Report to the Legislature

Quarterly Child Fatality Report (October to December 2006)

RCW 74.13.640

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Department of Social & Health Services
Children's Administration

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INTRODUCTION

This is the October to December 2006 Quarterly Child Fatality Report provided by the Department of Social and Health Services (DSHS) to the Washington State Legislature. RCW 74.13.640 requires DSHS to report on each child fatality review conducted by the department and provide a copy to the appropriate committees of the legislature. This report summarizes the information from 26 completed fatality reviews from fatalities that occurred in 2005 and 2006. All of these fatalities were reviewed by a regional Child Fatality Review Team.

The reviews included in this quarterly report discuss fatalities that occurred in Regions 1, 3, 4, and 6. Region 1 completed six reports, Region 3 completed seven reports, Region 4 completed six reports, and Region 6 completed 7 reports.

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

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

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

The chart below provides the number of fatalities reported to CA, and the number of reviews completed and pending for calendar years 2005 and for calendar year 2006. The number of pending reviews is subject to change if CA learns new information through reviewing the case. For example, we may learn that the fatality was anticipated rather than unexpected, or there is additional CA history regarding the family under a different name or spelling.

Child Fatality Reviews for Calendar Year 2005 – 2006			
Year	Total Fatalities Reported to Date requiring a review	Completed Fatality Reviews	Pending Fatality Reviews
2005	59	46	13
2006	59	9	50

The numbering for the Child Fatality Reviews in this report begins with the number 05-30. This indicates the fatality occurred in 2005 and is the 30th report completed for that calendar year. The number is assigned when the Child Fatality Review and report by the Child Protective Services Program Manager is completed.

Child Fatality Review #05-30
Region 4
DCFS Office of African American Children's Services

This five-month-old African American male died on 10/03/05, from dehydration.

Case Overview

On 10/02/05, the child had diarrhea and was vomiting; his mother took him to Swedish Hospital. A physician gave the mother Pedialyte and Niocate, a pre-digestive formula. The child was not admitted. On October 3, 2005, the child became more lethargic and unresponsive. His mother called 911. Medics tried to resuscitate the child; they took him to Children's Hospital where he was pronounced dead at 5:33 p.m.

The King County Medical Examiner reported the cause of death as "Dehydration due to probable metabolic disorder of unknown origin" and the manner of death as Natural.

The deceased child's 27-year old mother has given birth to three children. Her first son was born April 16, 2001. Her second son was born February 27, 2004. Her third son (the deceased) was born May 21, 2005.

The first report involving the mother was received August 13, 2002. It alleged her oldest son, then 15 months of age, was found by himself four units away from his apartment. Apartment staff walked him back to his apartment and found the mother on the phone. The mother grabbed the child from the staff, kept talking on the phone, and closed the door. This referral was accepted for investigation for negligent treatment and assigned to a CPS worker in the King Eastside office.

There was one face-to-face contact with the child and mother in the home. The worker found the mother to be attentive and the child, at that time, was being properly supervised. In addition, the worker noted the child appeared healthy and normal. The investigation was Inconclusive for negligent treatment and the overall level of risk was rated 2 – Moderately Low Risk.

The second report was received May 23, 2005. It states that the mother gave birth to a baby boy May 21, 2005. The mother was late to obtain pre-natal care and had three pre-natal visits. The mother admitted to heavy alcohol and ecstasy use during her pregnancy, and the reporter stated there was a history of domestic violence between the parents. The report did not identify her partner. This referral was screened out as Information Only.

The most recent report preceding the child's death was received August 2, 2005. The referrer was a nurse with Swedish Family Medicine at Providence Hospital. The report states the deceased child was seen by medical professionals on two occasions since his birth. On June 1, 2005, he was nine ounces above his birth weight. On July 7, 2005, he was admitted to the Swedish Hospital ICU where he was "almost dead." He weighed the same as he had on June 1. Since the mother was "appropriate and good" with the baby, Swedish Hospital did not make a referral to CPS. The nurse stated that the mother has not followed through on medical

appointments for the children. The mother did not keep an appointment set for August 2, 2005. The boys were not up to date on immunizations. This report was accepted for investigation and assigned to a CPS worker in the Office of African American Children's Services (OAACS) on August 3, 2005.

The Safety Assessment completed during the investigation indicated that a safety plan was necessary because the child was diagnosed as failure to thrive and had been in respiratory arrest at five weeks of age. The Safety Plan included the following goals:

- assuring the safety of the child in the family
- further assess the need for community resources and services
- agreement that the mother would continue to work with the public health nurse
- follow through with all medical appointments.

The worker had one face-to-face interview with the mother and children, and three collateral calls to the nurse who made the report to CPS. The investigation was Unfounded — the worker wrote there was no evidence that negligent treatment or maltreatment had occurred. The overall level of risk was rated 2 –moderately low. The case was closed September 22, 2005.

Issues and Recommendations

Policy Issues

An Information Only report was received regarding the deceased child when he was a newborn and there was no referral to a public health nurse. CA Policy 2552: Referrals on Drug/Alcohol-Exposed Newborns states: "The CPS intake social worker shall accept referrals from mandatory reporters on drug/alcohol-exposed newborns. These referrals include, but are not limited to, infants with a positive drug screen at the time of birth." The referral states the mother admitted heavy alcohol and ecstasy use during pregnancy. However, the baby was apparently healthy and the mother was not impaired, so they were released from the hospital. Since there were no allegations of CA/N or Risk of Imminent Harm, Intake screened this as Information Only.

Recommendation: Information Only referrals such as this need to be flagged for further review by a field supervisor. A referral to the CPS-PHN Early Intervention Project (EIP) would have resulted in a PHN assignment and follow up visits to the mother and infant.

System Issues

No referral to CPS by the hospital after the deceased was admitted in July in very critical condition.

Recommendation: The reviewers recommend that hospitals report such cases to CPS. We can work collaboratively to decide whether an investigation needs to occur.

There was some confusion about whether the nurse providing services to the family was a public health nurse (PHN), or someone else. The record refers to a PHN being involved, but actually the nurse worked for a private health care entity.

Recommendation: Social workers can easily determine if a PHN is assigned, and should do so.

Practice Issues

No urinalysis (UA's), screening or assessment of the mother for substance abuse when the case was opened in August, 2005. The social worker took the mother's word that she stopped using when she found out she was pregnant with the deceased child.

Recommendation: Always pursue information that a parent of a newborn may be abusing substances. A UA and an interview with a Chemical Dependency Professional (CDP) will at least establish a baseline and may lead to treatment if indicated.

The Safety Plan was in the form of a brief and vague service plan and did not contain the characteristics of effective safety plans:

- focus on the child's safety needs;
- increase the child's visibility;
- include a number of parties who share the role of assuring child safety;
- are realistic and achievable;
- are developed in consultation and agreement with parents;
- are specific, detailed and contain timelines for completion; and
- clearly identify the roles and responsibilities of various adults in helping to keep the child safe.

Recommendation: All supervisors and social workers should review the elements of effective safety plans and write them accordingly.

Child Fatality Review #05-31
Region 4
DCFS Office of African American Children's Services

This two-month-old African American male died on December 13, 2005, from brain damage he sustained on November 16, 2005, during a near-SIDS incident.

Case Overview

On November 16, 2005, the two-month-old's parents checked on him in his bed at about 2:00 a.m. He was not breathing and had blood on his face. First responders were able to revive him and take him to Children's Hospital. He suffered severe brain damage from loss of oxygen. He did not recover, and he died at Children's Hospital on December 13, 2005. Per the King County Medical Examiner, the cause of death was complications of hypoxic encephalopathy – brain damage due to lack of oxygen – following resuscitation from near-SIDS. The manner of death is natural.

This family had four CPS referrals preceding the death of the infant. The first was received December 05, 2003. At that time, the family members included the mother and her two sons (eight and eleven years old). The eight-year-old told his teacher that his mother would hit him when he gave her a note from the school. He subsequently reported that he was hit again. He described his mother hitting him with a belt all over his body when he is in trouble. This was accepted for investigation by CPS, and the finding was Unfounded for negligent treatment/maltreatment and Inconclusive for physical abuse.

The second CPS report was received March 07, 2005. A teacher received a call from another mother, whose son told her that the eight-year-old had recently offered him "weed" and beer. This was screened as Information Only.

The third report was received by CPS on October 21, 2005. This report involved the eight-year-old and three friends each telling their parents they were staying at one boy's house but stayed elsewhere instead. This was screened as Information Only.

The fourth report was received November 16, 2005. The two-month-old child (deceased) nearly died from SIDS but the first responders were able to revive him. At first, the circumstances were unclear and this referral was accepted for investigation. The parents gave different accounts regarding whether the baby was found in the bassinet or in the bed with the father. Tukwila Police Department investigated and did not find evidence of a crime. Dr. Ken Feldman from Children's Hospital concluded that there was no evidence of child abuse. The CPS worker determined it was Unfounded for negligent treatment/maltreatment and physical abuse.

Issues and Recommendations:

Systems Issue

We need to reinforce the importance of education for parents of newborns and the community on SIDS Risk Reduction Strategies. This baby died in the hospital several weeks after the near-SIDS incident, so the Medical Examiner did not do a scene investigation in the family home. The report to CPS does state that the mother used the "back to sleep" position for the baby, had a pediatrician, and went out of the bedroom to smoke.

Recommendations: Continue to spread the word to families of infants about safe sleep environment and "back to sleep."

Child Fatality Review #05-32
Region 4
King South DCFS Office

This one-month-old Caucasian male died December 5, 2005. On July 10, 2006, the King County Medical Examiner ruled that the cause of death is SIDS and the manner of death is natural.

Case Overview

The King County Medical Examiner's Office responded to the scene of a child fatality where the 30-day old infant was found deceased in his mother's bed. The mother stated she laid the baby in bed with her and went to sleep. When she awoke, she couldn't find the baby. The mother found the baby among the blankets, smothered by a sheet. A call was made to 911.

Renton police responded to the scene. Neither the detective nor the medical examiner smelled intoxicants on the mother. According to the detective, the mother and the grandparents were "appropriate." He did not feel that the other children were at risk.

The father of the child is level I registered sex offender (RSO). There was a question of lack of protection by the mother. It was thought that she may have been allowing the father to have unsupervised contact with the surviving children. But there was no evidence he had been alone with them and he sleeps in a truck in front of the house.

A review of the case history with the Children's Administration revealed that the child was not born at the time the family last received services from Child Protective Services (CPS). This family has a chronic history of referrals that include allegations of negligent treatment, physical abuse and sexual abuse. The recurrent themes are the mother's substance abuse, mental health issues, and ongoing concerns about the presence of the father. He was convicted for committing a sexual offense against his daughter. He is not supposed to be living with children. The father has also allegedly committed domestic violence against the child's mother.

The child's brother (now nine-years-old) was the subject of a dependency action. CPS filed a dependency petition on November 8, 2000. Dependency was found as to his father (not the same father as the deceased) on February 21, 2001, and as to the mother on April 6, 2001. The nine-year-old had two placement episodes with his maternal grandmother and the dependency was dismissed on January 20, 2004. Services included substance abuse evaluations, a psychological evaluation, Family Preservation Services, anger management, supervised visitation, the Apple parenting class and Child Haven therapeutic child care.

