Report to the Legislature

Quarterly Child Fatality Report

RCW 74.13.640

April - June 2010

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Children's Administration Quarterly Child Fatality Report

Executive Summary

This is the Quarterly Child Fatality Report for April through June 2010 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 14 completed fatality reviews of fatalities that occurred in 2009 and nine completed reviews of fatalities that occurred in 2010. All 23 of the child fatalities were reviewed by a regional Child Fatality Review Team.

The reviews in this quarterly report include fatalities from each of the six regions.

Region	Number of Reports
1	3
2	3
3	2
4	10
5	4
6	1
Total Fatalities Reviewed During 2nd Quarter, 2010	23

Child Fatality Reviews are conducted when children die unexpectedly from any cause and manner 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 from a natural cause or accidental), 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 on the following page provides the number of fatalities reported to CA, and the number of reviews completed and pending for calendar year 2010. 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 Year 2010			
Year	Total Fatalities Reported to Date Requiring a Review	Completed Fatality Reviews	Pending Fatality Reviews
2010	30	8	21

The numbering of the Child Fatality Reviews in this report begins with number 09-44. This indicates the fatality occurred in 2009 and is the forty-fourth report completed during 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.

Notable Findings

Based on the data collected and analyzed from the 23 deaths reviewed between April and June 2010, the following were notable findings:

- Children three months or younger accounted for approximately 30% (7) of the 23 fatalities reviewed, and children less than a year old accounted for a little less than half (48%) of the total deaths. The next largest group was that of teenagers, ages 13-16, representing 22% (5) of the child fatalities reviewed as shown in Table 1.1 on page 6.
- Of the 23 child fatalities reviewed, 57% (13) were females and 43% (10) were males.
- Of the 23 child fatalities reviewed, 61% (14) of the children were white, 26% (6) were African American, 9% (2) were Native American and 4% (1) was unknown.
- Natural and accidental deaths, as classified by the medical examiner or coroner, accounted for approximately 57% (13) of the total deaths. The manner of death of the remaining cases was as follows: 4 (17%) were due to unknown/undetermined causes, 4 (17%) were the result of homicides, and 2 (9%) were the result of suicide.
- Sudden Infant Death Syndrome (SIDS) or Sudden Unexplained Infant Death (SUID) was listed as the cause of death in 28% (7) of the child deaths reviewed.
- All of the infant deaths attributed to SIDS or SUID with the exception of one included an unsafe sleep environment such as an adult bed or couch. Co-sleeping with an adult or sibling or animal was found in 43% (3) of the infant deaths reviewed.

- One infant death not classified as SIDS or SUID, was declared an accident in manner of death, with positional asphyxia as the cause of death, due to suffocation while co-sleeping with a relative. The child had been placed on a Native American baby board when put into bed, and during the night, the infant rolled over face down into a blanket.
- Of the 23 child fatalities reviewed, all but one (4%) had prior contact with Children's Administration (CA). Ninety-six percent of the child fatalities reviewed had at least one prior intake. Forty-eight percent had five or more intakes prior to the fatality.
- One child fatality occurred in a licensed facility (child care).

Due to the small sample of cases reviewed, no statistical analysis was conducted to determine relationships between variables.

Table 1.1

2nd Quarter 2010, Child Fatalities by Age and Gender						
Age	**Number of Males**	**% of Males**	**Number of Females**	**% of Females**	**Age Totals**	**% of Total**
<1	5	50%	6	46%	11	48%
1-3 Years	1	10%	3	23%	4	17%
4-6 Years	-	-	-	-	-	-
7-12 Years	3	30%	-	-	3	13%
13-16 Years	1	10%	4	31%	5	22%
17-18 Years	-	-	-	-	-	-
Totals	10	100%	13	100%	23	100%

N=23 Total number of child fatalities for the quarter.

Table 1.2

2nd Quarter 2010, Child Fatalities by Race	
Black or African American	6
Native American	2
Asian/Pacific Islander	-
Hispanic	1
White	15
Unknown	1
Totals*	**25**

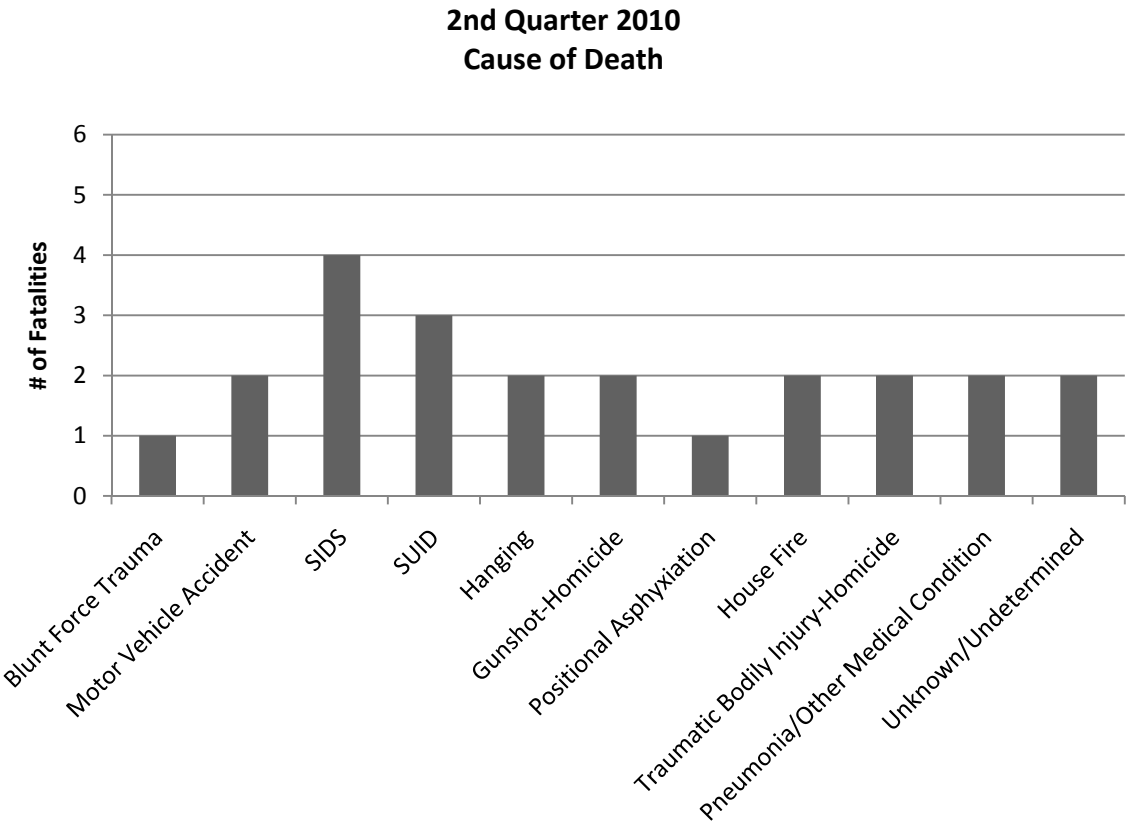
*Some children are in more than one category.

Table 1.3

2nd Quarter 2010, Child Fatalities by Manner of Death	
Accident	6
Homicide (by abuse)	2
Homicide (3rd party)	2
Natural/Medical	7
Suicide	2
Unknown/Undetermined	4

N=23 Total number of child fatalities for the quarter.

Table 1.4



N=23 Total number of child fatalities for the quarter.

Table 1.5

2nd Quarter 2010, Number of Reviewed Fatalities by Prior Intakes						
Manner of Death	**0 Prior Intakes**	**1-4 Prior Intakes**	**5-9 Prior Intakes**	**10-14 Prior Intakes**	**15-24 Prior Intakes**	**25+ Prior Intakes**
Accident	-	-	5	-	1	-
Homicide (by abuse)	-	1	-	-	-	-
Homicide (3rd party)	-	1	1	-	-	-
Natural/Medical	-	5	1			-
Suicide	-	-	-	2	-	-
Unknown/ Undetermined	1	5	1	-	-	-

N=23 Total number of child fatalities for the quarter.

Summary of the Recommendations

Of the 23 child fatalities reviewed between April and June 2010, 20 (83%) had issues and recommendations identified during the child fatality review process. Issues and recommendations from fatality reviews impact policy, practice and systems associated with CA. At the conclusion of every case receiving a full team review, the team decides whether any recommendations should result from the fatality review. In most instances where the death was categorized as being preventable, some recommendations were made.

Issues and recommendations that were cited during the child fatality reviews completed during the quarter fell into the following categories:

2nd Quarter 2010, Issues & Recommendations	
Contract issues	1
Policy issues	-
Practice issues	29
Quality social work	9
System issues	15
Total	**54**

Recommendations about safe sleep education and appropriate sleeping arrangements for children were made in five cases (22% of child deaths during the quarter). In those instances, the team determined that sleeping arrangements were possibly, and sometimes very clearly, a factor in the child's death. Specifically, the recommendations about sleeping

conditions fell into the areas of increasing caregiver education and knowledge of specific safe sleep practices for children and the importance of infants sleeping in cribs.

Child Fatality Review #09-44
Region 4
King County

This 11-year-old African American male died from multiple injuries after he was hit by a car.

Case Overview
On October 10, 2009, this 11-year-old autistic male ran from his mother's home. His mother called 911 to report his absence. The Washington State Patrol (WSP) reported receiving multiple calls from witnesses reporting the child was seen on or near State Route 99. A WSP officer was dispatched to find him.

The child was hit by a car at 4:45 p.m. near northbound State Route 599 and northbound State Route 99. The WSP report documents the deceased child ran to 116th off of State Route 99 and went over the guardrail and entered the southbound lanes of State Route 99. He crossed the lanes to the median, crossed over the guardrail and entered the northbound lanes of State Route 99.

The driver of a pickup truck came around a corner and saw the child and tried to avoid him, but could not. The vehicle struck him and the impact threw him forty to fifty feet. The child landed in the grassy shoulder.

The WSP Officer who was called to search for the child was the first on the scene and provided rescue breathing until the aid car arrived. The child sustained serious injuries, but was still alive when he arrived at Harborview Medical Center. He died from his injuries a day later on October 11, 2009.

The King County Medical Examiner reported the child died as the result of a pedestrian collision with a pickup truck. He sustained multiple fractures, a subdural hematoma, and blunt force injury of the head, torso and extremities. The manner of death is listed as accidental.

Children’s Administration (CA) had an open Child Protective Services (CPS) case on the family of the now deceased child at the time of his death. CA received a report in September 2009 that the child had escaped from his home late at night; he was found and returned home by a police officer. CA opened a case at the time, and this case was still open at the time of the accident.

Intake History
On September 15, 2000, Child Protective Services (CPS) intake received a report of domestic violence between the child’s parents. The mother and father were never married.

The mother fled the relationship about two weeks prior and was staying with maternal family members.

The mother reported being yelled at, pushed, shoved, and hit. The father reportedly beat her up a number of times in front of the children. The father would keep the mother from getting help. In August 2000, the mother and children came to Washington state for a visit and did not return to the east coast.

The mother also reported suspected sexual abuse of her then five-year-old daughter—the sister to the child who is the subject of this report. She too, is autistic and non-verbal. The mother reported her daughter spent an afternoon with her paternal grandfather, after which her behavior changed: She started urinating on herself, pulling her underwear down and saying “grandpa...grandpa.” The mother shared her concerns with the paternal family. The mother learned the grandfather sexually abused his daughter when she was eight or nine. He also sexually abused a stepdaughter on multiple occasions and was prosecuted.

The father minimized the mother’s concerns. Three months prior, the mother brought her concerns to the police and CPS. An investigation was started but was slow to progress because of the sister’s inability to talk. The CPS and law enforcement investigations occurred in New Jersey where the alleged abuse occurred.

On May 2, 2002, CPS intake received a report from a relative who reported the child, then three years old, and his sister, then six, were locked in their room for several hours and at times all night long while their mother would go to the garage and smoke marijuana. There was no food in the refrigerator and the mother only fed them once a day. At times, the children are seen eating out of the garbage or eating flowers. It was also alleged that the mother used welfare money to support her drug habit.

The children's clothes were too small, stained, tattered and dirty. Their hygiene was poor. The home was very dirty. There was spoiled food and mold in the kitchen sink with the dirty dishes. There were feces on the floor including the child’s mattress. The sister was enuretic and wet her bed.

The referrer reported a week prior to the May 2 intake, the child ran out in the middle of the street naked. He had cigarette burn scars on his foot, forearm, and leg apparently inflicted by the mother's boyfriend. The referrer called police to do a welfare check. The CPS investigation was completed with an unfounded finding for negligent treatment or maltreatment and physical abuse.

