Report to the Legislature

Quarterly Child Fatality Report

RCW 74.13.640

April - June 2009

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Table of Contents

Children's Administration Quarterly Child Fatality Report

Executive Summary 3

Child Fatality Review #08-55 6
Child Fatality Review #08-56 10
Child Fatality Review #08-57 12
Child Fatality Review #08-58 13
Child Fatality Review #08-59 16
Child Fatality Review #08-60 19
Child Fatality Review #08-61 21
Child Fatality Review #08-62 23
Child Fatality Review #08-63 26
Child Fatality Review #08-64 28
Child Fatality Review #08-65 32
Child Fatality Review #08-66 34
Child Fatality Review #08-67 37
Child Fatality Review #08-68 40
Child Fatality Review #08-69 44
Child Fatality Review #08-70 46
Child Fatality Review #08-71 49
Child Fatality Review #08-72 50
Child Fatality Review #08-73 54
Child Fatality Review #08-74 57
Child Fatality Review #08-75 60
Child Fatality Review #08-76 64
Child Fatality Review #08-77 67
Child Fatality Review #08-78 69
Child Fatality Review #08-79 74
Child Fatality Review #08-80 77
Child Fatality Review #09-01 80
Child Fatality Review #08-81 86

Executive Child Fatality Reviews

Sarenadee Leingang 91
Izayeh Denison 105

Executive Summary

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

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

This report summarizes information from 28 completed fatality reviews of fatalities that occurred in 2008. All were reviewed by a regional Child Fatality Review Team.

This report includes two expanded Executive Child Fatality Reviews completed during the quarter. These completed reports are attached at the end of this report. These reports are also found on the DSHS website. http://www.dshs.wa.gov/ca/pubs/fatalityreports.asp

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

Region	Number of Reports
1	0
2	5
3	6
4	5
5	7
6	6
Total Fatalities Reviewed During 2nd Quarter, 2009	28

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

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

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

The chart below provides the number of fatalities reported to CA, and the number of reviews completed and pending for calendar year of 2008 and 2009. The number of pending reviews is subject to change if CA learns new information through reviewing the case. For example, CA may learn that the fatality was anticipated rather than unexpected, or there is additional CA history regarding the family under a different name or spelling.

Child Fatality Reviews for Calendar Years 2008 /2009			
Year	Total Fatalities Reported to Date Requiring a Review	Completed Fatality Reviews	Pending Fatality Reviews
2008	88	88	0
2009	29	1	28

The numbering of the Child Fatality Reviews in this report begins with number 08-55. This indicates the fatality occurred in 2008 and is the 55th report completed for that calendar year. The number is assigned when the Child Fatality Review and report by the Child Protective Services Program Manager is completed.

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

Child Fatality Review #08-55
Region 5
Kitsap County

This two-year-old African American female died from complications related to a birth defect of her heart.

Case Overview
On October 3, 2008, this child died from sudden cardiac arrest while at a Kitsap County hospital. The Kitsap County Coroner reported the child was not in good health. The child was born with a birth defect characterized by an undeveloped left side of the heart. This defect was not correctable. This child had a prior stroke as well as multiple surgeries and medical procedures. Prior to the child's death, heart surgery was postponed due to the child's weakened health. The County Coroner indicated there was no plan for further investigation of the circumstances of death. The Kitsap County Community Child Death Review Team declined to review the incident given indications of a clear medical cause of death.

Referral History
On August 4, 2006, an anonymous report was made to Child Protective Services (CPS) intake alleging domestic violence (DV) between the parents of the deceased child. The mother allegedly threw objects at her husband; he tried to protect the children. This referral was screened out for investigation.

On September 5, 2006, a report was made to CPS intake alleging the deceased child's two-year-old sister was molested by a non-related teenager. He is a registered sex offender. This information was forwarded to the Bremerton Police Department. This referral was screened out for investigation.

On November 30, 2006, a social worker reported to CPS intake that the uncle of the deceased child was visiting the family home. He is a registered sex offender and was not to be in the home with children present. This referral was screened out for investigation.

On February 12, 2007, a mental health professional reported to CPS intake the mother of the deceased child said she had photographic evidence that the children's father was harming her two daughters. The referrer said the mother has a history of making false allegations about others harming her children. This referral was screened out for investigation.

On March 7, 2007, a home health care worker reported to CPS intake the then seven-week-old sister of the deceased child had a medical condition that limited her ability to gain weight. The child's mother did not show for an appointment to bring this child to a doctor. The health care worker reported she is the main caregiver during the day and the children

are ignored at night. All three of the children in the home have serious medical conditions or developmental delays. This referral was screened out for investigation.

On March 8, 2007, a medical professional reported to CPS intake the then seven-week-old sister of the deceased child had a sinus infection and her parents did not give her the proper dosage of medications to treat this condition. This infant had poor weight gain. This referral was screened in for investigation for negligent treatment or maltreatment and closed with an inconclusive finding. Children's Administration staff continued to work with the family after the initial CPS investigation. The family was already working with the Division of Developmental Disabilities, public health, and an Infant Toddler and Early Learning Program. The family accepted additional services including day care, parenting class, NCAST (Nursing Child Assessment Satellite Training) assessment, nutritionist, and home based service funds. During this time the deceased child's heart situation deteriorated according to the heart specialist.

On March 13, 2007, a report was made to CPS intake alleging the deceased child's father spanked her then two-year-old sister leaving brief marks. The mother told the referrer she had proof. This referral was screened out for investigation. The case remained open for services.

On March 23, 2007, a report was made to CPS intake alleging the parents of the deceased child and her two sisters shake and yell at them. The mother carried the 12-month-old sister, but did not support the baby's head. Both the mother and father pick up the children by the arm, and, they yell at the children threatening to beat their butts. They spanked the children and flicked them on the face. The referrer also reports the mother allowed her brother, a registered sex offender, to visit the home. This referral was screened in as Low Risk. The case remained open for services.

On August 29, 2007, a Head Start worker reported to CPS intake the seven-month-old sister of the deceased child was not getting nutritionally sufficient and appropriate food. This referral was screened in for investigation for negligent treatment or maltreatment and closed with an inconclusive finding. The case remained opened to provide Intensive Family Preservation Services (IFPS) to the family.

On June 11, 2008, a report was made to CPS intake alleging the deceased child's mother was pregnant. This referral was screened out for investigation.

On September 22, 2008, a report was made to CPS intake that an in-home care provider had spanked one of the children. No marks or bruises were left on the child. This referral was screened out as a Third Party referral.

On October 3, 2008, hospital staff reported to CPS intake that the deceased child died while hospitalized. She was born with a congenital heart defect and her death was determined to be natural. This referral was screened out for investigation.

Issues and Recommendations

Issue: While the entire family history of involvement with CA was reviewed in summary, primary and detailed focus during the review was on the last 14 months prior to the child's demise from a medical cause of death (congenital heart defect). No significant practice, policy, or system issues were identified. Several minor errors and practice deficits were noted during the child fatality review. None appeared to have any obvious impact with regard to the circumstances of the child death. These are included below as documentation of the discussions occurring during the child fatality review.

Recommendation: None.

Issue: A CPS referral made in late August 2007 identified only the mother as a subject of allegations of negligent treatment. However, the referent stated concerns of possible neglect by both parents to the deceased child's seven-month-old sister and thus the father should have also been identified as an alleged subject.

Recommendation: None.

Actions Taken: Region 5 Intake Supervisors and Intake Area Administrator were provided feedback regarding the failure to identify all subjects in the August 2007 intake.

Issue: CPS Investigation:

The most recent CPS investigation, initiated 14 months prior to the fatality incident, involved a younger sibling of the deceased. An unannounced home visit and face-to-face contact with the alleged victim and contact with the parents were conducted in a timely manner. The family was receiving Division of Children and Family Services Family Voluntary Services (FVS) at the time of the referral, and there is documentation that the CPS worker collaborated with the assigned FVS worker for the case and most of the collateral contacts were made by the FVS worker. The CPS worker did not contact the referent (mandated reporter). Best practice would suggest such contact be made routinely, but especially when there is conflicting information gathered from other professional sources. The CPS case assignment remained inactive from mid-October 2007 until mid-February 2008 (four months) at which time there were no CPS investigative activities. Notification of finding was sent to the alleged subject at that time, and this is well after prescribed timeframes for completion of the CPS investigation and notification of findings to an alleged subject. Additionally, some documentation by the CPS investigator was not input into the CA data base until 3-4 months after the actual activity took place, in violation of documentation policy. The Investigative Assessment as completed by the CPS

worker indicates a finding of "Inconclusive" as to the allegation of negligent treatment by the mother. However, the worker stated in at least two key narratives that the allegation was clearly "Unfounded." The worker stated during the review that he clearly remembers the allegation being unfounded, but he may have inadvertently marked the wrong check-box when completing the findings section of the Investigative Assessment.

Recommendation: None.

Actions Taken: The social worker who conducted the August 2007 CPS investigation, the CPS supervisor, and the current CPS Area Manager participated in the review and received feedback regarding delayed documentation, excessive inactivity, and delayed CPS case closure. The deficits were acknowledged as having occurred but were presented as not being reflective of a pattern of practice within the Bremerton DCFS office.

Issue: Family Voluntary Services:

During the nine months the FVS case was active (May 2007-February 2008), efforts to meet the health, safety, and welfare needs of the children in the home appear to be exceptional in terms of service provision and risk reduction. However, the worker did not obtain signed service plans nor conduct any Comprehensive Family Assessments as required by policy for provision of FVS. Numerous and continuous contacts with professionals involved with the family were well documented. While such contacts with individual providers merits recognition as good practice, a more collaborative process such as conducting a multi-disciplinary team staffing may have been more productive in terms of developing a family plan at case closure.

Recommendation: None.

Child Fatality Review #08-56
Region 4
King County

This two-month-old Samoan male died from accidental asphyxiation.

Case Overview
On October 9, 2008, the deceased child was breastfed and put to sleep face-up on his parent's bed. The parents reported to the King County Medical Examiner investigator that around midnight the father placed the deceased child's two-year-old brother in the parents' bed too. At that time, all four family members were sleeping in the same queen-sized bed. When the father woke up the next morning around 7:00 a.m., he found the two-year-old sleeping on top of his infant brother. The father reported the deceased child was lifeless. The parents called 911, but this child was pronounced dead at the scene. The Medical Examiner investigator noted the home was unkempt, filthy, and the bedroom was very hot, 75 degrees Fahrenheit. The bed was very soft. A heavy synthetic blanket was used as a sheet and similar ones for top coverings. The investigator noted several risk factors including maternal smoking, evidence of extensive smoking in the apartment, and overlying while bed sharing with multiple family members. The Medical Examiner determined the cause of death to be compressional asphyxia. The manner of death is listed as accidental.

Referral History
The mother of the deceased child has given birth to four children. Her first child was born when she was 15-years-old. Her second son was born a year later. The father of these children is not the father of the deceased child or his brother. When the mother was 18-years-old, Child Protective Services (CPS) received the first report of abuse or neglect of her two oldest children. On August 25, 2003, CPS accepted a referral for investigation after a police officer found her two sons, ages two and three, unattended in an apartment parking lot. The children were put in protective custody and placed with relatives. The children were eventually returned to their parents' care and the department engaged in a lengthy effort to provide services to the mother and children. These services included therapeutic child care and other in-home services. However, conditions did not improve. A third report to CPS on March 15, 2004, resulted in another removal from the home and a legal finding of dependency. The parents did not engage in services. On July 20, 2006, the court terminated the legal rights of the parents (and the mother to the deceased child) as to her oldest two children. These boys were adopted. The mother gave birth to children in 2006 and 2008 (the deceased child). Both of these children remained in the care of the mother and the deceased child's father.

On July 10, 2006, a social worker reported to CPS intake that the deceased child's mother was pregnant with his older brother. She previously had her parental rights terminated to two other children. This referral was screened as information only.

On November 2, 2006, a social worker reported to CPS intake that the deceased child's mother was pregnant and due to deliver at any time. Her parental rights were terminated in June 2006 of her two children due to neglect. The mother has developmental delays and a history of abusive relationships. She did not engage in services to get custody of her children. The referrer contracted with Maternity Services to see the mother. This referral was screened as information only.

On December 23, 2006, hospital staff reported to CPS intake that the mother gave birth to the older brother of the deceased child. The baby was born in good health, and no concerns were noted at the time of his birth. The family lived with extended family members and engaged in services including Family Preservation Services, parenting classes, and a public health nurse. This child remained in his parents' care. This referral was screened out for investigation.

On April 18, 2008, a visitor to the family home reported to CPS intake that the 18-month-old brother of the deceased child had a bloody face and his eyes were swollen shut. His mother said he had eczema. The landlord said the child had food allergies. This referral was screened in for investigation by CPS and closed with an unfounded finding for physical abuse.

Issues and Recommendations

Issue: Reducing the risk of accidental asphyxia for infants and very young children while sleeping.

Recommendation: The reviewers recommended that there be a population-based, public health strategy to inform and educate caregivers about the dangers of accidental asphyxias. Current interventions focus on SIDS risk reduction, but similar measures concerning positional and compressional asphyxias should also be developed. The regional program manager was to discuss this with Public Health and the NISA/SIDS Foundation.

Child Fatality Review #08-57
Region 3
Skagit County

This 17-year-old African-American male died from a self-inflicted gunshot wound.

Case Overview
On November 24, 2008, the deceased youth was visiting his brother's home in Pierce County. The youth was away from the home while his brother and his wife were at work. They returned later in the day and found the youth dead inside their home. He had gotten back into their locked residence and shot himself with the brother's rifle.

The youth's family was involved with Mt. Vernon Child Protective Services (CPS) with a case closing two weeks prior to the fatality incident. CPS investigated allegations that the mother inappropriately responded to the deceased youth taking a lethal dose of Tylenol. She drove her son almost 100 miles to hospital near the family home rather than taking him to the nearest hospital. He told a social worker he was not depressed or suicidal. He was offered, and declined, mental health counseling. He was instructed how to access counseling should he want it in the future.

Referral History
On April 10, 1995, a neighbor reported to CPS intake that the three children in the home, including the deceased youth, then five-years-old, were poorly supervised. The children, with ages ranging from five to ten-years-old, played a game of running onto a busy road and forcing cars to stop. The referrer reported the mother was aware her children played this game, but did nothing to stop it. It was also alleged there was domestic violence in the parents' relationship. This referral was screened in for investigation by CPS and closed with an inconclusive finding for negligent treatment or maltreatment.

On October 7, 2008, a relative reported to CPS intake the deceased youth swallowed two bottles of Tylenol. The family was visiting relatives in Tacoma at that time. The mother took her son and left, presumably to take him to a nearby hospital. The referrer found out later the mother took him to a hospital near their home two hours away. The referrer added the mother left the nine-year-old brother home alone while she worked late. This referral was screened in for investigation by CPS and closed with an unfounded finding.

On January 22, 2009, CPS intake was alerted to the death of this youth. The youth died from a self-inflicted gunshot wound on November 24, 2008 in Pierce County while visiting his adult brother. This referral was screened out for investigation.

Issues and Recommendations
Issue: No issues identified

Recommendation: None

Child Fatality Review #08-58
Region 3
Skagit County

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

Case Overview
On November 24, 2008, the mother of the deceased child was visiting overnight at a friend's house with her three small children. She fell asleep on a bed after feeding her two-month-old infant. When she awoke in the morning she found him unresponsive on the bed beside her. He was unable to be revived. At the time of this report, the County Coroner had not released an official cause and manner of death. The Coroner's official finding is pending the outcome of the police investigation.

This is the third infant to die in this mother's care. A child born in June 2004 died less than one month after being born. The death was officially attributed to Sudden Infant Death Syndrome (SIDS). CPS was not notified of that birth/death at the time and did not become aware of it until three years later.

In October of 2005, the mother gave birth to her third child while Children's Administration had an open case. The social worker closed the case after working with this family for five months. The mother participated in several services. She agreed to frequent urinalysis. During this 5 month timeframe, her initial urinalysis was positive for marijuana; all others were clean.

Her fourth child was born in March of 2007. A referral concerning the death of this child came from the Medical Examiner's office two months later. At that time Child Protective Services (CPS) opened a case and filed dependency petitions on her two surviving children based on the history of substance abuse, continuing issues of domestic violence, and the prior infant death. The children were temporarily removed from the home. When the autopsy report was concluded, the cause of death was officially listed as "undetermined" and the manner as "natural". After two weeks, the court agreed to return the children to the mother's care, based on her clean urinalyses and her quickly accessing the recommended services. The children were made dependents of the court and services were court ordered. The children were placed with their mother.

Between May 2007 and October of 2008, (when the deceased child died) the mother and the children had intensive monitoring and services from the department. She participated in 12 step groups, had clean urinalyses, and participated in counseling. When the department learned the mother was pregnant with the deceased child, the social worker recommended the court continue the dependency with in-home services and monitoring until after the new baby was well established.

It appeared that the mother maintained sobriety after the deceased child's birth. In addition to his scheduled doctor visits, she took him to at least three medical visits when she had concerns. She also received an apnea monitor from Children's Hospital with instructions for use. On the night of the infant's death, the mother, along with the maternal grandmother, and the three small children went to a friend's house where the adults drank and they all spent the night. The deceased child's mother did not have the apnea monitor with her. When she awoke in the morning, her infant was beside her on the bed unresponsive.

The mother never disclosed the name of the father of this baby. She was adamant it was not the father of her older children, a relationship marked by domestic violence. There were suspicions that she resumed her relationship with him and allowed the children to see him. This was adamantly denied by the mother and the information was not verified.

Referral History

On May 24, 2005, a neighbor reported to Child Protective Services (CPS) intake that the mother's two-year-old child was home alone. This neighbor brought the child into her apartment and kept her overnight. The neighbor reported that the next morning she returned the child and the mother was unaware the child was gone. CPS and law enforcement arrived and found the father of this child hiding in the house in violation of a domestic violence restraining order. He was arrested. The mother worked with the social worker and participated in a variety of services. After five months and several clean urinalyses, the case was closed. The investigation was closed with an unfounded finding for negligent treatment or maltreatment.

On June 23, 2006, a report was made to Child Protective Services (CPS) intake that the mother's three-year-old child was seen near a busy intersection alone dressed only in a tee shirt. A passer-by returned the child home; the mother was found asleep. She was again asked to submit a urinalyses test and it was positive for marijuana. The case remained open until October, when the mother entered inpatient treatment. The investigation was closed with a founded finding for negligent treatment or maltreatment.

On November 16, 2006, a report was made to Child Protective Services (CPS) intake that the mother aborted treatment after only one month, against the advice of the treatment agency. This referral was generated as a result of that premature departure from treatment. At that time she was six months pregnant with another child, who later died at two-months of age. The case was closed with an unfounded finding for negligent treatment or maltreatment.

On May 14, 2007, a report was made to Child Protective Services (CPS) intake that the two-month-old infant daughter of the deceased child's mother died overnight in a motel room where the mother, her boyfriend (and father of her older children) and their two other young children were spending the night. The mother told law enforcement that the infant

had been sleeping in the bed with her and at least one of the other children. She was found non-responsive when she awoke in the morning. A small amount of drugs was found in the room. The boyfriend was arrested for violation of a no-contact order. The cause of the infant's death was not immediately apparent, but was later ruled as "undetermined" cause, and the manner as "natural." The investigation was closed with an inconclusive finding for negligent treatment or maltreatment.

On August 22, 2007, a therapist reported to CPS intake that the deceased child's mother and her long time boyfriend were again having contact around the children despite prohibitions against it in the protection orders and the dependency orders. This referral was screened to the Alternate Response System and a service plan was put in place.

On October 18, 2008, law enforcement reported the death of this child. The two surviving children, ages three and five, were placed in protective custody and remained in foster case until January 2009 at which time they were returned to their mother's care on an in-home dependency.

Issues and Recommendations

Issue: Prior to the birth of this infant, the social work staff identified that the additional stress to the family would be a potential risk factor in the mother's ability to maintain sobriety. It was at precisely this time, however, that the relatively stable team that had been working with the family was disrupted by personnel changes. Although the amount of contact with the family during that time was within policy, the case did have less attention during this time than would have been advisable.

Recommendation: The issue of case transfers within units and from one unit to another should be addressed at a meeting of supervisors. That discussion should include a review of the protocol for transfers, as well as suggestions from the group on the best strategies for ensuring that the supervisor(s) and the newly assigned worker(s) both transmit and understand the most critical pieces of information related to the case that concern the children's safety.

Child Fatality Review #08-59
Region 4
King County

This 17-year-old Caucasian female died from asphyxiation.

Case Overview
On October 21, 2008, the body of this deceased youth was found in Lake Ballinger in Snohomish County. The youth was previously reported as a missing person. The police investigation determined that on October 14, 2008, the deceased youth vomited inside a vehicle while drinking alcohol with five males. One of the men allegedly became furious that she vomited. Law enforcement reports state that he walked with her to a dock on the lake, strangled her, stabbed her in the neck with a screwdriver, pulled her into the lake and held her under water until he was certain she was dead. The Snohomish County Medical Examiner's Office determined that the cause of death was asphyxiation due to strangulation and the manner of death is homicide.

The alleged perpetrator was arrested on October 28, 2008 and charged with first-degree murder. He is currently awaiting trial.

Referral History
On July 23, 1992, a neighbor reported to Child Protective Services (CPS) intake that the deceased youth's mother often left the deceased youth, then 14 to 16 months old, home alone while she went out for long periods of time. The child was seen pounding on the windows late a night. This referral was investigated by CPS.

On June 21, 1993, an anonymous referrer reported to CPS intake that the deceased youth's mother hit her when was a baby. The referrer saw the child with bruises to her arm and neck. The referrer was unsure how the child got the bruises. This referral was investigated by CPS.

On March 10, 1994, a doctor reported to CPS intake allegations that the deceased youth may have been a victim of sexual abuse by her father. The child made a disclosure of abuse following a visit to her father in California. The doctor said there was no evidence of abuse. This referral was investigated by CPS.

On July 11, 1997, a social service professional reported to CPS intake that the deceased youth, then five-years-old, had a congenital hypothyroid condition that required daily medication to control. The child needed to be tested twice a year to determine if her condition is under control and required medication. Her mother neglected to obtain medical care and the medication. The mother missed many appointments despite reminders by medical staff. This referral was investigated by CPS.

On February 23, 1998, a hospital staff reported to CPS intake that the deceased youth's mother has a history of medical neglect. The referrer said the child had a congenital hypothyroid condition and had complications because her mother did not attend to her medical condition. This referral was investigated by CPS for medical neglect.