On September 29, 2000, an emergent CPS referral was received from a mental health professional (MHP), who reported that the mother was taken to jail on September 28, 2000 for child abandonment. The mother went across the street leaving a child home alone. Bicycle police witnessed the child leave the residence and cross a busy street attempting to locate the mother. The child was placed with the mother's sister and the mother was taken to jail. This investigation was Founded for negligent treatment.

On November 1, 2000, an emergent CPS referral indicated that a three-year-old boy (now nine years old) was brought to the maternal grandmother's home with two dog bites, which looked infected. The child had been taken to a doctor, but his mother had not filled the prescription. The mother lost her temper and threatened to "blow her head off" with a shot gun. The mother also threatened the referrer. This investigation was Unfounded for negligent treatment and medical neglect.

On December 14, 2001, a non-emergent CPS referral was received alleging that the childcare van driver noted that the mother appeared intoxicated when she picked up her son. There was an open CWS case at the time of the incident.

On August 9, 2002, an emergent CPS referral was received alleging negligent treatment and reckless endangerment. The mother was arrested because she was intoxicated and planning to drive with her five-year-old son in the car. The child's dependency had just been dismissed by Kent DCFS about a month prior to the referral. The investigation was Founded for negligent treatment.

On December 2, 2002, a non-emergent CPS referral alleged that an eight-year-old boy had marks on his ear and said that he did not know how he got the marks. He indicated that his mother slapped him over the weekend when he wanted some water. His left ear had several marks inside and on the cartilage on the outer rim. Police stated that there was a bruise, but did not place the child into protective custody. This investigation was Inconclusive for physical abuse.

On June 18, 2004, a non-emergent CPS referral alleged that the mother was at the Kent Community Services Office (CSO) with the father of her one-year-old son, to apply for benefits. The CSO believed the father was on probation and was not supposed to be around the children. The mother said the father was sleeping in his truck. The Superior Court Management Information System documented that the father has convictions for Rape of a Child First Degree and Assault Second Degree/Domestic Violence. This investigation was Unfounded for negligent treatment.

On August 4, 2004, a non-emergent CPS referral received from the father's probation officer stated that the previous evening the father was in the home with the children present. The father is a level I RSO. The mother said that the father had been staying in the home for the last two nights. The father was incarcerated. This investigation was Unfounded for negligent treatment.

On October 21, 2004, a non-emergent CPS referral was received from the childcare provider. The childcare provider was informed by the Department of Corrections (DOC) that the father was an RSO and should not be on child care center premises. Every day, the father drops the children (aged 2 and 7 years old) at childcare and picks them up while the children's mother is in the car. This investigation was Inconclusive for negligent treatment and Unfounded for sexual abuse.

On October 21, 2004, an Information Only CPS referral was received from DOC. DOC reported that the father was arrested for violating his supervision conditions by having contact with minor children. The father was living with the mother and her two sons. The RSO is the father of the

younger child. The mother was aware of the father's RSO status and was told that he could not have contact with her children.

On January 6, 2005, a non-emergent CPS referral alleged that the mother was arrested for Driving under the Influence (DUI) and a Failure to Appear warrant. The mother was with her younger son's father at the time of her arrest, but the children had just been dropped off at the babysitter's. The father (an RSO) was allegedly having contact with the children. This investigation was Unfounded for negligent treatment. The case was closed February 16, 2005.

This family had twelve reports to CPS in a five-year period, all of this occurring before the birth of the deceased child. The mother had persistent difficulties with substance abuse and mental health. This led to legal violations and brief periods of incarceration. A registered sex offender fathered at least one of her sons. He was reportedly living with or having contact with the mother and her children on several occasions. This was in violation of his criminal court order.

Issues and Recommendations

Systems Issues

The family has issues of chronic neglect and the mother has engaged in services. This mother has definite strengths — she has participated in services, and has support from her extended family. Although she relapsed this summer and had a 2nd DUI, she called intake and asked to have her case re-opened so she could receive more help. The case is currently open for voluntary services. Her nine-year-old son is receiving mental health services. Her three-year-old is about to start attending Child Haven. The mother is on medications and wants to resume out-patient treatment for substance abuse at Recovery Centers of King County. Her partner is a level I RSO, has committed domestic violence against her and she still has contact with him. She did participate in grief and loss counseling with a PHN after her child died.

Recommendation: The team recommended that the social worker arrange a family meeting with service providers present. The goal would be to review what services the family is receiving and identify what additional services might be helpful in strengthening the family.

Practice Issues

There were numerous concerns regarding the presence of a Registered Sex Offender (RSO), in violation of his court-ordered conditions. The record does not show evidence of DCFS collaboration with the probation officer, yet it was an issue in four referrals made to CPS.

Recommendation: Collaborate with the probation officer and other community experts about how to respond to reports such as this. The King County Sexual Assault Resource Center (KCSARC) has great skill in working with mothers who have husbands or partners who are sex offenders.

Child Fatality Review #05-33
Region 3
Bellingham DCFS Office

This four-day-old Caucasian male died as a result of birth trauma.

Case Overview

In May of 2005, CPS learned that the mother was pregnant and due to deliver in August. She was in jail at that time. A few weeks later, CPS learned from a counselor that the mother stated that she was not planning to have a medically attended delivery, so that CPS would not be aware of the birth. As she had so little pre-natal care, the anticipated date of the birth was uncertain. On June 4th, she arrived at St. Joseph's hospital by ambulance. The infant had been born breech and he was in serious distress. Assistance had not been called to the home until it was obvious that the birth was very problematic. By the time the hospital called CPS, the mother was released. The infant was transported to Children's Hospital, where they were hoping to help him survive his birth trauma. After three days, it appeared that he was not likely to survive and the mother made the decision to withdraw life support.

The mother previously had a child removed from her care by CPS through a court order. The mother had very little pre-natal care during this pregnancy. When she went into labor with the child, she did not call for medical assistance until it was apparent that there were very serious complications with the birth. Because of this, the investigation concluded with a Founded finding of negligent treatment/maltreatment against the mother.

The mother's family of origin had a lengthy CPS history. The concerns included sex abuse by the mother's older half brother, inadequate care and housing due to her own mother's alcoholism, being the victim of intense school bullying and making suicidal statements. There were several references in the record to the mother being physically assaultive and developmentally delayed. It appears from the record that the mother was in foster care as a teen, but returned home after she turned 18. The mother was the youngest child in the family and there was no further CPS contact with the family after she turned 18.

There were eight prior referrals regarding this family, beginning in 2003. The referrals were concerning an older sibling of the deceased child, an infant girl who was removed from the mother's care almost immediately after her birth. The infant was placed into foster care and the mother had relinquished her rights to this child by the time she gave birth to the deceased child.

In January of 2003, CPS received the first referral concerning the mother as a parent. A social worker from St. Joseph's hospital called to report that the mother was pregnant and due to deliver in April. The medical social worker was concerned that the mother had little pre-natal care, a history of mental illness and alcohol abuse, and would soon be homeless. There were three more referrals with the same concerns. The allegations were not investigated because CPS policy allows investigations of referrals regarding unborn children, under specific circumstances, within 30 days of the anticipated birth. The mother was referred to all the community supports

available to her, including the DSHS First Steps program. She had some minimal involvement with that program.

In April 2003, the mother gave birth to a daughter. CPS was notified by hospital staff, who (after observing her behaviors in the hospital) were concerned about the mother's ability to parent. An agreement was reached with the parents that the infant would reside with her father, and the parents would participate in services. It soon became apparent that the infant's father was not providing the care necessary for the infant, and a dependency was filed. She went into foster care, and eventually the parents relinquished their parental rights to the child.

Child Fatality Review #05-34
Region 3
Bellingham DCFS Office

This three-year-old Native American male was killed in October 8, 2005, when a car accidentally rolled over him in a private driveway at the home of a third party.

Case Overview

The child's family was homeless and the parents went to look at a fifth wheel trailer that was for sale. When they arrived at the home, the parents turned off the motor, exited the car and left their three sons (ages 8, 5, and 3) sleeping inside the car. The parents met with the owner of the fifth wheel and were looking at it but were within sight of their children in the parked car approximately 75 feet away. The parents heard the sound of crunching and responded immediately. They attempted to lift the car tire off the child, called 911, moved the car and then administered CPR. The child apparently got out of his car seat, out of the car and was run over in the driveway after one of his siblings knocked the car out of gear. The investigating law enforcement agency reported to CPS that they viewed this as an accident.

The family had prior history with Children's Administration. The child's mother was possibly a victim of child abuse in her family when she was about sixteen. There is no prior CPS history on the father.

The first referral concerning the family was received in 1997. An emergency room (ER) physician made a CPS referral about the parents' first born son who was then six months old. The mother brought him to the ER with bruises and contusions on his face and head. The mother, supported by her sister and her sister's child, stated that the injuries occurred when the mother's three-year old niece climbed into the child's crib and beat him with his bottle. This occurred when the mother and her sister stepped out onto the porch for a few minutes. The child's injuries healed with no permanent effects. The case was closed after investigation with a finding of Unfounded and with referrals for services for the three-year old niece.

The next time CPS became aware of this family was in 2000. The mother was pregnant with their second son. While at the doctor's office with her oldest child, the mother had been admonished by the doctor for being impatient with him and "yanking" on his arm. There was no injury. The mother was working with a public health nurse, who had never seen anything of concern. The referral was taken as Information Only.

Two months later, the mother was in the hospital delivering her second son. Hospital staff called CPS to report that the father had physically abused the oldest child as they were leaving the hospital. They observed the child crying for his mother and the father yanked him, screamed at him and threw him to the ground while going to the car. The referent also reported the mother claimed she had been physically assaulted by the father six months earlier. The father was attending anger management classes because she reported the incident to police. The mother also told the referent hat she used marijuana weekly during her recent pregnancy.

The newborn did not test positive for drugs and he was allowed to go home with his parents. The investigator learned that the father had been assessed and diagnosed with severe alcohol and marijuana dependence, and methamphetamine dependence in remission. He was required to attend chemical dependency treatment as a part of his domestic violence case and a Driving under the Influence charge. He did not comply with treatment and was ordered to 15 days of in-home detention. The treatment facility report indicated that his prognosis for recovery was poor.

During the CPS investigation, a new CPS referral was made about the family. An anonymous caller stated that the father was heard yelling, slamming doors, and "screaming obscenities," particularly at the oldest child. The investigator asked the mother to submit to a urinalysis for drug use, but she refused. The parents refused to attend parenting classes, but the father did complete 26 weeks of domestic violence counseling. After four months of working with the family and offering services, the case was closed. Although the family's engagement in services was minimal, the department believed there was not sufficient basis to file a dependency petition. The findings of the investigation were Unfounded.

The department heard nothing about the family until the spring of 2005. By that time the family had three sons. The youngest son was born in 2001. The daycare provider expressed concern to CPS about the oldest boy. He was reported to have been seen "slapping himself" and stated that his parents "slapped him all the time." He told the teacher that his parents "hate me and they hit me." The center had never seen evidence of physical abuse. The referral was screened as Information Only.

The next referral was in October of 2005, when the department learned of the fatality.