On July 24, 2003, CPS intake received a report from law enforcement who reported police officers responded to a call from a citizen who discovered the child, then four years old, in the middle of a road. Police recognized him as one who had escaped from home earlier and took him to his residence. The officer reported the front door was wide open and the

mother appeared to be intoxicated and passed out. The officer placed the child in protective custody; he was placed with his grandmother. The officer did not know the whereabouts of the seven-year-old sister. The mother agreed to sign a Voluntary Placement Agreement (VPA) to keep her children in care.

The children were moved to a foster home as the grandmother was unable to provide the level of care they required.

On August 11, 2003, the foster parent reported the now deceased child ran away from her while she was taking out her garbage. He ran into the middle of traffic. She ran after him, but could not catch him. This report was screened in for investigation by the Division of Licensed Resources/Child Protective Services (DLR/CPS) and closed with an unfounded finding.

The children were returned to the mother's care on August 28, 2003. The CPS investigation into the July 24, 2003 intake was closed with an inconclusive finding. The mother worked with a Family Preservation Services (FPS) worker to safety proof her home and to obtain mental health services and a drug/alcohol evaluation. The Division of Developmental Disabilities (DDD) offered respite care for the mother.

On January 3, 2004, Seattle Police called CPS intake to request placement of the child and his sister. The mother called police to report she had been raped and robbed. Police arrived at the home to find the mother extremely intoxicated and incapable of meeting her children's needs. The mother told police she wanted to die and she had been drinking wine with a friend and her friend stole the bottle of wine. The mother clarified she was not raped or robbed. The mother was transported to Harborview Medical Center for a mental health treatment evaluation. The children were placed in foster care. The mother signed another VPA to keep her children in foster care. The CPS investigation was closed with an inconclusive finding.

In March 2004, dependency petitions were filed on both children. Dependencies were established in June 2004. In August 2005, the court ordered the children to begin transition back to their mother's care.

On September 12, 2005, a teacher reported to CPS intake that the child's mother was dropping him off at school and trying to get him settled into class when she slapped him on the head twice. The intake was screened as Low Risk.

On January 8, 2006, a teacher reported to CPS intake that the child was being assisted in the bathroom and noticed a large rectangular ruler-sized raised bruise on his right inside thigh area. The child and his sister were still dependent and the case was still open to a Child Welfare Services unit at the time. The child was autistic and non-verbal. The intake was screened in for investigation by CPS and was closed with an inconclusive finding.

On February 22, 2006, a report was made to CPS intake that the child had a rectangular bruise on his right thigh. He also had a series of bruises on the outside of the right thigh.

The referrer stated that there was a similar injury observed which was reported in January 2006. The mother was also observed on one occasion hitting the child in the classroom. The intake was screened in for investigation by CPS and was closed with an inconclusive finding.

On February 23, 2006, a teacher reported to CPS intake that the child had two finger marks on both sides of the cheek. The marks were pencil-sized in diameter and length. The child and his sister are both non-verbal and autistic. The referrer spoke with the on-going caseworker about these marks. The intake was screened in for investigation by CPS and was closed with an inconclusive finding.

On May 4, 2006, a school counselor reported to CPS intake that the child's mother reported that her partner was hurting her son, the now deceased child. The mother filed a No Contact order against him, but was afraid of his retaliatory tactics. Since the last report this referrer made in February 2006, there were no disclosures made by the children nor had the referrer seen any marks or bruises on them. The two reports in February 2006 documented unexplained injuries on the two children. The mother reported it was her partner who was hitting her son. The children's uncle moved into the home to address safety concerns. This intake was screened as Information Only.

On June 10, 2006, an anonymous referrer called CPS intake and reported that the child's mother gave her kids methadone and sleeping medicine so they would go to sleep earlier. The referrer believes the mother may have been abusing illegal drugs because her behavior changed. The referrer reported she was delusional and schizophrenic. The mother called the police on her relatives. She was threatening and confrontational to her relatives. The investigation was completed with an unfounded finding.

On June 12, 2006, an anonymous referrer called CPS intake and reported drug use by the child's mother. The referrer stated the mother lost a lot of weight and acted "crazy." The referrer explained by "crazy," a situation in which mother left her nephew to be cared for by a person she just met and left him for the day. The referrer also said the child's mother was trying to get custody of her nephew.

The referrer was asked about the mother's care of her own children, the child and his sister. The referrer reported they looked good; they are clean and well fed. The referrer had no concerns for them other than the mother's alleged drug use and the fact that she spent a great deal of time on the phone and referrer was concerned that the children are not being supervised. The intake was screened as Information Only.

On April 17, 2007, a teacher reported the child, then eight years old, had a red mark on the front of his neck and a number of superficial scratch marks on the right side of his neck. The referrer said the child had similar marks before which were unexplained. This intake was screened in for investigation and completed with an unfounded finding for physical abuse.

On February 21, 2008, a teacher called CPS intake to report that the child came to school with a one-inch long bruise on his left cheek of an unknown origin. The bruise was blue in color and had a small scratch in the middle of it. The child was autistic, non-verbal and unable to give any explanations of his injuries to his teacher. The referrer reported that the child was a very active and hyperactive boy; he ran and paced in the classroom a lot. This intake was screened in for investigation and completed with an unfounded finding for physical abuse.

On September 27, 2008, CPS intake received a law enforcement report alleging the now deceased child, then eight years old, was out of control at a restaurant. He had no parent with him and he tried to eat patrons' meals. One of the patrons told police he came into the restaurant and pulled an ice cream cake out of a freezer and began eating it. When the store clerks took it away from him he started taking customers food and drinks. The youth had no identifiers or an ID bracelet on him. The child was placed in the officer's patrol car to keep him from running away. He had no shoes.

Approximately 20 minutes later a person claiming to be the youth's mother contacted law enforcement looking for him. She told police she went to check on him and noticed he was gone. The officer returned the child to his mother's home and conducted a welfare check. The officer met with the woman claiming to be the child's mother. She later admitted that she was not his mother; she was his babysitter, and his mother was not home. The officer felt the babysitter showed no concern for his well-being. The police officer contacted the child's mother and asked her to return. The officer went inside of the house, which was cluttered, but not to the point that it posed an immediate danger to the child. There was food in the kitchen.

The child's mother returned home and was crying hysterically and could hardly speak. She was told what had happened and she stated that her son was a flight risk and that he cannot talk. She was advised to find some way of identifying him in case he gets away in the future. The officer asked why her babysitter was allowed to watch her son when she obviously did not care about his well being. The mother stated that she needed one hour to get decorations for her other child's birthday and that she thought her babysitter could handle her son. She stated that this would not happen again. This intake was accepted for investigation and closed with an unfounded finding.

On January 9, 2009, a school nurse reported to CPS intake that the now deceased child was seen on this day with a bruise on the left side of his face near his eyebrow. The bruise is

greenish blue and swollen. The referrer said it was larger than a silver dollar. His right arm had two bruises on the forearm. The bruises are purple and oblong. There was a bruise on his left arm upper just below the shoulder and towards the back of his arm. There was also a mark on his thigh that appeared it could have been caused by a ruler or a belt. He also had a bruise on his left thigh near his knee. The referrer was advised to contact the police about these injuries.

Law enforcement and the CPS social worker attempted an interview of the child. His injuries were observed. Police officers placed him into protective custody. The mother met with social workers and signed a Voluntary Placement Agreement. His placement in foster care was brief due to his extreme behaviors and destruction of property. He was moved to a group home. He was returned to his mother's care in April 2009, with FPS in the home. Funds were used for door and window alarms to keep the child from running away. The Division of Developmental Disabilities (DDD) was also very involved with this family, providing services and support to the family. The intake was accepted for investigation by CPS. The investigation was closed with an unfounded finding for physical abuse.

On July 11, 2009, a police officer reported to CPS intake that he placed the deceased child in protective custody on July 11, 2009. The officer reported the child was dropped off at a local hospital by an unidentified male adult at approximately 4:45 a.m. This passerby told hospital staff that he found the child wandering down a busy four lane road in Tukwila wearing no shoes and no shirt. The child was wearing a diaper and pants. The officer said he appeared physically healthy and emotionally happy.

The CPS investigator determined that the child's mother checked on him at 3:30 a.m. and he was still in his bed. He left the home out of a window at 4:00 a.m. The mother took the necessary steps to ensure that he did not leave again by putting locks on most of the windows in the home. She also put an alarm on the door. She also had a relative living with her to help her with the child. The CPS investigation was closed with an unfounded finding for negligent treatment or maltreatment.

On September 23, 2009, law enforcement sent a report to CPS intake reporting that on September 10, 2009, the child ran out of the front door of his home, in front of his caretaker and his mother, who ran after him. He ran out into traffic. Police were called by a passing motorist. Police located the child running down the street. He was stopped by police and returned home. The CPS investigation was closed with an unfounded finding for negligent treatment or maltreatment.

On September 30, 2009, law enforcement sent a report to CPS intake that at approximately 10:30 p.m. on the previous night, police found the child running down a street in south Seattle. He was taken back to his home. His mother was unaware that her son had gotten out of the house. The law enforcement report indicated the mother was unable to properly

supervise him or keep him from leaving his residence. The CPS investigation was closed with an unfounded finding for negligent treatment or maltreatment.

On October 10, 2009, CPS intake received a report that the child was hit by a car while walking on State Route 599. He was taken to Harborview Medical Center where he died the next day on October 11, 2009 from blunt force injury to the head, torso, and extremities. The CPS investigation was closed with an unfounded finding for negligent treatment or maltreatment.

Issues and Recommendations
Issue: The social workers, supervisors and providers demonstrated a lot of caring and commitment to the deceased child and his family. They made sincere efforts to engage with and support the mother, who had the very challenging responsibility of raising two autistic children.

Recommendation: None

Issue: Adequacy of services - While all involved with providing services to this family were focused on safety in the home, the family needed autism-specific services. There currently is not a system or resource in place to accomplish that.

Clearly, the child was very bonded with his mother, and wanted to live at home, not in an institution. At the same time, he was very skilled at defeating safety measures. There should be a system in place that ensures families such as this one can have quality electronic alarm systems to minimize the risk of elopement.

Recommendation: Increase payment for respite care providers. The review team considered this as a method of getting more people interested in providing respite care for hard to place children. In this case, this single mother of two very high needs children could have benefited from more respite care. It can be difficult locating respite care providers for children like the deceased child who have exceptional gross motor skills and can elude supervision easily.

Use placement dollars to pay for in-home services instead, such as an electronic alarm system and GPS tracking. This could also include staff trained to manage autistic children. The review team considered this a way to keep a child with hard to manage behaviors in his or her own home in lieu of relying on expensive specialized placements.

Work with housing authorities to re-assess a parent's criminal history, so that the family can be eligible for subsidized housing.

There should be a DSHS review of funding sources and to make funding portable across administrations and programs.

Child Fatality Review #09-45
Region 5
Pierce County

This two-month-old Caucasian female died from Sudden Infant Death Syndrome (SIDS).

Case Overview
On the evening of October 27, 2009, the mother of this two-month-old child reportedly fed her and placed her down to sleep. An hour later the mother checked on the baby and saw "milk all over the place" and the child unresponsive. Paramedics were called to the residence and performed CPR during transport to St. Claire Hospital in Lakewood. Resuscitation efforts continued at the hospital emergency room until the infant was pronounced dead just after 10:00 p.m. CPS was notified by the hospital and the case was assigned due to recent Children's Administration (CA) involvement in Thurston County relating to the older half-sibling.

The hospital reported no obvious indications of physical injury, but blood was found around the baby's rectum. The post mortem examination found no trauma and based on evidence collected it was concluded that use of a rectal thermometer at the hospital was the likely source of the blood. Lakewood Police Department assigned a detective to investigate but given the lack of any evidence of abuse or neglect, the investigation is no longer active.

In early February 2010, Children's Administration (CA) received confirmation from the Pierce County Medical Examiner's Office that the death was determined to be natural; the cause of death is listed as SIDS.

Due to on-going concerns regarding the mother's care of the two-year-old half-sibling of the deceased child, the CPS case was transferred to Family Voluntary Services. The case remains open for services at the time of this report.

Children's Administration did not have an open case on the family at the time of the child's death. CA received a Low Risk intake on October 2, 2009. A social worker made contact with the mother and offered her a community resource list. This Low Risk case was closed 15 days prior to the child's death.

Intake History
On April 12, 2009, a family friend reported to Child Protective Services (CPS) intake that the mother's home was dirty. She had her two-year-old daughter in her care. There was garbage stacked up to the level of the windows in the home. The child was dirty. She was allowed to play in the yard which had fish hooks, knives, and an axe. The assigned worker conducted two home visits, contacted the child's medical provider, and provided the parent with a list of community resources before closing the case. The intake was screened in for

investigation and closed with an unfounded finding for negligent treatment or maltreatment.