On August 12, 1998, a hospital staff reported to CPS intake that the deceased youth's mother did not give the child her medication for the day as instructed by the referrer. The referrer said the child was prescribed a thyroid supplement; not taking this medication can cause learning disabilities, mental retardation and poor developmental growth. This referral was screened as low-risk and was not investigated by CPS.

On September 8, 1998, a neighbor reported to CPS intake that the deceased youth's father was a drug user and dealer. The referrer said both parents use drugs. The referrer also observed the mother hitting and pushing the deceased youth, then six-years-old, and her younger brother. This referral was investigated by CPS and closed with an unfounded finding.

On May 22, 2001 a relative reported to CPS intake that the infant sister of the deceased youth had pink eye in one eye and her mother did not seek treatment for this condition. The child's father said she had this condition for three weeks and she was unable to open her eye. He took the child to the hospital for treatment. The referrer said the mother was drug involved and sold drugs out of the family home. This referral was investigated by CPS and closed with an unfounded finding.

On August 24, 2005, a youth shelter employee reported to CPS intake that the 14-year-old deceased youth came to the shelter with her five-year-old sister and said both were homeless because their mother kicked them out of the house several days prior. The youth said she was "hanging out on the Avenue." The referrer said the deceased youth left the center and her whereabouts were unknown. This referral was screened in for Family Reconciliation Services.

On December 8, 2005, a relative reported to CPS intake the deceased youth's mother uses marijuana and fights with the deceased youth. The mother admitted to the referrer that she pulled the hair of the deceased youth and beat her. The referrer said they never saw marks or bruises on the children. The referrer said the mother hung around with drug users. This referral was investigated by CPS. The investigating social worker saw no evidence of abuse or neglect and the children made no disclosures of abuse.

On March 26, 2007, school personnel reported to CPS intake the deceased youth's six-year-old sister reported her father kicked her causing pain to her toe. The child said she was knocked out of the chair. This referral was investigated by CPS and closed with an inconclusive finding.

On May 29, 2008, school personnel reported to CPS intake the deceased youth's seven-year-old sister was seen with bruises on her for the fourth time this school year. The referrer said the child's bruises were dark and purplish/blackish in color. The child said her brother pushed her into a table. About three weeks prior she gave the same reason as to how she got a bruise on her calf. She reported that her brother caused each of the four bruises. The child did not express fear of her 14-year-old brother. This referral was investigated by CPS and closed with an unfounded finding.

On October 22, 2008, the Snohomish County Medical Examiner contacted CPS intake to report the death of this youth. Her body was found in Lake Ballinger. Her death was treated as a homicide. This referral was screened out for investigation by CPS.

Issues and Recommendations

Issue: In regards to the referral dated May 29, 2008, this was the first case for a brand-new worker. She was closely supervised and her documentation demonstrates that she not only investigated the allegations, she also focused on the family history. Her findings and risk assessment show critical thinking. There was no information that raised questions about the youth's safety. The case was properly closed following the investigation.

Recommendation: Continue to emphasize close support and supervision for new CPS workers.

Issue: The family had multiple reports of child maltreatment from 1992 to 2008. It appears that several of the intakes were not thoroughly investigated and documented. It is possible that parental substance abuse may have been more of a factor in the chronicity, but this was not examined thoroughly when it was reported as an issue.

Recommendation: Continue to develop tools and resources for social workers that will increase the ability to engage and assess families. This, in turn, will help to provide more effective services.

Issue: Regarding the referral dated August 24, 2005 screened as "Information Only" for Family Reconciliation Services (FRS): This should have been screened in for a CPS investigation. The deceased youth, then age 15, had her five year-old sister with her. The youth told a mandated reporter that their mother had kicked them both out several days ago, and they were "hanging out on the Avenue."

Recommendation: The regional CPS Program Manager will discuss this with the intake supervisor and worker that screened the report.

Child Fatality Review #08-60
Region 6
Mason County

This 16-year-old Caucasian female died in a house fire.

Case Overview
On October 24, 2008, this 16-year-old youth and her four-year-old brother died in a house fire at the family home located in Mason County. It was initially reported that the fire started on a couch. The other four children in the home as well as the mother escaped without injury. The father was not home at the time. The parents are licensed foster parents and had adopted the two deceased children. A seven-year-old foster child was also in the home for a weekend respite placement. He was unharmed. An investigation by the Bureau of Alcohol, Tobacco, and Firearms (ATF) determined that most likely the deceased youth started the fire.

There was another fire in this home in October 2007. Before the investigation into the 2008 fire, it was believed this fire was accidentally ignited by the 12-year-old sister of the deceased youth. ATF investigators investigating the 2008 incident, speculate that the deceased youth started both fires. The County Coroner ruled the 4-year-old's death a homicide. The deceased youth's death was ruled an accident. The official cause of death for both children is asphyxiation due to fire.

Referral History
On February 6, 2006, school personnel reported to Child Protective Services (CPS) intake that the seven-year-old brother of the deceased youth told his teacher he was upset because of problems he was having at home. The child said his parents call him "bad words." He also said his father gets mad and pulls his ears. The child had no visible injuries, though complained his ear was tender. The referrer noted what appeared to be a faint grab-like mark on the child's arm. The child's teacher reported to intake that the boy tends to exaggerate. This referral was screened out for investigation by CPS.

On July 8, 2008, a juvenile detention staff reported to CPS intake that the deceased youth was picked up by a Kitsap County Sheriff's deputy. She was gone from home for 12 to 13 hours and was found approximately 30 miles from home riding a bike. This referral was screened in for Family Reconciliation Services (FRS). The mother expressed interest in this service.

On October 25, 2008, a report was made to Child Protective Services (CPS) intake regarding the house fire that occurred at this licensed foster home. The investigation revealed that the deceased youth started the fire that claimed her life and the life of her four-year-old brother. The referral was screened in for investigation by the Division of

Licensed Resources/Child Protective Services Section (DLR/CPS) was closed with an unfounded finding for negligent treatment or maltreatment.

Issues and Recommendations
Issue: None identified.

Recommendation: None

Child Fatality Review #08-61
Region 6
Mason County

This 4-year-old Caucasian male died in a house fire.

Case Overview
On October 24, 2008, this child and his 16-year-old sister died in a house fire at the family home located in Mason County. It was initially reported that the fire started on a couch. The other four children in the home as well as the mother escaped without injury. The father was not home at the time. The parents are licensed foster parents and had adopted the two deceased children. A seven-year-old foster child was also in the home for a weekend respite placement. He was unharmed. An investigation by the Bureau of Alcohol, Tobacco, and Firearms (ATF) determined that most likely the 16-year-old sister started the fire.

There was another fire in this home in October 2007. Before the investigation into the 2008 fire, it was believed this fire was accidentally ignited by the 12-year-old sister of the deceased child. ATF investigators investigating the 2008 incident, speculate that the 16-year-old started both fires. The County Coroner ruled this 4-year-old's death a homicide. The official cause of death is asphyxiation due to fire.

Referral History
On February 6, 2006, school personnel reported to Child Protective Services (CPS) intake that the seven-year-old brother of the deceased child told his teacher he was upset because of problems he was having at home. The child said his parents call him "bad words." He also said his father gets mad and pulls his ears. The child had no visible injuries, though complained his ear was tender. The referrer noted what appeared to be a faint grab-like mark on the child's arm. The child's teacher reported to intake that the boy tends to exaggerate. This referral was screened out for investigation by CPS.

On July 8, 2008, a juvenile detention staff reported to CPS intake that the 16-year-old sister of the deceased child was picked up by a Kitsap County Sheriff Deputy. She was gone from home for 12 to 13 hours and was found approximately 30 miles from home riding a bike. This referral was screened in for Family Reconciliation Services (FRS). The mother expressed interest in this service.

On October 25, 2008, a report was made to Child Protective Services (CPS) intake regarding the house fire that occurred at this licensed foster home. The investigation revealed that the 16-year-old sister of the deceased child started the fire that also claimed her life. The referral was screened in for investigation by the Division of Licensed Resources / Child Protective Services Section (DLR/CPS) was closed with an unfounded finding for negligent treatment or maltreatment.

Issues and Recommendations
Issue: None identified.

Recommendation: None

Child Fatality Review #08-62
Region 5
Kitsap County

This two-year-old African American female died from unknown causes.

Case Overview
On the morning of November 2, 2008, a family friend caring for the deceased child went to a bedroom where the deceased child was sleeping and found the child unresponsive and lifeless.

The deceased child was being cared for by a friend of her mother. The mother was unable to properly care for her young children while she recovered from a medical procedure. So, she arranged for her oldest daughter to visit her father and the deceased child stayed in the home of the mother's long-time friend, the friend's paramour, and his three children. The paramour's fourth child died suddenly of unknown cause and undetermined manner in June 2008.

The mother of the deceased child was aware of the prior child death in the friend's home. She was told the child died from Sudden Infant Death Syndrome (SIDS). The deceased child's mother said she believed the friend's home was a safe place for her daughter. The mother reported that neither the deceased child nor her sister ever showed signs of fear around the mother's friend.

While staying at the home of a family friend, the deceased child was reportedly put to bed by the friend's paramour around 10:30 in the evening of November 1, 2008. He stated that he "swaddled" the two year old in a comforter. He checked on the child before he went to bed; the child was alive and breathing. The mother's friend reported getting up during the night and checked on the children, a routine she had been doing since the death of her paramour's son earlier in the year. She reports that all the children were fine.

A preliminary post-mortem report indicated no signs of trauma. Asphyxiation is a possible cause of death; the manner of death is still under investigation. The deceased child's mother is not a suspect in her daughter's death.

Referral History
On May 9, 2008, the mother of the deceased child reported to Child Protective Services (CPS) intake that her oldest daughter was being emotionally abused by her father during court ordered visitation. The mother reported her then two-year-old daughter returned from visitation saying her younger sister (the deceased child) was bad and that she wanted to live with her birth father. The mother made a referral to a therapist. This referral was screened out as Information Only.

On October 22, 2008, an anonymous referrer reported to CPS intake that the three-year-old sister of the deceased child may have been sexually abused. This child had chronic yeast infections and pain in her genital area. It was reported the child's mother had various male visitors in the home. The child had a medical examination for sexual abuse and the result was no evidence of abuse. This referral was investigated by CPS and closed with an unfounded finding for negligent treatment or maltreatment.

On November 5, 2008, a report was made to CPS intake regarding the death of this child. The deceased child's mother allowed a friend to baby sit her child (the deceased child). This friend recently experienced the death of another child in her home. The deceased child was wrapped in a comforter and put to bed. The friend's paramour woke in the morning and heard other children playing and went to a back bedroom and found the deceased child with froth coming from her nose. She appeared deceased. An autopsy was completed; no trauma was found. The coroner raised concerns about this child fatality as he investigated the prior child death in this home. At the writing of this report, the coroner has yet to release the findings of the autopsy. This referral was screened in for investigation by CPS. The finding of the investigation is pending the result of the autopsy.

Issues and Recommendations

Issue: In review of the history of involvement with Children's Administration for the family, no significant practice, policy, or system issues were identified. Two minor practice issues were discussed during the Child Fatality Review held on April 15, 2009. Neither issue appeared to have any implication with regard to the circumstances of the two-year-old child's death. The noted practice issues (below) are included in this section of the Child Fatality Report for the limited purpose of documenting discussions occurring during the Child Fatality Review.

(1) During the fatality review the social worker investigating the October 2008 referral recalled having spoken to a nurse from the pediatrician's office early in the investigation regarding the alleged victim (oldest child). However, the worker did not document this contact in the case file. (2) A Structured Decision Making (SDM) risk assessment was conducted on the mother (identified subject) for the October investigation regarding the three-year-old sister, the half-sibling of the now deceased child. The biological father and his wife were not identified subjects and therefore completing an SDM on that household would not be required. However, the child did split time evenly between the two households and consideration might have been given to complete a paper version of the SDM on the father's household especially as there were concerns regarding the father's history as a juvenile.

Recommendation: None

Actions Taken: The CPS investigator, the CPS supervisor, and the CPS Program Area Administrator participated in the review and received feedback regarding the two minor practice issues.

Child Fatality Review #08-63
Region 4
King County

This two-year-old Caucasian male drowned.

Case Overview
On November 7, 2008, this two-year-old child and his 13-year-old stepbrother were passengers in a car driven by their sixteen-year-old cousin. At around 8:30 a.m., while driving in south King County, she failed to negotiate a curve in the road and lost control of her car. The car slid off the road and rolled down an embankment and into the Green River. The 16-year-old driver escaped from the car and made her way back to the road. She was unable to rescue her cousins. Police cited her for failure to use caution on a wet road, covered with leaf debris.

The river was swollen due to heavy rain and the swift current made recovery impossible until November 11, 2008. On that date, the vehicle was pulled from the river. The body of this two-year-old child was found still secured in a carseat in the back seat of the vehicle. The second passenger, the thirteen-year-old stepbrother, was not found and to date his body has never been recovered.

The King County Medical Examiner determined that the deceased child's Cause of Death was Asphyxia Due to Drowning (Traffic-Related) and the manner of death was accident.

Referral History
On June 20, 2008, it was reported to Child Protective Services (CPS) intake that the mother of the deceased child was seen driving erratically on May 8, 2008 with her two sons, ages three and two-years-old (the deceased child) in the car. The mother was stopped by Renton Police and performed field sobriety tests. She passed a breathalyzer, but failed the sobriety tests and was arrested. She was under the influence of two prescribed medications she took that morning for back pain. The mother told police her doctor advised her to pay close attention to her driving abilities while taking these medications. The officer contacted a family member who responded to the scene and took custody of the children. This referral was screened in for investigation by CPS and closed with a founded finding. The worker left the case open for monitoring. The mother was charged with reckless endangerment. She passed all court-ordered urinalysis.

Issues and Recommendations
Issue: Safety Assessments, Safety Planning and Service Plans. The assigned social worker consulted with his supervisor (now retired) soon after the case was assigned and they decided that a safety plan was not necessary. The social worker instead gave the mother community resource information, and the mother arranged for counseling and parenting classes at the Children's Home Society of Washington.

The mother was already doing urinalysis (UA) through district court for her traffic violation. She also agreed to a UA that the assigned worker arranged.

Because the mother was cooperative with the social worker and all collateral reports and direct observations were positive, the worker did not ask the mother to sign a voluntary service plan. Instead, he kept the case open to monitor her progress.

Recommendation: Children's Administration can improve investigations and assessments through early recognition of safety issues and subsequent safety planning. Written and signed voluntary service plans help all parties in a case to do what is expected.

Cases can best be managed when the work is completed in each phase in the life of a case. Investigations should be completed within 45 days and if the family wants to continue with services, the case should be transferred to the Family Voluntary Services Unit.
The King South office is scheduling training with an expert in safety assessments and safety planning. The worker in this case will attend that training.

Child Fatality Review #08-64
Region 3
Whatcom County

This two-year-old Native American male died from Sudden Unexplained Toddler Death.

Case Overview
On November 13, 2008, the deceased child's mother called 911 shortly after she woke up at 12:30 in the afternoon and discovered her two-year-old son deceased. She reported that she had found him lying face down wedged between the wall and a cushion on the bed where she put him down to sleep along with his twin brother. The mother reported that her son was cold and appeared to have been dead for some time. The children's father left for work earlier that morning and did not notice his son's condition. The family slept in one room. The three children, the three-year-old daughter and twin sons, all slept in the same bed, a chair that folds into a bed. There were no signs of trauma to the child. The cause of death was certified as Sudden Unexplained Toddler Death and the manner of death was undetermined.

The parents reported they drank heavily the night before their son died. A report was made to Child Protective Services (CPS) intake of this child's death. The parents entered into a safety plan in which they agreed to address their alcohol abuse. When this failed to happen, the worker and supervisor approached the tribe and gained support in filing a dependency petition to ensure the safety of the surviving children. The surviving children were placed in relative care.

Referral History
On November 28, 2005, it was reported to CPS intake that the deceased child's parents were so drunk they were unable to properly care for their infant daughter, sister to the deceased child. It was further alleged that the father attempted to make sexual contact with his 17-year-old stepdaughter. This referral was screened in for investigation by CPS and closed with an unfounded finding for negligent treatment or maltreatment and an inconclusive finding for sexual abuse.

On January 28, 2007, an anonymous caller reported to CPS intake that he lived in the family home and on the day of this call reported he was "severely beaten" by the deceased child's parents. He said the parents were often too drunk to care for their 14-month-old child and four-month-old twins. He said the house was usually dirty, smelled like garbage, and there was very little food in the house because the parents spent their money on alcohol and drugs. This referral was screened as information only.

On February 21, 2007, a report was made to CPS intake that the deceased child's parents were extremely intoxicated during a motel stay. The father was arrested for domestic violence. The parents stayed in one room with the three small children. The police

observed many empty beer bottles and broken beer bottles on the floor. The paternal grandmother picked up the children. This referral was screened in for investigation by CPS. However, the assigned social worker was unable to locate the family and the case was eventually closed without a finding.

On November 21, 2007, an anonymous report was made to CPS intake alleging the deceased child's mother was drinking heavily and smoking marijuana in the same room with her children. The caller also stated the father is violent toward the mother and sometimes made her and the children sleep in the van. This referral was screened in for investigation by CPS. Again, the assigned social worker was unable to locate the family and the case was eventually closed without a finding.

On November 14, 2008, police reported to CPS intake the death of this two-year-old child. The child's mother woke around 12:30 in the afternoon and found the child face down wedged between the wall and the cushion on the bed. The surviving children were temporarily placed with relatives. The parents agreed to participate in services to address their alcohol abuse and the children were returned to their care. The parents never fully complied with the service plan and the children were removed from their care. The social worker consulted with the Tribe and a dependency petition was filed on the surviving children.

Issues and Recommendations

Issue: The referral dated February 21, 2007 was closed out after several failed attempts to locate the family. A member of the Lummi Child Protection Team (CPT) offered to supply information about the family's whereabouts, as they were believed to still be on the Lummi Reservation, but there was no documentation of follow-up on that request.

Recommendation: An agreement was reached with the Lummi Children's Services that if a social worker needs information on a case, and a member of CPT offers to assist in providing that information, it will be made available to the worker within a few days of the CPT meeting, or at the very latest, at the next CPT meeting. CPT meetings are held weekly.

Issue: The referral dated November 21, 2007 was closed out without sufficient contact with the family to conduct an investigation. This referral was not staffed with the Lummi CPT.

Recommendation: It appeared that during the time the CPS worker was trying to locate this family, they moved very frequently on and off tribal lands. The team recommended that in this kind of situation, the worker explore the possibility of contacting the office providing the Temporary Assistance for Needs Families (TANF) assistance and attempt to have the benefits held until contact is made.

The team recommends the unit be reminded of the need to staff each referral involving a Lummi child with the CPT.

Issue: The Family Team Decision Making (FTDM) meeting following the death of this child was chaotic and adversarial, with thirty people present from the Tribe, most appearing unexpectedly. The concerns that the CPS worker had about the safety of the surviving children were not addressed at that meeting.

Recommendation: The team recommends that the agency continue its emphasis on adherence to the FTDM model. Additionally, when an FTDM needs to be held following the death of a child, this team recommends that the department explore the possibility of:

1) Having a person trained in grief/trauma issues present at an FTDM that is held immediately following a child death.

2) Having an Area Administrator or two supervisors present at an FTDM that has the potential for bringing forth heated emotions.

3) Delaying the FTDM until after the most intense grieving has passed, with the surviving children remaining in a safe situation until then.

Issue: This case involved the close family member of a Division of Children and Family Services (DCFS) employee. That employee became involved in the case causing some complications.

Recommendation: The team recommends that the department explore the feasibility of an administrative policy requiring self disclosure when an employee becomes aware that a close relative has become involved with DCFS.

Issue: Despite the difficulties the social workers encountered at the FTDM meeting, the supervisor new to that unit was then able to reach out and engage the parents in a commitment to address their substance abuse issues. He was able to gain the support of the Tribe in a dependency action when it became apparent that would not be sufficient to keep the surviving children safe.

Recommendation: None

Issue: The second referral on this family was made by an anonymous caller but contained allegations that the parents were frequently too drunk to care for the four-month-old twins. It was taken as information only. The team believed this referral should have screened in for investigation.

Recommendation: This referral should be discussed for consensus building at the next meeting of Regional Intake Specialists, which includes the representative from Central Intake.

Issue: Two referrals received on this family prior to the fatality were assigned but closed without contact being made with the family. The staff investigating these two referrals did not follow regional protocol that specifies the efforts that should be made in attempting to locate the family before closing out the referral.

Recommendation: The regional protocol should be updated and distributed again to ensure that all CPS staff are reminded of it.

Child Fatality Review #08-65
Region 2
Skamania County

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

Case Overview
On November 9, 2008, the Skamania County Sheriff's Office reported the death of this four-month-old infant. The parents woke around 2:00 a.m. and found their son non-responsive. They took him to a relative who lived nearby and he called 911. Medics performed CPR on the child and transported him to a local hospital where he was pronounced dead. The parents and the infant were co-sleeping in a twin size bed. Yakama Tribal police completed an investigation due to the incident occurring on tribal trust property. The child's mother is well known to county law enforcement as a user of methamphetamine. The autopsy was completed by the Clark County Medical Examiner. The autopsy showed no trauma or abuse. The official cause of death was determined to be SIDS.

Referral History
On March 4, 2005, it was reported to Child Protective Services (CPS) intake that the deceased child's mother used methamphetamine during her pregnancy with her older child. This child, the deceased child's brother, tested positive for methamphetamine and marijuana at the time of his birth. The mother agreed to voluntarily place him in foster care while she attempted to get clean and sober. She was unable to remain drug-free. The department eventually filed a dependency petition on her son. Her parental rights were ultimately terminated for non-compliance with court ordered services. The child's father voluntarily relinquished his rights. This child has since been adopted. The referral was screened in for investigation by CPS and closed with a founded finding for negligent treatment or maltreatment.

On November 21, 2006, a social work professional reported to CPS intake that the deceased child's mother reported to staff at a DSHS office that she was pregnant. She was living with a person known in the community as a drug user and dealer. She appeared to be using methamphetamine because her teeth were in serious decay and she had sores all over her face. The mother was in her first trimester of her pregnancy. This referral was screened as information only.

On February 11, 2008, a social work professional reported to CPS intake that the deceased child's mother was pregnant and due in August 2008. It was unknown if she obtained prenatal care for this pregnancy. The referrer believed the mother continued to use drugs as she had obvious sores on her face. Due to the history of involvement with the department, the referrer wanted to inform Division of Children and Family Services (DCFS) of this information. This referral was screened as information only.