Issues and Recommendations

Exceptional Social Work Practice

Most of the work on this case prior to the fatality was performed by the Bremerton DCFS office in 2000. In a very comprehensive investigation that included many collateral contacts, the social worker identified the risk factors the family presented and began the process of establishing the children’s tribal identity once their Native American ancestry was revealed. It turned out to be a lengthy process, not reaching completion until well after the case was closed. Despite extensive efforts to engage the family, the social worker was only partially successful in connecting the reluctant parents with services, and the case was closed per policy. The active efforts made on this case, however, were commendable.

Child Fatality Review #05-35
Region 3
Office of Foster Care Licensing

This 10-month-old Caucasian male child died when he accidentally choked on the fingertip of a latex glove he found on the kitchen floor in his foster home.

Case Overview:

On October 30, 2005, the biological and foster children in the foster home were gathered in the kitchen preparing their Halloween costumes. The foster father was home alone with the children. The ten-month-old foster child, who had been placed with the family almost since his birth, was in the kitchen with some the other children. He suddenly began to choke, and the other children alerted the foster father. After attempting to intervene, the foster father called for emergency aid. Medics transported the child to St. Joseph's hospital. Medical staff tried to resuscitate him to no avail. Medical staff discovered that the child had choked on a fingertip portion of a latex glove that he picked up from the kitchen floor. The older children had been cutting up latex gloves for their Halloween costumes and some pieces had fallen to the floor.

The day after the death, the medical examiner made a referral to CPS. He believed that the responding officers were "uncomfortable" with the condition of the home (very small, cluttered, little food, considerable alcohol in the trash). Law enforcement officers at the scene were contacted. They did not share the medical examiner's concerns.

The one remaining foster child (a nine year old boy) was removed from the home after the fatality. The foster parents signed a supervision plan with the Division of Licensed Resources/Child Protective Services (DLR/CPS), agreeing to keep small objects picked up that may present a choking hazard. Licensing issued a "stop placement" on the home, which prevented additional placements until the investigation was complete.

Child's History
The mother became pregnant with the deceased when she was 21 years of age. During her pregnancy, her pre-natal care was irregular. She did have the services of a public health nurse for a brief period. Her relationship with the child's father was brief. Due to the assessment that the child would not be safe going home with his mother, a dependency petition was filed within a few days of the child's birth and he was placed into foster care. The mother's adoptive family declined placement of the infant due to their fear of the mother's behaviors.
Two CPS referrals on the child's mother as a parent were received within a week of each other, just before she gave birth to the deceased. In both referrals, concern was expressed that the mother might be unable to parent the child, due to her substance abuse issues. The first referrer alleged that the mother was using methamphetamines during her pregnancy. The second CPS referral was from the hospital -- tests confirmed that the mother was using drugs. The hospital staff also felt that the mother's mental condition appeared somewhat unstable.

The child's biological mother received services for her mental health and substance abuse issues prior to her pregnancy. These included regular urinalyses and drug court. During her pregnancy,

she briefly utilized the services of a public health nurse and had some pre-natal care. Other services were offered to her and the child's father after the dependency was filed. The mother did not follow through with the recommendations for treatment beyond the initial assessments and the father did not participate in any services.

While the deceased was with his foster parents, he was diagnosed with tracheomalacia (described as a weakness in the trachea.) He needed to be on nebulizer treatments and to have oxygen administered. Medical staff told the foster parents that the child would likely outgrow this condition at 12 to 18 months of age. The oxygen use became unnecessary but the nebulizer treatments continued as needed.

Facility History

This foster home was originally licensed in April 1998 as a foster home with a private agency in Bellingham. They have moved 4 times since their original license was granted. The foster parents moved to another address in October of 2005. There had been a home visit to the new address to begin the licensing process of the new home, but the license had not yet been issued at the time the child died.

When the child was placed in this home, the foster home became one child over the capacity allowed by their license. The home remained over-capacity by one child during the entire ten months of the deceased child's placement. An Administrative Approval for a foster home that is over-capacity is required by policy. Approvals were each signed for a period of thirty days. There was documentation in the record of approvals for all but one month of the time the child was in care. The Administrative Approval dated May 9, 2005, for the child states:

"This infant has been diagnosed with tracheomalacia, a condition characterized by an abnormal collapse of the tracheal walls. Physicians feel this infant will outgrow this condition at 12 to 18 months of age. Additional supervision may be required to monitor the health and well being of this infant."

Other Administrative Approvals did not have this wording, saying only "age-appropriate supervision" is necessary.

There was one referral regarding the foster home prior to this incident. In August of 2001, the private agency that licenses the foster home reported that the foster mother told the agency that a five-year-old girl, who had been placed in the foster home as a pre-adoptive placement, was acting out sexually with other children in the foster home. The referral was assigned to the DLR/CPS for investigation. It was closed as Unfounded for lack of supervision.

Issues and Recommendations

Systems Issues

The DLR Area Administrator identified the foster family's stress involved in determining if DSHS could participate in the payment for the funeral as an issue. She stated that it

added to the family's stress that there did not appear to be a ready answer for them to this problem.

Recommendation: Develop a regional protocol to enable this issue to be addressed quickly in the event a child should die in care without sufficient funds for a funeral.

During the ten months that the child was in this foster home, the home was over their licensed capacity by one child. There were signed administrative approvals for this overcapacity for most of that time. The current system for securing administrative approval for overcapacity situations in foster homes in this region is cumbersome, and does not include alerting the Area Administrator.

Recommendation: The review team recommends that this system be reviewed by the Region 3 Foster Parent Retention and Support committee.

Child Fatality Review #05-36
Region 3
Bellingham DCFS Office

This 17-year-old Caucasian female died just after midnight on December 29, 2005, when she was a passenger in a car that left the road and hit a tree. She was pronounced dead at the scene. The vehicle was driven by a 29-year-old man, who was arrested on charges of vehicular homicide. Alcohol appeared to have been a factor in the accident.

Case Overview

At the time of this fatality, the child was a dependent of the state. She was placed with her mother. They lived with the child's maternal grandmother and her uncle.

There is no history of any child abuse or neglect in the childhood of the mother or her brother. The mother and her siblings grew up in a reportedly strict religious atmosphere with parents who had emigrated from the Ukraine. As an adult, the mother had some difficulties with maintaining a home of her own, due to limited cognitive functioning and chemical dependency issues. The child and her mother had lived with the maternal grandmother and uncle since the child was a baby (the child's father had died when she was very young). According to the child and her uncle, the mother would be gone much of the time, living in homeless shelters and with other people. As the child came into her mid-teens, she began rebelling and experimenting with tobacco, alcohol and marijuana.

CPS first became aware of this family at the end of August, 2004. The child's uncle called Children's Administration. He was concerned that the child, whom he described as severely anorexic and possibly suffering from Fetal Alcohol Syndrome (FAS), was refusing to come home. He said that the child had been staying at a teen shelter. The mother had been absent from the household for several weeks. The assigned social worker attempted unsuccessfully to engage the family in services. The case was closed in November, 2004.

In January of 2005, the child was placed in the Bellingham Crisis Residential Center (CRC) by the police. Police picked her up for alcohol use and they were not able to locate her family. Although the mother was eventually located, she was living on the street with a boyfriend. Because of the instability of the child's living situation, CPS filed a dependency petition. In February, the child was placed in a group home in Everett. She enrolled in school and attended counseling. Because the child was having increasing problems with marijuana use, the chemical dependency counselor recommended that the child go to in-patient treatment. The child also had pending misdemeanor charges in both Skagit and Whatcom counties.

The child entered in-patient treatment in Tacoma in late February. After completing treatment, on April 26, 2005, she was placed in her uncle's care. Her mother was also living there. The child continued services with her probation officer. The mother participated in services ordered by the court to address her own chemical dependency and mental health issues. On June 30, 2005, the court approved an in-home dependency with the mother.

The social worker made a home visit with the child and her mother on December 13, 2005, in preparation for the dependency review hearing in January. The child had earned her GED, was planning on attending community college, had taken care of all legal requirements for her misdemeanors, and was attending clean and sober support meetings daily. She was scheduled to start her first job and talked about her career plans in the health field. The mother appeared appropriately involved in her daughter's supervision. The case plan was to request dismissal of the dependency at the court hearing.

On December 29, 2005, the child was killed in a one-car accident.

On January 6, 2006, the assigned social worker made a home visit to the mother and the maternal grandmother. The mother said that on the day of the accident, the child took the bus to the mall. She called home later, asking her mother if she could get a ride home from the mall with a family friend. The mother knew the man and considered him to be a responsible, sober person, so she agreed.

Issues and Recommendations:

Practice Issues

From August of 2005 until the youth's death in December of 2005, this dependent youth was seen once by a social worker in her home for a complete Health and Safety visit. This was not in compliance with the Health and Safety policy in place at that time.

Recommendation: The Policy for Health and Safety visits has been revised. There will be region-wide training on how that policy will be implemented in fall 2006. The revision includes new requirements for monitoring the safety of children who are beginning trial visitations with their parents. It is recommended that these new requirements be placed on the computerized "to do" lists for assigned social workers.

Policy requires monthly supervisory reviews of all cases. The policy was met until the case was transferred to another unit. From August 2005 until the youth's death in December of 2005, there was one documented supervisory review of the case.

Action taken: The issue of supervisory reviews in this case has been discussed with the Area Administrator. The supervisor of that unit is no longer supervising in Children's Administration.

Child Fatality Review #05-37
Region 3
Smokey Point DCFS Office

This three-month-old Caucasian male died on May 26, 2005. According to the forensic results, the cause of death was determined to be SIDS.

Case Overview

On the morning of May 26, 2005, the mother of the deceased called her mother to report that she had fallen asleep with the infant and when she woke up she discovered her two month old baby was dead. Emergency personnel were called to the home. The investigator from the Snohomish County Medical Examiner's Office reported that the preliminary examination was done the same day. According to the forensic results, the cause of death was SIDS.

The mother was known to the Children's Administration as a child with her family of origin. There were four referrals on that family from 1991 to 1998. Although a sibling was the focus of many of the referrals, there were allegations that the mother was sexually abused by her father.

In March of 2004, CPS received two referrals alleging drug use (marijuana and methamphetamine) by both parents. Neither referral met the criteria to be investigated by CPS.

The mother moved to Wenatchee later that year and partnered with a new boyfriend, aged 30. This boyfriend had a history with the agency and had considerable criminal history, suicidal and other behaviors by the time he was 17. The criminal activity continued into adulthood with numerous felony and misdemeanor convictions--including assault and drug charges.

A CPS referral was accepted for investigation in June of 2004 by Wenatchee DCFS. The referrer alleged the family was homeless and the parents left the three year old napping in their locked vehicle while they were in a building. The child had blisters on his feet from going without shoes or socks. The boyfriend had an upcoming court hearing for automobile theft, which the referent felt he would avoid by leaving the area. The referral was investigated and the agency supplied temporary housing for the family. The allegations of abuse and neglect were Unfounded and the case was closed.

By late December of 2004, the family was again living in Snohomish County. An Information Only referral from the family physician reported that the mother was pregnant (due to deliver the following March), the mother tested positive for marijuana use and the maternal grandmother had concerns about the care being given the older brother. While the referral was not assigned for investigation, appropriate service referrals were made.

In late January of 2005, maternal relatives contacted CPS. They believed the mother and her boyfriend were using drugs and neglecting the four year old. Allegations included that the mother left the boy with her extended family for several days at a time, usually dirty and with a cold/earache, then would suddenly pick him up and disappear for awhile. The relatives also reported that the four year old had a language delay. This referral was Information Only.

