Report to the Legislature

Quarterly Child Fatality Report

RCW 74.13.640

July - September 2009

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Children's Administration Quarterly Child Fatality Report

Executive Summary

This is the Quarterly Child Fatality Report for July through September 2009 provided by the Department of Social and Health Services (DSHS) to the Washington State Legislature. RCW 74.13.640 requires DSHS to report on each child fatality review conducted by the department and provide a copy to the appropriate committees of the legislature:

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

This report summarizes information from 20 completed fatality reviews of fatalities that occurred in 2009. All were reviewed by a regional Child Fatality Review Team.

There were no Executive Child Fatality Reviews completed during the third quarter of 2009. All prior Executive Child Fatality Review reports are found on the DSHS website: http://www.dshs.wa.gov/ca/pubs/fatalityreports.asp.

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

Region	Number of Reports
1	3
2	0
3	3
4	8
5	4
6	2
Total Fatalities Reviewed During 3rd Quarter, 2009	20

Child Fatality Reviews are conducted when children die unexpectedly and their families had an open case or received services from the Children's Administration (CA) within 12 months of their death. Child Fatality Reviews consist of a review of the case file, identification of practice, policy or system issues, recommendations, and 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 accidental in nature), to a larger multi-disciplinary committee where the child's death may have been the result of abuse and/or neglect by a parent or guardian.

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 2009. 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 Years 2009			
Year	Total Fatalities Reported to Date Requiring a Review	Completed Fatality Reviews	Pending Fatality Reviews
2009	44	21	23

The numbering of the Child Fatality Reviews in this report begins with number 09-02. This indicates the fatality occurred in 2009 and is the second report completed for that calendar year. The number is assigned when the Child Fatality Review and report by the Child Protective Services Program Manager is completed.

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.

Child Fatality Review #09-02
Region 4
King County

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

Case Overview
On January 16, 2009, the deceased child's mother placed her one-month-old son face-up near the head of her bed. She told investigators she did this around 6:15 a.m. The mother then laid next to him and fell asleep. She woke up around 11:00 a.m. and found her son face up, but unresponsive. She called 911 and was instructed to perform CPR. Paramedics arrived and pronounced this child dead at 11:44 a.m. No foul play was indicated. The home was noted to be dirty and unkempt. The police said that the parents have an extensive history of domestic violence. There are past reports of the parents using drugs and the child's father in legal trouble. The police reported there was a current restraining order on the father to stay away from the child's mother; however, he was not in the home at the time of the child's death.

The medical examiner listed the cause of death as SIDS. It was also noted that bed-sharing was a risk factor. The manner of death is natural.

Referral History
The family has a history of ten reports, prior to the death of the deceased child. Nine were screened for Child Protective Services (CPS), and one for Family Reconciliation Services (FRS). Of the nine CPS reports, six were accepted for investigation.

The CPS reports are remarkable for domestic violence (DV) and the presence of firearms in the home. On November 15, 2000, CPS intake received a report that the parents smashed out the windows of each other's cars. The case remained open for over a year with services in the home.

On February 21, 2003, CPS intake received a report that the deceased child's father had guns in the home. He already served jail time for possession of cocaine, and weapons charges. The five-year-old brother of the deceased child was interviewed by investigating social workers. He made no disclosures about problems in the home. This investigation was staffed with the community Child Protection Team (CPT). The case was closed after an offer of services was made to the parents. The parents did not engage in services. The case was closed with an inconclusive finding for negligent treatment or maltreatment.

On November 17, 2003, school officials reported the deceased child's six-year-old brother had a small bruise on his face. This was assigned for investigation, but the family moved before contact was made. The case was closed with an inconclusive finding.

CPS received no new reports for nearly four years. On January 11 2008, a school counselor reported attendance issues regarding the deceased child's 10-year-old brother. This referral was screened Information Only.

On March 5, 2008, the school counselor reported the 10-year-old brother of the deceased child was sleeping in class. The child said he had difficult sleeping because adults were in and out of his home at night. This referral was screened Information Only.

On May 11, 2008, a hospital social worker reported the 16-year-old brother of the deceased child was found passed out on a city bus. Law enforcement responded to this incident. A referral was made to CPS intake and the mother then asked for Family Reconciliation Services (FRS). The assigned FRS worker made attempts to contact the mother, but she did not respond to repeated requests to meet.

On May 29, 2008, law enforcement reported to CPS intake that the deceased child's parents poured gasoline on each other during a domestic violence incident. Both parents were arrested and police left the children with another family. The children were not placed in protective custody. The parents had separate homes. This referral was closed with a founded finding for investigation for negligent treatment or maltreatment. The worker reviewed the case with the CPT and received approval to close the case. Neither parent would engage in services.

On January 16, 2009, the King County Medical Examiner reported the deceased child's death. This referral was screened Information Only. The death was determined to be SIDS. In the fatality review, it was learned that the mother had some prenatal care, the infant was born full term (seven pounds, ten ounces), and was gaining weight satisfactorily.

Issues and Recommendations

Issue: This family had a history of moving and avoiding CPS as much as they could manage. A more effective response may have been to respond and engage with them as soon as possible in order to offer and provide services.

Recommendation: Maintain emphasis on initial face-to-face contact with victims, and engagement through Solution-Based Casework.

Issue: Infant death with bed-sharing as a risk factor in a family with a history of CPS involvement.

Recommendation: Children's Administration, or at least individual regions, should consider making a referral to the contracted Early Intervention Program (EIP) to provide a public health nurse for every family opened for investigation with an infant under the age of twelve months.

Child Fatality Review #09-03
Region 4
King County

This 12-month-old African American male died from an inflammation of the heart muscle.

Case Overview
According to the King County Medical Examiner, this one-year-old was pronounced dead at Children's Hospital, following unsuccessful attempts to resuscitate him. He was visiting his father at the father's home, and had a cold at the time of his death. He was sitting on his father's lap when he gasped and stopped breathing. Paramedics were called and performed CPR. The child was later transported to Children's Hospital. The autopsy revealed that the cause of death was lymphocytic myocarditis. This is an inflammation of the heart muscle, typically associated with a virus, and is an auto-immune response. It prevents the heart from beating. The manner of death is natural.

Referral History
On July 1, 2005, a relative called Child Protective Services (CPS) intake to report the police responded to a domestic dispute call on the night of June 30, 2005. The deceased child's mother and maternal grandmother argued, when the mother got a kitchen knife and attempted to leave with her baby (the older sister of the deceased child). Police responded and placed the child with the grandmother. This referral screened in for investigation by CPS and closed with an unfounded finding.

On May 13, 2006, a hospital social worker reported the then 13-month-old sister of the deceased child was admitted to the hospital for a skin infection around her eye. The parents had not cared for or attended to this child. They would not change her diapers or comfort her while she was in the hospital. The case was opened and remained so during the next three months. This referral screened in for investigation by CPS and closed with an unfounded finding.

On June 5, 2006, a relative called CPS intake and reported the parents had separated. The mother was evicted from transitional housing and left her daughter with questionable caretakers. This referral was screened as Information Only.

On June 29, 2006, a relative reported the parents left their daughter with her maternal grandmother after being evicted from a shelter. The parents were homeless. This referral was screened as Information Only.

On July 7, 2006, law enforcement reported to CPS intake a domestic violence incident that occurred between the parents in front of their 15-month-old daughter. The father assaulted the mother. He was intoxicated at the time of his arrest. The child was placed with her maternal grandmother on an informal basis. The referral was screened in for investigation

by CPS and completed with an inconclusive finding. On November 28, 2006, the parents signed a Voluntary Placement Agreement (VPA) formalizing the placement with the grandmother. On January 18, 2007, the parents separated again after another domestic violence incident.

The assigned social worker arranged for a Family Team Decision Meeting (FTDM) and decided to file a dependency petition. The petition was filed January 24, 2007. The daughter became dependent and remained with the grandmother. She was returned to her mother on November 5, 2007. Her dependency continued until June 4, 2009, when it was dismissed.

On January 4, 2009, a relative reported the mother left her infant son (the deceased child) with his grandmother for two weeks and did not provide supplies, money or other support. The referrer reported the mother had been parenting him adequately and there were no allegations of child maltreatment. The assigned Child and Family Welfare Services (CFWS) worker arranged for an in-home FTDM, and the team found that the mother's home was a safe environment for the children. This referral was screened as Information Only.

On January 25, 2009, the King County Medical Examiner reported this child died during the night. This referral was screened in for investigation by CPS since the circumstances were unclear. However, it was determined this child died of an illness and the investigation was closed with an unfounded finding for negligent treatment or maltreatment.

Issues and Recommendations

Issue: The decision to screen in for investigation the report of this child's death. The death was sudden and unexpected, but there was no allegation of child maltreatment. A CPS investigation may not have been necessary.

Recommendation: The Regional CPS Program Manager should discuss this issue with other CPS Program Managers throughout the state to determine if there is a general consensus on how to screen child fatality intakes that do not allege abuse or neglect.

Action Taken: The regional CPS Program Manager discussed this screening decision with the other regional CPS Program Managers and the consensus is that these intakes should not screen in for investigation.

Child Fatality Review #09-04
Region 4
King County

This three-month-old Caucasian male died from Sudden Infant Death Syndrome (SIDS).

Case Overview
According to the King County Medical Examiner, the mother attempted to wake the deceased child at 8:00 a.m. on January 28, 2009. He was blue and unresponsive. The mother called 911 and medics responded. After attempting CPR, medics transported him to Children's Hospital in Seattle. Medical personnel advised that the deceased child was in very critical condition but did have some heartbeat activity when he left the home. He was taken to Children's Hospital and died there on January 29, 2009. Law enforcement and medical examiner's investigators found no obvious signs of neglect. The home was well kempt. Both the bed and crib appeared to have been slept in. The autopsy determined his cause of death to be SIDS (temporarily resuscitated) and the manner of death is natural.

Referral History
On January 2, 2009, a relative called Child Protective Services (CPS) intake with concerns about the deceased child. The referrer expressed concern about attachment issues and felt there was no bond between mother and this baby. The child was approximately three-months-old and weighed less than nine pounds. The mother did not bathe him and put rice formula in his bottle against medical advice. The mother moved to Washington State three weeks prior. She delayed in taking him to a doctor.

This intake was screened for Alternate Intervention and assigned to a public health nurse. The nurse reported the mother was very attached to her infant and appropriately concerned for his care. She discussed nutrition, growth and development, and sleep safety/SIDS risk factors with the mother. The family did not respond to the nurse's efforts to meet with them for grief support after the death of her son.

On February 4, 2009, law enforcement reported to CPS intake their investigation of the death of this child. This intake was screened in for investigation and closed with an unfounded finding.

