Washington State
Department of Social
& Health Services

Report to the Legislature

Quarterly Child Fatality Report

RCW 74.13.640

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Children's Administration Child Fatality Report

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INTRODUCTION

This is the January – March 2005 Quarterly Child Fatality Report provided by the Department of Social and Health Services (DSHS) to the Washington State Legislature as required by RCW 74.13.640. Passed during the 2004 Legislative Session, HB 2984 (RCW 74.13.640) requires the department to report on each child fatality review conducted by the department and provide a copy to the appropriate committees of the legislature. This Quarterly Child Fatality Report summarizes the 10 reviews that were completed during the first quarter of 2005. All of these fatalities were reviewed by a regional Child Fatality Review Team.

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

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

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

The chart below provides the number of completed Child Fatality Reviews as well as those yet to be completed for the years 2004-2005. The number of reviews not yet completed is subject to change if CA learns through a record review that the fatality was anticipated rather than unexpected or if CA history on a family is later located under a different name or spelling.

Year	Child Fatality Reviews completed and submitted since July 1, 2004	Child Fatality Reviews to be completed
2004	16	34
2005	0	21

The numbering for the Child Fatality Reviews in this report begin with #04-02. This indicates that the fatality occurred in 2004 and is the second report completed for that year. The number is not assigned until the child fatality review and report by the CPS Program Manager are completed.

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

6 reports are from Region 1—Spokane (5) and Clarkston (1)
1 report from Region 2—Yakima
1 report from Region 3—Bellingham
1 report from Region 4—Seattle
1 report from Region 5—Bremerton

In addition to the quarterly Child Fatality Reviews, CA will be completing an Annual Child Fatality Report which will provide statistical information as well as issues and recommendations from reviews on child fatalities that occurred throughout the entire year. The next annual Child Fatality Report will be for the year 2003.

Child Fatality Review #04-02
Region 1
Spokane Office

Case Overview

This six-month-old boy died on July 3, 2004 while in his mother's care. They were temporarily residing at the maternal grandparents' home in Coeur D'Alene, Idaho. The mother told authorities that she had placed her son on the bed for a nap, surrounded by pillows. She reported that she later went to check on him and found him wedged between the bed and the wall. The mother said her son appeared blue. Cardio-pulmonary resuscitation was performed by the maternal grandfather and 911 was called.

History

At the time of this child's death, the family had an open Child Protective Services (CPS) case. On December 17, 2003, CPS received a referral alleging the mother tested positive for cocaine and was not keeping prenatal appointments with her physician. When the child was born, the social worker made contact with the mother at Sacred Heart Hospital. The urinalysis on the mother and the meconium screen for the child were negative for drugs and alcohol following the child's birth.

The mother has another son who was two-years-old at the time of the sibling's birth. That child was residing with the maternal grandparents in Idaho. The mother reported that the fathers of both of her children were incarcerated.

The mother was involved in services that included visits from a First Steps nurse, counseling with the Childbirth and Parenting Alone Program (CAPA), and participated in services through the Temporary Assistance for Needy Families (TANF) program. The mother was also referred for a drug and alcohol evaluation and random urinalyses. She took four urinalyses during the case activity, and they all tested negative for drugs and alcohol.

The providers that worked with this mother expressed concerns regarding bonding and attachment between her and the children. The case was staffed with the CPS supervisor and a Child Protection Team (CPT) on March 2, 2004. The CPT recommended placement in out-of-home care for the children.

The social worker submitted a shelter care and dependency petition on March 9, 2004. The petitions were returned to the assigned social worker by another Division of Children and Family Services (DCFS) social worker who is a court specialist. The court specialist's responsibility is to review cases for legal sufficiency prior to filing. The petitions were returned without being filed with the indication that there was not a basis for a dependency action.

On March 16, 2004, the providers working with the family met to discuss the intervention plan. The team recommended the mother continue with the current services, including beginning work on attachment/bonding issues at the Martin Luther King Jr. Center.

In April 2004, concerns were reported to the CPS social worker that the mother had been a victim of domestic violence at least twice in the previous month. The altercations reportedly occurred after the newborn's father was released from jail in March 2004.

On April 9, 2004, the mother told the CPS social worker she was moving with both of her sons to her parents' home in Idaho. The children were taken to the maternal grandparents, but the mother remained in Spokane the majority of the time. The maternal grandfather later reported the children were in their care until May 26, 2004. The worker made attempts to contact the mother and later learned of the child's death on July 12, 2004.

Issues and Recommendations

I. Practice Issues

A. Issue: The DCFS social worker at juvenile court reviewed the dependency petition and returned it to the CPS social worker stating that the document did not meet filing criteria. It is unclear if an Assistant Attorney General reviewed the petition.

Recommendation: *Juvenile court social workers will have an Assistant Attorney General review each petition drafted for filing to determine the legal sufficiency of the information provided.*

II. System Issues

A. Issue: Information sharing and communications between the DCFS and DSHS Community Services Offices (CSO) should be improved.

Recommendation: *It is recommended that social workers at DCFS and CSO each have access to the computer systems Employment-Jobs Automated System (EJAS) and Case and Management Information System (CAMIS).*

B. Issue: There is a lack of clear expectations for CPS social workers when providing interventions for families with domestic violence events that do not cause physical injury to child witnesses. April 2004 mother was victim of domestic violence at least twice.

Recommendation: *It is recommended that legislation and/or Children's Administration policy be developed with clear direction for social workers providing interventions with families experiencing domestic violence.*

Child Fatality Review #04-03
Region 1
Spokane Office

Case Overview

This four-month-old girl died on June 28, 2004 while in her mother's care. The mother reported to tribal law enforcement that on the evening of June 27, 2004 she put her twins (four-months-old) down to sleep. One twin slept in an infant carrier and the other twin slept in the bed with the mother. The mother stated that she had been drinking heavily that evening and went to bed at midnight.

The mother reported that at 4 am on June 28, 2004 she awoke to feed the twin in the bed and they both went back to sleep. She also reported waking up again at 7:30 am due to the twin in the infant carrier crying, and she noticed that the hands of the twin in the bed were blue, and the child was not breathing. The mother was still impaired by her alcohol consumption and could not remember if the baby was underneath her when she awoke.

Law enforcement reports indicate that due to the mother's intoxication, they were unable to receive a written statement. An autopsy was conducted on June 29, 2004. There was no evidence of trauma or signs of Shaken Baby Syndrome, but an examination of the child's back showed marks indicating possible overlay.

History

The mother first came to the attention of Child Protective Services (CPS) on May 28, 1993 while she was in jail. The mother had a paramour that was caring for her daughter. The paramour brought the child to the jail to visit. The paramour was arrested due to an outstanding warrant. Child Protective Services was contacted to provide a safe place for the child until the mother was released from jail. The child was placed with her maternal grandmother. The mother was released a couple of days later, and the child was returned to her care.

On November 21, 1995, a referral was received by CPS alleging physical neglect. The child had told a teacher that she was staying with her maternal grandmother and aunt while her mother was in jail. The child stated that her grandmother was using drugs in the home and that the mother's paramour was drunk and driving with the child and other children in the vehicle. Once the mother was released from jail she indicated that she would not be allowing her mother to be a caretaker. The case was closed.

On August 19, 1996, CPS was contacted by the Colville Tribe requesting an overnight placement for the child as she had become separated from her mother during the Omak Stampede celebrations. One night of care was provided, and the case was handled by the Colville Tribe.