In March of 2005, an Everett hospital reported that the mother had given birth to another boy. They were concerned about a positive marijuana test on the mother and her lack of resources to care for two children. She and the baby were going to a local Everett motel when they were released from the hospital. This referral was assigned and investigated by CPS. The investigation was closed as unfounded on April 7, 2005. The mother was convincing in her denial of methamphetamine use and the family physician stated no more specific concerns.

On April 22, 2005, there were two more referrals received by CPS. One was made by a family friend and the other by the family physician, who had received some additional information from the maternal grandmother. Both referrals concerned the lifestyle of the parents, homeless, drug use, domestic violence in front of the children, and the oldest boy's frequent bouts of vomiting after being with his mother for a few days. The grandmother attributed this illness to being around methamphetamines. Both of these referrals were assigned for investigation.

After initial difficulty locating the family, the assigned social worker, the mother and her two sons met in the CPS office on May 9, 2005. She stated that she was now separated from her boyfriend (father of the deceased infant) for the sake of the children. She admitted there was domestic violence, he was not good for the children, and she was not going to return to the relationship. She adamantly denied that she or her boyfriend used drugs use other than marijuana. Based primarily on this information, the social worker made referrals for services for the family. These referrals included a referral for the four-year-old brother of the deceased for counseling (for witnessing domestic violence) and the mother was asked to complete a drug test on that day. Although she accepted the offer of services, the mother did not follow up on any of the referrals.

Two weeks later, the department learned the infant had died of SIDS. The baby's father was released from jail because of his son's death. The mother and father reunited and made themselves unavailable to the agency. After considerable searching, the family was located. The mother tested positive for methamphetamines. The four-year-old was taken into custody and placed with a relative. The parents are working on completion of court ordered services.

Issues and Recommendations

Practice Issues

The Intake decision for the referral received on March 29, 2004 was Information Only but should have screened in for investigation by CPS. The referral received March 2, 2005, should have also identified the older child as a victim in the neglect allegations, based on the known history of the family.

Recommendation and Action Taken: Issues with each of these referrals were addressed with the supervisors involved.

The investigation of the March 2005 referral did not comprehensively address all of the risk factors known to CPS at the time of the referral. The transfer of this case from one office to another within the county after its initial assignment may have contributed to the brevity of the investigation.

Recommendation and Action Taken: There was a CPS program review in the office where the investigation of this referral was completed. That review addressed the issues of depth/breadth of investigation as they arose in other cases. A protocol was established that ensures that a case will remain with the original investigating worker, even when the family moves from one catchment area to another within the county.

The referral received on 6/23/04, was assigned a high standard of investigation. However, the activities taken on the case failed to address all of the requirements of a high standard investigation. There was no documentation of contact made with the mother.

Recommendation: Follow policy.

The last investigation on this family, just prior to the death of the infant, involved allegations of drug use and consequent neglect of both children. Per policy, the social worker completed an Investigative Assessment at the conclusion of the investigation to summarize the risks and findings. The substance abuse section of that Assessment did not accurately reflect the activities of the worker regarding substance abuse as a contributing factor to the abuse/neglect.

Recommendation and Action Taken: Training in the areas of neglect and substance abuse is currently being delivered to all social workers in the region. This training includes clarification of issues in the use of substance abuse questions in the Investigative Assessment.

System Issue

The CPS Referral received on January 27, 2005, had an intake decision of Information Only when it should have been accepted for investigation. After the intake decision on this referral was given final approval by the supervisor, additional concerning information and concerns were added by the social worker. The computer system used for intake does not automatically return an intake to the supervisor when additional information is added after review by the intake supervisor.

Recommendation and Action Taken: The accuracy of screening decisions could be improved if the supervisor receives notice of changes made to a referral after it has been approved. The fatality review team has recommended to the "CAMIS Replacement Project" of the Children's Administration Technology Services that the project considers this in the new statewide system under development.

Child Fatality Review #05-38
Region 3
Mount Vernon DCFS Office

This two-year-old Caucasian female died on December 24, 2005. She had been having flu-like symptoms for several days and aspirated on her vomit.

Case Overview

The mother of the deceased brought her two-year-old daughter to the Skagit Valley Hospital emergency room on December 23, 2005. She was concerned that her daughter was experiencing severe "flu-like" symptoms. The child was treated for croup and released to her parents the next day. On December 24, 2005, the mother put her daughter to bed at home, propping her up with pillows to assist her with breathing. When she went back to check on the child, she discovered that she was not breathing. The mother immediately called 911 and began to administer CPR. The Emergency Medical Team responded and transported the girl to Skagit Valley Hospital. The attending medical provider told the hospital social worker that the child “had aspirated on her vomit." Mount Vernon Police were on the scene at the hospital and spoke to medical staff and the family. The hospital social worker said there was no suspicion of neglect, and there would be no autopsy.

There is no Children’s Administration history for either of the parents of this child in their own families of origin. There were three prior referrals to Children’s Administration regarding this family.

Children's Administration’s first contact with the mother came in 2001. At that time, she had one child, a boy about three months of age. The mother was living with the boy's father. CPS received information that the mother had been "continuously beat up" by her son's father, and that both of them had substance abuse issues. When the social worker went out to the motel where the family had been staying, she found the mother there alone. Her boyfriend had been arrested for violation of a no-contact order. The mother had placed their son with her mother, authorizing her mother to obtain medical services for him. The mother signed a voluntary service plan with the CPS worker. She agreed to a chemical dependency assessment (and treatment if recommended) and other services. After a number of missed appointments, it became apparent that neither of the parents were ready to parent. The mother agreed to allow the maternal grandmother to obtained legal custody of the older child. The case was then closed. This referral was Founded for the father

In October of 2005, the financial worker for the family with the Community Services Division (CSD) of DSHS contacted Children’s Administration to report the mother had been hospitalized the previous weekend for a suicide attempt. She had an almost two-year-old daughter (the deceased). The mother was going to be on a 30 day leave from her place of employment. The CSD provided child care for her daughter for one month after the suicide attempt. Her application to have child care extended beyond a month was denied. The referral was Information Only and was not investigated.

The mother called Children’s Administration on December 2, 2005, requesting assistance for child care so she could attend mental health classes and group therapy sessions. The referral was assigned

to CWS. The record shows a message was left by the assigned social worker about childcare. The call was not returned and the case was closed.

Issues and Recommendations

Practice Issues

In the 2001 CPS referral, the mother was listed as the subject of emotional abuse allegations along with the father. A finding of Founded was documented on the father, but no finding was made on the mother.

Recommendation and Action Taken: Since the time of this investigation, there have been trainings conducted in the region on the making of findings in assessments, and more are planned.

On 12/2/2005 the mother requested child care services. This was recorded as a "CWS Intake" and assigned that day to a social worker for response. There was no documentation of a response by that social worker. A brief note was entered by the supervisor approximately three months later indicating that the social worker had left a message for the mother but received no response. This is not in compliance with policy to keep documentation current within thirty days.
Recommendation and Action Taken: This issue has been addressed with the Area Administrator for the section.

It is the belief of the fatality review team that there is a general lack of clarity of expectations on how to proceed with requests for child care assistance only. Current policy and procedures regarding intake decisions, response time expectations, and eligibility requirements are generally unclear and not understood.

Recommendation and Action Taken: Expectations for the handling of child care assistance requests is on the agenda for the Region 3 Greater Management team meeting. The team includes supervisors of the new service units, created in the organizational restructuring of the division, where this type of request will now be handled. The Regional Safety Program Manager will address the issue with those supervisors.

Child Fatality Review #05-39
Region 6
Long Beach DCFS Office

This one-month-old Caucasian female died on September 14, 2005, as a result of positional asphyxia.

Case Overview

On September 14, 2005, the Long Beach Police Department was called to the Ocean Beach Hospital because a deceased infant had arrived at the hospital. The father reported that he fed the baby a bottle at 2:30 a.m. Following the feeding, the father reported that she fell asleep on his chest while he was in bed with her mother. The father awoke at approximately 8:30 a.m. and found his daughter cold to the touch. He called 911. Hospital staff said there were no obvious signs of trauma when the infant was brought to the hospital.

The autopsy was conducted on 9/16/05. There was no evidence to suggest a crime had occurred. The pathologist conducting the autopsy stated he believed the death was a result of positional asphyxia. There were no concerns about the circumstances surrounding the death.

When the child's death was reported to CPS, there were no allegations of neglect. However, the Long Beach DCFS office had been working with this family and providing services for chemical dependency treatment and the visiting nurse program. The workers involved in the case were concerned that the substance abuse of the parents contributed indirectly to the death of the baby. They believed that both parents had been using at the time. No urinalysis tests were performed to determine drug usage by the parents. The police reports did not indicate that either of the parents were under the influence.

The parents were the subjects of numerous referrals prior to the death of this baby girl. There were also referrals related to previous paramours of the father, which resulted in his other children being placed in out-of-home care. The father of the deceased currently has two children in an active dependency with the Kelso office. The assigned social worker reports that the father has threatened social workers and is verbally abusive; he has not kept in contact with the social worker for his other children and has not complied with the services required in the case plan.

The father had another infant from a previous relationship who died at a very young age. The suspected cause of that death was SIDS, due to the extreme prematurity of the infant. The father was not with the child at the time of death.

When the deceased infant was born, CPS received a referral alleging prenatal exposure to methamphetamines. The case was accepted for investigation by CPS as a moderately low response. The mother had tested positive for methamphetamines twice during her pregnancy. For the two months prior to the birth she was tested weekly, with each test coming back negative. At the time of delivery, neither the infant nor the mother tested positive for any illegal substances.

The assigned DCFS social worker offered the family services. The mother admitted to prior drug use and expressed an interest in continuing her sobriety. A safety plan was completed with the family. The mother was referred to a variety of resources for herself and her infant. The father was reported to be fishing in Alaska at that time.

The mother was offered and refused treatment for her ongoing chemical dependency problem. She was also offered services from the public health department. Although she agreed to the service, her attendance and cooperation was sporadic. The public health nurse offered First Steps and made a referral to the WIC program. In addition, a referral was made to the Birth to 3 Program to assess the development of the baby. There were regular medical appointments scheduled with a local physician to monitor growth and the baby continued to meet the growth expectations.

The father has CPS history with his four other children. He fathered twins: one died at birth, and one died of SIDS. The other two children are currently in a dependency with the Kelso DCFS office. They are placed with relatives. The father has a significant history of substance abuse and assaults, including a prison sentence for an assault 2. He was offered services including: drug and alcohol assessment, parenting classes and a psychological evaluation.

The mother sporadically attended meetings with the public health nurses and later began cancelling visits with the baby's physician. The social worker and public health nurse scheduled a meeting with the mother and baby on September 15, 2005.

On September 14, 2005, the worker was informed that the baby had been found deceased in her parents' bed. The initial cause of death was unknown.

The mother has a longstanding history of drug addiction, including heroin and methamphetamine. Her older child, who is now 6 years old, is living with his father due to her substance abuse and neglect.

Issues and Recommendations

The review was attended by the social worker, supervisor, area administrator, and public health nurse who provided services to the family. It was evident throughout the review that the office had a very close working relationship with the public health department. The public health nurse attempted to engage the family on numerous occasions, and kept the social worker apprised of the situation.

