Report to the Legislature

Quarterly Child Fatality Report

RCW 74.13.640

January - March 2009

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Children's Administration Quarterly Child Fatality Report

Executive Summary

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

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

This report summarizes information from 18 completed fatality reviews of fatalities that occurred in 2008. All were reviewed by a regional Child Fatality Review Team.

The reviews included in this quarterly report discuss fatalities from all six regions.

This report does not include the one Executive Child Fatality Review completed during the quarter. This executive child fatality review report is posted on the DSHS website: (http://www.dshs.wa.gov/pdf/ca/Phelps.pdf).

Region	Number of Reports
1	3
2	1
3	3
4	3
5	5
6	3
Total Fatalities Reviewed During 1st Quarter, 2009	18

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

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

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

The chart below provides the number of fatalities reported to CA, and the number of reviews completed and pending for calendar year of 2007 and 2008. The number of pending reviews is subject to change if CA learns new information through reviewing the case. For example, CA may learn that the fatality was anticipated rather than unexpected, or there is additional CA history regarding the family under a different name or spelling.

Child Fatality Reviews for Calendar Years 2007 / 2008			
Year	Total Fatalities Reported to Date Requiring a Review	Completed Fatality Reviews	Pending Fatality Reviews
2007	59	59	0
2008	90	59	31

The numbering of the Child Fatality Reviews in this report begins with number 08-37. This indicates the fatality occurred in 2008 and is the 37th report completed for that calendar year. The number is assigned when the Child Fatality Review and report by the Child Protective Services Program Manager is completed.

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

Child Fatality Review #08-37
Region 5
Pierce County

This five-month-old African American female died from an unspecified medical condition.

Case Overview
On June 19, 2008, Tacoma Police Department and the Pierce County Medical Examiner were called to the home of the aunt of the deceased child. The child's aunt woke around 7:30 a.m. and found the child not breathing. Law enforcement did not document any concerns regarding the condition of the home. The death was not medically unexpected due to issues relating to severe pre-term delivery at 23 weeks gestation. The cause of death was determined to be due to complications of prematurity, and the manner of death is listed as "natural."

The deceased child and her twin sister were born on January 23, 2008 at 23 weeks gestation. Their 18-year-old mother moved to Washington from Sacramento, California one week prior to their birth. She had no prenatal care. The children were not expected to live after delivery.

The mother returned to Sacramento in April 2008 as she could no longer stay with her sister. She was arrested shortly after her return to Sacramento. Prior to leaving, the mother signed a letter giving her sister custody of the twins until they were healthy enough to go to Sacramento. The infants were released to their aunt's care on April 29. Both were still considered medically fragile. Both were on oxygen, medications for reflux, and in the care of an ophthalmologist.

A Public Health Nurse (PHN) working with the aunt went to the home on the morning of the child's fatality. She observed that all oxygen tanks were empty. The Medical Examiner and law enforcement were aware that the infant's travel oxygen tanks were empty at the time of the child's death, but both said this had no direct connection to the child's death.

The Child Protective Services (CPS) social worker did not identify the death as directly related to child maltreatment. However, the CPS investigation resulted in a founded finding for negligent treatment by the aunt for failing to ensure the oxygen dependent infants had a sufficient oxygen supply. The surviving twin was placed in protective custody on June 20. She was placed in foster care and the department filed a dependency petition.

Referral History
On January 23, 2008, Child Protective Services (CPS) intake took a report from a hospital social worker reporting the mother of the deceased child gave birth to her and her twin sister on January 22. Both infants were born premature at 23 weeks gestation. The mother received no prenatal care. She came to Washington State on January 14, 2008 from

California. The doctor estimated the children's survival rate at less than ten percent. The mother was offered resources to assist with her pregnancy, but she never followed through. This referral was screened as information only.

On May 8, 2008, hospital staff reported to CPS intake concerns about the well being of the deceased child and her twin sister in their aunt's care. Hospital staff were concerned about lack of bonding and attachment between the deceased child's twin sister and her aunt. In April the biological mother left for California. Hospital staff had no contact with her after she left. The maternal grandmother reported the mother was arrested and spent some time in jail in Sacramento. The mother gave custody of the twins to her sister until they were healthy enough to go to Sacramento. The deceased child was released to the aunt's care on April 29, 2008 and was doing well. There were concerns that the hospital was unable to provide resources to the aunt because she was not the custodial parent. There were skilled nurse visits for first two weeks, but those had ended. This referral was screened as information only.

On May 20, 2008, a nurse at Tacoma General Hospital reported to CPS intake allegation of medical neglect by the deceased child's aunt. The aunt had an informal agreement to care for the twins until the mother finished her community service in California. The referrer reported the doctor told the aunt he wanted to see the deceased child two to three days after the discharge from the hospital. The aunt had an initial appointment but canceled it. She did reschedule for four days later. The next appointment was to see an eye specialist due to high risk of blindness from medications the infant was taking while at the hospital. The aunt failed to bring the child in for two scheduled appointments. The infant's eyes were not checked for three weeks; this was concerning to the hospital staff. Hospital staff were concerned that the aunt was unable to meet the high needs of the twins as she was unable to meet medical needs of the one twin. This referral was screened in for investigation by Child Protective Services and closed with a founded finding for negligent treatment or maltreatment. This finding was made after the child's death.

On June 19, 2008, a Public Health Nurse working with the deceased child's aunt reported to CPS intake that the child died. Police and the medical examiner found nothing of concern at the aunt's home. This referral was screened in for investigation by Child Protective Services and closed with an unfounded finding for negligent treatment or maltreatment. The twin sister of the deceased child was placed in foster care after this referral.

Issues and Recommendations

Issue: There were no substantive practice, policy, or system issues identified during the child fatality review.

There was agreement among panel members that all intake decisions, including those made prior to the fatality incident, were supportable. Overall the documented investigative

activities appeared to meet or exceed expected practice. Medical and support services were in place in the home at the time of the child's demise, including a Public Health Nurse (PHN) who had made five home visits within a 30-day period. The deceased child was seen by physicians three times between March 23 and June 6, 2008, with no reported concerns.

The investigative finding of "Founded" appears reasonable in the context of the aunt failing to ensure sufficient oxygen supplies were on hand in the home. Without supportive evidence from either the Medical Examiner or law enforcement regarding negligence on the part of the child's caretaker, the CPS investigator did not identify the death as being directly related to child maltreatment. However, the CPS investigation resulted in a finding of founded for negligent treatment by the aunt for having presented a clear and present danger to the deceased child’s health and welfare when she failed to ensure the oxygen dependent infant had a sufficient oxygen supply on hand at the residence.

Some missed opportunities for best practice were noted during the review. The CPS worker might have inquired more in depth as to the aunt's history of abuse/neglect as a child and the self-reported parentification at an early age. Such inquiry may have led to an understanding of the aunt's motivation to care for her nieces which may have exceeded her ability to care for the twins. The CPS worker had few documented observations of the aunt's biological children as they were not all present in the home during social worker home visits. Understanding the parent-child relationships between the aunt and her own children may have benefited any assessment of risk and protective factors. The caregiver (aunt) presented well to both the CPS worker and to the PHN. It is conceivable that the way the aunt presented to those involved may have influenced how information was interpreted, filtered, and assessed.

Recommendation: None

Actions Taken: Both the CPS investigator and supervisor participated in the review and received feedback regarding suggestions for improved practice.

Child Fatality Review #08-38
Region 6
Wahkiakum County

This 15-year-old Caucasian male died from an unspecified medical condition.

Case Overview
On July 25, 2008, this 15-year-old foster child was taken to a doctor's appointment for headaches and lack of appetite by foster parent. The youth was placed in this foster home on July 16, 2008. The child's primary care physician recommended taking him to the emergency room at Oregon Health and Sciences University (OHSU) in Portland, Oregon. The foster mother took the child there and he was admitted. On Sunday, July 27, 2008, his condition stabilized and he was scheduled to be released. On Monday July 28, 2008, his condition worsened. He had trouble breathing, weakness in the legs, and headaches. Doctors wanted to place a probe in this head/scalp to monitor and/or read some bodily functioning areas. Hospital staff said the doctor wanted this done immediately as the youth was failing fast. The biological father was contacted and consented to the procedure. Prior to this procedure, the youth's heart stopped beating; attempts were made to revive him. Medical staff contacted the social worker and said doctors were recommending that if the youth's heart stopped again that no further efforts be made to save him. Doctors met with the youth's father and he was in agreement with this recommendation. The youth died approximately an hour later. At the time, doctors were unsure what caused this youth's death.

Referral History
On January 5, 2005, Child Protective Services (CPS) intake took a report from school staff. The older brother of the deceased youth said he saw his stepmother slam the head of the deceased youth, then 11-years-old, into a wall. The deceased child reportedly had a red mark the side of his head where he was injured. The brother said two years prior, the deceased youth told him their stepmother smeared dog feces in his face. The brother claimed he observed his stepmother slap the deceased youth across the face with the back of her hand. The youth almost fell to the ground, but he did not have any marks afterward. This referral was screened in for investigation by CPS and closed with an unfounded finding. The child victims denied physical abuse.