On August 19, 1997, a family member reported an allegation of physical neglect regarding the oldest daughter and the second daughter. A similar referral was received by CPS on October 7,

1997. The same family member was the referent in both referrals. Both of these allegations were investigated and determined to be unfounded.

On February 13, 1998, the mother was arrested and her daughter stayed with the maternal grandmother. The grandmother observed blood in the toilet after the daughter had been in the bathroom. The grandmother brought the daughter to the doctor for an examination which indicated that she had been sexually abused. Law enforcement was notified and the child was placed into protective custody. The child did not make any affirmative statement that she had been abused when she was interviewed. On March 4, 1998, the child was placed with her father. Childcare was provided while the child was in his care. In April 1998, the mother and father reunited and moved with the child to Idaho. There were no new allegations of abuse or a basis for a new referral to Idaho. The case was closed in Omak on April 23, 1998.

On February 18, 2003, a referral was made by a doctor who reported that the mother had given birth to a baby boy on February 17, 2003. The mother admitted to frequent use of cocaine while she was pregnant, and she had poor attendance with her prenatal care. The Colville Tribe placed the baby boy into protective custody upon discharge from the hospital on February 19, 2003. On February 21, 2003, the case was transferred from the Colville Tribe to the Children's Administration (CA) Division of Children and Family Services (DCFS) as the family's residence was not on the reservation. The mother signed a Voluntary Placement Agreement, and the baby was moved to a foster home in Omak. The father remained in Idaho for most of 2003. The mother was provided daily visits with the baby. The baby developed some medical problems while he was in foster care. He had stopped breathing while in foster care and was brought to the doctor's office. He was evaluated for cardiac concerns. The child was returned to the mother's care on April 25, 2003.

The mother had participated in a drug/alcohol evaluation and attended an inpatient program in Wenatchee in May 2003. She also had a parent educator visit with the baby through May and June of 2003. A home support specialist had weekly contact with the mother and baby once the baby was returned home. Both children had stayed with a relative for part of May while the mother was in treatment. The mother left treatment reporting there had been a death in the family in Wyoming. She received a certificate of completion from the treatment program, but it was unclear where she went after leaving the program. The maternal grandmother reported that the mother had gone to California. The mother returned to Omak at the end of June and reported that she had brought the children to Montana to see their father for one week. The case was closed to DCFS, but services continued through the Tribe: after care for substance abuse, GED education, parenting education, and other Work First requirements. After the DCFS case was closed, it was reported that the mother and the children moved to Oregon.

On January 21, 2004, the mother contacted the Omak DCFS office requesting childcare assistance. She was 32 weeks pregnant with twins and had been recommended to bed rest as she was at risk for premature labor and delivery. The request was accepted, and childcare would be provided with an in-home provider once a criminal background check and CPS records check was completed. The mother never followed through with completing the paperwork, and the request was closed February 13, 2004.

The mother gave birth to twin girls on February 6, 2004. A referral was received on June 28, 2004 reporting that one of the four-month-old twins had died. There was no evidence of trauma.

Issues and Recommendations

I. Practice Issues

A. Issue: There is no documentation of a supervisory review for referral received on August 19, 1997 or the referral received October 7, 1997.

Recommendation: *Follow policy for supervisory reviews and document in the electronic case record.*

B. Issue: It is unclear and not documented that the victim(s) were seen face to face by the assigned social worker for referrals received on November 21, 1995, August 19, 1997, or October 7, 1997.

Recommendation: *All child victims need to be seen face to face by the social worker and clearly documented. It is current policy to see child victims face to face and to clearly document this interaction. AIRS policy states, "Reviews may address individual employee actions and decisions in the specific case under review. However, if there are recommendations regarding corrective or disciplinary actions against individual employees, the chairperson will discuss this separately with the Regional Administrator and the Assistant Secretary and will not include this in the report."*

C. Issue: The review panel questioned whether the case was closed prematurely following CPS interventions in June 2003.

Recommendation: *It is recommended that cases with substance abuse issues be monitored for a period of time in order for the parent to demonstrate stability following inpatient treatment.*

II. System Issues

A. Issue: The Colville Tribe provides social services to families without a consistent method for obtaining social information about the family served by public social services.

Recommendation: *The Colville Tribe's Child Protective Services and Tribal social services recommends access for the Tribe to the State's Case and Management Information System (CAMIS) and the State's Temporary Assistance to Needy Families (TANF) records. This is viewed as an essential communication between the Colville Tribe and the State's public services.*

Child Fatality Review #04-05

Region 1
Spokane Office

Case Overview

On June 2, 2004, Child Protective Services (CPS) received a report from Grant County Sheriff's office reporting the fatality of a two-month-old child. The child's mother reported that she had returned home at approximately 7:15 am after working the graveyard shift. The father of the child left for work. The mother reported that she checked on the child who was in an infant carrier, took a bath, and went to her bedroom to take a nap. She brought the child, in the infant carrier, into her room while she was sleeping. She woke a couple of hours later to the sound of her three other sons fighting in the living room. The child was reportedly still in his infant carrier, but no longer in the mother's room. The child was in the living area with the other children. The mother reported that she checked the baby and noticed he was not breathing.

Emergency response was contacted by 911 at 10:27 am. The child was deceased when he arrived at the hospital, and it was estimated that he had been deceased for approximately one hour prior to his arrival at the hospital.

The Chelan County Medical Examiner conducted an autopsy and determined the child's fatality to be of natural causes due to bronchopneumonia. It was noted during the review that the mother brought the child to the doctor on June 1, 2004. Pneumonia was not diagnosed at that time.

History

The mother and her three oldest sons, ages one, two, and four-years-old, came to the attention of CPS in October 2002. Three consecutive referrals were received: October 6, 2002, October 15, 2002, and October 28, 2002. The primary allegation was a lack of supervision by the mother of the three boys. The boys were reported to be running into the street, playing in a construction area, and hitting, biting, and fighting with each other. A CPS social worker was able to meet with the mother and children regarding the first two referrals. The mother explained that she works graveyard shift and needs to sleep some during the day. While she is sleeping, the children get out of the house. The social worker offered door latches and discussed childcare arrangements.

The CPS social worker was unable to make contact with the family after receiving the third referral. There were five attempted home visits as well as letters mailed to the home and none of these yielded a response from the mother. The case was staffed with a Child Protection Team (CPT) on January 2, 2003 with a recommendation to close the case.

On January 6, 2003 an allegation of physical abuse and negligent treatment was made to CPS. The one-year-old was reported to have a questionable head injury that required medical attention. The mother reported to a doctor that her two-year-old son had hit the one-year-old in the head with a screwdriver. A CPS social worker investigated the allegation and made a founded finding

for negligent treatment as to the mother. The mother entered into a voluntary service agreement with CPS which included Family Preservation Services (FPS).

On February 27, 2003, the FPS provider wrote a letter of concern to CPS regarding safety issues for the three children. On the same day a CPT was held, and a recommendation was made to remove the children from the mother's care. The mother and her children were determined to be Native American, and all decision making was in concert with the Grand Ronde Confederated Tribe of Oregon.

On February 28, 2003, the children were placed in protective custody with relatives and dependency petitions were filed in court.