The mother's referral history is concerning, but there were no specific allegations at the time that would have met the criteria to screen the case in for investigation. The worker expressed concern that they would have preferred to have the fatality review earlier to help promote closure on the case. No other practice issues were identified during the review.

Child Fatality Review #05-40
Region 6
Centralia DCFS Office

This 17-year-old Caucasian female died on May 5, 2005, shortly after her family made a decision to discontinue life support. The death was ruled natural due to meningococcal meningitis.

Case Overview

This almost 18-year-old female presented at the Woodland Urgent Care Center because she had developed a sudden and rapid rash after being seriously ill for two to three days. She had an upper respiratory infection about a week prior, had a severe headache and had been vomiting for over two days. She was transferred to St Peter's Hospital emergency room in Olympia. When she arrived at the ER, she was alert enough to provide some history. Her condition continued to deteriorate while she was in the ER and she was admitted to the ICU, where she had cardiac arrest. Ultimately, the family made a decision to discontinue life support and she died shortly thereafter.

The first recorded CPS referral on this family is dated April 3, 1990. The only information in the system is a CPS referral on the family, but no specific allegations are documented because the incident occurred prior to the implementation of the electronic tracking system.

The first referral with complete information was received in 1993. It alleged that the deceased, then 5-years-old, had been sexually abused by a cousin and adult babysitter in Snoqualmie. The mother was protective of her daughter and the incident was investigated by law enforcement.

Six years later, in 1999, the department received a referral alleging the mother had picked her 11-year-old daughter up by the armpits and threw her about four feet against the wall because she broke a glass. No injuries were reported, but the father told the mother that he would call the police if she did it again. This referral was not investigated by CPS.

The next referral was received on September 11, 2001. The girl disclosed that two weeks earlier she and her mom were involved in a physical altercation. She claimed her mom kicked her in the stomach, knocked her onto the couch and then jumped on her. She also said that she kicked back. The referral was accepted for investigation of physical abuse. The social worker interviewed the girl and her mother. The girl eventually disclosed to both the school counselor and the CPS social worker that she made the whole thing up because she missed her father and wanted to go live with him. Information on counseling resources were provided to the mother and the referral was closed as Unfounded.

On January 31, 2005, a new CPS referral was received and screened in for negligent treatment or maltreatment of the deceased by her mother. She disclosed that her brother, aged 14, punched her in the face on 1/27/05, hitting her in the left eye and causing some bruising. He was also throwing knives at her and he threatened to stab her. The mother was not home at the time. The mother told her daughter to ignore her brother, but the deceased felt that the problem was escalating. The incident was investigated by the Chehalis Police and her brother went to live with his father. He

eventually returned to the family home, was charged and placed in detention. The case was closed Unfounded.

The last two referrals on this family were received on May 4, 2005, and May 10, 2005, regarding the deceased child's meningitis. The first referral was from an anonymous referent who indicated that the girl had been sick for some time and the mother did not get her medical treatment in time. The second referral was also from an anonymous referent who alleged that the grandmother hated the girl's brother and wanted to give him a glass of water that the deceased had drank from. Neither referral was investigated.

Issues and Recommendations

No issues or recommendations were identified by the fatality review.

Child Fatality Review #05-41
Region 6
Centralia DCFS Office

This 12-year-old Caucasian female of Cuban descent died on April 28, 2005. The cause of death was listed as natural/medical from static encephalopathy.

Case Overview

At approximately 5:00 a.m. on April 28, 2005, the foster mother went into the deceased's room to feed her. At 7:30 a.m., the foster mother went back into the room to change the girl and get her ready for bathing. She found the child unresponsive and not breathing. The foster mother called 911 and started CPR. The ambulance crew pronounced the child dead at the scene.

The deceased had a long history of static encephalopathy, severe spastic quadriplegia with a seizure disorder, was on multiple medications and was seen by a local pediatrician on a regular basis. The post-mortem examination indicated her death was due to static encephalopathy. There is no suspicion that child abuse or neglect played any part in the death and no autopsy was performed.

Child's History:
The child came from a family with a history of substance abuse and domestic violence. Her disabilities are believed to have been caused by an extremely high fever in the summer of 1994. Her biological father took her to the local physician, who was able to reduce the fever. The father then returned the child to her mother. It was the hottest day of summer and the mother lived on the upper floor of an apartment building with no air conditioning. The following morning, the child was having seizures and was later determined to have suffered permanent brain damage due to the fever. She remained medically fragile for the rest of her life. The deceased was placed in the foster home by the department through a voluntary placement agreement on 1/1/95. A guardianship was established on 8/15/96 with the foster parents. The DDD worker noted that the foster mother provided excellent care to this medically fragile child.

Facility History:
There were six referrals regarding the foster family prior to the death of this girl.

On 08/18/1993, CPS received allegations that the foster mother slapped a child on the face and legs and caused the child to have seizures. CPS investigated allegation, contacted the referent (another foster parent), who reported that she had never made such a report. CPS determined the allegations were Unfounded.

On 10/30/95, CPS received a referral that alleged the foster father had a fight with his wife, who had to defend herself with a "butcher knife." The foster mother said the incident occurred between her and her first husband. Licensing determined the referral was not valid.

On 11/20/1995, CPS received allegations that the foster father hit foster children (a sibling pair) in his home. These allegations were determined to be Unfounded by CPS.

On 2/06/1996, CWS received a referral which was resolved 04/19/1996. A terminally ill foster child in the foster home died from medical complications due to birth defects. No Licensing action was taken.

The foster mother called in a referral on 8/30/1999. She was dressing a medically fragile child after giving the child a bath when she heard a "pop." The child was crying, so she took the child to the ER where the child was x-rayed. No injuries were found and the licensing complaint allegations were found not valid.

Another Licensing Complaint was received on 2/10/2000. The foster parents' biological son died of accidental asphyxiation after passing out because he had the flu. The Coroner's report classified the death is as accidental. The referral was screened out for CA/N and Licensing.

Issues and Recommendations

System Issues

The Division of Developmental Disabilities (DDD) does not have Medicaid personal care for children in foster care and doesn't require nursing oversight.
Recommendation: This issue will be brought to DDD's attention.

Respite care providers are sanctioned by DDD, but Children's Administration licensing staff record when DDD children are in respite care in the computer system (CAMIS). DDD does not have access to CAMIS to view child information
Recommendation: DDD social workers who are providing supervision for DDD dependency cases should be given" read only" access to CAMIS. DDD and Licensing staff should communicate more frequently regarding respite care homes that are sanctioned by DDD.

Exceptional Social Work

The DDD social worker provided exceptional support to the foster home.

Child Fatality Review #05-42
Region 6
Centralia DCFS Office

This three-month-old Caucasian male died of Sudden Infant Death Syndrome (SIDS) on January 4, 2005.

Case Overview

The Lewis County public health nurse contacted the CPS Intake supervisor in Centralia on January 10, 2005, to advise the department of a child fatality. The death certificate indicates the death was due to SIDS. Lewis County Health Department reported first responders and those who subsequently investigated the death had no concerns about child abuse or neglect. The public health nurse was in the home the day before the child died and noted no concerns of child abuse or neglect.

Six CPS referrals were received on this family between December 2000 and January 2005, one screened in for investigation. The first referral, in December 2000, alleged that the deceased's mother had sexually abused her brother (currently a resident at Echo Glen) when he was 10 or 11. The referrer was concerned about the potential danger the mother posed to her (then infant) first daughter. There was no CPS investigation.

A second referral was received in December 2003. The referrer was concerned that the children were being neglected by their mother. Her three children (aged 10 months, 2 and 3) often appeared at the child care center dirty with dirty clothes. The oldest child, who was potty trained, had started to wet her pants and was very quiet. The child care center staff talked to the mother about their concerns. This referral was screened out.

The third referral, received in April 2004, was about concern that a registered sex offender (RSO) may have been living in the home with the three children. Law Enforcement went to the home and did not find the RSO in the home with the parents and their children. This referral was also screened out.

The fourth referral, received in September 2004, was screened in for investigation. The three-year-old daughter had bruises on her buttock and shoulder. The investigating social worker went to the child care center with law enforcement to examine and interview the child. There were two small, ¼ inch bruises at the base of the child's left buttock. She had a scrape above her pelvis on the left side about one inch in diameter and another small bruise higher on her back. The child did not speak. The social worker also interviewed the four-year-old sister, who had some bumps on her face. When the 4-year-old was asked what happened, she said she "fell down, fall off a chair." The social worker went to the home and spoke with the parents, who said that the younger child bites and pinches his three-year-old sister. The social worker referred the family to the public health nurse and child care. During the course of the CPS investigation, the family moved to a larger home and reports from the public health nurse were that the children were appropriate in their hygiene and behavior. The referral was Unfounded for abuse.

The fifth referral, received in December 2004, alleged the newborn baby boy was not being cared for properly. The infant had a soaked diaper which had not been changed for some time. The referral was screened out and the case was closed when the referral regarding the baby's death was made.

Issues and Recommendations

Practice Issue

In reviewing this case and the narrative documentation by the social worker during the course of his investigation, it was discovered that the child care provider told the social worker that bruises were not usually seen on the children. The last time she saw injuries on the children was on 4/19/2004, when the three-year-old had a black eye and scratches on the left side of her face. When the child care staff asked what happened, the child said her mother scratched her and punched her in the face. The child care provider did not make a CPS referral regarding this incident.

Recommendation: The investigating social worker made a referral regarding the child care center's failure to report suspected abuse and neglect. The referral was made on October 19, 2005.

Child Fatality Review #05-43
Region 6
Vancouver DCFS Office

This one-month-old Caucasian female died of Sudden Infant Death Syndrome (SIDS) on June 10, 2005.

Case Overview

The baby girl was placed on her back in her crib after she was fed a bottle about at 11:30 p.m. on June 9, 2005. The father reportedly got up at 2:30 a.m. to check on her. He thought she was in a face down position and was not breathing. The mother and the grandparents were alerted and 911 was called. The baby was transported to Southwest Medical Center where they were unable to revive her and she was pronounced dead on June 10, 2005.

The mother of the child is a 17-year-old female who was in an in-home dependency with her adoptive mother. The baby's father was also living in the home. The CPS referral did not report any concern about abuse or neglect of the infant. There were no other referrals on the deceased's mother or father as parents, although both have a history with the agency when they were children.

The Children's Administration (CA) became involved with the family when the adoptive parents of the deceased's mother requested Family Reconciliation Services (FRS) in January 2002.The request was based upon by the then 14-year-old's uncontrollable behavior and refusal to follow household rules. Limited stabilization was achieved at that time through individual and family counseling.

The baby's mother was hospitalized in July 2002, due to an overdose of psychotropic medications. She was diagnosed with Major Depressive Disorder and PTSD, and was transferred to a residential treatment program in Idaho. She completed that program and was discharged to her family's care. She ran away from home several times and her adoptive parents signed a Voluntary Placement Agreement in May 2003. Dependency was established in October 2003. The mother then began a pattern of failed foster placements, running away, drug use, suicidal behavior/ideation, impulsivity, sexualized behavior, and juvenile justice involvement.

