
**Report to the Legislature**

# Quarterly Child Fatality Report

RCW 74.13.640

January - March 2006

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# Children's Administration Child Fatality Report
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## INTRODUCTION

This is the January – March 2006 Quarterly Child Fatality Report provided by the Department of Social and Health Services (DSHS) to the Washington State Legislature. RCW 74.13.640 requires DSHS to report on each child fatality review conducted by the department and provide a copy to the appropriate committees of the legislature. This report summarizes the 19 reviews that were completed during the first quarter of 2006. Five of these cases were fatalities that occurred in 2004 and 14 were fatalities that occurred in 2005. All of these fatalities were reviewed by a regional Child Fatality Review Team.

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

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

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

The chart below provides the number of fatalities reported to CA, and the number of reviews completed and pending for 2004-2006. The number of pending reviews is subject to change if CA learns new information through reviewing the case. For example, we may learn that the fatality was anticipated rather than unexpected, or there is additional CA history regarding the family under a different name or spelling.

**Child Fatality Reviews for 2004 – 2006**

| Year | Total Fatalities Reported to Date | Completed Fatality Reviews | Pending Fatality Reviews |
|---|---|---|---|
| 2004 | 63 | 52 | 11 |
| 2005 | 58 | 22 | 36 |
| 2006 | 16 | 0 | 16 |

The numbering for the Child Fatality Reviews in this report begin with #04-52. This indicates the fatality occurred in 2004 and is the 52nd report completed for that year. The number is assigned when the Child Fatality Review and report by the CPS Program Manager is completed.

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

Region 1 (5 reports)
- 4 Spokane
- 1 Division of Licensed Resources

Region 2 (1 report)
- 1 Tri Cities

Region 3 (4 reports)
- 2 Indian Child Welfare Unit
- 1 Lynnwood
- 1 Oak Harbor

Region 4 (7 reports)
- 1 Division of Licensed Resources
- 1 Indian Child Welfare Unit
- 1 Kent
- 1 King Central
- 2 King West
- 1 Office of African American Children's Services

Region 5 (1 report)
- 1 Bremerton

Region 6 (1 report)
- 1 Long Beach

In addition to the quarterly Child Fatality Reviews, CA completed the 2003 Annual Child Fatality Report which provided statistical information on child fatalities that occurred throughout 2003. The next annual Child Fatality Report will be for the year 2004.

**Child Fatality Review #04-52**
Region 3
Oak Harbor Office

**Case Overview**

This three-month-old Caucasian male was found deceased on October 14, 2004. His death was homicide by abuse. It is unknown as to whether the perpetrator was the caretaker or someone from outside the family**.**

The child's father was on the couch in his mother's home with his two sons a 23-month-old and the three-month-old. The father fell asleep and was awakened sometime later by his mother. When the father awoke, he realized that he was lying on top of the infant, who was not breathing. The fire department responded, but the child could not be resuscitated.

The allegation in the referral concerning the death of the child was coded as "negligent treatment or maltreatment." Both parents were determined to be founded for negligent treatment or maltreatment regarding this incident.

When the mother was a young teen, Family Reconciliation Services (FRS) were provided in an attempt to maintain her in her parent's home. The Department also provided mental health and substance abuse services to the mother as a youth during the eight months she was incarcerated at Echo Glen Children's Center.

The mother of the deceased infant came from a somewhat chaotic home life with drug and alcohol issues that continued until this incident, at age 21.

The mother was removed from her mother's home for the first time late in 1997 at age 14. Removal was due to maternal drug and alcohol use and mental health issues that impacted her mother's ability to function and required medications. The deceased child's mother had shown some aggressiveness toward her mother. It was alleged at one point that she had attacked her mother with a hammer. This mother went to live with maternal relatives in Whatcom County. She later returned, but her behaviors were beyond her mother's control, and she again went into the foster care system and her problematic behaviors continued. The mother as a youth, was using drugs, was involved in theft and was on the edge of gang involvement. She often ran from placement, but generally returned. She eventually was incarcerated for eight months at Echo Glen Correctional Center where she completed drug and alcohol treatment and made great strides toward completing her General Education Development (GED). When she left Echo Glen, she was seventeen, on psychotropic medication, and was placed in her grandmother's home.

In April 2001, the mother celebrated one year of sobriety. Shortly after that, however, she relapsed and problematic behaviors returned. She again went into foster care. She entered Job Corps near her 18$^{th}$ birthday, and the Department closed the case.

The father of the deceased infant was 24 at the time of the child's death. He also had some history with the Department as a youth. In 1995, when he was about 15 years of age, the Department received a referral from the school alleging that his father was extremely abusive. It was reported that he used drugs heavily (this was later confirmed by his widow), and that he physically abused both his wife and the children. It was reported that at one time, when his wife was pregnant, he sat on her stomach and held a gun to her head. This was witnessed by the children. He died in 1996. When the father of the decedent was 17, there was a referral requesting FRS due to runaway behavior that was quickly resolved.

There is little information in the record concerning the period of time when the mother and the father began their relationship. In fact, the first notation the Department has of the family is a Child Protective Services (CPS) referral received on October 8, 2004 from the paternal grandmother. The paternal grandmother called concerned about the living conditions of the mother, father, and two babies. The grandmother was concerned there was too little space, it was cluttered, and the trailer was not up to code. She reported the mother was not taking her medications for a "bi-polar disorder." This referral was screened out as information only.

It was later learned the couple had been living with the paternal grandmother in her home for at least the first year of their life together with children, and had only recently moved into the trailer. Shortly after that referral, the mother and the father had an intense argument that resulted in the father putting his hand through the car windshield. The father moved back into his mother's home, taking the children with him. It is believed the argument was about the mother's relationship with another man.

When the county coroner initially called to report the death of this child on October 15th, he stated the father reported he was sitting on the couch with the two boys, that he fell asleep and was awakened by his mother. When he woke up, he found that he was on top of his son. The fire department responded, but the infant could not be resuscitated. He stated that full body x-rays showed no past or present fractures, the external exam showed the child appeared healthy, no signs of abuse, and ophthalmologist test showed no retinal hemorrhage. Later the coroner stated that he was confident the father rolling over on the baby did not cause this baby's death. He said he had interviewed family members over the weekend. He reported the father and mother had "passed the children back and forth last week." He described the trailer they had lived in previously as filthy and "uninhabitable." At this time, he was not certain of the cause of death, but advised the mother should not take the older child. The older child was placed with a family friend.

A few days later, the coroner called to say he was signing the death certificate with the cause of death as a skull fracture. This had now been confirmed by microscopic analysis. He believed he could pinpoint the time of the injury to when the baby was in his mother's care. According to law enforcement, there were witnesses of her hitting this baby. Several people stated the mother had little patience and was easily stressed by the children. After extensive review of time frames and where the children were at what time, it appeared the incident that caused the death had occurred while the mother had the children. As of the writing of this report, however, there have been no criminal charges filed.

A dependency petition was filed on the remaining child and placement was made with the paternal grandmother.

The coroner and law enforcement reports were not available to the review team. However, some information from both reports was available via the documentation made in the case record by the social worker after contacts with those agencies.

**Issues and Recommendations**

I. Policy Issue

A. Issue: There were no collateral contacts made at intake before screening out the referral received on October 8, 2004. The referral was screened out as second hand information without an attempt to get additional information.

*Recommendation: Collateral calls should be used at intake whenever it may possibly affect the screening decision.*

**Child Fatality Review #04-53**
Region 6
Long Beach Office

**Case Overview**

On May 6, 2004, this two-month-old Caucasian female died due to unknown causes.

The mother put the child down for a nap at 5:00 p.m. When she checked an hour and a half to two hours later, she discovered the child was cold. Efforts to resuscitate the child both on site and at the hospital failed. The child's body had a swollen upper lip with a sore on it; there was also a lesion on the buttock. The autopsy has ruled out Shaken Baby Syndrome.

There is no trauma consistent with abuse per the officer present at the autopsy. The written autopsy report states the cause and manner of death is undetermined. Sudden Infant Death Syndrome (SIDS) has been excluded. "The presence of methamphetamine was not determined to be cause of death. The infant's methamphetamine blood concentration of .11 mg/L is problematic to interpret because of a) the unknown identity and potential lethality of the undetermined medical cause of this infant's chronic failure to thrive, and b) because of the limited data in the literature on methamphetamine levels in infants. In other words, the methamphetamine level is of uncertain significance as the cause of a contributory cause of the infant's death...Underlying disease (not specifically diagnosed, but nevertheless causing failure to thrive) would seem to create a greater than average risk for an adverse outcome..."

The mother and father were first referred to the Department in 1999 regarding a sibling of the decedent. The concerns were that this ten-month-old child was not being properly fed. The mother was contacted and responded appropriately to the joint visit of the Child Protective Services (CPS) worker and Public Health Nurse. Appropriate food was available in the home at the time of the visit.

Four months later, the parents were the subject of a low risk referral as suspected drug abusers and that the home was unsafe. During the visit by the CPS worker, the parents indicated that they were in a "feud" with a neighbor. The home was found to be safe, the child healthy, and school personnel spoke positively about the parents.

The next referral was in 2001 alleging neglectful supervision. The workers found the child being properly supervised by the mother. The mother described a reasonable supervision schedule.

The mother was cited for driving under the influence (DUI) sometime after this referral. Her intoxicated condition resulted in a serious accident which left two people in the other car in critical condition. The mother sustained massive injuries which affect her mobility to this date. During the time needed for her recovery, the child was sent to live with her grandmother in Florida.

A new CPS investigation in 2002 found the mother angry and resistant to CPS intervention. She refused services. The father did not keep his promised contact with the CPS worker. The

mother actively avoided the CPS worker during the course of this investigation. She was subsequently arrested in what is believed to be a drug related charge, and the father was hospitalized with a Labor and Industry injury. This older sibling was placed once again by the family in the care of the grandmother. The grandmother enrolled the child in Early Childhood Education and Assistance Program (ECEAP) with the assistance of the CPS worker.

In early 2004, a referral alleged the mother was pregnant and using drugs. The older child was reported to be healthy and doing well. This referral was determined to be information only. Later, in January 2004, a referral was accepted which reflected that the mother was not at home to receive the child when the bus dropped her off from school. The CPS worker investigated, and found that the mother was receiving prenatal care from a midwife known to the Department and with whom the agency successfully collaborated. Information subsequent to the death of the two-month-old reveals an unmarried mother and father who slipped further and further into a destructive pattern of substance abuse. The interventions of the maternal grandmother frequently maintained the safety of the older child.

**Issues and Recommendations**

I. System Issue

A. Issue: This case involved the death of an infant child who tested positive for methamphetamine blood concentration of .11mg/L which is problematic to interpret.

*Recommendation: Increase statewide training as to substance abuse awareness, and identification of patterns and physical signs of substance abuse. Increase emphasis on dangers inherent in situations with parents having substance abuse issues and very young children.*

II. Policy Issue

A. Issue: The Investigative Risk Assessment was not completed timely on the May 6, 2004 referral. It was completed outside of the required 90 day time frame. The Investigative Risk Assessment made a finding of founded as to both parents for physical abuse and negligent treatment/maltreatment. It is unclear from the assessment the rationale for the finding of physical abuse. The assessment needs to clearly detail the basis for overall risk and describe how the worker arrived at the founded finding for both physical abuse and negligent treatment/maltreatment.

*Recommendation: The Area Administrator will review the policy and procedure on completion of the Investigative Risk Assessment time frames with the social worker and supervisor. The Area Administrator will review the Investigative Risk Assessment, and ensure the assessment is revised to appropriately reflect the founded decision and rationale behind the decision.*

B. Issue: A January 30, 2004 referral did not have an Investigative Risk Assessment completed.

*Recommendation: The social worker needs to complete the Investigative Risk Assessment for this referral.*

III. Practice Issue

A. Issue: Due to limited resources, coordinating investigations with the Pacific County Sheriff's Department was difficult because the capacity did not exist for that Department to assign a single detective to investigate this case.

