lethal in adults. The Toppenish Police Department has reopened an investigation into the child's death.

According to law enforcement, criminal charges and prosecution by the Yakima County Prosecutor's office are pending as of the date of this report. The cause of death is still listed as respiratory arrest prior to cardiac arrest. An addendum to the child's death certificate to change the cause and manner of death will be issued when prosecution is formalized.

Children's Administration (CA) did not have an open case on the mother of the 14-month-old. The most recent contact with the family was an Alternate Response System (ARS) intake in May 2009 alleging the mother and the maternal grandmother smoked cigarettes near the twins, aggravating their respiratory problems. The ARS case was closed in July 2009.

The mother of the twins also had another child, a two-year-old girl, who was with her maternal great-grandmother when her younger brother passed away.

Intake History

On October 22, 2008, a neighbor reported to Child Protective Services (CPS) intake that the mother left her then eight-month-old baby (the older sister of the now deceased child) alone in her apartment when she went out in the hallway to smoke. The referrer said the baby was always hungry. The mother was also caring for her boyfriend's baby and didn't take very good care of that child either. The referrer said the apartment was dirty and smelled strongly of animal feces, urine and garbage. The intake was screened for the Alternate Response System (ARS). The case was assigned to an Early Family Support Services (EFSS) provider. The provider closed out the case when another intake was received on November 14, 2008.

On November 14, 2008, a neighbor reported to Child Protective Services (CPS) intake that the mother could be heard yelling at her then nine-month-old child. The mother yelled at the baby to shut up. The referrer stated the mother could be heard through the wall patting the child, indicating that she was patting her too hard. It was also alleged that the mother left the child alone in the apartment to visit her boyfriend (the child's father) in another apartment. On November 13, 2008, there was a domestic violence incident in the home and the mother was arrested. She was released from jail soon after. The child stayed in the care of her father. The intake was screened in for investigation by CPS.

The mother was court ordered to complete anger management and domestic violence courses. Collateral contacts confirmed the child was not present when the domestic violence occurred. The parents separated. The mother had family support and was involved in several community services such as Woman, Infant, and Children (WIC) and First Steps. The CPS case was closed with an unfounded finding for negligent treatment or maltreatment.

On May 26, 2009, hospital personnel reported to CPS intake that the mother brought her twin boys into the Toppenish Community Hospital Emergency Room because they had a chronic cough. This was the second time she brought them in for the same reason. The twins were born prematurely at approximately 34 weeks gestation and had pulmonary issues since after birth. The referrer reported the mother was residing with the maternal grandmother, and the grandmother's boyfriend. All three adults in the home were smokers and smoked inside the home in the presence of the children. The referrer

reported the mother was advised by doctors not to smoke around her children and was further told that exposing her twins to cigarette smoke would make the cough condition worse. The referrer reported the mother did not follow through with the doctor's recommendation. According to the referrer, the mother and grandmother had no understanding of the problem and refused to accept any responsibility. The twins appeared well while at the emergency room. The intake was screened in for the Alternate Response System (ARS). An ARS provider made contact with the mother and children. The mother was provided with housing and child care resources.

On May 26, 2010, Toppenish Police contacted CPS intake to report the death of the 14-month-old. The twins were being cared for by their grandmother. She was arrested for suspicion of manslaughter. A social worker arrived and the surviving twin was taken to a hospital for observation and examination. Police placed the surviving twin in protective custody and was briefly placed in a foster home. The grandmother told police officers that she put the children down to sleep at 9:00 p.m. on May 25, 2010 and did not check on them until noon on May 26, 2010. The intake was screened in for investigation by CPS.

The Yakima County Medical Examiner gave a verbal report on May 28, 2010 that the 14-month-old died from respiratory arrest caused by a heart related condition.

The case remained opened for services. The mother was participating in Family Preservation Services (FPS). The surviving twin was returned to his mother’s care on May 28, 2010 on the recommendation of a Child Protection Team (CPT).

The CPS case was completed with a founded finding on the grandmother for negligent treatment or maltreatment and unfounded on the mother. The case was transferred to the Family Voluntary Services (FVS) unit.

Criminal charges and prosecution by the Yakima County Prosecutor’s Office are pending as of the date of this report. In addition, an addendum to the child's death certificate to change the cause and manner of death will be issued when prosecution is formalized.

The FVS case remains open at the time of this report. The mother is participating in FPS, public health nurse services, and child care for her children.

Issues and Recommendations

Issue: The determination on the cause and manner of death was made prior to receiving significant toxicology results. The manner of death was originally listed as natural but after the toxicology screen found lethal amounts of morphine in the child's body, the cause and manner of death will be amended.

Recommendation: The Yakima County Coroner has agreed that the cause and manner of death in any child fatality where toxicology samples are sent out will not be released until

the results from the toxicology screens are returned. The Yakima County Coroner will begin this protocol within his office for Yakima County immediately.

Issue: The consensus from the review team is that the intake received dated May 26, 2009 should have screened in for investigation for negligent treatment or maltreatment. The referrer on this intake was a medical professional who expressed concern for a medically fragile infant.

Recommendation: Since this intake was taken by Central Intake and then forwarded to the field office, this issue will be forwarded to the Area Administrator of Central Intake and the Toppenish Division of Children and Family Services office for their information and/or action.

Issue: POST FATALITY: There was a delay in transferring this case file from the CPS unit to the Family Voluntary Services (FVS) unit. The last face-to-face visit with the children and caregiver by the CPS worker occurred on July 16, 2010. On July 19, 2010, a case transfer/closing summary case note by the CPS worker indicated that the case was being transferred to the FVS unit. This review team was notified at the time of this review that the FVS social worker had just received the case on October 7, 2010. The case transfer between the CPS unit and the FVS unit took nearly three months. No 30 day visits occurred during this transition.

Recommendation: The Area Administrator for this field office was a part of this review team and will be bringing this issue forward with a corrective action at the next scheduled supervisors meeting on October 20, 2010. The Regional Administrator was also notified of this issue.

Issue: POST FATALITY: A case note dated May 28, 2010 entered by a Central Intake social worker indicates that the mother's aunt wanted to speak with the assigned social worker. The aunt stated that she may have additional information that CPS did not have which might have been important in determining whether the surviving twin was safe to be returned to the mother. She felt that the surviving twin may have been in danger. The case note indicates the information from the aunt was forwarded to the assigned social worker. The investigative CPS social worker informed the review team that he was unaware of this case note entry.

Recommendation: The primary worker to a case should be notified via a tickler whenever someone else enters a case note on their assigned case. If the information is significant to a high profile, serious injury or child fatality, the primary assigned social worker should also receive a phone call by the person entering this information. This information will be forward to the FamLink design team. The Region 2 Regional Administrator was also notified of this issue.

Child Fatality Review #10-26
Region 6
Clark County

This five-month-old Caucasian female born in January 2010 died from renal failure. Children's Administration (CA) had an open case on the family at the time of the infant's death.

Case Overview
On June 9, 2010, a Legacy Emmanuel Children's Hospital social worker reported that the five-month-old infant was released to her home with her family on June 1, 2010 and that hospice care was referred. The hospital social worker added that the infant was in significant renal failure and doctors were unable to fully diagnose her condition. She was sent home with hospice services in place to provide comfort care measures.

The assigned Children's Administration social worker contacted the hospice care provider and was told that the infant had passed away on June 4, 2010. The five-month-old was being treated by medical staff for multiple medical conditions at the her time of death. She had difficulty eating and had poor muscle tone. She had difficulty gaining weight. She was eventually provided with a gastrostomy tube (G-tube) to help sustain her calorie intake but eventually under medical care, she went into renal failure.

The autopsy revealed that the infant suffered from a degenerative neurological disease called Alpers' Disease; a rare genetic disease of the brain. The first sign of the disease usually begins early in life with convulsions. Other symptoms are developmental delay, progressive mental retardation, hypotonia (low muscle tone), spasticity (stiffness of the limbs), dementia, and liver conditions such as jaundice and cirrhosis that can lead to liver failure.

Children's Administration (CA) had an open case on the family at the time of the infant's death. A case was opened in May 2010. The child was three months old at that time and she had serious medical issues. The mother was also caring for the infant's twin sister. The mother was overwhelmed with the care of two infants with one needing constant care. The infant died from renal failure while the department was in the process of investigating the intake for risk and offering services to the family.

Intake History
On January 8, 2010, a hospital social worker reported to Child Protective Services (CPS) intake the birth of twins. The children's mother reported that she used marijuana during her pregnancy. A toxicology screen at birth was negative. The referrer reported the children were born healthy. The intake was screened Information Only as there was no allegation of child abuse or neglect.