On October 2, 2009, a relative contacted CPS intake and reported that she cared for the sister of the now deceased child. The sister was two years old at the time. The relative had the sibling in her care for two months. The child's mother picked up this child from the relative. The relative reported witnessing the mother bite the two-year-old in July 2009. This bite did not break the skin, but did leave a red mark. The referrer also stated that the mother has been seen on several occasions "smacking" the child. The report was screened for alternate intervention. The worker made telephone contact with the mother. The mother denied the allegations. The worker again provided community resources to the mother and closed out the low risk assignment.

On October 27, 2009, a hospital social worker called CPS intake to report the death of the two-month-old child. The child was transported to the hospital emergency room by ambulance. Paramedics responded to the 911 call and performed CPR for 20 to 30 minutes. The child was pronounced dead at the hospital. The mother told hospital staff that she fed her baby formula milk and then put her down to sleep on the bed. She checked her about one hour later and it appeared the child had vomited the milk. The mother's live-in boyfriend was present at their residence. There were no obvious physical injuries to the child. This intake was screened in as a Risk Only investigation and the case assigned for assessment of the well-being and safety of the surviving sibling.

In early February 2010, the department received confirmation from the Pierce County Medical Examiner's Office that the manner of death was determined to be natural; the cause of death is listed as SIDS. The CPS case was closed and transferred to Family Voluntary Services. The case remained open for services at the time of the child fatality review. The family was offered assistance with housing, parenting/bonding, child care, and grief and loss counseling.

Issues and Recommendations

Issue: Regarding the intake dated April 12, 2009: this intake was originally taken by Central Intake (CI) for assignment as an Alternate Intervention (AI) response, the intake was upgraded by Tumwater intake for assignment as a CPS investigation (72 hour response). Full consensus was reached by the review panel that the decision by the Tumwater office to upgrade the intake was supportable based on the reported hazards at the home and additional risk factors presented by the referent, and the local field office intake decision represented quality social work.

Action Taken: The Tumwater intake supervisor participated in the review along with the Tumwater DCFS Area Administrator (AA), and received the positive feedback.

Action Taken: Following the child fatality review, CI was informed of the panel review findings regarding this particular intake.

Recommendation: None

Issue: Regarding the CPS investigation of the April 12, 2009 intake. The April 2009 CPS investigation did not involve the now deceased infant who was not born until late August 2009. Upon review, the April 2009 investigative activities appeared to have met or exceeded most practice expectations. The initial face-to-face (IFF) with the alleged victim occurred within one day of the intake (well within the 72 hour response requirement). The subject interview and home visit were timely. The investigator made collateral contact with the primary care physician (PCP) and with the child's grandmother. A list of available community resources were provided to the mother. Overall the documentation met expectations in terms of content and timely entry. The investigation was completed in a timely manner and the case was closed in mid-June 2009. Although the basis for the finding (unfounded) was not clearly articulated in the investigative assessment, the explanation for the finding as provided to the panel by the social worker during the review was deemed supportable.

Some practice issues were noted during the review. Although none were found to have any significance to the circumstances surrounding the death of this two month old infant in late October 2009, they speak to areas where practice could have been improved. (1) There was no documentation that the worker contacted the referent, although the worker stated to the review panel that he remembers possibly having made such contact. (2) Although the mother, her two-year-old daughter, and the grandparents functioned as a household, when the social worker completed the Structured Decision Making (SDM) risk assessment tool he only assessed the mother's history and not that of all household members as required. The worker appears to not have known of previous sexual abuse allegations involving the mother's family of origin, specifically relating to the father (the grandfather of the child) who was a member of the household at the time of this investigation.

Action Taken: During the review the worker and supervisor acknowledged areas where practice could have been improved, and received feedback regarding the areas where the social work met or exceeded practice standards.

Recommendation: None

Comment: It is unknown if failure to assess the "household" for certain items on the SDM was isolated to the April-June 2009 investigation or is a pervasive issue in the Tumwater DCFS office or in Region 6 in general. It may have been due to the fact that the CPS worker was relatively inexperienced at the time of his investigation and assessment. Region 6 might consider refresher training in the use of SDM as it was acknowledged during the review that it had been several years since the initial training and

implementation of the SDM and re-visiting SDM practice may be beneficial to CPS social workers.

Issue: Regarding the intake dated October 2, 2009: In addition to the concerns reported for neglect, the referent also stated she had witnessed the mother biting the daughter three months prior. A review of FamLink documentation at intake shows the intake worker correctly marked "Yes" to physical abuse on the Intake Decision Tree, but questionably failed to identify physical abuse as one of the allegations for the intake. Additionally, the review panel discussed the lack of explanation by the CI supervisor as to why the initial screening decision (assignment for 72 hour CPS investigation) was changed to an Alternate Intervention. The review panel was unable to reach full consensus as to the reasonableness of the final CI screening decision, but were in complete agreement that an explanation by the CI supervisory would have been helpful.

Action Taken: Following the child fatality review, CI was informed of the panel review findings regarding this particular intake.

Recommendation: None

Issue: Regarding the Alternate Intervention contact in October 2009: Upon review, the October 2009 investigative activities appeared to have met practice expectations for low risk intervention. The assigned worker made telephonic contact with the mother to discuss the reported conflict with the grandmother over the caretaking of the oldest child. The worker did discuss the biting incident that allegedly occurred three months prior, and the mother denied the allegation. The mother reported that she had recently given birth to another daughter and was residing in Pierce County with her fiancé. The worker closed out the Alternate Intervention (AI) assignment with a well documented letter to the mother.

Consideration might have been given to transfer the case from Thurston County to Pierce County, but given that the assignment was for alternate intervention the decision not to transfer the case was deemed defensible upon review. Had the intake been taken for CPS investigation, transfer to the Tacoma CPS office would likely have occurred. The worker did not inquire as to the name of the mother's fiancé. Even in recognition of the fact that the case involved an alternate intervention rather than a CPS investigation, best practice would have been to inquire as to the name of this person for searching the CPS data base.

Action Taken: The worker, supervisor, and Area Administrator involved with the October 2009 alternate intervention participated in the review and received feedback regarding practice issues.

Recommendation: None

Issue: Fatality Investigation: Although the major focus of the child fatality review was on CA involvement prior to the SIDS death of this two-month-old child, a general review of post-fatality activities by CPS did occur. The social work activities, including the decision to transfer the case to Family Voluntary Services (FVS), appear to meet most expected practice. There was a missed opportunity early on by the CPS worker in Pierce County to conduct a FamLink search for the mother's fiancé who failed to mention when initially interviewed that he had prior CPS involvement regarding his biological children (unfounded for neglect and physical abuse). In review of the current status of the family (open FVS case), the review panel indicated concern that the son of the mother's fiancé, who has been reported to be sexually aggressive towards other children including molesting a sibling, is now residing with his father who lives with the mother and her daughter.

Actions Taken: The CPS investigator assigned the Risk Only fatality intake, and the current Family Voluntary Services worker, participated in the review and received feedback regarding areas of good practice, where practice might have been improved, and suggestions for service provision to the family.

Recommendation: None

Child Fatality Review #09-46
Region 1
Okanogan County

This three-month-old Caucasian female died from acute bacterial pneumonia.

Case Overview
On November 2, 2009, the parents of this three-month-old infant were co-sleeping with their daughter. The mother woke to find the infant not breathing. The child's father started CPR while the mother called 911. The infant was transported by ambulance to an Omak area hospital where resuscitation efforts were not successful. The infant died on November 2, 2009.

The mother had taken her daughter in for medical treatment the week prior due to apparent illness. When the child did not appear to be any better, the mother brought her to the emergency room later the same day, at which time she was diagnosed with an upper respiratory infection.

An autopsy was completed. The County Coroner reported the cause of death is acute bacterial pneumonia. The manner of death is natural/medical.

Children's Administration (CA) had an open Child Protective Services (CPS) case on the family of this infant at the time of her death. CA investigated intakes received on September 22, 2009 and October 21, 2009. The investigations of both intakes were open at the time of the child's death.

Intake History
The family includes four other children. Their ages at the time of their sister's death were 2, 3, 7, and 9 years old.

The family was first reported to CPS intake on April 28, 2004 due to an allegation of physical abuse. An anonymous referrer reported the nine-year-old brother, who was 22 months old at the time, had two black eyes, a large bruise on his buttocks and another bruise on his back. The mother told the assigned social worker that the black eyes were from a fall down the stairs, and the bruises were from spankings administered by her live-in boyfriend.

The intake was screened in for investigation. The investigation was closed with a founded finding on the live-in boyfriend for physical abuse. The investigation was closed with a founded finding as to the mother for neglect for failing to protect her son. Services were offered and accepted by the family with a voluntary service agreement signed on June 30, 2004. The case remained open with Family Preservation Services (FPS) in the home through December 2004. The home based service provider educated the mother and her

boyfriend about appropriate discipline, developmental stages of the children and life skills for managing the home. The case was closed January 2005.

Additional information obtained during the investigation was that the mother's live-in boyfriend was a level one registered sex offender. He was considered a low risk to re-offend and there were no restrictions placed on him.

On October 13, 2006, a doctor contacted CPS intake to report the mother disclosed to him that she suspected a former partner, name unknown, may have sexually abused her two oldest children. The mother's current live-in boyfriend is a registered sex offender.

The physician reported the mother did not request an examination of the children nor did she provide any further details. The doctor told the mother to make a report to law enforcement and CPS. The doctor was not sure the mother would follow through and make the report. The intake was screened as Information Only.

On July 2, 2007, the mother contacted CPS to request respite foster care for four of her children for one weekend. She said she was having difficulty keeping up with home maintenance and caring for four children as a single parent. Respite foster care was provided from July 13, 2007 to July 16, 2007. This was a one time request and service. CA opened a Child Welfare Services (CWS) case. The mother continued to work with a Public Health Nurse and the case was closed.

On July 28, 2009, the mother contacted CPS intake to request child care for two of her children for two weeks due to a medical requirement for bed rest during her pregnancy with her fifth child. The assigned social worker scheduled a home visit with the family. The mother spoke to the social worker stating she no longer required bed rest, therefore no longer needed any services from the department. The case was closed.

The mother gave birth to her fifth child in August 2009.

On September 22, 2009, CPS accepted an intake for investigation alleging neglect by the mother. She was home with her newborn, and her four older children, then ages 2, 3, 7, and 9 years old. The 2 and 3 year olds were found by a neighbor in the street in their pajamas at 7:45 a.m. The neighbor brought the toddlers home. The intake social worker made a collateral contact with the owner of a child care on the same street who confirmed the young children were often unsupervised outside and reported concerns for the children. The mother explained that she was working weekends and was up at nights with her newborn baby. She admitted she was sleeping when two of her children exited the home and were found by the neighbor. The mother reported that she would increase her supervision of the children so this wouldn't occur again.

The mother was also reminded by the social worker of a law that prohibits leaving her children with a sex offender. The intake was screened in for investigation and closed with a founded finding for negligent treatment or maltreatment.

On October 21, 2009, while the previous investigation was open, CPS received a new intake that was screened in for investigation. The three-year-old brother told his mother that his seven-year-old brother was inappropriately touching him and their two-year-old sister. The mother reported the older brother admitted to inappropriately touching his siblings. During the investigation, the older brother denied touching his younger siblings. The older brother participated in counseling with a mental health therapist following the allegations that he inappropriately touched his siblings.

The mother made arrangements on her own to place her seven-year-old son outside the home prior to the CPS social worker making contact. She said he could not return home as she did not think the other children would be safe and that she cannot supervise him all the time. On October 23, 2009, the department located a foster home that could take the seven-year-old brother. A Family Team Decision Meeting (FTDM) was conducted and the mother stated at the meeting that she wanted her son placed out of the home due to concerns about his alleged sexualized behavior.

The assigned social worker filed a dependency petition on the seven-year-old brother on November 4, 2009. The child's father responded, and given the absence of allegations against him and his desire to assume responsibility for his son, the dependency petition was dropped. The social worker worked out a transition plan for the seven-year-old brother to say goodbye to his siblings.

The now deceased child was brought to the doctor on October 28, 2009 by her mother. The mother reported that her children had fevers and were coughing for the past few days. The mother herself had chills, abdominal pain and mild nausea. She told the doctor she was worried because her baby has been exposed to others that have been ill. An influenza swab was done and was negative. The doctor diagnosed the baby with a viral upper respiratory infection. The mother was instructed to bring her back to the doctor if symptoms got worse or the fever increased.

At 8:40 p.m. on October 28, 2009, the mother brought the baby to a hospital emergency room. She had a fever of 102.9F. A RSV swab was done and was negative. The diagnosis was an upper respiratory infection.