On July 29, 2008, a social work professional reported to CPS intake that the deceased child's mother gave birth to this child earlier in the week. The mother was very well known in the community as a methamphetamine user. It was unknown if the hospital tested the mother or the child for drugs, however, no medical professional expressed concerns about the child's well-being at birth. This referral was screened as information only.

On November 9, 2008, law enforcement reported to CPS intake the death of this child. The parents and this child all slept in the same bed. The mother is a known methamphetamine user. Law enforcement did not find anything suspicious during their initial investigation. No inflicted trauma or abuse was evident during the autopsy. The medical examiner ruled this death to be the result of Sudden Infant Death Syndrome. This referral was screened as information only.

Issues and Recommendations

Issue: The referral dated July 29, 2008 initially was screened in high risk emergent by the White Salmon office in Region 2, due to the mother's CPS history, a history that includes termination of parental rights on a previous child. When it was discovered that the incident address defaulted to the Stevenson office in Region 6, the referral was transferred to the Stevenson office and the intake supervisor in Region 6 changed the screening decision to Information Only.

Recommendation: A family's history in which parental rights had been terminated in the past should elevate the standard by which a new intake is assessed and subsequently screened for investigation. When there is a disagreement on a level of risk between offices, it is best practice to take the issue up the chain of command.

Child Fatality Review #08-66
Region 5
Pierce County

This 17-year-old Caucasian male died from coronary artery disease.

Case Overview
On December 14, 2008, this 17-year-old youth returned home after being out with friends. He said he was not feeling well and went to lie down. Within the hour he was found unresponsive in his room by a friend who alerted the youth's father. The father gave CPR until Emergency Medical Services arrived. The boy died later that day. Pierce County Sheriff's Deputies reported no signs of trauma were found and there was no evidence to suggest suspicious circumstances regarding the death. The Medical Examiner determined this youth died a natural death caused by coronary artery disease. While coronary artery disease is the leading cause of death worldwide and in America, heart attacks are very rare in children including teens.

Referral History
On December 4, 2007, family friend reported to Child Protective Services (CPS) intake that there was no food in the home and that the home was unsafe and dirty. The children were said to be dirty, had head lice, and did not get their basic needs met. The referrer said the home was overrun with animals. It was also reported that the deceased youth's father was selling or abusing drugs. This referral was assigned for Alternate Intervention and sent to the local Alternative Response System (ARS) provider. A Family Support Worker made an unannounced home visit and found the home to be somewhat cluttered but not in the condition described by the referent. The family reportedly was receptive to the ARS worker, but declined any further services.

On December 30, 2008, a report was made to CPS intake that this youth had died. There were no allegations of abuse or neglect. An autopsy revealed the youth died from coronary artery disease. This referral was screened as Information Only.

Issues and Recommendations

Issue: The Child Fatality Review was held at the Tacoma East DCFS office on April 23, 2009. The family history of Children's Administration (CA) involvement prior to the fatality was limited to a single alternate intervention intake in December 2007. Several issues were discussed during the review but none appeared to have any obvious impact with regard to the circumstances of the child death which involved a medical cause (Coronary Artery Disease).

The issues emerging during the review are included below for the limited purpose of documenting the discussions occurring during the child fatality review.

Issue: Regarding the referral dated December 4, 2007:

An acquaintance of the family reported having observed the living conditions in the family home to be unsafe and unsanitary. The referrer also reported that the children had head lice, were dirty, and their basic needs were not being met. There was speculation on the part of the referent as to substance abuse in the home and possible drug dealing. The initial report was taken by Central Intake (CI) and accepted for CPS investigation.

The intake was reviewed at a Region 5 intake consensus team meeting the following day. The consensus team that day included participation by two Area Administrators. Following discussion of the intake, the report was downgraded to Alternate Intervention (AI) and sent to Alternative Response System (ARS), which is now called Early Family Support Service (EFSS). The reason for the intake decision change was based on the low risk levels associated with the reported health hazards, the lack of any prior history involving the family, and the ages of the children (no young children in the home).

In review of this intake, fatality review panel members agreed that the decision to downgrade to alternate intervention appeared reasonable and supportable.

Recommendation: None

Issue: Regarding the ARS intervention:

Timelines were met per CA policy and the current EFSS contract. Initiation of engagement was within ten calendar days from date of referral. The home visit was unannounced which is consistent with best practice. Face-to-face contact was made with the mother and the oldest child (now deceased). The other two children were in school at the time of the home visit which would suggest they did not have head lice. The assigned Family Support Worker (FSW) did not observe the home to be in the conditions described by the referent. The FSW recalled that the deceased youth appeared to be healthy (not obese or overweight) although the worker admittedly only had limited contact with the boy. Offered services were declined by the mother and a follow-up letter was sent to the parents with (1) a list of services available at the nearby Family Support Center, (2) resources available in Pierce County, and (3) a client satisfaction survey. The ARS Termination Summary was received in a timely manner by DCFS. The ARS documentation as reviewed appeared sufficient and overall the intervention met expected standards of practice for alternate intervention.

Recommendation: None

Action Taken: The Family Support Worker who conducted the ARS intervention was present during the review and received the feedback as to meeting expected practice standards for EFSS.

Issue: As part of an agreement with Tacoma CPS, the Tacoma-Pierce County Medical Examiner's Office provided a courtesy notification to CPS intake on December 16, 2008, of the death of this 17-year-old youth. There were no suspicions for child abuse or neglect at the time of the notification. An update was documented by intake on December 23, 2008, following contact with the assigned Pierce County Sheriff's Detective who confirmed there were no suspicions regarding the circumstances of the child death. The information was initially documented in a Fatality Log (no referral) as there were no suspicions for child abuse or neglect and the last referral to CPS (alternate intervention) was over 12 months prior.

The Region 5 Fatality Program Manager reviewed the family case history and found that while the referral date for the prior referral was over a year before the youth's death, the ARS intervention had actually closed only 11 months earlier. Due to the family having received "CA services within 12 months prior" [see CA Administrative Incident Reporting Policy January 2005] an intake was created as well as an incident report generated. In review of the intake, the review panel agreed that the screen out decision (no assignment) appeared to be appropriate, especially given later confirmation that the death was due to a medical cause (coronary artery disease).

Child Fatality Review #08-67
Region 6
Clark County

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

Case Overview
On November 9, 2008, the deceased child's mother found her unresponsive in her crib. The family reported at 5:30 p.m. the deceased child's father put her in her crib on her back. At midnight, he heard her crying. He got up and gave her a bottle of Enfamil formula. The father reported he left the bottle with the child in the crib. He added that she calmed down and went back to sleep. At approximately 4:30 in the morning, the mother checked on her daughter and found her lying face down, unresponsive in her crib. Police and medics responded after the mother called 911. The child was pronounced dead without treatment at 4:47 a.m. An autopsy was completed and nothing suspicious was found.

Referral History
The deceased child's mother first came to the attention of the department in 2002 on a report that her then four-year-old son was being sexually abused by her and the child's maternal grandfather. In addition, there were allegations of domestic violence between the mother and her partner, the deceased child's father. These allegations came during a heated custody battle. The allegations were investigated and closed with an unfounded finding. Ultimately the father of this child was granted custody.

The mother gave birth to another son in August 2003. Although there were some concerns about the mother using illegal drugs, the department attempted to work with her and the father to provide in-home services to support their care of the infant. The child was placed in foster care when there were concerns about drug use. The family would engage in services and the child would be returned. In June of 2004 the child was placed into foster care where he remained until his adoption.

The mother proceeded to give birth to two more boys in September of 2004 and February 2006. These children were immediately removed from their parents' care. The department offered additional services and attempted to reunify the family. The services offered included: chemical dependency treatment, pregnant/parenting programs for chemical dependency, random urinalysis, relapse programs, transportation services, mental health services, anger management classes, domestic violence classes, visitation, child care, bus passes, Intensive Family Preservation Services (IFPS), and parenting education and support. The deceased child's parents would initially engage in services, but would soon disengage and not follow through. A variety of services and service options were offered to support this family and support the parents being reunified with their children. Ultimately the department filed for termination of parental rights and it was granted. All three boys were placed in the same home and ultimately adopted by this family.

The case was closed at the time the mother gave birth to the deceased child.

On August 7, 2008, hospital staff reported to Child Protective Services (CPS) intake that the mother recently gave birth to the deceased child. This staff person was aware that the mother had four other children removed by CPS in the past. The mother had a negative urinalysis (UA) at delivery and two negative UAs during her prenatal care. At the time of this child's birth, the mother was living in a homeless shelter. This referral was screened as Information Only.

On November 6, 2008, a report was made to CPS intake by a homeless shelter staff person who reported the deceased child's parents had relapsed and were using methamphetamine in the presence of their three-month-old infant daughter. Another resident in the shelter saw a glass pipe and the methamphetamine near the infant. A shelter staff reported no confirmation that either parent used drugs prior to the death of their daughter on November 9, 2008. This referral was screened in for the Alternate Response System (ARS).

On November 10, 2008, law enforcement reported to CPS intake the death of this child. It was reported the mother checked on the child at 4:30 a.m. and found her unresponsive. An autopsy was completed and nothing suspicious was detected. A toxicology screen was conducted on the child and it came back negative. This referral was screened in for investigation by CPS and closed with an unfounded finding for negligent treatment or maltreatment.

Issues and Recommendations

Issue: Regarding the placement of an older sibling in 2003, there were concerns about the reunifications with the family and then re-entries into foster care. It was unclear what type of risk assessment was used to determine that the child should be reunited, and what criteria was being considered. This child was placed into foster care immediately following his birth on September 2, 2003. He was reunified with his parents on October 7, 2003 and removed from their care again on May 4, 2004. He was back in foster care for seven days and returned to his parents on May 11, 2004 until June 17, 2004, when he returned back to foster care for the final time.

Recommendation: The group conducting the review discussed the request by the office for refresher and ongoing safety assessment/risk assessment training for Child and Family Welfare Services (CFWS) workers, in addition to training opportunities for Structured Decision Making.

Action Taken: The Area Administrator has been in contact with Risk Management at Headquarters to schedule this training.

Issue: The review team discussed the screening of the two referrals just prior to the death of the deceased child. During the initial paper review of the file it was unclear as to why

the referrals were not screened in for response by CPS. Upon reviewing this with the review team it was discovered that not all of the information was available to the intake workers at the time of the screening due to the case being administratively locked. The intake workers reported a delay in gaining access to information on cases that were marked administrative and at times they needed to proceed with the information they had in front of them in order to meet the time allowed by policy to complete the investigation.

Recommendation: This should no longer pose an issue with the new automation system, FamLink. All intake supervisors have access to view restricted cases and can assist their workers in having this information if needed to make an appropriate screening decision.

Issue: The record clearly showed a pattern of assaultive behavior on the part of the deceased child's father. He was ordered to anger management classes, and had a history of violence with the child's mother. In addition, he followed a DSHS staff to her vehicle and verbally assaulted and threatened her in the parking lot. This required the response from law enforcement. The workers involved in this case felt that the father was loud and inappropriate, but did not feel there was a safety issue.

Recommendation: The Danger to Worker indicator should be marked on this case to ensure staff safety if the case were to return at some point in the future

Child Fatality Review #08-68
Region 5
Pierce County

This three-month-old Hispanic female died from Sudden Infant Death Syndrome (SIDS).

Case Overview

On December 3, 2008, the deceased child's parents returned to a relative's home where they were staying due to homelessness. According to the couple, it was late in the evening, and they were unable to wake the relative to get inside the house. They decided to spend the night in their car parked in the driveway. They had their three-month-old daughter with them. The relative later told police that the mother and the deceased child were welcome in her home, but the father was not. The mother voluntarily chose to stay the night with the father in the car. The parents put the three-month-old infant in her car seat to sleep. A six-year-old half-sibling was elsewhere at the time. The temperature that evening was in the 40 degree range. The car heater was used several times to heat the vehicle according to the parents.

The parents report having fed the baby around 1:30 a.m. They changed her diaper between 3:00-4:00 a.m. prior to driving to a nearby store for food and returning to the driveway and going back to sleep. When the couple awoke around 6:00 a.m. the infant was unresponsive with bloody mucous from the nose. The parents transported her to a nearby hospital in Pierce County where death was pronounced.

Law enforcement investigated and found no evidence of foul play. In March 2009, the mother was notified by the Medical Examiner's Office that her daughter's death may have been caused by a medical condition involving her heart muscle. The possible connection to a heart condition was confirmed in early April 2009 when the Medical Examiner determined the cause of death to be "Sudden Unexplained Death in Infancy, associated with cardiomegaly; sleeping overnight in motor vehicle in cold weather (undetermined if external factors involved)." The manner of death was designated as undetermined.

Referral History

On July 23, 2008, it was reported to Child Protective Services (CPS) intake that the deceased child's mother was not meeting the basic needs of her six-year-old daughter (older sibling of the deceased child). It was alleged that the mother used food stamps to buy drugs and left her daughter in a drug house while she went panhandling. This child had head lice and missed a substantial amount of school. This referral was screened in for investigation by CPS. The mother was actively engaged in services including parenting classes, maternity support, housing support, and drug/alcohol evaluations. The case was closed with an unfounded finding for negligent treatment or maltreatment.

On December 3, 2008, a nurse reported to CPS intake that the deceased child was admitted to a Tacoma area hospital at 6:14 a.m. after being found in her car seat not breathing. The child was non-responsive to CPR. The child was declared dead at 6:55 a.m. There were no signs of trauma. This referral was screened in for investigation by CPS. The case remains open at the time of this report. Law enforcement also investigated this child fatality. The mother and her surviving daughter were referred to grief counseling. The mother was also referred to community mental health for other issues. The CPS investigator referred the mother for chemical dependency assessment which resulted in admission into a treatment program. The child's father had moved out of state.

Issues and Recommendations

Issue: The Child Fatality Review was held at the Tacoma West DCFS office on April 29, 2009. The entire family history of involvement with Children's Administration (CA) was reviewed. The CA history was limited to a single CPS investigation prior to the deceased child's birth and her subsequent Sudden Unexplained Death in Infancy (SUDI) associated with cardiomegaly (enlarged heart). During the review several issues were discussed but none appeared to have any obvious impact with regard to the circumstances of the child death.

The issues emerging during the review are included below for the limited purpose of documenting the discussions occurring during the child fatality review.

Issue: Regarding the referral dated July 23, 2008, the overall intake decisions appeared reasonable and supportable. A minor intake issue surfaced during the Child Fatality Review. The live-in boyfriend and father of the then unborn child was not identified as a subject, caretaker, or client although his identity and role within the family was known at the time of the intake. While the review panel did not reach agreement as to whether the deceased child's father should also have been identified as a subject for neglect of the six-year-old sister, full consensus was made that he should have at least been identified as a client and connected to the case.

Recommendation: None

Issue: Regarding the investigation of the CPS referral dated July 23, 2008, the worker met or exceeded policy and practice standards for conducting a CPS investigation. The quality of work appeared exceptional. Interviews with the alleged child victim, the subject, the father of the unborn child, and the referent occurred in a timely manner. A Safety Assessment was conducted and documented in CA Case and Management Information System Graphical User Interface (CAMIS GUI) within the prescribed timeline. The worker conducted the Global Appraisal of Individual Needs Short Screener (GAIN-SS) for substance abuse and mental health issues with the mother, the father of the unborn, and with the relative who was involved in caring for the child. An Ethnic Identity form was completed for the deceased child's sister with the mother's participation and signature.

The CPS worker obtained a signed Exchange of Information from the mother permitting the worker to contact service providers. The worker made numerous contacts with professionals involved with the family, including medical (for both the mother and for her oldest daughter), WorkFirst, housing, and a Woman's Empowerment and Employment Program. The worker was never able to connect with the Maternity Support Services worker who had been assigned to work with the mother through the Community Services Office (CSO). However, the medical provider indicated that overall the mother did well with pre-natal care and efforts to involve the mother in a Parent-Child Interactive Program and with a local community mental health agency was in process. Urinalysis testing was done on the mother (positive for marijuana only). A Pierce County Resource Directory was provided to the mother that included sources for drug and alcohol services.

Prior to closing the CPS investigation, the worker appropriately identified both risks and strengths as part of the Investigative Assessment. Although the Structured Decision Making (SDM) tool did not indicate significant risk for neglect or abuse, only the mother was assessed as the deceased child's father was reportedly no longer a member of the household. It is unknown if the SDM scores would have significantly changed had the father been considered as a secondary caregiver for the purpose of assessment.

Recommendation: None

Action Taken: The CPS worker was unavailable to participate in the Child Fatality Review due to an emergent field response assignment. However, the worker's supervisor and Area Administrator were present and received positive feedback from panel members regarding the excellent work. The worker was made aware of the feedback shortly after the review concluded.

Issue: A Pierce County hospital nurse reported to Central Intake (CI) the death of this child who had been transported by her parents after being found unresponsive. The referent had limited information and the intake was taken for information only purposes. There were no reported concerns that the death was suspicious for child abuse or neglect (CA/N). Given the limited information available to the nurse and provided to CI, the decisions made at initial intake appear to be reasonable. Supervisory reviews by CI were documented and an Administrative Incident Report was appropriately generated by CI due to the family having recently been involved with CPS.

The referral was then reviewed by Tacoma intake. The hospital was re-contacted and additional information gathered. Although there was still no reported evidence of abuse or neglect related to the child death, sufficient concerns were emerging, such as the father's observed behaviors at the hospital and slightly varying details of the circumstances surrounding the death (e.g., the infant and parents had slept the night in a car). The intake was again reviewed by two Area Administrators in the Tacoma DCFS office and the decision was made to upgrade the referral abuse or neglect allegations the intake was

screened in under Imminent Harm. The basis for the revision at intake was documented. The deceased child was identified as a victim of possible imminent harm. It would have been more reasonable to identify the surviving child as being possibly at imminent harm of neglect than the deceased child.

During the review discussion occurred as to whether the fact that the parents slept in a car with their infant on a moderately cold (40 degree) night showed "a serious disregard of the consequences to the child" such that it created "a clear and present to danger to child's health, welfare, and safety" [WAC 388-009: What is child abuse and neglect?]. The panel was unable to reach consensus on that issue. However, the review panel did reach general consensus that the decision to open a case for CA involvement was reasonable given very recent CPS involvement and the high media coverage of the child death incident.

The case was assigned to a CPS worker out-stationed at the Pierce County Child Advocacy Center (CAC) and eventually transferred to Family Voluntary Services (FVS) although the SDM score did not indicate a need for extended services. The mother reportedly declined FVS and the case was transferred back to CPS for case closure.

Recommendation: None

Child Fatality Review #08-69
Region 3
Snohomish County

This 10-year-old dependent Caucasian male died in a house fire.

Case Overview
On November 22, 2008, the private agency foster home where this foster child lived caught fire. This child and an 11-year-old died of asphyxiation. This foster home housed five behaviorally disturbed children. Everyone in the home was asleep at the time and smoke detectors were working. The foster parents, their adult daughter, and the other three foster children escaped with minor burns and smoke inhalation; none required hospitalization. The fire was originally thought to have started about 1:00 a.m. from electrical wiring. Another 11-year-old foster child in the home later said he started the fire. Law enforcement is investigating his statements. The Arlington Fire Department is investigating the cause of this fire, but did not issue the final report by the writing of this review. The foster father reported to a Children's Administration social worker that he had no reason to be suspicious of the boy who started the fire. He had no known history of starting fires and didn't appear interested in fire in any way. These foster parents never saw this boy play with matches or lighters prior to the event and never would have suspected him of playing with fire.

Referral History
On March 22, 2005, it was reported to Child Protective Services (CPS) intake that an eight-year-old foster child was choked by the foster father and hit by the teenaged daughter of the foster parents. This referral was accepted for investigation by the Division of Licensed Resources, Child Protective Services Section (DLR/CPS). During the investigation it was determined that this eight-year-old hit the foster parents' daughter. At this point, the foster father held the child's chin in an attempt to get him to look at him in the eye while he scolded him for hitting his daughter. There was no evidence or disclosure to verify that the foster father choked this child. The foster father agreed that he would not hold the child by his chin. This investigation was closed with an unfounded finding.

On October 23, 2006, the foster mother called CPS intake and reported her 17-year-old daughter was watching the children (two eleven-year-old boys) and she caught one of the boys looking down the pants of the other. She stopped this behavior and notified her parents. This referral was screened as a licensing complaint and closed with a not valid finding for improper supervision.

On December 20, 2007, a report was made to CPS intake alleging an adult relative visiting in the home spanked the eight-year-old and threatened to spank an 11-year-old child in the home. The relative was babysitting at the time and the foster parents were away from home. This referral was screened as a licensing complaint. This relative was visiting during

the holidays and was left with the children for a short time. The children later disclosed they were not spanked. This referral was screened as a licensing complaint and closed with a not valid finding for improper discipline.

On August 21, 2008, the parents of a foster child in this home reported to CPS intake that their son had a one-inch long bruise on his arm visible when he visited with his parents. The child told his parents the bruising was caused by other boys in the foster home. This referral was screened as a licensing complaint and closed with a not valid finding for improper discipline.

On November 10, 2008, a report was made to CPS intake alleging a 12-year-old boy was covered with bruises after being in this foster home for three days. The boy told family members that he was pinched and hit by the foster father while he was wrestling with him. This boy was reported to have severe behavior problems. The other boys in the home disclosed the foster father broke up a fight between this 12-year-old and another child and used just enough force necessary to break up this fight. This referral was accepted for investigation by the DLR/CPS and closed with an unfounded finding for physical abuse.

On November 13, 2008, during the investigation of the referral dated November 10, 2008, a child reported the foster mother picked up a child by the collar of his shirt and held him against the wall and told him to “shut up." None of the children interviewed in that investigation reported any abuse in this foster home. This referral was screened as a licensing complaint and closed with a not valid finding for improper discipline.

On November 22, 2008, a report was made to CPS intake that a fire erupted at this foster home in the middle of the night killing an 11-year-old legally free foster child and this 10-year-old dependent foster youth. Three other children in the home survived with minor injuries. The Arlington Fire Department and Snohomish County Sheriff are investigating the cause of the fire. This referral was screened out as a licensing complaint. The licensing file indicates that the foster family was current in all trainings. They had regularly practiced fire evacuation plans. They had one drill within two months of the fire.

Issues and Recommendations

Issue: POST FATALITY: Five children involved with Children's Administration were affected in various ways by this fire. There were many social workers in several Division of Children and Family Services (DCFS) offices involved with these children, in addition to the private agency and DLR. It later became apparent that in the days and weeks following the fire the communication and coordination among these many partners was inadequate, possibly affecting the timely provision of services.