On May 4, 2010, a hospital social worker reported to CPS intake that the five-month-old (who was three months old at the time) had difficulty gaining weight and had poor muscle tone. There was concern that the infant's mother was feeling overwhelmed in caring for her and her twin sister. Also, there were additional concerns that an aunt who was caring for the child allowed the child to sleep and did not feed her for 10 to 12 hours. As a result, the infant was lethargic and was hospitalized in the Neo Natal Intensive Care Unit. The intake was screened as Risk Only and a case was opened on the family.

The case remained opened and services were provided to the parents. Services provided to the family included Maternity Support Services, Public Health Nurse, and substance abuse evaluations.

The child passed away on June 4, 2010. The case remained opened until July 2010. In addition to already offered services, the parents were also offered assistance with grief counseling.

Issues and Recommendations
Issue: None.

Recommendation: None.

Child Fatality Review #10-27
Region 5
Kitsap County

This four-year-old Caucasian female died from injuries sustained in a car accident. Children's Administration (CA) did not have an open case on the family at the time of the child's death.

Case Overview
On June 23, 2010, the mother of the four-year-old was driving on a highway in Mason County when another vehicle merged into her lane. She swerved to avoid the other vehicle and her car went off road in a rollover accident. There is no report that the mother was under the influence of any substance or was in any way at fault for the accident. The accident was entirely caused by the negligence of the other driver.

The mother suffered survivable injuries. Her four year old daughter was severely injured in the rollover accident. She was taken to Tacoma General/Mary Bridge Hospital in Pierce County where she was declared dead.

The Pierce County Medical Examiner determined the manner of death was accidental. The cause of death was motor vehicle accident.

Children's Administration (CA) did not have an open case on the family at the time of the infant's death. The most recent case on the mother and her daughter was closed in January 2010. In February 2006, the mother gave birth to her daughter. Hospital staff contacted Child Protective Service (CPS) intake with concerns about the mother's ability to care for a newborn. She was homeless and had alleged methamphetamine use. A dependency petition was filed on the child and she was placed in relative care. The dependency was dismissed in December 2009 and the case was closed in January 2010.

Intake History
On February 23, 2006, a hospital social worker reported to Child Protective Services (CPS) intake that the mother gave birth to a baby girl. Hospital staff had significant concerns about her stability and ability to care for a newborn. She was homeless and had no family support. Hospital staff reported a history of domestic violence between the mother and her boyfriend, the child's father. The mother and baby were both negative for drug screens. The intake was screened in for investigation and completed with an unfounded finding for negligent treatment or maltreatment. The case remained opened.

On February 25, 2006, a hospital social worker again called CPS intake. The call on February 25 was to report that the newborn was placed on an administrative hold. There was concern that the mother would try to run away with the child. There was also concern that the father, who was at the hospital, may become violent. Hospital security

was notified. The hospital staff wanted a social worker come to the hospital to assist. The intake was screened in for Risk Only. The case remained opened. The mother agreed to voluntarily place her child in relative care while she started services. The mother was not meeting with the social worker and was missing visits with her daughter. In May 2006, the assigned social worker filed a dependency petition on the child.

In May 2007, a termination petition was filed after the parents made minimal progress on completing court ordered services. The services ordered addressed parenting deficiencies, domestic violence, mental health, psychological evaluations, substance abuse and housing. In late 2007, the mother began to show progress in participating in services and making changes in her life.

The child's father was incarcerated for much of the period during the dependency.

Throughout 2008 the mother continued to make progress with the court ordered services. She was non-compliant in some areas of the court order including not attending a domestic violence group. The child remained placed with relatives.

The mother made significant strides in service engagement and in March 2009 the court found her to be in compliance and making progress and granted a motion to begin the transition home process which occurred in June 2009. The father was found to be out of compliance and not making progress. He had no significant involvement with his daughter. Additional parenting and community supports were provided to the mother and dependency was dismissed in December 2009.

Issues and Recommendations
Issue: None.

Recommendation: None

Child Fatality Review #10-28
Region 1
Spokane County

This 20-month-old African American male drowned. Children's Administration (CA) had an open case on the family at the time of the death of the 20-month-old.

Case Overview
On June 25, 2010, at approximately 6:30 p. m., Spokane Police responded to the report of the drowning of a 20-month-old child. The child was found in approximately 14 inches of water in a child's wading pool in the backyard of the home. The child's mother found him in the pool and pulled him out. A neighbor heard her cries for help and called 911. Neighbors also helped with CPR. The child was wearing a yellow one piece pajama outfit with white sneakers. The mother carried her son inside the house. The mother was interviewed by law enforcement. She indicated she was sitting in the living room. It had become quiet and she didn't hear her son so she went out the back door and saw him lying in the pool. She jumped in, picked him up and took him into the house. An aunt reported to law enforcement that the 11 and 12 year old sisters of the now deceased child left the house leaving the back door open. The aunt believes the 20 month old followed his sisters out the door. The mother noticed it was quiet and walked out and saw her son floating in the pool. She jumped in the pool and pulled him out.

The child was taken to Holy Family Hospital where he was pronounced dead.

The Spokane County Medical Examiner determined the manner of death was accidental. The cause of death was drowning.

CA had an open case on the family at the time of the death of the 20-month-old. In November 2009, a Child Protective Services (CPS) investigation was opened on allegations that the 11-year-old sister was a victim of a third party sexual assault by an older cousin. The family includes children 18, 12, 11¸and 7 years of age; and 20 months old.

Intake History
The family history includes 12 reports to the Children's Administration. The reports span a seventeen year period from March 1993 to February 2010. Six of the reports were made several years prior to the birth of the 20-month-old child. Three were screened as Information Only as there were no allegations of child abuse or neglect alleged.

Three reports were screened in for investigation by CPS. The three investigated reports alleged neglect of the four older siblings. All three investigations were closed with an unfounded finding. One of the reports alleged the mother was not dressing her infant for the weather and had no car seat to transport her infant daughter. A Public Heath Nurse

(PHN) was contracted to work with the mother. The case was closed and the PHN reported the mother was successfully meeting the needs of her child.

Another intake alleged that the house was a health hazard. There was food, clothes and garbage all over, urine on the floor from children and dirty diapers left on the floor. The CPS investigation was completed with an unfounded finding.

A report made on May 9, 2005 alleged the family dog found rat poison. The referrer assumed that the poison was accessible to the children in the home. The intake was screened as Information Only.

On November 20, 2008, a hospital social worker reported to Child Protective Services (CPS) intake that the mother gave birth to twins, one male and the other female. They were born at 28 weeks gestation. The mother tested positive for marijuana and the twins' meconium screen was positive for alcohol. The twins remained in the hospital for several weeks due to their prematurity. The referrer had concerns regarding the twins' father who has been arrested in the past for domestic violence. The intake was screened as Information Only.

On January 16, 2009, CPS intake received a report from a school counselor with concerns that the 11-year-old daughter (then 10 years old) reported that her mother drinks alcohol and smokes marijuana every day. There were other adults staying in the home while the mother stayed with the twins at the hospital. The twins remained hospitalized since their birth in November 2008 because of compromised health due to extreme prematurity. The 11-year-old reported the other adults also smoke marijuana but not her grandmother who also lived in the home. The 11-year-old wrote a letter to her father (who is not the father of the 20-month-old twins) stating that she didn't like it at her house anymore and wanted to runaway to live with her paternal grandmother. The intake was screened in for investigation with a 24 hour response time. Additional information received this date was the twins were ready for discharge and there were no concerns noted by hospital staff. The assigned social worker met with the mother and offered in-home support services and urinalysis. The mother declined to participate in all services.

On March 26, 2009, CPS intake received a report that the 18-year-old sibling in the home was picked up at school as a runaway and was placed at the Secure Crisis Residential Center. The intake was screened in for Family Reconciliation Services (FRS).

On May 7, 2009, the female twin died at a Spokane area hospital. She was born prematurely and suffered chronic respiratory problems since birth. Her mother brought her to see a doctor on April 27, 2009 who diagnosed her with the ear infections. The mother brought her to an emergency room and she was admitted on April 29, 2009 with respiratory distress and bacterial pneumonia, secondary ear infections, and dehydration.

This child was hospitalized for a week, but was unable to recover due to her medically fragile condition.

On November 18, 2009, a CPS supervisor reported information to intake that was obtained from a detective assigned to investigate a third party sexual assault case involving the 11-year-old and an older male cousin. It was alleged that the mother was allowing her nephew to be in the home around her daughter. This intake screened in for investigation with a 72 hour response.