Issues and Recommendations
Issue: The January 29, 2009 report was appropriately screened and assigned for Early Family Support Services. The public health nurse was very thorough in reviewing sleep safety and SIDS risk reduction strategies with this young mother, and yet the infant still died.

Recommendation: Children's Administration should consider collaborating with Public Health and others to find the most effective ways to inform clients about infant death risks and to have the clients comply with that information.

Issue: The decision to screen in for investigation a report of the infant's death. It may not have been necessary since there were no allegations of child abuse or neglect.

Recommendation: The Regional CPS Program Manager should discuss this issue with other CPS Program Managers throughout the state to determine to see how child fatality intakes are screened.

Action Taken: The regional CPS Program Manager discussed this screening decision with the other regional CPS Program Managers and the consensus is that intakes that do not allege abuse or neglect should not screen in for investigation.

Child Fatality Review #09-05
Region 3
Whatcom County

This 12-month-old Caucasian female died from unknown causes.

Case Overview
On January 21, 2009, the deceased child had been fussy and slightly ill with a cold. Her mother took her into the doctor for a scheduled well child visit for check up and vaccinations. The deceased child was deemed well enough to receive the vaccinations, and she had four that morning. Her parents reported giving her Tylenol as directed that day and put her to bed about 5:30 p.m. She began fussing an hour or two later and her father reported comforting her and she went back to sleep. Her parents checked on her again around 9:00 p.m. and she was non-responsive. Emergency responders were called to the home. Attempts to revive her were unsuccessful, and she was declared dead. When evidence was being collected, officers located some marijuana in a closed container under the crib. The parents both admitted they smoked marijuana that day.

The toxicology reports from the autopsy were negative for any suspicious substances. There was no indication of physical trauma and no evidence of infection. Her airway was clear. The autopsy concluded that the child was an age appropriate female without evidence of trauma, abuse or neglect. A complete forensic autopsy revealed no specific cause for the child's death. The parents were referred to several services, including grief counseling, when the social worker made a home visit made after the death of their daughter.

Referral History
On January 2, 2009, medical staff called Child Protective Services (CPS) intake after the deceased child's parents brought her in to an emergency room with a blistering burn on her right hand. The parents were not precisely sure how the burn had happened, and hospital staff thought the situation suspicious. The child had crawled under the sink area and was pulling herself up on the pipes under the cabinet when super-heated water from the malfunctioning heater and leaking pipe spilled onto her hand. The parents had not been aware of the heater problem or leak.

The family doctor reported that the parent were conscientious about their daughter's health care, had a good record for bringing her in to the doctor for appropriate concerns. This referral was accepted for investigation and the CPS case was closed with an unfounded finding.

Issues and Recommendations
Issue: The team reviewed the record with the two social workers who were involved in the case. No issues were identified. The practice in this case was commendable, both in the

CPS investigation of the burn and the assessment done after the death. It was thorough, well documented work in accord with all policies.

Recommendation: None

Child Fatality Review #09-06
Region 6
Clark County

This 12-year-old Caucasian female died from a stab wound.

Case Overview
On February 22, 2009, this 12-year-old youth was reported missing by her parents at around 1:00 a.m. Police began a search of the area near the family home. The youth was found by her stepfather dead in a field later that morning. Police later arrested a stranger who met the youth just prior to her death. Law enforcement did not suspect family members in her death. The autopsy revealed the youth was raped and stabbed to death. The perpetrator pled guilty to murder and was sentenced to life in prison. The manner of death is listed as third party homicide.

Referral History
On February 4, 2008, a report was made to Child Protective Services (CPS) alleging sexual abuse of the deceased youth by her stepfather. The referrer reported the stepfather had no memory of an incident of abuse because he was intoxicated. The mother was working at the time of this incident. The referrer had no prior concerns of inappropriate behavior by the stepfather. The referrer said the mother most likely did not know of the alleged abuse. This intake screened in for investigation by CPS and closed with an unfounded finding for negligent treatment or maltreatment and sexual abuse. The child denied any abuse. The stepfather agreed to services to address his alcohol abuse.

Issues and Recommendations
Issue: During the course of the fatality review it was discovered that the stepfather, who was the subject of the sexual abuse allegation, was only identified at intake by his first name. The investigative social worker obtained the stepfather's last name but did not add him to the case file and did not make a finding as to the stepfather. The social work supervisor reviewed the case file for closure but did not catch that the stepfather was not added to the case.

Recommendation: The Area Administrator met with the social work supervisors and discussed case file review at closure addressing the need for the supervisors to make sure they are thoroughly reviewing cases at closure and returning to the worker to add participants in the case file as appropriate. This was also addressed during a management meeting with supervisors in July 2009.

Child Fatality Review #09-07
Region 4
King County

This nine-month-old Caucasian male died from Sudden Infant Death.

Case Overview
On February 18, 2009, the parents took the deceased child to a Pierce County hospital to be seen for cold symptoms. At the hospital the child was diagnosed with an ear infection, fever and bronchiolitis. He was given prescription medications. At home, the infant was fed and given a second dose of medications. Around 3:00 a.m. the infant went to sleep with both parents in their bed. The infant was placed face down on the father's chest. At around 8:00 a.m. the parents woke and found the infant lying stomach down on the father's arm and the infant's face was covered in blankets but not down in the bedding. The father started CPR, and the mother called 911. Medics arrived at the home but were unable to revive the infant.

The cause of death is sudden infant death associated with tracheitis and bronchitis and co-sleeping with an adult. Tracheitis is a bacterial infection of the trachea that can cause swelling and an upper airway obstruction.

The manner of death is undetermined.

Referral History
On January 8, 2007, a report was made to Child Protective Services (CPS) intake alleging the sister of the deceased child, then age four, was seen with bruising on her face, stomach, and cheek. The child also had a black eye. The parents explained that she was clumsy. The referrer reported seeing a handprint bruise on the child's buttocks. The investigating social worker interviewed the child and stepmother and concluded the report was unfounded for physical abuse. The parents were advised to enroll this child in Head Start.

On June 14, 2007, a teacher reported to CPS intake that the deceased child's sister had a black eye. The teacher also saw other bruising on this child. The parents' church offered parenting classes, but the parents declined. The intake was accepted for investigation of physical abuse. The CPS investigation was closed with an unfounded finding based on the child's explanation of being accidentally hit by a door. Law enforcement investigated and did not file charges. Medical records were obtained. Medical personnel had no concerns about the child's injuries.

On June 14, 2007, a teacher reported to CPS intake that the deceased child's parents had a child together. This report was sent to Law Enforcement to determine whether a criminal investigation needed to occur based on the age difference between the mother and father. The intake was screened as Third Party.

On October 10, 2007, a teacher called CPS intake and reported that the deceased child's mother complained that teachers did not properly supervise her daughter at school and she was attacked by another student on the playground. The child missed three days of school after stitches on her forehead opened. The referrer states that child never reported being harmed by anyone while at school or on the playground. This intake was screened in for investigation and closed with an unfounded finding for negligent treatment or maltreatment.

On February 29, 2008, school personnel contacted CPS intake and reported the deceased child's five-year-old sister missed her bus and decided to walk to school. She was found half a block away from the bus stop on a busy street. A passerby found the child and took her to school. Later, the child missed her school bus again and was seen on two major streets and was almost hit by a car. A school security officer found her and drove her to school. The child claimed her parents would not take her to school as they were asleep, so she decided to walk again. This intake was screened in for investigation and closed with an unfounded finding for negligent treatment or maltreatment.

On February 19, 2009, police contacted CPS intake to report the death of this nine-month-old child. The child slept in bed with his father nestled between his father's arm and his side. The parents woke and found he was not breathing. They attempted CPR.
The deceased child had a small bruise under his right eye that was suspicious in nature.

The previous night, the deceased child's two-year-old sister was seen in a hospital emergency room for lacerations on the inside of her mouth and on her chin. The deceased child's parent told police their six-year-old daughter pushed the two-year-old and her teeth went through her lip. This was confirmed by doctors at the hospital.

The parents reported that the deceased child was also seen that night for respiratory issues.

Police chose not to place the two and six-year-olds in protective custody. Law enforcement later determined that this child fatality was not the result of abuse of neglect. A finding is pending on the CPS investigation.

Issues and Recommendations
Issue: The investigation of a pattern of injuries on a four-year-old child.
The King South (Kent) office in Region 4 investigated two reports of suspicious injuries to the deceased child's eldest sibling. The parents claimed the child was clumsy; another time the mother accidentally closed a door and struck her on the head; a third injury during the second investigation was a laceration to the head when she was said to have slipped in the dark and hit her head on a corner.

Although workers obtained medical records, there was no consultation with Children's Administration medical consultants child abuse doctors, nor was the family asked to get an updated physical examination of their daughter.

Recommendation: Request medical consultation and physical exams when there is a pattern of reports and injuries to a young child.

Issue: Engaging the family in services.
The parents were very young and could have benefited from an evidenced-based parenting intervention, such as Parent-Child Interaction Training (PCIT) or The Incredible Years. Social workers suggested or recommended parenting but did not create a service plan or really engage the family to do that.

Recommendation: Focus on engaging families to participate in services that will actually improve their parenting skills and reduce the risk of child maltreatment.

Issue: Completion of the investigation by Region 5 CPS concerning this child's death. The assigned worker has confirmed that the investigation will be unfounded. However, the investigative assessment is still not completed in the electronic record.

Recommendation: Complete investigations within policy timelines.

Issue: Unsafe sleep environment.
The parents slept with an infant placed face down on his stomach and on the father's stomach.

Recommendation: Children's Administration should consider ways of partnering with public health and other agencies to increase caregiver's awareness of the risks of bed-sharing with an infant, and to promote safe sleep practices for infants.

Child Fatality Review #09-08
Region 1
Grant County

This four-month-old Native American male died from acute pneumonia.

Case Overview
On the morning of February 16, 2009, the mother of this four-month-old infant found him turning blue. She called 911 and the infant was transported to a hospital where he was pronounced dead. No abuse or neglect was suspected in this child's death. The Grant County Coroner's office determined that this infant died of acute pneumonia. This child was born prematurely and remained hospitalized for two weeks after his birth due to his lungs being underdeveloped.

The manner of death is natural/medical.

Referral History
On March 1, 2006, a report was made to Child Protective Services (CPS) intake alleging the deceased child's mother left her three children with babysitters. It was also alleged the mother used methamphetamine. This information was sent to the mother's tribe. This intake was screened Information Only.

On January 29, 2007, a report was made to CPS intake that the deceased child's brother, then six-years-old, was hit by his father and blackened his eye. The child's father was intoxicated at the time. Another sibling, then five-years-old, was still in diapers. She had a rash and did not speak. It was believed the mother was in jail. The referrer acknowledged she was told the child had a black eye; she did not see this herself. The referrer added she made this report in retaliation for an allegation of abuse made against her. This intake was screened as Information Only as the referrer had only third hand information about the allegations.