Issue: The team agreed that in the event of another such event that affected so many in this agency and others, consideration should be given to the appointment of one person to act as coordinator for the activities of the others.

Child Fatality Review #08-70
Region 3
Snohomish County

This 11-year-old dependent Caucasian male died in a house fire.

Case Overview
On November 22, 2008, the private agency foster home where this foster child lived caught fire. This child and a 10-year-old died of asphyxiation. This foster home housed five behaviorally disturbed children. Everyone in the home was asleep at the time and smoke detectors were working. The foster parents, their adult daughter, and the other three foster children escaped with minor burns and smoke inhalation; none required hospitalization. The fire was originally thought to have started about 1:00 a.m. from faulty electrical wiring. Another 11-year-old foster child in the home later said he started the fire. Law enforcement is investigating his statements. The Arlington Fire Department is investigating the cause of this fire, but did not issue the final report by the writing of this review. The foster father reported to a Children's Administration social worker that he had no reason to be suspicious of the boy who started the fire. He had no known history of starting fires and didn't appear interested in fire in any way. These foster parents never saw this boy play with matches or lighters prior to the event and never would have suspected him of playing with fire.

Referral History
On March 22, 2005, it was reported to Child Protective Services (CPS) intake that an eight-year-old foster child was choked by the foster father and hit by the teenaged daughter of the foster parents. This referral was accepted for investigation by the Division of Licensed Resources, Child Protective Services Section (DLR/CPS). During the investigation it was determined that this eight-year-old child hit the foster parents' daughter. At this point, the foster father held the child's chin in an attempt to get him to look at him in the eye while he scolded him for hitting his daughter. There was no evidence or disclosure to verify that the foster father choked this child. The foster father agreed that he would not hold the child by his chin. This investigation was closed with an unfounded finding.

On October 23, 2006, the foster mother called CPS intake and reported her 17-year-old daughter was watching the children (the deceased child and another eleven-year-old boy placed in this home) and she caught one of the boys looking down the pants of the other. She stopped this behavior and notified her parents. This referral was screened as a licensing complaint and closed with a not valid finding for improper supervision.

On December 20, 2007, a report was made to CPS intake alleging an adult relative visiting in the home spanked the eight-year-old and threatened to spank the deceased child, then 10-years-old. The relative was babysitting at the time and the foster parents were away

from home. This referral was screened as a licensing complaint. This relative was visiting during the holidays and was left with the children for a short time. The children later disclosed they were not spanked. This referral was screened as a licensing complaint and closed with a not valid finding for improper discipline.

On August 21, 2008, the parents of a foster child in this home reported to CPS intake that their son had a one-inch long bruise on his arm visible when he visited with his parents. The child told his parents the bruising was caused by other boys (including the deceased child) in the foster home. This referral was screened as a licensing complaint and closed with a not valid finding for improper discipline.

On November 10, 2008, a report was made to CPS intake alleging a 12-year-old boy was covered with bruises after being in this foster home for three days. The boy told family members that he was pinched and hit by the foster father while he was wrestling with him. This boy was reported to have severe behavior problems. The other boys in the home disclosed the foster father broke up a fight between this 12-year-old and another child and used just enough force necessary to break up this fight. This referral was accepted for investigation by the DLR/CPS and closed with an unfounded finding for physical abuse.

On November 13, 2008, during the investigation of the referral dated November 10, 2008, a child reported the foster mother picked up a child by the collar of his shirt and held him against the wall and told him to “shut up." None of the children interviewed in that investigation reported any abuse in this foster home. This referral was screened as a licensing complaint and closed with a not valid finding for improper discipline.

On November 22, 2008, a report was made to CPS intake that a fire erupted at this foster home in the middle of the night killing an 11-year-old legally free foster child and this 10-year-old dependent foster youth. Three other children in the home survived with minor injuries. The Arlington Fire Department and Snohomish County Sheriff are investigating the cause of the fire. This referral was screened out as a licensing complaint. The licensing file indicates that the foster family was current in all trainings. They had regularly practiced fire evacuation plans. They had one drill within two months of the fire.

Issues and Recommendations

Issue: POST FATALITY: Five children involved with Children's Administration were affected in various ways by this fire. There were many social workers in several Division of Children and Family Services (DCFS) offices involved with these children, in addition to the private agency and DLR. It later became apparent that in the days and weeks following the fire the communication and coordination among these many partners was inadequate, possibly affecting the timely provision of services.

Issue: The team agreed that in the event of another such event that affected so many in this agency and others, consideration should be given to the appointment of one person to act as coordinator for the activities of the others.

Child Fatality Review #08-71
Region 2
Franklin County

This 10-year-old medically fragile Hispanic female died from cardiac arrest.

Case Overview
On December 6, 2008, this 10-year-old medically fragile child was brought into a Pasco area hospital with a fever of 103.8 and a swollen knee. It was later determined her leg was broken. This child was a high risk for seizures due to a severe brain injury at birth and a diagnosis of cerebral palsy. She had many hospitalizations since her birth and a disorder that caused fragility of her bone structure. It was determined that this child needed to be immediately transported to a Spokane hospital by ambulance as the local hospital could not provide the level of care that she required. This child died en route from Pasco to Spokane. Her death was not the result of abuse or neglect.

An autopsy was conducted and the medical examiner listed the manner of death as Undetermined. Her cause of death is listed as Unknown, otherwise cardiopulmonary arrest. Other conditions contributing to her death are chronic medical illness and encephalopathy (a disease of the brain).

Referral History
On May 17, 2008, hospital personnel reported to Child Protective Services (CPS) intake that this child was brought to a hospital with a fracture to her left femur. This was the fourth femur fracture in a two year period. Medical personnel did not consider the fractures suspicious injuries. This child had many special needs. She has been diagnosed with cerebral palsy with seizures and had very thin bones that were prone to easily breaking while being transferred. She is also totally bedridden and used a feeding tube. This child was to be evaluated by an orthopedic specialist. This referral was screened as Information Only.

Issues and Recommendations
Issue: None indicated

Recommendation: None

Child Fatality Review #08-72
Region 5
Pierce County

This three-month-old Caucasian female died from intersititial pneumonitis (a form of pneumonia).

Case Overview
On November 28, 2008, the deceased child's mother and her three children were at the home of the mother's boyfriend, who is the presumed father of this three-month-old infant. The mother reported to law enforcement that she had gone to bed with her infant sometime around 10:30 the evening of November 27, 2008. The infant, mother, and her boyfriend were all sleeping in the same bed. The boyfriend awoke around 4:30 a.m. and went to back to sleep in another room in the house. The mother fed the infant at around 6:30 a.m., burped her, and then laid her across the mother's stomach in the prone position (on stomach with face turned towards mother). They both went back to sleep. The mother said she later awoke with the infant in the same position as when they fell asleep, but the child was blue and cold to the touch. She notified her boyfriend who called 911. Fire and Rescue was dispatched to the scene as the parents attempted to revive their daughter. The child was pronounced dead at 9:44 a.m. Law enforcement was notified and arrived on scene around 10:00 a.m.

There is a reported discrepancy in the events. A responding fireman told police that the mother went back to sleep with the boyfriend around 6:30 that morning and both adults were in same bed when the baby was found not breathing and blue in color. This information conflicts with the mother's later statement to law enforcement that the baby's father was sleeping elsewhere at the time the baby was discovered unresponsive.

Following autopsy and toxicology studies, the cause of death was determined to medical in nature (intersititial pneumonitis) and the manner of death natural. Interstitial pneumonitis is a form of pneumonia that involves the connective tissues of the lung, and can be caused by an infection, toxic inhalation, or a virus.

Referral History
On May 14, 2007, a neighbor reported to Child Protective Services (CPS) intake that the deceased child's nine-year-old sister had a black left eye. The referrer asked this child about the bruise and she said her mother hit her. The nine-year-old said her mother hit her all the time as did the mother's boyfriend. Another neighbor said this child had a bloody nose from being hit a month prior. This referral was investigated by CPS and closed with an unfounded finding.

On November 6, 2008, a teacher called CPS intake and reported that the deceased child's mother had relapsed on methamphetamine. The mother told the referrer she and her

children had lost their housing and were going to live in a car. The family moved around to various friends' homes. The deceased child's eight-year-old brother has Attention Deficit Hyperactivity Disorder (ADHD) and is developmentally delayed. The referrer reported he was not in school for three weeks. This referral was screened as Information Only.

On December 10, 2008, law enforcement called CPS intake and reported the death of this three-month-old infant. Neither the medical examiner investigator nor law enforcement found anything unusual or suspicious about this child's death. This referral was screened as Information Only.

On January 1, 2009, CPS intake was contacted by staff at a King County area hospital where the deceased child's mother was admitted to the psychiatric ward for suicidal ideation and extreme depression. It was reported the mother was struggling after the death of her child. An emergency room social worker received information from a relative that the mother's boyfriend (the deceased child's father) was previously abusive to her eight-year-old son. This child disclosed he was punched until he passed out. He also disclosed that the mother's boyfriend placed a pillow or blanket over the now deceased child's face until she would stop crying. The intake was accepted for investigation of physical abuse regarding the eight-year-old son. The children were in the care of relatives prior to opening the investigation and remain in their care. The mother's boyfriend left the home and his whereabouts are unknown. The CPS investigation resulted in a founded finding for physical abuse of the eight-year-old by the mother's boyfriend. Law enforcement still had an open case regarding the child fatality.

Issues and Recommendations

Issue: In May 2007, CPS received a report alleging physical abuse of the then nine-year-old sister of the deceased child. The allegations did not involve the now deceased child who was not born until September 2008. The CPS investigator appears to have met most policy and practice expectations for conducting an investigation, including timely interviews with the alleged victim and subject. However, in review there were some noted practice deficits from the 2007 CPS investigation, none of which were found to have any significant implication to the child fatality 18 months later.

The worker did not input the Safety Assessment into the CA Case and Management Information System Graphical User Interface (CAMIS GUI) until well past the prescribed timeline. The Global Appraisal of Individual Needs Short Screener (GAIN-SS), which is designed to be completed with the client, was sent to the parent to fill out and return by mail. The CPS investigator was aware of a male roommate but did not pursue further information. No audio recording was made of the alleged victim interview. Audio recording of physical abuse interviews was expected practice in 2007. The social worker who had been the investigator in 2007 participated in the review and received feedback regarding the investigation. The worker acknowledged deficits and areas where improved practice, including best practice, might have been conducted.

Recommendation: None

Issue: The decision to screen out the referral taken on November 6, 2008 appears reasonable. There were no specific allegations being reported. While there were identified risk factors, none singularly or cumulatively appear to have represented imminent risk of serious harm at the time of the intake. Just over two weeks later CPS intake received by mail the hardcopy school report from the original call made to intake. The same intake worker who processed the call-in also reviewed the mail-in report. The worker noticed information on the hardcopy school report that had not been originally presented at the time of the call-in, and the worker documented the additional information in a Service Episode Report (SER) case note. The panel was unable to review the hardcopy school report. According to the SER by the intake worker, the school report was discarded due to there being no previous CA case file. This was an error as there had in fact been a CPS investigation conducted in 2007 and a case file for the family existed at the time of the November 2008 intake.

The worker did document in SER that according to the school the mother admitted to drug use. Additionally it was being reported that an unnamed live-in boyfriend was involved with making and selling methamphetamine (not specified if such was occurring at the home or elsewhere). The fact that the intake worker compared the details from the hardcopy school report with what had been documented in CAMIS-GUI reflected good practice. However, the panel review members were in full consensus that the additional information found in the mailed-in school report should have generated at least further discussion with the intake supervisor about a possible screening revision or generating a new referral based on the additional information of the methamphetamine manufacturing and selling. Minimally the intake worker might then have been directed to re-contact the referent to find out who was the primary source of the information being reported.

Recommendation: None

Action Taken: The Region 5 Area Administrator overseeing regional intake has agreed to address with the Tacoma intake supervisor and intake worker for general feedback the specific intake issues discussed during the Child Fatality Review.

Action taken: Regarding the referral taken on November 6, 2008, it will be used as a training opportunity during the next scheduled Tacoma DCFS intake unit meeting. Primary focus will be on discussing consultation and shared decision making following additional information received on an already completed intake.

Issue: A month following the death of her infant the mother was hospitalized. While the family was visiting at the hospital, a hospital social worker became aware that eight-year-old brother of the deceased child had disclosed to family members that the mother's boyfriend was physically abusive in the past. The eight-year-old told relatives that

mother's boyfriend punched him and held a pillow over the deceased child's face until she stopped crying. He gave no specified time frame for these incidents. It was noted that the mother's boyfriend no longer had contact with any of the children since the deceased child death in late November 2008.

The intake was screened in by Central Intake (CI) for Alternate Intervention and sent to the appropriate Children's Administration jurisdiction (Tacoma) where the report was reviewed by the Tacoma Intake Supervisor and an Area Administrator. The decision was made to change the CI Alternate Intervention designation to "accepted for CPS investigation." In review, the Child Fatality Review panel was in full consensus that the upgrade to CPS investigation appeared to be more supportable than the original low risk referral decision. This opinion was shared with the CI liaison to Region 5 following the Child Fatality Review.

At intake only the eight-year-old brother was identified as an alleged victim. Information gathered and documented during the CPS investigation appears to have been sufficient to have the older sister added as a victim of abuse by the mother's live-in boyfriend. Less clear was whether there was sufficient information to add the deceased child as a victim of pre-fatality abuse and neglect. Documented statements from the mother suggested that she might have been added as a subject for failing to intervene in the abuse of her eight-year-old son but the review panel was not able to come to any clear consensus as to supportability of such a decision. The CPS investigator for the post-fatality intake and her supervisor were present during Child Fatality Review and acknowledged the reasonableness of adding at least the older sibling to the intake as a victim.

Recommendation: None

Child Fatality Review #08-73
Region 4
King County

This 17-year-old Caucasian female died after suffering a stroke.

Case Overview
On December 12, 2008, this 17-year-old youth died at Harborview Hospital. Earlier, she was taken to another hospital for a fever. While at the hospital she suffered a stroke and was airlifted to Harborview Hospital where she died. There were no suspicions regarding child abuse or neglect.

It was determined that the immediate cause of death was a bacterial infection leading to intercerebral hemorrhage (stroke). The teen was found to have infectious endocarditis - an infection of the lining of the heart chambers and heart valves that is caused by bacteria, fungi, or other infectious substances. The manner of death was determined as natural, and a medical condition is listed as the official cause of death.

Referral History
On September 20, 2000, a teacher called Child Protective Services (CPS) intake and reported the then six-year-old sister of the deceased youth said her privates hurt when she walked. She made no further comment. This referral was screened for the Alternate Response System (ARS). The ARS provider was unable to locate the family.

On June 17, 2002, a teacher called Child Protective Services (CPS) intake and reported the then four-year-old brother of the deceased youth said his mother hit him on the nose. There appeared to be a bruise on the child's nose. This referral was screened in for investigation by CPS. The social worker was unable to locate the family. The referral was closed without a finding.

On February 9, 2007, a teacher called Child Protective Services (CPS) intake and reported the then 13-year-old sister of the deceased youth said her stepfather hit her two years prior. This referral was screened as Information Only.

On March 22, 2007, a teacher called Child Protective Services (CPS) intake and reported the then nine-year-old brother of the deceased youth said his older brother, then age 15, woke him up by hitting and kicking him on the head and the legs. The older brother also pulled his ear. The nine-year-old said his mother is always sleeping when his brother is doing this. There was indication that the mother drank a lot. The nine-year-old said his mother got mad at him for telling and did not do anything about it. Mother denied to the teacher's yesterday that there was abuse between her sons. Referrer stated there were a lot of bruises on his right front leg from the knee down. This referral was screened in for investigation by CPS and closed with an unfounded finding.

On December 4, 2007, a teacher called Child Protective Services (CPS) intake and reported the then 13-year-old sister of the deceased youth said her stepfather pushed her and threw a cup of water with maggots in it at her. The child had no marks or bruises. This referral was screened as Information Only.

On May 2, 2008, a report was made to CPS intake that the 15-year old brother of the deceased youth inappropriately touched his 10-year-old brother. The information was sent to law enforcement. The 10-year-old was interviewed at a sexual assault clinic and made disclosure of abuse. This referral was screened out as Third Party abuse.

Issues and Recommendations
Issue: All six intakes (2000-2008) were reviewed. In examination, the panel agreed that the intake decisions were appropriate and reasonable with the exception of the first intake from September 2000. In review it appears that the referral dated September 20, 2000 should not have been accepted even as a low risk referral assignment to Alternative Response System (ARS). The single concern that was reported did not appear to meet legal sufficiency for CPS services. It was noted during the panel discussion that such assignments to ARS as a means to offer services to families were part of accepted practice in the Bremerton DCFS office in 2000. It is currently not the practice.

Recommendation: None

Issue: Six years prior to this youth's death Bremerton intake received information that the younger brother of the deceased youth disclosed being hit in the nose by his mother. The referral was appropriately assigned for investigation. Although Children's Administration (CA) policy and practice requirements for conducting CPS investigations have changed significantly since 2002, full consensus was reached by the Child Fatality Review panel that the CPS investigator failed to meet basic practice standards. The review panel found no credible evidence of any attempt to conduct an investigation. Documentation of reported attempts to contact the alleged victim, the family, and the child's school was made in a single case note in November 2002 just prior to closing the case as "unable to locate."

Following the Child Fatality Review the CA "Guidelines for Reasonable Efforts to Locate Children and/or Parents" was electronically disseminated to the Bremerton Area Administrator and supervisors overseeing the CPS program. This was not in response to any indication of a current problem within the CPS units, but rather in recognition of an opportunity to update and reinforce Region 5 practice expectations in the Bremerton DCFS office regarding "unable to locate" situations.

Recommendation: None

Issue: In March 2007 Bremerton intake received information that the deceased youth's younger brother disclosed being physically abused by his older brother on a frequent basis.

This child indicated that he had told his mother but she was not doing anything about the situation. The referral was appropriately assigned for investigation of negligent treatment (parent not adequately intervening in sibling-to-sibling abuse). The CPS worker met or exceeded most practice and policy. The field response time was immediate. The alleged victim was interviewed at school using a sign language interpreter. The investigator conducted an unannounced home visit and both parents were interviewed. The deceased youth and her siblings were also interviewed although none were identified as victims. The CPS worker made contact with the schools of all the children as well as spoke with a relative who lived near the family home. The investigation was completed in a timely manner and the finding (unfounded) appears to be supportable upon review. Overall the investigative activities and documentation were of excellent quality. The CPS worker participated in the review and received feedback regarding her investigative practice and documentation.

Recommendation: None

Child Fatality Review #08-74
Region 2
Kittitas County

This one-month-old Caucasian male died from Overlay Asphyxia.

Case Overview
On December 3, 2008 the Ellensburg Police Department and Emergency Services were summoned to the home of a relative of the deceased child. The child's family was living with this relative. The deceased child was found in the morning not breathing. The mother and infant were co-sleeping on a sofa. The infant was described as being found in a face up position. It was reported that the child was wedged between the sofa back rest and mother. The child was not breathing when the mother woke up.

Law enforcement reported there are no obvious signs of injury or smothering. Law enforcement was immediately concerned as the mother reported she had another child die in her care in 2006. The mother and father were co-sleeping with this older sibling when he passed away. The mother reported the sibling died of Sudden Infant Death Syndrome (SIDS).

Based on this history, law enforcement chose to investigate the most recent infant death despite no obvious signs of maltreatment. The Medical Examiner determined that the manner of death was accidental and the immediate cause was overlay/asphyxia and co-sleeping with adult.

Social Service professionals and family members reported they warned the parents on numerous occasions of the risks that co-sleeping posed to this child. Law enforcement has determined that the mother's negligence by ignoring the advice not to co-sleep with her child, especially since she lost another child in a similar situation, reached the charging level of Manslaughter. Law enforcement forwarded their case to the Kittitas County Prosecutor's office for review. The prosecutor has not made a decision whether to charge the mother.

Referral History
On August 8, 2007, a relative reported to CPS intake that the deceased child's parents regularly yelled at each other and their children. The father was arrested on a warrant for failure to appear on a stolen vehicle charge. The yard was full of trash, dirty diapers, and beer cans and bottles. There were three children approximately ages three and two-years-old and an infant in the home. Law enforcement did not find drugs or paraphernalia. The mother self-reported she had a male infant die about a year prior of SIDS. This referral was screened in for investigation by CPS and closed with an unfounded finding for negligent treatment or maltreatment. The parents agreed to participate in Family Preservation Services (FPS), parenting classes, and random urinalysis.

On June 16, 2008, a relative reported to CPS intake that the family home was filthy on a regular basis. The deceased child's parents, a four-year-old sister, the maternal aunt and her two children all lived in one home. The referrer reported there was too much partying; so much that the parents could not meet needs of the children. There were empty beer cans and bottles in the house and both parents were under age. The referrer suspected that the mother was not drinking as she was pregnant at the time. The referrer also believed the mother was depressed as she did not attend to children needs. The children were dirty and the older children were allowed to go outside with inadequate clothing for the weather.

This referral was screened in for investigation by CPS and closed with an inconclusive finding for negligent treatment or maltreatment. The families cleaned up the home. The deceased child's parents agreed to participate in FPS services. All three adults in the home agreed to submit to urinalysis. The deceased child's mother engaged in mental health counseling, and the family worked with a parenting coach.

On December 3, 2008, law enforcement called CPS intake to report the death of this child. Emergency services were summoned to the family home after the child was found in a face up position and not breathing. There were no obvious signs of injury or smothering. Law enforcement decided to investigate thoroughly to rule out the possibility of death by abuse based on the mother's history of a previous infant death in 2006. The parents agreed to place the surviving four-year-old daughter in the care of her grandfather pending the outcome of the law enforcement and CPS investigations. This referral was screened in for investigation by CPS. The finding is still pending as of the date of this report.

Issues and Recommendations

Issue: Review members indicated concern over the inability to complete in-state criminal background checks on subjects as was previously practiced.

Recommendation: Review members would like the in-state criminal background check re-instated to compliment the existing process of the National Crime Information Center (NCIC). This request is for the sake of thoroughness as field staff have reported NCIC checks sometimes do not capture local crimes and convictions. The DSHS Background Check Central Unit (BCCU) checks also produce Record of Arrest and Prosecution (RAP) sheet that field staff can easily review.

Issue: Although it was unclear if domestic violence was an issue in this particular case, the review committee acknowledged that CA does not have a definitive policy regarding domestic violence. Best practice supports assessing whether domestic violence is a cause of harm or creates a risk of imminent harm to a child.