Wraparound/mental health services were provided to the mother, she obtained her GED and her behavior stabilized significantly in the summer of 2005, after she discovered she was pregnant. She voluntarily attended parenting classes, signed up for WIC, and kept her medical appointments. She investigated several independent living options, including those that focus on young mothers, but found none of them satisfactory. The mother's social worker became concerned when she had not identified a stable living situation with only a few weeks remaining in state care. The baby was delivered on May 11, 2005, and returned with her mother to the foster home. The mother phoned her social worker requesting that she be allowed to leave the foster home because the baby's 21-year-old father was not allowed to visit the home. She was denied permission to leave the foster home with the baby.

On Sunday May 15, 2005, she phoned her adoptive mother, who agreed to take her and the baby into her home. Although they had had a tumultuous relationship in the past and had not lived together for

two years, a genuine reconciliation between the two appeared to have been generated by the baby's birth. By report and observation the new young mother was loving and nurturing.

A shelter-care hold and out-of-home placement for the newborn was considered, but after conducting interviews with the mother and the maternal grandparents, it was determined that an in-home dependency with sufficient monitoring and service compliance would minimize any risk to the infant. The dependency proceeding was cancelled when the baby died in June. The baby's father was also living in the maternal grandparent's home at the time of death. By report and observation, he was a caring and involved father. No evidence of child abuse or neglect was reported or found. The young couple has since established their own residence and has maintained intermittent contact with the DCFS social worker.

Issues and Recommendations

No issues or recommendations were identified in this review.

Child Fatality Review #05-44
Region 6
Vancouver DCFS Office

This one-month-old Caucasian male, born prematurely at 25 weeks, was removed from life supports and died on August 29, 2005.

Case Overview

This baby boy was born with a positive toxicology screen for methamphetamines. Due to respiratory distress and pulmonary immaturity, he was immediately placed on constant mechanical ventilation and was not discharged from the hospital. It was anticipated that the child would be in the hospital for at least several months.
Medical providers and parents met over the weekend and decided it was in the infant's best interest to be removed from life supports due to neurological compromise and long term prognosis. On 8/29/05, life supports were removed and the infant died at 5:45 p.m.

There were three referrals on this family between July and August 2005.

The first referral was received 7/25/2005, three days after he was born. It was reported that the baby's mother had sporadic prenatal visits and had self-reported use of methamphetamines. In addition, she had been abused physically and sexually by her father and her brother, had been in treatment multiple times, and was involved with Healthy Steps. The baby was born at 25 weeks and if he survived, would be in the hospital for some time. The alleged father was in the county jail, with a release date of 8/16/05. The plan was for the mother to live with her mother when she was released from the hospital.

Children's Administration received two referrals on 8/01/05. One referent reported concern about the mother's ability to make medical decisions regarding her medically fragile infant. The referent completed an evaluation for services on 6/16/05 and was concerned about the mother's cognitive ability. The referent reported she was concerned that the mother may have some other delays as well. A mental health evaluation, including tests for IQ and parenting ability was scheduled for 7/25/05, but the mother was in the hospital. The hospital social worker arranged housing for the mother near the hospital, but she left without providing any contact information. This referral was screened Information Only.

The second referral on 8/01/05 was screened in for investigation. Hospital staff reported the mother was not visiting the baby and the doctor was very concerned that she could not follow basic instructions. The doctor recommended further assessment and support because there were many very important medical decisions that needed to be made by the baby's mother. An advocate for the baby appeared to be needed. The CPS investigator determined that the allegation was Inconclusive for negligent treatment/Maltreatment.

The mother had sporadic contact with the deceased throughout his stay in the hospital. During conversations with staff she often cited transportation problems, even though medical transportation

was made available. When the mother was present at hospital she was not able to follow hospital staff's directions (wearing hospital gown, etc). During an overnight stay, staff reported the mother and grandmother had a heated conflict and the grandmother reporting that the mother had assaulted her.

The alleged father was on work release for probation violations from a possession of methamphetamines charge. Although the father was more engaged during meetings with staff, his behaviors were often hyperactive and over sexualized. These behaviors are consistent with someone abusing methamphetamines.

The infant was never released from the Neonatal Intensive Care Unit (NICU) at the hospital. The baby's drug screen tested positive for amphetamines and marijuana. Since his respiratory system was not fully developed at birth, he was on a ventilation machine throughout his life. The machine eventually began to cause damage to the baby's lungs and attempts to take him off the machine failed. There was some concern that the high frequency ventilator could cause his lung to pop. The baby's doctor became increasingly concerned about the long-term neurological impact of the life support machines.

Due to concerns that the parents could not be located for permission if the child needed surgery, a dependency petition was filed and the child was placed in shelter care status. On 8/29/05, the baby's parents made the decision to have their son removed from life supports. Both parents were at his bedside at the time of death. The dependency was dismissed.

The parents have voiced plans to have other children and the DCFS social worker attempted to engage the parents in services to address their substance abuse and other concerns; the parents did not attend the meeting.

Issues and Recommendations

No issues or recommendations were identified by the review team.

Child Fatality Review #05-45
Region 6
Vancouver DCFS Office

This 17-year-old Hispanic male died from a gunshot wound on May 8, 2005.

Case Overview

The youth was on the run from the Crisis Residential Center at the time of his death. He was in a stolen vehicle. When law enforcement approached the vehicle, he drove off. A high speed chase ensued; the youth eventually lost control of his vehicle and hit a utility pole. When law enforcement approached the vehicle again, the youth put the van in reverse and hit one of the officers. It appeared the officer was pinned under the vehicle and the other officers fired their weapons at the youth, killing him at the scene.

Children's Administration received two referrals regarding this family.

The first referral for CPS was screened in as low risk and included allegations of physical abuse. The youth arrived at school with a black eye and was heard saying his father had punched him. Contact was made with the family, who stated that the youth told them he was break dancing at a friend's house and had hit his head on a table.

The second referral was for Family Reconciliation Services on March 25, 2005. The youth was being released from detention and his father was concerned about him returning to the family home. His father did not want him to return home because he was fearful that his son would continue to use methamphetamines, placing his family at risk. He feared for the safety of his six-year-old daughter. While on methamphetamines, the youth would steal cars and become aggressive; he had stolen from the family and was constantly running away.

The father met with the social worker and signed a Voluntary Placement Agreement to place the child in the Crisis Residential Center. The youth agreed to go into the HOPE program. While he was in the HOPE program he attended daily out-patient treatment and GED classes. He was also working on his relationship with his father.

Issues and Recommendations

Practice Issues

The first CPS referral was screened in moderate low with a low standard of investigation. Upon review of this referral, it was felt that it should have screened in at a moderate level with a high standard of investigation.

Recommendation: The Vancouver office has changed their intake procedures since this referral was taken. There is one single intake unit where referrals are taken and assigned out to a CPS unit through the intake supervisor.

It does not appear that a family assessment was completed during the FRS services and placement in the HOPE program. It is unclear if the CPS history was reviewed by the FRS worker. There was no documentation in the case file between April 22, 2005 and August 2005.

Recommendation: The Area Administrator will review with the FRS supervisor the need to complete family assessments and review CPS history on all families receiving FRS services. The FRS supervisor will provide this information to the FRS staff at a unit meeting. The area administrator will also ask that the FRS worker assigned to this case document actions taken between April 22, 2005 and August 2005.

Child Fatality Review #05-46
Region 3
Region 3 ICW Unit

This four-year-old Native American male died in a motor vehicle accident on May 30, 2005.

Case Overview

On May 30, 2005, at approximately 9:00 p.m., the mother of the deceased left her family home to pick up her almost five year old son at his father's house. She said they were going out for ice cream. Later that night, the father reported them missing. Their vehicle was discovered the next day by Department of Transportation staff who were attempting to remove a fallen tree from a roadway off the Mt. Baker highway. The little boy was dead in the front seat of the car, still restrained by a shoulder seatbelt. The mother had minor injuries. Law enforcement determined that the vehicle had left the roadway without any evidence of avoidance, in an area that does not have a distinct curve. It appeared that the vehicle struck a large tree and stopped, flipped onto its back and the tree fell onto the underside of the overturned car. The Medical Examiner determined that there were no injuries found on the deceased child that would have preceded the motor vehicle accident, that there was no evidence of abuse, and that the time from the crash to the child's death would have been very short.

The incident was referred to CPS intake for negligent treatment/maltreatment. CPS intake was concerned because:

- There was no apparent reason for the car to be where it was if the mother was just taking her son out for ice cream.
- There were no indications that the mother had attempted to brake prior to going off the road.
- There were empty beer cans found in the car.

However, the referral was not screened in for investigation because there were no surviving siblings. Policy in this type of situation has since been clarified. Child Protective Services now screens in any child fatality when there is an allegation of abuse or neglect by a caretaker, regardless of whether there are surviving siblings.

There were no criminal charges filed against the mother as a result of this incident. The law enforcement investigation did not show that drugs or alcohol were a factor in this incident.

This family first came to the attention of Children’s Administration in November of 2004. A referral was called in to CPS by a therapist from an in-patient psychiatric treatment facility where the mother had just been admitted. The caller reported that the deceased’s mother she believed her son was being molested by his father and she gave some detail of why she thought this was so. The therapist stated that the mother was having auditory and visual hallucinations during her report to him.

The referral was assigned for investigation and the CPS worker went to the child’s home, where he lived with his mother, maternal grandmother and aunt. The mother stated that she had recently separated from her husband, although she did not disclose the reason for the separation. The mother appeared to the investigator to be scattered and disorganized in her thinking. At more than one point in the interview she alluded to unknown "people" coming into her house and "bothering" them. She

said she couldn't see the "people," only their hands. The investigator then interviewed the little boy alone; he did not disclose any type of abuse.

The social worker called the father and explained the reason for CPS involvement. The father was aware of the allegation, but said that his wife was suffering from mental illness and feared it was getting worse. He had his son only part of the time, because he was a truck driver and gone a lot of the time. He confirmed that his wife and son were enrolled in the Lummi tribe and said his wife was getting mental health services from the tribal clinic. He was hopeful that her condition would improve. A collateral call to the referent confirmed the seriousness of the mother's mental illness.

The case transferred to the Native American unit for follow-up in a staffing in December, 2004. The newly assigned worker received a call from a psychiatric social worker saying that the mother had self-admitted to the hospital again. She reiterated her allegations about sex abuse by her son's father. According to the social worker, the mother was apparently doing well and stabilizing on her medications. In March the Native American unit supervisor reviewed the case and the plan at that time was to follow up with the family and staff with the Lummi tribal Child Protection Team (CPT).

The next contact concerning this family was when CPS was notified of the automobile crash and the young boy's death. DCFS learned at that time that the parents had been officially divorced two weeks prior to the death, through the Lummi Tribal court. They had joint custody of the child, but the mother was designated as primary caretaker.

The mother was killed in a fatal one-car accident on January 4, 2006.

Issues and Recommendations

Practice Issues

This referral was assigned to the regular CPS unit for investigation, despite a "yes" response to the question regarding the mother's status as Native American.
Recommendation: Supervisors of both units involved indicate this was an oversight. Practice remains that cases identified as Native American are to be investigated by the Indian Child Welfare CPS units.

After the initial investigation, the case was transferred into the Indian Child Welfare (ICW) Unit. There is no documentation that the assigned worker in the ICW unit contacted the mother or took other action to develop and monitor a safety or service plan with this family.
Recommendation and Action taken: This issue has been addressed with the ICW unit supervisor and Area Administrator. The ICW units are now combined with the other units under the same section leadership. Beginning January 1, 2007, the ICW section, along with the other units in the office, will be re-configured. The new model will assist in defining roles and place new emphasis on the implementation of safety and service plans for families after initial investigation.