During the course of the investigation of the intake dated February 12, 2007, it was discovered that the mother contacted law enforcement about the assault of her son. The child had bruising to his face, ear, and buttocks. Police investigated the allegation and charged the child's father with Assault of a Child. The CPS Intake supervisor contacted law enforcement to impress the need for law enforcement to report incidents of child abuse to Children's Administration for investigation and case monitoring.

On February 12, 2007, a relative reported to CPS intake that the deceased child's mother left her two older children with drug users and the children were victims of severe neglect. These allegations were also reported to the tribal social services. The intake was accepted for investigation.

Law enforcement went to the family home and placed the children in protective custody due to the condition of the living environment. The mother completed a service plan aimed at addressing the risk to her children and the children were returned to her care. The CPS investigation was closed with a founded finding.

On July 20, 2007, hospital emergency room staff reported the deceased child's then two-year-old brother broke his leg. Hospital staff questioned the mother's explanation that her four-year-old daughter knocked him out of his car seat resulting in the injury. A treating physician said the injury was consistent with the mother's explanation. This intake was screened as Information Only.

On October 10, 2007, a neighbor called CPS intake and reported that the deceased child's mother was arrested. The referrer was babysitting the children and was unable to care for them long term. The mother was contacted in jail and made arrangements for her sister to care for her children. This intake was screened Information Only.

On October 25, 2007, a neighbor contacted CPS intake and reported the deceased child's mother was partying around all of her children. The intake was screened in for Alternate Response. The mother was contacted but declined all services and interventions.

On November 10, 2007, a report was made to CPS intake after fire fighters responded to a fire at the deceased child's mother's home. The mother left food cooking in the oven generating a lot of smoke. Firefighters noted the mother was very intoxicated and holding her infant daughter. The mother had her four children with her at the time.

The children were taken to a local hospital and placed in protective custody. Dependency petitions were filed on the three oldest children in tribal court. A dependency was filed in county Superior Court on the youngest child. The CPS investigation was closed with a founded finding.

Services provided through the dependency included drug/alcohol treatment, mental health evaluation and counseling, parenting classes, Home Support services, and Family Preservation services. The children remained placed in out-of-home care. The mother completed all of the recommended services.

The children were returned to her care in June 2008.

On February 16, 2009, the death of this four-month-old child was reported to CPS intake. The child's mother found him in the morning not breathing. He was taken to a local hospital where he was pronounced dead. Law enforcement was notified of this child fatality. A CPS Risk Only case was opened to assess the safety of the four siblings in the home. The child died of acute pneumonia.

Issues and Recommendations

Issue: No issues or recommendations were concluded by the fatality review committee. The child had been seen regularly by a physician and there were no concerns of abuse or neglect related to the death caused by acute pneumonia.

Recommendation: None

Child Fatality Review #09-09
Region 4
King County

This three-month-old Caucasian male died from positional asphyxiation.

Case Overview
On February 27, 2009, this three month-old infant was co-sleeping with five other family members when his mother awoke and found him unresponsive and partially covered by his three-year-old brother.

The family was staying overnight at the maternal grandmother's residence in King County. Medical Examiner Investigators attempting to re-create the scene at the residence learned that the uncle, his girlfriend, the deceased child, his three-year-old brother, and their mother were all sleeping on one mattress on the floor.

The deceased child was last seen alive around 1:30 to 2:00 a.m. on February 27, 2009. The mother reported she fed him, and placed him on his back to her left on the mattress, away from the others. During the night the three-year-old, who had been sleeping in a chair, also got into bed with the other family members. The mother awoke around 6:30 a.m. and found the deceased child now on her right side, face up, partially covered by his three year-old brother.

An aid unit responded to the 911 call from the family. The aid unit transported the deceased child to a local hospital where he was pronounced dead.

According to the King County Medical Examiner Record, the cause of death is asphyxia due to overlying. It also lists bed-sharing with multiple adults and children as a risk factor. The manner of death is accidental.

Referral History
On June 2, 2003, a mandated reporter contacted Child Protective Services (CPS) intake to report the brothers of the deceased child had sexualized behaviors after visiting relatives. This intake was sent to law enforcement for review. This referral was screened as Third Party.

On October 26, 2004, a child care staff reported to CPS intake that the deceased child's brother, then age two, had an untreated burn on his arm. He had several other burns on his torso. The family's apartment was filthy. The children's clothing was dirty. The intake was accepted for investigation of physical abuse and negligent treatment or maltreatment. The CPS investigation was closed with a founded finding for physical abuse and unfounded for negligent treatment or maltreatment.

Law enforcement investigated and placed all the children in protective custody. The investigating social worker filed a dependency petition. The court ordered out-of-home placement. In December 2004, the court ordered the children returned to the mother with services. The services included parenting instruction, a psychological evaluation with a parenting component, advocacy and support from a community domestic violence agency. The court and the agency were satisfied about the family's compliance and progress and the dependency was dismissed in March 2005.The case was closed in June 2005.

On October 29, 2005, law enforcement reported to CPS intake that the deceased child's mother and her boyfriend got into a verbal dispute. The mother later called police to report she saw marks on the deceased child's brother and alleged her boyfriend physically abused him. The child had a red mark on the side of his head, two dark marks on both sides of his face, and dark marks on both sides of his neck and collarbone. In addition there were red marks on his lower back and buttocks. A Safety Plan was written that included no contact with the boyfriend. The case remained open for services and monitoring. The intake was investigated by CPS and closed with a founded finding on the boyfriend for physical abuse and founded on the mother for failing to protect her child.

On September 7, 2007, CPS intake was contacted by a neighbor who reported a pattern of lack of supervision and harsh treatment by the mother. This intake was screened as Low Risk. A letter was sent to the mother advising her of the report and emphasizing the need for closer supervision.

On January 22, 2009, a school counselor reported that the deceased child's brother went to school with scabies and ringworm. His mother did not take him to the doctor until four days later. She took some of her children but not all. The school would not allow the others back in school until a doctor had examined and cleared them. This intake was accepted for investigation of Negligent Treatment or Maltreatment and closed with an unfounded finding.

The assigned worker conducted her investigation and observed the home environment to be relatively clean and spoke with the mother about the scabies issue. This case remained open for services. During this time, the mother's youngest child died while the family was spending the night at the maternal grandmother's home. The case continued to be open for grief support and Family Preservation Services (FPS).

Issues and Recommendations
Issue: Information about the infant's sleep environment.

Recommendation: When a family has an infant, workers should always ask about where the infant sleeps, and ask to see the room. Where available in the community, workers should provide a safe, portable crib to families in need, and a "safe sleep" kit to reduce the risk of sudden unexpected infant death.

Issue: Use of the Public Health Nursing Early Intervention Project (EIP).

Recommendation: Wherever available, workers should always make a referral for EIP services when a family has a child less than twelve months of age. Nurses are especially skilled at informing parents about safe sleep environments for infants.

Issue: Planning for safe sleep.

Recommendation: When workers learn of situations in which parents are bed-sharing with infants, they should write safety plans that will end that practice and replace it with a safer alternative.

Issue: The 2006 adverse finding on the mother for "failure to protect" herself and her children from domestic violence. The mother was the victim; her assailant tried to kill her.

Recommendation: Workers should become familiar with the Children's Administration new policy on domestic violence, which strongly discourages this practice in favor of holding the perpetrator accountable.

Child Fatality Review #09-10
Region 3
Snohomish County

This 11-month-old Caucasian female died from hyperthermia.

Case Overview
On March 2, 2009, this 11-month-old infant was found non-responsive by her nine-year-old sister when the sister went to get her from the crib. Emergency medical personnel were called but they were unable to revive her. The officers who came to the home said the room temperature was 100 degrees. The child's internal temperature was 106 degrees when she arrived at the hospital.

The investigating detective said the deceased child's parents left the home that morning around 9:00 a.m. to visit their newborn daughter who was in the hospital. They left their four children in the care of a relative. At 1:00 p.m., an emergency call came in to 911 saying there was a baby not breathing. The first detectives to the scene said the apartment was in "deplorable" shape with one and a half feet of debris on the floor of the deceased child's bedroom. The room was very hot. There was a thick blanket in the crib.

After the autopsy, the cause of death was determined to be hyperthermia and the manner was undetermined.

Referral History
On June 19, 2000, an anonymous called reported to Child Protective Services (CPS) intake on the condition of the mother's apartment where she lived with her then one-year-old daughter. The apartment had dirty diapers and other trash throughout. The child had to sleep in a bedroom with a broken window. This intake was accepted for investigation by CPS and closed with an inconclusive finding for negligent treatment or maltreatment.

On November 10, 2003, a social services worker reported to CPS intake a domestic violence incident between the deceased child's mother and her husband. It was also alleged her husband hit the mother's oldest daughter (not this child's father). The mother obtained a restraining order. They later divorced. The intake was accepted for investigation of physical abuse and negligent treatment or maltreatment. The CPS investigation was closed with a founded finding against the mother's husband and unfounded as to the child's mother.

On June 28, 2004, a neighbor reported to CPS intake that the deceased child's mother left her five-year-old and one-year-old home alone for several hours and that the apartment was dirty with cat feces. The intake was investigated by CPS and closed with an unfounded finding for negligent treatment or maltreatment.

On September 8, 2005, CPS intake was contacted by a neighbor who reported the conditions in the home were unsanitary and that the children, ages 6 and 2, were unkempt. There was also minimal food in the apartment. CPS social workers made an unannounced home visit the next day and found the situation to be within acceptable limits. This intake was accepted for investigation and closed with an unfounded finding for negligent treatment or maltreatment.

On July 31, 2008, law enforcement reported the deceased child's mother was receiving threatening messages on her phone from her ex-husband. She said he had assaulted her in the past. On this day he had left papers indicating he was seeking custody of their daughter. Police advised her to get a restraining order due to the threats and past violence. This intake was screened as Information Only.

On March 2, 2009, a father to one of the mother's four children called CPS to report that his daughter had to live in the same home as a "violent offender." He filed for custody of her and said the family court judge told him to call CPS with his concerns. He reported in 2007 police arrested the deceased child's father for assaulting the child's mother. The referrer believed the deceased child's father pled guilty and spent time in jail for the assault. He later returned to living with the mother and children. He said his daughter had witnessed the 2007 domestic violence incident. This intake was screened as Information Only.

Later on March 2, 2009, police called CPS intake to report a child death. The temperature of the bedroom in home was 100 degrees. The apartment was in deplorable shape. The child had a temperature of 106 degrees. Medics were unable to revive child. CPS began working with the family immediately with intensive services. The child's mother appeared enormously stressed during that first few weeks after the death, but agreeable to the services.