On March 7, 2005, the father of the deceased youth contacted CPS intake to request Family Reconciliation Services (FRS). He reported his 13-year-old daughter (sister to the deceased child) was being disruptive at home. He requested help filing an At-Risk Youth (ARY) petition. The youth was in counseling at the time. This referral was accepted for FRS.

On June 17, 2005, CPS intake received a report from a county juvenile detention officer that the 13-year-old sister of the deceased youth disclosed that her 15-year-old brother

touched her chest and genital area. She said this occurred when her parents were gone. She also said he has inappropriately touched her friend. She said this occurred many times and that she had told her grandmother and her mental health counselor. She reported that her grandmother doesn't listen and that her counselor has not reported these incidents. This referral was screened in for investigation by CPS and closed with an unfounded finding as the parents were unaware their son was molesting his sister. Law enforcement arrested the brother.

On August 22, 2006, the father of the deceased youth contacted CPS intake to request Family Reconciliation Services (FRS). He reported his son (the deceased youth) was being mouthy and defiant. He was also violent to other family members. He requested help filing an At-Risk Youth (ARY) petition. This referral was accepted for FRS.

On April 17, 2007, school staff reported to CPS intake the 15-year-old sister of the deceased youth came to school with what looked like two black eyes. She told the referent she came home wearing makeup. Her stepmother got home and washed her face with a hand towel and soap to clean off the eye makeup. This referral was screened as information only.

On October 4, 2007, school staff reported to CPS intake seeing a half-inch long bruise near the outer corner of the deceased youth's eye. The youth disclosed his stepmother hit him with an open hand. His father was present, but did nothing about it. The deceased youth reported when he got home from school on October 3, 2007, his stepmother was swearing at him and asked him to approach her. When he did, she hit him on the left side of the face. The stepmother told him to go put an ice pack on his face so she wouldn't get into trouble. The youth reported the same thing happened to his sister when she came home. The deceased youth expressed fear of going home saying it would happen again. School staff contacted law enforcement. This referral was screened in for investigation by CPS and closed with an unfounded finding for negligent treatment or maltreatment and an inconclusive finding for physical abuse. The family agreed to participate in services.

On October 11, 2007, school staff reported to CPS intake the deceased youth reported his stepmother hit him on the left side of the face, resulting in a bloody nose. The deceased youth said this occurred on the evening of October 10, 2007. He said she hit him with full force using an open hand. He said his parents were angry with him over his chores. He said his father called him names and said he no longer wanted him in the house. The youth added his father punched him in the abdomen with a closed fist. No injury was observed. He expressed concern that people did not believe him. This referral was screened in for investigation by CPS and closed with an inconclusive finding for negligent treatment or maltreatment and physical abuse.

On February 8, 2008, school staff reported to CPS intake the deceased youth refused to go home after school. The youth said that his dad twice slapped him on the face. He added

his stepmother also slapped him. The deceased youth had a shunt in his head and his parents have been told repeatedly by medical personnel and CPS not to hit him on the head. School authorities were concerned about the treatment of the boy (particularly the school psychologist) and felt there was a great deal of emotional abuse in the family. A police officer took the deceased youth home and interviewed the parents. A Family Preservation Service (FPS) provider who worked with the family was also present. The youth's father admitted slapping the youth. His stepmother denied slapping him and denied her husband slapped him. Law enforcement placed the youth in protective custody. The deputy felt the youth was not safe with his parents. The youth was placed with his grandparents and a dependency petition was filed on his behalf. He was later made a dependent of the court. This referral was screened in for investigation by CPS and closed with an inconclusive finding for physical abuse.

On February 19, 2008, school staff reported to CPS intake that the deceased youth's sister had ran away from home because her stepmother was mean to her and hit her. The sister ran away to a family friend's home. She was later picked up by her stepmother. School staff reported this child was not an accurate reporter. The school staff were concerned about her safety as her brother was recently removed from the home. This referral was screened as information only.

On July 16, 2008, a social worker from Oregon reported the grandparents of the deceased youth did not want him in their home any longer. He was returned to Washington State for placement in foster care. While in a local Division of Children and Family Services (DCFS) office he disclosed abuse in his father's home. He reported to CPS intake that his father was sexually abusing his 16-year-old sister. The deceased youth said he knew this occurred as his father called his sister into the bedroom and locked the door. He also reported seeing his sister pulling up her pants and getting ready to leave, while their father was still in the bedroom. The intake social worker could not report when this occurred as the deceased youth was developmentally delayed and did not know timeframes. This information was sent to law enforcement for consideration of a criminal investigation. CPS did not investigate as there were no disclosures by the sister. This referral was screened as information only.

On July 30, 2008, a licensing report was made on the foster home the deceased youth was placed in at the time of his death. His foster mother took him to the doctor after he reported chronic headaches and loss of appetite. During the appointment, it was decided he needed to go to the Oregon Health and Sciences University Emergency Room (OSHU). The foster parent transported him to OHSU. While there, he experienced leg weakness and breathing difficulties and was admitted to the hospital. On Monday, July 28, 2008, OSHU phoned DCFS requesting consent for a procedure placing a probe in his head/scalp to further diagnose what the problems may be related to. The father gave consent. The medical team could not get the deceased youth's heart stabilized to perform the procedure and he passed away on this date. An autopsy was performed on July 29, 2008. The licensing complaint

was closed as not valid. There were no concerns noted in the way the foster mother handled this situation. It was reported she even exceeded some of the prescribed protocols.

Issues and Recommendations

Issue: The foster parent notified the assigned social worker of the deceased youth's hospitalization, however, this was after hours and the message was left on the assigned social worker's telephone voice mail. The worker did not learn of his hospitalization until Monday morning when they came to work.

Recommendation: Send a message out to all foster parents in Region 6 letting them know that they need to make contact with after hours (Central Intake) when a child placed in their care is hospitalized after hours. Randy Roberts, the Division of Licensed Resource (DLR) Area Administrator agreed to send language to use in the foster parent newsletter to the Regional CPS Program Manager Sonja Heard.

Issue: The Division of Developmental Disabilities (DDD) and The Division of Children and Family Services (DCFS) had little communication regarding this common client.

Recommendation: Kelso DCFS will partner with and invite DDD staff to case staffings on common clients including inviting them to Family Team Meetings (FTM).

Issue: Using Barcode at intake to see if clients are open with other DSHS agencies.

Recommendation: Kelso Intake will conduct a barcode check on all intakes to see if the clients are open for services with other DSHS agencies.

Child Fatality Review #08-39
Region 1
Lincoln County

This two-month-old Caucasian female died of Sudden Unexplained Infant Death Syndrome (SUID).

Case Overview
On July 20, 2008, the 19-year-old mother of the deceased child called 911 to report her infant daughter was not breathing. An ambulance was dispatched and took the baby to the hospital. The cause of death is unknown, and there were no signs of abuse. The mother reported she checked on the baby at 6:00 a.m. and changed her diaper. Around noon, she checked on the child and found her not breathing. When the child arrived at the hospital, staff made attempts to revive her. They reported her prognosis was not good. Attempts to revive the child ceased. There were no signs of trauma or abuse evidenced.

The deceased child and her three-year-old sister were on in-home dependencies at the time of the fatality. The mother had a history of being homeless, but had an established residence at the time of her child's death. The mother had left her older daughter, then two-years-old with unsafe persons. The mother voluntarily placed this child with the maternal grandmother. A dependency petition was filed on behalf of this child after the mother was non-compliant with a service plan and was unable to secure permanent safe housing. When the deceased child was born in 2008 a dependency petition was also filed on her behalf. She remained in her mother's care on an in-home dependency. She was left with her mother to promote bonding and attachment. The mother complied with court ordered services including staying clean and sober. She maintained a stable household and consistently visited with her eldest daughter.

Referral History
On July 13, 2007, Child Protective Services (CPS) intake took a report from a probation officer who reported the deceased child's mother allowed a person with an outstanding DUI to transport her child. It was also alleged the mother allowed a register sex offender to be with her daughter, then two-years-old. The referrer said the mother left her daughter with anyone for extended periods of time. It was also alleged the mother traded a vehicle for marijuana. This referral was screened in for investigation by CPS and closed with an inconclusive finding. The mother signed a Voluntary Placement Agreement and the child was placed with the maternal grandmother. In October 2007, the department filed a dependency petition on behalf of this child.

On March 13, 2008, a social worker reported to CPS intake that the three-year-old sister of the deceased child was placed with her grandmother on a dependency due to the mother's lifestyle and substance abuse issues. The social worker said the mother was trying to have her daughter placed back with her. The mother was six months pregnant with the deceased

child. On March 12, 2008, the mother had a party with underage juveniles involved. The mother was drinking alcohol. The police went to the home and broke up the party. This referral was screened as information only.