Recommendation: CA's Practice Guide to Intake and Investigative Assessment recommends considering risk factors affiliated with domestic violence at the time of intake and recording those factors. Developing a policy which directly addresses screening for

domestic violence at intake and throughout the life of a case supports early identification along with the development of strategies to assist in alleviating such risk factors.

Issue: The referral dated June 16, 2008 referenced neglect due to a filthy home. At the time, the household consisted of two families, the deceased child's family, his aunt and her children.

Recommendation: A referral should have been generated on each family to eliminate any confusion when documenting assessments and when providing services.

Issue: The currently assigned Child and Family Welfare Services (CFWS) social worker reported that the deceased child's mother is again pregnant (at the time of this report).

Recommendation: The worker's supervisor will consult with the Assistant Attorney General on direction for possible filing of a dependency petition on the child when it is born.

Child Fatality Review #08-75
Region 4
King County

This one-month-old Caucasian female died from Sudden Unexplained Infant Death (SUID).

Case Overview
On December 20, 2008 the King County Medical Examiner's Office called Child Protective Services (CPS) Intake to report the death of this one-month-old infant. She was found dead by her mother at 7:40 a.m. The mother told the death scene investigators that her daughter was possibly ill on the night of December 19, 2008 as she was very fussy and would not sleep. At about 3:00 a.m. the mother was breastfeeding her in bed, with the mother lying on her side. She could not remember if she or the infant fell asleep but when she woke up, her daughter was dead.

According to the scene investigation report, the deceased child was last placed on her side in the mother's bed, with the mother, at 3:45 a.m. She was last known alive at 3:45 a.m. She was found dead at 7:00 a.m., and the mother's bra was entangled with the infant.

The death scene investigators noted the temperature of the room was very hot. The environment was described as clean but cluttered. The King County Medical Examiner ruled the Cause of Death as Sudden Unexplained Infant Death (SUID). It could not be determined if external conditions related to bed sharing contributed to the death. The manner of death is undetermined.

Referral History
On April 22, 2003, it was reported to CPS intake the deceased child's mother was six months pregnant and continued to use methamphetamine, crack, and marijuana. She refused to enter substance abuse treatment and did not have consistent prenatal care. The referrer stated the mother lived with her mother who was dealing drugs from the home. The referrer also reported the mother had a seven-year-old son in her care. The referrer reported she briefly lost custody of her son after she was arrested for child endangerment in California. The mother was briefly incarcerated for felony assault. This referral was screened in for investigation by CPS and closed with an unfounded finding for negligent treatment or maltreatment.

On August 3, 2003, a hospital staff reported to CPS intake that the deceased child's mother tested positive for amphetamines and marijuana while in the hospital to give birth to a baby boy. She had poor prenatal care and tested positive for methamphetamine, marijuana, cocaine, and opiates while pregnant. Doctors placed a medical hold on the newborn infant. This referral was screened in for investigation by CPS and closed with a founded finding for negligent treatment or maltreatment. A dependency petition was filed on behalf of this

child. He was placed in foster care. Eventually the mother's parental rights were terminated.

On September 24, 2003, a report was made to CPS intake that the then seven-year-old sibling of the deceased child was left home alone at 5:45 p.m. The mother had gone to court and said she would not be back until 8:00 p.m. This referral was screened in for investigation by CPS and closed with an inconclusive finding for negligent treatment or maltreatment. A dependency petition was filed on behalf of this child and the mother's parental rights were terminated.

On November 9, 2008, a medical professional reported to CPS intake that the mother gave birth to the deceased child. The referrer reported the mother had little or no prenatal care, tested positive for marijuana upon admission to the hospital, and gave birth to the deceased child prematurely. Hospital staff observed the mother was rough in handling the baby and was inappropriate with the infant. The mother was seen accidentally kicking this newborn on the head. The newborn was examined and found to be fine. Nurses had to coach the mother on proper handling techniques. This was her fourth child. The mother had three other children removed from her care because of substance abuse and neglect issues. The mother briefly lived in Michigan and gave birth to a child there. The child was reportedly removed and placed into CPS custody in Michigan. This referral was screened in for investigation by CPS and closed with an unfounded finding for negligent treatment or maltreatment.

On December 20, 2008, the King County Medical Examiner reported to CPS intake the death of this one-month-old infant. The mother found the infant dead at 7:40 a.m. on December 20, 2008. The mother told the medical examiner that her daughter was fussy and perhaps had picked up an illness by spending time relatives who were ill. The deceased child was unable to sleep on the night of December 19, 2008. At 3:00 a.m., the mother breastfed the infant in bed (co-sleeping). The referrer said the mother was trying to get her life together. There were no outward signs of infection. The child died from Sudden Unexplained Infant Death. This referral was screened in for investigation by CPS. The CPS case remains open at the time of this report.

Issues and Recommendations

Issue: According to the CPS workers, the hospital nurse who made the November 9, 2008 call to CPS Intake thought the report was an inaccurate account of her statement. She told the CPS workers who responded that she did not say the mother tested positive for marijuana. In fact, the mother was not tested while in the hospital. The mother told the referrer that she used marijuana during the third trimester for nausea. The infant was negative for all substances. The nurse did not think the mother was inappropriate with the infant. The nurse was present when the mother's foot accidentally brushed the head of the infant and the infant was not injured. The nurse did think a report was necessary based on the mother's statements about her history.

Recommendation: Intake workers can help ensure the accuracy of reports by reading the text of the allegations back to the caller and making corrections as necessary

Issue: The mother had CPS history in the state of Michigan and had been in substance abuse treatment. There were no calls to Michigan to verify this history or request records.

According to the mother, she gave birth to a daughter while living in Michigan in 2006-2007. She said CPS took custody of the infant and she relinquished her rights so the paternal grandparents could raise her. She also said she was on probation for possession of cocaine and in intensive out-patient treatment there.

Recommendation: Social workers should always contact other states for information when a client has a case history there. This can provide valuable information to help determine a caregiver's impairment, strengths and risks.

Issue: The assigned CPS social worker read the case files from the Division of Children and Family Services (DCFS) King East office concerning the termination of parental rights of her oldest children. However, neither she nor her supervisor contacted the Child and Family Welfare Services social worker who had been assigned the case and still works in the King East office.

Recommendation: The best practice would be to contact the previously assigned workers. Had the previously assigned worker been contacted about the birth of the deceased child, he may have been able to provide additional information or case history to better inform the latest worker.

Issue: The need for policy guidance on the response when mothers give birth after their parental rights have been terminated as to other children.

Recommendation: Since February 1, 2009, FamLink (Children's Administration's new electronic case management information system) allows reports of infants born to caregivers with prior termination of parental rights to be opened as "Risk Only," meaning there is imminent risk of serious harm but no current allegation of child maltreatment.

When Children's Administration releases the updated "Practice Guide to Intake and Investigative Assessment" later in 2009, it will provide more guidance on how to respond to such intakes.

Issue: The decision to allow the deceased child to go home with her mother.

The assigned social worker made this decision based on information provided by the first responding social worker and on contact with the mother at the hospital. The mother exhibited early positive signs that she was committed to parenting this child. She made

living arrangements that included living with another adult (her mother) to monitor the baby's safety and provide her additional support. She also demonstrated her commitment by making firm arrangements to seek treatment for mental health and substance abuse issues.

Recommendation: More collateral contacts (as mentioned previously) could have strengthened or altered the decision to have the infant go home with the mother.

Issue: The CPS social worker observed the positive interactions between the mother and infant, in the home. The mother was able to breast feed without difficulty. She saw the sleeping arrangements for the infant and mother. The home was noted to be very clean and neat, the mother had her own bed, and there was a crib for her child. The grandmother, a trained LPN, also lived in the home and provided support.

The worker gave the mother a "Safe Sleep" kit, provided by the Northwest Infant Survival Alliance/SIDS Foundation of Washington. The kits include information for parents on SIDS and risk reduction, safe sleep position, and other prompts to make the sleep environment as safe as possible. The worker carefully went over the contents of the kit with the mother. The mother said she smoked outside.

Recommendation: When writing safety plans with families who have infants, it may be appropriate to list all the safe sleep practices and have the caregivers sign acknowledgement and agreement to adhere to them.

This office has since initiated a safe cribs project for their clients. Children's Administration should consider ways of partnering with communities to emphasize infant safe sleep and risk reduction strategies.

Issue: The CPS worker made a referral to the Early Intervention Project, a contract with Public Health Nursing. The assigned nurse visited with the mother and infant in the home. The mother was exclusively breastfeeding. The deceased child's growth and development was within normal limits. She was enrolled at Women, Infants, and Children (WIC). She had a primary care pediatrician and had had her initial well child check. The nurse noted that the infant lived in a safe and nurturing environment. The nurse was aware of the mother's history concerning mental health and substance abuse, and her current treatment arrangements. The nurse visited the deceased child in the home three days before she died. From the Public Health Nurse (PHN) perspective, it was appropriate for this infant to be living at home with her mother.

Even with specific instruction to the contrary from the CPS worker and the PHN, the mother still decided to bed-share with her infant on at least one occasion. Also, the odor of cigarette smoke was noted to be in the home and the bedroom was very hot at the time of the death investigation.

Recommendation: Children's Administration should consider joining community efforts to find the most effective ways of delivering infant safe sleep information to at-risk families.

Child Fatality Review #08-76
Region 6
Jefferson County

This eight-month-old Caucasian male's cause of death is undetermined.

Case Overview
On December 25, 2008, the deceased child and his mother went sleep in the same bed. The mother was on the right side of the bed and the deceased child was in the middle of the bed. The mother was awakened by another resident of the shelter in which they were living. This resident found the mother asleep on the floor near the bed. She did not know how she ended up sleeping on the floor. After the resident left the room, the mother noticed that her son, the deceased child, was blue and not breathing. She screamed for help and another resident called 911. When the medics arrived on the scene a female resident showed them where the deceased child was located. The child was laying on his back his arms out and palms up. He was on the bed with his head towards the center of the bed, unresponsive and not breathing. He was not revived. The child had been sick when his family arrived at the shelter approximately 10 days before his death. The mother was advised by shelter staff to take him to see a doctor, but she did not follow this advice.

Law enforcement opened an investigation into this fatality. Law enforcement also determined that the mother was in no condition to care for her surviving child. The mother was taking medications for depression and anxiety. Following her son's death, the mother took a combination of nine prescribed medications and lost consciousness; she was hospitalized. The police placed the surviving two-year-old sister in protective custody. The Division of Children and Family Services had an open case on this family at the time of this child's death. A referral was screened in alleging general neglect of the children's hygiene needs and level of supervision due to mother's mental health needs and her use of alcohol.

The death certificate lists cause and manner of death as undetermined.

Referral History
On May 30, 2007, a pediatrician for the deceased child's sister called Child Protective Services (CPS) intake and reported that her parents did not take her in for any well baby checks or immunization updates for four months. The referrer stated there were no medical needs or concerns about the child. This referral was screened as Information Only.

On April 22, 2008, a hospital staff reported to CPS intake that the mother gave birth to the deceased child. He was born seven weeks premature. The mother had a history of alcohol use. The mother's roommate told a nurse that this mother had a serious drinking problem and binged on a case of beer the previous weekend. The mother denied this. There is a

history of domestic violence with the deceased child's father. The deceased child appeared fine at birth. This referral was screened as Information Only.

On December 2, 2008, a report was made to CPS intake that the deceased child's mother neglected him and his older sister. The deceased child was not bathed in days and needed a diaper change. The deceased child's sister fell while climbing out of her crib/play pen. She later climbed up on the bed and wrote all over herself with markers and put them in her mouth. The referrer reported it took a while to wake the mother. The referent stated that the mother had a migraine and took pain medication that made her sleep. The referrer reported this situation has occurred several days in row. The shelter staff addressed this issue with the mother, but there was no change in her behavior. The family's room was dirty and smelled terrible. This referral was screened as Low Risk referral.

On December 11, 2008, a report was made to CPS intake that the deceased child's mother neglected her children because she did not get up and meet their daily needs. The children were not bathed regularly. The referrer indicated that the mother acknowledged she had difficulties in dealing with her situation and caring for the children. The family's room again smelled terrible and was dirty. This referral was screened in for investigation for negligent treatment or maltreatment and closed with an unfounded finding.

On December 25, 2008, law enforcement called CPS intake to report the death of this child. The child was found not breathing and unresponsive. The child was taken to a hospital by ambulance and was later declared dead. The deceased child's two-year-old sister was still in the home. Law enforcement said the mother was unable to parent her as the mother was over-medicated. The family lived in the shelter for approximately 10 days. Staff at the shelter saw the family on December 24, 2008 and everyone appeared healthy. The family's room again smelled terrible and was dirty. This referral was screened in for investigation for negligent treatment or maltreatment and closed with a founded finding. The two-year-old sibling remained in foster care on a Voluntary Placement Agreement.

Issues and Recommendations

Issue: The deceased child was listed as the subject in the December 25, 2008 intake rather than the victim. This intake was entered by Central Intake unfortunately the CPS investigator and supervisor did not realize this and completed the investigative assessment making it impossible to change the child to a victim in the computer system.

Recommendation: The Deputy Regional Administrator sent an email to Central Intake regarding this issue. Supervisors and social workers will carefully review subject and victims identified in intakes prior to completing tasks in FamLink. This will be discussed at the June 2009 consensus building meeting with all CPS and Intake supervisors.

Issue: During the course of the review it was found that the Structured Decision Making (SDM) tool was completed at the close of the case and had a score of "No" on the question

addressing the caregiver's past or current mental health problem. The review team discussed why this was answered no when the mother admitted to being depressed and on medication. The social worker and supervisor said that SDM manual specifies the Mental Health question should not be indicated on the risk assessment that a parent or child has mental health issues unless this has been documented by a medical or mental health professional. In this case the social worker did not have documentation from a medical or mental health professional.

Recommendation: On a statewide level the SDM manual and definitions should be reviewed with the Children's Research Center to discuss the feasibility of changing the Mental Health definition to more appropriately reflect the issues identified at investigation when a client admits to being depressed both to the social worker and by answering the Global Appraisal of Individual Needs (GAIN SS) in the affirmative to the mental health questions. At the regional level, set up a process to review SDM procedures and practice with supervisors and staff.

Issue: The Investigative Assessment indicated that there were no safety issues identified during the course of the investigation; however the deceased child's mother indicated to the social worker that she was depressed and also had migraine headaches and was sleeping a lot. There was no documentation in the case file regarding the social worker and the mother discussing the safety needs of the children and how the mother was going to provide a safe environment for her children.

Recommendation: The Regional Administrator and Deputy Regional Administrator will meet to review all of the information on this case. The Deputy Regional Administrator, Area Administrator and Supervisor will meet to review policy and practice regarding assessing the safety needs of children under the age of five.

The issue of assessing the safety needs of children under the age of five will also be discussed at the June 2009 consensus building meeting with all supervisors in Region 6.

Child Fatality Review #08-77
Region 3
Skagit County

This one-month-old Caucasian female died following a seizure.

Case Overview
On December 19, 2008, this one-month-old infant was found non-responsive by her maternal grandmother. The infant was sleeping in a bed with her mother. This infant and her mother were both living in the maternal grandmother's home. The grandmother performed CPR on the infant and she was revived. When medics arrived the deceased child was taken to a local hospital and then transferred to Children's Hospital in Seattle and placed on life support. The decision was made to withdraw the life support when it was determined that there was no longer brain function. The child died on the fourth day after the incident. An autopsy revealed the death was due to a probable seizure caused by hypoxic/ischemic encephalopathy related a brain injury at birth. Hypoxic/ischemic encephalopathy occurs when the brain and central nervous system are damaged because the oxygen supply to the brain is interrupted. It was also determined that there was no evidence of overlay. The infant had a seizure disorder related to her difficult delivery.

Referral History
On November 16, 2008, hospital staff reported to Child Protective Services (CPS) intake that the deceased child and her mother were to be discharged from the hospital after a difficult delivery. This infant remained hospitalized for nine days after her birth due to tremors in her arms. Doctors diagnosed this child with a seizure disorder. There was a concern that mother planned to take the newborn to live in the home of the presumed father and his wife. The father's children were recently removed from that home due to unsafe and unsanitary conditions. The mother was resistant to services offered by the department. She was actively involved in the Women, Infant, and Children (WIC) program as well as maternity services. This referral was screened in for investigation by CPS and closed with an unfounded finding for negligent treatment or maltreatment.

On November 18, 2008, hospital staff again reported to CPS intake that the deceased child and her mother were to be discharged from the hospital and continued to say she and her newborn daughter were moving in with the baby's father. The referrer said this home was very cold and dirty. There were cat feces on the floor and the sink was piled with dirty dishes. The septic system did not work and the toilet was backed up. The referrer was concerned about bringing a newborn infant into this home. The mother later decided not to move in with her child's father. This referral was screened in for investigation by CPS and closed with an unfounded finding for negligent treatment or maltreatment.

On December 15, 2008, law enforcement reported to Child Protective Services (CPS) intake that they were called out to a home when the deceased child was first discovered

non-responsive. The child's grandmother initiated CPR and the child was revived and taken to a hospital. She died four days later. This referral was screened in for investigation by CPS and closed with an unfounded finding for negligent treatment or maltreatment and physical abuse.

Issues and Recommendations

Issue: The assigned CPS worker made arrangements with the Children's Hospital social work staff to notify CPS when this particular child was discharged, so the worker could check on the child's living conditions at home. This did not happen as arranged and CPS was unaware until ten days after the discharge that the infant had returned home.

Recommendation: The Region 3 Medical Consultant set up a system with Children's Hospital to notify Children's Administration when a medically complicated foster child is discharged. She will discuss with the hospital the possibility of expanding this system, or streamlining the communication between Children's Administration and Children's Hospital on all medically complicated, high risk cases.

Child Fatality Review #08-78
Region 6
Mason County

This 11-year-old Caucasian male died from Methadone Intoxication.

Case Overview
On November 25, 2008, the mother of this deceased youth was unable to wake him. He was unresponsive, so she called 911 and performed CPR until medics arrived and took over. CPR was stopped at 8:55 a.m. at which time the youth was declared dead. There were no unusual marks noticed on the youth's body except for the obvious marks from the CPR that had been performed. The family was in the process of moving to Pacific County three days prior. The home was clean overall with moving boxes in the living room.

The toxicology report was received by law enforcement which showed the child had a blood Methadone level of .72. Law enforcement found that the Methadone was a prescribed medication for the youth's mother and was kept in a child friendly pack which looked like a stuffed reindeer. The medication was easily accessible to the children in the home. This youth was known to wander in the night. He would get into the kitchen and refrigerator and eat things and take some things to hoard in his room. His mother had a security device at a previous residence which was described as a motion detector because of this youth's habits. The mother also had a lock box in which she kept her medicines. At the new home where they had just moved, the medication was not in the lock box nor was a door alarm or motion detector installed. The medication was not put in a safe location and was in a child friendly container.

The manner of death has been ruled undetermined; cause of death is Methadone Intoxication.

Referral History
On January 8, 2007, a neighbor contacted Child Protective Service (CPS) intake to report the family home was filthy. There were used diapers at least a week old, old rotting food and no fresh food. The referrer said the mother had mental health issues and was unable to care for her children. She slept most of the day and the children had to fend for themselves. The older boys, including the deceased youth, were said to be developmentally delayed. All the children were always sick, but when they visit other homes, they are not sick. The children's stepfather had just moved out of the family home. The mother threatened to kill herself and her children if her husband did not return home. This referral was investigated by CPS and closed with an unfounded finding for negligent treatment or maltreatment.

On February 8, 2007, a relative reported to CPS intake the deceased youth's mother was taking a lot of medications which altered her personality to extremes. The referrer said the deceased youth and his 12-year-old brother were slapped a lot. They had no privileges and

their mother favored their sisters. The referrer said their parents were aware that both boys needed glasses, but did not get them. The referrer added the boys have a hard time seeing the blackboard at school. The boys told the referrer that at times their mother deliberately withheld food from them, but would feed the girls. The home was alleged to smell like dog and cat urine. There was clothing and clutter all over the home. The deceased youth's older brother told the referrer that he believed his then two-year-old sister was taken to the hospital because she got into their mother's medications. The mother reported it was her husband who took her medications. He entered drug/alcohol treatment for his addictions. The mother also reported her boys had glasses but needed new glasses based on the result of their last eye exams. This referral was screened in for Alternate Response System (ARS) and forwarded to the CPS investigator who was investigating the previous referral.

On April 2, 2007, a relative reported to CPS intake that the deceased youth's two-year-old sister was taken to a Mason County hospital because her mother thought she ate some of the mother's medications. The referrer reported the hospital tested the child and found no evidence that she ingested medications. The referrer also reported she saw the same two-year-old eating dog feces in February 2007. This referral was screened as Information Only.

On April 2, 2007, a relative reported to CPS intake that the deceased youth had injuries caused by his mother. The youth alleged his mother choked him with such force that he couldn't breathe. The deceased youth told the referrer he had mucus running down his face, which his mother smeared into his hair. The referrer said the youth had a scratch on his Adam's apple one-half inch in length. The youth had a bruise on his left arm that was palm sized and oval shaped allegedly caused by the mother grabbing him. A CPS investigation was opened. The deceased youth was interviewed and denied he was hurt and that he could not breathe. No marks were seen on his neck. This referral was closed with an unfounded finding of physical abuse.

On April 19, 2007, a social service professional reported to CPS intake that the deceased youth's mother sought assistance with a local domestic violence victim agency to file a Protection Order against her husband. She also planned to file for divorce. The referrer reported the father/stepfather made inappropriate comments to the mother about her sons' genitalia. The father/stepfather had no contact with the children because of the Protection Order. This referral was screened as Information Only.

On June 18, 2007, a social service professional reported to CPS intake that the mother confided to the referrer that her estranged husband was sexually inappropriate with the deceased youth and his older brother, then ages 12 and 10–years-old. The mother reported that in the past he attempted to instruct the boys how to masturbate, threatening to masturbate them himself if they did it incorrectly. The mother said she believed he never touched her sons' genitalia, but had possibly exposed himself to them and had forced each to touch their own genitals. It was believed such incident or incidents had occurred before

March 2007. The mother stated her husband said he was diagnosed as bipolar and had further issues with alcohol and misuse of both prescription and non-prescribed medications. The referrer said all four children in the home have disabilities of varying severity. The mother also said her husband was verbally abusive to the children. He called the boys “faggots” and “retards.” This referral was screened as Low Risk CPS. The case was still open on a prior CPS investigation. The investigating CPS social worker addressed these allegations with the mother. Law enforcement was notified and interviewed the deceased youth and his brother regarding the allegations of sexual abuse. Neither boy disclosed being sexually abuse by their stepfather.