The detective reported the prosecutor chose not to prosecute due to the inconsistent disclosures by the 11-year-old. The mother enrolled her daughter in mental health services. The case was to be closed with an unfounded finding for negligent treatment or maltreatment.

On February 16, 2010, a mental health counselor for the 11-year-old reported physical abuse allegations of incidents that occurred 8 to 12 months prior. The intake was screened as Information Only.

On June 28, 2010, Spokane Police reported to CPS intake the death of the 20-month-old from drowning. The police report indicated that the 20-month-old followed his older sisters outside when they left the home to go to a community pool. The mother realized it was quiet outside and went to check on her son and found him lying in a pool with 12 to 18 inches of water in it. The intake was screened in for investigation. The case remained opened and services were offered to the family, including mental health counseling for all family members and Family Preservation Services. These services were accepted by the family. The CPS investigation was closed with an unfounded finding for negligent treatment or maltreatment.

Issues and Recommendations

Issue: The review committee identified the intake on May 9, 2005 as an incorrect screening decision of information only. The intake narrative documents a clear allegation of physical abuse and should have screened in for an investigation.

Recommendation: There have been many changes to intake over the past five years with additional training provided to intake staff and supervisors. There are new tools available to intake staff that assists with identifying child abuse and neglect allegations that meet the WAC definitions.

Issue: The May 9, 2005 intake has been deleted from the FamLink database but exists in the hardcopy file. The review committee discussed retention timeframes and expressed the timeframe for record destruction for information only intakes as too short.

Recommendation: Records destruction timeframes should re-set and start over when subsequent allegations of child abuse and neglect are received. If an information only intake is screened and a new intake is received within three years, the three year timeframe should adjust and the information only report be retained.

Issue: It is unknown by the review committee if a law enforcement report was made following the May 8, 2008 intake alleging third party sex abuse. There is no documentation in the file to support the report to law enforcement.

Recommendation: It is recommended that Children's Administration develop procedures for staff to ensure and document reports are made to law enforcement for both third party crimes as well as reports for cases requiring joint investigations by Children's Administration and law enforcement.

Issue: No case notes were entered after January 17, 2009 regarding the investigation for the intake received January 16, 2009 with the exception of supervisory reviews in March 2009, May 2009 and August 2009.

Recommendation: Current policies exist that address documentation expectations. The social worker and supervisor will receive feedback regarding this review.

Issue: Supervisory reviews were not documented on a monthly basis during the time this case was open to Children's Administration.

Recommendation: Current policy exists regarding the requirement for monthly case staffings and documentation. The supervisor will receive feedback regarding this review.

Issue: The Family Reconciliation intake accepted on March 26, 2009 was not assigned to a worker. There is no documentation regarding the FRS case in FamLink or the hardcopy file.

Recommendation: The FRS supervisor is no longer employed with Children's Administration. The current FRS supervisor will receive feedback regarding this review.

Issue: The review committee found that many case notes and an investigative assessment were back dated for activities in FamLink up to 18 months prior to the activities being documented in FamLink.

Recommendation: The Office of Risk Management (Children’s Administration) develop documentation guidance for activities that occurred prior to a critical incident that have not yet been recorded in FamLink. The protocol should specify that any missing case information entered post critical incident must include a statement that the activity occurred prior to the critical incident.

Child Fatality Review #10-29
Region 6
Clark County

This 11-year-old African American male died from complications from multiple congenital conditions. Children's Administration (CA) had an open case on the family at the time of the 11-year-old's death.

Case Overview
On July 3, 2010, Clark County Sheriff's Department contacted Child Protective Services (CPS) intake to report that the 11-year-old was found at his home not breathing. At the time of his death, he was being cared for by his 12-year-old sister.

The sister told police that her brother had fallen asleep on July 2, 2010 at 5:00 p.m. At around midnight she reported that her brother began having labored breathing. A short time later she noticed that he wasn't breathing at all and called 911.

The 12-year-old sister told medical and police personnel that her mother was out of town in California for a business trip and was due back on July 5, 2010. The sister said her mother had left the day prior and that she and her brother were being cared for by an adult caregiver. The caregiver was at the home earlier in the day, but left around 5:00 p.m. leaving the sister to care for her younger brother. The adult caregiver had not returned to the home. Police officers made several attempts to reach the caregiver with no success.

Police eventually contacted the children's mother and informed her of the death of her child. She stated she left the state to attend a wedding and left the children with a caregiver. This caregiver had been caring for the 11-year-old for over a year and was supposed to be at the home the entire time. The mother reported the caregiver was previously contracted through the Division of Developmental Disabilities (DDD) to care for her son. DDD was notified immediately after the child's death and her contract was terminated.

The children's mother identified a family friend who could care for her daughter until she could return to town.

The 11-year-old had a significant history of medical problems. He was born with "global" cerebral palsy caused by a blood disorder. He suffered multiple strokes prior to being born. In June 2009 he was diagnosed with a serious respiratory condition related to his cerebral palsy. In addition, he suffered from a seizure disorder, also related to his cerebral palsy. The 11-year-old boy was unable to walk or talk and had been fitted recently with a feeding tube. Due to these medical conditions he was frequently hospitalized and had

ongoing contact with his physician. The most recent hospitalization prior to his death was July 2, 2010.

The Clark County Coroner determined the manner of death was natural. The cause of death was complications from multiple congenital conditions.

Children's Administration (CA) had an open case on the family at the time of the 11-year-old's death. In June 2010, the mother called CPS intake to request services. She reported she was overwhelmed and needed help with her two children, including a high-needs medically fragile son. A voluntary service case was opened and the assigned social worker worked with the mother to engage in services and locate a potential long term care provider through a medical facility. This case was still open when the 11-year-old died on July 3, 2010.

Intake History

On October 25, 2008, a school counselor reported to CPS intake that the 11-year-old (9 years old at the time of this report) weighed 28 pounds and had cerebral palsy. The referrer had not seen the child. The referrer was at a meeting regarding this child and it was suggested that CPS intake be called due to the child's low weight. The referrer reported the child was under frequent observation by his physician and was on a strict feeding regimen. The referrer said there were numerous professionals in the child's life and if there were concerns of neglect by the mother there would have been other calls prior to this time. The referrer had contact with the mother and had no concerns about her care for her son. The intake was screened as Information Only.

On January 28, 2009, a school counselor called CPS intake with concerns for the special needs child. It was reported he was left home alone with his older sister who gave him anti-seizure medication. The referrer said the sister had to push him in his wheelchair to school one day. This intake screened in for investigation. The sister, then 12 years old, reported her mother would wake her and her brother for school and would get her brother ready for school, including giving him all of his medications. The sister reported her mother would leave for work; the sister would later go to the bus stop where she and her brother caught the school bus. On the day of the intake, the sister reported she was late getting to the bus stop and missed the bus. She chose to push her brother to school. The assigned social worker met with the mother and she arranged for a neighbor to be available in case the sister needed assistance. The CPS investigation was closed with an unfounded finding for negligent treatment or maltreatment.

On May 12, 2009, CPS intake received a report from a school counselor with concerns that the 11-year-old special needs child came to school often congested and needed to be suctioned. The referrer reported there was a conflict between the mother and school staff on when the mother should send the suction machine to school. Doctors left this to the mother's judgment. School staff had to call 911 a couple of days prior because the

child's breathing was very shallow. The suction machine was brought to school on this day but it did not work well. This intake screened in for investigation. The medical providers for this child were contacted and reported the child was not expected to live long. For this reason they had already had conversations with the mother regarding a resuscitation plan. The mother signed a Do Not Resuscitate (DNR) order for her son. She chose to not use the medical devices given to her for her son and the medical community supported her decision to do this. The CPS investigation was closed with an unfounded finding for negligent treatment or maltreatment.

On October 21, 2009, a school teacher contacted CPS intake to report the 11-year-old (10 years old at the time of this report) had an asthma attack five days prior and the school was unable to give the child any medication with his nebulizer as his mother did not provide one to the school. School staff called 911 and the child was taken to the hospital.

On October 20, 2009, the child stopped breathing during a seizure. The child's mother reported that there was some medication the child takes which would have benefited him during the seizure. The referrer stated that the mother did not provide any of the child's medications or medical equipment. The intake was screened for the Alternate Response System (ARS).

On November 4, 2009, a school teacher reported that the child's mother had failed to provide the nebulizer, the pump for her son's feeding tube, and seizure medication. The referrer reported that there had been ongoing conversations with mother about this and she either refused or agreed to provide them, but in either case she won't send the needed supplies. The intake was screened for the Alternate Response System (ARS).