*Recommendation: No recommendations were identified.*

**Child Fatality Review #04-54**
Region 3
Indian Child Welfare Unit

**Case Overview**

This two-month-old Native American male died on December 7, 2004 due to streptococcal pneumonia.

This child had been living with his father, his 20-month-old brother, his paternal grandmother, and the paternal grandmother's boyfriend. The father states he put his two-month-old to bed about 1:30 a.m. He stated the baby had been fussy. He said he next checked on him at 5:00 a.m., and he was fine. He stated he checked on him again at 11:00 a.m. and found him unresponsive.

There is evidence that the child was in such a condition (coughing, fever, crying) that both the father, who was caring for the infant at the time, and his mother should have known that his condition was serious enough to warrant seeking medical attention. It is agreed that had the father known the infant's condition was that serious, he would have sought help immediately. Both parents were determined to be founded for negligent treatment or maltreatment by the social worker investigating this referral.

The Indian Child Welfare (ICW) Area Administrator worked with tribal authorities to gain access to the family and assess the safety of the sibling. The father and the sibling were reportedly moved to a safe place by the tribe.

Following the disclosure of the family's whereabouts by the tribe, a Division of Children and Family Services (DCFS) social worker was able to make contact with the family after the fatality. At that time, both parents had moved back in together into a relative's home with their older son. They agreed to a safety plan that involved the mother's commitment to leave the home if she relapsed with her drug/alcohol addiction, and the father's commitment to leave the home with their older son and stay with family in Bellingham if the mother were to relapse. Chemical dependency treatment was offered to the mother, but she did not accept services.

The history the Department has on this family is not extensive. In 2001, the first referral on this family alleged that the mother was drinking and driving with her daughters by a previous relationship in the car. They were aged three and four at that time. The allegation was denied, and that denial supported by her family, therefore, no services for chemical dependency were recommended at that time. The case was closed as inconclusive.

The mother then entered into a relationship with the father of the decedent, and the decedent's sibling was born. There was no Child Protective Services (CPS) record until the mother's pregnancy with the second boy, the decedent. Late in that pregnancy, a referral was received with allegations that the mother had a serious drug/alcohol problem, and was not receiving any prenatal care. She and the father were living apart at this time, and the older son was staying

with his father. The mother did receive services from the tribe at that time, including periodic urinalyses. That investigation was also closed as inconclusive.

At the time of the infant's death, the parents were living separately. The father was living with the two children in the home of his mother and his mother's boyfriend. There are many references in the record to heavy drinking by his mother and her boyfriend, but no mention of the father using substances. The father stated that because of the drinking in the house, he and the children mainly stayed in one bedroom.

As soon as the father and the mother separated and the father began caring for the children, the Upper Skagit Tribal children's worker began to meet with the father once a week to go over issues with the children. After the death of this baby, the children's worker expressed that she had been concerned about the father developing acceptable support systems, as he was separating from the women in his family.

Although preliminarily it appeared that the death of this infant may have been Sudden Infant Death Syndrome (SIDS), the autopsy revealed that he had died of streptococcal pneumonia. The investigating social worker made a finding of founded for neglect against both parents, as the primary physician stated this illness would have produced symptoms that should have alerted a caregiver to seek medical attention.

The Department's involvement with both parents as children and with extended family dates back to 1993. There are approximately thirty referrals on the families of the mother and the father, including allegations that the father raped an adult female relative. There are numerous referrals in the extended family alleging chronic drug/alcohol problems.

**Issues and Recommendations**

I. Practice Issue

A. Issue: The new father did not have sufficiently high parenting knowledge/skills to care for an infant at that time.

*Recommendation: The tribe will focus on new parents that do not have established parenting skills sufficient to provide adequate parenting. This will be done by available tribal programs.*

**Child Fatality Review #04-55**
Region 3
Indian Child Welfare Unit

**Case Overview**

This two-month-old Native American male died on November 1, 2004 due to unknown causes.

The referrer was told by officials on site that the child was in an infant swing--a freestanding child swing--wrapped in a blanket in which a generic Prozac pill was found. Because the cause of death could not be determined, it was deemed suspicious, and an autopsy was performed.

According to law enforcement authorities, there were no "overt" visible marks or other indications of physical trauma to the infant's body. There was some concern initially expressed that due to the child's positioning within the swing his airway may have been hampered, which led him to stop breathing.

An autopsy was completed on the baby's body on November 2, 2004. The Whatcom County medical examiner found a "trauma fracture to the child's left forearm." The medical examiner stated that evidence supports that this injury occurred just prior to the child's death, and is the type of injury that would be consistent with child abuse. The medical examiner further found lividity on the child's face (based on the blood pattern) that would support that the child was laying face down prior to his death. The doctor is speculating that the child's cause of death may be the result of "positional asphyxiation." According to the doctor, the mother and family members deny that the child was lying face down before his death. The doctor also stated that the child had been removed from the swing prior to the arrival of 911 personnel, and the scene (home) was disrupted before the first emergency responders arrived.

The doctor stated that he had concerns for the safety of the other children in the home, six and eight years of age, and suggested that Child Protective Services (CPS) evaluate their safety. The doctor explained that he did not believe that the baby's mother and her family were very cooperative and forthcoming in details during his forensic interview with them after the autopsy on November 2, 2004. The doctor was asked if a Prozac pill given to an infant would be lethal, and he responded that it would be. The medical examiner's autopsy report states "toxicology results are non contributory".

The mother of the baby, her sister, and her mother, the three female caretakers in the home at the time of the baby's death, were listed in the CPS referral as subjects of possible "negligent treatment/maltreatment." This was due to the possibility of child abuse/neglect raised by the circumstances of the death.

The grandparent has an eight and a six-year-old, in addition to teen children who still live in the home. A CPS social worker interviewed the children separately, away from their mother. The social worker also addressed safety concerns with the mother. This family had high risk factors to consider on behalf of the safety of the children in the home. These risk factors include chronicity and intermittent incidents of abuse or neglect in the family home. It was believed that

the 15-year-old mother lacked parenting skills. The grandparents and family home had a lengthy history of alcohol/substance abuse and domestic violence between the grandparents. There were prior CPS referrals that resulted in CPS investigations. Additionally, the baby's mother had been arrested on April 19, 2003 for assault and battery, domestic violence - 4th degree assault for an altercation with her mother. It is further alleged that there are many teens and young adults who come and go from the family home.

The referrals are all regarding the grandparents of the deceased infant. The 15-year-old mother lived at home during this time. Prior to his death, there had been no referrals on the care of the two-month-old.

The services offered to the family included domestic violence, substance abuse, group counseling, and family counseling. Group counseling services were accepted by the family.

In January of 2001, the 15-year-old mother's physician reported to the Tacoma CPS office that the mother, then 11 years of age, was drinking and having unprotected sex with a number of partners. This referral was taken as information only. Less than a month later, another referral with similar information was called in to CPS by a Puyallup Nation social services provider. The tribe was providing services to her family, including attempting to get the baby's mother into detoxification for alcohol issues. Her age was a barrier to this, however, and they were not successful. They were also concerned with services to her mother on domestic violence issues. This referral was screened out. The family's father was in inpatient treatment for chemical dependency at that time.

The day after that referral, however, CPS assigned a referral from law enforcement stating the mother of the family had been arrested for supplying alcohol to her children and their friends. It was alleged that they were drinking until they passed out. There were four children in the home at that time, including the baby's mother, ranging in age from five to 14.

Less than two weeks later CPS had assigned another referral that had the same allegations adding that the mother of the family was leaving the children alone in a hotel room for long periods, including overnight, and leaving young children in the care of teenagers who were intoxicated. At the beginning of the investigation, the social worker learned that the father of the family had recently completed inpatient treatment, but had relapsed. The family was moving from motel to motel. The social worker contacted the referrer from Kwawachee tribal counseling services of the Puyallup Nation. The referrer stated her belief that the children needed to be placed in foster care to stabilize while the parents of the family worked on their issues. The social worker continued in attempts to locate all members of the family. Some of the children were located and interviewed, but the social worker was unable to locate and discuss the allegations with the parents. About six weeks after the beginning of the investigation, it was learned that the family had relocated, and were now on the Lummi reservation in Bellingham. The supervisor made a call in March 2001 to the Office of Indian Child Welfare (ICW) in Bellingham, and there was agreement that the case would be transferred to Bellingham. However, there was no documentation of any activity on this case from then until 2004 indicating that the transfer was completed.

The next contact between CPS and this family was in February of 2004 in Bellingham, when CPS was assigned a referral regarding possible physical abuse to the six-year-old boy by his father. This was investigated and closed in February of 2004, with statements that the mother of the family was reporting that the father was out of the home, she had a protection order against him, and that things were much better now. She had refused the offer of family counseling, but did have one of their children engaged in group counseling. This referral was closed as inconclusive. The next contact between the family and CPS was at the time of the baby's death November 1, 2004.

Within days after the death, an ex-parte pick up order was filed in Lummi Tribal Court and the younger children were removed temporarily from the home. After investigation by the FBI and the Whatcom County Medical Examiner, the orders were dismissed and the children were returned to their home. There was a "Prozac" capsule, found during initial examination of the scene, laying in the baby swing where the family said the child had been first observed to be unresponsive. This was not a factor in this baby's death. The Medical Examiner's Office autopsy report stated that the baby had a fracture of the left arm, which apparently occurred near the time of death. It listed the manner of death as "undetermined." The report states, "No suggestions of an infectious disease process is found. There is no anatomic explanation for the death. Toxicology results are non contributory."

**Issues and Recommendations**

I. Practice Issues

A. Issue: There was insufficient evidence from which to determine a cause of death.

*Recommendation: The CPS unit should offer to the tribe the use of the Children's Administration's contracted medical consultant. This would consist of gathering available medical information and sending it to the consultant for assessment.*

B. Issue: This case was transferred from Tacoma CPS when they were unable to complete the investigation due to the family moving to Bellingham in March 2001. The Bellingham office, however, took no action on the case until responding to another referral in 2004.

Recommendation: *Region 3 CPS supervisors and Area Administrators should review their policies on transferring CPS cases, and create additional protocols as needed to ensure that each case transfer is successful.*

C. Issue: A Family Reconciliation Service referral in 2003 was screened as information only. This referral contained CPS allegations and should have been screened as such.

Recommendation: *Follow policy in screening referrals.*

**Child Fatality Review #04-56**
Region 3
Lynnwood Office

**Case Overview**

This four-month-old Caucasian female died due to pneumonia February 13, 2004. The manner of death is natural.

The mother of the four-month-old was in the home with the baby's father and their two-year-old daughter. The mother reported she left the baby in the living room for a short time and found her unresponsive when she returned. Emergency medical personnel responded to the home, and the infant was revived and transported to the hospital. The infant was dead upon arrival at the hospital. The mother stated that the baby had been ill for the last couple of days. There was some variation in the events of that day as related by each of the parents, according to the investigating officer. The doctor's office did verify that the mother had contacted them the day before about the baby's condition, but there was variance about what was communicated at that time. It was later determined the baby died of pneumonia.

Both parents were present in the home at the time of death. Both were listed as subjects of negligent treatment/maltreatment in this referral as it was unknown at that time what their involvement was in this fatality.

There was no safety plan put into effect on initial investigation of the fatality referral. On a subsequent home visit, the social worker found reason to call law enforcement, and the children were placed in protective custody. Both surviving children, ages 11 and two, continue in out of home placement with relatives under court supervision.

There was one referral after the death of the infant on March 10, 2004. In that referral it states that social workers were conducting a home visit and found the home and the surviving two children in extreme disarray and dirty. It appeared that drug use may be involved, and the social worker observed through the window the father push the mother. Law enforcement was called, and the children were then taken into protective custody. After the death of the baby, the Department offered counseling, which was refused.

The father of the children in this family was the youngest of his siblings. He graduated from high school and later took a few automotive classes. He worked off and on as an auto technician.

At age 23, he married a woman, who brought into the marriage her three-year-old daughter from a previous relationship. They soon had a son.