On April 10, 2003, the children were returned to the mother's care with an agreed in-home dependency status. The mother was court ordered to urinalysis monitoring, a psychological evaluation and follow any treatment recommendations, a domestic violence assessment, parent education, and FPS. The father of the two youngest children was ordered to have a domestic violence evaluation and follow recommendations, parent education, and FPS. The children were to participate in the birth to three program. The mother had completed a psychological evaluation in April and started counseling in June. She attended six sessions and a closure session. A review hearing was held on June 17, 2003, and a report to the court documents the mother's compliance with the court order. No treatment recommendations were made as a result of a chemical dependency evaluation. The case was staffed with a CPT on October 2, 2003 with a recommendation to dismiss the dependency action in court. On October 8, 2003 the Guardian Ad Litem (GAL) assigned to the case also supported dismissal. The case was closed.

On March 16, 2004, the mother gave birth to another son. There were no referrals made to CPS from the time of the case closure to the time of child's death.

Issues and Recommendations

I. Practice Issues

A. Issue: The referral received on October 28, 2002 was screened in at Intake as a moderate level risk referral.

Recommendation: *It is recommended that Intake increase the level of risk on cases when multiple referrals are received in a short time period. In this case there were three referrals in one month that demonstrated the same or escalating allegations.*

B. Issue: Primary information from a psychologist was not shared with the chemical dependency professional (CDP) during the referral service. The psychological evaluation contained information that may have been significant to the CDP.

Recommendation: *Best practice indicates that sharing the psychological evaluation which contained historical information and an Axis I diagnosis for amphetamine dependence would be relevant to the assessment for chemical dependency.*

II. Contract Issues

A. Issue: The staff involved with this case did not have access to a professional psychiatric consultant to clarify information or consult regarding information in the psychological evaluation.

Recommendation: *Region 1 needs to fill the vacant contracted position for psychiatric consultations.*

Child Fatality Review #04-09
Region 1
Spokane Office

Case Overview

This two-month-old Caucasian boy was brought to the Spokane Valley Hospital by ambulance at approximately 9:30 am on May 18, 2004. His father reported that he found the child limp and blue in the crib and called 911. The child was intubated and cardio-pulmonary resuscitation was preformed for approximately 30 minutes. He was transported from Valley Hospital to Deaconess Hospital via MedStar. It was determined that the child had previous rib fractures, a skull fracture, and was experiencing respiratory failure. After approximately 16 hours, life support was withdrawn and he died. His father later admitted to "head butting" him and stuffing socks in his mouth to stop him from crying.

History

On April 22, 2004, a referral was made to Child Protective Services (CPS) with concerns for the 19-month-old sister of the two-month-old boy. The referral was made by Even Start childcare facility due to a pattern of injuries to the sister. Three separate injuries were documented by different childcare employees between January 2004 and April 2004. The sister was observed by different employees to have a bruise to the left side of her forehead on January 15, 2004, a black eye on March 15, 2004, and another black eye on April 8, 2004. The injuries in January, March, and April 2004 were not reported to CPS until April 22, 2004.

The social worker at Even Start had concerns for the mother and the children due to the mother's relationship with the father. The CPS social worker also had concerns about the father due to his history as a child, teen, and adult. Child Protective Services accepted the referral for investigation. The child's mother provided an explanation for each injury incurred by the child. In the first three weeks of the abuse investigation, concerns for domestic violence in the home emerged. The mother was offered an alternate residence with her two children as well as domestic violence services. The mother refused both. She denied there was any violence occurring in the home and did not want to participate with services offered by CPS. Three and a half weeks later, on May 18, 2004, CPS received a referral that the two-month-old boy was brought to the hospital in cardiac and respiratory arrest. The two-month-old later died of anoxic encephalopathy due to non-accidental injury. His death has been ruled a homicide.

The two-month-old boy suffered significant trauma that resulted in his death. The father admitted to "head butting" him. The boy also had healing injuries at the time of his death, which indicate a pattern of physical abuse. The father was convicted in the death of this child and received sentencing of more the 23 years in prison.

The investigation of the mother was founded for negligent treatment of the boy as she failed to protect him from physical abuse. It is unknown/undetermined if the mother also perpetrated physical abuse against him. Law enforcement signed an authorization for protective placement for the 19-month-old sister. She is placed with her maternal grandfather and his wife.

Issues and Recommendations

No issues or recommendations were identified by the review team.

Child Fatality Review #04-1

Region 1
Clarkston Office

Case Overview

This five-month-old boy died on September 1, 2004. He was found not breathing in his home. He was transported to St. Joseph's Hospital in Lewiston, Idaho where he was pronounced dead. Both parents reported to law enforcement that at approximately 4 am the mother prepared two bottles and fed the baby. She then brought him into their bed to sleep. The father of the baby later woke the mother telling her that the baby felt cold. There were no signs of trauma observed.

Law enforcement investigated the death scene in Asotin County, Washington and an autopsy was performed in Nez Perce County, Idaho. The cause of death was determined to be Sudden Infant Death Syndrome (SIDS).

This was an unexpected death, and there were no indications that child abuse and/or neglect was a factor. There was one previous referral made regarding the family. There are no other children in the home of these parents.

History

One referral on May 17, 2004, indicated that a couple of weeks prior, the mother told a referent that the mother, father, and several friends were smoking marijuana with the child present in the same room. The referent reported that the mother and father also "get cranked up sometimes (methamphetamine) and don't wake up for nothing."

The referent said that approximately three weeks ago the referent's sister reported she called the family home several times in the morning (9 or 10 am) and that neither parent answered the phone. The referent said the sister went over to the family's home and went inside the residence. The sister reported to the referent that the infant was crying and neither parent awoke so the sister took the child to her residence and continued to call the family home. The referent said the sister reported calling the family home several more times in attempt to wake the parents and the mother finally answered phone. The mother was upset that the sister took the child from the family home without their knowledge.

The referent said she suspects the parents were oversleeping as a result of methamphetamine use, but has no way to substantiate this except that the father of the baby used methamphetamine while the referent had a relationship with him. The mother has admitted to this referent that she and the father use methamphetamine.

The referent said she was concerned about the child being neglected by the parents as a result of methamphetamine use. The referent was scheduled to provide care for the child while the mother works. The referent arranged to provide care so she could be a protective factor for the child during the day.

The referral was investigated and closed as a 'moderate low risk' to the child. No indications of abuse or harm are noted in the file.

Issues and Recommendations

No issues or recommendations were identified by the review team.

Child Fatality Review #04-12

Region 1
Spokane Office

Case Overview

This three-month-old Caucasian boy was at a licensed childcare home on April 15, 2004. He was laid down for a nap between 11:30 and 11:40 am. It was reported that the child was fed a bottle of Parent's Choice formula mixed with Gerber rice cereal before being placed down for a nap. He was placed in a playpen on his left side with a wedge behind his back. There were no other children in the room. This child was checked at 1:00 pm, and he was fine. He was checked again at 1:40 pm and at this time he was not breathing. Cardio-pulmonary resuscitation was initiated and 911 was called. An ambulance transported the child to the hospital where he later died.

A child fatality review occurred with the Department of Health in Spokane County on December 7, 2004. The cause of death was determined to be SIDS by the Spokane County Medical Examiner. The death of this child was unpredictable and unpreventable.

History

The licensed childcare home had five prior referrals at the time of this child's death. One of these five referrals alleged physical abuse of a child in the home. The other four were licensing referrals indicating that the home was in violation of licensing regulations. These included issues with over capacity, improper restraining, and a threatening dog in the home.