Other records show that the other children in the home were receiving appropriate well child exams and no medical concerns were noted for the children. The school for the school aged children had no concerns for any of those children and was aware that the mother sought a placement for her oldest son. At the FTDM held on October 30, 2009, all

participants of this meeting saw the infant and it was reported the infant appeared to be mildly ill.

On November 2, 2009, staff from the county prosecutor's office reported to CA intake the death of this three-month-old child. The mother was sleeping with the child and woke to find her not breathing. The child's father was also present. He started CPR while the mother called 911. The hospital notes indicated the child's body temperature was above normal when she arrived at the hospital but she could not be resuscitated.

The Coroner's office reported that the child died from acute bacterial pneumonia. The medical records show that the mother was routinely taking the child to medical appointments and the infant was steadily gaining weight. She was seen on October 6, 2009 for her one month check up and weighed 8 pounds 10 ounces. The doctor noted that the mother and baby were co-sleeping and the doctor strongly encouraged the mother to move her infant to a crib.

The maternal grandmother is a licensed foster home provider and has been a consistent source of support to the family and children. Other extended family members have also been a support.

Issues and Recommendations
Issue: No issues or recommendations were identified during this review.

Recommendation: None

Child Fatality Review #09-47
Region 4
King County

This 14-year-old African American female committed suicide by hanging.

Case Overview
On November 6, 2009, this 14-year-old youth died at Seattle Children's Hospital. According to the King County Medical Examiner's report the youth was admitted to the hospital after being found hanged in her bedroom closet on November 1, 2009.

The King County Sheriff's Office investigated this incident. On October 31, 2009, the youth was at a party and met a boy, who was not her boyfriend. On November 1, 2009, she told a friend she felt guilty for cheating on her boyfriend. She told her boyfriend, who then broke up with her. She was upset and told her friend she was going to do something crazy. Later a family member found the youth in her bedroom closet, hanging with a belt around her neck secured to the clothes rack. Two notes of intent were found in her clothes, one expressing that she was sorry and loved her family, but nobody understood her. The other, with a similar theme, was directed to her boyfriend.

The cause of death is asphyxia due to ligature hanging; status post resuscitation with anoxic encephalopathy (brain damage due to lack of oxygen). The manner of death is suicide.

Children's Administration (CA) did not have an open case on the family of the youth at the time of her death. In October 2009, CA received an information-only report that the youth's mother encouraged her to get in a fight with another student at her school.

Intake History
On October 9, 1995, a mental health counselor contacted Child Protective Services (CPS) intake to report the youth's mother overdosed on amphetamines in a suicide attempt. The now deceased youth was then a four-month-old infant. A relative found the mother lying on top of the infant, and prevented what could have become an infant death. The intake was screened in for investigation. The mother and her infant daughter lived with an aunt, who was a licensed child care provider. The mother's mental health issues stabilized. The CPS worker determined that relatives would report any further concerns. The case was closed with an unfounded finding for negligent treatment or maltreatment.

On December 19, 1995, CPS intake received another report, this one from a public health nurse with concerns about neglect of six-month-old infant (the now deceased youth), the mother's mental health and possible substance abuse. The mother would take her infant daughter out in the cold not dressed for the weather. The infant had a skin condition that looked like burns. The mother moved between relatives and a child care provider's home.

This intake was screened in for investigation. The CPS investigation was closed with an inconclusive finding.

On January 9, 1996, a relative reported to CPS intake the mother's multiple moves between her aunt and grandmother. A Public Health Nurse (PHN) also expressed concerns that the mother's infant daughter was overdue for well baby checkup. The PHN reported the mother could be histrionic and hysterical. The mother made complaints to 911 which did not check out. The intake was screened in for investigation and closed with an inconclusive finding for negligent treatment or maltreatment.

On April 23, 1996, a relative called CPS intake to document two burns on the infant's legs observed by the paternal grandmother. The investigation revealed that the child was accidentally burned with a curling iron. The case was closed on June 2, 1996 with an inconclusive finding. There were no more reports on this family to CPS intake for about seven years.

On March 18, 2003, a relative contacted CPS intake to report the mother was seven months pregnant and was actively using drugs. She had a live-in boyfriend whose children also lived in the home. The parents would leave the children alone when they would go out to buy drugs.

A collateral contact was made with a hospital Mother and Infant Clinic nurse who reported the mother tested positive for marijuana twice during her pregnancy, but otherwise there were no concerns. She made all of her prenatal appointments.

School staff reported no concerns with the parenting by the mother or her boyfriend. The children were well behaved and always well groomed. The parents were active in their children's schooling. The intake dated March 18, 2003 was closed with an unfounded finding.

On March 27, 2005, a hospital social worker reported to CPS intake an incident of domestic violence between the mother and her live-in boyfriend. He broke a glass bottle over her head and she needed stitches. The children reportedly witnessed this incident. The intake was screened in for investigation.

The mother said domestic violence was not an issue in her relationship. Following this event, she worked with a domestic violence advocate. The boyfriend's children were returned to their biological mother's care. The mother's boyfriend was eventually convicted of assault. The investigation was completed with an inconclusive finding, and the case was closed on October 23, 2005 with no services provided.

On November 25, 2008, a school counselor reported to CPS intake the now deceased youth and her mother got into an altercation. The mother hit her daughter on the head with a

skillet. The worker concluded, after interviewing family members and law enforcement that no abuse had occurred. The investigation was completed with an unfounded finding. No bruises, marks or scratches were observed on the youth's body. She did not disclose that her mother hit her with a skillet. Law enforcement and the social worker did not find evidence to confirm physical abuse. The youth was in counseling for anger management issues. The allegation of physical abuse was unfounded as to the mother.

On March 23, 2009, a school counselor made a report to CPS intake. The now deceased youth's 10-year-old sister was aggressive with other kids at school and school staff could not locate the mother to come get her from school. This intake was screened as Information Only.

On May 18, 2009, police reported to CPS intake that the five-year-old sister of the now deceased youth arrived home from school in a taxi and no one was home. The child rode a taxi to and from school every day. This intake was screened for the Alternate Intervention Response.

On October 19, 2009, school staff reported to CPS intake that the youth was involved in an altercation with another student at school. The mother met with school officials and told her daughter she should have beaten up the other child. This intake was screened as Information Only.

On November 2, 2009, a hospital social worker contacted CPS intake to report this youth attempted suicide by hanging herself. She was in critical condition at the time the referrer contacted CPS intake. In the notes she left for family and friends, was a section indicating that her stepbrother was sexually assaulting her. The youth passed away on November 6, 2009 at the hospital.

Law enforcement and CPS investigated the allegations of sexual abuse by the adult stepbrother. The surviving siblings were interviewed and denied being abused. The sister was also interviewed and denied being abused by the stepbrother. Law enforcement concluded an investigation without filing charges. The investigating detective found no evidence of sexual abuse.

The CPS investigation of the intake was completed with an unfounded finding for negligent treatment or maltreatment. The case was transferred to Family Voluntary Services and remained opened at the time of this report (April 2010). The family was engaged in Family Preservation Services, the Comprehensive Assessment Program (CAP) and therapy to address with grief and loss issues.

Issues and Recommendations

Issue: No services were offered or provided to the family until the November 2, 2009 Intake.

Recommendation: Workers should use all the assessment tools available to them to help determine a family's need for services. Workers should engage families and ask them about participating in services.

Issue: Screening an intake dated May 18, 2009 in for a ten day response (Alternate Intervention), when the family had, at that time, a history of nine prior reports.

Recommendation: By itself, the incident (the child arriving home by taxi and a caregiver could not be located) was not high risk. However, considering the case history and patterns, another choice could have been to screen it in for investigation—or, the receiving office could have changed the screening decision and assigned it for investigation.

Issue: The work performed by the CPS and FVS social workers and supervisors at the Martin Luther King, Jr. office since the case was reopened on November 2, 2009 has been commendable.

Recommendation: None

Issue: Training for Children's Administration workers on youth suicide prevention. The Washington State Youth Suicide Prevention Program (www.yspp.org) provides training for professionals for a fee.

Recommendation: Children's Administration should consider budgeting for this training, and include it in the training menu for the next fiscal year.

Child Fatality Review #09-48
Region 5
Pierce County

This one-month-old African American male died from an undiagnosed human DNA virus.

Case Overview
On November 17, 2009, the mother put her infant son down to sleep at approximately 11:30 in the evening. The mother and her three children were living at the maternal grandmother's home. The mother and her baby slept on the couch. The mother reports waking around 2:30 in the morning and was unable to wake up the baby. The grandmother reportedly began CPR, but when medics arrived there was no resuscitation in process. Emergency Medical Technicians attempted resuscitation but were unsuccessful. The infant was declared deceased at the residence the morning of November 18, 2009.

There were no concerns noted by any of the first responders or law enforcement regarding the home environment or the children. There were no reported concerns regarding child abuse and/or neglect by any first responders or death scene investigators.

Upon autopsy and ancillary study results, the cause of death was determined to be from a human DNA virus likely transmitted in utero. The Medical Examiner determined the manner of death was natural. Currently there are no known vaccines available for preventing a cytomegalovirus (CMV) infection. CMV is a common and widespread virus. CMV spreads through bodily fluids.

Children's Administration (CA) did not have an open case on the family at the time of the child's death. CA received an Information Only intake on January 26, 2009.

Intake History
On September 5, 2007, a relative reported to Child Protective Services (CPS) intake that the mother hit, kicked, and pulled the hair of her two-year-old son. The mother reportedly had thrown him across the room when she was angry with him. The referrer also reported the mother left bruises on her six-year-old daughter. The referrer said the six-year-old had bruises on her buttocks and on the upper leg. At the time, the children were enrolled in child care and the mother was receiving mental health counseling. This intake was screened in for investigation and closed with an unfounded finding for physical abuse.

On January 26, 2009, a relative reported to Child Protective Services (CPS) intake that she and other relatives were considering seeking custody of the mother's two children. The referrer said the mother partied all night, slept all day, and left her home in horrible condition. There had been an assault at the home. The mother was pregnant. The intake was screened as Information Only.

On November 18, 2009, CPS intake received a report from an anonymous referrer that the mother of the deceased child was using drugs (unspecified as to whether prescribed or illicit) and breastfeeding the baby the day before his death. CA was already notified of the death of this child when this report was made. The intake was screened as Information Only.

Issues and Recommendations
Issue: Regarding the intake dated September 5, 2007, the screening decision by Central Intake (CI) to accept for CPS investigation of physical abuse appeared appropriate. However, the referrer also reported that the mother was sleeping until noon and leaving her 20-month-old child to fend for himself. The inclusion of an additional allegation of neglect would have been reasonable.

Action Taken: Central Intake did not participate in the review, but feedback regarding the review panel's conclusion was provided post-review to Central Intake.

Recommendation: None

Issue: Regarding the investigation of the intake dated September 5, 2007, the CPS worker demonstrated good practice in a number of areas. In person contact with both children occurred within 72 hours as required by policy. The worker interviewed the maternal grandmother and conducted a home visit and subject interview in a timely manner. The social worker's documentation showed that discussion occurred with the mother as to how taking two prescribed narcotic pain medications may affect the ability to parent. The social worker had contact with the oldest child's non-custodial father. The Safety Assessment was completed in timely manner.

There were noted practice deficiencies. The worker appears to have relied heavily on the mother's denials of the allegations. Given mother's claim that the report made against her was retaliatory, a conversation with the referrer may have proven beneficial to reconcile the differing stories. The children's daycare, the oldest child's school, and the primary care physician (PCP) for the toddler might have been sources for additional information, but there was no evidence that such collateral contacts were made. The case remained inactive (no activities documented) for five months until closure in March 2008 (unfounded), at which time all case notes were entered. Both the period of inactivity and delay in documentation violated CA policy and practice expectations. Additionally, there was no documentation regarding any supervisory reviews during the five months of inactivity which also was not consistent with CA policy.

Individual Action Taken: Neither the assigned CPS worker or supervisor from the 2007 investigation were able to participate in the review. Following the review, the CPS Pierce West Area Administrator provided feedback to the worker and the supervisor, and renewed expectations regarding collateral contacts and closure of cases.

Recommendation: None

Comment: The practice issues identified occurred primarily in late 2007. However, it is noted that in early 2010, Region 5 DCFS renewed efforts to close CPS cases that were open and awaiting closure (no activity). This directive renewed the focus on timely closure of cases. It was reiterated the expectation for documented supervisory review of all open cases. Additionally since 2007, Region 5 has continued to offer training every summer ("Summer Academy") for CPS workers that focuses on expected practice in conducting investigations.