When their son was approximately age six, Child Protective Services (CPS) received two referrals, a year apart. These referrals alleged methamphetamine use by both their parents. The mother was arrested twice in this period for possession and intent to deliver methamphetamine. The Department filed a dependency petition on their son, and placed him with his paternal grandparents. The mother went to prison for the drug crimes. The father was temporarily

restrained from seeing his son during this period due to domestic violence issues. The father did participate at that time in court ordered services, such as parenting classes, domestic violence therapy (which he failed to complete) and random urinalysis for one and a half years.

During this time, the father divorced his wife and began a relationship with his former sister-in-law. It was while they were living together as a couple that the court allowed the father's son to return to his care. In June of 2002, the father was able to obtain custody of his son, the dependency was then dismissed. By that time, the father and his new girlfriend had their own child together. The father received financial support from his parents during the time of these legal issues, and in fact, his father provided the use of one of his houses to this family. The father was unemployed during much of the Department's involvement with this family.

The Department next had contact with this family when a CPS referral was received in October of 2003. By this time, the father's and his significant other's first child was almost two years of age. The source of concern in this new referral was that the significant other had just given birth again (prematurely) and was leaving the hospital against medical advice. It was believed by hospital staff that this was to avoid tests for the presence of illegal substances. The hospital staff had reason to suspect drug use. When the social worker went to the home to see the family, it also appeared they were under the influence of substances. They asked the parents to participate in services, which they refused. The plan at that point was to close the case, as the parents had refused services.

The following February, with the case still open, the Department received information from the coroner that this infant had died in the family home. He reported the baby had symptoms of pneumonia. There were some concerns about the timeline of the call to 911, and the law enforcement officer responding had concerns about the father's behavior during their contact with him. It appeared the parents had called the pediatrician when the baby became ill, just two days before her death, and asked about appropriate dosage of Tylenol for fever.

In home visits shortly after this, it became increasingly obvious that the parents were still using drugs. At one visit, the house was extremely disorderly, the father appeared glassy-eyed and had difficulty pronouncing his daughter's name. The older child appeared dirty and unkempt. At the end of one of those home visits, as the social workers were escorted out the door by the father, they could see through the window the father pushing his girlfriend. This concerned them sufficiently to call law enforcement to ask for a welfare check. When the police arrived they surveyed the situation and took both children into protective custody. The Department then placed them with the paternal grandparents and filed dependency petitions.

The medical examiner's office called to say the toxicology result from the autopsy was received, and the cause of death was pneumonia. The urine screens showed methamphetamine and nicotine in the infant's system. Neither was seen as the proximate cause of death. Both parents denied any use of methamphetamine.

**Issues and Recommendations**

I. Practice Issue

A. Issue: A referral (risk tag of five) was received on October 26, 2003, and the child was seen on October 28, 2003. The safety assessment, which according to policy should have been completed on October 30th, was not completed until three and a half months later on February 17, 2004, the day after the death of the infant. There was no documentation of case activity entered on this referral from two days after the referral was received on October 28th until after the death the following February.

*Recommendation: Follow policy on timely completion of safety assessment and documentation of case activity.*

B. Issue: The safety assessment described above listed each question as "not indicated", despite concerns of leaving immediately after birth of the less than five pound infant against medical advice in order to avoid toxicology, and the social worker's observance of mother's activities with the baby which should have led the social worker to realize that mother's "...ability to parent is severely impaired at the present time due to substance abuse, mental illness, developmental delay, or other condition." Following policy, she should then have sought to have the children removed from the danger, or devised a safety plan to remedy the situation. This safety assessment was signed by the acting supervisor. There was no safety plan put into effect.

*Recommendation: Follow policy regarding development of safety plan when indicated, including careful supervisory review.*

C. Issue: The referral received on October 26, 2003 was designated as non-emergent. This was in error as risk of that level should have been marked emergent.

*Recommendation: Follow policy regarding screening on high risk referrals.*

D. Issue: There was no Investigative Risk Assessment written on the October 26, 2003 referral and no evidence of supervisory review.

*Recommendation: Follow policy on completing Investigative Risk Assessments timely, and supervisory review of assessments.*

E. Issue: After this fatality, two social worker's were at the home as a part of their investigation. The other two children remained in the home. They documented seeing a propane tank with other materials they believed to be involved with use/manufacture of methamphetamine. They left the home and did not report this to law enforcement.

*Recommendation: Follow policy with regard to reporting to law enforcement when coming in contact with evidence of a crime concerning children.*

F. Issue: When the October 26, 2003 referral was being investigated, the social worker was conducting a home visit. The concern was that parents were using methamphetamine, and putting the newborn at risk. The social worker stated that during this visit, the mother was standing with the infant and swaying from side to side, with the newborn's head flopping side to side and just missing dangerous objects by inches. She appeared to be under the influence, as did the father. Despite this, the social worker left the home and did not contact law enforcement for a welfare check.

*Recommendation: Follow policy for contacting law enforcement when a child's safety appears endangered.*

G. Issue: There was no Investigative Risk Assessment completed on a referral which was assigned in January of 2000 that was related to drug use and consequent neglect of the oldest child of the father and his wife at that time.

*Recommendation: Follow policy regarding completion of Investigative Risk Assessments.*

H. Issue: The investigation of the October 26, 2003 referral was incomplete according to the policy for a high risk standard of investigation. The social worker failed to interview any collaterals, including the family's son.

*Recommendation: Follow policy for investigation of high risk standard of investigation.*

**Child Fatality Review #05-09**
Region 4
King West Office

**Case Overview**

This four-month-old Caucasian female died on while in bed on July 18, 2005. The cause of death is unknown and the manner of death is undetermined.

The Seattle Police Department responded to a report of a deceased infant. The baby shared a bed with both parents and an older sibling. The King County Medical Examiner wrote the following opinion: "This four month-old female infant has no anatomic or pathological cause of death. Based on the scene investigation (bed sharing by two adults and one child), negative toxicology and anatomic findings (laceration of the frenulum), an asphyxial death could not be excluded. Therefore, the manner of death is classified as Undetermined."

Per the Investigative Risk Assessment, the home was described as unsuitable for a young child by multiple individuals, and the three-month-old was not checked on until 11:30 a.m. The sibling was released to the grandparents by the Seattle Police. The referral was made emergent and assigned to a social worker so the worker could assess the safety of sibling and ensure the grandparents can and will protect the child.

This family had just one referral preceding this child's death. On May 16, 2005, Central Intake received a referral, and it was screened as low risk and sent to the King West office.

The allegations were as follows: "Referrer reported that parents are using methamphetamine and marijuana and smoke cigarettes around the children, 2 year-old and 7 week-old. Referrer reported that throughout the day the baby cries and cries and the parents just sleep. Once dad fell asleep with the baby in his arms and the baby fell off his arms and fell on the floor. The toddler just runs around the house and fends for himself, otherwise mom yells at him. There is not much food in the house for the baby or the toddler. The house is not clean. Mom started using after the birth of the first child. The baby has bowel movement problems. The baby struggles and pushes throughout the day before she can "poop." This has been going on since she was born. Three weeks ago mom took the baby to the doctor and was told that "it is normal." Referrer believes that but mom should take child in for a second opinion but mom is not."

The PHN Alternate Response System (ARS) Coordinator reviewed this referral for potential assignment to ARS. The PHN who covers the King West assignments had a very full caseload at that time. The PHN ARS Coordinator instead sent referral for assignment to the Public Health Nursing Early Intervention Program (EIP), also known as the Child Protective Services (CPS)-PHN Program. ARS and EIP are both contracted services, managed by Public Health Seattle-King County. Both programs involve interventions by PHNs. However, ARS has PHNs who manage low risk referrals only, while EIP can include everything from information only referrals to ones that are high risk with assigned CPS workers.

On June 6, 2005, the EIP Coordinator notes the family can't be located per returned letter. The EIP referral was closed.

When law enforcement and the medical examiner's office responded to the death scene, they found the interior to be very dirty and drug paraphernalia was present. In addition, there was a very large pit bull dog, and the exterior of the residence had surveillance cameras. The family slept together on a mattress. It was evident to the responders that the home environment was not safe for children.

**Issues and Recommendations**

I. Policy Issue

A. Issue: There is no documentation that Intake checked Automated Client Eligibility System (ACES) to confirm the accuracy of the address.

*Recommendation: Intake policies and timelines should allow for sufficient time to check ACES or other data to assure the address is up to date and accurate.*

II. Practice Issue

A. Issue: A consensus-building exercise with CPS supervisors and program managers concluded that this referral should have been rated higher and should have been assigned for investigation. The participants in this Child Fatality Review reached the same conclusion. The reasons noted include a seven-week-old infant, risk of parental substance abuse including methamphetamine, the allegation of dropping the baby, and lack of food.

*Recommendation: Referrals with this combination of risks and allegations should be investigated. The assigned CPS worker could request an EIP PHN, thus having both a CPS social worker and a nurse providing a coordinated response.*

III. Contract Issue

A. Issue: The provider's response to not being able to locate the family.

*Recommendation: The provider has changed its internal procedures for CPS referrals with children under the age of three years. If the provider cannot locate a family, the provider will report that back to Intake for further action. The provider should attend the next available Children's Administration training on ACES. This would allow the provider to check the addresses given on CPS referrals for accuracy if the family is receiving any public assistance.*

**Child Fatality Review #05-10**
Region 2
Tri-Cities Office

**Case Overview**

This two-year-old Caucasian female died on July 16, 2005 after being hit by a car.

The social worker record reflects, "On 7/16/05, the Department received a referral that 2 year-old got hit by a car and was at Kennewick General Hospital with severe injuries. Upon investigation, it was found that she had died from the injuries she sustained. The mother and her two year-old and her four year-old had been at a local storage facility with the mother's reported boyfriend. The boyfriend was accused of running over the two year-old with a vehicle. A witness reported that the mother and the boyfriend had left a short time prior to the accident leaving the children at the facility by themselves. After they returned, they got into an argument. The mother got out of the truck and continued to argue with the boyfriend through the window. The children were playing on preschool toys behind the truck. The boyfriend became angry, put the car in reverse and ran over the two year-old while the four year-old was yelling "no, no, my Josie!" The boyfriend then fled on foot. The Kennewick Police Department went looking for the boyfriend and continued to investigate the incident to determine if the mother was negligent. There was an active no contact order as the boyfriend had "threatened to ram police vehicles, kill his girlfriend and baby." He was restrained from "contacting victim, victim's family and victim's residence." This restraining order was in effect due to a charge of assault domestic violence against the mother."

The four-year-old child was taken into protective custody by law enforcement and placed in relative placement on July 17, 2005.

There are a total of seven previous referrals received regarding the mother. Four of the seven previous referrals, including the most recent referral, were accepted for investigation and the mother was the subject of all four of these investigations. The father was a subject in two of these four investigations. The allegations have been regarding physical neglect and alleged drug use including methamphetamines and marijuana, domestic violence, and a filthy home. The findings on three of the referrals have been inconclusive for both the father and the mother. The current referral is still being investigated. Two other referrals were received while the case was open and were tagged low risk. Two other referrals were information only. The allegations were similar in nature to the referrals that were investigated. However, there were also concerns about the mother's mental health as she suffers from anxiety and depression.

The family was involved in the following services while involved with the Department: the mother had been involved with Family Preservation Services (FPS), Nueva Esperanza Family Counseling, food bank referrals, legal aid, and Support Enforcement in the past. She had been referred for a drug and alcohol assessment on several occasions, but refused this service. She also did not follow up with getting the four-year-old involved in Head Start.

Per the social worker's closing/transfer Service Episode Record (SER): "Throughout their history with the Department, the father and the mother have made concerning accusations against one another. The father has had concerns about the mother using drugs and has reported being afraid of her friends. They have had affairs while they have been married. They have been involved in domestic violence situations and the mother has reportedly threatened to kill herself and their two children by driving off a cliff. The father has described her as being "psychotic." The mother had reported that the father had been staying with her and he attempted to touch her. She tried to get away but the father had put tape on the locks and ripped the phone out. She was scared so she tried to push the window out which broke and injured her hand. A police report confirmed this incident. While they both reported that there was no physical assault, they did admit to a verbal argument. Both children were present and had to be placed with relatives due to the father being hysterical and the mother being taken to the hospital. The father was also assessed by the Crisis Response Unit at that time; however, it is unknown what the diagnosis and recommendations were.