During the provision of services, however, it became increasingly apparent that the mother's mental health deteriorated to the point that she was unable to safely care for the surviving children. The deceased child's father and her extended family appeared unable to assure the safety of the children. The department consulted with doctors and hospitals who had been involved with the family for the past two years. In consultation with these practitioners, the agency determined that the mother was not able to safely parent her children and filed a dependency petition on the children. They were placed with their maternal grandmother.

Issues and Recommendations

Issue: The June 19, 2000 referral was closed without contact by CPS. The investigative assessment was completed by reliance on the report by law enforcement that documented their contact with the family.

Recommendation: The review team concluded that there may be a pattern among investigators of undue reliance on law enforcement, given the differences in methods and goals of investigation. The team recommended continued training for agency staff in working with law enforcement.

Issue: In the investigation of the referral dated September 8, 2005, the mother disclosed co-sleeping with her children. There was no documentation of discussion of this as a potential SIDS issue. It is the thought of this review panel that this agency may be able to take a more active role on education of families to this issue.

Recommendation: The team recommends that at the next regional CPS supervisors' meeting there be discussion of a regional protocol for education of selected families related to SIDS risks. This could include training by a certified SIDS trainer in "risk management" of SIDS; i.e., a discussion of how to reduce risk of SIDS in co-sleeping situations.

Issue: In the CPS investigations of three of the past referrals in this case, the review team noted that the investigations lacked thoroughness. In particular, there was inadequate use of collateral contacts to validate the statements of the person being interviewed.

Recommendation: It was the thought of this review panel that in order to avoid a pattern of less than complete investigations in this region, this topic should be discussed at the next CPS supervisors' meeting. It is recommended that there be an open discussion of "complete investigations" that include adequate use of collateral contacts to validate family statements.

Child Fatality Review #09-11
Region 4
King County

This 17-year-old Caucasian male died from drug overdose.

Case Overview
On March 3, 2009, this 17-year-old youth died from an accidental drug overdose. He was found dead, in his bed with his face in a pillow. The family described a normal evening the night before his death. He was last known alive at 10:30 p.m. on March 2, 2009. He was heard in his room, talking on his phone. At 5:00 a.m. on March 3, 2009, his parents heard his phone ringing and his father called to him. His mother found him unresponsive. They called 911, but the youth was pronounced dead at the scene.

The investigators learned that the deceased youth had a history of depression and Attention Deficit Hyperactivity Disorder (ADHD). He was diagnosed at age 15 and had been prescribed an antidepressant. There were also two notes the deceased youth wrote that raised the question of suicide. He had lost a close friend a year ago. He wrote an "Ode" to this friend, as well as a letter. This letter included a line, "I will see you in heaven." His parents were also concerned that he may have taken his mother's prescription medications.

The cause of death was determined to be acute combined methadone and citalopram (an antidepressant) intoxication, with the underlying causes of pulmonary congestion and congestive splenomegaly (engorgement of the spleen with blood). The Medical Examiner determined the manner of death to be accidental.

Referral History
On September 7, 2000, a mandated reporter reported to Child Protective Services (CPS) intake that the deceased youth's father was not being protective of his sons by allowing contact with an older cousin. The cousin, age 16, allegedly sexually abused the deceased youth's brother, then six-years-old, several years prior. This intake was accepted for investigation by CPS. This information was forwarded to law enforcement. The assigned worker closed this case with an unfounded finding.

On September 19, 2003, the deceased youth's mother contacted CPS intake to request an At-Risk Youth petition for her oldest son. He was physically assaultive to family members, ran away from home, and did not follow rules. The intake was accepted for Family Reconciliation Services (FRS). The assigned social worker contacted the mother and offered an appointment but she did not follow through and the case was closed.

On July 18 2006, the deceased youth's brother called CPS intake to request FRS in order to file a Child In Need of Services (CHINS) petition. He stated his mother was violent and hit all three boys. The brother said his mother grabbed him by a necklace he was wearing and

punched him in the chest. This was investigated by law enforcement and CPS. The parents have a high level of conflict over child custody. It was determined that the allegations were unfounded, and the case was closed.

On November 27, 2006, a mental health worker reported to CPS intake that police brought the deceased youth to a hospital, due to suicidal ideation. There were additional risk factors, including the mother's mental health issues and lack of compliance, the sons' medication and lack of monitoring. There were on-going child custody issues between the parents. This intake was accepted for investigation and closed with an inconclusive finding for negligent treatment or maltreatment. The youth completed a psychological evaluation and was under the care of a pediatrician.

On May 16, 2007, a relative called CPS intake to report the father's neglect of his three sons. The youngest, age 12, was picked on and hurt by the older two brothers, including the deceased youth. The referrer stated the father was not following through with counseling for the deceased youth. This intake was screened in for investigation of negligent treatment or maltreatment and closed with an unfounded finding. The youth was seeing a mental health counselor and taking antidepressant medications.

On February 27, 2008, a relative called CPS to report that the older brothers, including the deceased youth, were abusive to their 12-year-old brother. The last time the referrer observed this was between July and December 2007. The intake was accepted for investigation. The assigned worker spoke with all three boys; they denied any mistreatment. They spoke about the on-going child custody issues and conflict with their mother. (Note: despite being divorced, the deceased child's parents were living in the same residence at the time of their son's death). The investigation into this intake was closed with an unfounded finding.

On March 3, 2009, the King County Medical Examiner reported the death of this youth. It appeared the youth died from an overdose, either accidental or suicide. The Medical Examiner noted nothing suspicious about the death. The youth had a history of depression and was seeing a psychiatrist. This intake was screened as Information Only.

Issues and Recommendations
Issue: None

Recommendation: None

Child Fatality Review #09-12
Region 4
King County

This five-year-old Native American female died from asphyxiation due to fire.

Case Overview
On January 22, 2009, this five-year-old child died from the inhalation of the toxic products of combustion and thermal burns. The manner of death is accidental. A King County Fire Investigator called the Medical Examiner to report the death of this five-year-old female. She was found in an upstairs bedroom covered by insulation that had fallen from the attic with a dog nearby. Her body was badly charred. This residence was a fully engulfed structure fire.

The members of the home included the mother, her sons ages 17, and four, and her daughters ages ten and five (the deceased child). On January 22, 2009, around 4:45 a.m. to 5:00 a.m. the mother left the home to take a friend to work. 911 received a call about the fire at 5:41 a.m.

According to investigators, the 17-year-old woke to the smoke alarm. He found a fire in his mother's bedroom and his four-year-old brother in his mother's bed. He took him upstairs and tossed him out the window to the lawn. He told his 10-year-old sister to jump. He looked for the deceased child but the smoke was too thick. He jumped from the window with the 10-year-old. The four year-old brother suffered life-threatening injuries from the fire, but survived.

The King County Sheriff's Fire Investigation Unit determined that the source of the fire was an electrical event with an outlet in the mother's bedroom.

Referral History
The family has a history of eighteen reports to Child Protective Services (CPS) preceding the death of this five-year-old. These take place between October 11, 1996 and April 25, 2008. Sixteen reports were screened accepted for investigation of neglect (negligent treatment or maltreatment). Two reports were screened Information Only. Five investigations were closed with founded findings-more likely than not, abuse or neglect (as defined in the Washington Administrative Code (WAC)) occurred. Five reports were closed with unfounded findings-more likely than not, abuse or neglect did not occur; two were closed with inconclusive findings and four had no finding documented in the electronic record.

The history documents chronic neglect with multiple incidents of very young children left unsupervised, hungry, dirty and in dirty diapers. The father has a sex offense conviction. Substance abuse may have been a contributing factor to the abuse. In 2007, the deceased

child and her then three-year-old brother were badly burned when they pulled a pot of boiling water off of the stove.

The responsibility for providing services to this family has been shared between the Children's Administration Office of Indian Child Welfare (ICW) in Region 4 and the Indian Child Welfare program with the Muckleshoot Tribe. The Tribe and Region 4 have an arrangement in which CPS investigates, but the Tribe will also assign a social worker to arrange services. The Muckleshoot Tribe has a tribal court and can assert legal jurisdiction as to their children and families (at the time of this child's death, the four children were under a Tribal Court In-Home Dependency Order). Children's Administration cannot initiate dependency proceedings on children whose family is domiciled on an Indian reservation.

From 1996 to 2002, CPS received nine reports but there are few case notes in the electronic record. Only one of these reports in 1997 is listed as founded for neglect. The detailed case records begin with the intake received April 25, 2003 and screened in for investigation of neglect. The report alleged that the mother left the deceased child's older brothers to care for their younger sister while she worked evenings. (The father's teenage son was also living with the family at this time, though no longer lived in the home at the time of the fire). She did not make adequate arrangements for their physical care and the boys had behavioral problems. The assigned CPS investigator worked closely with Muckleshoot ICW program to assess risk and develop a service plan.

On September 24, 2003, the Muckleshoot ICW social workers and the Region 4 ICW social workers met with the tribal ICW Committee (which has a similar role to Children's Administration Child Protection Teams) to discuss and review this case. It was mutually agreed that the case could be closed because the parents followed through with treatment and provided for the children's basic needs. The parents followed through with the plan and recommendations of the tribal substance abuse program. The investigation was unfounded for neglect and the case was closed.

On October 26, 2004, CPS intake received a report that the deceased child's sister, then age six, had chronic head lice, multiple school absences, and may have been left alone with a younger sibling (the deceased child). The mother had been hospitalized for complications of pregnancy and gave birth to a son in November 2004. The parents maintained that they had supportive friends who were helping to care for the other children while the mother and the baby remained hospitalized. This intake was screened in for investigation and closed with an unfounded finding for negligent treatment or maltreatment and the case remained open.

On January 27, 2005, hospital staff reported that the parents visited their premature infant twice in 11 days. Also, before his transfer from another hospital, staff there noted infrequent visits too. The parents claimed that they were ill and were told not visit if ill; the

mother said she called daily. The assigned workers made a referral for a public health nurse (PHN). On May 25, 2005, this case was reviewed with the tribal ICW Committee. The team decided to have the workers visit the home one more time, then close the case. The investigation was completed with an unfounded finding for neglect and the case was closed.

On May 10, 2006, CPS intake received a report that the deceased child, then 2-years-old, and her brother, then 17 months of age, were found unsupervised on a playground next to the Muckleshoot Tribal Housing Office. They were very dirty and appeared to have respiratory problems. A housing worker brought them to the office and no parent inquired about them, even after three hours had passed. A sheriff's deputy found the father and brought him to the housing office.