Issue: Regarding the Intake dated January 26, 2009 (prior to the birth of the deceased child and 10 months prior to fatality): The intake lacked key information such as what the referrer meant by "horrible condition" of the home, mother "sleeping all day" and leaving the children "unattended," and the nature of a recent assault in the home. The review panel found that even without additional information there appeared to be sufficient information to have generated an Alternate Intervention intake, and possibly, had the intake worker sought additional information, the intake may have screened in for CPS investigation.

Individual Action Taken: The intake worker met with the fatality review team and received feedback on this intake. The intake worker acknowledged that the January 2009 intake lacked important clarifying information and had additional inquiry been made with the referrer the screening decision may resulted in a different screening decision. The worker stated during the review that she was new to intake at the time but currently as an intake supervisor she requires her intake workers to seek additional descriptive details when a referrer is vague.

Recommendations: None

Comment: Noted during the review was the fact that in March 2010, CA provided new guidelines for gathering information at intake [CA Practice Guide to Intake and Investigation Assessment].

Child Fatality Review #09-49
Region 4
King County

This three-month-old Caucasian male died from undetermined causes.

Case Overview
In the morning on November 20, 2009, this three-month-old infant was found in his playpen, unresponsive, by his father. The child's father called a social worker with Children's Administration (CA) to report the death of his son.

According to the records of the King County Medical Examiner, a King County deputy prosecuting attorney called the Medical Examiner's office and reported the death of this three-month-old infant with suspicious circumstances.

Officers with the Duvall Police Department, along with detectives from the Coalition of Small Police Agencies, went to the home to investigate this child's death. Law Enforcement obtained a search warrant and the scene investigation began.

The King County Medical Examiner documented in his report that the adult sibling told police and the Medical Examiner he last fed the child two ounces of formula at 2:00 a.m. He was put to sleep with a bottle, propped by a small blanket. At around 7:30 a.m. the child's father arrived home and found him in his playpen lying face down, tightly swaddled in a blanket. Beneath him was a bath towel, then the playpen mattress. The room temperature was 75 degrees. Police reported there were no initial signs of trauma.

The Medical Examiner noted this child had a femur fracture that was sustained in uncertain circumstances. This injury was previously documented with the Children's Administration on October 10, 2009. CPS had an open case with this family because of this injury.

The Medical Examiner reported the autopsy did not reveal other injuries or natural disease to account for the death. The toxicology reports were all negative. The Medical Examiner was unable to determine a cause of death. The manner of death is also undetermined.

Children's Administration (CA) had an open Child Protective Services (CPS) case on the family at the time of the child's death. CA received an intake on August 13, 2009 shortly after the birth of the now deceased child and his twin brother. Two more intakes were reported to CPS intake on this family including an intake dated October 10, 2009. This intake alleged the now deceased child, then two months old, sustained a broken right femur. The family included the parents, the father's 19 and 17 year old sons from a prior marriage, a 15-month-old daughter, and the three-month-old infant twins.

Intake History
On August 13, 2009, hospital staff reported to Child Protective Services (CPS) intake that twins, including the now deceased child, were born at 32 weeks gestation and would remain at the Neonatal Intensive Care Unit. Hospital staff were concerned about the father's rough treatment of the one-year-old sister. He would pick her up by one arm and changed her diaper in a rough manner. He was also controlling of the mother. The referrer described the mother as partially blind and slightly developmentally delayed. The referrer reported the family had an open CPS case in New York and that they just came to Washington state a few months prior. The intake was screened in for investigation for Risk Only.

The parents were resistant to voluntary services. The doctor offered to make a referral for Public Health Nurse (PHN) services several times to the parents, but they declined. The family had support from extended family. The parents participated in the Women, Infants, and Children (WIC) program. The assigned social worker contacted the infants' pediatrician. The pediatrician's office reported the twins were doing "great." A well baby check was done on September 14, 2009. The twins were scheduled to see the doctor again on October 12, 2009. The CPS Risk Only investigation was completed on October 7, 2009.

On September 15, 2009, a school counselor contacted Child Protective Services (CPS) to report that the 17-year-old half brother had been diagnosed with depression and was on anti-depressants; however, the father did not ensure he received his medication. The intake was screened as Low Risk Alternate Intervention. The assigned social worker from the previous intake contacted the family about the September 15, 2009 intake. The father confirmed his teenage son had medication for one week. The father had problems with his health insurance paying for the medications.

On October 10, 2009, hospital staff reported to CPS intake that the three-month-old infant had a suspicious fracture of his femur. Law Enforcement was contacted and placed this child, his twin brother and his 15-month-old sister in protective custody. They were returned home on October 12, 2010 with a safety plan that required the father move from the home. He moved to his mother's home pending the outcome of the investigation. The mother stayed in the home with her three children and her 19-year-old stepson. A Public Health Nurse (PHN) was in the home two times a week; a grandmother was checking in with mother and children daily. The father was required to have supervised contact with children.

There were no criminal charges filed against the father. The CPS investigation was completed with a founded finding for physical abuse. The father told social worker and police that his 17-year-old son sat on the infant. The father believed the infant's hip was dislocated when this happened. He pulled on the infant's leg to put it back into its socket. He pulled and reported hearing a pop sound. Dr. Kenneth Feldman, a child abuse consultant, reported this infant's injury was caused by his father's "inappropriately forceful

caretaker act." The infant, along with his twin brother and 15-month-old sister, had full skeletal x-rays, no other injuries were found on the children.

The case remained opened for services. This included the PHN, who provided an in-home assessment.

On November 20, 2009, the father contacted the assigned social worker to report his three-month-old son was found deceased in his crib earlier that morning. The father was living with his mother at the time of this incident. Per the safety plan, he was allowed to come over to the home during the day. His adult son was living at the home with his stepmother and the children. He reported to police officers that he went to the family home at 7:30 a.m. to help his wife prepare for a home visit by the CPS social worker. He checked on his three-month-old son and found him lying on his stomach and was cold to the touch.

On November 20, 2009, the parents signed a Voluntary Placement Agreement to place the 15-month-old sister and the surviving twin brother in relative placement with a paternal aunt. A criminal background check was conducted on the aunt prior to placement. On November 25, 2009, the aunt notified the social worker that she was no longer able to care for the children. The Regional Administrator advised social workers to file dependency petitions on these two children based on the prior injury to the infant and the absence of information into the cause of his death. Dependency petitions were filed on December 2, 2009. They became dependents in March 2010 and remained in out of home care.

On November 24, 2009, CPS intake received a letter from a neighbor of the family dated November 22, 2009 with concerns about the safety of the home. This letter detailed a history of concerns the neighbor had with the family prior to the death of the child. This letter was received four days after the death of this child. The referrer said the two teenagers slept outside the home in a shed. The home smelled of mold and urine. There were bags of garbage within reach of the small children. There were many ants and ant poison covering the kitchen. The roof appeared to be caving in. The referrer expressed concern about the care of the newborn babies. The parents did not support the babies' heads while holding them. The referrer expressed concern that the parents would drop them. The parents fed the newborns jar baby food. The referrer reported seeing the babies very dirty, with very soiled diapers and diaper rashes. The 15-month-old sister and surviving twin brother were already moved to a relative placement when this report was received. The intake was screened in for investigation. The CPS investigation was completed with an unfounded finding for negligent treatment or maltreatment.

Issues and Recommendations

Issue: Creating case notes versus creating an intake when there is a report of a child death on an open case. In this instance, law enforcement officers were initially suspicious and obtained a search warrant, but did not find evidence of a crime and did not call Intake the

same day. When they did call, they did not report allegations, so case notes were created instead.

Recommendation: No action is necessary. Intake creates an intake when a child dies unexpectedly on an open case if there is a suspicion that the child's death is the result of abuse or neglect. If a child on an open case dies, and there is no allegation of abuse or neglect, the child's death is documented in the child's Person Card in FamLink and in case notes. In addition, policy requires that child fatalities on open cases must be documented in the Administrative Incident Reporting System (AIRS).

Issue: How to verify safety plans when a caregiver is asked to leave the home, pending an investigation. A safety plan was implemented subsequent to the October 10, 2009 intake regarding the now deceased child's broken femur. The father was asked to leave the home. This is consistent with CA Policy 2331, Investigative Standards, E. Response to Serious Physical Abuse and Sexual Abuse.

Recommendation: Children's Administration has strengthened practice by requiring Regional Administrator approval for any safety plan requiring a caregiver to leave the home. All safety plans now require a review by a Regional Administrator designee.

Issue: Infant Sleep Safety information for the parents. The Family Voluntary Services (FVS) social worker did stress this with the parents prior to this child's death.

Recommendation: If the surviving siblings are reunited with their parents, there should be specific instruction, with illustrated material and reminders, demonstrating safe sleep. This should include the illustrated "Keep your baby safe while they sleep" cards, provided by Safe Kids King County-South, MultiCare and Northwest Infant Survival and SIDS Alliance (NISSA).

CA should also provide the parents with a safe crib for the now 8-month-old infant. Region 4 is partnering with NISSA, to provide a supply of safe cribs for CA clients. This is part of the national Cribs For Kids program, in which GRAYCO Pack & Play cribs are distributed to families with infants.

Child Fatality Review #09-50
Region 4
King County

This 15-year-old Caucasian youth committed suicide by hanging.

Case Overview
According a King County Sheriff's Office report, this 15-year-old youth and his mother got into an argument on November 2, 2009 at 7:20 p.m. The youth wore his shoes into the house. His mother told him to remove his shoes and he said no and proceeded to wear them in the home. The mother told him that if he didn't remove his shoes she would break his guitar. The youth then threw a basket of shoes into the front yard. The mother went outside to pick up the shoes and basket. The youth then went to his bedroom, and shortly after that, went into the bathroom. His nine-year-old brother wanted to use the bathroom but the youth said he was using it. A few minutes later the younger brother returned and found his brother hanging from a belt. The younger brother alerted his mother and siblings. The call to 911 was received at 7:48 p.m. A next door neighbor was summoned for help. The mother administered CPR until paramedics arrived. The youth was transported to Harborview Medical Center at 8:52 p.m.

The youth was later moved to Seattle Children's Hospital, where he was maintained on life support for 22 days. According to the King County Medical Examiner's report, this youth died on November 25, 2009 as a result of anoxic brain injury due to ligature hanging. The manner of death is suicide.

Children's Administration (CA) did not have an open case on the family at the time of the youth's death. CA received an Information Only intake on July 30, 2009. This intake alleged the children were traveling with their non-custodial father in California and during the trip it was alleged that he offered the children alcohol and marijuana.

Intake History
On April 16, 2002, the mother called Child Protective Services (CPS) intake to request services. She stated that she had five children in her care. The two oldest (older brothers of the now deceased child) were diagnosed with attention deficit hyperactivity disorder (ADHD). The third child (the now deceased child) was also reported to have ADHD, but had not yet been diagnosed.

The mother stated that the children's father was verbally abusive and demeaning to them. The mother stated she was willing to protect them from physical abuse. The mother reported she asked her husband to leave the home, which he did. The mother said none of her children had bruises or marks on them.

The mother asked for services to help manage her children who have ADHD. She requested family counseling. The mother said the father needed anger management and he too struggled to deal with his children's behaviors. A case was opened for Child Welfare Services (CWS). The family was offered and accepted Family Preservation Services (FPS) and child care.

On April 29, 2002, a nurse at Seattle Children's Hospital contacted CPS intake and reported that an older brother of the now deceased child was choked by his father. The child was 10 years old at the time of this incident. The incident occurred two weeks prior to the report and the father had since moved out of the home. The mother reported the father had been physically abusive to the children in the past. This information was forwarded to King County law enforcement. The CPS intake was screened in for investigation and completed with an inconclusive finding on the father for physical abuse.

On October 31, 2006, a teacher called CPS intake after the youth, who was then 12 years old, was overheard telling a friend that his mother's boyfriend grabbed him and threw him to the floor. A school bus driver overheard the conversation and had the impression this was an ongoing situation at his home. The youth told the bus driver that he was grabbed by the nape of the neck and thrown to the floor by his mother's boyfriend. The youth said he then ran out of the house and stayed away for about four hours. The youth's older brother heard the disclosure and accused the youth of lying. A younger brother agreed that the incident did occur. The referrer talked with the youth later in the day and he changed his report to say his mother's boyfriend pushed him by the back of the neck and he tripped and fell. He then left the house for about 30 minutes. The referrer saw no marks or bruises on the youth. The referrer reported the mother's boyfriend is verbally abusive to the older children. There was no more information provided about the verbal abuse. This intake was screened as Information Only.

On November 6, 2008, a teacher called CPS intake and reported the youngest brother of the now deceased youth had anger issues and often had angry rages at school. He was seven years old at the time. He had an episode on the day his teacher called CPS intake. He kicked tables and walls, and threw books from the shelves. He later calmed down and told the school psychologist and a school administrator that his two older brothers, including the now deceased youth moved back home after they were living with their father. The father could not keep them and sent them back to their mother's care. After they returned they started threatening him and their mother with a knife. The seven-year-old said "they do bad and scary stuff" to him. He also reported that his brothers drowned the cat and tried to set his hair on fire.