On June 1, 2010, the mother contacted CPS intake to request assistance. She reported her employment was ending and needed to move. She was unable to take care of her two children. The mother said she was completely overwhelmed and needed help. She stated she may need placement for her children. The intake was screened in for Family Voluntary Service (FVS). The social worker discussed with the mother placement options for her son in a medical facility. The worker supported the mother in locating a placement and completing the paperwork. The child was placed on a list to enter a medical facility for care in August 2010, one month after he died.

On July 3, 2010, Clark County Sheriff's Office called to report the mother left her 11-year-old son in the care of his 12-year-old sister and went to California. The police could not locate the mother or the adult caregiver left in charge. The mother was eventually contacted and informed of the death of her son. She stated she went to California to attend a wedding. The mother told law enforcement that she arranged for an adult caretaker to be with her children and that this caretaker had been providing in-home care of her son for "a couple of years."

The 12-year-old sister said the caretaker left the house around 5:00 p.m. The sister called 911 when her brother stopped breathing. By the time medics responded, the 11-year-old had died. The mother authorized the 12-year-old sister to be placed with a family friend for the night until she could return to the state. The intake was investigated for neglect and determined to be unfounded. The mother made adequate arrangements for the care of her children and utilized a provider contracted through the Division of Developmental Disabilities (DDD) to care for her children. DDD was immediately notified and the caretaker's contract was terminated.

Issues and Recommendations

Issue: The caregiver at the time of the death was added to the investigative assessment as a subject in the allegation of neglect. A finding of founded was made on the caregiver although the caregiver did not meet the definition of loco parentis.

Recommendation: The investigative assessment will need to be corrected to have the contracted caregiver removed as a subject and remove the finding from FamLink.

Issue: At the time of the intake it was screened as a 24 hour response. The Central Intake Supervisor staffed the case with Headquarters personnel and it was decided not to send out the field response worker to assess the safety of the surviving sibling. No extension or exception was entered into FamLink and as a result the office was considered out of compliance in response to the 24 hour timeframe.

Recommendation: It is recommended that the Central Intake review this intake and the process for staffing and screening cases following a fatality.

Child Fatality Review #10-30
Region 3
San Juan County

This 14-year-old Caucasian male committed suicide. Children's Administration (CA) did not have an open case on the family at the time of the youth's death.

Case Overview
On July 6, 2010, the 14-year-old was found with a self-inflicted gunshot wound to his head. He was at the home of his grandparents in Grays Harbor County. The 14 year old had been living with his grandparents since March 2010. The mother sent her son to live with his grandparents because of his behavior issues.

The Grays Harbor Coroner reported that cause of death was a gunshot wound to the head and manner of death is suicide.

Children's Administration (CA) did not have an open case on the family at the time of the 14-year-old's death. The most recent contact between the department and his family was approximately 11 months prior his death. In July 2009, CPS intake received a report that the youth and his sister were left home alone while their mother would go out for the evening. This report was screened for the Alternate Response System (ARS) and contact was made with the mother in July 2009.

The family includes children ages, 14, 11¸ and 8 years old.

Intake History
On August 20, 2004, a relative reported to CPS intake that the parents were neglecting their three children. There was a protection order against the father due to domestic violence and reports that he had attempted suicide. It was also alleged that the mother was using drugs and the father is an alcoholic. There were allegations that the mother violated a protection order. This intake was screened in for investigation and closed with an unfounded finding for negligent treatment or maltreatment.

On October 24, 2004, a report to CPS intake alleged the parents were separated and that the mother was not paying attention to her children. It also alleged that the mother would continually separate and reunite with her husband. The referent also alleged past drug use by the parents. This intake was screened as Information Only.

On January 4, 2005, a report by school personnel to CPS intake alleged the 14-year-old (then nine years old) and his 11-year-old sister (who was six years old at the time of this report) had behavioral problems at school. There were concerns that the parents frequently separated and reunited. The referrer alleged the parents were involved in domestic violence and were abusing drugs and alcohol. This intake was screened as Information Only.

On January 12, 2005, a report to CPS intake alleged there has been extensive domestic violence between the parents. The referrer reported the week prior, the parents got into an altercation and the mother went to the hospital with a separated shoulder. She had gone to her husband's house to get money for bills. There was no indication that the children were present when this incident occurred. This intake was screened as Information Only.

On February 7, 2005, a report to CPS intake alleged the 14-year-old (then nine years old) was riding a 4-wheeler with his father and fell off. The mother reported that she didn't take him to the doctor immediately, but after she did, the doctor stated that the youth broke his arm in two places. This intake was screened as Information Only.

On March 25, 2005, a school teacher reported to CPS intake that the 14-year-old (who was nine years old at the time of this report) had put a blanket over his younger sister's head causing her to have difficulty breathing. The younger sister was six years old at the time of this report. The 14-year-old youth was displaying behavioral issues and had urinated on a school wall. The intake was screened in for investigation. The sister was interviewed and reported she could breathe with the blanket over her head, but said this scared her. She told her mother and her mother intervened. The assigned social worker met with the mother. She got her son into counseling. This intake was closed as unfounded for negligent treatment or maltreatment.

On October 7, 2005, a relative contacted CPS intake to report that the mother had overdosed on medication the night before. The children were placed with the referrer but she was unable to care for them. The mother had been hospitalized. There was a restraining order barring the father from having contact with the children. The referrer expressed concerns about the father's "violent behavior." The intake was accepted for Child Welfare Services. Law enforcement placed the children into protective custody and dependency petitions were filed on the three children. The children remained placed with relatives until October 11, 2005. The sister remained placed with her aunt, the 14-year-old and his younger brother were moved to foster care placements.

On October 10, 2005, a social service professional reported to CPS intake that relatives were caring for the three children in the family. Relatives feared the father would kill the children in front of the mother and then kill her. There was extensive domestic violence and police involvement with the parents. Relatives also reported the mother used methamphetamine and father abused alcohol. It was reported that the 14-year-old (then 10 years old) was attacking animals. This intake was screened in for investigation.

The case remained opened from the previous intake on October 7, 2005. The children remained in out-of-home care. The mother entered, and eventually completed, a 30-day inpatient treatment. She also began to participate in counseling and domestic violence services. The mother arranged for her son to reconnect with his counselor. On December 17, 2005, the parents agreed to an in-home dependency with the children placed with

their mother. The mother continued to participate in court ordered services and the dependencies on the three children were dismissed on July 12, 2006. The Children's Administration case remained opened to help the mother participate in services including child care for her children and counseling for her. The case was closed in October 2006.

On July 10, 2009, a relative contacted CPS intake to report the mother was neglecting her three children. The intake alleged the mother was going out most evenings and leaving the three children (ages 13, 8, and 7) alone. The referrer stated that another relative lived less than 100 yards away but it was unknown if she was an emergency contact for the family. The intake was screened for the Alternate Response System (ARS). An initial face to face and investigation was completed. The mother acknowledged leaving the home. She left her son, then 13 years old, in charge. A list of community resources were provided to the family and the ARS case was closed on July 29, 2009.

Issues and Recommendations
Issue: There were four information only intakes between October 20, 2004 and February 7, 2005 that were not in the FamLink database but referenced in the physical case file. They appear to have been deleted/expunged per state law.

Recommendation: The Region 3 Child Fatality Review Facilitator will speak to Headquarters' Fatality Review staff about the impact of expunged records on Child Fatality Reviews.

Issue: When the case was open with Children's Administration, the 14-year-old was not assessed by a child psychologist at Children's Hospital. The mother didn't follow through with this recommendation made by the CFWS social worker before the dependency was dismissed.

Recommendation: Once a social worker makes a referral for a client to complete a service, the social worker should follow through to ensure the client completed the service before closing the case or document why the services are no longer needed or applicable.

Issue: There is no evidence at the beginning of the case, that the CPS social worker referred parents to participate in a urinalysis (UA) though there were substance abuse allegations. There is no evidence that a social worker obtained a release signed by the parents for permission to contact the domestic violence agency. There is no evidence that collateral calls were made regarding the first screened in intake.

Recommendation: Social workers will contact agencies involved with the case and will request information about the families who are engaging in services.

Issue: There were four information only intakes that were called in between 2004 and 2005 prior to the March 25, 2005 intake. The team had a concern that social workers and supervisors did not critically look at the history about the case including information only intakes.

Recommendation: When social workers and supervisors are reviewing a case for final case closure, they should critically look at all intakes and case activity and be assured that the social worker adequately looked at the safety of the children.