The biological family had no history with Child Protective Services (CPS).

Issues and Recommendations

The review team made the recommendation that infants need to be placed on their back when sleeping.

Child Fatality Review #04-13
Region 2
Yakima Office

Case Overview

This 12-year-old Caucasian girl died on December 21, 2004. She had an operation at Shriner's Hospital on November 30, 2004 for Perth's Disease which is a juvenile form of osteoporosis. She had to use a walker and wheelchair as a result of the disease. On December 21, 2004 while in her grandparent's home, she was having trouble sleeping and got up to use the restroom. She was using her walker to go from the bedroom to the bathroom when she apparently became unstable and fell. The grandmother who was also having trouble sleeping heard the child fall. She responded to her and found the child face down on the walker, but initially responsive. The girl stopped breathing and the grandfather attempted to perform cardio-pulmonary resuscitation while the grandmother called 911. She was transported to Memorial Hospital in full cardiac arrest where they attempted to revive her using epinephrine and a defibrillator. The attempts to revive her were unsuccessful. In Yakima, an autopsy was performed and the official cause of death as determined by the coroner was Massive Bilateral Pulmonary Thromboemboli (Blood Clot).

The social worker was informed of the incident by the Intensive Family Preservation Services (IFPS) worker with Institute for Family Development. The social worker notified the area administrator and initiated a Child Protective Services (CPS) referral. The Institute for Family Development was actively providing IFPS to support the family regarding the 17-year-old brother's drug and alcohol addiction and mental health issues. The social worker worked to support the family through financial donations to assist with funeral costs and any other needs which may arise. Service providers will continue to support the family. The social worker stated that the family received $170 of Concrete Services through the IFPS Program; $500 from the Institute of Family Development; and $540 through donations from the Yakima office social work staff. Intensive Family Preservation Services remained in the home and continued to provide supportive services for the family. The family was referred to community resources for support.

The child's fall appears to be directly related to the Perth's Disease, with the fall potentially having led to the child's death. Mental health services have been offered to the mother and grandmother. It is believed that the family will accept services after they have had time to grieve their loss. In addition, substance abuse services have been offered to the 17-year-old brother, but have been refused to date. The brother is currently hospitalized due to drug and mental health issues. The IFPS caseworker and DCFS social worker are monitoring the brother weekly.

The brother is also currently being followed by Dr. Gottlieb of Yakima Valley Farm Workers Clinic.

History

This family came to attention of CPS in 1996. The mother had four children: boy (DOB 10/7/87), boy (DOB 5/2/91), decedent (DOB 6/26/92), and boy (DOB 10/25/97).

Reports began on April 19, 1996. This report alleges that the family has numerous animals in the house and everything in the house is dirty, including the laundry. The children were reportedly filthy and improperly dressed for the weather. One child has asthma and the parents continue to smoke in the house. This report was screened in as a 'low risk,' and a letter was sent to the family.

On November 13, 2001, the child reported to a school counselor that she had a conflict with her step-father. She reported to the referent that she wanted the step-father out of the home, and she did not feel safe being in the home with him there. The youth did not report a recent incident where he hit her. This referral was 'information only'.

On February 22, 2002, a report was made alleging that the home is filthy. There were many hazards identified within the home, such as a broken window. This was an 'information only' referral.

On August 5, 2003, a report was made indicating that the decedent was being molested by her oldest brother's father. He was in prison for this crime. This referral was 'information only' due to the step-father being in prison and was not a current threat of harm.

On December 30, 2003, it was alleged that the father came home, could not get in the house, and broke out a window to get in. He cut his head trying to get in through the window. The mother and children were not home. Law enforcement went to the house and found that it was not fit for children. There were numerous animals in the home and there was animal feces all over. The referral was accepted for investigation and assigned to a social worker. Services were accepted and completed, and the case was closed in February 2004.

On April 28, 2004, a referral was received alleging the youngest child had been hit by the school teacher. There was no action taken against the teacher by the school district. This referral was not assigned for investigation.

On May 4, 2004, a referral was received alleging the youngest child was out walking with an aunt at 10:40 pm. The referral indicates the child is not going to school since the mother and child do not like the teacher. The referent reported there was a party at the home which lasted until the following morning, and there was fighting and arguing up and down the street. The referral was determined to be 'information only.'

On June 11, 2004, a referent called in to report the decedent had been slapped across the face and there was a red mark as a result. There were no bruises. The child had found a bag of white powder in the mother's compact. The referent states the mother is using illegal drugs. There are animal feces all over the house. The mother locks herself in the bedroom. This referral was

accepted and referred to Alternative Response System (ARS). Alternative Response System goes out to offer services to the family.

On August 12, 2004, a report was made alleging there is no electricity in the home. The report also states there is an odor in the home. The odor smells like animal and human waste. It is reported the grandmother has the three youngest children living with her and the oldest is with another relative. This referral was 'information only' and was not assigned for investigation.

On September 21, 2004, a report was made indicating the oldest child was admitted to the hospital for alcohol poisoning. The child stated he received the alcohol from his mother. He also used oxycodone. The child lived in a trailer behind grandmother's home. The child was assessed as being suicidal. The referral was assigned to a CPS social worker. The child disclosed that the mother had left alcohol and her medication out on the counter. He was depressed at the time. He was placed by his therapist in a facility to treat the depression. Intensive Family Preservation Services was engaged in the family upon his release. He refused drug and alcohol treatment. He remained in placement with his grandmother.

On December 21, 2004, the report of the fatality was made. The case was open at the time due to the family receiving services for the oldest child. The children were living with relatives at the time of this referral. This referral was 'information only'.

Issues and Recommendations

No issues or recommendations were identified by the review team.

Child Fatality Review #04-14

Region 5
Bremerton Office

Case Overview

This two-year-old Native American boy died as the result of a lawnmower accident on June 26, 2004. The grandmother had placed the child in a play area about 25 feet away. The child was hit when the grandmother was backing up the lawnmower in a narrow area of lawn. The child was last observed approximately 25 feet away prior to the accident. As the grandmother backed up the mower, she ran over the child. She was unable to lift the riding mower off the toddler. She called 911. Emergency records show the child was without a pulse and breathing had ceased during transport to the hospital. The child was pronounced dead enroute to Mary Bridge Hospital. The cause of death was not from bodily injury as first reported (although there were multiple contusions and fractures), but from mechanical asphyxia due to the weight of the riding lawnmower.

There was an open case at the time of the child's death, and a safety plan was in effect. This incident was accidental according to the law enforcement investigation. There was nothing to suggest that the surviving sibling was at risk of any harm and remained with the relatives.

Support to the family was offered.

History

The parents were involved with a number of services independent of the Child Protective Services (CPS) intervention, such as chemical dependency assessments, drug and alcohol treatment, urinalysis monitoring, pediatric and prenatal medical care, Public Health Nurses and Women, Infant, and Children. Child Protective Services worked with the family on paper work regarding their Native American status, and offered daycare and parenting class resources. Additionally, a voluntary service agreement was initiated, which reinforced continuation of drug treatment and on-going medical care for the children.