System Issue

A timely safety assessment was completed for the initial referral alleging sex abuse on 11/29/04. That assessment documented that the mother's ability to care take was severely impaired by mental illness, yet no safety plan was created. The investigator noted that this was because there was no indication at the time that the child's safety was in jeopardy.

Recommendation: The Area Administrators and the workers involved agree that a safety plan should have been implemented in this case. The review team recommended that training in this area be made available to the workers and supervisors in the region. The team recommended that this training concern safety planning in mental health cases, and address issues related to severe mental health problems and how those issues impact the children of parents suffering from these problems.
The Lummi Nation has agreed to pursue getting representation from the mental health discipline to their Lummi Child Protection Team.

Child Fatality Review #06-1
Region 1
Colville DCFS Office

This one-month-old Caucasian male died on April 14, 2006, from an undetected heart defect.

Case Overview

On April 14, 2006, the deceased child's mother was sleeping while her paramour cared for her one-month old son. The paramour reportedly fed the child a bottle, burped him, and laid him on the couch next to him while he played video games. The paramour noticed that the child looked limp and went to wake the child's mother. A call was made to 911 and resuscitation efforts were performed at the residence as well as at the hospital, where the infant was transported. The child died a short time later. The Spokane County Medical Examiner completed the autopsy and determined that the child had a congenital heart defect. The conclusion of the autopsy showed a cortriatriatum biventricular heart defect. The child had been seen post-birth by a physician and had a circumcision two weeks prior to his death. His heart defect was not detected at that time.

There was one previous CPS referral regarding the family. On November 18, 2005, CPS received a call from a Community Services Office (CSO) employee indicating that information being reported was second hand information from a client of the CSO. Allegedly, the deceased child's mother was six months pregnant and smoked marijuana on a regular basis in front of a two-year-old child she was caring for. The referral further alleged that the two-year-old child did not have any boundaries or structure. This report was screened as Information Only.

Issues and Recommendations

Policy Issues

The inability for Children's Administration to intervene early with substance abusing pregnant women is a barrier to protecting children.

Recommendation: Children's Administration should consider early intervention for reported substance abusing pregnant women.

Child Fatality Review #06-2
Region 1
Spokane DCFS Office

This six-month-old Caucasian female died January 31, 2006, from SIDS.

Case Overview

On the morning of January 31, 2006, the child's father left his residence at 9:00 a.m. to take the child's mother to work. The deceased child and her older brother were left in the care of a family friend. The baby was sleeping when they left. At approximately 10:30 a.m., the father returned home and checked on his daughter. She was not breathing.

On February 1, 2006, Spokane Police Department reported the death of the six-month old girl to Child Protective Services (CPS). Her older brother was placed into protective custody by court order. At the conclusion of the autopsy and toxicology screening, the Spokane County Medical Examiner determined that the death was the result of Sudden Infant Death Syndrome (SIDS). The older brother was returned home and the family is receiving services from CPS.

A review of CAMIS revealed the following history with Children's Administration:

On September 11, 2000, CPS received a referral alleging Imminent Harm. The child's mother was in the third trimester of pregnancy and expected to deliver in November 2000. A public health nurse (PHN) from the First Steps Program had concerns regarding the mother's ability to care for the infant. The concerns were based on the mother's borderline intellectual functioning. The father of the infant was in jail for violating a no contact order that stemmed from a domestic violence incident against the mother. The mother was lacking family support to assist with the care of her infant. The mother's father was terminally ill and her mother was institutionalized for mental health issues. The baby girl, born on November 30, 2000, was removed from the mother's care at birth due to the mother's poor judgment and inability to meet her infant's needs. The mother relinquished her parental rights on December 9, 2002.

On May 6, 2003, CPS received a report that the mother was bringing her boyfriend (father of the deceased) to her first daughter's adoptive family's residence for visits. The adoptive family was unaware that the boyfriend was a registered sex offender (RSO). On June 24, 2003, the same general information as reported.

On October 17, 2003, CPS received an informational report that the mother was pregnant. She was in her first trimester of pregnancy. The report included information that the mother was diagnosed as borderline intellectual functioning and the alleged father was a level 1 RSO and diagnosed with antisocial personality disorder.

On March 9, 2004, CPS accepted a referral for investigation due to the mother's prior CPS history and relinquishment of a previous child. On May 4, 2004, the deceased's older brother was born. The mother and father participated in psychological assessments. The psychologist recommended that the father successfully complete anger management and parenting classes

before having unsupervised contact with his son. The mother and father temporarily separated, participated in services, and then moved to Utah. The case was closed and determined Unfounded for negligent treatment.

On March 31, 2005, CPS received an informational report that the mother was pregnant and in the first trimester of pregnancy.

On September 10, 2005, CPS accepted a referral for investigation due to an allegation of negligent treatment. The report alleged that the mother left her children with "anybody and everybody" and that one of the caretakers was involved with CPS. The allegations were investigated and determined to be Inconclusive. The parents applied for a childcare grant via the CSO, and agreed to leave the children with appropriate caregivers.

On September 23, 2005, a neighbor reported that the father inappropriately disciplined his son and had unrealistic expectations of him. On October 26, 2005, the same neighbor made a referral that the father left the children unattended in the apartment, spanked his son too much, and that his son was mean to his infant sister (the deceased). This report was investigated. At the time, both the mother and father were employed, had regular contact with a PHN, and both children attended full time childcare. The case was closed as Inconclusive for negligent treatment.

Issues and Recommendations:

System Issue

The Fatality Review panel identified a lack of resources for Children's Administration to assist families with transitioning to independence through aftercare plans following CPS interventions.

Recommendations: Children's Administration should consider a childcare assistance program for families needing support following CPS intervention.

Child Fatality Review #06-3
Region 1
Spokane Office of Foster Care Licensing

Case Overview
This eight-year-old Caucasian male died on March 25, 2006, due to an ongoing medical condition. He died in the home of his legal guardian, who was a licensed foster parent.

The child had many physical disabilities (including cerebral palsy), developmental delays, vision and hearing impairments, and a seizure disorder. He was non-ambulatory, was tube fed and had been having frequent seizures. On the morning of March 25, 2006, the child experienced multiple seizures. His guardian called 911, the paramedics arrived and during the intervention, the child's heart stopped. He was transported to Holy Family Hospital, where he died.

A review of CAMIS revealed the following history with Children's Administration:

On August 6, 1998, Child Protective Services (CPS) received a referral from a physician at Sacred Heart Hospital. The child was brought to the emergency room by his father. He had bilateral distal femur fractures in both legs and a fracture of the right humorous. Prior to these injuries, the child had been diagnosed with cerebral palsy, developmental delays, vision and hearing impairments, and a seizure disorder.

The Spokane County Superior Court found the child dependent on April 16, 1999. He was placed with his maternal grandmother for one year. He moved to foster care when his needs became too great for his grandmother to handle. The child's birth parents were not able to meet his needs. In April 2001, his foster mother was granted a Dependency Guardianship. The child remained in the care of his foster mother until his death.

The child's foster mother became licensed to provide foster care on October 12, 1992. She has not been the subject of any referrals or complaints. She self-reported falling with a child in 2000 that resulted in a bump to the child's head.

Issues and Recommendations

No issues or recommendations were identified.

Child Fatality Review #06-4
Region 4
King South DCFS Office

This 16-year-old Caucasian male was killed in a car accident on March 24, 2006.

Case Overview

The child was killed in an automobile accident at 2:30 a.m. on March 24, 2006. He was driving his parents' car, which they had reported stolen. Kent Police spotted the car and tried to get the child to pull over. When he refused to pull over, the police pursued him at a high rate of speed. The child lost control when he failed to negotiate a curve at 80 miles per hour. The child was scheduled to have a hearing on his At-Risk Youth Petition (ARY) the following day.

The deceased child has a twenty-one-year-old brother, who is disabled and receives SSI. There were 11 referrals to Child Protective Services from 1987 to 1999, including allegations of Physical and medical neglect, physical abuse and domestic violence.

In 2000, the deceased youth had a Child In Need of Services (CHINS) petition and was in foster care for about one month. In 2001, a dependency was established. He was reported as a runaway in 2003, and the dependency was subsequently dismissed.

The deceased youth is listed as a client on his mother's CPS referrals. However, there is no evidence that he was residing with her. He was living his father and step-mother in Kent.

On November 11, 2004, a Pierce County deputy sheriff picked up the deceased child based upon a runaway report which was filed by his father and step-mother. The parents expressed fear of the child, claiming he had pulled a knife on the father. Two referrals were accepted for Family Reconciliation Services (FRS) and assigned to the King South DCFS office in Kent. Identified problems included suicidal ideation (followed by a mental health assessment at Fairfax), learning disabilities and school difficulties, and the father's intense focus on physical strength and aggression when dealing with conflicts. The case was closed in December 2004, noting that the family filed an ARY petition and a court order was in effect.

On February 13, 2006, the step-mother requested FRS again. She wanted a family assessment for another ARY petition. At the time the child was in Overlake Hospital for attempting to cut his wrists. She described him as impulsive, compulsive and a runaway. A referral was accepted for FRS. On February 15, 2006, the father and son signed the family assessment and planned to meet the step-mother at court to file the ARY petition. The family wanted to wait to begin FRS Phase II counseling until after the court hearing (set for March 24, 2006, at 2:30 p.m.).

Issues and Recommendations

Systems Issues

High speed pursuit by law enforcement

***Recommendation: CA will discuss this in November 2006 with a group of professionals in King County who review traffic-related fatalities*.**

Exceptional Social Work

The assigned DCFS social worker provided the family with an assessment that they used to file an ARY petition. She found lots of strengths with the child and his parents. The child died just twelve hours before the petition was scheduled to be heard in court.

Recommendation: At-Risk-Youth can mean just that — youth who may act impulsively and make very poor choices that endanger their lives as well as others. CA should continue to support the efforts of families who seek help for their adolescents.

Child Fatality Review #06-5
Region 4
King East DCFS Office

This 15-year-old Caucasian female was shot to death at a rave after-party in Seattle on March 25, 2006.

Case Overview

The child was a homicide victim in a high profile shooting in Seattle. According to The Panel Report to the Seattle Police Department on the March 25 2006 Capitol Hill Shooting, July 17, 2006, "In the early morning of March 25, 2006, 28-year-old Kyle Huff shot eight young men and women, six of them fatally, at a rave after-party on East Republican Street in the Capitol Hill section of Seattle. The gunman, a transplant from Montana, then committed suicide just as the police arrived on the scene."

The first referral to Children's Administration regarding the child and her family is dated January 23, 2001. It was a request for Family Reconciliation Services (FRS). At that time, the concern was for the older sister of the deceased (now 18-years-old, but 12-years-old twelve at the time of the referral). The sister was in in-patient treatment for psychotic episodes. The mother requested FRS because the sister was to be discharged January 29th. Family Preservation Services (FPS) was authorized and the case was closed on May 7, 2001, with a Service Episode Record (SER) stating "Family completed FRS services. No further services requested. Case to be closed."