On July 20, 2008, a law enforcement officer reported to CPS intake the death of this child, then seven-weeks-old. The child died at approximately 12:00 noon. The mother called 911 and reported her daughter was not breathing. The cause of death is unknown and there was no sign of abuse. Hospital staff attempted to revive the child, but her core temperature was 92.1 degrees indicating that she had been dead for some time. This referral was screened in for investigation by Child Protective Services and closed with a founded finding for negligent treatment or maltreatment. This investigation revealed the mother allowed the deceased child to be alone with unapproved caregivers prior to her death. The mother also slept the child on her stomach against the instructions of the Public Heath Nurse and Home Support Specialist.

Issues and Recommendations
Issue: Child Protective Services currently does not have statutory authority to access autopsy reports through the course of an investigation or on cases that Children's Administration was involved within 12 months of a child's death. This is a barrier for Children's Administration when investigating child abuse and neglect reports as well as facilitating a required child death review.

Recommendation: The review committee recommends an addition to RCW 68.50.105 for release of autopsies and post-mortem reports to Child Protective Services when services were provided to a family within 12 months of a child's death, the case is open at the time of death or when the death is a result of alleged child abuse or neglect.

Issue: Home Support Specialists employed by Children's Administration do not have any particular training requirements or access to position specific trainings.

Recommendation: Children's Administration should develop curriculum and provide standardized trainings to all Home Support Specialists. Curriculum should include at a minimum child development, current public health information such as safe sleep practices and recommended immunization schedules as well as safety and risk assessment.

Issue: Communication and decision making for case planning between the Assistant Attorney General's office and department social workers appears to need improvement.

Recommendation: An Area Administrator in Region 1 will contact the Assistant Attorney General supervisor to initiate a workgroup to discuss the communication and roles of the attorney general and social worker when developing case plans that may need legal interventions.

Child Fatality Review #08-40
Region 5
Pierce County

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

Case Overview

On July 27, 2008, the teen mother of twin infants, including the deceased child, spent the night at the home of the children's father. At the time of his son's death, the father was a teen dependent youth living with his grandmother. The father had an open case in the Tacoma Division of Children and Family Services (DCFS) office.

The mother reported that around 3:00 a.m. the morning of July 27, 2008, she cradled the deceased infant while both were sleeping on the floor. The mother placed the child on a couch cushion. She awoke about five hours later to find her son cold, stiff, and not breathing. When emergency responders arrived, the baby was intubated and taken to the hospital where he was pronounced dead at 9:14 that morning. The death of this infant did not appear to be the result of child abuse or neglect. There was no referral on this family prior to the death of this child. Both parents were minors.

The investigating detective from Pierce County Sheriff's Office stated there were seven adults living in the home. The teen parents were staying in one room and slept on the floor with their two babies on couch cushions. The detective stated there was a crib in the home that the mother could put the deceased child or his surviving twin in to sleep. She was advised that the twin should sleep in the crib with tighter fitting sheets, no stuffed animals, or thick bedding. The detective did not put the twin brother in protective custody. The detective considered this as an option if the autopsy indicated abuse or neglect as the cause of death. The detective noted that the infant appeared to have died from positional asphyxiation or SIDS.

The father was offered services for grief and loss issues. The parents declined. The father requested help with finishing his education. The assigned social worker identified various programs in which he could enroll to complete his high school education.

Referral History

On July 28, 2008, Child Protective Services (CPS) intake took a report from the Pierce County Medical Examiner's office reporting the death of this child. No cause of death was identified. The child's mother reported sleeping with him cradled in her arm, both lying a cushion on the floor. She found him cold and stiff shortly before 8:00 in the morning. This referral was screened out for investigation.

Issues and Recommendations

Issue: The teen mother of the deceased twin had no prior involvement with Children's Administration, either as a child or as a caretaker. The mother and her twin infants appear to have been residing with her parents, and occasionally visiting the home of the teen father.

The teen father was dependent and living in the home of his maternal grandmother. The teen mother and the twins were staying the night at the teen father's residence when the fatality incident occurred. The death of the infant does not appear to be the result of child abuse or neglect.

The assigned worker for the teen father's dependency case had in-person contacts with the teen in January, April, May and June 2008. At no time did the teen or anyone else indicate that the father had a pregnant girlfriend. It was not until the death of the infant in late July 2008 that the worker became aware of the situation. The father told the DCFS social worker and supervisor during the first post-fatality home visit that he had kept the information a secret. It is unknown when exactly family members knew of the pregnancy or the eventual birth of the twins. The teen father's Court Appointed Special Advocate (CASA) stated during a pre-review interview that he had no knowledge the teen had fathered twins until notification of the fatality incident. The CASA stated that based on his many years working with the family, such lack of forthcoming information was consistent with the family's customary behavior.

The father aged-out of care upon reaching the age of majority in December 2008.

In reviewing the available DCFS case file documentation and post-fatality information gathered from other sources, no issues relating to policy, procedures, or practices were identified that had any direct connection to the circumstances of the sudden unexpected death of the infant on July 27, 2008.

Recommendations: None

Issue: Several practice issues were noted and discussed during the child fatality review which had no apparent direct connection to the circumstances of the child death. These ancillary issues relate to casework activities for the teen father's dependency case and have no relationship to either the teen mother or the twins. These are included in this report solely as documentation of discussion occurring during the child fatality review.

(1) There was a period of time covering several months in 2007 when neither the Guardian Ad Litem (GAL) nor the assigned social worker could locate the teen father or his relative care provider. While the inability to meet the Health and Safety Monitoring Visit requirements was documented by the assigned social worker, efforts to locate the child appeared to be minimal. Best practice would suggest the need to be more active in

contacting relatives and others involved in trying to find the whereabouts of a missing dependent child, and to document such efforts. Procedures for responding to children missing in care are outlined in the Practices and Procedures Guide (Chapter 4000) and a revised Children Missing from Care Policy was made effective October 1, 2007.

(2) When the teen father went to live with his maternal grandmother, the placement change was not entered into CAMIS/GUI. At the time of dependency dismissal when the father turned 18-years-old, the CA database still showed placement with a maternal aunt. It is clear in case documentation, confirmed by an interview with the father's CASA, that the court was aware that the teen had moved to the residence of his grandmother, but this was not reflected in the CAMIS Placement Module.

(3) It is known that various extended family members either lived or had intermittent stays at the grandmother's residence while the father was residing there. The assigned worker did conduct visits to the home, but admittedly never inquired with either the teen or the grandmother as to who else might be living in the home.

(4) A review of case documentation showed that an intern conducted a Health and Safety Monitoring Visit in June 2008 a month prior to the death of the father's infant son at the home. The use of interns for such visits appears to have been a common practice in the Tacoma DCFS Indian Child Welfare/Child Welfare Family Services (ICW/CWFS) unit despite being clearly in violation of CA practice expectations (Practice and Procedures Guide Chapter 4000). This practice appears to have been contained to the particular unit and not pervasive to other child welfare units in the Tacoma DCFS office. Soon after an interim supervisor had assumed duties for the ICW unit in mid-2008, the use of interns for Health and Safety visits was discontinued and only the assigned social worker conducted such visits.

Recommendations: There are no recommendations. As indicated, none of the discussed policy and practice issues related to the circumstances of the death of the dependent teen father's infant. Policies and procedures are in place regarding the identified issues, and the deficits noted do not appear to be pervasive in the Tacoma DCFS office.

Action Taken: The Area Administrator whose duties include oversight of the ICW/CWFS unit in Tacoma has agreed to talk to the newly appointed supervisor for the unit to confirm that the Health and Safety Monitoring Visit policy is being followed, and that only assigned social workers are conducting the required visits.

Action Taken: The assigned social worker participated in the review and received feedback regarding practice deficits and areas for improved practice. The worker acknowledged that in the future she will inquire more in depth as to current household members and household visitors in relative (non-licensed) placement cases. Additionally

the worker indicated that in the future she would more fully document efforts to locate a child or family that has disappeared.

Recommendation: None

Child Fatality Review #08-41
Region 1
Spokane County

This four-month-old African American male died from unknown causes.

Case Overview
On July 27, 2008, the mother of the deceased child put him on his back to sleep on her bed. He was placed on top of the sheets and a blanket. He had a baby blanket placed over him. The child's mother reported that she checked on him shortly after midnight. At that time she noticed her son was on his stomach. She attempted to reposition him and noticed he was limp and not breathing. She called 911 and started resuscitation efforts until the ambulance arrived. The infant was transported to the hospital where he was pronounced deceased.

This child was born at home and later transported to a hospital. At the hospital, he tested positive for cocaine. During his brief life, the deceased child was diagnosed with Thrush, Influenza, and an ear infection. Medical records show he was within adequate growth parameters for weight and length.

The Spokane Division of Children and Family Services (DCFS) office had an open Child Protective Services (CPS) case at the time of the child's death. The assigned social worker observed the infant's sleep area. The social worker informed the deceased child's father to remove the clothes and stuffed animals in the crib.

The parents denied drug and alcohol abuse. Submitted urine samples for both parents were negative. Both parents agreed to complete drug/alcohol assessments and participate with Public Health Nursing services. The social worker monitored the parents' compliance with these requests. The child's mother followed through with the plan.