The workers decided that the children could return home with a safety plan. The plan included medical exams, the Birth to Three programs at daycare, PHN, and a back-up plan for help with supervision. The father signed this plan. This intake was screened in for investigation of negligent treatment or maltreatment and closed with an unfounded finding. The Muckleshoot ICW program and Region 4 ICW mutually agreed to close the case.

On July 11, 2007, CPS intake received a report that the deceased child, then age three, and her two siblings, age eight and two, were left home alone for over five hours. The children went to neighbors several times asking for food and even when the father returned in the evening he did not provide care. They did not look well cared for. The two girls' hair was matted and needed to be brushed. The three-year-old had visible tooth decay. The two year-old was wearing only a diaper all day. The intake was accepted for investigation by CPS and closed with a founded finding for negligent treatment or maltreatment.

On August 10, 2007, two separate reports were made to CPS intake. Muckleshoot Tribal Housing Authority staff reported during a routine inspection that the three youngest children were observed to be filthy; there was an odor of spoiled food and garbage, and the residence was a health hazard.

Another intake alleged that the deceased child and her younger brother pulled a pot of boiling water off the stove and suffered severe burns. The brother had burns covering 22 percent of his body and the deceased child was burned on 7 percent of her body. They were airlifted to Harborview Hospital. The father claimed he had answered the door or had a phone call when this incident occurred.

The social workers arranged for contracted Intensive Family Preservation Services (IFPS) and for more PHN services. The parents cleaned up their apartment and discarded many of the children's items due to lice infection. They replaced clothing and bedding items. These intakes were screened in for investigation of negligent treatment or maltreatment and closed with founded findings.

The parents followed through on medical appointments but were slow to respond to the IFPS and PHN services. They were initially compliant, then stopped engaging in services and conditions in the home appeared to deteriorate again. A shared planning meeting on October 15, 2007 with the service providers resulted in a decision to continue the voluntary services plan.

On November 13, 2007, an IFPS provider reported that she came to the home for an appointment and found the deceased child in her underpants and her younger brother with no clothes on. The father was asleep and the kids had to wake him. The house smelled of garbage. The kids were not attending tribal day care because they were behind in immunizations again. This intake was accepted for investigation and closed with an inconclusive finding. The case remained open with an extensive voluntary service plan, with little compliance or progress.

On April 25, 2008, CPS intake was again contacted after the deceased child and her younger brother were found outside, in diapers, unsupervised. The parents were not home, the house was dirty. There were no clothes for the children. The deceased child had head lice. Law enforcement was contacted and placed them in protective custody with a grandmother in Tacoma.

This intake was accepted for investigation and was eventually closed with a founded finding. The Muckleshoot ICW social worker filed a dependency petition in Muckleshoot Tribal Court and arranged for an aunt to move into the family home while the parents moved out. This allowed the children to continue with school and services without disruption. The Children's Administration case was subsequently closed, but the Muckleshoot ICW case remained open.

The case was still open with the Muckleshoot ICW Unit at the time of the house fire that resulted in this child’s death and severe injuries to her brother. The legal status of the children at that time was in-home dependency as ordered by the Muckleshoot Tribal Court.

The report of the fire and death was received on January 22, 2009. This intake was screened in for investigation of negligent treatment or maltreatment. The King County Medical Examiner reported the death of this child in a house fire at the family residence. The preliminary information was that the mother left the house around 5:00 a.m. to take a friend to work. Two children woke to the smoke alarm. Three of the children were able to get out of the house. The oldest brother attempted to find the deceased child, but could not find her due to smoke. Her body was later found by investigators. The King County Medical Examiner determined this fatality to be an accident due to faulty electrical wiring. The CPS investigator was waiting for the fire investigator’s final report to make a finding in the case. The worker’s supervisor approved of this action. The case remained open with both Region 4 ICW Office and Muckleshoot ICW Unit.

Issues and Recommendations
Issue: Addressing families with repeated referrals for child maltreatment.

Recommendation: Region 4 will offer a meeting with the tribe to discuss the state-tribal partnership in addressing families with repeated referrals for maltreatment.

Issue: There currently is not a signed Memorandum of Understanding between the Muckleshoot Tribe and Region 4, pertaining to each agency's roles and responsibilities for Indian Child Welfare cases.

Recommendation: Region 4 and the Muckleshoot Tribe should consider finalizing a Memorandum of Understanding.

Issue: The CPS investigation has not been completed. This is an unusual case and the investigator needed information from other sources in order to make a finding.

Recommendation: Now that the social worker has this information, he should complete the investigation.

Child Fatality Review #09-13
Region 4
King County

This four-month-old Caucasian male died from hypoxia.

Case Overview
On March 7, 2009, this four-month old died at a King County hospital. He was admitted to the hospital on February 28, 2009 for breathing difficulties and a bronchiolitic cough. He was placed in the pediatric intensive care unit. On March 3, 2009, he experienced cardiac arrest resulting in neurological damage. A neurological examination on March 6, 2009 revealed that he would not recover. The family decided to withdraw life support on that date and the child died on March 7, 2009.

The autopsy was done at the hospital, not by the Medical Examiner. The cause of death was hypoxia (lack of oxygen) with the underlying causes of hypoxic ischemic encephalopathy (brain damage caused by hypoxia), and bronchiolitis (an acute viral infection of the small air passages of the lungs). The manner of death is natural.

Referral History
On May 6, 2008, a neighbor reported to Child Protective Services (CPS) intake that the deceased child's brother was with their mother's boyfriend at the school bus stop. The boyfriend appeared to be intoxicated. The referrer said the boyfriend is a drug dealer and was recently released from jail.

When the caller spoke with the mother, she also appeared high on some drug. The mother does not come to the school bus stop to pick up her son. The referrer walked him back to the mother's home several times. The referrer claimed the mother is a heroin addict and is on methadone as well as using methamphetamines.

This intake was screened in for investigation by CPS. The investigation revealed that the mother had an addiction to Oxycontin, which occurred after she was prescribed this drug for a prior injury. She was on methadone for this addiction. The mother submitted to random urinalysis which confirmed the only drug found was methadone. The issues with family members meeting the six-year-old at the bus stop after school were also resolved. The intake was accepted for investigation and closed with an unfounded finding for negligent treatment or maltreatment.

On February 4, 2009, a relative contacted CPS intake to report the deceased child's mother asked his father to take care of the child. The referrer felt that the father was incapable of caring for an infant. The father picked up his son (the deceased child) from the mother he had a diaper rash, smelled badly and was dirty. The referrer said the mother is physically

abusive toward the father and other adults. The referrer feared the mother or her boyfriend could be a danger to the child. This intake was accepted for investigation by CPS.

This relative was caring for the child when the father was arrested. She called Seattle Police to report she could no longer care for the child. The deceased child was placed in protective custody by Seattle Police. The mother was unaware that this relative was caring for her son or that the child's father was arrested. The assigned social worker determined that the child could be safely returned to the mother with a safety plan.

On March 2, 2009, the social worker received a message from the public health nurse (PHN) working with this family. She said that the deceased child was admitted to the hospital with Respiratory Syncytial Virus (RSV). This attacks the lungs and breathing passages, and can be severe for infants. It is the most common cause of bronchiolitis and pneumonia in infants.

On March 6, 2009, the social worker received a call from a relative who reported the hospital was taking the deceased child off life support. The social worker made follow-up appointments with the family and obtained the medical records and death certificate. The investigation was closed with an unfounded finding.

Issues and Recommendations
Issue: None

Recommendation: None

Child Fatality Review #09-14
Region 1
Whitman County

This three-month-old Caucasian female died from asphyxiation.

Case Overview
On the morning of March 15, 2009, the mother of this three-month-old infant and her two children, a two-year-old and the deceased child, were co-sleeping in one bed. The mother awoke at approximately 10:00 a.m. and noticed her daughter was not breathing. She picked up the infant and went out on her apartment balcony screaming for someone to help her. The apartment manager contacted 911 and came in the apartment to initiate CPR. First responders to the scene continued CPR although it was clear that the infant was deceased. The County Coroner estimated the time of death to be approximately between 5 a.m. and 6 a.m.

Referral History
On August 30, 2006, a report was made to Child Protective Services (CPS) intake alleging the deceased child's mother would not allow the father of her oldest child to have contact with their son. The referrer reported that the mother is bi-polar, off her medications, drinks and drives with the baby in the car. It was further alleged that she becomes violent when she drinks.

The intake was screened as low risk and referred to the Alternate Response System (ARS). A referral was made to the Early Intervention Program (EIP). The EIP nurse met with the mother. The mother denied being diagnosed bi-polar or taking medications. She also denied drinking with her son in the car. The mother received information regarding infant case management through Public Health and elected to use that program instead of EIP.

On December 13, 2006, CPS intake received a report that the deceased child's mother was arrested for driving under the influence. Her oldest child, a six-month-old son, was in the back seat of her vehicle. Law enforcement charged her with child injury due to her son being in the car. This intake was accepted for investigation. The investigation was completed with a founded finding for negligent treatment. The case remained open for services.

On January 5, 2007, a Public Health Nurse (PHN) contacted CPS intake with concerns that the deceased child's mother, following her DUI arrest, had her seven-month-old back in her care. The intake was screened Information Only as it was a report of the DUI and no new allegations of child abuse or neglect. The case was still open from the previous intake.

On February 5, 2007, CPS received information that the deceased child's mother was extremely intoxicated and there was an altercation that resulted in a police response. CPS

had spent three months attempting to have the mother engage in a chemical dependency evaluation and other services.

On April 5, 2007, a neighbor reported witnessing the mother use methamphetamine and drinking alcohol with her son present. Law enforcement went to the home on April 6, 2007 at CPS' request to conduct a welfare check of the child. Police found evidence of marijuana use. The home environment looked good as did the child. The mother had a positive urinalysis for marijuana. The CPS investigation was closed with an inconclusive finding.

On November 15, 2007, CPS intake received a report from law enforcement that the mother's paramour was arrested following a domestic violence incident. Both the mother and her paramour appeared intoxicated. Police left the child in her care. This incident occurred over a weekend, but law enforcement waited to report this incident directly to the local office instead of contacting Central Intake afterhours.

The mother filed a restraining order against her paramour and she agreed with a safety plan. Drug/alcohol and mental health assessments were scheduled for the mother. She did not actively engage in these voluntary services. She later moved in with her parents who have been protective and informative in the past. The case was closed with an unfounded finding.

On December 26, 2008, CPS was notified that the mother gave birth to a baby girl (the deceased child) at her parents' home. The mother was involved with Women, Infants, and Children (WIC) and Public Health. CPS referred this case to Early Family Support Services (EFSS) through Public Health. The EFSS provider closed the case on February 1, 2009 with an exit summary that the mother originally agreed to participate with EFSS then refused. She said she would work with the infant case management through Public Health.