History Prior to Birth of Children

When the mother was an adolescent, one referral was received requesting Family Reconciliation Services (FRS). This child had run away, was failing school, and was due to go to alternative school. She missed her drug and alcohol evaluation, was verbally abusive, breaking curfew, and refusing to follow the rules. The case was open with FRS for two months. The mother's self-reported drug history indicated her first use of marijuana and methamphetamine was at age 14. She finished tenth grade.

The father as an adolescent had two FRS referrals. In June 2000, his mother called requesting services after he had returned from being on the run for three months. She believed her son to be using methamphetamine. He was defiant and oppositional. Family Reconciliation Services accepted the case. Within a week the child had run again and the mother requested help

regarding an At-Risk-Youth (ARY) petition. His mother was hoping to get her son into court ordered treatment. Family Reconciliation Services records show the only contact by FRS was by phone due largely to his running behavior. The case closed in November of 2000, a month after the child turned 18.

The parents met when they both were "on the streets" at the ages of 15 and 16-years-old. According to the mother, they have been together since that time except for a one year separation prior to the child's birth.

History as Parents

On January 9, 2002, the Community Services Office (CSO) called to report second hand information. The paternal grandmother had been taking care of the child, and she was upset that the mother wanted the maternal sister to take the child. This sister reportedly was an intravenous drug user who had her child removed in the past. The grandmother was contacted by CPS Intake and told that if she arrived at the aunt's home and found the conditions to be inappropriate, to contact law enforcement. This referral was received as 'information only' and was not assigned for investigation.

On June 28, 2002, a relative reported concerns about drug use by the mother. The mother would sleep for long periods of time. The child's father was reportedly involved with drugs. The mother was moving from place to place and her current whereabouts were unknown. There were no obvious signs of abuse to the child, but the referent was concerned that the mother would leave the child in the care of others for days at a time. This referral was 'information only.'

On December 26, 2002, a relative reported that the parents were doing drugs. The mother's drug tests were clean. The parents were reportedly asleep all day leaving the 15-month-old child unsupervised. When re-contacted by CPS Intake the relative stated she was not positive the parents actually slept all day. This referral was 'information only.'

On April 21, 2003, the paternal grandmother reported the father had found the mother with another man. There was an incident involving a gun being pulled. There was no concrete information indicating the child was present or at risk. The home reportedly was in disarray with dirty dishes and dirty clothes all over. Both parents reportedly were doing drugs. Another caller contacted CPS and reported there were syringes and drug pipes lying around the residence. This referral was accepted for investigation.

The parents denied any incident involving another man, but later indicated there had been a weapon discharged by an adult male outside the residence. The father admitted he and the mother were methamphetamine users. The home was clean and in order and the child was with the maternal grandmother. Referrals for urinalysis were given to the parents. The father missed his appointment. Law enforcement indicated that the parents were well known to them and the home was always found to be clean and the child was taken care of. The father was arrested for parole violations. The mother completed drug and alcohol assessment and went into 21-day in-patient treatment in June. The child stayed with the maternal grandmother. Following in-patient treatment, the mother entered out-patient care and her urinalyses were clean. Later the mother

stopped showing up for out-patient sessions and was not showing up for urinalysis. The findings for the referral were 'unfounded' and legal intervention was not warranted. The case was closed in November.

On December 8, 2003, a referral was received alleging that the mother was again doing drugs. There was no information about the child or how the mother's drug use was impacting the child given by the referent. This referral was 'information only' and was not assigned for investigation.

On March 4, 2004, a CSO worker called concerned the mother was entering the third trimester of her pregnancy and was probably doing drugs. The mother was out of compliance with Work First requirements. The father's benefits were stopped due to having a drug felony conviction. This referral was 'information only.'

On April 2, 2004, the paternal grandmother called suspecting her son was doing methamphetamine again. The mother was pregnant and allegedly using methamphetamine, as well. There were no allegations of abuse or neglect regarding the child and Intake contacted the hospital to alert them of the impending delivery. This referral was 'information only.'

On June 8, 2004, a report was made indicating the mother was within 30 days of delivery and possibly using drugs. The referral was accepted for Low Risk Standard of Investigation (LRS). The worker attempted contact with the CSO that had previously had concerns. The CPS worker contacted the paternal grandmother who reported the father, mother, and child were living with her. The mother was attending out-patient treatment, attending NA/AA and signed "release of information" to confirm she had prenatal care. The social worker did not indicate any concerns regarding the child during the home visit. The family was receiving services from Women, Infant, and Children (WIC) and Public Health Nurses (PHN), and agreed to a voluntary service plan with CPS that included the condition the family would live at the paternal grandmother's home. On June 23, 2004, CPS was informed by Harrison Hospital that both the mom and baby tested negative for drugs.

On June 28, 2004, a report was received regarding the child having been accidentally run over by a riding lawn mower driven by a relative. Based on the information provided by law enforcement investigators, the incident appeared to be a tragic accident. There were no allegations regarding child abuse or neglect. This referral was identified as 'information only' on an open case.

Issues and Recommendations

I. Practice Issues

A. Issue: On the June 8, 2004 referral, the infant's teen mother was not identified as the primary caregiver of the child. The referral identified the maternal grandmother as the primary caregiver of the infant and therefore the referral does not show up under the mother's referral history. There was no indication a search was done at Intake on the allegedly inappropriate relative caretaker whom the mother had asked to care for the

child. The referent indicated the named relative in question had her children taken away by CPS due to drug use. A CAMIS search of that relative would have been reasonable and possibly could have influenced the screening decision due to the fact that the named relative had a history of CPS involvement. The decision at Intake to screen in the report as 'information only' was determined by the review panel to be reasonable. None of these issues were viewed as having any significance to the fatality incident two years later.

Recommendations: *None. Policies and practice standards for doing CAMIS searches at Intake are in place. Practice standards for identification of primary caretakers, including teen parents are available to Intake workers (Practice and Procedures Manual; CAMIS manual). The issue of teen parents in referrals has been discussed at regional Intake meetings on several occasions in the last several years and there are consensus staffings for Intake in place in Region 5.*

B. Issue: The information provided by the relative at the time of intake indicated a number of risk factors, but none that would suggest the infant was endangered (elevated risk, but not imminent). The most concerning allegation was that the mother would sleep for long periods of time with the infant present. The referral documentation was not clear as to whether or not the mother and infant were by themselves (i.e., no other adults present) when such long sleep periods occurred. Clarity of the situation would have been beneficial. The panel accepted the argument the referral might have been screened in with more specific information, but the decision of 'information only' was also considered reasonable.

Recommendations: *None. Improvements have subsequently occurred state-wide in disseminating to Intake workers the practice expectations regarding interviewing referents at Intake. This has largely come from training when statewide intake centralization occurred and via Peer Review data (both regional and state peer reviews).*

C. Issue: Consideration to accept the report for investigation was evidenced by the identification of subjects and victim. Efforts to get more information from the referent were documented. After being re-contacted, the referrer admitted she did not have actual knowledge about the parents sleeping all day and leaving the infant unsupervised. As the lack of supervision was the only allegation (although other risk factors noted), the referent's inability to state even indirect knowledge of such, made the 'information only' screening decision reasonable. The panel noted that at this point in the referral history, a pattern of inter-related concerns reported by relatives was surfacing.

Recommendations: *None*

D. Issue: The decision to screen in the report appears appropriate, given the additional information called into Central Intake (addendum to allegations). The identification of physical abuse as one of the identified CA/N codes was questionable, but the consensus

of the review panel was that the identification of negligent treatment/maltreatment was appropriate.