On October 12, 2007, a school staff reported to CPS intake that the deceased youth, then 10-years-old, exhibited what the referrer thought was significant forms of acting out behaviors at school. He tried to choke himself and said he was going to kill himself. The deceased youth told another student he was going to bring a gun to school. This latter comment was forwarded to law enforcement. The deceased youth’s mother was contacted. She said he was in treatment with a psychiatrist from Children's Hospital. Because of the gun comment made by the deceased youth, the mother was advised to have him immediately assessed by a county mental health professional at the local county hospital. This referral was screened as Information Only.

On January 23, 2008, a social worker at Children’s Hospital called CPS intake and reported the deceased youth’s two-year-old sister fell out of a shopping cart while the family was shopping. The mother immediately took her for medical care and she was medically cleared. Days later, the mother noticed a spongy area on the child’s head and took her to the emergency department at Children's Hospital. A skeletal survey was performed and the child was admitted to the hospital. The mother's explanation was consistent with the child’s injury. The referrer spoke with a relative who reported the mother was on Methadone and Percocet for pain. This relative believed the mother had Munchausen's by Proxy because she regularly took her children to the doctor. The relative did not think the mother would harm her children. This relative was concerned that the mother would drive with children in the car while she was using prescribed drugs. This referral was screened in for investigation by CPS and closed with an unfounded finding for negligent treatment or maltreatment.

On August 30, 2008, the deceased youth’s mother contacted CPS intake and requested Family Reconciliation Services (FRS). The mother said her 13-year-old son refused to follow the house rules and he constantly threatened to run away. He bullied the younger children and has a severe hygiene problem. He refuses to change his clothes or bathe. The mother requested family counseling. This referral was accepted for FRS.

On November 26, 2008, a relative called CPS intake to report this youth died in Pacific County. This relative suspected the youth died because of his mother’s neglect. The referrer said the youth died in his sleep, was vomiting and was underweight. The referrer

expressed concerns for the deceased youth's older brother as it was alleged the mother didn't feed the deceased youth or his older brother. The referrer said the deceased youth's younger sister had the same symptoms as the deceased youth. This referral was staffed with the CPS Intake Supervisor and Area Administrator. Based on the case chronicity and the child fatality, it was decided to screen in this referral for investigation by CPS.

The mother was assessed by a mental health professional as she expressed suicidal ideation after the loss of her son. The CPS case was closed with an unfounded finding though the case remained open under a safety plan. This safety plan required the mother to follow through with all medical recommendations for her surviving children, lock up her medications, and allow for relatives to come to her home and verify compliance with this plan. The surviving children remained in their mother's care.

On January 14, 2009, the Pacific County Coroner reported the results of the toxicology report on this deceased youth's autopsy. The youth died from an overdose of Methadone. The youth had twice the lethal amount in his system. His mother was taking prescribed Methadone for pain management. The mother reported she and all four of her children are diagnosed with neurofibromatosis. Neurofibromatosis is a genetic disorder that affects the development and growth of nerve cell tissues. The county coroner confirmed the child suffered from neurofibromatosis. The CPS investigation into this youth's death was closed with a founded finding as the mother was previously warned about keeping her medications where her children had access to them. The case remained open under the safety plan drafted during the previous CPS investigation.

Issues and Recommendations
Issue: The fatality review team looked at the screening decisions for the referrals/intakes received on this family. The referral dated February 8, 2007 was screened in as a low risk intake. After looking at this intake more closely, the team felt it should have screened in for a high standard of investigation.

Recommendation: None.

Action Taken: Although the referral should have screened in for investigation, this referral was received at a time when Children's Administration had an open case on this family. The social worker had face to face contact with the mother in her home and addressed the methadone issue (alleged in the intake) with her. After the deceased youth's two-year-old sister was taken to the hospital on suspicion of ingesting the methadone, the mother found out through the father's admission that he had taken her methadone. The social worker also found the home clean and did not find it in the condition as described in the referral. The social worker spoke with the mother about securing her medication away from the reach of the children. The social worker did not document this conversation with the mother. The mother also mentioned that the hospital also spoke with her about securing the medication. There is no documentation in the case file that this was verified with the hospital. The team

noted that intakes should not be screened down or out just because the case is open at the time of a new intake. The supervisors involved in the review will discuss this with their staff as well as the importance of reviewing case history when assessing risk.

Issue: The mother had a locked box and at times secured her medication in the box. At some point she stopped securing her medication in the locked box and used a child friendly bag at the time of the deceased youth's death

Recommendation: None

Action Taken: The current social worker has confirmed that the mother is using the locked box for her medications and has it out of the reach of the children.

Child Fatality Review #08-79
Region 2
Yakima County

This seven-day-old Caucasian male died from complications of a premature birth.

Case Overview
On December 21, 2008, this child's mother delivered him at 29 weeks gestation while sitting on a toilet. Medics responded to a 911 call and took the infant to a Yakima area hospital. According to the hospital social worker, the mother was high on methamphetamines and benzodiazepine when she delivered. The newborn was intubated and put on ventilator; his body temperature was 30 degrees. He weighed three pounds. On December 28, 2008, this infant died. The mother has two older children who are in a legal guardianship with their maternal grandparents. The mother did not visit this infant at hospital. The death certificate indicates the manner of child's death was natural and the cause was due to pre-mature labor and methamphetamine use.

Referral History
On May 9, 2004, a relative contacted Child Protective Service (CPS) intake concerned that the deceased child's mother and boyfriend left their 10-month-old son (older brother of the deceased child) in the care of an 83-year-old great grandmother for days at a time.

This child suffered a seizure while in her care. The great grandmother called 911 and paramedics required the parents' permission to treat. The parents were unavailable. Paramedics recommended the child go to a doctor as soon as possible. The parents were informed of this, but never sought medical care for the child. Relatives believe the parents were using drugs as they appear drug affected when they return and often had to sleep it off. The referrer said the parents routinely engaged in domestic violence. It was also alleged the deceased child's mother was seen at a hospital emergency room in April 2004 after she slit her wrists. The referrer also reported both parents were participating in Alcoholics Anonymous meetings, but the father was kicked out after becoming violent with other attendees. This referral was investigated by CPS and closed with an unfounded finding for negligent treatment or maltreatment.

On July 16, 2004, a relative reported to CPS intake that mother will take her 12-month-old baby (brother of the deceased child) to drug houses. The referrer reported the mother sometimes left him in one of the drug houses and went elsewhere for drugs. On July 15, 2004, the mother was high on methamphetamine and took the baby in a stroller walking down in the middle of the road. The referrer followed her to make sure the mother and baby were unharmed. This referral was investigated by CPS and closed with an unfounded finding for negligent treatment or maltreatment.

On October 21, 2004, a worker at a Yakima County DSHS office reported to CPS intake that the deceased child's mother and boyfriend came into the DSHS office under the influence of some drug. No alcohol was detected. The father was so high he could hardly talk. The mother was heard on her cell phone telling her father she had not taken any pills. The referrer was unsure where their 15-month-old son was located. It was assumed he was in the car as the mother kept going out to the car and the couple had no place to live. This referral was screened in for investigation by CPS and closed with an inconclusive finding.

On June 28, 2005, law enforcement reported to CPS intake about a domestic violence incident between the deceased child's mother and her boyfriend. The mother was over eight months pregnant at the time. The mother and her boyfriend got in an argument in their car and the boyfriend allegedly kicked the mother in the stomach and drove off with her in the car and the door open. It was thought that their 23-month-old son was also in the car at the time. A relative called 911, and a state trooper located the couple. The mother had two stab wounds to her thigh. She was extremely irate and difficult with law enforcement. The boyfriend was arrested and charged with Fourth Degree Assault /Domestic Violence. The mother was arrested and charged with Disorderly Conduct. She was taken to a Yakima area hospital where her wounds were treated. She was also given a drug test which came back positive for methamphetamine. The mother said she stabbed herself. This referral was screened in for investigation by CPS and closed with an inconclusive finding. The assigned CPS social worker contacted several Yakima area hospitals to alert them that this mother was due to deliver her baby soon and to contact Children's Administration staff when the baby was born.

On July 12, 2005, a doctor reported to CPS intake that the deceased youth's mother gave birth to a girl. The doctor requested that CPS assess the family environment prior to being discharged. The mother tested positive for methamphetamine and opiates. The newborn and her two-year-old brother were placed in protective custody and a dependency petition was filed for both children. Both were placed in relative placement. During the early dependency period, social workers coordinated with the mother and her boyfriend to complete court ordered services. Initially, the mother was cooperative with services; she completed a 28 day inpatient treatment program. Ultimately, both parents were out of compliance with the service plan. They were offered parenting classes, mental health, and domestic violence evaluations. They did not participate in any of these services. They stopped attending supervised visits with their children. The dependency petition was withdrawn after the grandparents obtained Third Party custody of both children.

On August 8, 2008, a nurse at a Yakima area hospital reported to CPS intake that the mother came into the emergency room due to bleeding from complications of her pregnancy. She was about nine weeks pregnant. The referrer said she tested positive for opiates and benzodiazepine and may have been under the influence of some drug when she came in. She also had needle tracks marks on her. The mother's two older children were in the custody of their grandparents. This referral was screened as Risk Only.

On November 12, 2008, a hospital social worker reported to CPS intake that the deceased child's mother was pregnant and due on March 7, 2009. She was admitted to the hospital and tested positive for methamphetamine, benzodiazepines, and opiates. The referrer said the mother was seen at the hospital eight times in 2008 and 16 times in 2007. This referral was screened as Information Only.

On December 21, 2008, a hospital social worker called CPS to report the mother gave birth to the deceased child on this date. He was born at 29 weeks gestation and weighed three pounds. The mother gave birth to him at home while sitting on the toilet. The mother tested positive for methamphetamine and benzodiazepine. The referrer stated that the mother has a long history of substance abuse and drug seeking behaviors. The mother had minimal pre-natal care. The child died on December 28, 2008. A CPS investigation was opened at the time of the child's birth and closed with a founded finding for negligent treatment or maltreatment. Law enforcement investigated the death of this child but chose not to forward charges to the Prosecuting Attorney's office. This child never left the hospital.

Issues and Recommendations

Issue: The CPS investigation was missing an important collateral contact with the first responders who were dispatched to the home where the mother delivered her baby. Possible information that could have been collected would have been statements made by individuals, demeanor of individuals, physical description of individuals and of home and contents.

Recommendation: As best practice, whenever there is a case opened to CPS due to a child abuse and neglect related fatality, near fatality, or serious injury, the CPS investigator should make contact and interview the first responders that were dispatched to where the emergent incident occurred.

Child Fatality Review #08-80
Region 2
Yakima County

This 19-month-old Caucasian male died of Sudden Infant Death Syndrome (SIDS).

Case Overview
On December 28, 2008, the foster mother of this 19-month-old male found him in bed and unresponsive at approximately 7:00 a.m. The foster parents attempted CPR and transported him to a Yakima area hospital. They arrived at the hospital at 8:05 a.m. The child was examined by an attending physician. Resuscitation efforts by medical professionals were unsuccessful, and the child was pronounced dead at 8: 25 a.m. Upon arrival at the hospital, his body was very cold, indicating he had been dead for a few hours. There was no bruising or obvious signs of trauma.

The child's social worker reported he had no known medical issues. His foster mother took him to the doctor regularly, and he was otherwise healthy. The foster mother reported she swaddled him in a blanket and placed him on his stomach with his face to the side. She checked on him at 7:00 a.m. and found him in the same position she put him in when she put him to bed, but with the blanket only slightly off his shoulders.

She reported she swaddled him every night, and he usually woke up without a blanket. The foster mother said he was swaddled to help him sleep. There were no prior reports to Child Protective Services intake on these foster parents.

The Yakima Coroners Office reported this appears to be a natural death. The Coroner found this child's airway was clear and there is no indication of foul play. The Coroner confirmed that suffocation was ruled out as the cause of death. The Coroner was unable to determine the cause of death but did report that there was no bruising or obvious trauma.

The deceased child and his two siblings came into foster care in May 2008. Children's Administration intake received a referral alleging physical abuse of the deceased child's seven-year-old brother. Law enforcement placed the deceased child and his two siblings in protective custody.

A dependency was established for all three children and all were placed in the same foster care home up until this child's death. During the dependency period, the birth mother participated and successfully completed all court ordered services. In April 2009, the department returned the two surviving siblings to their birth mother. Children's Administration social workers are monitoring their progress and will dismiss the case in October if there are no additional concerns.

Referral History
This referral history is on the deceased child's mother. There were no prior referrals on the foster home where he and his siblings were placed at the time of his death.

On May 21, 2008, a school nurse reported to CPS intake that the seven-year-old brother of the deceased child had bruises and red marks from his lower legs to the middle of his back. The boy said his mother beat him with a cable. The referrer said the marks were consistent with his statements.

Police officers did a well child check, and said the child's injuries were enough to place him in protective custody. This child said his mother also beats his 3-year-old sister with the cable and slapped his 12-month-old brother (the deceased child). The CPS investigation was closed with a founded finding for physical abuse. The children were placed in foster care, and a dependency petition was filed.

On September 29, 2008, the child's social worker reported to CPS intake that the deceased child's three-year-old sister reported her mother drank a lot of beer and let men touch her and her older brother. The seven-year-old brother was very angry at his mother and threatened to kill his mother. The CPS investigation was closed with an unfounded finding for sexual abuse, sexual exploitation and negligent treatment.

Issues and Recommendations
Issue: The foster parents chose to transport the deceased child to the hospital in their car rather than calling 911. The foster parents said they made this decision because it was faster to transport him themselves rather than waiting for emergency medical services to respond in the rural area where they live.

Recommendation: Washington Administrative Codes (WACs) and pre-service training material implies that 911 should be called in medical emergency situations. However, there is no clear language that states 911 must be called. Training material should reflect that absent telephone service, 911 must be called whenever there is a medical emergency involving a foster child.

Issue: Concerns were raised about the foster mother swaddling the child and placing him on his stomach. The DLR and law enforcement investigations revealed that the deceased child was swaddled and placed on his stomach when he was put to sleep by his foster mother.

Recommendation: Foster parents need to abide by WAC 388-148-270, which reads, "You must follow the recommendation of the American Academy of Pediatrics, placing infants on their backs each time for sleep, unless advised differently by the child's physician"

In addition, the team recommended foster parents participate in the "Safe Sleep" training to inform and educate on them on the practice of swaddling, to include age appropriateness.

Issue: The notification to the deceased child's biological mother of his death was received beyond a reasonable amount of time. The child's official time of death was 8:25 a.m. and mother was notified at 3:50 p.m. later that same day.

Recommendation: When Children's Administration has legal custody of a child and that child sustains a serious injury or dies while in the custody of the state, the biological parent shall be notified at the earliest possible time after such injury or death occurs.

Child Fatality Review #09-01
Region 4
King County

This 4-month-old African American female died of Sudden Infant Death Syndrome (SIDS).

Case Overview

The mother of this child went to work on the evening of December 31, 2008. Her fiancé, who is the father of the deceased child, remained at the Auburn home with the child until 9:00 p.m. At that time he went out for the evening leaving the four-month-old in the care of her grandmother who resided in the home. The father returned home around 12:30 a.m., got the infant from grandmother, and went to the basement area of the home where he, mother, and the children slept.

The father placed the infant to sleep in the older sibling's bed with a comforter, stomach down, with her head tilted to the side. He then went to sleep on the couch. The deceased child's mother returned home from work sometime after 7:00 the morning of January 1, 2009. The mother discovered the baby was not in the bassinet, the usual sleep location, but rather on a bed. She found her daughter unresponsive. Emergency response was called to the home.

A death scene investigation was conducted (including doll re-enactment and use of the Sudden Unexpected Death Investigation form). The King County Medical Examiner was dispatched to the home and found nothing suspicious, and no visible trauma. Auburn Police Department detectives also investigated. Although the room was found to be hot, there were no noted hazards or environmental concerns. The living conditions were described as neat and well kept.

The cause and manner of death was eventually determined to be Sudden Infant Death Syndrome (SIDS) with bed-sharing as a risk factor. The child's death is listed as natural.

Referral History

The referrals identified relate to Children's Administration's (CA) involvement with the deceased child's father and his two other children from another relationship. Until the fatality notification there had been no prior CA involvement with the deceased child's mother or her two other children.

On July 22, 2008, it was reported to Child Protective Services (CPS) intake that a family practitioner found two fractures on the right arm of the father's two-year-old son. This child's mother said she did not know how her son got hurt, but admitted that there had been significant delay before she brought him in to be examined. She further admitted that he was not using his right arm. In addition to the mother being identified as an alleged

subject of physical abuse and negligent treatment, the non-custodial father (the deceased child's father) was also identified as a potential subject given that the child had been in his care during the weekend prior to the discovery of the fractures. There was also a suggestion that the child may have been hurt at his child care center.

A referral was also generated to Division of Licensing Resources/Child Protective Services (DLR/CPS) and notification given to Department of Early Learning (DEL). The medical findings supported the likelihood that the arm fracture was most likely the result of a fall (accidental trauma). The CPS investigation on the parents was closed with an unfounded finding for negligent treatment or maltreatment and an inconclusive finding for physical abuse. The DLR/CPS investigation of the child care facility resulted in an unfounded finding. DEL found no licensing violations as to the child care facility.

On February 22, 2008, a hospital social worker reported to CPS intake that the two-year-old identified in the referral above pulled a pot of boiling water off the stove and suffered a water burn to his elbow. This occurred while the boy and his brother were being watched by their father (the father of deceased child). The father treated the burn but did not take the boy to a doctor. The child's mother took him to the hospital emergency room for additional treatment of the burn. The CPS investigation on the parents was closed with an inconclusive finding for negligent treatment.

Issues and Recommendations

Issue: The Child Fatality Review was held at the Tacoma West Division of Children and Family Services (DCFS) office on June 8, 2009. The entire family history of involvement with Children's Administration (CA) was reviewed. The CA history prior to the deceased child's death on January 1, 2009 in Auburn, Washington, was limited to two recent CPS investigations (neither founded) involving the father and his two other children and another partner. The deceased child's mother had no prior CA involvement.

The issues emerging during the review are included below for the limited purpose of documenting the discussions occurring during the child fatality review. There were no recommendations emerging from the Child Fatality Review.

Recommendation: None

Issue: The CPS investigation of the referral dated February 22, 2008.

A hospital social worker reported that the mother of the child victim brought her toddler in for a hot water burn that had occurred earlier in the day when the child was being watched by the non-custodial parent. The concern was as to the delay in seeking medical attention. The decisions at intake appear appropriate.

The CPS worker made an unannounced home visit and had initial face to face contact with the alleged child victim within 72 hours of the intake. The mother was interviewed, and a Safety Assessment was done. A Safety Plan was made although it was limited due to the father not being available for engagement. The Global Assessment of Individual Needs Shorter Screener (GAIN-SS) was administered to the mother of the child victim (not the mother of the deceased child) and her responses indicated a need for further assessment of mental health. There was no documentation that a referral for an assessment was sent. The father did not make himself available for interview by CPS. In review, the worker might have considered some additional resources to locate the father although how successful additional attempts would have been remains speculative. All case activity ceased for a period of two months before case closure in early June 2008. The length of case inactivity was not consistent with expected practice. The Structured Decision Making (SDM) tool was utilized and indicated low risk for neglect and abuse, supporting the case closure disposition.

The allegation was determined to be inconclusive as to negligent treatment or maltreatment by the father. The lack of a subject interview was a barrier to making a more conclusive finding (founded or unfounded). The hot water burn incident was likely accidental as reported. Although hot water burns can sometimes be an indication of neglect (failure to properly supervise) or abuse (intentional infliction), the review panel agreed that there was no evidence that either condition was involved. Evidence of medical neglect by the father would have relied on a medical opinion that the child had required immediate professional medical intervention treatment and had not gotten it. No medical opinions or medical records were sought. The medical records obtained during a later investigation showed the burn in February was only a mild partial thickness burn and not a serious deep dermis burn. The medical record did not show any exceptional treatment was required when the mother took the child to be seen at the ER.

The worker who conducted the February 2008 investigation did participate in the review along with the CPS supervisor, and received direct feedback for noted good practice as well for noted practice that could have been improved.

Recommendation: None

Issue: The CPS investigation of the referral dated July 16, 2008.

A family practitioner reported a fractured arm on a toddler. The child’s mother had no explanation of how the injury occurred but appeared to have delayed seeking a medical assessment. While the mother's statements suggested the injury occurred prior to the visitation with his father, both were identified as subjects for physical abuse and negligent treatment. Due to a remote possibility that the child was injured while attending child care, an additional intake was generated for Division of Licensing Resources/Child Protective Services (DLR/CPS). On review, the screening decisions by Central Intake (CI) appear to

be reasonable. The case was assigned for investigation through the local Child Advocacy Center (CAC). Overall the CPS investigation activities met expected practice.

Face to face contact with the victim was within 24 hours, and interviews were conducted in collaboration with medical, law enforcement, CPS, and DLR/CPS. Both of the children were examined (full skeletal). No other injuries were found. The DLR/CPS worker interviewed the child care center staff. The CPS worker completed a Safety Assessment and Safety Plan. Efforts by CPS and law enforcement to speak with the non-custodial father were not successful. In review, the worker might have considered some additional resources to locate the father although how successful additional attempts would have been remains speculative.

Collateral contacts were documented and medical records (current and past) were obtained. The fractures of the toddler's arm were determined by the regional CA Child Abuse Medical Consultant to be more consistent with a fall rather than non-accidental trauma.

An Investigative Assessment was completed. Several SDM questions appear to have been answered incorrectly and this artificially elevated the Neglect, Abuse, and overall Risk Level scores. The mother initially agreed to Family Voluntary Services (FVS) but then later declined. Consultation with the Attorney General's Office did occur and the decision was made to close the case. All allegations against the father were determined to be unfounded and he appears to have had little connection to the incident. The negligent treatment allegation (delay in seeking medical treatment) as to the mother was determined to be inconclusive. The review panel did not reach full consensus as to whether there had been sufficient evidence for a finding of founded rather than inconclusive. The DLR/CPS investigation supported a finding of unfounded as to the child care provider. The Department of Early Learning (DEL) licensor's investigation showed no valid licensing issues.

The CPS investigator and her supervisor participated in the review. Both received feedback regarding noted good practice and areas that might be improved.

Recommendation: None

Issue: The fatality intake dated January 1, 2009.