Child Fatality Review #10-31
Region 5
Kitsap County

This two-month-old Caucasian female born in May 2010 died from asphyxiation. Children's Administration (CA) did not have an open case on the family at the time of the child's death.

Case Overview
On July 12, 2010 at around 8:00 a.m. the mother of this two month old infant fell asleep during feeding. The infant awoke fussy around 8:45 a.m., was comforted back to sleep and placed on her stomach in a bassinet-type infant bed with a poorly fitted foam mattress pad. According to the mother, her daughter slept best on her stomach. The mother then fell asleep and awoke several hours later and noticed her daughter wedged in the corner of the bassinet in an awkward position. The baby was stiff and not breathing. Other household family members were alerted and a call to 911 was made around 12:30 p.m. First on the scene were a Kitsap County detective and a neighborhood volunteer firefighter. CPR was in progress at time of their arrival with the child observed to be unconscious, unresponsive; her face and extremities appeared blue in color. Medics and other fire and rescue crew members arrived shortly after and death was pronounced at the residence.

A death scene investigation was initiated, including photographs of the residence, which was described as cluttered. Detectives conducted interviews of the household members. At the home at the time of the incident were the parents, their infant daughter and the mother's two other children who live with their father. They had been dropped off earlier that morning for a visit with their mother. The relatives who owned the residence and their 16-year-old son were also present.

In consideration of the circumstances of death, the scene investigation, the medical history, as well as the post mortem examination including toxicology screenings, the cause of death was ascribed by the Kitsap County Coroner to be from probable asphyxia secondary to smothering or suffocation as a result of placing the infant in the prone position on the corner of a small bassinet. The manner of death was classified as an accident.

Children's Administration (CA) did not have an open case on the family at the time of the death of the two-month-old. The most recent department involvement with the family was in June 2010. CPS intake received a report from hospital staff following the birth of this child. It was reported that the mother's toxicology screen was negative but the baby's was positive for opiates. Hospital staff said the positive toxicology screen was not from parental substance abuse. This report was screened for the Alternate Response System

(ARS) and referred to an Early Family Support Services (EFSS) provider who made contact with the mother in June 2010.

Intake History

On November 15, 1999, hospital staff reported to Child Protective Services (CPS) intake that the mother gave birth to a newborn. Both the mother and infant tested positive for marijuana at delivery. The mother had prenatal care, reportedly had good supports, and was involved with First Steps. The intake was screened for the Alternate Response System (ARS).

On May 16, 2010, hospital staff reported to Child Protective Services (CPS) intake the birth of a healthy baby girl born via C-section. The hospital had been notified by the local Community Services Office (CSO) of concerns regarding the mother being out of compliance for chemical dependency treatment. The hospital social worker indicated that the mother's toxicology screen was negative, but the baby was positive for opiates. The referrer reported this is thought to be from medical intervention at delivery. Although not clear as to any specific allegation of child maltreatment, a number of risk factors were noted at intake, including past substance abuse issues involving both parents. Central Intake accepted the report and designated the case for Alternate Intervention as a "10 day response for follow-up with the CSO." Bremerton intake then routed the report to the local Kitsap County Early Family Support Services (EFSS) contracted provider. The EFSS provider conducted a home visit on May 24, 2010, noting no substantive concerns following observations of the home environment and parent-child interactions. After the initial screening visit the mother did not engage further with EFSS and the provider closed out services June 18, 2010.

The family also received services through the Kitsap County Health District following a referral from the hospital. A Public Health Nurse (PHN) from the Parent Child Health and "Welcome Home Baby" Program conducted a home visit ten days after the baby was born. An additional PHN home visit was conducted on July 2, 2010, which was 10 days before the infant died. Records obtained post-fatality indicated the PHN found the infant to be healthy, well nourished, alert, and well cared for. The mother appeared to be nurturing, and there was no indication of postpartum depression. The public health nurse reviewed SIDS and safe infant sleep recommendations, proper car seat/child restraint, and "Shaken Baby" materials. The nurse was aware that the mother was choosing to put the infant down to sleep on her stomach (prone) position rather than the recommended back (supine) position.

On July 13, 2010, the Kitsap County Coroner reported to CPS intake the death of the two-month-old infant. The intake was accepted for investigation of allegations of negligent treatment or maltreatment, although it is unclear as to any specific allegations being reported. Bremerton CPS continued to gather information from law enforcement and the county coroner. In mid-September the Kitsap Coroner provided CPS with the finalized

postmortem results. The cause of death for the two-month-old was ascribed to be from probable asphyxia secondary to smothering or suffocation as a result of sleep position and sleep surface. The manner of death was classified as an accident. The CPS investigation was closed with an unfounded finding for negligent treatment or maltreatment.

Issues and Recommendations

Issue: June 2010 (Alternate Intervention): Neither the mother nor the newborn infant tested positive for illicit drugs at delivery. There was no information that the newborn had been substance-exposed or substance-affected and by Children's Administration (CA) Prenatal Substance Abuse Policy (2007) the intake should have screened out.

Action taken: Feedback was provided to the Central Intake Program Managers regarding the intake issues discussed during the Child Fatality Review.

Recommendation: No specific recommendations.

Issue: Alternative Intervention (EFFS June 2010): The Alternate Intervention provider met the terms and conditions of the current DSHS Client Services Contract for Early Family Support Services (EFSS). Contact with the parent was made by the EFSS therapist within 72 business hours, a home visit occurred within 10 working days, efforts to engage were documented and documentation at termination of services met requirements.

Action Taken: Feedback was provided directly to the EFSS therapist and her supervisor who participated in the review. Additional follow-up was done with the Director and the local Assistant Director of the provider agency. The provider was receptive to the suggestion emerging during the child fatality review that when working with families with infants, their EFSS workers should consider routinely inquiring and assessing infant safe sleep in the client's home, although there is no requirement by current contract.

Recommendation: No recommendations.

Issue: The post-fatality investigative activities largely focused on the gathering of information from a variety of sources, including law enforcement, county coroner, and public health. To that regard the worker did excellent work. A number of areas were identified for which practice could have been improved. The social worker did not document some activities, such as his brief safety interviews with the two older half-siblings who were visiting their mother the day of the fatality incident. There was a missed opportunity to contact the Community Services Office worker who had significant involvement with the mother. A majority of the documentation was entered into FamLink beyond the timeframes specified in CA policy.

Action Taken: The worker and his supervisor participated in the review and received feedback regarding the minor practice issues discussed.

Recommendation: No specific recommendations.

Child Fatality Review #10-32
Region 2
Benton County

This nine-year-old Caucasian male died from an intestinal infection. Children's Administration (CA) had an open case on the family at the time of the child's death.

Case Overview
On July 15, 2010, this nine-year-old child was transported by ambulance to Kennewick General Hospital after he collapsed at home. His mother had called 911 when he collapsed. Emergency Medical Technicians arrived and performed CPR before taking him to the hospital. The hospital reported the nine-year-old went into cardiac arrest and was pronounced dead at the hospital. Officers from the Kennewick Police Department also responded to the home. A detective reported the child presented with a fever late the previous night. His mother attempted to get him into the bath to bring down his fever when he collapsed. She called 911 and he was transported to Kennewick General Hospital by ambulance. Attempts were made to resuscitate him both in transport and at the hospital. He was pronounced dead on July 15, 2010.

The treating physician told the police detective that the child may have had a perforated intestine resulting in him bleeding out. The child had surgery on July 7, 2010 at Children's Hospital in Seattle for a long standing bladder problem. It is unknown at the time of his death if complications from the surgery caused his death.

According to the Benton/Franklin County Coroner's office, the cause of death was an intestinal infection. The manner of death was natural/medical.

Children's Administration (CA) had an open case on the family at the time of the death of the nine-year-old. CPS intake received a report of physical abuse of the nine-year-old during a visit with his father. The child lived with his mother, his custodial parent, and had regular visits with his father. The investigation of physical abuse allegations by the father was still open when the child died from the intestinal infection.

Intake History
On December 11, 2001, a case worker with a Community Services Office (CSO) reported to Child Protective Services (CPS) intake concerns about the nine-year-old (who was seven months old at the time of this report) and his older sister. The mother brought the seven-month-old infant into the CSO with no coat, socks, or blanket to keep him warm. He was wearing only a light shirt and pants; his face and feet were bright red. The referrer questioned the mother about this concern. The parents said they lived in a 28 foot trailer with no bathroom, functional toilet or shower. The intake was screened for the Alternate Response System (ARS).