The assigned social worker was informed of the child's death on July 28, 2008. The Spokane Medical Examiner determined the cause of death to be undetermined. There were trace amounts of cocaine in the infant's blood stream. The manner of death was undetermined. The Medical Examiner explained the amount of cocaine to be a trace and was less than 0.01 mg per liter. This did not directly cause the child's death.

Referral History
On May 13, 2008, a hospital social worker reported to CPS intake that the deceased child was born at the family home on March 11, 2008. He was brought to the hospital after the birth and was in overall good health. The infant tested positive for cocaine while in the hospital. The referrer was told the mother tested positive for cocaine earlier in her pregnancy. This referral was screened as information only.

On July 7, 2008, a pediatric nurse reported to CPS intake that the mother brought the deceased child in for a well child exam and she fell asleep on the table. The doctor had no

concerns about the child. The mother did not keep a follow up appointment to treat the infant for thrush. The mother was in non-compliance with her welfare benefits as she did not show for a drug and alcohol assessment. The social worker had telephone call with Maternity Services at Holy Family where a referral was made for the mother. They stated there was no active case and no record of seeing her. This referral was screened in for investigation by CPS. The investigation was closed with a founded finding for negligent treatment or maltreatment.

On July 28, 2008, CPS intake received a report of the death of this infant. There was no allegation of abuse or neglect and the referral was screened as information only.

Issues and Recommendations

Issue: Child Protective Services currently does not have statutory authority to access autopsy reports through the course of an investigation or on cases that Children's Administration was involved within 12 months of a child's death. This is a barrier for Children's Administration when investigating child abuse and neglect reports as well as facilitating a required child death review.

Recommendation: The review committee recommends an addition to RCW 68.50.105 for release of autopsies and post-mortem reports to Child Protective Services when services were provided to a family within 12 months of the child's death, the case is open at the time of death or when the death is a result of alleged child abuse or neglect.

Issue: There is no documented shared decision making process reflected in the case file regarding the accepted high risk, emergent referral from July 7, 2008.

Recommendation: Social workers and supervisors should utilize some form of a shared decision making process when a high risk, emergent referral is received with extremely vulnerable victims. Examples are Family Team Decision making meetings, Child Protection Team meetings and supervisory review staffings.

Issue: Family case files are not automatically requested and consolidated when files and records exist in a different field office or in records retention.

Recommendation: Each office or region should have a process for automatically consolidating case files when more than one exists for a family.

Child Fatality Review #08-42
Region 3
Whatcom County

This 17-month-old Caucasian male died from asphyxiation.

Case Overview

On August 4, 2008, the child was asleep upstairs in his bedroom in the family home when the ventilator became disconnected and his father, asleep downstairs, failed to hear the alarm. By the time emergency personnel arrived, the child could not be revived. The cause of death was listed in Whatcom County Vital Records as: (a) vacterl syndrome (a series of birth defects affecting multiple parts of the body); (b) tracheostomy and ventilator dependent; (c) dextrocardia with small ventricular septecal (birth defect of the heart); (d) defect right hypoplastic lung. The child was medically fragile and only able to live at home with considerable medical assistance. The manner of death is listed as natural.

The deceased child was born with complex medical congenital issues and was hospitalized for the first ten months of his life. He underwent several surgeries and needed several more. He had a tracheotomy and was on a ventilator for his breathing issues. Medical staff instructed the parents that the deceased child was to be on a ventilator at all times.

On the night the deceased child passed away, his father spent the night with his children. The mother was away for the evening. The father fell asleep and failed to hear the ventilator alarm when it became disconnected, even though the alarm sounds frequently. The ventilator tube would often disconnect when the deceased child would reposition himself in bed. The father fell asleep downstairs, but the deceased child's bedroom was upstairs. A neighbor heard the alarm from the open window upstairs and called 911. The father awoke to emergency personnel knocking on the door. The deceased child was unable to be revived.

The Bellingham Division of Children and Family Services (DCFS) office had an open case on this family at the time of this child's death. The department had an extensive service plan with the family that included services to reduce the stress level in the home and to support and assist the mother in coordinating all the activities necessary in caring for the deceased child as well as the two pre-school girls. This plan was in effect until the child died.

Referral History

On March 26, 2008, a Children's Hospital social worker reported to Child Protective Services (CPS) intake with concerns about the care given to this medically fragile child who needed to be on a ventilator. Medical staff were concerned after the mother said that

on two occasions she had removed the deceased child from the ventilator for short periods, believing he was happier without it. The mother on two occasions left the home without taking the back-up ventilator with her. This should have been left with the child for emergency use in case the primary one should fail. This referral was screened in for investigation by CPS. The CPS investigator observed the mother was extremely stressed by the needs of her son and two daughters. She was agreeable to a service plan to help her manage the needs of her family. This CPS case was closed with an unfounded finding for negligent treatment or maltreatment.

On April 23, 2008, law enforcement reported to CPS intake that the mother was seen yelling at two small girls while struggling to get them into their car seats. There was no report of injuries. There was no allegation of abuse or neglect and the referral was screened as information only.

On July 29, 2008, a neighbor called CPS intake to report they heard screaming coming from the family's apartment and that one of the girls appeared to have an injury to her nose. This CPS case was closed with an unfounded finding for negligent treatment or maltreatment. The mother was offered Family Preservation Services (FPS) and help with child care to alleviate her stress.

Issues and Recommendations

Issue: The documentation in this case reflects the high quality of work done with the family in the Family Voluntary Services (FVS) unit. There was one social worker assigned to the case for the entire time it was open. She assiduously monitored the service plan developed with the family and exceeded performance expectations in her contacts with the family.

Recommendation: No specific recommendation was made to the above issue.

Recommendation: The safety plan written by the CPS investigator with the family after the initial CPS referral relied on the mother's agreement to follow medical advice regarding the deceased child and to contact certain people if she were feeling stressed. While this plan did not violate standard practice expectations, the methods for monitoring the plan were not specifically addressed. The office had, by the time this review was held, decided that the safety planning and its documentation could be further strengthened by additional training and made arrangements for this training.

Supervisory reviews were not consistently documented during the time the case was open. However, the unit supervisor stated to the review team that he and the assigned worker staffed the case frequently and that he was always aware of developments in the case as they occurred.

Child Fatality Review #08-43
Region 3
Whatcom County

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

Case Overview
On August 8, 2008, the grandmother of the deceased child found her lying face down with no pulse and no apparent injury. The grandmother performed CPR until paramedics arrived. The child had no pulse or respiration on arrival at the hospital emergency room. The Whatcom County Medical Examiner's autopsy report lists the cause of death as, "Sudden Unexplained Infant Death" and the manner as "undetermined."

The mother of the deceased child has three surviving children, all older than the deceased child. Children's Administration had no knowledge of the family prior to the one CPS referral in January 2008. The allegations in this referral did not rise to the level of abuse and did not screen in for investigation.

Child Protective Services intake became aware of the death of this infant through a newspaper obituary. The local hospital was contacted for additional information. The other children in the family had breathing issues and the deceased child was hospitalized at age one-month for choking difficulties. The exact cause of death was unknown. Medical personnel did not suspect child abuse/neglect of the children in this family.

Referral History
On January 8, 2008, an anonymous referrer reported to Child Protective Services (CPS) intake that the mother and children recently vacated a home in Whatcom County and when they left, the walls were covered in nicotine. The referrer also said the mother was seen slapping the children on the head. This referral was screened as information only.

Issues and Recommendations
Issue: None identified

Recommendation: None

Child Fatality Review #08-44
Region 4
King County

This four-month-old Caucasian female died from Sudden Infant Death Syndrome (SIDS) while in a licensed child care facility.

Case Overview
On August 5, 2008, the deceased child died on her first day at the child care provider's home. According to the Medical Examiner's report, the child care provider placed the child in a crib at 1:00 pm, checked on her a half hour later and the infant was unresponsive. The provider placed the deceased child on her stomach. The infant was found in that position. This death was certified as a SIDS fatality. The King County Medical Examiner reported no trauma and no foul play was suspected. However, the provider had the crib in an area of the house that had not been included in the license and had not followed Department of Early Learning (DEL) protocol by sleeping the infant directly on her back. The DEL Licensor wrote a compliance plan with the provider and helped her obtain bereavement support. The licensor's initial plan was to write a compliance agreement and issue a probationary license. However, due to the provider's lack of cooperation, the SIDS death and potential risk to other children, DEL summarily suspended the provider's license with intent to revoke.

Referral History
On January 8, 2008, a former child care employee contacted Child Protective Services (CPS) intake and reported a two-year-old child in the child care accidentally locked himself in a room. The child care director was away from the home. The child fell asleep. The referrer suggested calling 911 or a locksmith. The child care director/owner did not want to call 911 or pay for a locksmith. A locksmith was eventually called and opened the door. The child was in the room for over four hours. He slept most of the time. This referral was screened out for investigation by CPS. It was screened in as a licensing complaint investigation and closed with a Not Valid finding.