Recommendation: *None. A process for field Intake to provide feedback to Central Intake is already in place. Beginning in April 2004 a twice-annual statewide intake peer review process has been initiated, and the review tool has sample allegations and CA/N coding. Statistical data regarding compliance with expected Intake practice standards is generated twice a year as well.*

E. Issue: The investigation was initiated in a timely manner. The social worker made face-to-face contact with the alleged victim and subjects within timelines provided in policy. Collateral contacts were made with law enforcement, probation, paternal grandmother of the child, and later with chemical dependency evaluator/treatment provider. Criminal background checks were completed on the father and on the paternal grandmother (for potential placement decision), but not on the mother. The safety assessment was completed in a timely manner, as was the safety plan. However, the safety plan appears to be more of a service plan than a safety plan. A subsequent informal "safety plan" was also documented, and it relied heavily on "promise keeper" conditions (e.g., mother promises not to do drugs, etc.). Service Episode Records (SER) were generally entered within the timeframes designated by policy. The investigation was not completed within the expected timeframe, and the Notification of Findings was not sent to the parents in a timely manner (see below for additional findings regarding the Investigative Risk Assessment (IRA)). While many practice standards for conducting a high standard of investigation were met by the investigating social worker, some were not. None of these issues were viewed as having significance to the fatality incident one year later.

Recommendations: *None. High Standard of Investigation Training and Safety Assessment/Safety Plan Training are made available to regional social workers at least once a year in both Region 5 offices. Consensus building on Safety Assessment/Safety Planning has been conducted at the unit level in both regional offices, and is scheduled to occur every 3-6 months.*

Comment: The investigating worker was not present for the review. The supervisor, while not being available to participate in the review, was presented with the review panel's findings post review.

F. Issue: The investigation was not completed within 90 days as evidenced by the fact that the Investigative Risk Assessment and Notification of Findings were not completed until October 2003 (6 months from the referral date). Additionally, the risk assessment did not meet practice standards set forth in Region 5. The IRA did not summarize the investigation or the rationale for the finding decision. Region 5 practice standards require workers to write text for any risk factor in the matrix that is assessed as moderate risk or above. This did not occur. While the overall level of risk appears relatively accurate, there was no inquiry as to the parent's history of CA/N as children and the protective factors did not adequately address the family situation.

Recommendations: *None. Basic Risk Assessment training has been offered several times a year in Region 5 since 1998. Additionally, timeframes for completing investigations and findings is covered in High Standard of Investigation training offered annually to each CPS office in Region 5.*

Comment: The investigating worker was not present at the review. The supervisor, while not being available to participate in the review, was presented with the review panel's findings post review

G. Issue: At the time of closure for the investigation of the referral on April 12, 2003, documented information regarding the mother's post inpatient treatment progress (UA results, participation in out-patient treatment) indicated a deteriorating situation. Additionally, there was no documentation with regard to drug issues of the father who was in the home at the time of case closure. While the assigned worker did correctly assess the substance abuse factor to be of a significant risk factor (see Investigative Risk Assessment), the lack of progress of the parents to address substance abuse issues was deemed concerning by the review panel. However, the panel agreed that despite the mother's move from full compliance to no compliance after inpatient treatment, there was no sufficiency for filing a dependency due to the lack of evidence that the child had been significantly impacted or was endangered. It is important to note that subsequent contact with the family in June 2004 (prior to the fatality) showed the mother to be back in treatment and at the delivery of another child, tested negative for drugs.

Recommendation: *None. Children's Administration conducted "Lessons Learned from Child Fatalities" in every region in the state in 2004. A major component of that training involved critical thinking about a parent's failure to make progress in substance abuse treatment. The Department recognizes the need to give additional consideration to this issue in all cases where such issues exist, and to do so in a "shared decision making" process, should improve case disposition decisions.*

Comment: The investigating worker was not present at the review. The supervisor, while not being available to participate in the review, was presented with the review panel's findings post review.

H. Issue: For the referral on December 8, 2003, the decision to screen as 'information only' appears appropriate. The referent did not have information regarding the circumstances of the child.

Recommendations: *None*

I. Issue: The decision to screen the March 30, 2004 referral as 'information only' appears appropriate. The information regarding possible drug use by the mother who was entering the third trimester did not meet the criteria for acceptance of such a report.

Recommendations: *None*

J. Issue: The decision to screen the April 2, 2004 referral as 'information only' appears appropriate. Again, the information provided did not meet the sufficiency screen for accepting the report for investigation. The decision to "alert" the local hospital in anticipation of the mother delivering within the next two months was determined to be appropriate.

Recommendations: *None*

K. Issue: The decision to screen in the report of a drug using pregnant woman within 30 days of delivery was deemed appropriate for the referral on June 8, 2004. The CA/N history section of the intake indicated 16 prior referrals. This was misleading as many of those previous referrals involved the parent's families of origin.

Recommendations: *None. Beginning April 2004 a twice-annual statewide intake peer review process has been initiated, and the review tool samples the History of CA/N section of the referral module. Statistical data regarding compliance with expected intake practice standards is generated twice a year as well.*

II. Exceptional Social Work

A. Issue: The referral on June 8, 2004 was accepted as a Low Risk Standard (LRS) of investigation. The assigned worker made contact with the paternal grandmother who stated the parents were living with her and were currently "clean" (not using methamphetamine). A home visit was conducted which is unusual for a LRS case, but within policy. The child was observed in the home, and appeared to have both positive response and secure attachment to the mother. The mother was receiving WIC, PHN, and drug treatment services. The assigned worker did a Safety Assessment (although not required for LRS), and a voluntary service plan which stated the expectation that the family would continue to live with the paternal grandmother. A Family Assessment was also completed. Two days later the mother gave birth and hospital staff reported neither the newborn nor the mother tested positive for illicit drugs. Five days later the child was tragically killed when the paternal grandmother accidentally ran him over with a riding lawnmower.

Recommendations: *None*

Comments: The assigned worker exceeded the practice standards for conducting an LRS investigation. The worker and supervisor were present for the review and received the feedback.

Child Fatality Review #04-15
Region 3
Bellingham Office

Case Overview

This eight-year-old Caucasian girl died on September 1, 2003. She was profoundly impaired from Cerebral Palsy and had significant physical and intellectual compromises. She did not walk, talk, or have other verbal skills. She was extremely small for her age, which is not unusual given her disabilities.

The child had been put to bed at the normal time, and she was being fed through her feeding tube. The mother checked on her at 3:00 am and then again at 9:30 am. At 9:30 am she appeared blue, cool to the touch, and was not breathing. The mother started cardiopulmonary resuscitation and called 911.

The fire department responded and had stopped efforts to revive the child when the Sheriff's deputy arrived. Deputy Childers reported he had responded to a report of an unattended death. When he arrived at the residence, the fire department had just stopped efforts to revive the child. The mother stated the child had been adopted from Oregon and that she suffered from cerebral palsy. The child was on a number of medications (Chloral Hydrate for sleep and Caramazepine for seizures). Referent observed that she had a feeding tube in her stomach and was wearing diapers. The child has been under the care of Dr. Braun whom she last saw four months ago, and Dr. Heisinger, who originally prescribed the medications. The mother said she gave the child her normal medications on the previous evening, checked on her at 3:00 am, and then again at 9:30 am. At 9:30 am, the child appeared blue, cool to the touch and was not breathing. The mother started cardiopulmonary resuscitation and called 911. Mother told the referent that there are five children in the home, four of whom suffer from Cerebral Palsy.