The father has reported that he has found the children with complete strangers babysitting them while the mother has gone out without telling him where she is going. The mother has reported that the father also has a mental health history. He reportedly has gotten angry with her, and has left her, taking the children and her belongings. He has also hit her. Although a no-contact order has been in place per Benton County Superior Court, neither the father nor the mother have followed it. In April of 2005, the father had concerns that the mother was manufacturing methamphetamines in a hotel room with the children present. Upon investigation by police, it was found that the mother was having her boyfriend baby-sit the children. The boyfriend had several warrants out for his arrest and a no contact order is in place at that time. A search of the boyfriend's car was done and a glass bong was found. A search of the hotel room was done and several unused glass pipes were located. They were recognized by the officer as drug paraphernalia. A "meth-style pipe with white powder residue" was found and "field-tested positive for the presumptive presence of methamphetamine." The mother admitted to using methamphetamines with the father the night before. The children were not in the hotel room. Despite the father's repeated concerns about the mother's drug use and mental health history, he has stated that he wants the children to remain with their mother. It appears that neither parent is capable of protecting this child based on this history.

Numerous services have been provided to the mother. Family Preservation Services (FPS) were in place from August 18, 2004 until February 18, 2005. The mother was assisted with the following: accessing community resources, transportation, emotion management, financial budgeting, parenting skills, child development education, communication skills development, and marital separation conflict. The Department strongly encouraged the mother to have a substance abuse assessment due to the allegations of drug use. She did not follow up on this although several referrals were provided to her. The mother was involved with Nueva Esperanza Counseling Center for treatment of her mental health issues and for assistance with problems with the four-year-old's behaviors. Although, it is likely that she did not follow-up on these services as she moved out of the area sometime in the spring of this year. She was also

encouraged to obtain services through Columbia Basin Domestic Violence Services as she has reported that both her relationship with the father and her boyfriend were violent. There is no indication that she made any attempts at obtaining these services.

Staffings have been conducted throughout the life of the case. Recently, a Family Team Decision Making meeting was held to discuss placement. While the mother was unable to attend, she was able to write a statement and both her and the father have agreed to the placement of the four-year-old with his maternal aunt and uncle.

Paternity has been established in regards to the above named child. The father and mother were married when the four-year-old was born and are currently married although a legal separation has been filed with the Division of Child Support.

The four-year-old has been placed with his maternal aunt and uncle. All family members who were spoken to agreed to this placement. They are considered to be a long-term placement should that need arise. The maternal grandparents would also like to be considered for placement should they be needed.

A dependency petition was filed. The service plan for the mother includes:

1) 90-day inpatient drug treatment program
2) Locate stable housing
3) Hair follicle and UA testing
4) Abstain from any use of illegal drugs
5) Psychological evaluation
6) Domestic violence assessment
7) Parenting education program
8) Maintain current releases of information
9) Initiate and maintain weekly contact
10) Refrain from contact or association with persons involved in untreated substance abuse or criminal activities
11) Individual counseling to address emotional issues surrounding her separation from her child, grief and loss issues
12) Provide reliable contact information
13) No contact with her husband"

**Issues and Recommendations**

I. Practice Issue

A. Issue: There was an extraordinary long delay in the response by local after hour social workers upon law enforcement making the initial call to Central Intake requesting CPS assistance.

*Recommendation: Law enforcement will have the ability to contact after hours workers, and after hours supervisors directly in the event of long delays for better coordination of services to children and families. After hours workers will make sure they do not travel outside the range of their pagers and cell phones when they are on-call.*

**Child Fatality Review #05-11**
Region 1
Spokane Office

**Case Overview**

This 17-year-old Caucasian male died on June 3, 2005 due to methamphetamine intoxication.

Spokane law enforcement responded to 911 emergency calls on May 29, 2005 regarding a suspicious person. This child was located in the vicinity lying in the street. He was able to give his name to the officer and disclosed taking methamphetamine. Medics were called to the scene, and he was transported to Sacred Heart Hospital. His heart rate had elevated at the hospital, and his temperature was 109 degrees. He was admitted to the hospital where he remained in intensive care. He was placed on life support. With his family's permission, the machines were terminated on June 2, 2005. The Spokane medical examiner determined that his death was a result of acute methamphetamine intoxication, and his death was ruled accidental.

Of the eight referrals received regarding the mother of the decedent as the subject, and her three sons; two referrals identified the decedent as a victim. Based on documents reviewed and social workers interviewed, it is difficult to determine where the decedent resided during particular times in the past six years.

There was an additional referral that identified the decedent as the victim and his father as the subject.

Services offered to this family include mental health, substance abuse, public health, medical services and Family Reconciliation Services (FRS). Mental health and FRS services were refused by the family. The remaining services were accepted.

The child and his family first came to the attention of Child Protective Services (CPS) on September 2, 1999. An adult who had been residing with the family reported physical neglect of all the children in the household. The household was comprised of the mother, as well as two of her sisters, their children, and the maternal grandmother. There was a total of seven children ages 11 years and younger. The concerns reported included the mother using "crack". She was approximately four months pregnant. The home environment reportedly had maggots and rotting food on the floor and in the carpets. CPS accepted this referral for investigation.

During the investigation, the mother went to detoxification and entered a chemical dependency inpatient treatment program and outpatient treatment program. She voluntarily participated with an advocate from Parent-Child Advocacy Program (P-CAP) and attended counseling through Casey Family Partners in Spokane. The maternal grandmother provided care for the decedent and his sibling while the mother completed her inpatient treatment.

On January 28, 2000, the mother gave birth to a son.

In March 2000, the mother obtained her own residence separate from her mother and sisters. She left the decedent in the care of her mother when she moved, indicating that she would have him move in with her when spring break from school was concluded.

On April 27, 2000, the mother was discharged from her chemical dependency treatment due to lack of attendance.

On June 1, 2000, CPS received a report that the decedent had found a spoon that he believed was used for drug use. This referral was screened information only as there was no allegation of child abuse or neglect. The mother and her children had returned to the maternal grandmother's residence by this time. The assigned social worker noted continued concerns for the decedent and his siblings, but was closing the case as the mother was no longer participating with voluntary services that had been offered with the exception of a Public Health Nurse that had contact since the birth of her son in January 2000. The September 2, 1999 referral was unfounded.

On January 26, 2001 CPS received and accepted a referral alleging physical neglect of all children in the household. Again, the residents of the home included the mother, the maternal grandmother, her two sisters, and all of their children. The report alleged all adults in the home were using drugs, what one child called "crystal white powder". The older children were reportedly caring for the younger children, and all children had access to drugs and drug paraphernalia. Law enforcement was called by the referent to make contact with the children in the home. Law enforcement did so, but did not determine there was sufficient information or evidence to place any of the children in protective custody. The referral was assigned for CPS investigation. There was no finding made on this referral.

Another referral was received on March 4, 2001 alleging that the mother was using drugs and leaving her (then 13-month-old) son with inappropriate caretakers. The mother stated she did have a 13-year-old girl baby-sit, but it is unclear if she left her son overnight with the teenager. This referral was unfounded for physical neglect.

On March 6, 2001, a referral was called in reporting that the mother was prostituting from her home and would lock the children out of the house. The referral was screened as information only. During the month of March 2001, the mother told the social worker that her oldest son, the decedent, would be moving in with his father.

On March 26, 2002, CPS accepted a referral for investigation with allegations of physical neglect of a two-year-old. The home environment was reported to be filthy with dirty diapers and cigarette butts on the floor. The social worker made an unannounced home visit and did not observe the home environment to be as reported. The home was small but tidy. The mother had her three sons with her as well as a niece. The case was immediately closed with an unfounded finding for physical neglect.

On January 30, 2003, CPS received a referral with the father listed as the subject of physical abuse towards the decedent. This child had been residing with his father for approximately two years but also spent time with his mother. The child reported that two weeks prior he and his father had an argument, and his father hit him on the back of his head. There was no injury. The child stated that he ran away and stayed with friends. The father filed a runaway report, and the police located the child and placed him at the Secure Crisis Residential Center (SCRC) on January 30, 2003. The mother and the father both met with the social worker and the child at SCRC. Both parents reported a significant behavior change with their son in the previous twelve to sixteen months. He admitted to marijuana use at this time. He stated that he wanted to live with his mother. His parents, CRC staff, and the assigned social worker developed a plan to have their son move from the secure CRC to the CRC where he and his parents could participate with family counseling and transition him to one of the parent's home. Both parents agreed that would be the mother's home. The case was closed approximately six weeks later with unfounded findings for physical abuse.

On December 16, 2003, CPS received and accepted a referral alleging that the mother left her 12-year-old son home alone for the weekend. It is unknown where the other two boys were at this time. An investigation determined that the mother had made appropriate arrangements for her 12-year-old son in her absence and the case was closed as unfounded.

On March 31, 2005, CPS received a referral alleging the mother was using methamphetamine and leaving her five-year-old son with teenagers. Due to no specific allegation of child abuse or neglect this referral was screened as an information only report.

On June 3, 2005, Sacred Heart Hospital contacted CPS to report that the decedent had been in the hospital for several days and life support efforts were being terminated. This child had overdosed on methamphetamine.

**Issues and Recommendations**

I. Practice Issue

A. Issue: The referral dated January 26, 2001 does not have a completed Investigative Risk Assessment and no findings of the investigation were documented. Three children were identified as victims in the referral, but only one child was seen face to face. Two children were not seen or interviewed.

*Recommendation: Social workers will document Investigative Risk Assessments and findings of the investigation per policy. The high standard investigation policy will be followed to include face to face contact with all identified child victims.*

**Summary of Review and Recommendations**

This fatality review was of a 17-year-old adolescent which brought about much discussion regarding general adolescent issues, as well as Child in Need of Services (CHINS) petitions specifically. Although a CHINS petition was not identified as a factor that would have changed the outcome of this case, the team noted that CHINS petitions were worthy of a discussion between Children's Administration and Spokane County judicial officers. It appears that the intent and practice regarding filing CHINS petitions varies significantly.

**Child Fatality Review #05-12**
Region 4
Division of Licensed Resources

## Case Overview

This 17-year-old Caucasian male died on July 17, 2005 from complications to an inoperable heart defect, Truncus Arteriosus Type IV.

He was a resident at the Children's Country Home, a Division of Licensed Resources (DLR) facility for medically fragile children.

Approval to bypass the remainder of the review in his case is justified because he was not a Children's Administration client, and he died of natural causes with no concerns of child abuse or neglect. He was a client of the Division of Developmental Disabilities (DDD). The only CPS referral concerning his family occurred in 1994, in which a nurse who helped to care for him at the family residence may have injured him. According to Children's Country Home records, he was born with an inoperable heart defect, Truncus Arteriosus Type IV. He was not expected to live beyond his first year. He was on a ventilator and supplemental oxygen most of his life. He also had seizures and serious cognitive impairment related to encephalopathy of an unknown cause. His mother cared for him at home until he was 11-years-old, when he became a resident at the Children's Country Home. The mother had approved a Do Not Resuscitate order for him. On July 8, he began a serious decline that included irregular heartbeats, diminished level of consciousness and shallow breathing. On July 17, his heart stopped and he was pronounced. With his mother present, he was taken off the ventilator. The King County Medical Examiner declined jurisdiction and there was no autopsy.

## Issues and Recommendations

No issues and recommendations identified.

**Child Fatality Review #05-13**
Region 5
Bremerton Office

**Case Overview**

This three-week-old African American female died on January 24, 2005 due to accidental asphyxia.

The mother was napping on the couch with the infant, and when mother awoke, the infant was blue. The mother called 911 and medics transported the infant to Harrison Memorial Hospital. At 10:42 a.m. on January 24, 2005, child was pronounced dead.

The initial information provided to CPS intake indicated that the fatality was likely the result of an accidental suffocation, and was not suspicious for child abuse or neglect. A staffing occurred between Central Intake and the Kitsap Area Administrator. A decision was made to send a social worker out the next morning to assess safety and risk to the surviving children.