Central Intake (CI) received what appears to have been a courtesy notification from the King County Medical Examiner's Office (KCMEO) of an infant death in Auburn. Prior to notifying CI, a Medical Examiner conducted a death scene investigation and found nothing suspicious and no visible trauma. The notification was staffed at CI and the decision was made to screen in for investigation of negligent treatment as to the child's death.

There was active debate by review participants as to two key intake considerations. The first was regarding the existence of allegations as to the fatality situation. In review, the majority view was that there were no specific child abuse or neglect allegations as to the circumstances of the deceased child's death, nor any reported suspicions from anyone responding to the child fatality scene. There were no concerns regarding the deceased child's mother's other children who are older. The second consideration was to the existence of significant risks associated specifically with the deceased child's father that would be a reasonable foundation for assignment to CPS when lacking any allegations.

The basis for screening in the fatality notification for investigation was given by CI due to the father's recent history. However, in review of that history, the prior July 2008 investigation as to the father's son's arm fractures showed the injury had most likely been from accidental trauma (based on CA Child Abuse Medical Consultant review) and the father (non-custodial parent) was found to have no identifiable involvement in the situation.

The earlier (February 2008) investigation as to the father possibly having failed to seek necessary medical treatment was inconclusive. There is no evidence that medical treatment had been necessary (mild second degree burn on the toddler's elbow), although his ex-partner did have the child seen by a doctor. The majority of child fatality review members did not support the view that the father's history, even if recent, was sufficient to prompt screening in the January 2009 fatality notification for investigation. However, some review participants were more agreeable with the CI decision largely based on a "better to error on the side of the child" argument.

The CPS worker from the Kent DCFS office was not able to attend the child fatality review, but in a pre-review interview (shared with panel members) stated that he had questioned the intake decision at the time of his case assignment. In the investigator's opinion, the CPS response had been an unwarranted and unnecessary intrusion to the family. Prior to the fatality review, Central Intake staff had been notified of the likelihood that discussion would occur regarding the fatality intake and were invited to comment or attend the Child Fatality Review. No response was received.

Recommendation: None

Issue: The investigation of the referral documenting the fatality dated January 1, 2009.

A veteran CPS worker from the Kent DCFS office was assigned to investigate allegations of negligent treatment by the deceased child's father in the death of his daughter. The worker in a pre-review interview indicated confusion as to what exactly he was to investigate given the information provided at intake.

The time frame requirement for face to face contact with the alleged victim was extended due to the fact that the identified victim was deceased. The use of the "extension" code was an error, as the requirement should have been coded as "exception." A home visit was conducted several days after the death and a Safety Assessment completed (no Safety Plan needed). The deceased child's father (the subject) was elsewhere at time of the home visit and the CPS worker only had contact with the child's mother. In a pre-review interview the worker stated that the preliminary information gathered from the KCMEO clearly supported a non child maltreatment death, which later was confirmed by final cause and manner of death determination (SIDS). The worker indicated that he did not see the need for any further intrusion to the family and did not attempt to interview the father. The worker acknowledged that policy and practice dictated interviewing identified subjects. The case was closed within six days of the referral as unfounded. While the investigation appeared to be quickly closed, the disposition was viewed as understandable in terms of minimizing intrusion on the family during an investigation that for some panel members was questionably initiated.

The Kent CPS worker and his supervisor did not attend the Child Fatality Review, but were made aware of possible discussion issues relating to the fatality investigation. As noted elsewhere, the CPS worker was interviewed by the Region 5 Child Fatality Program Manager prior to the review, and the worker's responses were shared with review panel participants.

Recommendation: None

Child Fatality Review #08-81
Region 5
Pierce County

This two-month-old African American male died of Sudden Unexpected Death in Infancy (SUDI).

Case Overview
On December 25, 2008, the deceased child and his twin sister were put down to sleep for the evening in their parents' bed. The children reportedly slept between the parents on "horseshoe" shaped pillows. The deceased child was snuggled up to his father's stomach and covered with a blanket. On the morning of December 26, 2008, the deceased child's father was awakened by his brother in-law who had stayed the night. The relative had come into the bedroom and could see the deceased child's twin sister on her pillow but could not see the deceased child. He noticed the father was lying on his side and awoke him to ask about the deceased child. The father rolled over on his back and discovered the deceased child cradled in his arm and not breathing. The father said he believes he may have accidentally been lying on his infant son. The father attempted CPR while the relative called 911. Later, the relative continued to perform CPR after putting the infant on the floor.

The deceased child was transported by Emergency Medical Technicians (EMTs) to a local hospital emergency room, but it is likely the child was deceased prior to arrival (asystolic, without respirations, unobtainable blood pressure, and mottled appearance). Both law enforcement and the Medical Examiner's investigator responded. Doll re-enactment was conducted at the home. Early post-mortem indications were that death may be related to overlaying.

It is known that the deceased child had diarrhea prior to his death. He was seen earlier in the month for his Well Child Exam and medical records indicate the infant received immunizations and other vaccinations and appeared well developed and well nourished. According to the father, the deceased child was very fussy on Christmas day

Children's Administration (CA) received the final cause and manner of death determination from the Pierce County Medical Examiner's Office. The cause of death was determined to be a Sudden Unexpected Death in Infancy (SUDI). It was undetermined if the identified external factors of bed sharing and slight interstitial pneumonitis contributed to the death. Interstitial pneumonitis is a form of pneumonia affecting the meshwork of lung tissue rather than the air spaces.

Referral History
On February 27, 2004, it was reported to Child Protective Services (CPS) intake that the deceased child's mother was not giving seizure medication to one of her children. This referral was screened as Information Only.

On March 12, 2004, a HeadStart staff reported to CPS intake that the four-year-old half-sister of the deceased child had a small circle similar to a cigarette burn or healing injury on her wrist. This referral was screened in for investigation by CPS. A case was opened and services were offered to address the mother's past substance abuse issues and domestic violence in her most recent relationship. The CPS investigation was completed with an unfounded finding for physical abuse.

On June 18, 2004, hospital staff reported to CPS intake that the deceased child's mother did not give seizure medication to her six-year-old. The child later had two seizures. This referral was screened in for investigation by CPS. A case remained open on this family. The mother agreed to voluntarily place her three children with relatives while she addressed parenting and substance abuse issues. Eventually CA filed a dependency petition on these children after the mother failed to comply with a service plan. The CPS investigation was completed with a founded finding for negligent treatment or maltreatment.

On February 25, 2006, a relative reported to CPS intake that the mother allowed her stepfather, a Level 3 Registered Sex Offender, to be present while she had unsupervised visits with her children. This referral was screened in for investigation by CPS and completed with an unfounded finding. The children were dependents at this time. Eventually, the children were returned to the care of their mother and the dependency was dismissed in July 2007.

On October 24, 2007, a relative reported to CPS intake that the mother of the deceased child was often incapacitated due to prescription drug use resulting in poor supervision of her children. It was reported that the family was temporarily living with a relative who was a Level 2 Registered Sexual Offender. This referral was screened in for investigation by CPS and closed with an unfounded finding for negligent treatment or maltreatment.

On October 9, 2008, a hospital social worker reported to CPS intake that the mother recently gave birth to the deceased child and his twin sister. In the hospital she tested positive for Vicodin (had active prescription from her physician). The mother had regular prenatal care. This referral was opened for Child Welfare Services (CWS).

On December 26, 2008, law enforcement reported to CPS intake that the twin infants were put to sleep in the parent's bed. The children reportedly slept between the parents on horseshoe shaped pillows. In the morning the deceased child was found unresponsive. The father believed he may have accidentally rolled over on his infant son. Although there was

no evidence that the death was abuse or neglect related the surviving twin and the year old half-sibling were placed into protective custody by law enforcement. The three older half-siblings were allowed to remain with their biological father. Eventually the official cause and manner of death was determined by the Pierce County Medical Examiner's Office. Subsequently the dependency actions were dismissed while still in Shelter Care status and all of the children were returned to the care of their parents. The CPS investigation was closed with an unfounded finding.

Issues and Recommendations
Issue: While the entire family history of involvement with CA was reviewed, primary and detailed focus during the review was on the last 14 months of CA involvement prior to the child's demise from Sudden Unexpected Death in Infancy (SUDI) - an undetermined manner. There were no recommendations emerging from the Child Fatality Review.

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

Recommendation: None

Issue: Investigation of the intake referral dated October 24, 2007.

Overall most practice expectations were met by the CPS worker during the investigation. Practice issues were identified although none were found to have any significance to the SUDI death of the deceased child.

There were missed opportunities for gathering additional information from collateral sources. Neither referent was ever contacted by the CPS worker. Although sufficient evidence existed that two relative Registered Sex Offenders (RSO) had been at the home, the worker did not check the Safety Assessment question regarding the existence of any RSO who may be having frequent access to children in the home.

Also noted during the Child Fatality Review was the fact that the father (also a subject) was never interviewed.

The case remained inactive for two months pending closure by the supervisor. The length of case inactivity was not consistent with expected practice.

Recommendation: None

Issue: CWS request for placement and Family Voluntary Services dated October 9, 2008. A year after the prior CPS investigation closed, the Tacoma intake unit received notification of the delivery of the deceased child and his sister. The mother was prescribed Vicodin by her physician and at least one of the twins was reportedly showing signs of being both drug exposed and drug affected. Intake was informed by the hospital social worker that the mother was in agreement to sending the deceased child's newborn twin sister to the newborn nursery at Pediatric Interim Care Center (PICC) in Kent, Washington. The intake was accepted under CWS request for temporary placement.

The assigned FVS worker met or exceeded practice expectations. The documentation was exceptional in both amount and quality of information. The Family Voluntary Services (FVS) worker attempted to maintain contact with the parents and encouraged them to visit their infant at PICC and to continue with urinalysis testing (all results were negative for illegal drug use).

The worker continued to pursue additional sources of information regarding the father's mental health issues and possible prescription drug abuse by the parents. The worker documented contacts with providers and outside agencies in an effort to identify service needs. The FVS worker initiated a community Child Protection Team (CPT) staffing prior to the return of the twin sister from the PICC placement. The Child Health and Education Tracking (CHET) worker's activities and documentation also met or exceeded practice expectations.

Case documentation from both the Division of Children and Family Services (DCFS) worker and the Family Preservation Services (FPS) provider showed that the parents were cautioned against bed sharing with the twins, particularly if taking prescription medications that could affect their responsiveness. Cribs were provided for both twins through Home Based Service funds. While the Medical Examiner could not determine if overlaying contributed to this child's death, the fact that both the FVS worker and the FPS worker made attempts to dissuade the parents from co-sleeping with the twins was noted during the review.

Both the DCFS FVS worker and the contracted provider participated in the review and received feedback regarding practice.

A number of practice issues were identified although none were found to have any significance to the SUDI death of this child. The Voluntary Service Plan (VSP) was signed by only one parent. CA guidelines suggest that a full family focused case assessment be completed in conjunction with the development of a service plan.

In this case no Comprehensive Family Assessment was done. No Plan of Safe Care (PSC) was developed. However, CA Prenatal Substance Abuse Policy only requires a Plan of Safe Care when a case is accepted for CPS investigation or Alternative Intervention. In this

case the referral was accepted for CWS request for services and not CPS or Alternate Intervention. Therefore it can be argued that a Plan of Safe Care would not be required, although there would be no preclusion for doing one. As part of the service plan, Family Preservation Services (FPS) was initiated.

There was discussion during the Child Fatality Review as to whether FPS was the best option. It was suggested that a more appropriate option might have been Catholic Community Services Home Based Pediatric Interim Care (CCS PIC) which services infants and children under three years of age who have been drug affected, drug exposed, or who were born with medical issues and who have an open case with Children's Administration.

Both the DCFS FVS worker and the contracted provider participated in the review and received feedback regarding practice.

Recommendation: None

Issue: Regarding the referral dated December 26, 2008.

Central Intake (CI) was notified by a Pierce County Detective of the death of this child. At the time of the notification the possibility of overlaying (smothering) was identified. It was known at the time that the family was receiving FVS and there had been prior dependency actions on the older children. The intake was accepted for CPS investigation and assigned to a specialized investigator connected to the local Child Advocacy Center (CAC) in Tacoma. In review the CI intake decision was found to be reasonable.

Recommendation: None

Children's Administration

Executive Child Fatality Review

Saranadee Leingang

November 16, 2008
Child's Date of Death

April 16, 2009
Executive Review Date

May 11, 2009
Final Approval Date

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*Robert Brockman, Detective, Benton County Sheriff's Office
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Table of Contents

Executive Summary	93
Case Overview	95
Findings and Recommendations	102

Executive Summary

On November 15, 2008, Children's Administration (CA) Central Intake (CI) received a report of serious injury to 3-month old Sarandee Leingang (S.L.). The referent, hospital emergency personnel, told CI the infant was brought to the emergency room with no pulse and not breathing. Medical staff reported they were able to obtain a pulse through resuscitative efforts, however, the prognosis was not good, and the infant was transported to Children's Hospital in Seattle. Hospital staff also reported an anonymous female, who identified herself as a relative and refused to disclose her name, called and stated the parent(s) had suffocated the infant. Hospital staff stated they were contacting local law enforcement.

Additional concerns were raised when it was learned the parents of S.L. had two additional children and their whereabouts were unknown at the time of S.L.'s admission to the hospital. CA contacted law enforcement for assistance in locating S.L.'s siblings, 3-year old K.M. and 19-month old B.M. Following contact with S.L.'s mother (M.M.)[1] at Children's Hospital it was learned the two siblings had been left in the care of a former foster parent of the children's mother. CA was able to locate the children and confirm their health and safety. Given the condition of S.L. and the unknown origin of her injury, law enforcement placed S.L.'s siblings in protective custody. The children remained in the care of the mother's former foster parent who was still licensed.

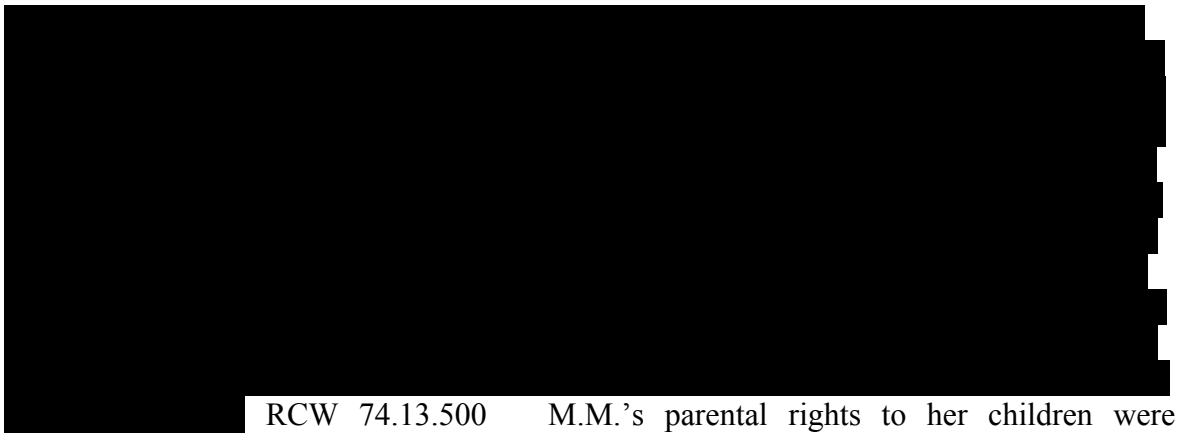
Children's Hospital medical staff reported the infant did not have any outward evidence of physical abuse. There was no bruising, skull fracture and the chest x-ray did not reveal any fractures or abnormalities. The parents were notified S.L.'s prognosis was extremely poor and on the following day she died as a result of her injuries. The attending ophthalmologist diagnosed S.L. with bi-lateral retinal hemorrhages and stated such an injury is consistent with shaken baby syndrome.

Following the death, King County Medical Examiner's office conducted an autopsy of and determined the infant's cause of death was *"anoxic encephalopathy[2] of unknown etiology, manner undetermined."*

Prior to the November 2008 report referencing S.L.'s injuries and subsequent death, Child Protective Services (CPS) had been involved with the family as far back as 1995 when S.L.'s mother was a child. However, the most significant history begins in April 2001 when M.M. was 13-years old and pregnant with her first child, [redacted]

[1] The full name of the child's mother is not being used in this report as the criminal investigation remains open and no decisions have been made regarding criminal charges.
[2] Anoxic Encephalopathy - Brain damage which occurs from an absence of oxygen. Reference: http://www.healthline.com
[3] Family Reconciliation Services (FRS) is intended to preserve, strengthen, and reconcile families. The range of services provided is designed to develop skills and supports within families to maintain the family as a

[redacted]



RCW 74.13.500 M.M.'s parental rights to her children were terminated in December 2004. Following termination of her parental rights in late 2004, M.M. gave birth to her third child whom remained in her care for the duration of her dependency. Over the course of the next five years, eight additional intakes were received regarding M.M. and the care of her children including the November 2008 intake referencing serious injury and subsequent death of S.L.

In April 2009, CA convened an Executive Child Fatality Review[4] committee to review the practice and service delivery in the case of three-month-old Caucasian infant, S.L. and her family. S.L. was born on August 6, 2008.

The fatality review committee members included CA staff and community members who had no involvement in the case. Committee members received case documents including a summary of CPS referrals regarding S.L. and her family, case note documents of the November 2008 investigation, along with the complete case file including medical information. During the course of the review the committee members had the opportunity

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unit and prevent out-of-home placement of adolescents. Services are voluntary for families, family-focused, and depend upon family participation in determining the focus of intervention.

[4] Given its limited purpose, a Child Fatality Review by Children's Administration should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. A review is generally limited to documents in the possession of or obtained by DSHS or its contracted service providers and the panel may be precluded from receiving some documents that may be relevant to the issues in a case because of federal or state confidentiality laws and regulations. A review panel has no subpoena power or authority to compel attendance and generally will only hear from DSHS employees and service providers. The panel may not hear the points of view of a child's parents and relatives, or those of other individuals associated with a deceased child's life or fatality. A Child Fatality Review is not intended to be a fact-finding or forensic inquiry or to replace or supersede investigations by courts, law enforcement agencies, medical examiners or other entities with legal responsibility to investigate or review some or all of the circumstances of a child's death. Nor is it the function or purpose of a Child Fatality Review to take personnel action or recommend such action against DSHS employees or other individuals.

to meet and interview the social worker who conducted the fatality investigation and the CPS supervisor who provided supervisory oversight of the case for several years.

The review committee addressed issues related to intake and investigation practice and procedures, safety and risk assessment, and information sharing between partner agencies and service providers. In addition, the review committee discussed child fatality investigations and the merits of establishing regional child fatality investigation teams. Following a review of the documents, case history, and interviews with CA staff, the review committee made findings and recommendations which are detailed at the end of this report.

Case Overview

The review committee reviewed 17 CPS intakes referencing this family and the screening decisions made on those intakes. The first eleven alleged issues related to negligent treatment of M.M. as a child or as a mother to her own children and the remaining six included S.L.'s father (R.L.)[5]. The following is a brief summary of the CPS history affiliated with S.L's parents and a brief description of each intake received and action taken by CA beginning in April 2001.

The intake history referencing M.M.'s family includes several investigations which noted M.M. as a parent to her own children and as a child under the care and supervision of her parents. Family history includes significant substance abuse issues by M.M.'s parents, criminal behavior, domestic violence, and inconsistent and at times absent parenting. In total there are seventeen prior intakes associated with this family referencing M.M. or her children. Of the 17, eight include M.M. as a subject of physical neglect and/or abuse accepted for investigation. Of the seven investigated intakes findings were: 5 unfounded, 1 inconclusive and 2 founded for physical neglect and physical abuse.

The deceased child's father's (R.L.) CPS history with CA includes seven referrals; five affiliated with the child's mother and the two surviving children and two referrals when he was a child.

Intake 1

[5] The full name of the child's father is not being used in this report as the criminal investigation remains open and no decisions have been made regarding criminal charges.

[redacted]
RCW 74.13.500

Intake 2

[redacted]
RCW 74.13.500

Intake 3

In January 2002, CA received its first intake referencing M.M. and the care of her own child. The referent called concerning a two-month-old child who, though according to the referent appeared to be gaining weight, had thrush, congestion and smelled of smoke. The referent said there was little to no food in the house and no formula for the infant. Referent was unsure who was living in the home with the family as it was their understanding M.M.'s father had custody of her but lived elsewhere in the area. The intake was assigned for investigation.

Following investigation, the case was to be monitored given the existing risk factors i.e. vulnerability of the infant, ages of the parents (14 and 16 years old) and, instability in maintaining consistent housing. Public Health Nurse Services (Early Intervention Program – EIP[6]) were offered and accepted with the agreement M.M. would keep respective agencies notified in the event she changed addresses. The case remained open for several months for monitoring purposes and was closed in April 2002 when M.M. moved back in with her father and agreed to ensure a safe secure home environment for the infant. Case was closed with a finding of unfounded for physical neglect despite a moderate risk level for possible reoccurrence given parents' ages and family's previous history with the department. EIP services continued.

Intake 4

[6] Early Intervention Services Program: Public Health nurses provide services to children and families identified by Child Protective Services to be at risk for child abuse and/or neglect through home visits and case management. Parenting skills and child development education are provided, along with access to child care and other resources.

[redacted] RCW 74.13.500

Intake 5

In September 2002, a low risk intake was received and screened for Alternative Response Services (ARS)[7]. The referent stated M.M. (subject of negligent treatment) was pregnant with her second child at age 14 and due in April 2003.

[redacted] No other information regarding this referral was available. RCW 74.13.500

Intake 6

[redacted] RCW 74.13.500

Intake 7

In February 2003 an intake was received reporting concerns related to physical neglect issues and domestic violence allegations. M.M. and the father of her 15-month old child were listed as subjects. The referent said M.M. was attempting to apply for financial assistance and while on the phone could hear a male voice screaming in the background largely to the adolescent (M.M) at which point the call abruptly ended. The referent could not give any information regarding the welfare of the child in the home and was uncertain if any service providers were visiting the family. The intake was screened as information only.

[7] Alternative Response Services (ARS) are services provided to low-risk families through regional contractors to help reduce the risk of child abuse/neglect.

Intake 8

A week later in February 2003, an intake was received regarding M.M. and her own mother's willingness to allow her to reside in an apartment with her 17-year old boyfriend, father to her infant daughter. The referent reported a significant number of people in and out of the home and law enforcement had recently been to the apartment to arrest the infant's father for drugs. The referent was concerned M.M.'s mother was not ensuring her safety and lying to the landlord about her age. The intake was accepted for investigation. The investigation was unfounded for neglect and the case was closed. Case information indicates M.M.'s mother was cooperative and willing to make changes and provide supervision for her daughter and granddaughter. A safety plan was completed, and the case closed late February 2003.