The second referral, dated April 21, 2005, indicated that the child's mother wanted to file an At-Risk Youth Petition (ARY) on her daughter (deceased child, then aged14). The identified problems included: running away, defiance, and substance abuse. The child had refused to attend school since she was 12-years-old. The referral was assigned to a social worker, who had a telephone conversation with the mother and provided her with resource information. There was no further request from the family for services and the case was closed May 20, 2005.

Issues and Recommendations:

System Issues

Apparently nobody knew of the killer's plans. Access to firearms, allowing under-age youth to attend the rave venue and the after-rave party were all contributing factors.

Recommendations: The best way to protect a teenager from risk of premeditated violence such as this is for parents to be fully aware of where the youth plans to go, what is happening at the event, who will be there and to set appropriate limits.

Child Fatality Review #06-6
Region 4
King West DCFS Office

This 12-day-old African American female died on March 31, 2006, at Children's Hospital due to complications from the mother's drug use, which caused premature delivery. According to the King County Medical Examiner, the cause of death is "respiratory distress syndrome, intra-cerebral hemorrhage, and spontaneous perforation due to prematurity due to placental abruption due to maternal cocaine use." The manner of death is accidental and the manner subcategory is drugs.

Case Overview

This infant was born at twenty-nine-weeks gestation due to maternal cocaine use. She had multiple medical complications due to her prematurity. She lived for 12 days.

The deceased child's mother gave birth to three children in four years (2003-2006). The two boys were placed for adoption after parental rights were legally terminated. The daughter died of complications due to maternal cocaine use. Another girl was stillborn. Child Protective Services (CPS) was involved extensively with the three children who were born alive.

CPS received a referral on July 19, 2003, with allegations of negligent treatment or maltreatment. The mother gave birth to the deceased's oldest brother, tested positive for cocaine and reported incidents of domestic violence with the father. The brother was originally placed on a Voluntary Placement Agreement (VPA). The mother did not comply with her Voluntary Service Plan, which included a drug/alcohol evaluation. She stopped visiting the child. Dependency was established and an order of Termination of Parental Rights was entered August 03, 2005.

A second CPS referral was received January 15, 2004, it was screened Information Only and did not require an investigation. Harborview Hospital reported that the mother arrived by ambulance at the emergency room for leg pains. She was two months pregnant and under the influence of marijuana.

On August 09, 2004, Swedish Hospital made the third CPS referral because the mother tested positive for cocaine after delivering her second son on August 08, 2004. The baby boy tested positive for cocaine as well. The referral was accepted for investigation. The mother initially signed a VPA and the child was placed at the Pediatric Interim Care Center, a facility for drug-affected infants. The CPS allegations of negligent treatment/maltreatment were Founded. The second son was placed in the same foster home as his brother. Dependency was established and on August 03, 2005, an order of Termination of Parental Rights was entered.

Children's Administration received two CPS referrals dated April 19, 2005; they reported the stillborn birth of a twenty-two-week-old female fetus. The first report was by the social worker at Swedish Hospital and the second was from the King County Medical Examiner. The official

cause of death was "Intra-Uterine Fetal Demise due to acute maternal cocaine use." The CPS reports were screened as Information Only and no investigation was completed.

On March 19, 2006, the mother delivered a two-pound baby girl, twenty-nine-weeks gestation. The mother and the infant both tested positive for cocaine. There had been no pre-natal care and the child was in critical condition. She was transferred to the Children's Hospital Neonatal Intensive Care Unit (NICU).

The mother was essentially absent and did not participate in medical decisions concerning the child. The assigned CPS worker filed a dependency petition and the court granted the state the authority to make decisions in consultation with the medical staff at Children's Hospital. On March 28, 2006, in the presence of the CPS Supervisor, medical staff removed the child from life supports. The child died March 31, 2006. The CPS supervisor was present.

Issues and Recommendations

Exceptional Social Work

The two CPS social workers and the CPS supervisor had to deal with an extremely premature, medically fragile infant in a neonatal intensive care unit at Children's Hospital. The parents were not present to help make medical decisions, and CPS obtained a court order to authorize medical care. The supervisor was at the hospital every day. Eventually the mother did come to the hospital and signed a Do Not Resuscitate (DNR) order. The CPS Supervisor was present when the child died, and he helped to take care of her.

The CPS Supervisor arranged a memorial service for the child, a funeral home cremated the body at no cost, a cemetery donated a headstone and a relative of a DCFS employee donated a burial plot not only for the child, but also gave two plots to Children's Hospital for future needs. Staff from DCFS and Children's Hospital attended the service.

The close work between DCFS and Children's Hospital helped to form a bond between the units. Changing perceptions and improving community relations is an added benefit. The excellent work done by CA staff helped to confirm their professionalism and caring attitude.

Systems Issue

There needs to be a way to pay for funeral expenses when indigent children die.

Recommendation: This would be a worthy private grant for someone wishing to create a charitable foundation for this purpose.

Child Fatality Review #06-7
Region 1
Spokane DCFS Office

This one-year-old African American female died on February 18, 2006, from a congenital medical condition.

Case Overview

The licensed relative foster father was transporting the deceased child to the hospital on the evening of February 18, 2006, due to concerns surrounding chronic medical issues. The child had a diagnosis of esophageal atrisia (lower esophagus does not connect to stomach), tracheo esophageal fistula (lower esophagus connects to trachea), lyrangeo-malacia (cartilage is malformed or collapse of cartilage can interfere with breathing), reflux, bronchopulmonary dysplasia and developmental delay secondary to prematurity. When the foster father noticed that the girl was not breathing, he pulled his car to the side of the road, called 911, and started CPR. The medics arrived and continued resuscitation efforts while transporting the child to Sacred Heart Hospital. The little girl was pronounced dead at the hospital.

The Spokane County Medical Examiner determined the cause of death was exacerbation of chronic lung disease; premature birth. This child's death has been determined a natural/medical death by Spokane County Medical Examiner.

Issues and Recommendations

After review of Children's Administration's files, including the licensing file, there are no policy or practice issues that would have prevented this natural/medical death.

Child Fatality Review #06-8
Region 1
Spokane DCFS Office

This four-year-old Caucasian female died in a motor vehicle accident on June 15, 2006. She was living with her mother in Idaho on an in-home dependency. The child and her mother were killed by a car driven by a man who had allegedly murdered his wife. At the time of the accident, he had his wife's head in the trunk of his car. He thought the police were pursuing him, so he deliberately drove his car into the car driven by the mother in an attempt to kill himself. He had no relationship with the mother or the child.

Case Overview

On 10/01/02, the deceased child's mother requested FRS services for her 13-year-old daughter who ran away from home, refused to do her chores, and had other teens over to the home without her mother's permission.

On 6/04/03, the deceased child's 5-year-old sister ran to a park a few blocks from her mother's home. The child's father caught up with her and brought her home. The referrer was concerned about the children in the home because of suspected drug use by adults in the home. This referral was screened out as Information Only.

On 9/10/03, CPS received a referral alleging that the deceased child's mother was allowing unsupervised contact between a level 2 sex offender and her 5-year-old daughter. This referral was investigated in conjunction with a referral received on 9/29/03, which alleged that the mother's 14-year-old daughter was sexually abused by her mother's boyfriend (father of the deceased child). According to the referral, she told her mother about the abuse and her mother told her not to tell. When interviewed by CPS, the 14-year-old confirmed the allegations. She also said that her mother and her boyfriend would steal checks out of people's mailboxes and her mother made her forge checks. She said that her mother and her mother's boyfriend used methamphetamines. The mother was arrested and two of the children were placed in foster care; the middle child was placed with her father. The allegations were Founded for sexual abuse of the oldest daughter by the mother's boyfriend and for negligent treatment by the mother.

The deceased was placed with her maternal grandparents in Boise, Idaho in July of 2005. On 4/13/06, the court approved the deceased child's placement with her mother in an in-home dependency.

Issues and Recommendations

After review of the case file, it was determined that there are no policy, practice or performance issues that need to be addressed. The manner of death has been determined a homicide by a third party who intentionally caused a motor vehicle collision witnessed by a Boise, Idaho police officer. This homicide was unforeseeable and could not have been prevented through any Children's Administration's actions.

Child Fatality Review #06-9
Region 1
Spokane DCFS Office

This one-month-old Caucasian female died of Sudden Infant Death Syndrome on March 23, 2006.

Case Overview

This four-week-old baby girl was found deceased on the morning of March 23, 2006, by her mother. The Spokane Medical Examiner determined the cause of death to be Sudden Infant Death Syndrome (SIDS).

The mother of the deceased first came to the attention of Child Protective Services (CPS) as a child. She later requested Family Reconciliation Services (FRS) from Children's Administration as an adolescent.

The mother came to CPS' attention as a parent on August 11, 2005. A mandatory reporter contacted CPS after a visit to the family home. The referent expressed concerns regarding the home environment. The home was described as filthy, with a strong odor. Numerous small items that posed a choking hazard were within reach of the 16-month-old child. The father of that child was residing in the home at the time and reported that he had his parental rights terminated on his two children from a previous relationship. Contact was made by a CPS social worker and the family was attempting to clean up their home.

Public health nursing services started in September 2005, and the parents followed directions for securing hazards in the home. Headstart professionals who worked with the family indicated the mother had low cognitive functioning. She appeared to follow very specific directions but had difficulty identifying new risks or problem solving on her own. CPS monitored the family and their participation with Public Health; Women, Infant, and Children (WIC) and Headstart. On February 17, 2006, the mother gave birth to a daughter.

The mother appeared bonded and connected to both of the children. She was happy about her pregnancy and the birth of her daughter. Both children were seen by their pediatrician and were current on their immunizations. The parents appeared to have some unrealistic expectations of their son for his developmental level. The family had a minimal level of support. The case plan was for CPS to close the case and community agencies would continue working with the family.

On March 23, 2006, CPS received a report from the Spokane Medical Examiners office. The baby girl had died and it appeared to be a SIDS death. There was no trauma evidenced and no allegations of child abuse or neglect. The final autopsy conclusion was that she died of SIDS.

After their daughter died, the parents became resistant to assistance and services from CPS and other community services. They declined any type of counseling and would avoid the public health nurse and Public Health Social Worker.

CPS continued to monitor the family situation. The father indicated that he had multiple foster care placements in his own childhood. He told the social worker that he had had his parental rights terminated on some of his other children. The home environment began to deteriorate and on May 25, 2006, the parents signed a Voluntary Placement Agreement to place the deceased child's older brother in relative care. On that same day, a 15-year-old female reported that she had been raped by the father of the deceased child. Law enforcement and CPS investigated these allegations and identified additional safety and risk concerns. A dependency petition has been filed and the brother remains in relative care.

Issues and Recommendations

System Issues

Lack of access to law enforcement databases and support enforcement information posed a barrier to the social worker's ability to accurately assess risk to the children. The father has a significant law enforcement history in multiple states, some of which are sex crimes against minors. He also has several children with different mothers, whom he has allegedly abused or neglected. His parental rights were terminated on some of these children. This information was learned by the social worker after the death of this infant.

Recommendation: Child Protective Services investigators should have access to the National Crimes Information Center (NCIC) database as well as Support Enforcement Management System (SEMS).

This information on this family and the information on the father's previous children were not linked in CAMIS.

Recommendation: The social worker corrected this once she learned there was additional information in CAMIS related to this father.