Issues and Recommendations
Issue: WAC 170-296-1060 mandates that child care providers follow the recommendations of the American Academy of Pediatrics (AAP) for putting infants down to sleep. Licensors address this with providers during in-home or in-center orientation as part of the licensing process. Specific SIDS training is not included in the contracted State Training and Registry System (STARS).

Recommendation: The Northwest Infant Survival Alliance - SIDS Foundation of Washington (NISA-SIDS) has a training curriculum specifically for child care providers. DEL should consider ways of making this available to providers.

Child Fatality Review #08-45
Region 4
King County

This three-month-old Caucasian female died from Sudden Infant Death Syndrome (SIDS) while in a licensed child care facility.

Case Overview
On October 10, 2008, the deceased child died at the child care provider's home. It was her first day in this provider's care. According to the Medical Examiner's report she was placed on her back in a bassinette in the living room around noon. This is when she was last known to be alive. At 1:15 p.m. she was found on her back and unresponsive; her lips were blue. The child care provider immediately called 911. She was pronounced deceased at 1:30 p.m. The medical examiner certified her death as a SIDS fatality. Two King County Sheriff's deputies responded to this fatality. Both reported there were no suspicious circumstances and no accidental circumstances with this child's death.

Referral History
There are no prior referrals on this child care provider or the biological family of this child.

Issues and Recommendations
Issue: Safe Sleep Information for Child Care Providers

Recommendation: Public Health will provide updated materials and brochures on Safe Sleep to the Department of Early Learning (DEL). A Public Health Nurse supervisor and an infant death specialist were both participants in this child fatality review.

Child Fatality Review #08-46
Region 4
King County

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

Case Overview
On August 7, 2008, the King County Medical Examiner reported the deceased child was placed in her crib at 9:30 a.m. The mother placed her on her back in her crib. Her mother checked on her at 10:30 a.m. and she was fine. The child was found unresponsive in her crib at 12:30 p.m. She was found on her back, but had moved nearly 180 degrees in the crib. There were multiple blankets underneath and on top of her. She was found with a blanket over her face and upper torso. The temperature of the room was 80 degrees and there was no air circulation. The death was certified as SIDS.

Referral History
On March 5, 1999, a report was made to Child Protective Services (CPS) intake that the parents use drugs around their baby. It was further alleged that parents partied all the time, used crank and stole to buy drugs. The family was residing in Yakima County. This referral was screened out for investigation.

On October 19, 2001, staff at a drug and alcohol treatment facility reported to Child Protective Services (CPS) the deceased child's mother left her children unattended in a bedroom, did not follow doctor recommendations, and could not recognize her children's feeding cues. Two of the children moved in with the mother's boyfriend. There was prior domestic violence between the mother and her boyfriend. All of these children are older siblings to the deceased child. This referral was accepted for investigation by CPS and closed with no finding.

On March 23, 2005, an anonymous referrer reported to CPS intake that the mother of the deceased child allowed a level three sex offender to frequent the family home. This referral was accepted for investigation by CPS and closed with an unfounded finding for negligent treatment or maltreatment.

On October 9, 2007, a school staff member reported to CPS intake that the then seven-year-old brother of the deceased child said he was slapped by his mother. The referrer observed a bruise on the tip of his ear lobe. The sibling talked about abuse of his siblings as well as domestic violence between his parents. This referral was accepted for investigation by CPS. The investigating social worker spoke with the seven-year-old and his two older siblings. The older brothers denied being abused and denied their seven-year-old brother was physically abused. The mother denied domestic violence in her current relationship with the deceased child's father. She admitted there was domestic violence in

her relationship with her sons' father. The CPS social worker documented observing the children and did not see any bruising on the seven-year-old or the two-year-old (the deceased child's brothers). The referral was investigated and closed with an unfounded finding for physical abuse and negligent treatment or maltreatment.

Issues and Recommendations

Issue: Some of the reports, most notably the referral dated March 5, 1999, taken in Region 2 were screened as Information Only. It appears that some could have been screened in for investigation.

Recommendation: Region 2 should review the screening decisions on reports concerning this family.

Issue: Sleep Safety: the infant was in a crib, but there were several blankets and it was a hot summer day.

Recommendation: The Regional CPS Program Manager will discuss this case with the King County Child Death Review team, under Public Health. The issue is to determine if this situation constitutes and unsafe sleeping arrangement and should be included in training provided by Public Health and safe sleep for infants.

Child Fatality Review #08-47

Region 5
Kitsap County

This 16-year-old Caucasian male died in a car accident.

Case Overview
On August 9, 2008, a van driven by an adult relative, rolled over and this youth was killed. This teenager was a dependent youth placed in the care of his aunt and uncle. He was placed in this home in November 2005. The family was on vacation in Wyoming in the Grand Teton National Park. The family was riding in a van driven by the father of the teenager's uncle. The deceased youth was seated in the rear of the van and was ejected from the vehicle at the time of the accident. He was pronounced dead at the scene by a responding doctor. The youth was not wearing a seat belt. One of the children involved in the accident stated that the driver of the van asked if everyone had their seat belts on, and the deceased youth said he did. The other six family members in the van were injured, but survived. National Park officials believe the tires of the minivan drifted onto the shoulder and the driver overcorrected, causing the vehicle to roll. The accident investigation report from Wyoming indicated no evidence of driver impairment.

Referral History
On August 19, 2008, the uncle of the deceased youth notified Child Protective Services (CPS) intake that the youth died in a car accident while on vacation in Wyoming. There was no allegation of negligence by the driver. The referral was screened as information only.

The mother of the deceased youth has an extensive history with the department dating from the mid-1980s to present. As primary caregiver or alleged perpetrator of child maltreatment, the mother has been reported to Washington State Children's Administration intake over forty times. Primarily the reported concerns have been neglect related (four investigations were founded), although on two occasions there were allegations of physical abuse (unfounded). Historically, there were repeated reports of dirty/unsanitary living conditions, poor hygiene maintained for her children, lack of adult supervision, leaving children with inappropriate caretakers, failure to protect, allowing access to drugs and drug paraphernalia, and a general failure to meet the needs of her children. Caretaker risk factors reported included use of illicit drugs, pre-natal drug use and positive drug screens at delivery, domestic violence, criminality, homelessness/instability of living situations, and lack of follow through with offered or recommended services.

Issues and Recommendations:
Issue: None identified.

Recommendation: None

Child Fatality Review #08-48
Region 3
Snohomish County

This 15-year-old Caucasian male died by hanging.

Case Overview
On August 23, 2008, the deceased youth was found hanging by a belt tied around his neck in his bedroom closet. This 15-year-old adopted youth was airlifted to Skagit Hospital then transferred to Children's Hospital where he was declared dead. It appeared that the youth was playing "the choking game." The choking game is an activity that involves intentional asphyxiation with a sort of noose to achieve a euphoric state.

This youth was adopted into this family at four years of age. He was doing well in the home prior to this incident. His adoptive parents reported he was alone in his room for no more than ten minutes before he was discovered by his sister, unconscious in his closet. The family just returned from a camping trip and the youth seemed happy. The parents do not believe their son's death by asphyxiation was purposeful (suicide). There was no specific information found during the investigation to determine that the youth intended to harm himself. Consequently, the manner of death was classified as undetermined. Grief counseling for the family was arranged through Children's Hospital.

Referral History
On December 14, 2002, a report was made to Child Protective Services (CPS) intake alleging the deceased youth's mother attempted to find an adoptive home for a 21-month-old child placed in her home without the consent of the child's social worker. The parents of the deceased youth are licensed foster parents. A licensing complaint investigation was conducted and no evidence was found that this occurred. The licensing complaint was closed with a not valid finding.

On April 15, 2002, a report was made to CPS intake regarding bruising seen on two foster children in the home of the deceased youth's parents. The five-month-old foster children had visible marks on their lower back and buttocks. The children's doctor confirmed the marks are Mongolian spots. This referral was screened out as a licensing referral and closed with a not valid finding.

On August 23, 2008, the King County Coroner reported to CPS intake the death of the deceased youth. The coroner reported this 15-year-old youth was found by his sister hanging from a closet rod. The youth was airlifted to Children's Hospital, where he was pronounced dead. The coroner speculated the youth was playing "the choking game." There is no indication the death was an intentional suicide. The referral was screened in for investigation by CPS and closed with an unfounded finding for negligent treatment or maltreatment.

Issues and Recommendations
Issue: None identified

Recommendation: None

Child Fatality Review #08-49
Region 1
Spokane County

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

Case Overview
On September 2, 2008, the deceased child was co-sleeping with both parents. At approximately 5:00 a.m. his mother awoke and noticed the child was cold to the touch. She called 911. The medical examiner determined the cause of death to be sudden unexplained infant death. No allegations of abuse or neglect were raised. The manner of death was determined to be natural/medical.