The safety plan called for the maternal grandfather to stay with the family to provide support and supervision.

Within a week subsequent to the initiation of the safety plan, the mother tested positive for methamphetamine and marijuana. Dependency petitions were initiated on the two siblings in the home, and they were placed in out-of-home care.

The father of the deceased child was born in Bremerton, Washington. There is no known DCFS history for the father as a child. Information from other sources indicate the father has been diagnosed as schizophrenic. The father has no known felony history, although had been arrested in the past for domestic violence assault and criminal trespass.

The mother of the deceased was born in Tacoma, Washington. The DCFS involvement with the mother as a child included two information only referrals in June of 1994 regarding alleged neglect. There is some indication that there was domestic violence (unspecified) in the mother's family of origin. Between January 1996 and May 1998 there were four Family Reconciliation Service (FRS) referrals where either this baby's mother or her mother requested services, largely due to the child's running away.

The biological father of the oldest child is not related to either the deceased child or the other sibling. The biological father of this child has DCFS history as a child, beginning with reported drug use by his parents in 1993. Most of the referrals (1995-1997) were related to complaints by his father who was seeking custody of his children. A referral on December 16, 1996 mentioned this father (then 15 years of age) being allowed by his mother to have sex at the home with a 13-year-old girl. While no last name of the girl was provided at that time, it is believed that they referenced the mother of the decedent. By 1997, this father had become involved with the juvenile justice system, including incarceration. He does have a felony history, and arrests have

been for various crimes (burglary, possession of a firearm, assault, domestic violence/harassment, parole violations). He is currently incarcerated in the state of Washington.

The CPS history as parents began in late March of 1999 when a hospital social worker reported concerns regarding a 16-year-old mother and her ability to meet her newborn's needs. The teen mother was living with her father who was unemployed, thus there were concerns for lack of support to meet the infant's basic needs. Interaction between the teen mother and the newborn was observed at the hospital, and the teen appeared to lack basic knowledge regarding how to hold an infant. The report was screened in and accepted for investigation based on risk factors rather than allegations, although the risk factors did not appear to meet the criteria for imminent harm.

A CPS social worker conducted a home visit and Family Home Support Services (FHSS) were initiated to work with the teen mother on infant care and parenting. Numerous publications were provided (e.g., "Why is my child crying," "Keys to care giving infants"). A Public Health Nurse (PHN) was also involved and provided monthly visits. The mother was connected with the local Community Services Office (CSO). Referrals for parenting class and independent living skills were discussed and/or provided. The teen parent chose not to follow through. Child care services were also discussed but refused. Family support was observed during visits and both the infant and mother appeared clean and healthy. Contact with the PHN in mid-August 1999 indicated that the baby was developing well, the home was clean and safe, and the mom was responsive to medical needs/appointments. Additional home visits by CPS corroborated the PHN's assessment, and parent-child interactions appeared positive and nurturing. The case was staffed with a local community Child Protection Team (CPT) with the PHN attending, and the Department's decision to close the case was supported. The finding was unfounded for neglect, and the case was closed late October of 1999.

In April 2003, this teen mother delivered a baby girl at Harrison Hospital in Bremerton. There appears to be no reported concerns regarding that delivery.

Almost five years transpired between referrals when in August 2004 a hospital social worker contacted CPS with concerns that this same mother was at twenty-two weeks gestation and had had no prenatal care. The patient had come to the local hospital emergency room due to decreased fetal movement. At that time she tested positive for marijuana, had no medical coverage, and had recently been sanctioned by the CSO. The report was referred to the Early Intervention Program (EIP).

On January 2, 2005, a hospital social worker reported that she had tested positive for methamphetamines and marijuana at delivery, and the newborn's test results were pending. The newborn was placed on hold until CPS could respond. The report was accepted by CPS for emergent response.

She denied drug use to the CPS worker, stating that any trace of drugs had gotten into her system through second hand contamination. The lab samples were retested and appear to indicate only canaboids were found for mother and infant. A safety plan was implemented and the child was discharged to the mother. PHN services were requested and mother agreed to drug testing. The

results of the initial drug tests showed decreasing levels of tetrahydrocannabinol (THC) until reaching negative. The father of the baby, who did not reside with the mother, stated he was not aware of any street drug use by her. He stated that she was a good mother and took good care of the children. The case was still open at the time of the fatality. The eventual finding for the hospital referral was unfounded for negligent treatment/maltreatment.

On January 24, 2005, CPS received notification from the Kitsap Coroner's Office of the death of the twenty-two-day-old. Preliminary indications were that the child may have been accidentally asphyxiated during co-sleeping with the mother on a couch. There was nothing to suggest that the death was child abuse or neglect related or suspicious at the time of the notification from the county coroner. Bremerton Police also investigated the circumstances surrounding the fatality, and did not find any evidence that the death was child abuse or neglect related. As there were two other children in the home and the case was open with CPS at the time of the death, the report was accepted for assessment of imminent harm to the surviving siblings.

It appears that the mother experienced great difficulty dealing with the death of her baby. When drug testing results for the mother came back positive for methamphetamine and marijuana on February 1, 2005, dependency petitions were initiated on the surviving siblings. The children were then placed in foster care, eventually moving to relative care. The case remains open with Child Welfare Services (CWS).

**Issues and Recommendations**

I. Practice Issue

A. Issue: The referral received on March 31, 1999, the intake decision was to accept the report for investigation as moderate risk. Although the sufficiency screen showed the "allegation" box was checked "yes" and "imminent harm" was checked "no," the risk tag section of the report showed that the decision to accept for investigation was based on risk factors only. The panel discussed whether the referral met the sufficiency screen. The majority view was that there were no allegations, the risk factors identified at intake did not meet "imminent harm" criteria, and the family could have reasonably been referred to community resources. The minority opinion was that the referral met sufficiency of low risk, and Alternative Response System (ARS) intervention would have been reasonable. The panel concluded that the issue regarding the intake decision had no impact on the child fatality nearly six years later.

*Recommendation:* *None*

B. Issue: In regards to referral received on March 31, 1999, a review of the case file documents suggested a mix of good and questionable practice regarding the investigation and assessment processes. The investigation was initiated within ten calendar days, as per policy at that time. Face-to-face with the alleged victim was not completed within ten working days as the assigned social worker apparently had difficulty locating the family. No supervisory waiver of the face-to-face contact timeframe was found in the case file.

Appropriate services appear to have been offered and/or provided to the family as noted in the case file documentation (e.g., written service plan). The panel was concerned with the lack of initial collateral contacts by the assigned social worker, especially in terms of contacts with medical providers. However, the initiation of PHN services did appear to ameliorate this issue.

The initial Summary Assessment (risk assessment) appears to have over-stated the overall level or risk, and the worker's explanations for several risk factors were found to be inconsistent with practice guidelines. The worker initially assigned to investigate did not make a finding before transferring the case, and another worker completed the finding.

The panel concluded that the practice issues noted for this investigation in 1999 had no apparent implications for the child fatality nearly six years later.

*Recommendation: None*

Note: Policy and practice standards regarding face-to-face requirements, including documenting timeframe exceptions, were sufficiently available to Children's Administration social work staff at the time of the referral. Practice standards regarding collateral contacts were sufficiently described in Children's Administration manuals at the time of the referral, and remain in current Children's Administration publications. Additionally, annual training conducted in Region 5 for "High Standard of Investigation" includes a review of collateral contacts as basic social work practice.

The initial worker assigned this referral is not currently assigned CPS cases, and was not present during the review. However, that worker recently completed mandatory Kids Come First (KCF) refresher training which reviewed the risk assessment process.

Recent changes in Children's Administration practice with regard to CPS investigative assignments and cases transferred for delivery of on-going services, has reduced the likelihood that a case could be transferred without the completion of the findings as occurred in this case in 1999.

C. Issue: In regards to the referral received on January 2, 2005, in review of the intake information, the panel was not initially able to determine if there was an actual "hospital hold" placed on the child. Further inquiry into this matter showed the local county hospital had been, for many years, contacting CPS intake for what could be described as informal "CPS holds." As in this referral, such practice has led to confusion for workers assigned to respond to such reports.

*Recommendation: None.*

Action Taken: In May of 2005, a working agreement between Bremerton CPS and the local hospital was undertaken. During that process, the types of legal holds and

protective custody situations (including administrative hospital holds) were clarified with the hospital staff. Furthermore, Bremerton Intake staff have since been given more direction as to seeking clarification in situations involving children being placed on holds or into protective custody.

D. Issue: The assigned social worker documented his attempted initial face-to-face contact with the identified victim. However, no initial face-to-face entry was found in the Service Episode Record (SER) and no supervisory waiver was documented. It is possible that the assigned worker saw the child at the hospital, but failed to document that activity as an initial face-to-face. Noted during the review was the fact that the unit supervisor had just recently been hired and may have been unfamiliar with some policies and practices at that time.

The social worker interviewed the alleged subject in a timely manner. SER entries were made in Case Management Information System (CAMIS) per policy, although it is noted that they were created post-fatality. While there is no Children's Administration policy requiring CPS investigators to interview children who have not been identified as victims in a referral, the regional practice expectation is for all children in a family to be interviewed when possible and where reasonable. There was no documentation regarding seeing or interviewing the siblings.

SER documentation indicated that child safety was assessed in a timely manner for the newborn, but the Safety Assessment tool was not documented in CAMIS until after the notification of the child fatality in late January 2005. A safety plan was initiated prior to the newborn being discharged into the mother's care, although not required by policy as the Safety Assessment did not indicate any "serious and immediate" safety issues. The safety plan overall appeared to be more of a service plan than a safety plan, and relied heavily on promise keeping by the parent. The safety plan was not created in CAMIS until after the fatality notification.

The parent's drug test results showed concern (high Creatine level and a "no-show" test). It is possible that the investigating social worker was not aware of what the Creatine level meant in terms of a potential tainted sample.

With the report of the fatality of the newborn, the assigned worker completed the Investigative Risk Assessment prior to transferring the case to a new CPS investigator. The Investigative Risk Assessment appears to be minimal and inaccurate for some risk factors, but given the immediacy for completion, the lack of thoroughness may be understandable.

*Recommendation: None*

Note: In June of 2005, Children's Administration initiated mandatory KCF refresher training for social workers and supervisors. This training reviews the Safety Assessment process, writing effective safety plans (including avoiding reliance on

"promise keeper" activities), and accurate risk assessment. Approximately 95 percent of the Bremerton social work staff completed the KCF tool training in 2005.

Region 5 annually offers High Standard of Investigation training for CPS workers. This training has included emphasis on making collateral contacts, seeing and interviewing all children in the home, and accurate assessment of risk. The assigned worker had participated in such training within the previous year. However, the worker is no longer an employee of Children's Administration, and was not present during the review.

With the current implementation plan to have Chemical Dependency Professionals in DCFS field offices, there will be increased availability for consultation on chemical dependency issues (including what drug test results may indicate). Implementation of this is expected to be completed in 2006.

II. Quality Social Work

A. Issue: In regards to the referral received on March 31, 1999, the documented service provision by the assigned FHSS worker was found to be exceptional. The family contacts and documented observations of the parent-child interactions and the home environment exceeded expected FHSS practice. Additionally, when the case was transferred to a new CPS social worker, that worker also demonstrated exceptional practice in terms of involvement with the family, making collateral contacts, making in-home observations, and staffing the case with the community CPT. The narrative reports from both the social worker and the FHSS worker were completed in a timely manner, and were found to be descriptive and informative.

*Recommendations: None. Both the FHSS worker and the social worker were present during the review and received the feedback.*

B. Issue: In regards to referral received on August 19, 2004, the intake decision to take this referral as information only was deemed appropriate and followed policy and practice standards. The additional decision to refer the family for public health services through the EIP was consistent with best practice standards.

*Recommendation: None.*

**Child Fatality Review #05-14**
Region 1
Division of Licensed Resources

## Case Overview

This 11-year-old African American male died accidentally after his tracheotomy tube was pulled out of his trachea.