On January 8, 2002, a case worker with a Community Services Office (CSO) reported to CPS intake concerns about the children. The nine-year-old was eight months old at the time of this report; his sister was 21 months old. The nine-year-old was born with his bladder outside of his body. He had reconstructive surgery. He had casts on each leg and a catheter. The mother failed to recognize the catheter was leaking down the casts. When the casts were removed, the child's legs had sores on them. Doctors were surprised that the mother did not realize the child was urinating down the casts. The doctors told the parents the child needed to come back for further reconstructive surgery. The mother refused to make an appointment for the surgery saying she was too busy. It was also reported that the parents slept late and they propped up the baby with a bottle in his mouth. The child had a reflux problem and vomited all the time.

The parents did not regularly change the diapers of either child. Their daughter developed a diaper rash as a result. The parents delayed in taking her to the doctor to have the rash treated. It was also alleged that the parents refused to take their children to the emergency room when needed. The intake was screened in for investigation. The CPS investigation was closed with an unfounded finding for negligent treatment or maltreatment.

On November 30, 2007, a school teacher reported to CPS intake the nine-year-old (then six years old) reported that when the child and his sister visit their father, the father watches pornographic movies in his son's presence. It was also alleged the father smoked marijuana in front of him and the sister. The referrer did not say how often the children visited nor had contact with their father, but they apparently spent part of the 2007 summer living with him. The CPS investigation was closed with an unfounded finding for negligent treatment or maltreatment.

On September 18, 2008, a mental health counselor reported to CPS intake that the sister (then eight years old) reported to the referrer that her stepfather had kicked her in the side on five separate occasions. The referrer reported the sister had a tendency to make things up or overly exaggerate. The referrer reported the stepfather admitted to kicking his stepdaughter one time to break up a fight between her and her brother. The children's mother told the stepfather he was not allowed to kick the children. The referrer said the mother and stepfather were having marital problems and were planning on getting a divorce. The intake was screened for the Alternate Response System (ARS).

On November 4, 2008, a staff member at a doctor's office contacted CPS intake to report that the mother was not bringing her son in for routine medical and health checks to address his Oppositional Defiant Disorder, anxiety, depression, attention-deficit/hyperactivity disorder (ADHD), and bladder problems he had had since birth. It was also reported that the mother was not following through with taking her daughter to see an orthopedic surgeon for her foot problem. The intake was screened in for investigation for negligent treatment or maltreatment. The assigned social worker

reviewed medical records received from several different clinics and hospitals where the children were treated. Additionally, both children had scheduled appointments in January of 2009 to address their specific medical concerns/issues. The information obtained during the investigation indicated that the mother was not negligent in obtaining medical care for her children. The CPS investigation was closed with an unfounded finding for negligent treatment or maltreatment.

On June 14, 2010, CPS intake received a report alleging physical abuse of the nine-year-old by his father. The child lived primarily with his mother and had visitation with his father. It was reported that the nine-year-old was disciplined by his father for wetting his pants. It was also reported that he was spanked twice by his father. The child had several bruises on both sides of his buttocks. He had a medical condition that made it difficult for him to control his bladder. The assigned social worker and a police detective met with the father who admitted to spanking his son and leaving bruises. The detective chose to charge the father with assault. The CPS intake was screened in for investigation and closed with a founded finding for physical abuse by the father. The mother had support from her extended family. She obtained a No Contact Order against the father. A list of community resources were sent to the family.

On July 15, 2010, Kennewick Police Department called CPS intake to notify the department of the death of the nine-year-old. He was residing with his mother, his sister, and his maternal grandparents. The police officer reported that the child presented with a fever the evening of July 14, 2010. His mother attempted to get him into the bath to bring down his fever. He ended up collapsing. 911 was called and the child was transported to Kennewick General Hospital via ambulance. Attempts were made to resuscitate him both in transport and at the hospital. He was pronounced dead at 12:12 a.m. on July 15, 2010. This intake was screened out for investigation.

Issues and Recommendations
Issue: This review team did not have any issues or recommendations as a result of this child fatality.

Recommendation: None

Child Fatality Review #10-33
Region 2
Yakima County

This 15-year-old Hispanic male died from a gunshot wound. Children's Administration (CA) had an open case on the family at the time of the youth's death.

Case Overview
On July 17, 2010, the 15-year-old youth was shot multiple times to the torso in a gang related drive by shooting. The youth was reportedly riding a bike on the street in Sunnyside when a car pulled up alongside him. One of the individuals in the car got out, approached the youth and shot him four times. He was taken to a local hospital where he was pronounced dead.

Sunnyside police officers reported the 15-year-old had gang ties and this was the motivation for the shooting. The youth's family disputes this claim.

Children's Administration (CA) had an open case on the family at the time of the 15-year-old's death. CPS intake received a report of neglect of the six and 10 year old sisters. They were unable to attend school due to an untreated lice problem.

The family includes children ages 19, 16, 15, 11 and 6 years old.

Intake History
On May 24, 2005, a Grandview police officer reported to Child Protective Services (CPS) intake that the mother called police when her six-year-old daughter was missing. The mother reported that she last saw her daughter with an older brother at 4:00 p.m. The mother reported the older sibling had gone to the park and that her daughter was with him. The older sibling told his mother that his sister did not go to the park with him. The mother called the police at 8:30 p.m. The child finally arrived home at 9:05 p.m. The police reported this was the second report of this child missing from the home. The intake was screened in for investigation. The six-year-old was interviewed by the assigned CPS social worker. She reported she went to a friend's home without permission from her mother. The CPS investigation was closed with a founded finding for negligent treatment or maltreatment. The family was provided a list of community resources if services were needed to assist the family.

On August 15, 2005, a police officer reported to CPS intake that the family home was condemned. The house had no power and was hooked up to the city water illegally. The parents were arrested for outstanding warrants. The children were placed with a maternal aunt. The intake was screened in for investigation. The CPS investigation was closed with a founded finding for negligent treatment or maltreatment. The case was staffed with a community Child Protection Team (CPT) on August 31, 2005. The CPT

recommended the children be returned and the case closed at the end of September 2005 if the mother provided clean urinalysis (UAs) and a stable home for the children. The mother did have clean UAs and found stable housing. The case was closed in October 2005.

On February 8, 2006, a school counselor reported to CPS intake the 15-year-old (then 10 years old) would come to school and just sit. The father came to school but appeared to be intoxicated. On the day of this report, the youth sat at school with his arms at his side and refused to talk. The referrer went to the home but the mother would not come to the door. During the home visit, the referrer smelled a strong odor coming from the home and got a headache from the smell. The referrer reported she called law enforcement to have welfare check done on the children. The referrer was suspicious that there was a meth lab on the property. The referrer reported that the father was involved in drugs in the past and the chemical smell may have been an indicator of problems. The intake was screened as Information Only.

On March 11, 2008, a police officer reported to CPS intake that he took the 15-year-old youth (then 12 years old) and his older brother (then 17 years old) into protective custody. The officer said the mother was arrested because of a citation regarding the truancy of her children. The officer indicated that three other siblings were already with relatives. The youth and his older brother were not attending school. Relatives were unwilling to take the 15-year-old youth and his older brother because of previous history of stealing from the relatives. The intake was screened in for investigation for negligent treatment or maltreatment.

The boys were placed in a Secure Crisis Residential Center. The mother was released from jail the following day and the boys were released to her care. The mother and her children moved in with relatives. The case was transferred to the Family Voluntary Services unit. The family was referred to the Home Support Specialist Program. The case was closed in June 2008. The CPS investigation was closed with an unfounded finding for negligent treatment or maltreatment.

On May 21, 2009, CPS intake received a report from a school nurse that the younger sister of the 15-year-old youth was sent to the school office because she had very poor hygiene. She was given a clean shirt and socks and was sent back to class. She did not come back to school for the next two days. The school had ongoing concerns of absenteeism for her and her two older brothers. The intake was screened for the Alternate Response System (ARS) and referred to the Early Family Support Services (EFSS).

A contracted EFSS worker made contact with the mother to address the concerns. Despite initial reluctance, the mother began to work with the EFSS provider. After several weeks, the mother stated she no longer wanted to continue with the EFSS program. The

EFSS provider did not feel that the children were in imminent danger and closed the case in June 2009.

On August 10, 2009, a former landlord called CPS intake and reported the family home did not have running water. The referrer was forced to shut off water and was unsure if the family had access to any water. The family did not pay rent and the referrer was in the process of formally evicting them. The home was cluttered and windows were broken. The intake was screened as Information Only.