Referral History
On February 23, 2008 the grandmother of the deceased child called Child Protective Services (CPS) intake to report that the deceased child's father and older brother were missing. The grandmother reported she called CPS because this was the second time in a week that the father had his son in his care while the father was under the influence of drugs and marijuana. The grandmother felt the father was unable to parent his son properly. This referral was screened as information only.

Issues and Recommendations
Issue: None identified
Recommendation: None

Child Fatality Review #08-50
Region 2
Yakima County

This two-month-old Caucasian female died from viral pneumonia.

Case Overview
On September 4, 2008, this two-month-old infant died while in her mother's care. On two occasions, the child was taken to a hospital emergency room in the month prior to her death. She was living with her mother as her parents were separated and living apart. The mother was 20-years-old and her father 19-years-old at the time of the child's death.

After the deceased child was born, her mother was offered visiting nurse services as there was concern that she overfed her baby and did not properly mix the child's formula. The mother was provided safe sleep education. Eventually she refused any additional home health services.

On August 11, 2008, the mother brought the child into a hospital emergency room after the deceased child fell off a couch. The mother and baby were sleeping together at the time. The child was not injured and was not admitted to the hospital.

On September 2, 2008 the mother brought the child to the emergency room to be treated for vomiting and diarrhea. The deceased child was admitted for observation and was diagnosed with viral pneumonia and reflux. The following day the child was discharged as there was no respiratory distress and oxygen levels were good. The mother was instructed to use a wedge, a special pillow to allow the child to breathe better. The child died the morning of September 4, 2008.

Referral History
On August 22, 2008 the grandmother of the deceased child called Child Protective Services (CPS) intake to report the home in which the child resided was not clean or safe for a newborn baby. The grandmother described the home as having piles of garbage, newspapers, books, and clutter all over the house to the point that there is only a path through the house. The mother and newborn slept together on the couch because there is nowhere else for them to sleep. They were staying in a three bedroom home with four other adults. The only place to set the baby down in the home was on the floor or in the car seat. The mother said she wanted to move but did not have the resources. This referral was screened as information only.

Issues and Recommendations
Issue: The referral reported on August 22, 2008 was screened information only because there was no known address and did not meet the sufficiency screen.

Recommendation: As an additional resource, the intake worker can contact the visiting home health nurse database whenever they encounter a referral involving a newborn. If

there is an open case with the visiting nurse program, they can assist with address and contact information.

Child Fatality Review #08-51
Region 6
Cowlitz County

This 12-year-old Caucasian male died from acute internal bleeding.

Case Overview
On September 7, 2008, the mother of the deceased child called the police to report he died at approximately 2:30 pm. The deceased child was a hemophiliac and had been sick for 24 hours with diarrhea and vomiting. Hemophilia is a rare bleeding disorder that prevents the blood from clotting properly. Law Enforcement investigated the death and did not report abuse or neglect at the end of their investigation. The Coroner's report indicates the cause of death was acute intra-abdominal hemorrhage. The Coroner found no evidence of lethal injury.

The deceased child was autistic. He was non-verbal and in his mother's care his entire life. His older brother is also a hemophiliac and developmentally delayed. He lives with his biological father. The deceased child's mother has a history of addiction to pain killers. At the time of the child's death the department did not have an open case on the family. The mother had no other children in her care.

Referral History
On November 22, 1996, law enforcement called Child Protective Services (CPS) intake to report an altercation between the deceased child's mother and father. They reportedly drank too much and a domestic violence (DV) incident occurred. The mother had a black eye; the father admitted he hit his wife. The referrer said there was a prior DV incident between these parents in which the deceased child, then five-months-old, was between them. The deceased child's father was on probation for assault at the time. This referral was screened in for investigation by CPS and closed with a founded finding.

On June 22, 1998, a pediatrician called CPS intake to report bruising on the arm of the deceased child, then two-years-old. The mother said another child caused the injury, the doctor suspected the father. The doctor stated the mother was caring for this child appropriately and the injury was not serious, but the mother's story was not consistent with the injury. This case was screened in as a CPS low-risk case. A letter was sent to the child's mother addressing these concerns and an offer of services.

On June 30, 2001, a doctor called CPS intake and reported the deceased child, then five-years-old, was treated for a cut on his thumb while opening a pop can. The mother became belligerent with hospital staff and left the hospital prior to her son being treated for his injury. The mother complained she waited for over two hours and got frustrated. The child was later observed and appeared fine. This referral was screened in for investigation and closed with an unfounded finding for negligent treatment or maltreatment.

On December 29, 2003, a doctor called CPS intake and reported that the deceased child's mother used her son's medical and physical diagnoses to illegally obtain pain medications for herself. The mother called the doctor's office to report her 17-year-old son broke his leg and needed pain medication. The doctor knew she did not have a 17-year-old son. The doctor was concerned that the mother did not follow up with medical care that was essential for the deceased child's well being. This referral was screened in for investigation and closed with an unfounded finding for negligent treatment or maltreatment.

On April 19, 2004, medical professionals called CPS intake to report the deceased child's mother failed to keep medical appointments for him regarding his hemophilia condition. The hospital did not see or evaluate the deceased child in over one year. The mother continually tried to obtain pain medication for the deceased child for her own personal use. Several doctors and pharmacies refused to write or fill prescriptions for the mother. This referral was screened in for investigation and closed with an unfounded finding for negligent treatment or maltreatment.

On June 21, 2005, a doctor called CPS intake to report the deceased child's mother tried to solicit medication through a clinic. The doctor also expressed concern that the deceased child was not seen by a doctor for over one year. This referral was screened in for investigation and closed with an unfounded finding for negligent treatment or maltreatment.

On December 15, 2005, a doctor called CPS intake to report the deceased child's was treated on December 13, 2005 for a swollen right ankle. The doctor determined the child needed care at a hospital emergency room and told the mother to take him immediately. The doctor followed up with the hospital and found the mother never took her son for follow up treatment. The doctor said the child had a serious medical problem leading to an infection. The investigation revealed the child did not have an infection and the mother called and consulted with the child's hemophilia clinic. This referral was screened in for investigation and closed with an unfounded finding for negligent treatment or maltreatment.

On May 11, 2006, school staff called CPS intake to report the deceased child's mother was not at the bus stop to get him when the bus dropped him off. School staff called the police. This referral was screened out for investigation.

On February 9, 2007, school staff called CPS intake to report the deceased child's mother was not home when her son was dropped off. This was a recurrent problem for school staff. This referral was screened out for investigation.

On April 4, 2007, school staff called CPS intake to report the mom of the deceased child was sought by police for theft. The mom and the deceased child lived alone in Longview. This referral was screened out for investigation.

On October 17, 2007, law enforcement called CPS intake and reported a family member said the mother was not taking care of the deceased child and was using drugs. It was alleged the deceased child was locked in his bedroom as a form of supervision. It was further alleged there was inadequate food in the home. Police went to the home and reported the deceased child appeared in good health. It was noted that the home needed to be cleaned and there was minimal food in the refrigerator. Police made contact with the deceased child's teacher who said the child was not a victim of abuse or neglect. He appeared to get enough food. This referral was screened out for investigation.

On February 12, 2008, a neighbor called CPS intake to report an apartment vacated by the deceased child and his mother smelled of feces and urine. The referrer saw the mother remove six bags of garbage from the apartment. The referrer said the deceased child mostly ate cereal. It was alleged that the mother kept the deceased child in his a room. The referrer reported finding a note written by the mother in which she said she wanted to quit doing drugs so she could spend more time with her four children (she only had the deceased child in her custody). School staff were called to verify the allegations reported. School personnel said the deceased child frequently came to school in foul-smelling clothes that had feces and urine on them. School staff believed the deceased child was left home alone a lot. The deceased child was frequently tardy. This referral was screened out for investigation.

On May 9, 2008, school personnel reported to CPS intake the deceased child, then 12-years-old, came to school with feces on his body and clothing. The referrer showered him and got him into clean clothes. This was the second time the referrer had to do this. The referrer heard from other school staff that this has been a recurrent problem. This referral was screened out for investigation.

On June 23, 2008, CPS intake received a report that the mother of the deceased child, then 12-years-old, would often yell and scream at him. She hit him on his hands when he misbehaved. The referrer did not report any markings or injuries. It was reported that the mother was unstable and moved a lot. She sold his diapers and screamed at him for having accidents in his pants. This referral was screened out for investigation.

On July 23, 2008, school personnel reported to CPS intake that the deceased child came to school dirty everyday. School staff had to shower him daily because he still had feces on him from the day before. The referrer said the deceased child was developmentally delayed and wore pull-ups because he was not potty trained. The referent also alleged the child came to school hungry everyday. This referral was screened out for investigation.

On August 29, 2008, school personnel reported to CPS intake that the deceased child arrived at school with urine soaked pants. He had feces on his shirt. He was not wearing a pull up that he needs because he cannot control his bathroom functions. He had a rash around his buttocks and genitals. His mother sent his medications to school in a Ziploc

baggy. There were needles poking out of the baggy. The school nurse could not use the syringes because they were dirty. This referral was screened out for investigation by CPS.