At approximately 5:30 p.m. on the evening of October 28, 2005, this child, along with other children in the foster home, were in the living room watching television. The foster mother was talking to her husband, who was in the Philippines, on the telephone while she was in the dining room, adjacent to the living area. The foster mother went into the living room to bring the telephone to the decedent, and she noted he was blue. His tracheotomy tube was pulled out of his trachea. The foster mother performed cardio-pulmonary resuscitation (CPR) and called 911. The child was transported to Holy Family Hospital then airlifted to Sacred Heart Hospital. He died the following morning, October 29, 2005, at the hospital. This case was reviewed by Children's Administration staff.

This child had been diagnosed with spina bifida, hydrocephalus, and had multiple shunt failures. He was placed into foster care on May 31, 2000 due to repeated allegations of neglect and substance abuse by his mother. A Juvenile Court Guardianship was established on August 29, 2001 with the current foster parents. Over time, this child's prognosis continued to deteriorate. On August 13, 2004, a Do Not Resuscitate (DNR) order was signed in Spokane Juvenile Court. The order includes the following: "This child has a number of medical problems including myelodysplasia and loculated hydrocephalus. He has undergone 26 surgeries in the last eight months due to complications from these conditions. This child is developing a collection within the inferior aspect of his brain stem and upper cervical spinal cord in conjunction with possible failure of his fourth ventriculopleural shunt. This child's neurosurgeon is not recommending any additional surgeries. He is likely to die after going into a coma as a result of pressure building on his brain."

The foster parents were in full compliance with all minimum licensing requirements at the time of his death. The foster parents have been described as making heroic efforts with this child. They always had his best interests at heart.

## Issues and Recommendations

No issues or recommendations identified.

**Child Fatality Review #05-15**
Region 1
Spokane Office

## Case Overview

This five-month-old Caucasian female died on July 3, 2005 due to unknown causes.

This child was put to sleep by her parents on the evening of July 2, 2005. The parents told law enforcement that the baby had been put down to sleep at 7:30 p.m. The baby was placed face down on the parents' bed. Shortly after 10:00 p.m. both parents thought they heard some noise from their room and went to check on their infant. The baby was completely covered by blankets and when uncovered she appeared blue in color and was not breathing. The parents became hysterical; neighbors came to see what was wrong and initiated CPR on the baby. Nine-one-one was called from the apartment. The baby could not be revived by medics and was transported to the hospital. She was later declared deceased at Sacred Heart Hospital. There was no trauma evidenced.

On May 19, 2005, Child Protective Services (CPS) received a report from an anonymous source stating that the mother was observed shaking her three-month-old infant daughter to the point of unconsciousness. The referent indicated the baby was unconscious for a few seconds and appeared to be fine afterwards but the referent called because it scared him. Approximately four hours later at 9:00 p.m. a CPS emergency worker responded to their residence. The mother denied the allegations and woke the baby up to have the social worker see her. The CPS worker documented no observed bruising to the infant's arms, torso, or neck. Her eyes appeared clear and focused with no indication of redness. The social worker explained the case would be assigned to an ongoing social worker the next day to follow up on the referral. The case was also referred to law enforcement.

The assigned social worker scheduled an examination of the baby with a doctor for June 2, 2005 regarding Shaken Baby Syndrome. The doctor met with the social worker, parents, and infant. The doctor indicated that the baby appeared normal and did not want to put the baby through testing if the source of the referral isn't credible.

The medical report indicates the child died from cardiac pulmonary arrest, possible Sudden Infant Death Syndrome (SIDS) death. There was no retinal hemorrhaging.

The investigation was closed as unfounded for negligent treatment and physical abuse on June 6, 2005. The case was awaiting supervisory review when the baby died.

## Issues and Recommendations

No issues or recommendation identified.

**Child Fatality Review #05-16**
Region 1
Spokane Office

**Case Overview**

This four-month-old Caucasian female died on May 9, 2005 due to sudden unexplained death.

A 15-year-old babysitter reported that he was asked by the mother to watch her three children the morning of May 9, 2005 while the mother attended an appointment scheduled for 7:30 a.m. The babysitter reported that he did not check on the decedent immediately upon arriving at the home but when he did, the decedent was not breathing. The babysitter called 911 at 8:14 a.m. Emergency response could not revive her.

The medical examiner's office reports that it is likely the child was deceased prior to the mother leaving the residence.

This case was open to Child Protective Services (CPS) at the time of the child's death. The assigned social worker and the supervisor responded to the family home to assess the risk of the surviving two siblings in the home.

This family first came to the attention of CPS on January 26, 2003. An informational report was received by CPS indicating that the mother had gone to the emergency room with symptoms of withdrawal from methadone which she reportedly stopped using four days prior. The mother reported that she had been buying methadone off the street. This referral did not include information that the mother was pregnant.

On February 26, 2003, CPS received a referral accepted as high risk, non-emergent. The mother was pregnant and went to Holy Family Hospital for withdrawal symptoms from reported oxycontin use. The referral included information that the mother had done this one month prior (the informational report of January 26, 2003).

On February 27, 2003, CPS received a referral accepted as high risk, emergent. A boy was born to the mother four weeks prematurely. He was delivered by Cesarean section due to low amniotic fluid. This baby boy was placed on a morphine drip due to withdrawal symptoms. He remained in the hospital for 16 days.

On March 3, 2003, the assigned social worker arranged for an emergency chemical dependency assessment for the mother. A Child Protection Team (CPT) meeting was facilitated on this date. The CPT recommendations included the mother completing any drug treatment that may be recommended by her assessment, the social worker refer the family for Public Health Nursing services, Support, Care, and Networking for Families (SCAN), Head Start, and a child development assessment for the baby boy at age 2-3 months.

This baby boy was released from the hospital on March 14, 2003 and was voluntarily placed with relatives. The mother entered inpatient chemical dependency treatment on March 25, 2003

and was successfully discharged on May 27, 2003. The baby boy was returned to the family home on June 6, 2003. The mother then entered intensive outpatient treatment on June 19, 2003 and was discharged on September 10, 2003 with the recommendation to continue with outpatient treatment. By this time the family was working with the Parent-Child Assistance Program (P-CAP).

On September 5, 2003, the Investigative Risk Assessment was completed and the finding was unfounded.

On April 5, 2004, the supervisor reviewed the case for closure.

On November 9, 2004 CPS received an informational report that the mother was pregnant and due in March or May. She told her P-CAP worker that she was using methamphetamine.

On January 29, 2005, CPS received an informational report that the mother gave birth to a daughter, the decedent, on January 28, 2005. The report states that the mother had a drug use history and was currently involved with the methadone program.

On February 15, 2005, CPS received a referral accepted as high risk, non-emergent. The decedent, 18-days-old, remained at Holy Family Hospital due to methadone withdrawal. The hospital staff was concerned that the mother was not capable of parenting this special needs infant.

On February 17, 2005, the assigned social worker saw the decedent at the hospital for discharge to the parents care. The decedent was discharged with a continued need for Phenobarbital.

The mother was attending the methadone clinic each morning in Spokane and had arrangements with a teenage neighbor to baby-sit while she was at the clinic. The mother's oldest child was attending public school, and the boy was attending Head Start. The family had an appropriate extended family support system, and the children were seen regularly in the community. There were no reports of concern regarding the parent's ability to meet their children's needs. The assigned social worker was preparing to close this case.

On May 9, 2005, CPS received a report that the decedent had died. The investigative risk assessment was completed with a finding of unfounded regarding the February 15, 2005 referral.

This case was closed on July 18, 2005. The Spokane Medical Examiner determined that the decedent died a sudden unexplained infant death. The factors contributing to this child's death were: Phenobarbital and diphenhydramine detected, significance undetermined, and co-sleeping with the parent. The manner of death was undetermined.

**Issues and Recommendations**

I. System Issue

A. Issue: Based upon the definition of a child, investigations of child abuse and neglect regarding infants prenatally exposed to teratogenic substances and who demonstrate negative affects can not be founded for abuse or neglect.

*Recommendation: No action required.*

II. Practice Issue

A. Issue: The assigned social worker did not enter service episode records after April 11, 2003. The case was not closed to the social worker until March 11, 2004.

*Recommendation: The social worker will input service episode records to reflect case activities occurring in* compliance with Case and Management Information System (CAMIS) policy and procedure #25.

***CAMIS Policy states:* 152253. Procedures:**

A. CA staff must complete the SER (narrative case recording) in CAMIS as soon as possible after an event, activity, or contact occurs to ensure accuracy of recording. In no case will the recording occur more than 30 calendar days from the date of the event or case activity except for the near-verbatim documentation of disclosure interviews as required by RCW 26.44.035. ("Written records involving child sexual abuse shall, at a minimum, be a near verbatim record for the disclosure interview. The near verbatim record shall be produced within fifteen calendar days of the disclosure interview, unless waived by management on a case-by-case basis.")

**Summary of Review and Recommendations**

It is recommended that the Regional Medical Consultant for Region 1 be utilized for regular staff trainings that may include care and needs for children prenatally exposed to substances with potential negative affects to those children.

**Child Fatality Review #05-17**
Region 4
Kent Office

## Case Overview

This 15-year-old Asian male was shot to death on August 28, 2005 as a result of a drive-by shooting.

The King County Medical Examiner reported the third party shooting death of this 15-year-old early Sunday morning, August 28, 2005. There are no allegations of parental abuse or neglect concerning this incident. The youth was shot though a basement window at a friend's home. The King County Sheriff's Office investigated. Two suspects, ages 18 and 16, were subsequently arrested. The King County Medical Examiner's determined the manner of death to be homicide.

The referral regarding the death was taken as information only and was not assigned. Field contact with the family was not necessary. There are no current concerns about the safety of the 12-year-old sibling living in the home.

The family had two referrals prior to the death of this child.

The first occurred on May 11, 1999 and was accepted for investigation for physical neglect. The Seattle Police Department reported a pedestrian-auto accident in which a five-year-old boy ran into the street and was hit by a car. The neglect issue was that the mother had been visiting a neighbor and had left the sibling and other children in the home. The mother is Cambodian and has several children. She does not speak English. The investigation was inconclusive.

The second referral is dated February 23, 2005 and was screened for Family Reconciliation Services (FRS). The Tukwila Police Department brought the decedent to the Spruce Street Secure Crisis Residential Center following an incident in which he was a passenger in a stolen car. The decedent was discharged to his mother and other relatives. On the same date, an FRS worker called the home and spoke with an 18-year-old brother, who was fluent in English. The FRS worker explained FRS to him, and he said he would explain it to his mother. The next day the FRS worker called and again spoke with the 18-year-old brother. He stated the family was not interested in FRS, and the case was closed.

## Issues and Recommendations

I. Practice Issue

A. Issue: Compliance with Limited English Proficiency (LEP) policy. The FRS worker communicated with an adult son in the home about FRS, since he spoke English. The worker did not speak with the mother, who is not fluent in English, nor was an interpreter used. We only know what the adult son said, not the mother.

*Recommendation: Use the AT&T Language Line when communicating by telephone with LEP clients. Families may be more likely to engage if the service is explained to them in their native language.*

**Child Fatality Review #05-18**
Region 4
King Central Office

**Case Overview**

This 16-year-old Native American male was found deceased on the morning of July 7, 2005 due to a drug overdose.

He was found by his adult sister and father. Per the law enforcement report, the adult sister could not wake her brother. Her father came into the room and found the decedent to be cold and not breathing. The father told the mother to call 911. Officers found that the child had a bruised left eye that was "in the process of healing." "It appeared 'black/blue' underneath." The officer also located a prescription bottle of Hydrocodone 750 tabs, made out to the father, on the floor of the decedent's room next to his bed. "The prescription had just been filled on 07-05-05 for sixty (60) each pills. The bottle was nearly completely empty with only six (6) pills remaining. These pills were yellowish in color with a small "V" on them and they did not appear pristine/sterile as they should be. Per the father, the prescription was his and he had last seen it in the bathroom cabinet on the morning of 07-06-05. He said he had only taken about six (6) at the most since having it filled." "Numerous syringes were located in the hallway bathroom along with small cotton balls, alcohol wipes and other drug paraphernalia." The parents stated their son, "had no serious medical conditions. They stated they knew that he had been experimenting with drugs/alcohol. They also said he made no mention of suicide to them ever." The King County Medical Examiner ruled that the cause of death as a drug overdose, and the manner of death as an accident.