An autopsy was not performed as the child's physician signed the death certificate indicating that it was an expected death. A call to the medical examiner provided information that they did not have jurisdiction as it was an expected death. The child weighed 17 pounds at the time of her death.

History

The family consisted of three biological children, ages 9, 14, and 17 in 1984 when the family began adopting young toddlers who were disabled by Cerebral Palsy and other conditions. Three girls from Washington State were placed in the home on the following dates: February 12, 1984, March 17, 1986, and January 9, 1988. On May 19, 1997, the decedent was placed in the home from Oregon. During 1998 the couple divorced with the father leaving the family home and apparently thereafter having limited contact with the children. Prior to the divorce, he appears to have been active in obtaining services and equipment for the adopted children. Following the divorce, the biological children, who were now adults, the four adopted children, and the mother were living in the home.

The case was open and receiving services from Division of Developmental Disabilities (DDD) for the disabled siblings from time of placement in the home. The decedent began receiving services December 1997. The DDD case manager saw the home and family at least one time per year and a nurse from the Northwest Regional Counsel was in the home at least every six months.

The first referral to Children's Protective Services (CPS) was made on September 20, 1999 by a registered nurse from the Northwest Regional Council who had visited the home. This referral occurred after the divorce and consisted of allegations of neglect. It was reported that 14 dogs were inside the trailer home; there were smells of dog urine throughout; three of the children were in cribs in one room with boxes stacked around them; and one of the children was getting food through a feeding tube that was leaking on the floor. There were no sheets on the beds; none of the children were clean; and the nasal passages were all closed with "crap and the tube into the belly is all crusted and caked." One of the children was tied to the crib although unable to stand up. The Division of Developmental Disabilities' records indicate that the three most disabled children were kept together, sleeping in cribs in a room 8' x 8'.

On September 27, 1999, a second referral from an anonymous referrer was received. This referral had similar allegations, but with additional information that the urine smell was so overwhelming that a utility worker could not even enter and complete their work. One room was so bad that he refused to enter. He had to open the window to breathe. This referral was screened 'information only.'

During the CPS investigation it was reported that the mother suffered from narcolepsy and sleep apnea, and her daughters were licensed practical nurses (LPN). One daughter was receiving funding from DDD to provide services to the children and was doing the medications for the children. It is reported the mother felt she was having problems getting the daughter to do the tasks assigned to her. The mother was eligible for up to 400 hours of supportive services from DDD during the month, and the daughter was supplying these services in addition to working 40 to 50 hours per week out of the home. The daughter was currently planning to move away. The nurse had concerns regarding the mother's inability to see her need for additional assistance once the daughter had moved.

One of the children's primary care providers was contacted and stated he knew the children well and had seen them four months ago. At that time, he stated that he did not have any concerns regarding the children, and the mother was perceived to be a steady, appropriate caregiver.

Basic needs funding and services and home support specialist services were provided to the mother so she could get her yard fenced and have the dogs outside.

On March 8, 2000, a summary assessment was completed with an overall risk level of '2 - moderate low risk,' and the case was closed.

A referral was received on February 3, 2003 from a registered nurse from Northwest Regional Counsel, who expressed concerns that children did not receive adequate stimulation and are kept in a dark room with broken light. It was reported that the home "reeks" of cat urine, and the mother was not consistent about washing her hands before cleaning the next youth. There was some help for the mother on weekends by her adult daughter and her husband who came over on Friday and Saturday.

This referral was investigated in cooperation with Adult Protective Services as some of the disabled children were now adults. The finding was 'unfounded for negligent treatment,' and the case was closed with a summary assessment of overall risk level being '1 - low risk.'

The last referral was received on September 6, 2003, which notified the Department of the child's death. The child had been put down to sleep at the normal time and the mother had checked on her at 3 am and then again at 9:30 am when she found the child. The child appeared blue, cool to the touch, and was not breathing. The child had been receiving her tube feeding, which took 16 hours to complete and which was done at night while child was sleeping as this was the quietest time.

The social worker who had responded to the February 3, 2003 referral was again assigned to the case. The social worker focused on an initial safety assessment for the one minor child remaining in the home and provided grief support to the mother and remaining disabled siblings who had been in the home at the time of the child's death.

Issues and Recommendations

I. Practice

A. Issue: The team felt that during the 1999 CPS investigation there was inadequate documentation of what the social worker saw when in the home and discussion with the caretaker regarding what had been reported concerning the children's condition. This is especially important given the allegations in the referral. The social worker documented the home as having a strong smell of animal urine and that it was necessary to conduct the interview on the porch due to the dogs inside barking. The lack of adequate exploration of the reported condition of the children as described in the referral leaves some questions of care unanswered. There was limited information regarding the medical condition or description of the children and only limited information regarding the cribs in the room where the children were kept. There was no documentation regarding their medical condition and how this impacted their care taking needs. There is no documentation of the caretaker's medical conditions being discussed or viewed in regards to the possible impact they may have upon the children's care.

There appeared to be an inadequate investigation regarding what role the daughter played in providing care for the children, and the issues identified by the mother of her not

completing tasks being paid for by DDD. The risk to the children and the impact upon the family of the daughter working out of the home was not explored, nor how this would impact the mother and her ability to provide adequate care for the profoundly handicapped children especially given the fact the husband was out of the home, and she was now a single parent and would be without assistance.

The social worker could have used stronger encouragement to the mother to obtain adequate in home services to address the caretaking needs of the children. There was no follow-up or attempt to obtain services for bathing and feeding that the mother indicated she could utilize, but were not covered under the Medical Personal Care contract. There was no documentation regarding who was residing in the home. There was inadequate planning and support provided to accomplish the necessary repairs and cleaning of the home in a timely manner. Tasks such as repair of the leaking roof and floor covering removal and replacement were not being accomplished. At the time of the closing summary assessment six months after the referral, there was documentation that the repairs still had not been completed, yet the case was closed without the social worker having viewed the residence to see if the children were still at risk. The home support specialist documented the mother's statement that it would be helpful to have somebody available to take her adult disabled daughter on outings. It does not appear that this was followed up on by anyone.

Recommendation: *Follow practice regarding thorough safety assessment and documentation.*

B. Issue: The documentation in the Summary Assessment did not adequately explain the basis for an inconclusive finding. The finding appears to be based on the physician's statement to the worker on the day of the referral that hygiene is important in that it could lead to respiratory problems given the children's condition. However, he would not advocate for the removal of the children for hygiene problems. There are issues surrounding what information may have been provided to the physician who had never been to the home. At the time of the conversation, the social worker also had not yet made a home visit. There was no documentation of the discussion with the mother regarding the allegations and concerns in the referral of the physical care of the children or her explanation for the conditions reported by the registered nurse. The focus of the investigation and provision of service appeared to turn to the physical needs of the home and away from the physical care of the children. The face-to-face with children and home visit did occur within the designated time frames. The documentation was lacking as to the basis for the finding of 'inconclusive.'

Recommendation: *Follow policy in regard to findings.*

Child Fatality Review #04-16

Region 4
Seattle Office

Case Overview

This 15-year-old Native American boy died on June 12, 2004 from a drug overdose. An investigator from the King County Medical Examiner's Office made the report to Child Protective Services (CPS).