On September 7, 2008, law enforcement called CPS intake and reported the deceased child died on this date. Detectives from the Longview Police Department interviewed the mother and reported no abuse or neglect. The mother said her son had been sick for the last 24 hours with diarrhea and vomiting. This referral was screened out for investigation.

Issues and Recommendations

Issue: Screening of new referrals at intake. In reviewing the 10 most recent intakes all were screened out. The review team agreed with eight of the screening decisions made at intake and disagreed with two of the screening decisions made at intake.

Recommendation: The team agreed that based on the information received at intake on July 23, 2008 and August 29, 2008 the intakes should have screened in. Prior to this fatality review a team of four regional staff reviewed 232 Information Only intakes taken by the Kelso office. Of those intakes reviewed the team agreed with 83% (193 intake) of the intake decisions made by the Kelso office. The team also reviewed 26 high standard intakes the team agreed with 96% (25 intakes) of the intake decisions made by the Kelso office. A meeting was held with the Intake supervisor and the Area Administrator after the review was conducted to debrief the findings of the review team. The intake supervisor will scrutinize information only screening decision more closely.

Child Fatality Review #08-52
Region 6
Lewis County

This 16-month-old Caucasian female died after being run over by a car.

Case Overview
On September 13, 2008, the parents of this child purchased a treadmill and had it delivered to their home. The driver of the delivery truck backed out of the driveway, did not see the child, and ran over her. The mother reported the family was loading the treadmill into the home when the driver backed up suddenly striking the child. The child was airlifted to Harborview from Centralia Providence Hospital. She was pronounced dead due to a blunt force injury to the head, ruled accidental by the Medical Examiner.

The Washington State Patrol, in addition to Child Protective Services (CPS), conducted an investigation in this fatality. The child was run over approximately 15 feet from the house. The driveway was considered part of the yard. It was deemed not unreasonable to allow a child to play in this area with an open door. CPS and law enforcement determined the fatality was an accidental death. The child appeared to be in a common play area and was run over. The door of the home was open and the mother was in the doorway.

The mother has a lengthy CPS history with findings of neglect. While concerning, and a risk factor, this history did not contribute to the accidental death of the child.

Referral History
This family has an extensive history with Children's Administration (CA). The deceased child is the third child born to this mother. In December 2003, the Department filed a dependency petition on the two older children (sibling of the deceased child). The children were placed in foster care where they remained until October 2004 at which time they returned to their parents' care on an in-home dependency. The dependency was dismissed in April 2005 after the parents successfully completed the recommendations of the department and court.

There were 18 referrals to Child Protective Services (CPS) Intake prior to the older children returning to their parents' care. Three referrals called in to CPS intake in 2003 were closed with a founded finding. One resulted in the assigned social worker filing a dependency petition and the children being placed in foster care. These referrals alleged the mother was suicidal and threatened to harm herself and her children. One referral alleged sexual abuse of the older daughter by the mother's former boyfriend. CPS and law enforcement investigated and no charges were filed and the referral closed with an inconclusive finding. Another referral was closed founded for negligent treatment or maltreatment as the mother knowingly left her daughter with the man the mother accused of molesting her. There were three prior referrals from 1999 to 2002 that alleged negligent

supervision of the children by the mother. Each of these referrals were closed with an unfounded finding.

On July 12, 2005, a relative called CPS intake to report the mother was neglecting her two children, then ages four and six. The mother took the children to homes where illicit drugs were used. The mother's boyfriend was an active addict/alcoholic and the mother allowed the children to spend the night with him. The mother left the youngest child alone in the car. This referral was screened in for investigation and closed with an unfounded finding for negligent treatment or maltreatment.

On April 3, 2007, a relative called CPS intake and reported the mother had a long history of mental health issues. The referrer stated the mother displayed manic behavior and was not taking care of the children. The mother was pregnant with the deceased child. It was alleged the house was cluttered. This referral was screened out for investigation.

On July 12, 2007, a therapist called CPS intake and reported the six-year-old brother of the deceased child said his mother hit and kicked him in the stomach and the back. He said he was slapped on the face on a daily basis. The child said his mother picked him up and threw him to the floor. He had no bruising. The brother said he and his sister lock themselves in the sister's bedroom to get away from their mother. The child alleged his mother kicked him in the stomach and he was taken to a doctor after this incident. He said he had a bruise on his stomach but the doctor did not ask him about it. The child said his mother lies in bed all day. This referral was screened as an Alternate Response System (ARS) referral. The child was interviewed by a CPS social worker and law enforcement. No criminal charges were filed against the mother.

On August 16, 2007, a neighbor called CPS intake to report the mother did not have her six-year-old son in a car seat or seat belt. The referrer mentioned this to the mother and she responded that her son was safe without being in a seat belt. The deceased child, then three-months-old, smelled of feces and needed a diaper change. The mother responded her eight-year-old daughter was the one who regularly cared for the baby. The older daughter was away visiting relatives at that time. The referrer said the baby received less attention to her daily needs with the sister gone. The referrer added the deceased child seemed listless and appeared to have lost weight. The referrer was told the mother and kids were homeless living in a van. The infant's doctor was contacted and had no concerns. The infant appeared healthy. This referral was screened in for investigation and closed with an unfounded finding for negligent treatment or maltreatment.

On August 31, 2007, a relative called CPS intake to report the eight-year-old sister of the deceased child had a rash on her face and her eyes were swollen. This child was taken to a hospital emergency room and was diagnosed with impetigo. The referrer reported this child had pink eye, flea bites, and visible bruises. The child said the bruises caused by her

younger brother. This referral was screened in for investigation and closed with an unfounded finding for negligent treatment or maltreatment

On May 9, 2008, a police officer called CPS intake and requested a social worker meet him at a local elementary school to interview the seven–year-old brother of the deceased child. The brother wrote a note to his mother disclosing sexual abuse by his father. The mother knew of this information but did not report this to law enforcement. The child lived with his father. This referral was screened in for investigation and closed with an unfounded finding for negligent treatment or maltreatment and sexual abuse.

On September 13, 2008, law enforcement called CPS intake to report the death of the deceased child. This referral was screened in for investigation and closed with an unfounded finding for negligent treatment or maltreatment.

Issues and Recommendations
Issue: Screening of new referrals at intake.

Recommendation: The review team felt that the department had provided this family with appropriate resources prior to the death of this child and during the dependency of the two older siblings. The team reviewed and discussed the decision making on the referral dated July 12, 2007 which was screened in with a low risk standard. While the team agreed with the screen in decision they did not agree with the standard of investigation and felt that a high standard of investigation was warranted. It should be noted however, that the assigned worker did have face to face contact with the child and parents, which is beyond the policy requirements for a low standard investigation. In essence, the assigned worker completed some of the high standard requirements for an investigation on a referral that was screened for a low standard investigation.

Child Fatality Review #08-53
Region 5
Pierce County

This 13-year-old African American male committed suicide.

Case Overview
On September 18, 2008, this 13-year-old youth fatally shot himself in the head with his father's pistol. The incident occurred at the family residence and family members were home at the time of the incident. Family members called 911. Emergency medics and law enforcement went to the home and transported the youth to a local hospital emergency room. He was resuscitated several times. Ultimately he was declared dead.

The gun used was reportedly stored separately from the bullets. The family could describe no behavioral indicators of suicide or any precipitating event that would indicate their son intended to harm himself. The child did not leave a suicide note. The death was declared a suicide by the Pierce County Medical Examiner.

Referral History
On April 9, 2002, staff at a local hospital called CPS intake to report a gunshot wound to the ear of the then three-year-old sister of the deceased youth. Law enforcement responded to the report of an accidental gun shot wound. The father had purchased two guns out of concern for possible assault of his wife and children. He told police he purchased the guns for protection. The deceased youth's mother kept her .22 caliber gun in her pocket. When she returned from the store she put her jacket, with the gun in the pocket, on the back of a chair. She left the room and shortly heard a gunshot. She found her daughter with a gunshot wound to her ear. Law enforcement described the mother as distraught about the injury to her daughter. Law enforcement said the child's injury was not life threatening. She was sent to a local hospital for reconstructive surgery of her ear. The child was not placed in protective custody. This referral was screened in for investigation and closed with a founded finding for negligent treatment or maltreatment.

On July 15, 2008, a juvenile probation officer reported to CPS intake that the deceased youth reported a typical form of punishment in his home was to be hit in the stomach. He added that he is hit hard enough to double over. The deceased youth said he expected to be hit for misbehaving. The child had no visible injuries. The father denied hitting his son. The family was offered Family Reconciliation Services (FRS), but declined the service. This referral was screened in for investigation and closed with an unfounded finding for physical abuse.

On November 24, 2008, law enforcement contacted CPS intake to report the suicide of this 13-year-old youth by a self-inflicted gunshot wound. Law enforcement reported this incident occurred on September 18, 2008. Law enforcement reported no concerns about

abuse of neglect based on their investigation of the incident. This referral was screened out for investigation.

Issues and Recommendations
Issue: Intake referrals dated April 9, 2002 and July 15, 2008.