On March 15, 2009, this child died of positional asphyxia while co-sleeping with her mother and brother. CA intake was notified after a social worker read about the death in the newspaper. An intake was created and screened as Information Only. The death was determined to be accidental.

Issues and Recommendations

Issue: Law enforcement in Whitman County reported, while calling in intake dated November 15, 2007, that Central Intake was not contacted during after hours because police do not know if someone will be dispatched and if so it takes too long for a response.

Recommendation: The area administrator and office supervisor will use existing forums to meet and discuss this issue with law enforcement throughout Whitman County.

Child Fatality Review #09-15
Region 3
Island County

This 13-year-old African American male died from a drug overdose.

Case Overview
On March 9, 2009, law enforcement responded to a call at the home of the deceased youth and his mother. The deceased youth collapsed in the kitchen about 4:00 a.m. Police officers began CPR, and he was taken to a local hospital and then to Children's Hospital in Seattle, where he died on March 14, 2009 without regaining consciousness. Initially the death was believed to be from natural causes, but after full autopsy results were received, the cause was determined to be anoxic encephalitis (swelling of the brain due to a lack of oxygen) and "probable acute opiate intoxication." Morphine was found in his system.

On July 1, 2009, law enforcement closed its investigation into this youth's death. The investigation revealed that the deceased youth talked with friends on the phone for several hours the previous evening before his collapse, and the friends reported he appeared to be fine. He told these friends that he had taken some pills. The police report concluded that, "it appears that this death is an accidental overdose of morphine, and it is unknown where the child obtained these pills."

The manner of death is undetermined.

Referral History
On December 4, 1996, a report was made to Child Protective Services (CPS) intake alleging an unrelated infant died of SIDS while in the care of the deceased youth's mother. It was suspected that she operated an unlicensed childcare. The mother was watching children and went to the store for wine, leaving friends to watch the children. When she returned, smelling of alcohol, the child had died. Police reported the mother was known to them as an alcohol and marijuana user with a "short fuse." This intake was investigated by the Division of Licensed Resources.

On June 25, 2002, a neighbor reported to CPS intake that the deceased youth's mother smoked "crack" cocaine in her poorly ventilated home in the presence of her son, then seven-years-old. She also sold prescription drugs openly and drank excessively. The referrer said the child's supervision was inadequate. This intake was accepted for investigation and closed with an unfounded finding.

On March 16, 2003, a neighbor reported to CPS intake getting into a verbal altercation with the deceased youth's mother that escalated to the point where the police were called, and the mother was arrested. Her son, the deceased youth, was present during this

altercation. This intake was accepted for investigation and closed with an unfounded finding.

On October 1, 2003, a neighbor called CPS to report that the deceased youth frequently had to wait up to two hours on the porch for his mother to return home. The referrer often heard the mother screaming at her son late at night. This intake was screened in for investigation, and the case remained opened. The mother agreed to a safety plan.

On December 14, 2003, a hospital social worker contacted CPS intake and reported the deceased youth's mother was brought to a hospital by ambulance after being found at her home, incoherent. She tested positive for cocaine, and the diagnosis was possible toxic psychosis from that substance. The youth was at his aunt's house. It was unknown how long he had been there. This intake was screened in for investigation and closed with a founded finding for negligent treatment or maltreatment. The mother agreed to a service plan.

On February 20, 2007, a social service professional reported to CPS intake that the deceased youth, then 11-years-old, and his mother were staying in a motel. It was reported that the mother was spending much time in the bar leaving her son alone in the room. She reportedly frequently had guests that were drug users and dealers. This intake was screened for an Alternate Response System (ARS) and a letter was sent to the mother.

On April 18, 2007, law enforcement responded to the motel where the mother and the deceased youth were staying. Both she and her boyfriend were drunk and disorderly and it took the officers to calm them down. The deceased youth was there and was also involved in trying to calm down his mother. Police officers did not believe the youth to be in danger. This intake was screened as information only.

On October 16, 2008, school staff called CPS to report they were concerned about the mother's state of mind. She had called the school that morning screaming, claiming someone had given her son (the deceased youth) a black eye. School officials were able to talk to the child who said he was not hit, rather he had just rubbed his eye. This intake was screened as information only.

On March 16, 2009, the King County Medical Examiner reported the death of this 13-year-old youth. The youth collapsed at home and was eventually taken to Children's Hospital, where he died on March 14, 2009. The referrer reported the youth appeared to die from natural causes. This intake was screened as information only.

Issues and Recommendations

Issue: The review team noted deficits in practice in the investigation of the earlier referrals, particularly those in 2002 and 2003. The investigations appeared cursory, with

inadequate child interviews and insufficient use made of collateral contacts to validate parent statements. Safety assessment and safety planning were also identified as issues.

Recommendation: The team recommends additional training for social workers in the region in the best use of the safety assessment tool and best practice in safety planning. This training should also address improving worker skills in validating information learned in the investigation stage.

ACTON TAKEN: The four primary investigations in this case were handled by two social workers, both of whom have left child welfare social work with families.

Issue: The review team saw the chemical dependency evaluation used in this case in 2004 as inadequate. An "expanded assessment" according to contract, should be much more inclusive than this appeared to be and should contain information gathered from collateral contacts.

ACTION TAKEN: Since the time of this evaluation, another provider has been contracted to provide the expanded assessments.

Child Fatality Review #09-16
Region 6
Clallam County

This nine-month-old Caucasian female died from asphyxiation.

Case Overview
On March 18, 2009, this nine-month-old child was taken to a local hospital then flown to Harborview Hospital. She was not breathing when paramedics were called. The child's father said he was in bed with the baby. The father weighs about 300 to 350 pounds. The bed was full of bedding. There were many sacks in the bedroom. There was a plastic sack on the bed and the baby rolled over onto the plastic sack.

The manner of death is undetermined.

Referral History
On February 27, 2009, an anonymous report was made to Child Protective Services (CPS) intake alleging months of physical and emotional neglect on the part of the parents, toward their two daughters, ages two-years-old and eight-months-old (the deceased child). The referrer stated the family lost their house and are now living with another family who has a lot of children and dogs. The referrer stated she always felt the children were being neglected in that the mother and father never pick up and hold the children and do not interact in a caring or nurturing way. The referrer stated that the deceased child is placed in a "jumper" and stays there all day. One year prior, the parents were working outside their house and their 2-year-old cried for over one hour, and they never responded to her needs. The children do not receive any affection and the father does not show any emotion. The referrer said it appeared that the parents had no interest in their children. This intake was screened for an Alternate Response System (ARS).

On March 18, 2009, law enforcement reported to CPS intake that this nine-month-old child was airlifted to Harborview Hospital. She was not breathing when paramedics were called. The child's father said he was in bed with the baby. The father weighs about 300 to 350 pounds. The bed was full of bedding. There were many sacks in the bedroom. There was a plastic sack on the bed and the baby rolled over onto the plastic sack. The referrer said the home was not fit for anyone to be living in. There is laundry, bags of clothing, food coming out of the oven, and on top of the stove. There are power saws on the floor in the home, and a heater that is close to flammable items. This intake was accepted for investigation and closed with a founded finding for negligent treatment or maltreatment. The surviving sibling was placed in protective custody.

Issues and Recommendations
Issue: The intake received on February 27, 2009, was appropriately screened in for Alternative Intervention. This intake was referred to Healthy Families of Clallam County.

Upon receipt of the March 18, 2009 intake contact was made with Healthy Families of Clallam County to find out the status of their involvement with the family. Healthy Families of Clallam County could not locate the case or paperwork referring the family to them. They did find faxes from the date the referral was sent to them and one that had only one page but no subsequent pages.

Action Taken: As a result of this, Healthy Families of Clallam County is requesting that anyone from the Port Angeles DCFS office who faxes documents to them, confirm with a follow-up telephone call.

Child Fatality Review #09-17
Region 5
Pierce County

This two-month-old Caucasian male died from asphyxiation.

Case Overview
On April 5, 2009, the Pierce County Medical Examiner's Office notified Child Protective Services (CPS) intake of the death of this two-month-old infant. On the morning of April 5, 2009, the mother reportedly found the infant unresponsive in bed. She and her son were co-sleeping. Emergency responders arrived and determined the infant to be deceased. He was not transported to a hospital. The Medical Examiner's (ME) Medical Investigator and law enforcement were called to the scene. There were no suspicions of child maltreatment with regard to the fatality situation at the time of notification to CPS.

In July 2009, the cause and manner of death were finalized by the Medical Examiner. The manner of death was determined to be accidental. The cause of death has been listed as asphyxia with contributing factors of co-sleeping and possible adult overlay. The ME also noted that at autopsy the child was found to have a rib fracture that was well into the healing stage, noting that such had no consequence to either the cause or manner of death. Consultation with Children's Administration Child Abuse Medical Consultant Dr. Yolanda Duralde was initiated by the assigned CPS worker. The medical opinion was that the rib fracture may well have occurred during the birthing intervention.

Referral History
On February 6, 2009, hospital staff reported to CPS intake concerns that the deceased child's mother was not demonstrating bonding or attachment toward her newborn (the deceased child). The child's parents were young and had minimal support and stability. This intake was accepted for investigation by CPS and screened as Risk Only.

On April 6, 2009, CPS intake received notification from the Pierce County Medical Examiner's Office of the death of this two-month-old infant. The infant had been sleeping with his mother who had placed the child on his stomach and later found him not breathing. There were no reported suspicions with regard to child maltreatment and the circumstances of the child's death. The intake was screened as Information Only.

Issues and Recommendations
Issue: There were no recommendations emerging from the Child Fatality Review.

Practice issues were noted and discussed during the Child Fatality Review. None appeared to have any obvious impact with regard to the circumstances of the child death and are included below for the limited purpose of documenting the discussions occurring during the Child Fatality Review.

Recommendation: None

Issue: In regard to the intake dated February 8, 2009, two months prior to fatality incident, Central Intake (CI) was contacted by a hospital social worker regarding a young couple that, after a period of indecision, had decided not to put their newborn up for adoption. Noted at intake were concerns by hospital staff that the mother had not shown bonding and attachment behaviors and that the couple's living situation had been tenuous until the paternal grandmother agreed to provide housing for the couple and the infant.

In review, a more reasonable intake decision would have been to defer the report to Early Family Support Services (EFSS) rather than open up a "Risk Only" (72 hour response) case assignment with CPS. While acknowledging the risk factors identified by the referent, it is debatable as to whether the risks posed considerable risk to the newborn. Hospital records later obtained by CPS showed that the referring hospital social worker was of the belief that the report would be sent by CPS for a public health nurse follow-up only. Notes from another hospital social worker did not indicate any substantive concerns about the parents or infant, and when contacted by the assigned CPS worker he indicated surprise that CPS had been assigned the case.