On March 29, 2010, a relative contacted CPS intake to report the children probably were not in school because one of them had lice. The referrer reported "the mother has history of filthy homes with no water." The referrer said the mother and children had been living in New Mexico and moved back to Washington in late February or early March 2010. The children's father passed away in September 2009. The referrer stated she spoke to the children's school counselor in New Mexico who said that the mother had not requested school records be transferred to the school the children would be attending. The referrer reported the 15-year-old rarely went to school and could not read. The referrer said the children lived on "junk food." The intake was screened as Information Only as there were no reports of child abuse or neglect. The mother was sent a letter indicating CPS intake received a report with concerns about her children. She was provided a list of services in her community to address the concerns identified.

On April 23, 2010, a school nurse called CPS intake to report the children were enrolled in school on April 12, 2010 and within three days were sent home for lice and had not returned as of April 23. The referrer reported the scalp of one child was "raw looking." The intake was screened in for investigation. A home visitor from the school went to the home and offered to treat the girls for lice but the mother declined. The assigned social worker met with the mother and children. None of the children had sores, or scabs on their heads. The family had moved in with relatives. The mother agreed to submit to urinalysis; the results were negative. The social worker provided lice treatment to the mother. The social worker also made a referral to the housing authority to help the family obtain permanent housing. This CPS case was closed with an unfounded for negligent treatment or maltreatment.

On July 22, 2010, law enforcement contacted CPS intake to report the 15-year-old was shot multiple times to the torso in a gang related drive by shooting. He was taken to a local hospital where he was pronounced dead. This intake was screened as Information Only.

Issues and Recommendations

Issue: The intake dated March 29, 2010 originally taken by Central Intake was screened in for investigation for negligent treatment or maltreatment. The screening decision was later changed to Information Only by the Sunnyside Division of Children and Family

Services (DCFS) field office. The review team believes the intake should have remained as a screen in due to the history of neglect in the family.

Recommendation: ACTION TAKEN: The Area Administrator for the Sunnyside and Ellensburg field offices has instructed all CPS intake supervisors in these two offices not to screen down/out intakes that are taken and screened in by Central Intake.

Child Fatality Review #10-34
Region 1
Spokane County

This nine-year-old Caucasian male died from a gunshot wound. Children's Administration (CA) had an open case on the family at the time of the child's death.

Case Overview
On July 18, 2010, the nine-year-old, his twin brother and his 17-year-old brother were brought in to Sacred Heart Medical Center in Spokane for injuries received during a domestic violence incident. Their mother was killed during the incident. The 17-year-old had his throat cut but managed to call 911. The nine-year-old was shot in the head and was brought to the hospital in critical condition. He later died from his injuries. His twin brother was unharmed. The perpetrator in the attack was the mother's former fiancé. After assaulting the family, the perpetrator went to his home where he shot and killed himself.

The Spokane County Medical Examiner determined the child's death to be a third party homicide. The mother's former fiancé had moved out of the family home eight months prior to the fatal incident.

Children's Administration (CA) had an open case on the family at the time of the death of the nine year old. In April 2010, Child Protective Services (CPS) intake received a report that the nine-year-old twin brother was possibly being over medicated. Staff at this school reported he was lethargic and unable to stay awake. His mother chose not to take him to see a doctor. This report was screened in for investigation by CPS. The investigation was open at the time of the child's death.

Intake History
On September 25, 2000, CPS intake received a report that the mother was pregnant with twin boys. She was due to deliver in December 2000. The mother admitted using methamphetamine while pregnant with the twins. The case was accepted for pre-natal intervention. The mother also had a seven-year-old son from a prior marriage. He was residing with his grandparents during the week and spending time with his father on the weekends. The mother did not have custody of her son. The intake was screened in for investigation

The mother participated with a First Steps nurse and received regular medical check-ups. She was closely monitored throughout her pregnancy; however, she started missing appointments. The CPS social worker contacted the maternal grandmother who reported the mother had used drugs since she was a teenager and did not think she would be able to parent twins. The mother agreed to enter an inpatient treatment program in October 2000. Her twin sons were born in November 2000. They remained hospitalized until

December 6, 2000 due to their low weights. The mother started inpatient drug/alcohol treatment in November 2000. The twins were released to her care at the time of their discharge from the hospital. In addition to offering assistance with substance abuse treatment, the family was also provided Home Based Services.

The CPS investigation was completed with a founded finding for negligent treatment or maltreatment.

On May 9, 2003, an anonymous referrer contacted CPS intake to report the mother's boyfriend was abusive to the mother and her twin sons. The referrer stated that the 10-year-old had observed the mother's boyfriend drop his twin brothers on their backs into their cribs and hit them on their backs. The referrer also stated that the twins show visible fear of their mother's boyfriend.

The intake was screened in for investigation. The mother denied abuse of her twins and admitted there had been a domestic violence incident earlier in the year between her and her boyfriend. The mother said her boyfriend had been drinking at the time of the incident but had later completed an inpatient program. At the time of this intake the mother's boyfriend was participating in outpatient treatment and anger management.

The assigned social worker learned that the twins were attending full day child care. The child care employees had very positive references for the mother and her care of the twins. The case was closed in June 2003 with an inconclusive investigative finding for physical abuse and neglect.

On August 19, 2004, CPS intake received information from a neighbor that there was constant screaming and crying. The twins were heard screaming "ouch Mommy, don't hit me, ouch." This intake was screened as Information Only.

On January 21, 2005, an Early Childhood and Parenting (ECAP) service provider reported to CPS intake that the mother admitted spanking her son (then four years old) hard and left welts. The mother told the ECAP provider that she observed a handprint on her son and that the mark was "blotchy red" that appeared to be broken blood vessels. On January 24, 2005, the intake worker contacted the child daycare center where the child was enrolled. The child care staff had not observed any injuries or marks on the child. The intake was screened as Information Only.

On November 30, 2009, the mother and a school counselor called CPS intake to report that the mother's fiancé was rough housing with her nine-year-old sons and injured one of them. The child's tooth went through his lip and he required a stitch in his lip. Note: the person identified as the mother's fiancé is not the same person identified as the mother's boyfriend in the May 2003 report.

The mother reported her fiancé was no longer living with her and the boys. She had secured a new residence and they would be moving. The intake was forwarded to law enforcement and they chose not to investigate. The intake was screened in for investigation by CPS.

The investigation and related documentation were not completed until after the death of the nine-year-old and his mother. The investigative finding was founded for physical abuse by the mother's fiancé.

On April 21, 2010, a school nurse reported to CPS intake that the nine-year-old twin brother was very lethargic and unable to stay awake. She suggested the staff call 911 but the principal contacted the mother instead. The mother came to the school and said she would monitor her son at home. The nurse wanted the child to be a seen by a doctor but the mother said it was unnecessary; the child had just changed medications. The intake was screened in for investigation.

The assigned social worker made contact with the child at school. He was jittery and had trouble focusing. The social worker contacted the child's doctor and confirmed the medications and dosage. The physician also identified that the side effects the child exhibited were possible side effects from the medications.

The investigation and related documentation were not completed until after the death of the nine-year-old and his mother. The investigative conclusion was unfounded.

Issues and Recommendations
Issue: The investigation of the May 9, 2003 allegations lacked an interview with the subject of physical abuse. The investigation also lacked a witness interview with a 17-year-old sibling (who was 10 years old at the time of the report) who was clearly identified as a witness in the intake.

Recommendation: Feedback was provided to the social worker, supervisor and Area Administrator by the CPS program consultant. Verbal feedback was provided as training on the elements of conducting thorough CPS investigations.

Issue: The November 30, 2009 intake includes information that the child victim was seen at a hospital emergency room and received stitches in the lip. The investigating social worker did not request medical records or talk to any staff at the hospital to gather information. It is unknown what the mother reported to the medical staff about her son's injuries.

Recommendation: Feedback was provided to the social worker, supervisor and Area Administrator by the CPS program consultant. Verbal feedback was provided as training on obtaining all records as part of a complete investigation. The feedback emphasized

that workers should not rely on the word of the subject of investigations; rather social workers should verify information from a person or agency other than a family member involved in the case.

Issue: The review committee found that the majority of case notes and an investigative assessment were back dated for activities that occurred up to 7 months prior to the fatality occurring.

Recommendation: The Office of Risk Management develop documentation guidance for activities that occur prior to a critical incident and have not yet been recorded in FamLink. Any protocol developed should specify that missing case information entered post critical incident must include a statement that the activity occurred prior to the critical incident.

Child Fatality Review #10-35
Region 6
Cowlitz County

This 13-year-old Caucasian male died after being hit by a car. Children's Administration (CA) did not have an open case on the family at the time of the youth's death.