The report to CPS in 2002 regarding a three year old girl being seen at a local emergency room for a non-life threatening accidental gunshot to the ear was initially designated for CPS investigation (non-emergent response). Two days later the intake was "downgraded" by a CPS Supervisor and designated for alternative intervention and sent to the Alternative Response System (ARS), apparently based on the referent having referred to the incident as being accidental and on the fact that local law enforcement had already become involved. Four days later, upon further review and consensus building, the intake was re-screened for a CPS investigation. The original decision at intake appears to have been correct, as supported by the fact that the report was later re-screened for a high standard investigation. The delay in correct assignment caused a delay in contact with the alleged child and her parents. However, contact with victim was still within 10 working days of the date of the referral which was CA policy at the time. Policy regarding face to face contact with alleged victims was revised in April 2005 and now requires such contact to be within 24 hours (for emergent response intakes) or 72 hours (non-emergent response intakes).

The physical abuse intake six years later (July 2008) was screened in for investigation. The review panel agreed with the intake decision for assignment to CPS for investigation based on the child's statement to a mandated reporter of having been punched in the stomach by his father.

Recommendation: None. Current Children's Administration policy and practice is less flexible than in 2002 as to the ability of CPS supervisors to "downgrade" intakes without shared decision making.

Issue: Investigation of the July 2008 referral [prior to fatality incident in September 2008] Overall the CPS worker appears to have met basic practice expectations for conducting investigations. Timeframe requirements were generally met for both investigative activities and documentation. There were no significant deficits noted regarding practice. Minor practice deficits and noted areas for improved practice (e.g., best practice) were discussed during the child fatality review and are included below as documentation of the discussion.

Given that all children in the family were home schooled, interviewing options were limited. An attempted unannounced home visit was conducted within 24 hours of the intake. The family was not at home likely due to the mother having just given birth. The worker was not able to make another attempt within the 72 hour policy requirements, and an extension for face-to-face contact was granted. The CPS investigator was able to contact the father by phone and address the allegations. This occurred several days before

interviewing the child. Normally best practice is to interview the alleged victim before or soon after interviewing subjects/caretakers when possible.

The CPS investigator interviewed the alleged victim at the family home. The social worker's documentation did not indicate if the interview was conducted outside the purview of the parents. However, during the child fatality review, the worker recalled that she had interviewed the boy privately at the home. While the Global Appraisal of Individual Needs-Short Screener (GAIN-SS) was available to use with the deceased youth there were no indications of substance abuse or mental health issues which might have suggested the need to administer the GAIN screening tool to the child. It is unknown as to how the youth would have answered questions regarding mental health or suicidal ideation at that time.

The CPS investigator was in process of interviewing the deceased youth's mother (outside the presence of the husband), when the youth's father interrupted the interview. It is unknown if the interruption was unintended or intended. The worker was not able to specifically address with the mother the concerns about her husband's alleged physical abuse to their son, although the mother did speak to her concerns about her son and his running away.

The worker did not conduct any sibling interviews. While policy only requires interviews be conducted with identified victims, best practice suggests that, where possible, interviews of siblings also occur. There were several siblings in the home (ages 7, 10, 14) who might have been interviewed regarding the allegations of physical abuse to their brother.

Although the previous CPS involvement (2002) involved a firearm injury to a child in the family, the worker did not inquire as to the current (2008) status of any guns in the home. In a pre-review interview the worker admitted that such inquiry had not crossed her mind during her investigation. The panel was divided as to whether or not it would be reasonably expected for the worker to have inquired as to guns currently in the home, given that the prior gun incident occurred six years prior. It was noted that information gathered by law enforcement during its fatality investigation in September 2008 indicated that the parents had attempted reasonable safe firearm storage in the home prior to their son's suicide and there was no evidence of usual behavioral indicators of suicidal ideation.

When interviewed during the child fatality review, the CPS worker indicated that there were cultural, religious, and family values issues that appeared to create barriers to routine investigative process. This included indicators of patriarchal control in the family, isolation of the family (no relatives in the area, minimal neighborhood/community involvement, home schooled children), and limited services available to the family which would accommodate the family's religions beliefs.

Recommendation: None.
Action Taken: Pierce East Area Administrator will attempt to schedule for summer 2009 training similar to the "CPS Summer Series Training" held in Region 5 in 2008. The training will function as both a re-fresher for veteran workers and new training for inexperienced workers. Topics would include practice considerations for conducting CPS investigations, serious injuries and child abuse, and interviewing subjects.

Action Taken: The CPS supervisor participated in the child fatality review and acknowledged areas in the worker's practice that could be improved. The CPS supervisor will discuss with the CPS investigator, as part of normal clinical supervision, strategies and resources available for dealing with cultural and religious issues that may present barriers to fulfilling investigative expectations.

Action Taken: The worker participated in the review process, and received feedback regarding good practice as well as areas where practice could be improved.

Child Fatality Review #08-54
Region 5
Kitsap County

This two-year-old Caucasian male died from diphenhydramine (Benadryl) intoxication.

Case Overview
On September 21, 2008, Children's Administration intake was contacted about this child fatality. The law enforcement report indicated that the two-year-old was found dead in the morning. He was lying face down with his head on a pillow. His mother called 911 and medics responded. Medics found the mother's boyfriend doing CPR on the child in his bedroom. After examining the child, medics determined that he had been deceased for some period time and that attempts to resuscitate would be futile. The mother reported her son had autistic-like behaviors. In addition, he had asthma symptoms and also had surgery at three-months-old for Cranial Synostosis, a condition in which the skull plates are fused together. In addition, the mother said all her children suffered from self injurious behavior and had trouble sleeping. To aide the children with their sleeping problem, the mother and her boyfriend often gave the children a combination of Benedryl and cough syrup. The mother said this was advised by her pediatrician.

The night that the child died, they used this combination on him. The Coroner reported both the mother and her boyfriend separately said they gave the deceased child a dose of Benedryl. The mother did first and then the boyfriend approximately two hours later. The boyfriend was interviewed by the Child Protective Services (CPS) social worker and denied giving the child a second dose of Benedryl. According to the Kitsap County Medical Examiner's autopsy results, the deceased child's cause of death is acute diphenhydramine intoxication. The manner of death is classified as an accident.

This family moved to Washington State in July 2006 from Texas. The mother said she moved to get away from an abusive husband. The mother moved to the Tri-Cities area with her three young boys all of whom are believed to be diagnosed with Autism or Autistic like behavior. The family moved to Kitsap County in June of 2008.

Referral History
On October 9, 2006, a relative called CPS intake to report the home was dirty with trash, old food, and there were dirty diapers all over the house. The children ranged from nine-months-old to four-years-old and all three wore diapers. The home smelled bad. The referrer felt the mother needed help cleaning her home. This referral was screened out for investigation.

On November 9, 2006, a child care staff reported to CPS intake that the deceased child and his then two-year-old brother had significant rashes on their thighs and rectal areas. The children came to child care hungry. This referral was screened in for investigation and closed with an unfounded finding for negligent treatment or maltreatment.

On March 23, 2007, it was reported to CPS intake that the then two-year-old brother of the deceased child walked away from the family home. Law enforcement was contacted and searched for the child. Police officers estimated that he was gone from home 30 minutes before he was found and returned home. The mother had many services in place to help her parent her high-needs children. This referral was screened in for investigation and closed with an inconclusive finding for negligent treatment or maltreatment.

On October 2, 2007, school staff reported the then three-year-old brother of the deceased child came to pre-school with poor hygiene. He had dried feces on his buttocks and regularly came to school with dirty clothes. He also had a rash on his face and stomach. This referral was screened in for investigation and closed with an unfounded finding for negligent treatment or maltreatment.

On September 21, 2008, law enforcement reported to CPS intake the death of this child. The mother and her boyfriend found the child dead, in the morning. He was lying face down, with his head in his pillow. Police said there was no furniture in the boys' room and the boys slept on the floor. The bedroom was dirty with feces on the wall. The referrer stated that the two older boys have been diagnosed with autism.

The mother told law enforcement she gave each boy Benadryl and cough syrup to help them sleep. The mother told the referrer this was advised by her pediatrician. The investigating CPS social worker contacted the child's doctor. He stated that no one on his staff gave the mother advice about medications. However, he reported it is possible she called after hours and could have spoken to an on-call doctor who advised her. The doctor stated that cough syrup and Benedryl would not cause problems. He said it was highly unlikely a medication overdose caused the death of this child. He saw the child the week prior at a well child check. The child appeared Autistic. The doctor described the mother as a concerned, dutiful mother and this was a tragic death. This referral was screened in for investigation and closed with an unfounded finding for negligent treatment or maltreatment.

Issues and Recommendations
Issue: Request for case file transfer from the Richland office to the Bremerton office did not occur.

Recommendation: Need to adhere to policy when receiving requests for Case Transfers: "The transfer must be made within seven working days after receipt of the request with a notation in the record as to any additional material to be forwarded and the specific date it will be forwarded".