Recommendation: None

Comment: While the intake decision was found to be questionable it must be viewed in the context of coming at the time of Department transition to a new data system (FamLink). At that time there was a mistaken belief statewide that since FamLink screening decisions were "locked" at intake, responding field offices were similarly "locked" into program assignment and unable to change any aspect of a screening decision. This issue was subsequently clarified and currently remedies are available for revising and documenting changes subsequent to initial intake. Also at the time of transition to FamLink, revisions were made as to the sufficiency screen criteria and accepting intakes under "Risk Only" (no allegations). Initially "Risk Only" was broadly interpreted resulting in an increase in questionable intakes being accepted for assignment to CPS. However, this trend has apparently abated through clarifying discussions within Children's Administration (CA).

Issue: Overall most practice expectations were met by the CPS worker assigned to the February 8, 2009 intake. This included making timely face-to-face contact with the infant (alleged victim), meeting with both parents, conducting parent-child observations at the family residence, contacting a hospital social worker, and gathering hospital records. The worker administered the Global Appraisal of Individual Needs Short Screener (GAIN-SS) to both parents. Documentation generally met practice expectations as to content and timeframes, the exception being that the Safety Assessment was not documented in a timely manner.

During the review the worker indicated she had planned to contact the Maternity Support Services (MSS) worker when case activity was interrupted by the child fatality incident.

Opportunities for improved practice were identified during the review. Although there is no specified time frame requirement for interviewing caretakers, there was a noticeable delay in the worker conducting a home visit and interviewing the parents. During the review the worker recalled having made phone contact with the parents soon after case assignment but had apparently failed to document the contact. The worker might have considered speaking with the paternal grandmother in whose home the family was residing. Additional consideration might have been made to contacting the maternal grandparents. Best practice would have been to contact the primary care physician as a potential information source.

The CPS supervisor acknowledged during the review that she had not entered any supervisory review notes, indicating that initial problems with the new CA database (FamLink) contributed to lack of required case review documentation.

Action Taken: Both the CPS worker and her supervisor participated in the review and received feedback regarding investigative activities and suggestions where practice might be improved.

Action Taken: In October 2009, hands-on training for supervisors on FamLink was conducted in Region 5. Four separate training sessions were held in the Bremerton and Tacoma Division of Children and Family Services (DCFS) offices to train supervisors how to complete required documentation and case reviews in FamLink.

Child Fatality Review #09-18
Region 5
Pierce County

This five-month-old African American female died from hypoxic encephalopathy (a lack of oxygen to the brain).

Case Overview
On March 26, 2009, Child Protective Services (CPS) intake was notified that this five-month-old was admitted to Mary Bridge Hospital Emergency Department and was not expected to live. The referrer reported that medical professionals did not have any suspicions about child abuse or neglect and were looking at a possible SIDS type situation. Reportedly the infant was found unresponsive that morning and Emergency Medical Services responded to the home and initiated resuscitation efforts. The child arrived at the hospital with very little chance of survival having minimal brain activity. The infant died two days later on March 28, 2009.

It is known that the infant had been born prematurely and had Turner Syndrome, a genetic (chromosomal) disorder found only in females. Approximately 98% of all fetuses with Turner Syndrome result in miscarriage. The incidence of Turner Syndrome in live female births is believed to be 1 in 2500. There can be significant medical problems associated with the syndrome, including heart defects and high blood pressure, both of which can cause hypoxic encephalopathy (lack of oxygen to the brain).

In July 2009, the Pierce County Medical Examiner determined that the infant died of hypoxic encephalopathy from an unknown cause or origin. Noted was that the child suffered Turner Syndrome with congenital cardiac anomalies and was found in a prone position in a crib, with abundant soft bedding. The Medical Examiner reported the manner of death was undetermined.

Referral History
On November 15, 2008, hospital staff reported to CPS intake that the deceased child's mother brought her to the hospital emergency room saying the infant's feeding tube was causing distress to the child. Medical staff told the mother she needed to keep the feeding tube in for another week. A nurse contacted CPS intake as she was not sure the mother understood or would comply with the medical advice. This intake was accepted for investigation by CPS and closed with an unfounded finding for negligent treatment or maltreatment.

On March 26, 2009, a hospital social worker reported to CPS intake that the deceased child was admitted to the ER and was not expected to survive. There were no suspicions about child abuse and initial indications suggested a SIDS type event. The intake was screened as Information Only.

Issues and Recommendations

Issue: There were no recommendations emerging from the Child Fatality Review. Practice issues were noted and discussed during the Child Fatality Review. None appeared to have any obvious impact with regard to the circumstances of the child death and are included below for the limited purpose of documenting the discussions occurring during the Child Fatality Review.

Recommendation: None

Issue: Regarding the intake reported on November 15, 2008, four months prior to fatality incident, Central Intake (CI) was contacted by a hospital ER nurse. The nurse requested that CPS check on the family because she was not sure if the mother would comply with medical advice regarding keeping a feeding tube attached on the infant who had begun to be bottle fed. Although accepted for investigation of negligent treatment it was not apparent to the review panel as to what parental actions, failures to act, or omissions [WAC 388-15-009] had occurred at the time of the intake, only that the referent speculated the parent might commit a negligent act. The intake was unclear as to how compromised the child's health status would be if the parent were to remove the feeding tube from her child, although neither imminent harm nor emergent response were indicated by the intake worker.

An argument could be made that lacking any allegation or identified imminent risk of serious harm, the referral could have screened out as information only. However, the review panel was in general agreement with the intake decision to accept the case for CPS involvement, and concluded that designating the intake as imminent harm (no allegations) would have been more supportable that screening in the report under allegation (no imminent harm) since the parent had not actually acted or failed to act in a negligent way.

Recommendation: None

Issue: In regard to the investigation of intake the reported on November 15, 2008, it was noted that overall most practice expectations were met by the CPS worker. This included conducting a home visit, interviewing the alleged subject, making face-to-face contact with the infant (alleged victim), and making collateral contact with one of the medical practitioners involved with the child. Documentation met practice expectations as to both content and timeframes. The CPS worker referred the family to the Alternative Response System and provided the family with a community resources list prior to closing out the investigation.

Opportunities for improved practice were identified during the review. Although the father was not identified as a subject of the allegations, an effort could have been made to

interview him. The worker might have considered interviewing at least one of the older siblings to assess the home environment, daily routine, and the general care being provided by the parents. Although the worker made contact with the gastrointestinal specialist nurse, inquiry with the primary care physician may have also been beneficial.

The CPS worker was aware of a scheduled dietician appointment that was to occur two days after the home visit was conducted, but did not follow up to see if the child was seen. The worker might have inquired more about family resources as mother had expressed being overwhelmed in caring for the children and being isolated from her family. Although no requirement to do so, the worker might have considered conducting a second home visit as an opportunity to engage the mother in additional conversation regarding her admitted chronic depression (she stopped taking her medication) and domestic violence history.

The mother was born in Mexico and although the worker recalled that the mother spoke English well, no inquiry was made as the client's language preference.

Both the CPS worker and her supervisor participated in the review and received feedback regarding investigative activities and where practice might be improved.

Child Fatality Review #09-19
Region 1
Okanogan County

This six-day-old Native American male died from undetermined causes.

Case Overview
On April 25, 2009, this infant's father fell asleep with his infant son on his chest while they co-slept on a couch. The father awoke and the infant was deceased with a mark on his forehead consistent with the seam on the couch. The county coroner reported the cause of death is undetermined while co-sleeping. The manner of death is undetermined. The child was seen by a doctor the day before his death and there were no concerns.

Children's Administration had no prior history on this family other than two intakes prior to this child's birth. Both intakes were called to Child Protective Services (CPS) intake during the mother's pregnancy.

Referral History
On November 17, 2008, staff at a medical clinic called CPS intake to report the deceased child's mother was 16 weeks pregnant and tested positive for methamphetamine and marijuana. There were no other children in her care. The intake was screened as Information Only.

On December 24, 2008, a social worker reported that the child's mother admitted to smoking marijuana for the first four months of her pregnancy. She said she quit using marijuana but was taking Suboxen for treatment of her addiction to pain medication. The intake was screened as Information Only.

On April 28, 2009, a social worker reported to CPS intake that this infant died suddenly on April 25, 2009. The infant was seen by a doctor a day prior to his death and no concerns were raised. The intake was screened as Information Only.

Issues and Recommendations
Issue: Although the screening decisions for both intakes for this family were screened appropriately per the Prenatal Substance Abuse policy, there is no documentation of referrals made to the First Steps Program by the intake worker, which is directed in the Prenatal Policy.

Recommendation: Feedback about documenting referrals to First Steps per the policy was provided to the intake worker and supervisor in the local office that screened the intakes.

Child Fatality Review #09-20
Region 5
Kitsap County

This 15-year-old Caucasian female died from alcohol overdose.

Case Overview
On April 18, 2009, this 15-year-old youth spent the weekend with the parents of her mother's partner, which she frequently did. Present in the home was their adult son and an unnamed 19-year-old friend of the family. Reportedly the deceased youth asked the family to let her have one last party before possibly going into foster care because her legal guardians (paternal grandparents) wanted her out of their home. The deceased youth was provided wine, schnapps, and multiple shots of whiskey.

The next morning, April 19, 2009, the youth was found unresponsive. The autopsy showed no trauma, but noted the surgical history of having had her large intestine removed years earlier. Post mortem test results showed a high level of alcohol in her system and evidence of marijuana. Although reportedly the teen had been given MDA (Methylenedioxyamphetamine), also known as the "love drug," there was no evidence of such.

The cause of death has been determined to be acute ethanol intoxication. The manner of death is undetermined although negligent homicide charges are being considered against the father of her mother's domestic partner for supplying the liquor that resulted in the death of the child.

Neither the legal guardians (the youth's paternal grandparents) nor the biological parents were involved in the incident –though her grandparents gave permission for the youth to spend the night with the family friends. The youth was in the care of her paternal grandparents on a Third Party Custody Order. Children's Administration (CA) did not have legal custody of this youth at the time of her death. CA was working with the grandparents to address the issues causing conflict in their home and to identify other suitable relative placements.

Referral History
On August 30, 2006, the legal guardians of the deceased youth called Child Protective Services (CPS) intake to request help dealing with their two teenage granddaughters (including the deceased youth) who threatened to run away. The intake was accepted for Family Reconciliation Services (FRS).

On June 4, 2008, CPS intake received a report that the deceased youth had non-consensual sex with a 20-year-old male while she was at a party. The intake was screened as Third Party. This information was forwarded to law enforcement.