On June 9, 2005, Harborview Hospital reported that the decedent was brought to the emergency room/intensive care unit for a drug overdose. He tested positive for marijuana and methadone. Medics described the home as very dirty. The decedent arrived at the hospital with dirty hands and dirty clothes. The mother and sister came to the hospital and appeared to be intoxicated. The family argued and swore. The decedent eventually left the hospital with his sister without proper discharge, with no shoes, and wearing a hospital gown as a shirt top.

During the Child Protective Services (CPS) investigation, the parents claimed they had abused drugs in the past but did not do so presently. They refused to participate in urinalyses or substance abuse assessments, but did want information about these resources for the decedent. The CPS case regarding this overdose was closed June 16, 2005 as unfounded for neglect.

This family had ten referrals preceding the decedent's death, covering a fourteen year period from 1991 to 2005. They received public assistance in both Region 3 and Region 4. The family requested child care services in 1991. The decedent was severely asthmatic. He needed expensive medications. His mother was resourceful and was able to clearly document the family's need for child care assistance and subsidy for medical costs. In 1993, while at a child care center, the decedent was the victim of a sexually aggressive five-year-old. In 1998, there were three CPS referrals about the family. Each of these mentioned possible beatings, substance abuse and the decedent's out-of-control, violent behavior. Two reports were investigated but no

findings were made. There is one information only report from 1999 that describes again the decedent's anger. Three reports in 2001 claim the parents were abusing drugs. One is information only and the other two were downgraded with a risk tag of "2", hence no investigation occurred.

**Issues and Recommendations:**

I. Practice Issue:

A. Issue: The first few years of involvement with this family, the parents seemed to be resourceful and appropriate. At some point the parents became involved with drugs, apparently heroin, per their self-report. The decedent became increasingly out of control at school. Once his mother came to school intoxicated. In his last year of life, it seems he did not live at home on any regular basis. His appearance was unwashed to the point of smelling of urine and body odor as if he had been living on the streets. He had numerous episodes of drug-taking behavior, including a severe overdose just days before his death. The Division of Children and Family Services (DCFS) seemed unable to penetrate the family's denial about the parental drug use. In the end, the parents refused to participate in urinalyses for themselves and felt powerless to intervene on behalf of the decedent's own substance abuse.

*Recommendations: DCFS needs more authority or leverage in regards to suspected parental substance abuse. Parental refusal to cooperate in urinalyses should result in court action. However, even in the face of that, many substance abusers continue to deny the problem during the substance abuse assessment.*

II. System Issue

A. Issue: The decedent's behavior was very out of control at school. In elementary school he was in special education and diagnosed as Attention Deficit Disorder/Hyperactivity Disorder (ADD/HD). It might have been helpful if the school had asked DCFS to participate in a review of this child, so that his Individual Educational Plan (IEP) was clearly articulated. Further assessment might have revealed that he needed group care placement (BRS). In his last year of life, the school was very aware of his extremely unsanitary and distressed condition but made no referrals to our agency to report this or advocate for services on his behalf.

*Recommendation: Remind schools that teenagers are still minors and mandatory reporting laws apply. Also, we should encourage partnerships and sharing of information when a youth is at risk.*

**Child Fatality Review #05-19**
Region 4
Office of African-American Children's Services

**Case Overview**

This two-month-old African American female died on August 15, 2005 due to Sudden Infant Death Syndrome (SIDS).

Children's Administration received a call from the King County Medical Examiner reporting the death of a child, age two months. The family has Child Protective Services (CPS) history and an active case. Other children remained in the home at the time. It was stated that the twins slept with the mother in her bed. The mother woke to feed the babies at 4:30 a.m., and they all went back to sleep. At 9:30 a.m., the mother was awakened by the cries of the other twin. At that time, she found the decedent face down lying next to her and unresponsive. She called out for help, and an aunt came in and began cardiopulmonary resuscitation (CPR). Medics responded and did not attempt resuscitation as the decedent was found to be "down too long." The decedent had no signs of external trauma. The mother appeared appropriate and did not seem to be under the influence of drugs or alcohol.

The cause of death is SIDS per the King County Medical Examiner, confirmed December 21, 2005.

A safety plan was developed to ensure the safety of the other twin. The plan was an agreement between the Division of Children and Family Services (DCFS) and the mother. The goal of the agreement was to ensure the safety and well being of other twin. The safety plan included: 1) The other twin was taken to the doctor. The mother was to follow up with all recommended medical treatment. 2) The mother was to attend the August 31, 2005 intake at Therapeutic Health Services (THS). 3) The maternal grandmother was to be the primary caretaker of the twin until the cause of death is determined.

The mother had given birth to four children by two different fathers. The father of the two oldest children, born December 18, 1993 and July 7, 1999, was the same. The twins, born on June 3, 2005, had a different father than the older children. There is no father named on their birth certificates.

On December 3, 2002, CPS received a referral that was accepted for investigation for negligent treatment/maltreatment and physical abuse. At that time, the three-year-old reported his father punched him in the neck. Interviews with both of the children, the mother and father, and the maternal grandmother occurred. At that time the mother was a client at THS. The investigation was unfounded and explained as play wrestling between the father and son.

On May 6, 2003, CPS received an information only referral. The oldest child told an employee at her school about an incident in a grocery store in which the mother was apparently intoxicated. On August 18, 2003, CPS received a referral that was accepted for investigation for negligent treatment/maltreatment. The oldest child called 911, and the mother was transported to

Harborview. The mother was partly conscious. She tested positive for "amphetamines, opiates, benzos and methadone." This investigation was founded. The third report in 2003 came on October 10th and was accepted for investigation of physical abuse. The second oldest child said his father hurt his ear. This was unfounded. There was one report in 2004 that was information only dated July 8, 2004. During 2004, the family received two authorizations for Intensive Family Preservation Services (IFPS). There were multiple instances in which the mother's behavior appeared to be drug-seeking.

The twins were born June 5, 2005. Swedish Hospital made a report to CPS on June 6th. This report of negligent treatment/maltreatment was accepted for investigation. The mother tested positive for methadone and opiates. Both babies also were drug positive, according to the Service Episode Record (SER). The mother told the assigned CPS worker that the maternal grandmother was taking care of the second oldest child at her home in Redmond, Oregon and would soon have the oldest child there when school ended for the summer. The mother's initial plans were to live with the twins at a friend's home, then move to public housing.

The mother left the hospital with the babies to live at an address in Seattle. The service plan with CPS included at least one urinalysis and a referral to Child Haven for the twins. Soon after, the mother and the twins left for a visit with the maternal grandmother and the other siblings in Oregon. On August 15, 2005, the King County Medical Examiner contacted CPS to report the death of this twin.

The surviving twin was subsequently hospitalized for medical testing. He was placed in foster care on a Voluntary Placement Agreement (VPA), and then placed with a relative with a dependency petition filed.

Court records document several incidents of domestic violence between the mother and the father of the older children. There is a current No Contact Order that is in effect until August 20, 2006. There are no records concerning domestic violence between the mother and the father of the twins.

**Issues and Recommendations**

I. Practice Issues

A. Issue: The importance of case history in helping to determine the case plan. It appears that the assigned worker may not have carefully reviewed the case file before deciding on a course of action. A review would have provided ample information when the twins were born that the mother was continuing a several-year pattern of abuse of pain killers while marginally participating in a Methadone maintenance program. With that information in hand, it may have been clearer that legal action would be warranted.

*Recommendation: Read the case file and if it is not physically in the office, read it on-line.*

B. Issue: Using Voluntary Services Plans when parents have known substance abuse issues. Workers want to provide reasonable efforts and services to prevent placement and legal intervention. On the other hand, voluntary plans may not be effective with substance-abusing clients who are in denial.

*Recommendation: Voluntary plans, if used at all, need to be for very short time frames, such as thirty days. Compliance should be very closely monitored.*

C. Issue: Using Family Preservation Services (FPS) or IFPS when a parent is not clean and sober. This family actually received two authorizations for IFPS. The substance abuse issues continued throughout both episodes.

*Recommendation: Preservation services should not be employed when a parent is using. The goals cannot be met and the safety of the children will not be enhanced.*

D. Issue: Making referrals to the Public Health Nursing (PHN) Early Intervention Program (EIP). In this case the hospital made a "regular" PHN referral, but the CPS worker did not subsequently request an EIP PHN. Doing so means the PHN will obtain consent for release of information and will provide the worker with written progress reports.

*Recommendation: Where available, request an EIP PHN for families with infants and children under age three, or with any child that has medical issues.*

**Child Fatality Review #05-20**
Region 4
Indian Child Welfare Unit

**Case Overview**

This 16-year-old Native American male died on June 10, 2005 due to Leigh's disease. Leigh's disease is a terminal metabolic/neurodegenerative disorder that results in multiple systemic abnormalities. This is a neurodegenerative disorder that causes multiple medical problems. The medical problems this disease causes include generalized slowing of physical and mental reactions, loss of muscle tone, defective muscle coordination, weakness, vision loss, eye movement abnormalities, seizures, difficulty in swallowing, and abnormal accumulation of lactic acid in the blood. It also causes degeneration of the central nervous system. It is a progressive disease that results in death, often within two years. This child was diagnosed with the disease at five-years-old.

This child became a dependent on November 9, 2004 due to neglect by his mother. This was an in-home dependency until April 13, 2005 when the court granted a motion to remove him from the home. The social worker assigned to this case had been attempting to find a foster home for the child for several weeks with no success. Due to the child's degenerative disease, he used a walker and wheel chair to get around. On Saturday, April 16, 2005, the child aspirated (choked) on something. His mother found him on the floor, and he wasn't breathing. She called 911 and he was brought to Harborview Medical Center where he was put on a ventilator. The doctor stated that the child could not return to his mother's care when he was released from the hospital. The child was placed at Ashley House on May 5, 2005. He had another incident needing resuscitation on May 30, 2005. He was transported to Mary Bridge Hospital and then, on June 1, 2005, he was transferred to the Pediatric Intensive Care Unit at Children's Hospital.

On June 9, 2005, the mother agreed to remove the temporary breathing and feeding tubes. There had been several staffings—one with the doctor, a pediatrician and researcher in children dying (the mother, child and this social worker were all present). There was a staffing with medical personnel, which included the mother and this social worker at Mary Bridge Hospital. There was another staffing at Children's Hospital at which the social worker was present and the doctor talked to the mother afterwards (the mother was intimidated by the large professional groups). The case was made more complicated by the fact that the mother is developmentally delayed and hearing impaired. It was difficult to detect if she was fully informed regarding procedures. However, she seemed to understand as much as she needed to make decisions. The mother wanted the birth father located and the social worker, after a day long search, was able to find him. The child was visited by family at the hospital.

The child died on June 10, 2005.

Children's Hospital performed the autopsy and reported the following:
Principal Diagnosis: Acute Respiratory Failure
Secondary Diagnoses:
1. Leigh syndrome.

2. Leber hereditary optic neuropathy.
3. Central hypoventilation syndrome.
4. Developmental delay.
5. Recurrent aspiration events.

The decedent was born September 2, 1988. He was both parent's third child. According to Public Health records, a 13-month-old daughter died of Leigh's Syndrome several years prior. Their first son was born in 1985. Their first son was afflicted with Leigh's Syndrome as well.

The mother is developmentally disabled and has received services from the Division of Developmental Disabilities (DDD). She is nearly deaf, and she may have a milder form of Leigh's Syndrome or something related. The mother raised her boys mostly without the presence of the father. There were domestic violence incidents between the mother and father. Case and Management Information System (CAMIS) documents 25 referrals from May 22, 1990 to April 19, 2005. There is an additional report in the Public Health records from 1988 which precedes CAMIS. Public Health documents a referral to Child Protective Services (CPS) in 1988 in which the father shook the decedent when he was an infant. Public Health clinic records also document that the mother sought appropriate, frequent, and timely health care for the decedent. The current case file begins in 2003. The earlier volumes are missing so it is not possible to know what services CPS may have provided between 1989 and 2002.