The referrer said the mother is physically and emotionally fragile and unable to adequately supervise the older boys and protect her younger children. The seven-year-old was interviewed by a CPS social worker and denied any unsafe behavior by his brothers, but did acknowledge being teased by them. The family was still participating in counseling.

The CPS intake was accepted for investigation and closed with an unfounded finding for negligent treatment or maltreatment.

On July 30, 2009, a mental health counselor reported to CPS intake that the father took the three oldest children with him on a trip to California. The children were given alcohol and offered marijuana; only one child accepted the marijuana. The referrer said the incident took place in California. The parents are divorced; the children live primarily with their mother and visit their father. This intake was screened as Information Only.

On November 3, 2009, CPS intake received a report from law enforcement that this 15-year-old youth attempted suicide by hanging himself with a belt. The youth was arguing with his mother just prior to the incident. He had been seeing a mental health counselor. The youth was transported to Harborview Medical Center and later transferred to Children's Hospital. This intake was screened in for investigation. The investigation was completed with an unfounded finding for negligent treatment or maltreatment.

On November 10, 2009, a relative contacted CPS intake and reported that the 15-year-old youth attempted suicide on November 3, 2009. He was in a coma at Children's Hospital. A decision to keep him on life support needed to be made soon. The referrer reported that the mother and her partner live in the home with the six children. The referrer reported that two days prior, the mother attempted suicide by taking three bottles of pills. The mother was taken to Northwest Hospital. The referrer was unable to provide any information on the mother's condition. It was later determined that the mother took an accidental overdose of three separate medications.

The intake was screened out as risk to the children was being addressed by the social worker who was assigned the CPS investigation earlier in the month of the November. There was no danger alleged to the children and the children were residing with their respective biological fathers (except the 16-year-old who was with her maternal grandmother).

The referrer reported that he wanted the 16-year-old sister to live with him. She wanted to remain with her maternal grandmother. The referrer reported that the mother and her 16-year-old daughter may have shared a bottle of Vicodin and Ativan in the past. The referrer also reported that the grandmother may have given the 16-year-old Vicodin and then said he could not confirm this information. The intake was screened as Information Only.

On November 25, 2009, the parents of this 15-year-old youth agreed to have him taken off life support. He died shortly after life support systems were removed. The family members, including the mother and the brother who found this 15-year-old youth, remained in counseling.

Issues and Recommendations

Issue: The importance of providing services to the family during this current service episode. Apart from Family Preservation Services and child care in 2002, Children's Administration has not provided contracted services. The family has made their own arrangements for mental health care, but there has not been close coordination with Children's Administration and the mental health therapists. The mother sought mental health services on her own, independently of a service plan with Children's Administration. The current Children's Administration social worker had not met with the mental health therapist(s) who are working with the family.

Recommendation: A shared planning meeting with the family, therapists, and school staff of the younger brother of the now deceased youth could be an effective way of determining the family's service needs. A CAP (Comprehensive Assessment Program) assessment could also be helpful with service decisions.

Child Fatality Review #09-51
Region 5
Pierce County

This 20-month-old Caucasian child's cause of death is listed as traumatic bodily injury.

Case Overview
On November 24, 2009, this 20-month-old child was found unresponsive by his mother's live-in boyfriend. The child was home with the boyfriend, who observed the child having a seizure and not breathing. He immediately called the child's mother, and she instructed him to call 911 and for him to perform CPR until the medics arrived. The mother eventually called 911. The mother's boyfriend performed CPR for approximately 20 minutes before emergency medical technicians arrived. Emergency medical technicians arrived at the home and transported the child to St. Anthony Hospital in Gig Harbor where resuscitation efforts continued for another 20 minutes. The child arrived at St. Anthony Hospital with no pulse and no respiration; his pupils were fixed and dilated. He was transferred to Mary Bridge Children's Hospital and placed on ventilation. Doctors at Mary Bridge reported the child did not present with signs of abuse or neglect when he first arrived at Mary Bridge Hospital. On November 25, 2009, medication and ventilation were discontinued and the child died early that afternoon.

Within the first eight months of life the child was diagnosed with numerous medical conditions including regular seizures, a congenital heart defect, renal anomalies, postnatal failure to thrive, dysmorphic features, and Gastroesophageal Reflux Disease. He was also diagnosed with Lissencephaly, a rare genetic brain malformation characterized by the absence of normal folds in the cerebral cortex and an abnormally small head. The child's pediatrician reported children with Lissencephaly commonly develop failure to thrive symptoms. This child required supplemental oxygen and had a gastronomy tube (g-tube) for feeding.

The treating emergency room doctor at Mary Bridge Hospital decided to complete a CT scan of the infant's head and skeletal survey. The CT scan revealed the child had bilateral retinal hemorrhages and a subdural hematoma.

The interim Pierce County Medical Examiner made a determination that this child died from non-accidental trauma. The manner of death is listed as homicide; however, there is medical disagreement over the cause of death. Dr. Yolanda Duralde, a pediatrician specializing in child abuse and neglect at Mary Bridge Children's Hospital, has concluded that the resuscitation efforts caused the retinal hemorrhages and subdural hematoma. Dr. Duralde sought the second opinion of Dr. Sam Gulino, the Chief Medical Examiner in Philadelphia. Dr. Gulino is a national expert pathologist on the deaths of children caused by abuse or other preventable causes. Dr Gulino concurred with Dr. Duralde's opinion that the injuries to this child occurred during live saving efforts.

The Pierce County Sheriff's office is still investigating this child fatality at the time of this report.

Children's Administration (CA) did not have an open case on the family at the time of this child's death. On August 24, 2009, the department accepted an Alternate Response System (ARS) intake and opened a case referred for Early Family Support Services (EFSS). The focus of the alternate intervention was on the non-custodial father of this medically fragile child. The EFSS provider was unable to make contact with the mother or father and closed the case in late September 2009.

Intake History

On September 11, 2008, a hospital social worker called Child Protective Services (CPS) after the mother brought this child in for an appointment at a gastrointestinal clinic. The baby was born with significant health problems. He was born at 36 weeks and had problems with his vision and was diagnosed as failure to thrive. He had developmental delays and other birth defects. He was on a feeding tube. He was admitted to the hospital a few days after birth in February 2008 and then again in June 2008 for three days for failure to thrive. He had a g-tube placed at that time.

The baby was seen at the gastrointestinal clinic on September 5, 2008. The referrer reported that the baby was crying and the mother, while cradling him, began shaking him. The referrer added the shaking was not violent. The mother did not appear to be soothing the child. The referrer felt that it was more of a controlled shaking and was unintentional. The baby continued to cry and the mother appeared very frustrated.

The staff at the gastrointestinal clinic worked with the mother but she was not following through with the services for Birth to Three, Children of Special Needs, and services through the Division of Developmental Disabilities. The hospital also referred the mother to another service to help her transition the baby from inpatient to outpatient services. This intake was screened in for investigation.

The CPS intake was closed with an unfounded finding for negligent treatment or maltreatment. Mother denied shaking the child; referent felt the shaking was not a violent shake, was controlled and unintentional. Staff at the gastrointestinal clinic did not observe any abuse or neglect of the child during their contact. The mother was actively involved in services arranged by herself, the maternal grandmother who is a registered nurse and the child's physicians. She eventually participated in the Birth to Three and Children of Special Needs programs.

On August 24, 2009, a hospital social worker from Mary Bridge Children's Hospital contacted CPS intake after the child's mother brought him to the emergency room for sunburn. The child was diagnosed with 2nd degree burns (sunburns) on his face, arms and legs with blisters on the face. The child's face and lips were swollen, but this did not

interfere with his breathing. The child had just spent the weekend with his biological father. When the mother picked him up from his father's care she noted that he had multiple sunburns on his face, arms and legs.

The mother reported she created a list of care instructions for the father, including placing their son on his side for sleeping, putting on sunscreen before going outside and suctioning out his mouth frequently. The mother said it was evident her son slept on his back and was not suctioned frequently.

The mother reported she confronted the father about the sunburn and said he felt badly. The father told her their son was outside for a few hours.

The child was released from Mary Bridge on August 24, 2009, with topical medications for the burns. The intake was screened as ARS and opened for Early Family Support Services (EFSS) intervention. The non-custodial father was the focus of this EFSS intervention. The EFSS provider was unable to make contact with the child's mother to get contact information for the father. The EFSS intervention was closed in September 2009.

On November 24, 2009, CPS intake received report from a doctor with Mary Bridge Hospital of this child being found unresponsive by his mother's boyfriend. The mother's boyfriend observed the child seizing and not breathing. He called the mother and she instructed him to call 911 and for him to increase the oxygen and he performed CPR until the medics arrived.

The incident was reviewed by Dr. Yolanda Duralde, a child abuse expert with Mary Bridge Hospital. Dr. Duralde reported she found no reason to believe this child's death was the result of abuse of neglect.

According to Dr. Duralde, seizures can cause bleeding associated with subdural hemorrhages and especially because this child also has a condition that made it difficult for him to produce blood clots.

According to Dr. Duralde, the boyfriend did intense CPR on the child for about 20 minutes prior to the ambulance arriving and after arriving at the hospital, he underwent another 80 minutes of aggressive CPR. Dr. Duralde stated that the intensity and duration of the CPR administered to the child could account for his injuries. Dr. Duralde has spoken to the medical examiner about her findings in this case.

The investigating detective with Piece County Sheriff's Office reported the mother and her boyfriend were interviewed and both were cooperative. The Sheriff's Office has not made a decision on this case.

The CPS investigation is still pending. The neglect issues regarding the mother's boyfriend appear to relate to concerns that he did not call 911 immediately when he noticed the child not breathing. At the time of the Child Fatality Review there was no substantive evidence to support a finding of neglect on either identified subject.

Issues and Recommendations
Issue: The review panel concurred with all screening decisions involving this case, with the exception of a minority opinion that the August 2009 Alternate Intervention (AI) intake should have screened in for CPS investigation of neglect on the non-custodial parent (allowing the child to get sunburned).

One minor criticism emerging from the review was that the September 2008 CPS intake appeared to be somewhat vague as to the "non-violent" shaking of the child by the mother during a medical appointment. More description in the intake report would have been beneficial. The documented decision by the Bremerton intake supervisor to change the intake worker's screen out decision to assignment for CPS investigation reflected good judgment and affirmed expected practice for supervisory review of all intakes.

Individual Action Taken: Following the Child Fatality Review the Bremerton intake supervisor was provided feedback as to the panel consensus that the supervisory review and change in the screening decision in September 2008 reflected quality supervision.

Recommendation: None

Issue: Regarding the CPS investigation from September 2008 (1 year prior to fatality). The CPS worker demonstrated a mix of good social work and areas where practice could have been improved. The worker conducted the initial face-to-face contact with the alleged victim in a timely manner consistent with CA policy. He conducted two visits with the family, interviewed the alleged subject, completed the Global Assessment of Individual Needs (GAIN-SS) with the mother, contacted the referrer, and interviewed the child's maternal grandmother who was very involved with her grandson's care and is a nurse.

Several areas for improved practice were noted during the review. The worker did not appear to follow up with the mother as to who else may be living at the home or the name of her current partner. The worker stated that he believed he did make such inquiries but had not documented. Case notes generally were not completed in a timely manner, with most of the documentation being entered two months after activities took place, which is not consistent with CA policy. The CPS worker acknowledged he had not clearly reconciled with the referrer as to statements of concerns reported at intake and the subsequent statement to the worker by the referrer a week later that she did not have any concerns with the child's care and treatment. Additionally, it was the view of some panel members that the worker may have relied too heavily on information provided by the mother and the grandmother.

The most prominent practice deficit involved missed opportunities to seek additional sources of information. While the worker's follow-up with the originating referrer (medical clinic social worker) was acknowledged, the worker might have considered contacting the primary care physician (PCP) and one or more of the providers reportedly working with the mother (e.g., Birth to Three, Children With Special Health Care Needs).

Individual Action Taken: The worker was provided feedback as to where good practice occurred and where practice could have been improved. The worker acknowledged practice deficits from the 2008 investigation, and following the fatality review the worker received additional guidance from his current supervisor affirming the expectation that contact with primary care physicians on all CPS cases involving young children and/or medically fragile children is to occur.

Recommendation: None

Comment: A series of child safety trainings is scheduled for July and August 2010 for Region 5 CPS and Family Voluntary Services (FVS). These trainings will include guidance on making contacts with medical providers for risk, safety, and well-being determinations.