On November 13, 2008, an intake was received by CPS intake. The deceased youth, then 14-years-old, was picked up by law enforcement after she ran away from home. She was placed in protective custody and placed in a Crisis Residential Center. She reported she was hit by her father prior to running away. The intake was screened as Information Only as to the abuse allegations and accepted for Family Reconciliation Services (FRS). The grandparents picked the child up from the Crisis Residential Center. FRS contacted the grandparents regarding services but they did not commit to service intervention. The case was closed December 26, 2008.

On January 15, 2009, a foster parent reported to CPS intake that two runaway teen foster girls were provided alcohol by the deceased youth's father. The girls were visiting the deceased youth who lived in the home of her legal guardians (grandparents). The deceased youth's father lived at the residence in a separate apartment area in the basement. This intake was screened as Third Party.

On February 3, 2009, school personnel called CPS intake and reported the deceased youth told a counselor that her father choked her during an argument. There was no injury and no disruption of her breathing. Her legal guardians (grandparents) were listed as subjects for neglect although it is unclear as to the basis for such identification. The intake was accepted for investigation by CPS and closed with an unfounded finding for physical abuse and negligent treatment or maltreatment.

On February 18, 2009, the grandparents of the deceased youth called CPS intake requesting the removal of the deceased youth from their home. The intake was screened as Information Only.

On February 24, 2009, the grandparents of the deceased youth again called CPS intake requesting the removal of the deceased youth from their home. The grandparents stated the teen was out of control, failing classes, into drugs and alcohol, and stealing from them. The grandparents were not interested in reconciliation services so a Child Family Welfare Services (CWFS) case was opened to explore placement options for the children under the Family Voluntary Services (FVS) program.

On April 20, 2009, CPS intake received notification of the death of this 15-year-old. The FVS case was still open at the time. The youth was found deceased on April 19, 2009, at the home of fictive kin. She died from ethanol intoxication and had traces of marijuana in her system. The youth was provided alcohol by at least one adult in the home during her weekend stay and the county prosecutor is considering filing criminal charges.

Issues and Recommendations
There were no recommendations emerging from the Child Fatality Review (CFR). Practice issues were noted and are outlined below.

Issue: Related to intake decisions
In the intake received on June 4, 2008, 10 months prior to the fatality, the deceased youth disclosed to her counselor that she had been raped in April 2008 when her grandparents were out of town and her father was supposed to be supervising but was passed out. The report was taken as a third party sex abuse report and sent to law enforcement. The review panel concluded that it would not have been unreasonable to consider screening in a neglect referral on the grandparents and the non-custodial father who also lived at the residence, with the basis being that the grandparents had left the teen to be supervised by a questionable caretaker who had lost legal custody of the child due to violence and a drinking problem and now had allegedly failed in the supervision of his daughter. The Bremerton intake supervisor was present during the review, received the panel feedback, and agreed with the consensus view that consideration could have been made to screen in a neglect referral on the father and possibly the grandparents.

In the intake received on January 15, 2009, the deceased youth's father reportedly provided alcohol to two runaway foster girls and his daughter at the home. A third party report was sent to local law enforcement regarding the criminal act of furnishing liquor to minors. There was no CPS intake generated on the father for having provided alcohol to his teen daughter. The furnishing liquor to minors law (RCW 66.44.270) specifically states that such actions do not apply to liquor given or permitted to be given to a person under the age of 21 years by a parent or guardian and consumed in the presence of the parent or guardian. Given the permissibility under law to give his daughter alcohol in the home, the majority view of panel members was that the decision to not generate an additional referral on the father was supportable although the reported incident was very concerning.

In 2008, an intake was accepted for Family Reconciliation Service (FRS). The field response from time of intake was timely. While efforts to try to engage the child's legal guardians (grandparents) in services were numerous and fairly well documented by the FRS worker in November 2008, no documentation was found as to the worker having met with or spoken to the teen. While there is no requirement to do so in cases where the child was seen by Crisis Residential Center (CRC) staff, best practice would be to have contact with the youth to discuss available services, and not just make contact with the legal guardians.

In the course of the CPS investigation of the intake received on February 3, 2009, four months prior to fatality, the deceased youth disclosed at school that her father had choked her during an argument (breathing was not interrupted). The legal guardians were also identified as possible subjects for neglect as the incident occurred in their home. Overall

most practice expectations were met by the CPS worker, including conducting a home visit, interviews with all alleged subjects and the alleged victim, and completing a Safety Assessment. Documentation generally met practice expectations as to both content and timeframes. Collaboration with law enforcement investigators was documented (no criminal charges). The worker completed the Global Appraisal of Individual Needs-Short Screener (GAIN-SS) with both the teen and her father. The worker's investigative findings (unfounded) were supportable by documentation.

Opportunities for improved practice were discussed during the review. The worker might have considered interviewing the older sibling (non-victim) who was present during the alleged incident. There was sufficient case file documentation regarding the deceased youth's use of alcohol, despite her denials of any problem, to prompt an opportunity for the CPS worker to engage the teen in a discussion of substance abuse resources specific for adolescents. Similarly, although all five GAIN-SS internalizing behavior (mental health) questions were indicated by the teen, there was no documentation by the worker as to any specific efforts to connect the child up with mental health services. During the review the worker stated that she recalled having discussed with the teen why she had discontinued counseling, but had not documented the discussion.

When completing the Structure Decision Making (SDM) risk assessment tool the worker did not include the father as a household member in any scoring. Father's presence in the home would raise the risk level such that the CPS disposition could reasonably have been to move the case directly to Family Voluntary Services (FVS) rather than to close the case and suggest the grandparents re-contact the Division of Children and Family Services (DCFS) to open a Child Family Welfare Services (CFWS) case. Both the CPS worker and her supervisor participated in the review and received feedback regarding investigative activities and suggestions where practice might have been improved.

Two months prior to fatality, per the suggestion of the prior CPS worker, legal guardians contacted DCFS intake and requested placement of their granddaughter (the deceased youth) as they were no longer able to care for the teen due their medical issues and the child's behavioral problems. Contact with the grandparents and youth was not timely but did occur. Contact was made with the biological father and an attempt was made to contact the biological mother who resides in Yakima. There were no substantive collateral contacts made or attempted outside the immediate family. The worker followed practice expectations for CWS intakes in gathering documents regarding who had legal responsibility of the child, obtaining caretaker's and child's views of the problems and possible resolutions, and trying to identify alternative services to keep the child in the home or alternative placement options. Consideration might have been as to initiating a Family Team Decision Meeting (FTDM) given the grandparents' decline of services other than placement. The case was still open at the time of the youth's demise on April 19, 2009, with no agreed plan for DCFS out-of-home placement of the child.

Opportunities for improved practice were discussed during the review. Policy and practice requires that when a case is opened as a result of a non-CPS intake, an initial Family Assessment is to be completed by the assigned CFWS, FVS, or FRS worker [see Practice and Procedures Guide: Sections 2432(1) and 2433(1b)]. No family-focused case assessment was completed. The worker was unexpectedly unable to participate in the review due to emergency field work obligations. In a post-review debriefing the worker acknowledged he had not fully reviewed available case records and had not been aware that the biological father had reportedly provided alcohol to the youth and two teen runaway foster girls earlier in the year.

Recommendation: None

Child Fatality Review #09-21
Region 5
Pierce County

This five-month-old Caucasian male died from undetermined causes.

Case Overview
On May 16, 2009, the Pierce County Medical Examiner's Office reported to Child Protective Service (CPS) intake that the father of the deceased child went to check on his five-month-old son and found the infant face down in bedding and unresponsive. The preliminary indications were that the death was not suspicious, noting that the child had had some medical problems since birth. Little is known about the circumstances of death.

In August 2009 the cause and manner of death were finalized. Both cause and manner were undetermined. Contributing factors noted were that the infant had been found face down in soft bedding and also suffered from congenital anoxic encephalopathy.

Referral History
On December 16, 2008, a hospital social worker called CPS intake to report a drug exposed newborn. A urine toxicology test had shown marijuana and mother's prescribed opiate medication present in the newborn's system. It was a term delivery and the newborn was not exhibiting withdrawal symptoms at the time of the report to intake. The intake was screened as Information Only.

On May 16, 2009, CPS intake received a report of this child's death. The Pierce County Medical Examiner Investigator found no suspicions regarding the circumstances of death. The child was born with numerous unspecified medical problems. This intake was screened as Information Only.

Issues and Recommendations
There were no recommendations emerging from the Child Fatality Review (CFR).

Practice issues were noted and are outlined below.

Issue: In regards to the intake dated December 16, 2008, five months prior to fatality, CPS intake was contacted by a hospital social worker reporting a drug exposed newborn (marijuana and prescription opiate) based on urine toxicology (meconium test was pending). It was a full term delivery and the newborn was not exhibiting withdrawal symptoms at the time of intake. The mother's medical records suggested a history of seeking pain medication for a medical condition. It was initially misreported that the mother had very late pre-natal care, but this was later corrected by the referent during follow-up contact with intake two days later. Also during the follow-up contact with intake the hospital social worker reported that the newborn might be showing signs of being drug

affected, stating he would re-contact intake if such were medically confirmed. The hospital social worker did not re-contact intake. It was reported that the mother had recently lived in Arizona. Documentation shows that the intake supervisor directed the intake worker to contact Arizona to check on any prior CPS history involving the mother and an older child. Arizona reported no known involvement.

In review the decision to screen out the intake was consistent with Children's Administration (CA) Prenatal Substance Abuse policy (2007) and deemed reasonable based on the initial information and the additional information obtained collaterally. The inquiry made with Arizona CPS was viewed as excellent practice. Consideration might have been made by intake to confirm the meconium test results as newborn urine toxicology tests are known to have only provisional reliability. Consideration also might have been made to call back the hospital social worker regarding the reported possible development of drug affected symptoms.

The intake area administrator from Region 5 and two regional intake supervisors were present during the review and participated in the discussions.

Recommendation: None

Issue: Regarding the fatality notification in the intake dated May 16, 2009, Central Intake (CI) received notification of the death of this five-month-old infant. Preliminary indications were that the death was not suspicious for child maltreatment. It was reported that the infant had had some medical problems since birth (unspecified/unknown by referent). The intake was screened out and an incident report was generated per policy (family had a recent information only referral). In review the screening decision appears supportable.

The intake contained very limited information, and the incident report indicated that the Medical Investigator (referent) did not have any additional information. However, inquiry with the referent as to whether the infant had been transported to a hospital might have been considered at the time of intake. It would be reasonable to assume additional medical information would be available if a hospital had been involved, such as clarification of the child's medical problems.

Recommendation: Practice Consideration: It is known that CA has convened a work group to review the child fatality reporting and child fatality review process. Consideration could be made to look at developing intake guidelines for taking child fatality reports, to include suggestions for intake workers as to specific questions to ask, depending on the source of the fatality notification. This could provide more consistency across intake units in the state with regard to child fatality intakes.