Case Overview
On July 24, 2010, this 13-year-old youth was riding his bicycle against traffic on a sidewalk along the Ocean Beach Highway. He was given permission to be away from the home by his parents. He visited a friend and was riding alone on his bike. There were reports to law enforcement that he was doing "stunts" as he rode his bike along the road. At one point, he left the sidewalk and turned directly in front of an oncoming car. The vehicle did not have time to brake. Longview police officers investigating the accident report the driver was unaware of the youth's presence until after the collision that caused him to hit the windshield.

Longview police determined that rate of speed, drugs or alcohol were not involved in the accident. The driver voluntarily submitted to blood testing and was not prosecuted. The accident scene investigators estimated the driver was traveling at 33 miles per hour. The youth died at the scene and was pronounced dead at the hospital. The Cowlitz County Coroner reports the cause of death was "atlanto-occipital disarticulation with high spinal cord transaction," which is traumatic injury to the upper spinal cord and the joint between the spinal column and the skull.

The manner of death was accidental.

CA did not have an open case on the family at the time of the 13-year-old's death. In October 2009, Child Protective Services (CPS) intake received a request for assistance in filing of an At-Risk Youth petition. The youth's mother reported he was harming himself and other family members. The case was open for Family Reconciliation Services (FRS) and closed in December 2009.

Intake History
On August 16, 1996, CPS intake received a report of a four year-old former foster child who alleged that the father of the 13-year-old kicked him in the leg and pulled his hair. The parents of the 13-year-old were licensed foster parents from 1994 to 2001. The intake was screened in for investigation. The children in the home were interviewed by a Division of Licensed Resources/Child Protective Services (DLR/CPS) investigator who determined that the allegations were unfounded.

On August 21, 1996, CPS intake received a report that a six-year-old former foster child alleged that the 13-year-old's father threatened to "tear his head off" after he urinated

on the floor. The six-year-old reported he was asked to clean it up with a washcloth. The child was interviewed by a DLR/CPS investigator who determined that the allegations were unfounded for negligent treatment or maltreatment.

On February 28, 1997, the parent of a child formerly placed in the home reported to CPS intake that she had to take her child to the emergency room at a local hospital because she felt the child was weak, had a fever, and was being starved at the foster home. DLR/CPS conducted an investigation. The child was seen by a pediatrician, who determined that the child was not malnourished or maltreated, but had an ear infection, which was treated. The DLR/CPS investigation was closed with an unfounded finding for negligent treatment or maltreatment.

On October 20, 2009, the mother of the 13-year-old contacted CPS intake to request assistance in filing an At-Risk Youth (ARY) petition for her 13-year-old son at the request of child's treatment team. The youth was reported to have engaged in self-harming behavior for which he was hospitalized twice. He was disruptive at school and assaulted his mother. He was already being treated by mental health professionals. The intake was screened for Family Reconciliation Services (FRS). The social worker completed a Family Assessment and assisted the family in filing the ARY petition. The FRS case was closed after the ARY petition was granted and the family reported being better able to manage his behaviors.

On July 26, 2010, Longview Police officers contacted CPS intake to report that the 13-year-old youth was involved in a motor vehicle accident while riding his bicycle on July 24, 2010. The youth turned in front of a vehicle traveling on Ocean Beach Highway and died at the scene. Law enforcement considered this an accident and did not conduct a criminal investigation of the driver of the vehicle. The intake was screened out for investigation as there were no allegations of abuse or neglect.

Issues and Recommendations
Issue: This review team did not have any issues or recommendations as a result of this child fatality.

Recommendation: None

Child Fatality Review #10-36
Region 3
Snohomish County

This five-month-old Native American male born in February 2010 died from Sudden Infant Death Syndrome (SIDS). Children's Administration (CA) did not have an open case on the family at the time of the child's death.

Case Overview
On July 27, 2010, an investigator from the Snohomish County Medical Examiner's Office called Child Protective Services (CPS) intake to report the death of this five-month-old infant. The child's mother and her live-in boyfriend reported to law enforcement that at about 7:30 a.m. the baby was placed in bed with his mother while she nursed him. Both the mother and baby fell asleep while still in the bed. The boyfriend got into bed at about 9:30 a.m. At that time the baby was alive. The mother stirred and turned on her back at about noon. The mother woke at approximately 1:00 p.m. and found her baby unresponsive. The 911 call was made at 1:28 p.m. When medics arrived, they determined the child was dead.

The Medical Examiner reported there was nothing suspicious about the death. The autopsy was completed on July 28, 2010. The autopsy report indicates that the five-month-old died of sudden infant death in the presence of an unsafe sleep environment. The manner of death was unknown/undetermined.

CA did not have an open case on the family at the time of the child's death. In February 2010, Child Protective Services intake received a report that the mother had recently given birth and there were concerns because the family was homeless and she was seeing the child's father, in violation of a restraining order.

The family also included children ages five and four years old.

Intake History
On September 30, 2008, a relative contacted CPS Intake to report the family home was unsafe and unsanitary. The referrer reported there were three to five bags of garbage inside the home. There was open food left out, some of which contained maggots. There was dirty clothing in the home and the bathroom had mildew and mold on the walls. The home had a strong odor of urine. The referrer reported the children were possibly developmentally delayed. There was broken glass and many cigarette butts outside the house. The intake was screened in for investigation. The parents agreed to allow their two children to stay with grandparents while they cleaned the home. After two days, the parents had sufficiently cleaned the inside and outside of the home. Both parents completed a urinalysis, which were negative for both. The children were returned to their

parents' care when the home was free of hazards. The CPS investigation was closed with a founded finding for negligent treatment or maltreatment.

On July 31, 2009, a relative reported to CPS intake that the family was homeless and the house on the reservation was in such a horrible state that they could no longer live there. The Tribe considered the home abandoned. The parents asked the paternal grandparents if the family could live with them. The intake was screened in for investigation. The assigned social worker was unable to locate the family. Contact was made with relatives and tribal social workers who did not know where the family had moved, but confirmed the family had moved from the area. The investigation was closed with no finding.

On November 4, 2009, a nurse reported to CPS intake that the mother came to a hospital emergency room that day and brought her two children with her. The children were extremely dirty and smelled badly. The mother admitted to being involved in a domestic violence incident the previous night with the children's father. He kicked the mother and children out of the house. The intake was screened in for investigation. The mother agreed to get a restraining order against the father and not allow the father any unsupervised contact with the children. The mother submitted a urinalysis which was negative. She worked with the tribal domestic violence advocate. Tribal social workers assisted the family on locating housing. The investigation was closed with an unfounded finding for negligent treatment or maltreatment.

On February 8, 2010, a hospital nurse contacted CPS intake to report concerns regarding the mother and her three children. The mother was discharged from the hospital with her newborn baby. The mother was homeless and was thought to be violating a restraining order with the father of the children. The intake was screened as Information Only.

On July 27, 2010, the Snohomish County Medical Examiner's office contacted CPS intake to report the death of this five-month-old infant. Medics arrived at the home following a 911 call made at 1:28 p.m. Medics determined the baby was dead. The Medical Examiner reporting there was nothing suspicious about the death. The intake was screened in for investigation and the CPS investigation was completed with an unfounded finding for negligent treatment or maltreatment.

Issues and Recommendations

Issue: Lack of coordination with the local tribe to ensure the tribal case manager is aware of current CA case information and plan.

Recommendation: The Smokey Point Area Administrator and Indian Child Welfare Supervisor will develop a transfer checklist to ensure the tribal worker receives pertinent case information when taking jurisdiction. The Smokey Point office will identify a supervisor to assist the local tribe with the newly available read-only FamLink tribal access.

Issue: In 2009, one of the Investigative Risk Assessments was completed with no findings as “Unable to Complete Investigation-Unable to Locate.”

Recommendation: All CPS supervisors will be retrained at the next CPS supervisor meeting to follow the diligent search process before closing a case.

Issue: On February 8, 2010, a CPS screened out information only intake was received from the hospital stating the mother and her newborn baby were being released from the hospital. The hospital also reported that the newborn was healthy but mother is homeless and may be violating a restraining order.

Recommendation: Region 3 intake supervisors will discuss with the regional intake unit the risk factors to consider when screening intakes involving newborn infants.

Issue: The crime scene death investigation did not go smoothly. Several patrol officers and detectives interviewed the witnesses. Witnesses were interviewed more than once. The timelines prior to the infant’s death on the various law enforcement reports did not match. CPS was not contacted until approximately six hours after 911 was called. The Medical Examiner's office called the intake line at 7:10 p.m.

Recommendation: Region 3 Safety Program Manager will contact Snohomish County Medical Examiner's office to review the child death notification protocol.