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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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,

RCW 74.13.500

[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 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.

[redacted] 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 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

[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.

(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.

RCW 74.13.500

Intake 1

Intake 2

Intake 3 **RCW 74.13.500**

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 –

[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.

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.

RCW 74.13.500

Intake 4

[redacted]

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

RCW 74.13.500

Intake 6

[redacted]

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.

RCW 74.13.500

[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.

[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. 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. 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.