This child had recently lost his grandfather. He had been cutting himself frequently. The medication box was locked, but he tore it open and ingested a lethal amount of his pills. The child was diagnosed with schizophrenia and when he was not on his medications he would become suicidal. He was taking Vicodin, Percoset and methadone.

The case was recently closed at the time of the boy's death. The following is the closing summary.

"Closing Summary as of December 31, 2003 on this 14 year old boy indicates that a petition was filed in June of 2000 due to neglect and physical abuse by his parents due to domestic violence, drug use, homelessness, etc. The boy's sister was also dependent, through the Kent office (This child was Native American through his father; the sister has a different father, is non-Native). This child had various placements; he didn't do very well in placement; didn't want to stay, and wanted to be with his mother. He had mental health and anger problems, as well as self-harm issues. He was returned home in July of 2002, and his sister was returned a few months later. In-Home Group Care was in the home through the YMCA until just now. The family stabilized much, had stable housing; both parents completed anger management and substance treatment, worked well with this worker and the YMCA. Dependency was dismissed in October of this year; case was held open until now so that the YMCA could continue with the family and provide them with services such as mental health services. Family has stable housing through Section 8; both brother and sister are in school. The boy will be attending a nearby mental health center where he will have his medication monitored. This has been a positive experience for the family; they have come a long way and are very committed to each other, though things will likely always be marginal due to family history and the boy's mental health issues."

There is a plan to provide Intensive Family Preservation Services (IFPS) to the family, as they have serious stress, grief, and loss issues due to the death of their son.

History

This family has a history of eleven CPS referrals, preceding this child's death. The referral history begins in 1994 and continues through October 2003. These referrals portray a family beset with domestic violence, substance abuse, neglect, physical abuse, and mental illness. Both this child and his sister were placed outside the home and were found to be dependent by the juvenile court. Eventually they were both reunited with their parents and the legal structure was dismissed.

On September 7, 1994, a referral was received indicating that two kids were playing outside late at night without supervision, and one child had asthma yet a family member smoked in the home. This referral was screened in as 'information only' and was not assigned for investigation.

On March 21, 1996, a second referral was received indicating that the mother's paramour reportedly threw a four-year-old girl into a couch, then the paramour "became psychotic" and went outside and threw a bicycle. This referral was screened in as 'information only' and was not assigned for investigation.

On November 4, 1997, the first accepted referral indicating allegations of physical abuse and physical neglect was reported. The brother and sister told a school counselor that mom's boyfriend/new husband was violent with both of them the night before. The children tried to stop a fight between the mother and boyfriend/new husband. They said he pulled a knife on the mom. There are no findings in CAMIS on this referral.

On February 4, 1998, a referral was received indicating the father slapped both children in their faces and assaulted his wife in front of the children and that the father had been convicted of assaulting his children and was recently released from jail. There are no findings in CAMIS on this referral.

On March 13, 1998, it was alleged the grandfather bit the girl on the "butt." It was accepted and assigned. There are no findings in CAMIS regarding this referral.

On May 19, 1998, a referral was received from a school nurse. She did not have any allegations, but thought the sister may have had more to tell her. This was received as "information only" and was not assigned for investigation.

On June 14, 1999, a referral was received documenting the family is having a great deal of difficulty providing minimally for the children. They were then living in a tent in a state park, and the kids were filthy. The parents were using drugs and were physically and emotionally abusive to them. This investigation was unfounded for physical abuse and founded for physical neglect.

On March 22, 2000, a school counselor called indicating allegations of emotional abuse and domestic violence. This was accepted for investigation. There was no finding in CAMIS.

On May 16, 2000, an anonymous caller reported that the mother was using crank and methamphetamine and that the drugs were accessible to the children. This was accepted and assigned for investigation. This referral was inconclusive for physical neglect.

On June 23, 2000, the Auburn Police placed the brother and sister into protective custody. This was accepted for investigation. The children had disclosed physical abuse to an aunt who then called police. The outcome was founded for physical neglect. The children were placed with the relatives, and the family went through services. The services included drug and alcohol assessment and treatment. The mother completed her services and improved, and both siblings

were returned in July of 2002. The dependency was dismissed in October 2002. The case remained open until December 31, 2003 to continue offering services to the family.

On November 22, 2002, a referral was received alleging domestic violence in the home. The boy hit his intoxicated step-father in the mouth and ribs. The mother and the child left the home and spent the night with relatives. This was screened in as 'low risk', and low risk cases do not require an investigation or a finding.

On October 24, 2003, a nurse reported the boy had been diagnosed with schizophrenia. She claimed he ran out of his medications and is hearing voices. He has a history of being suicidal. There was contact with the mother who claimed she supervised him 24 hours a day, seven days a week and all the medications were locked. This was screened in as 'low risk.'

Beginning in June 1999 there is extensive narrative in CAMIS (242 pages). There are two transfer/closing summaries that provide a great deal of information about the case activities. On August 5, 2002, the social worker wrote that the child was first placed on June 23, 2000. He had 14 placements, including with relatives, in foster homes, and group care. He had numerous runaway episodes, as well as detention for malicious mischief. The dependency was established as to the mother on September 13, 2000 and as to father on October 12, 2000. There was a guardianship petition with a relative filed.

The dependency was filed due to the ongoing substance abuse, domestic violence, neglect and physical abuse. Multiple community counseling, evaluation and treatment services were employed. This child transitioned to in-home group care services with the YMCA as of July 29, 2002. He also received psychiatric treatment for his psychosis and other disorders.

The social worker's closing summary dated December 31, 2003 stated the boy did not do well in placement, and always wanted to be with his mother. Despite all the problems, the family stabilized much, had stable housing, completed substance abuse and anger management, and worked well with the YMCA. The social worker thought the family had come a long way and were very committed to each other.

Issues and Recommendations

I. Practice Issues

A. Issue: The referral dated June 12, 2004 was never adequately investigated. The requirements for the High Standard of Investigation, Policy 2331, Practices and Procedures Guide, were not followed.

Recommendation: *The supervisor should monitor cases to ensure that all the required steps in an investigation are followed.*

B. Issue: On the referral dated June 12, 2004, face-to-face contact with the surviving sibling never occurred.

Recommendation: *The supervisor should monitor case progress to ensure that child victims are seen within the 10-day time requirements.*

C. Issue: The Safety Assessment was not completed until December 16, 2004 and without face-to-face contact with the surviving sibling.

   Recommendation: *The supervisor should monitor cases to ensure Safety Assessments are completed on time.*

D. Issue: The Investigative Assessment was not completed until December 10, 2004. The finding is 'unfounded for negligent treatment/maltreatment,' but without addressing any maltreatment as to the sister, the surviving sibling. The assessment was due September 13, 2004.

   Recommendation: *The supervisor should monitor cases to ensure investigations are completed on time, and that the basis for a finding is well-documented by SER and the Investigative Assessment.*

E. Issue: While the child was Native American through his father, the rest of the family is not. The case should be transferred to the King South Office, since the family resides in Auburn.

   Recommendation: *ICW should contact the King South Office to discuss the case transfer.*

Work Plan

The Area Administrator will develop a plan with her CPS supervisors for closer monitoring of CPS cases to ensure that policy requirements are met. The work plan development was completed on January 21, 2005, however, implementation has not been completed as of this writing.