Issue: The low risk Alternate Intervention intake in August 2009 stemmed from information provided by the mother to a mandated reporter regarding the father allowing the child to get sunburned during visitation. The alternate intervention was intended for the non-custodial parent who it was believed might benefit from Early Family Support Services (EFSS). The referral was routed to the Pierce County contracted EFSS provider, although the father lived in Kitsap County which is outside the service delivery area of the Pierce County EFSS provider. The EFSS provider did make several unsuccessful attempts to contact the mother as a way to try to make contact with the father. The father lived on a boat in a marina (no address, although directions to his residence were available). It is likely that any contact with the father would have required the EFSS worker to go to the father's place of residence (boat) at the Bremerton area marina. Thus it would have been more reasonable for the case to be created under the non-custodial father who was the intended recipient of the alternate intervention, and for the EFSS assignment to have been routed to the Kitsap County EFSS provider. The current practice appears to be that an EFSS referral is assigned to the provider from the county in which the child normally resides and the DCFS assignment always goes under the primary caregiver. This resulted in a major barrier to engagement opportunities with the non-custodial father who was not the primary caregiver.

Recommendation: It is recommended that CA review how EFSS referrals are processed when the alternate intervention intake involves households from separate counties where the child resides with one parent but the service engagement is intended for a non-custodial parent (subject of the allegations) who lives in another county. CA should provide

clarification as to which parent the case should be assigned in FamLink and as to which county EFSS provider should be designated for service delivery.

Issue: Due to the complex nature of the case, including lingering and dissenting medical opinions as to the manner of this child's death, the flow of information between CPS and law enforcement appears to have been limited to verbal reports in the six months since the child death occurred. Although it is recognized that the fatality incident was still under criminal investigation at the time of this Child Fatality Review, the lack of law enforcement reports presented a barrier to both the CPS investigation and to the review process. The unavailability of the autopsy report due to legislatively prescribed limits as to who may access autopsy reports (see: RCW 68.50.105) was also found to be a barrier to the review process which proceeded with limited information available.

Recommendation: RCW 26.44.030 authorizes CPS to obtain records from all mandated reporters (including Medical Examiners) when there is an active investigation of child abuse and neglect. However, RCW 68.50.105 limits who is entitled to receive autopsies and post mortem reports and records. CPS is not identified in that RCW as being entitled to access such reports unless the deceased child is legally dependent with the state. The existence of competing statutes has proven a barrier for CA in obtaining, in a timely manner, information regarding suspicious deaths of children. Efforts have been made by CA over the last several years to get legislated change so that CA may be authorized to obtain autopsy and investigative records from Medical Examiners and County Coroners. It is recommended that DSHS and Children's Administration continue to pursue this matter with the legislature.

Comment: RCW 26.44.030 authorizes law enforcement and CPS to exchange information on cases being investigated for child maltreatment. The information flow between Pierce County law enforcement agencies and CPS has generally been good. The barriers encountered with law enforcement in this case appear to reflect the unusual circumstances of the case rather than a pattern of problems that would require inter-agency discussion.

Child Fatality Review #09-52
Region 4
King County

This two-month-old African American female died from Sudden Unexpected Infant Death (SUID).

Case Overview
According a King County Sheriff's Office report, this two-month-old child died while bed sharing with her mother, three siblings and a small dog. She was last seen alive at 11:30 p.m. on December 10, 2009. Her mother fed her a bottle and the child fell asleep face down on her mother's chest. Her mother then rolled her onto her left side. The child was laying to the left of her mother, with three of her siblings to her left.

In the morning the child was in the same position, but her brother's hand was on her face. She was cold and stiff. The mother called 911 at 6:04 a.m. Emergency medical technicians responded but were unable to resuscitate the child. She was pronounced dead at the scene.

According to the autopsy report, the cause of death was Sudden Unexpected Infant Death (SUID). Bed sharing with one adult, three siblings and a small dog in an adult bed were contributing factors. The Medical Examiner concluded the manner of death is undetermined.

Children's Administration (CA) did not have an open case on the family at the time of the child's death. The most recent contact with the family was a Child Protective Services investigation in October 2009 involving alleged physical abuse of 11 and 12 year old siblings by their father. This investigation was closed in November 2009 with an unfounded finding.

The mother of this child has nine children ages, 14 years, 13 years, 12 years, 9 years, 8 years, 4 years, 3 years, 2 years and 2 months old (the now deceased child). The four youngest children were in their mother's care when the 2-month-old died. Four of the five oldest children are in their father's care; another child is in the care of a relative.

Intake History
On April 15, 2002, law enforcement reported to CPS a domestic violence incident between the mother and her ex-husband. Law enforcement reported he assaulted her in the presence of the children. There was also evidence that he had previously physically assaulted at least two of the children. The ex-husband was arrested. The CPS investigation was closed with an inconclusive finding. The mother completed a parenting class and the case was closed December 4, 2002.

On September 8, 2005, a relative contacted CPS intake and reported the mother used her public assistance grant to purchase alcohol. It was also reported that the mother's new boyfriend was arrested for a domestic violence assault against her and he returned to the home in violation of a no contact order. The intake was screened in for investigation of negligent treatment or maltreatment. This investigation has a finding of "unable to complete investigation, no finding" according to FamLink, the Children's Administration's information system.

On September 27, 2005, a school counselor called to report the 12-year-old brother (seven years old at the time of this report) talked about being at his father's home and being shown two large guns kept under his father's bed. The child expressed fear that his father would shoot and kill his mother. This intake was screened in for investigation of negligent treatment or maltreatment. A Public Health Nurse was assigned to work with the family. The investigation has a finding of "unable to complete investigation, no finding", according to FamLink. The case was closed March 17, 2006, per the supervisor's case note.

On May 5, 2009, a school nurse called CPS intake and reported the 13-year-old brother (then 12 years old) was diabetic and his mother did not send his insulin and injection supplies to school. He had episodes of both high and low blood sugar levels. The mother was not in regular contact with the school. CPS monitored and closed the case with an aftercare plan on July 15, 2009. The CPS intake was screened in for investigation of negligent treatment or maltreatment and closed with an unfounded finding for negligent treatment or maltreatment.

On June 15, 2009, a school counselor reported to CPS intake the 14-year-old sister (then 13 years old) came to school with bruising and scratches on her arms. She explained to the referrer that the scratches were from her cat and the bruises were from fighting with her fifth grade brother. This intake was screened as Information Only.

On August 10, 2009, CPS intake received a report from law enforcement alleging an incident of domestic violence between the mother and her boyfriend. He came to the home intoxicated. He was belligerent and the mother asked him to leave. He threw the mother, then seven months pregnant, onto a bed. The 12-year-old child threw a cup at the mother's boyfriend hitting him above the eye. He then left the home. He was stopped by police and arrested for violating a no-contact order. The intake was screened as Information Only.

On August 20, 2009, law enforcement sent a report to CPS intake that documented the children had scratches all over their bodies. The oldest child said their mother scratched them. The 12-year-old child said that the scratches come from them fighting each other. The 14-year-old sister said she wanted to live with her father. On August 8, 2009, she tried to commit suicide by slitting her wrists. The mother did not seek medical treatment for her. It was also alleged the mother did not administer the insulin for the 13-year-old correctly.

It was also reported that the children were frequently left alone due to mother's alcoholism and they fought with each other and the mother took no action.

Police conducted a welfare check of the 14-year-old. She told police that she was not getting enough attention and was always taking care of her younger siblings. The youth had very small little punctures on her wrists that did not require band-aids. The officer had no concerns for her safety. The mother had a mental health appointment scheduled for her daughter. The home was clean and organized. The mother was involved in domestic violence services. The intake was screened as a Low Risk intake. The case was assigned to a social worker for alternate intervention but no services were provided and the case was closed on September 16, 2009.

On August 31, 2009, a nurse at Mary Bridge Children's Hospital contacted CPS intake. A relative told the referrer that there was no food in the home and the 13-year-old appeared pale and seemed to have lost weight. Relatives stated this youth was vomiting and was incontinent which could indicate problems with his diabetes. In August, the mother missed a follow up medical appointment for her son's diabetes. The youth was last seen by his doctor on July 22, 2009. The father recently obtained custody of four of the children. This intake was screened in for investigation for negligent treatment or maltreatment and closed with an unfounded finding.

The assigned social worker spoke with the youth's medical provider who called in the intake. The medical provider called in the intake based on information that was provided to them by the relative. The youth's medical provider saw the youth on September 3, 2009 and reported that they no longer had any concerns in regard to the mother's care of the child's medical needs. They found the youth to be doing very well in regard to treating his diabetes.

On October 13, 2009, a school teacher contacted CPS intake and reported that 13-year-old brother of the now deceased child said his father punched him and his brother, now 12 years old, a number of times sometime in September leaving bruises. The youth also reported that his father smoked marijuana all the time and wore gang colors. This intake screened in for investigation of physical abuse and closed with an unfounded finding on November 30, 2009.

On December 12, 2009, CPS intake was notified by the King County Medical Examiner of the death of this two-month-old child. The CPS intake documented that the four children in the home were co-sleeping with their mother. A sibling's hand was found over the face of the child. The intake was screened in for investigation. The CPS investigation was completed with an unfounded finding for negligent treatment or maltreatment. The case remained opened under a Family Voluntary Services (FVS) case. The mother was offered and completed Intensive Family Preservation Services (IFPS) and continued to participate in counseling. She also continued to work with a domestic violence advocate. The mother

obtained a new home and beds for all of the children. The assigned FVS social worker documented that the children are sleeping in their beds now instead of sleeping with their mother.

Issues and Recommendations

Issue: Response to the first five intakes from 1998 to 2005. Few services were offered and the investigations were incomplete. Feedback to the assigned workers was not possible as most of the workers assigned to these cases have left the agency. Other formerly assigned social workers no longer work in Region 4.

Recommendation: No action is necessary because the current Children's Administration policies and FamLink mandate timely investigations and determination of service needs.

Issue: Safe sleep education for the mother. A Public Health Nurse did provide the mother with safe sleep instruction at the hospital after the now deceased child was born and before she was discharged. She also received it again at a WIC appointment. The mother had a full-sized crib but did not have room in her bedroom for her bed and the crib.

Recommendation: This mother may have had a stronger need to bed share with her children. She was fearful of the impending release of one of her batterers from jail, and had lost custody of her other children to the father and his extended family. In such a case, infant safety should be emphasized. Safe cribs are now available in limited numbers in King County through Public Health as well as Children's Administration and other agencies.

Issue: Non-parental custody action in Family Court. A relative of the father to the older children petitioned for and was granted third party custody of one of the older siblings, against the wishes of the mother. She was not provided the opportunity to be heard and the order contains provisions that are contrary to recommended practices with domestic violence survivors. The mother is seeking legal assistance.

Recommendation: None

Issue: Additional services for this family. The mother no longer wishes to have services from Children's Administration, and the case is being closed. The three youngest siblings (full siblings to the deceased child) could benefit from a grief program, “Journeys”, at Seattle Children's Hospital, as well as a children's domestic violence-mental health program through Seattle Mental Health (SMH). The mother could also benefit from a peer mentor-grief companion.

Recommendation: Since the mother continues to be engaged independently with SMH and a domestic violence advocate, Children's Administration will contact them and inform them of these additional resources for the mother and her children.

Issue: The investigations and work completed with this family in the King East Office have been very thorough. The workers helped to determine that there was no medical neglect by the mother concerning the 13-year-old's diabetes, nor were there other forms of child maltreatment occurring.

When the two-month-old child died, they conducted a sensitive investigation and were able to engage her with Homebuilders Intensive Family Preservation Services. When the mother wished to have her case closed, they assessed that it was safe to do so.

Recommendation: None

Child Fatality Review #09-53
Region 3
Whatcom County

This six-month-old Native American male died from Sudden Unexpected Infant Death (SUID).

Case Overview
On December 16, 2009, Lummi Tribal police reported the death of this six-month-old child. The child was in the care of a relative caretaker. The child's uncle fed him a bottle and then placed on his side onto soft bedding to nap. The uncle told investigators that he had swaddled the child. "Swaddling" is a technique sometimes used to comfort young babies that involves wrapping a blanket securely around the baby's arms so that the child's ability to move their arms is limited.

The uncle checked on the child approximately 20 minutes later and found the child had rolled face down into the bedding. He was unresponsive and not breathing. The uncle administered CPR for two minutes and called 911 at 9:47 p.m. He continued CPR until paramedics arrived. Paramedics declared the child dead on the scene. Police reported no indication of child abuse or neglect.

The official cause of death is listed as Sudden Unexplained Infant Death (SUID) with contribution from improper bedding and face down placement. The manner of death is listed as undetermined.