Nearly all the referrals are concerned with neglect, i.e., the mother's inability to provide proper care for the boys, especially the decedent, and her inability or refusal to participate in any services when offered. At least ten of these referrals specifically describe the home being a health hazard due to the presence of rotting food, garbage, feces on the floor, flies and cockroaches. It was not until August 2004 when the decedent was dehydrated to the point of needing hospitalization that the state intervened with legal action.

The Division of Children and Family Services (DCFS) filed a dependency petition and the decedent was placed at Ashley House, a special home for medically fragile children. He improved so dramatically in the area of feeding that Ashley House recommended he be returned to his mother before the end of September 2004. The decedent was returned home as an in-home dependency case. The case was transferred to Child Welfare Services (CWS). The school and other providers had on-going concerns about the quality of his care, however. The CWS worker referred the case to the Foster Care Assessment Program (FCAP). This resulted in good collaboration and communication between providers. The providers and FCAP held a team meeting on March 21, 2005. The consensus was that the child should be placed outside the home if the placement would maintain his very strong ties with his family and high school.

The court granted an order on April 13, 2005 for the decedent to be placed outside the home. DCFS had not yet found a placement for him, and on April 16, 2005 he aspirated at home. He was taken to Harborview and Children's, then placed back at Ashley House. While at Ashley House, he had another aspiration episode, leading to his death at Children's Hospital.

**Issues and Recommendations**

I. Practice Issues

A. Issue: The case files for this family preceding 2003 are missing and there are no SERs in CAMIS before that time.

*Recommendation: Keep electronic records and hard copies up to date.*

B. Issue: The prior focus seemed to be on the decedent and never on the older son. The older brother was apparently more capable as a caregiver than the mother, and a lot of responsibility fell to him to feed and care for the decedent. He was reported to be very angry and resentful about this. As an adult, he receives services from DDD and mental health.

*Recommendation: Assess risk and provide services to all siblings identified as victims*.

C. Issue: Chronicity—A case such as this should have been reviewed on a broad scale with all the providers together much sooner. This might have led to a more coordinated plan that addressed the reasons for the multiple referrals and more effective services.

*Recommendation: Implement the chronically referring family policy.*

D. Issue: The decision to place (or not)—The referrals beg the questions, should the decedent have been placed sooner? How can such conditions meet any standard of nurture, health and safety? What the most recent CPS intervention found was that despite the filth, the decedent was very attached to his mother and to his brother, and that his biggest fear was being placed in an institutional setting, awaiting his death away from his loved ones. An ideal situation would have been a home where the decedent and his mother could live, with other supportive adults in charge.

*Recommendation: Develop placement resources that have the capacity to take both the parent and child together.*

II. System Issue

A. Issue: Coordination and information-sharing between agencies. It appears that no agency actually took the lead to bring everyone to the table until 2005, when DCFS asked FCAP to become involved.

*Recommendation: Proactively bring other agencies to the table to discuss case coordination and services.*

B. Issue: Lack of placement resources. Ashley House is a wonderful resource, but the child might have earlier benefited from a well-trained, nurturing family home. Unfortunately such homes are not commonly found.

*Recommendation: The Division of Licensed Resources (DLR) should continue to recruit and develop family homes who can meet the needs of medically fragile children.*

**Summary of Review and Recommendations**

DCFS should look at cases such as this from a big-picture perspective. Review these cases on a regular basis and try to answer the question about the root causes. Find out about all the agencies and providers involved with the family. Bring everyone to the table. Use FCAP, a very helpful resource in this effort. Coordinated services and information-sharing may have reduced the chronicity and severity of the neglect.

**Child Fatality Review #05-21**
Region 1
Spokane Office

**Case Overview**

This seven-month-old Caucasian female died on August 19, 2005 due to Sudden Infant Death Syndrome (SIDS).

The father was caring for his infant daughter when he brought her to the emergency room. The baby was fussy the evening before. She reportedly had a temperature of 106 degrees when admitted to the hospital. She died at 9:42 a.m. on August 19, 2005. There was no trauma evidenced, and the death scene investigation was negative. The cause of death was determined to be Sudden Infant Death Syndrome (SIDS) by the Spokane Medical Examiner.

An on-call social worker attempted to make contact with the three-year-old sibling on August 19, 2005. The social worker did locate and contact the child on Saturday, August 20, 2005. The sibling was being cared for by her maternal grandmother. She appeared healthy and physically unharmed.

The teenage mother grew up in a family with an extensive history with Child Protective Services (CPS) starting in 1993. The mother first came to the attention of CPS as a parent on August 30, 2002. A social worker from the Community Service Office (CSO) called to report concerns of the father of her oldest child (then two-months-old). It was reported that this father threatened to kill the mother, and she obtained a restraining order against him. The CSO referred the mother to the First Steps program. This referral was screened as information only.

On May 1, 2003, an anonymous referent reported to CPS that the mother leaves her daughter, then 11-months-old, at a multi-service youth center for street kids, homeless and high-risk youth aged 13-17. She would leave her child so she could go with other teenagers to smoke pot or eat, leaving for an hour or more at a time. The referent reports that the mother moves between her mother's and father's households. This referral was screened as information only.

On December 8, 2003, CPS received a report with the grandfather as the primary caretaker. The report states that the grandfather was abusing family members for a long time, and he was very violent. He threatened to kill his daughter, the mother of the decedent. The intake worker told the referent to have the mother call if she would like Family Reconciliation Services (FRS). The report was screened as information only. The mother never contacted CPS regarding this matter.

On March 2, 2004, CPS received a report that the father of the oldest child was residing with the mother and the then year-and-a-half-old. The father was involved with a dependency of another child. The concern in that case was domestic violence between the father and his other partner. This report was screened as information only.

On June 3, 2004, CPS accepted a referral as emergent. The referral states the mother blows pot smoke in her two-year-old daughter's face, the mother has pulled her hair, called her names, and stated "I want to kill her."

On June 30, 2004, the mother tested positive for tetrahydrocannabinol (THC) at 28 mg. An Investigative Risk Assessment was completed on September 2, 2004. The assessment documents many services the mother was participating with including; CAPA (Childbirth and Parenting Alone) which provides counseling, childbirth education, First Steps case management, and parenting classes, and Doula (a mentor program for young single parents), The Circle of Security parenting program which includes extensive attachment and bonding work, and multiple services through the youth service center. The mother's daughter attended Early Head Start and would be returning when the school year started. The investigation was closed as unfounded with a moderate overall level of risk.

On March 22, 2005, CPS accepted a referral as emergent. Some teenagers came to the youth service center with the oldest child (two and a half years old) and the decedent (two-months-old). The children had been passed around to various teens to care for them. The mother could not be located by the youth service center staff.

Through the course of the investigation, the youth service center staff did not have information indicating that the teens that cared for the mother's children were inappropriate. The mother and her children were actually residing with the children's paternal grandparents. The living situation decreased the risks to the children. The mother was still participating in multiple social service programs with reported progress. The investigation was closed as unfounded on June 1, 2005.

On May 11, 2005, CPS accepted for investigation a referral of moderate-high risk. Staff at Crosswalk reported that the mother had the decedent in a front carrier and twice attempted to engage in a physical altercation with another client. The mother appeared to have no regard for the danger posed to the decedent or her other child who had been standing next to her.

Through the course of the investigation the mother indicated that the person she had a disagreement with was her sister. She admitted that it was not appropriate to yell while she was holding her infant daughter but denied that there was any physical altercation. The investigation was closed as inconclusive on June 1, 2005.

On May 25, 2005, CPS received an information report that the mother reported to Catholic Charities that her daughter, the oldest, had been sexually molested over the weekend. The mother stated she took the child to Deaconess Hospital. No other information was provided. This referral was reported while the case was still open due to previous referrals. Although this referral was screened as information only, the assigned social worker followed up on these concerns. The mother reported that her mother was caring for her oldest child a few weekends prior and her oldest "freaked out" while the grandmother was changing her diaper. The grandmother believed that was an indication of the child being touched inappropriately.

On July 18, 2005, CPS received an information report that the mother and both daughters are living in a household with six adults, three of whom were using methamphetamines. The

children reportedly are not in the room while these adults use methamphetamines. The reported address was that of the children's paternal grandparents.

On August 19, 2005, the Spokane Medical Examiner's office called to report the death of the youngest while in the care of her father. The medical examiner concluded the cause of death to be SIDS following a death scene investigation, autopsy, and toxicology testing.

**Issues and Recommendations**

I. Practice Issue

A. Issue: There were no specific issues identified by the review participants that would have prevented a SIDS death.

*Recommendation: The review participants did have discussion regarding more training and/or direction regarding practice involving chronic referrals. This case had nine referrals in a three year period. A statewide policy has been developed but not implemented yet, to address chronically referring families. This policy will assist social workers in identification and case planning for addressing the long term issues within the family.*

**Child Fatality Review #05-22**
Region 4
King West Office

**Case Overview**

This four-month-old Caucasian male died on September 20, 2005 due to Sudden Infant Death Syndrome (SIDS).

Child Protective Services (CPS) received a referral on this mother and child on August 16, 2005. The worker had a face-to-face with the mother and child on August 17, 2005 and developed a safety plan with the mother. The mother agreed to make an appointment at a Community Psychiatric Clinic and to make a well baby appointment by August 19, 2005. The mother and boyfriend agreed to random urinalysis and referrals were made. The mother agreed to keep the social worker informed of the family's whereabouts at all times and to report any changes in address immediately. The worker received three urinalyses, two of which were negative and one positive for cocaine. Shortly after this last urinalysis, the worker lost contact with the mother. The worker attempted home visits to the last known address, checked the Automated Client Eligibility System (ACES), and talked to the mother's sister and ex-boyfriend. No one had any information regarding the mother's whereabouts. The social worker had just staffed this case with her supervisor and decided to try Supplemental Security Income (SSI) to see if they had any information on the mother's whereabouts.

On September 20, 2005, the worker received a call from the mother's ex-boyfriend who reported that he had just received a call from the mother stating that she was in Minnesota and that the baby had died. The mother reported that the child had died of SIDS. She had gone into the room to check on him and he was cold. She reported that she called 911, but the child was already dead. The worker later talked to a detective in Minnesota who reported that law enforcement is investigating this incident. He asked for any information we had on this family that would aid in his investigation.

CPS received only one referral preceding the death of this child. The referral was received on August 16, 2005 and was accepted for investigation of negligent treatment/maltreatment. A relative of the mother called from Minnesota. She stated the mother left that state five months ago, while pregnant. The caller alluded to mother having some criminal history (forgery, possession of marijuana), as well as mental health problems. The mother told the referrer that she is cutting on herself and is to be evicted from her apartment. A second caller described the mother as a heavy drinker.

The assigned CPS worker spoke with health care collaterals, interviewed the mother and her roommates and saw the infant. The mother told the worker about a lot of trauma and loss in her family, mental health, Supplemental Security Income (SSI), substance abuse and criminal history. The worker obtained a safety plan which included urinalysis, mental health services, and well-baby exams. After missing medical appointments for the decedent and suffering further personal loss, the worker made arrangements with the mother to discuss a Voluntary Placement Agreement (VPA) for the decedent. The mother did not keep the appointment. She left her

residence in Seattle and one source reported they were living in a motel on Aurora Avenue. The worker was unable to locate them again.

On September 20, 2005, a collateral source contacted the assigned worker. He said the mother had just called him from Virginia, Minnesota, and the decedent had died that day from SIDS. The worker spoke with the detective. He confirmed the death and that all indications were the cause of death was SIDS. Subsequent copies of the law enforcement investigation and death certificate confirm that. The CPS investigation was unfounded and the case was closed.

**Issues and Recommendations**

I. System Issue

A. Issue: The need for universal in-home nurse visitation for mothers and infant.

*Recommendations: This baby was born at University of Washington Hospital. Given the mother's social history, a visit by a nurse to assist the young mother and to teach SIDS reduction strategies and Back to Sleep instruction might have been helpful.*