Intake 9

The next intake regarding M.M. and now two children was received in September 2003. The referent reported concerns referencing a one-week old infant and a 22-month old sibling living in a residence where there was no electricity or water. In addition, the referent expressed concerns about the parents (M.M.) supervision of the 22-month old as she had been left unattended in a small swimming pool and was often found by neighbors to be in the road unsupervised. Concerns regarding parental substance use were included as well as notice the young family was being evicted. The case was assigned for investigation.

Following a founded investigation for negligent treatment in September/October 2003 regarding the living conditions and supervision of the children, attempts were made by CA to provide in-home services as a means to ensure M.M. and her children's health and safety. However, non-compliance and high risk factors continued, and M.M. and her children were placed into protective custody by law enforcement in October 2003. M.M. was placed in the local Crisis Residential Center (CRC), and her children were placed in foster care.

Over the course of the next 18 months, services were provided to M.M. regarding her children while she herself was a dependent

[redacted] RCW 74.13.500 She maintained sporadic visitation with her children and spent a large portion of her time as a dependent on the run. In September 2004, CA filed a petition to terminate parental rights of M.M. and the children's father. In December 2004, both children were legally free and adopted in their respective placements by April 2006.

In December 2004, shortly after termination of her parental rights, M.M. gave birth to another child (K.M.) who was placed with her while she remained a dependent and in relative care. The infant along with M.M. were closely monitored while placed with M.M.'s older sister.

[redacted]

[redacted] RCW 74.13.500 This child was not made a dependent and remained in M.M.'s care when her dependency case was dismissed.

Intake 10

CA did not have any contact with M.M. from September 2005 until July 2007 when an intake was received regarding negligent treatment of her now two children, aged 2 ½ years and 3-months old. The intake alleged negligent treatment by M.M. regarding lack of follow through in obtaining medical care and treatment for her infant child. Concerns focused on the child's pre-maturity (born at 35 weeks) and minimal weight gain over the course of three months. The parent had missed several appointments and no showed for an appointment for immunizations and a well child check. The referring party was concerned mother's failure to access and follow up with medical services placed the children at risk. When asked by CA intake staff if the infant appeared failure to thrive, the referent expressed the infant needed a medical assessment to make such a diagnosis. Given M.M.'s history with the department, this referral was screened in for investigation and assigned.

Following a home visit and investigation, it was verified M.M. had taken her children to another clinic for their well child visits and immunizations. Home conditions were considered appropriate, and both children were observed and appeared to be doing well. The case closed with a finding of unfounded for negligent treatment with a referral for Maternal Support Services.

Intake 11

In August 2007, an intake was received following an unannounced home inspection revealing what the referent believed to be unsafe conditions for the children residing in the home. In addition, the referent stated the older of the two children answered the door naked with wet hair that had allegedly been washed in the toilet. The intake said the family had been referred to ARS in July 2007 following an investigation. Case file information indicates that according to Yakima Maternal Child Health Services a referral was pending for the family. An investigation followed and resulted in unfounded findings. Investigative notes indicate though the home was cluttered it did not pose a health or safety risk to the children.

Intake 12

In February 2008, an information only referral was screened regarding failure on behalf of M.M. to participate in Public Health Nurse Services and that conditions in the home indicated a cluttered environment overflowing with trash. This referral was not assigned for investigation.

Intake 13 and 14

On May 6, 2008, two intakes were received; one screened as information only referencing possible substance abuse (methamphetamine) by M.M. and the other for negligent treatment/supervision of her older child, now 3 ½ years of age. Allegations also noted the family, which now included the deceased child's father (R.L.), was at risk of eviction due to substance abuse. In addition, it was reported M.M. was approximately 26 weeks

pregnant and not receiving pre-natal care. M.M. had also been arrested recently for stealing gas and for shoplifting.

The second intake received on this date was from law enforcement reporting the older child had been found unsupervised on the road near the home in April 2003. The referent indicated this had not been the first occasion the child was found outside the home with no adult supervision. When returning the child home, law enforcement found a younger child in distress and the house cluttered and in disarray. It took several minutes before an adult caretaker emerged notably having recently awoken. The case was assigned for investigation. Findings were later determined unfounded for negligent treatment. M.M. had made arrangements for her boyfriend's father to watch the children while she went to the store and was unaware he was asleep and not supervising her children. Law enforcement did not place either child in protective custody.

Intake 15

Eight days later (May 14, 2008), an intake was received alleging M.M. was pregnant, using methamphetamine with her boyfriend (R.L.), not obtaining pre-natal care, and neglecting her children. The referent alleged approximately a week prior she had been in the home and noted blood on the kitchen floor and indicated it was a result of a domestic violence incident between M.M. and R.L. The referent stated M.M.'s two children were present during the altercation and witnessed the abuse. The referent was extremely concerned given the conditions of the home and the need for medical treatment for M.M. This referral was assigned for investigation.

Findings referencing the two investigations in May were unfounded for negligent treatment or maltreatment against the children's parents. Case documents indicate the CPS investigator did confirm the child's mother was receiving proper medical care while pregnant and provided a clean urinalysis (unobserved) noting no illicit substance use. Investigators stated they were unable to corroborate any domestic violence in the home. Case documents also state that at the time of both home visits by investigators the home was cluttered with no observable health or safety concerns. The investigation closed with a moderate high risk factor for future child abuse/neglect. Although findings were made on the case, the record does not reflect the case closed in May 2008. The next entry in the case is the November 2008 report of S.L.'s death. The case record does not reflect any contact with the family or supervisory review May 2008 through November 2008.

Intake 16

In October 2008 an information only intake was received reporting several vehicles at the family's residence, however, no one answered the door when knocked. The referent was concerned as she could hear a child crying for about 10 minutes. The referent called to report her concerns as the mother had recently disclosed a prior drug problem and had two children removed from her care in the past. It was reported three children were now living in the home ages; 3 ½ years, 18-months, and 2-months (S.L.).

Intake 17

On November 15, 2008, CA Central Intake received a report that three-month old S.L. was brought to the hospital by her parents with no pulse and not breathing. Medical staff was able to revive the child, however, prognosis was poor and S.L. was transported to Children's Hospital in Seattle. The explanation provided by the child's mother was she had laid her face down on the bed and was later found under the covers not breathing.

On November 16, 2008, Children's Hospital staff notified CA that S.L. was diagnosed with bi-lateral retinal hemorrhages and was brain dead. Medical consultation at the time confirmed the injury was consistent with shaken baby syndrome. Medical staff stated S.L. passed away shortly after notifying the parents of her condition. Following S.L.'s death and post autopsy, several physicians were consulted in regard to the retinal hemorrhages and whether or not S.L.'s condition may have been the result of non-accidental trauma. To date, there has been no definitive medical statement to indicate death was a result of non-accidental trauma. The autopsy noted cause and manner of death determined as: *"Cause: Anoxic encephalopathy of unknown etiology; Manner: Undetermined."* The CPS investigation resulted in founded findings for physical neglect and abuse. The criminal investigation remains open.

**Regarding siblings of S.L.; a dependency was filed on behalf of both children and they remain out of home in licensed foster care. The children are placed in the same home.*

The review committee discussed, at length, the referral history regarding this family; especially the intakes received since July 2007. Committee members expressed the presence of risk factors affiliated with child abuse and neglect and prior interventions by CA (having had children removed and parental rights terminated) warranted careful scrutiny when new allegations or information were presented.

The review committee found medical records following the birth of M.M.'s children indicated significant family support and assistance was evident. Medical records also note referrals were made to Maternal Support and Public Health Nurse Services as an additional support to M.M. However, they stated there did not appear to be communication between medical providers, home support providers or CA to ensure follow through by M.M.

The review committee also cited a lack of prognostic or Child Protection Team (CPT) staffings. The committee believed such staffings serve as a means to assess future risk of child abuse/neglect, and can recommend services to increase protective factors for the child remaining in M.M.'s care in 2005.

The review committee stated taking into consideration the family's CA history when screening more recent intakes (most notably information only intakes dated February 5, 2008, May 6, 2008 and October 8, 2008) warranted assignment of the intake based on high risk factors alone. In addition, the absence of photographs of the home environment and lack of documentation referencing collateral contacts throughout the family's history with CA made it difficult to obtain an overall assessment of the safety and risk factors within the family. Specifically, the committee noted the lack of documentation (photo and

narrative description) made it difficult to discern what was truly going on in the home particularly in May 2008.

Additionally the review committee cited minimal contacts with collaterals such as law enforcement to determine if any domestic violence calls had been made to the home, follow up with public health nurses regarding the family's participation in services, and unobserved urinalysis were missing elements in post August 2007 investigations. A particular issue which caught the attention of the committee was in reference to observed vs. unobserved urinalysis. The CPS supervisor interviewed by the review committee said to his understanding clients referred for urinalysis by CA as a result of allegations regarding illicit substance use are not generally observed, questioning the validity of the results in some circumstances.

Findings

- A family's complete alleged child abuse and neglect (CA/N) history, including Information Only intakes were not considered when intake screening decisions were made. Considering the complete alleged CA/N history, regardless of previous intake screening decisions, ensures a comprehensive review of all information available to assess risk and child health and safety. Attention to chronicity (recurrent episodes of alleged abuse or neglect over time) and severity (degree of abuse) helps to identify if there is a pattern of alleged child maltreatment over time rather than assessing an isolated incident.

- A family's history in which parental rights had been terminated in the past should elevate the standard by which a new intake is assessed and subsequently screened for investigation.

- Multiple community service providers, law enforcement, juvenile probation and medical providers had been involved with this family over time. However, the communication between providers and CA was inconsistent and lacked coordination.

- Key CPS investigative elements should have included:
    - Photographs of the home environment.
    - Monthly supervisory review as a means to monitor case progress/outcome.
    - Documented provider/collateral information.
    - Thorough identification of risk and protective factors as a means to reduce future risk of child abuse/neglect.
    - Request observed urinalyses for illicit drug screening as needed.

Recommendations

- The supervisory review of intakes should include a review of the intake history of the family including both assigned and screened out intakes. The review should be used when considering assignment of the intake based on allegations of child

abuse/neglect meeting the Washington Administrative Code 388-15-009 definition or the presence of risk factors.

- When multiple agencies and service providers over time have worked or are working with a family or have referred them for intervention, it is recommended to convene a multi-disciplinary or child protection team staffing. Staffings should be as early as possible in the case to ensure coordination and communication of services provided. Staffings can ensure the evaluation of family compliance and progress. Participation by family members should be included to represent priorities and solutions recommended and identified by the family.

- The department should facilitate sharing the child's past social history with his/her providers (e.g. medical providers and developmental specialists as well as mental health professionals). Knowing a child's complete social history ensures that those who evaluate the child have an accurate history of not only pre-natal exposure, but also the environment, nurture, nutrition and availability of caring parents or other adults in his/her past. The social history can assist in identifying children who are victims of neglect. These children are at significant risk of further neglect and death if they are returned to a negligent environment.

- Increase inter-agency training on collaboration and information sharing between medical providers, law enforcement and CA with a focus on recognizing the dynamics of child abuse and neglect.

- Observed urinalysis strengthens the evidence gathered during the investigative process and increases test validity. In communities where observed urinalyses are available, CPS investigators should confirm their request for an observed test when making a referral.

- Comprehensive CPS investigations conducted should include but are not limited to the following:
    - Secure photo documentation of the home environment and children (particularly in cases where home conditions are an identified issue).
    - Complete multiple collateral contacts and retain supporting documentation and contact information in the case file.
    - Utilize internal prognostic or CPT staffings, as required by policy, consistently to help ensure child health and safety.
    - Complete monthly supervisory reviews, as required by policy, as a means to monitor case intervention and progress.

- The department should consider providing photography training to CPS investigators as a means to ensure the quality and preservation of photographs while emphasizing the value of photographs as evidentiary information.

- The department should develop and review the feasibility of creating regional serious injury/near fatality/suspicious death investigation teams. Establishing teams in each region can ensure adherence to investigative protocols while supporting and assisting staff to complete a comprehensive and thorough investigation.

Children's Administration

Executive Child Fatality Review

Izayah Denison

October 2, 2008
Child's Date of Birth

December 28, 2008
Child's Date of Death

May 12, 2009
Executive Review Date

Committee Members:
*Tami Mistretta, Intake Supervisor, Division of Children and Family Services (DCFS), Region 6
*Dorene Perez, Intake Supervisor, DCFS, Region 2
*Marilee Roberts, Practice Consultant, Children's Administration
*Marilyn Walli, Public Health Nurse and Program Supervisor, Spokane Regional Health District

Observer:
* Mary Meinig, Director, Office of the Family and Children's Ombudsman

Facilitator:
*Nicole LaBelle, Regional Programs Administrator, DCFS, Region 1

Table of Contents

Executive Summary	107-108
Case Overview	108-110
Findings and Recommendation	110

Executive Summary

On December 26, 2008, Children's Administration (CA) Central Intake (CI) received a report of serious injury to 2 ½-month old Izayah Denison (I.D.). The referent, hospital emergency room staff member, reported the infant was brought to the Sacred Heart emergency room in Spokane, WA by Emergency Medical Technicians (EMT). At the time of admission (10:01pm) I.D. was non-responsive and could not breathe on his own. Referent reported it appeared he had suffered a brain injury; however no trauma to the head was visible at time of admission. The referent also reported bruising to the infant's buttocks of an unknown origin. I.D. was diagnosed with anoxic brain injury[8] and placed on life supports.

CA was notified by an emergency room nurse I.D.'s mother (age 22) had arrived at Sacred Heart emergency room alone earlier in the evening (7:25pm) for issues related to post-partum depression and self-disclosed suicidal ideation. She was notified I.D. had been admitted to the hospital and of his fragile condition. Law enforcement was notified and dispatched to the hospital. Child Protective Services (CPS) also dispatched an after hours worker to the hospital to collaborate with law enforcement. Inquiries with family members were made by CPS regarding the whereabouts of I.D.'s 3-year old sibling, D.O. CPS and law enforcement were able to determine D.O. was in his paternal grandmother's care in Tacoma, WA and had been since prior to the Christmas holiday.

The investigating police officer interviewed, Andrew Whitmire[9] (age 22) at the hospital the night of December 26, 2008. Mr. Whitmire stated he was caring for I.D. when his mother left the family home to go to the hospital. According to the investigating officer Mr. Whitmire admitted he shook I.D. and spanked him leaving several bruises. When unable to arouse I.D., he called 911 who dispatched the paramedics. Following his statement Mr. Whitmire was arrested for 1st Degree Assault of a Child while at the hospital.

On December 27, 2008, the attending physician notified family members I.D.'s prognosis was poor and on the following day he died as a result of his injuries. Given Mr. Whitmire's statement to law enforcement on December 26, 2008 charges were amended to 2nd Degree Murder and he is currently incarcerated in the Spokane County jail.

Following the death, Spokane County Medical Examiner's office conducted an autopsy and determined I.D.'s cause of death: *"blunt force head injury; manner: homicide."*

Prior to the December 2008 report referencing I.D.'s injuries and subsequent death CA had received one other referral on this family; a November 2008 referral screened as Information Only. A mandated reporter, a Public Health Nurse (PHN), providing services in the home contacted CA with concerns regarding a high volume of people coming and

[8] Anoxic brain injury results from a total lack of oxygen to the brain. Reference: http://www.brainandspinalcord.org/traumatic-brain-injury-types/anoxic-brain-injury/index.html

[9] The full name of Andrew Whitmire is being used in this report as he has been charged in connection to the incident and his name is a part of the public record.

going from the family home and allegations I.D.'s mother was smoking marijuana with a 16-year old neighbor. The PHN also reported the children looked good and the parents were engaged in nursing services. This referral screened as information only as allegations did not meet the Washington Administrative Code[10] definition of child abuse or neglect.

In May 2009, CA convened an Executive Child Fatality Review[11] committee to review the case practice and decisions regarding 2½-month-old infant, I.D. and his family. The fatality review members included CA staff and one community member all of whom had no involvement in the case. Committee members were directed to review case documents consisting of one CPS referral from November 2008, Service Episode Record (SER) information regarding the fatality investigation and autopsy information. At the time of review a verbal summary of records from the Spokane Public Health District and law enforcement regarding this family was provided to committee members.

The review committee addressed issues related to intake practice and procedures and referral screening decisions. Following a review of the documents and case history the review committee made findings and recommendations which are detailed at the end of this report.

Case Overview

The review committee reviewed the family's CPS history along with information provided by the Spokane Public Health District which began providing services to the family in April 2008.

The First Steps[12] (FS) program was initiated by a referral from the family's social worker at the Department of Social and Health Services, Community Services Office. Case record information from the First Steps services provider documents home visits to the family for 8 months. Provider notes detail information provided to I.D.'s mother during visits included information to ensure a healthy pregnancy and delivery. In addition, services were provided to support and assist the family in other activities such as caring and feeding

[10] Washington Administrative Code 388-15-009.

[11] Given its limited purpose, a Child Fatality Review by Children's Administration should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. A review is generally limited to documents in the possession of or obtained by DSHS or its contracted service providers and the panel may be precluded from receiving some documents that may be relevant to the issues in a case because of federal or state confidentiality laws and regulations. A review panel has no subpoena power or authority to compel attendance and generally will only hear from DSHS employees and service providers. The panel may not hear the points of view of a child's parents and relatives, or those of other individuals associated with a deceased child's life or fatality. A Child Fatality Review is not intended to be a fact-finding or forensic inquiry or to replace or supersede investigations by courts, law enforcement agencies, medical examiners or other entities with legal responsibility to investigate or review some or all of the circumstances of a child's death. Nor is it the function or purpose of a Child Fatality Review to take personnel action or recommend such action against DSHS employees or other individuals.

[12] The First Steps program is a Medicaid program administered jointly by the DSHS Medicaid Assistance Administration and the Maternal Infant Health program at the Washington State Department of Health (DOH).

of the newborn, safe sleep environments, and shaken baby syndrome. Varied topics focused on providing the family with the necessary supports that would assist them in making positive parenting and health care decisions.

In August 2008, the provider notes Mr. Whitmire moved in with the family. Though not the father of I.D., he did engage in and participate in educational services provider by the FS worker. Notes reflect he was present during discussions regarding *Safe Sleep, Shaken Baby Syndrome and Who is Watching Your Baby.*

In early October 2008, I.D. was born. FS record reflects the delivery was uncomplicated and following release from the hospital the family continued to engage in FS services. During a home visit in October, FS provider again discussed safe sleeping as the family did not have a crib for I.D. and they were sleeping together on a mattress on the floor. FS provider did order a crib from the Lend a Crib program for the family. The provider also verified during the October 2008 visit the family was actively engaged and participating in the Women, Infants, and Children (WIC) program.

It was in November 2008, CA received the first of only two referrals regarding this family. The first referral received states the following: "*The referent stated she is involved with the family and the parents are engaged. The referent stated the children look good and the home is in good condition except for the fact numerous people live there or come and go. The referent stated both children are sleeping in the same bed as the parents. A neighbor reported to the referent that [mother] is smoking pot with a 16-year old…he has an open CPS case and is on probation. The referent stated there are a lot of people in the home and they all discipline the 3-year old."* This referral was screened as information only.

The next referral received by CA regarding this family is the December 2008 notification of I.D.'s injuries and subsequent death. On the night of I.D.'s injury, (December 26, 2008), his mother had left him in the care of Mr. Whitmire to go to the emergency room to obtain medical care. The investigation determined I.D.'s mother was being admitted into the hospital at the time of I.D.'s arrival at the same hospital emergency room.

Statements made by Mr. Whitmire during the course of the investigation into what caused I.D.'s death resulted in the arrest and charging (Murder in the 2nd degree) of Andrew Whitmire. Findings made in the CPS investigation were as follows; founded findings for physical abuse against Mr. Whitmire and unfounded findings of neglect and negligent treatment of I.D. by his mother.

The review team discussed at length the screening decision regarding the November 2008 intake. The screening decision was based on the following factors: no specific allegations of child abuse and/or neglect were identified, the family had no previous CPS history, the family was engaged in services to support caring for their infant, and both children in the home appeared healthy and doing well. The review committee agreed based on the information provided at the time of intake the screening decision, *information only*, was appropriate.

The review committee did discuss intakes received from mandated reporters in general warrant close scrutiny. They noted the November 2008 intake screening decision was reviewed and approved by an Intake supervisor. In reviewing FS notes not all the information in the notes were captured in the intake received by CA. It was suggested when intakes are received from mandated reporters that may not support assignment for investigation, it is prudent to ask the mandated reporter what intervention if any they are expecting or if they have additional information related to safety or risk. Documentation of this additional information should then be recorded in the intake along with discussion regarding expectations of CA's intervention.

Referencing I.D.'s 3-year old sibling: D.O. remained in the care of his paternal grandmother for a period of time following I.D.'s death at the request of CA. Preliminary background checks (criminal history and child abuse and neglect history) were completed on the paternal grandmother with no concerns noted. D.O. was not placed in protective custody by law enforcement and remained in the care of his paternal grandmother. He is now in the care of his biological father and a parenting plan is in place supporting visits and contact with his mother.

Findings and Recommendations

The committee made the following findings and recommendations based on review of the case record, department policy and procedures, Revised Code of Washington (RCW), and Washington Administrative Code (WAC).

Findings

- Review of the First Steps provider notes appears some information may not have been captured in the November 2008 intake. Whether this is a result of CA not recording information received or the referent not including the information in their initial report is unknown.

Recommendations

- Re-contacting referents making reports of child abuse/neglect, particularly mandated reporters, to assist in screening decisions is recommended. Asking if they have additional information regarding safety or risk factors and what expectations regarding CA intervention they have may can be used in making screening decisions. Record additional information, if any, under the *Additional Risk Factors* tab on the intake report.

- At the recommendation of the Office of Family and Children's Ombudsman, CA should consider contacting law enforcement when information in an intake alludes to possible criminal activity at a residence (e.g. smoking marijuana with a 16-year old). Currently CA is required to notify law enforcement regarding referrals if its investigation reveals that a crime against a child has been committed (RCW 74.13.031(3)) or if a child is alleged to have died or had physical injury inflicted as

a result of alleged child abuse or neglect or has been subject to alleged sexual abuse (RCW 26.44.030(4)). While such contact may provide additional insights into possible risk factors if law enforcement is aware of any previous criminal activity or intervention associated with the family, CA should weigh this against the possibility that such reports may deter people from voluntarily seeking or participating in services through DSHS or other agencies.