Children's Administration (CA) had an open case on the family of this child at the time of his death. CA staff conducted a joint Child Protective Services (CPS) investigation with the Lummi Tribal Social Services. In November 2009, this six-month-old and his sister were placed in protective custody by tribal police. Dependency petitions were filed in Lummi Tribal Court and the children were placed in the care of paternal relatives.

Intake History
On June 4, 2009, hospital staff called CPS intake to report the mother gave birth to the now deceased child and she had late prenatal care. It was reported that she had been participating in drug treatment services for the past three months. The mother was agreeable to participating in a parenting program. Hospital staff made the referral for this program. This intake was screened as Information Only.

On July 27, 2009, a chemical dependency counselor contacted CPS intake and reported that the mother dropped out of her chemical dependency treatment and that she and her children's father used a lot of drugs. Their home was filthy and they did not take proper care of their two-month-old because of the drugs. The referrer stated that the parents smoked Oxycontin with a 15-year-old neighbor. The intake was screened in for

investigation of negligent treatment or maltreatment. This investigation has a finding of "unable to complete investigation, no finding" according to FamLink. The assigned investigator attempted to contact family but unable to locate them. Tribal social workers and relatives were unable to locate the family.

On November 19, 2009, law enforcement contacted CPS intake after receiving a report that the parents of this six-month-old child were using drugs. Law enforcement went to the home and found needles and other drug paraphernalia in reach of the 20-month-old sister. There was no food in the home. Police reported the home and children were filthy. Police placed the children into protective custody and called CPS. Dependency petitions were later filed in tribal court. The children were initially placed with a licensed foster care provider; they were moved to the care of paternal relatives six days later. The CPS intake was screened in for investigation of negligent treatment or maltreatment and completed with a founded finding for negligent treatment or maltreatment.

Issues and Recommendations

Issue: In the first referral on this family, the investigation and case were closed after the family moved from their residence and the social worker was unable to locate them. The social worker had not been aware of the "diligent search" protocol that should be followed in this region prior to closing a case as "unable to locate."

Recommendation: The team recommends that a "reminder training" on search efforts to be completed before an investigation is to be closed as "unable to locate" be included in the upcoming July policy rollout training.

A consideration should be given to training on "Barcode" and "Client Registry" systems for additional tools in locating client families.

Issue: The social worker was unable to access National Crime Information Center (NCIC) to assess the suitability of the uncle as a placement resource for this six-month-old, as the child was already in placement (foster care) at the time of the request.

Recommendation: The Background Check Central Unit (BCCU) supervisor was present at the review and has agreed to take up this issue with the NCIC system.

Issue: Packets of information given to relatives at the time a child is placed in their home should include information on safe sleep.

Recommendation: This office will verify that their packets have that information. Additionally, this issue will be included in the next "Lessons Learned" training in the region.

Issue: The regional medical consultant participating in the review suggested that having the medical records on the now deceased child would have been informative. This was especially true given that he had pre-natal drug involvement and he had not yet had a medical exam since he came into care.

Recommendation: Best practice would be for the social worker to immediately seek out past medical records for children as soon as they come into care. This issue will be addressed in the upcoming Region 3 “Lessons Learned” training.

Child Fatality Review #09-54
Region 1
Ferry County

This three-year-old Caucasian female died from burns in a fire.

Case Overview
On December 22, 2009, the apartment building where the family of this three-year-old lived caught fire. The family included the mother, maternal grandmother, this three-year-old child and her two-year-old sister. The children and the maternal grandmother were unable to get out of the apartment building and are presumed to have perished in the fire. Their remains cannot be positively identified. The mother was able to escape from the apartment building. However, she was hospitalized as she sustained burns to a significant portion of her body. The exact cause of the fire was never determined. The manner of death is accidental.

Children's Administration (CA) had an open case on the family of this child at the time of her death. On November 13, 2009, a Child Protective Services (CPS) investigation was opened regarding allegations of unsanitary conditions in the home. This investigation was still open on the date of the fatal fire.

Intake History
On October 25, 2006, CPS intake received a report from a mental health professional regarding negligent treatment of the now deceased child, then three months old. The referrer heard from another client that the mother lacked parenting skills by letting her baby cry constantly, not changing diapers or clothing regularly, and not supporting the infant's head when picking her up. This intake was screened in for investigation.

The assigned social worker made contact with the mother and child. The home was cluttered but appropriate. The social worker received information from collateral contacts that the mother was meeting her infant's needs including recommended medical care.

The investigation was completed with an unfounded finding. The mother was involved with Women, Infants and Children Program (WIC) and a well baby program at the local clinic.

On March 16, 2007, a neighbor reported to CPS intake that the mother allowed her infant daughter, then eight months old, to be around a registered sex offender. The intake was screened in for investigation.

Both parents confirmed they were aware their friend was a registered sex offender and both parents were adamant their daughter was never left alone with him. This friend was court ordered to have direct supervision when around children at all times.

The investigation was completed with an inconclusive finding for negligent treatment by both parents. The investigator documented that the family continued to be involved in community services including WIC and the well baby program. The case was closed.

On February 6, 2008, a social service provider contacted CPS intake and reported negligent treatment of the now deceased child, then one year old, and her seven-month- old sister. The referrer reported there were bugs flying around the home and clothes covering the floor. It was further reported the bathroom was covered with filth and urine, it smelled bad and there was dog urine on the carpet. The intake was accepted for investigation.

The social worker went to the home unannounced on February 9, 2008. The children were clean and appropriately dressed. The home appeared cluttered but lacked the filth that was reported in the intake. Plumbing problems caused some of the bad odor in the home. The investigation was completed with an unfounded finding for negligent treatment or maltreatment. The family had been living in Ferry County. In March 2008, the family moved to Spokane County.

On September 8, 2008, a social service professional reported to CPS intake concerns for the two children in the home due to the unsafe condition of the home. The referrer made a home visit and described safety hazards outside the home such as a refrigerator with unsecured doors, and an unstable deck. The referrer did not enter the home, but it appeared dirty from the outside. The report was accepted for investigation.

The children were dirty. The assigned investigator observed the hazards outside the home and the unsanitary condition inside the home. The inside of the home had cigarette butts on the floor.

The CPS investigation was completed with a founded finding for negligent treatment or maltreatment of both children. The case was transferred to a Family Voluntary Services (FVS) worker for on-going monitoring and provision of services.

The children were seen on October 15, 2008 by a doctor. The doctor reported the children were fine medically. The mother agreed to participation with Family Preservation (FPS) services and would consider a public health nurse. The family was offered child care services. FPS was referred and started working with the family.

The FPS provider had a total of 10 home based meetings from late October through the end of December 2008. The provider addressed several areas to improve including: lack of employment, limited income, mental health that impacts the children, no furnace, water pipes frozen for a full month, and a lack of insight as to CPS concerns.

The assigned FVS worker made a home visit on December 15, 2008 and reported the home was extremely dirty with things all over the floor. The family used space heaters to heat the

trailer as their furnace was not working. The assigned worker returned two days later and found the home was clean and warm. The neighbors provided water to the family.

The father had torn down an unsafe porch and disposed of the refrigerator in the yard.

The parents separated during this investigation. The mother and the two children moved from their home in Spokane County to the home of the maternal grandmother in Ferry County. The mother was offered to have services transferred to Ferry County; she declined and the case was closed in January 2009.

On November 13, 2009, CPS intake accepted for investigation a report from a medical professional alleging negligent treatment of the now deceased child and her sister due to the living environment at their apartment. The referent reported the apartment was filthy with feces and urine all over the floor, old food, clothes and garbage strewn throughout and the odor was unbearable. Both children were wearing T-shirts and diapers when the referent was in the apartment.

The assigned investigator went to the apartment on November 16, 2009 and observed the living conditions and met with the mother and both children. The home did not have foul odors or waste on the floor. The kitchen sink was full of dirty dishes. The children appeared well fed and were clean. The mother reported the children were up to date on immunizations. The social worker told the mother the children needed dental exams.

On December 21, 2009, the assigned social worker returned to the family's apartment to follow up from the previous visit. The apartment was cluttered. The assigned worker talked with the mother and grandmother about the substandard condition of their living environment and that until resolved, CPS was likely to continue receiving referrals.

The mother and grandmother complained the landlord did not provide electricity on a regular basis so hot water was not available for cleaning and showering.

The assigned worker discussed FPS, Early Head Start and parenting classes with the mother. The social worker made referrals for these services on December 22, 2009. The apartment building caught fire later that night.

The CPS investigation dated November 13, 2009 was closed without a finding.

Issues and Recommendations

Issue: Three of the five investigations involved concerns regarding the family's living environment. There were no photos taken of the living environment to support the investigative findings.

Recommendation: Social workers should take photos of conditions that are specific to the allegations. The photos can be used to support the investigative determination of findings and disposition.

Issue: The Family Voluntary Services case was closed in January of 2009 when the mother reported she and the children moved to another town. The FPS provider's exit summary included the following, "Family unable to access even the most basic community resources such as TANF. If the mother does return to live with the children's father and there is another referral I recommend that the parents receive parenting assessments and psychiatric evaluations."

Recommendation: A shared decision making process (Child Protection Team (CPT), Family Team Decision Meeting (FTDM), Administrative staffing) should be used when considering whether a case is transferred to another office or the case is closed while active interventions are being provided to a family.

Issue: There was a duplicate person as well as a duplicate case in FamLink. Partial history for the family was provided in one case (prior to FamLink) with more recent history in another case.

Recommendation: The case was identified for a case merge in FamLink to consolidate all history and records into one case.

Child Fatality Review #09-55
Region 1
Ferry County

This two-year-old Caucasian female died from burns in a fire.

Case Overview
On December 22, 2009, the apartment building where the family of this two-year-old lived caught fire. The family included the mother, maternal grandmother, this two-year-old child and her three-year-old sister. The children and the maternal grandmother were unable to get out of the apartment building and are presumed to have perished in the fire. Their remains cannot be positively identified. The mother was able to escape from the apartment building. However, she was hospitalized as she sustained burns to a significant portion of her body. The exact cause of the fire was never determined. The manner of death is accidental.

Children's Administration (CA) had an open case on the family of this child at the time of her death. On November 13, 2009, a Child Protective Services (CPS) investigation was opened regarding allegations of unsanitary conditions in the home. This investigation was still open on the date of the fatal fire.

Intake History
On October 25, 2006, CPS intake received a report from a mental health professional regarding negligent treatment of the sister of the now deceased child. The child was three months old at the time. The referrer heard from another client that the mother lacked parenting skills by letting her baby cry constantly, not changing diapers or clothing regularly, and not supporting the infant's head when picking her up. This intake was screened in for investigation.

The assigned social worker made contact with the mother and child. The home was cluttered but appropriate. The social worker received information from collateral contacts that the mother was meeting her infant's needs including recommended medical care.

The investigation was completed with an unfounded finding. The mother was involved with Women, Infants and Children Program (WIC) and a well baby program at the local clinic.

On March 16, 2007, a neighbor reported to CPS intake that the mother allowed her infant daughter, then eight months old, to be around a registered sex offender. The intake was screened in for investigation.

Both parents confirmed they were aware their friend was a registered sex offender and both parents were adamant their daughter was never left alone with him. This friend was court ordered to have direct supervision when around children at all times.

The investigation was completed with an inconclusive finding for negligent treatment by both parents. The investigator documented that the family continued to be involved in community services including WIC and the well baby program. The case was closed.

On February 6, 2008, a social service provider contacted CPS intake and reported negligent treatment of the now deceased child, then seven months old, and her one-year-old sister. The referrer reported there were bugs flying around the home and clothes covering the floor. The referrer also said the bathroom was covered with filth and urine, it smelled bad and there was dog urine on the carpet. The intake was accepted for investigation.

The social worker went to the home unannounced on February 9, 2008. The children were clean and appropriately dressed. The home appeared cluttered but lacked the filth that was reported in the intake. Plumbing problems caused some of the bad odor in the home. The investigation was completed with an unfounded finding for negligent treatment or maltreatment. The family had been living in Ferry County. In March 2008, the family moved to Spokane County.

September 8, 2008 a social service professional reported to CPS intake concerns for the two children in the home due to the unsafe condition of the home. The referrer made a home visit and described safety hazards outside the home such as a refrigerator with unsecured doors, and an unstable deck. The referrer did not enter the home, but it appeared dirty from the outside. The report was accepted for investigation.

The children were dirty. The assigned investigator observed the hazards outside the home and the unsanitary condition inside the home. The inside of the home had cigarette butts on the floor.

The CPS investigation was completed with a founded finding for negligent treatment or maltreatment of both children. The case was transferred to a Family Voluntary Services (FVS) worker for on-going monitoring and provision of services.

The children were seen on October 15, 2008 by a doctor. The doctor reported the children were fine medically. The mother agreed to participation with Family Preservation (FPS) services and would consider a public health nurse. The family was offered child care services. FPS was referred and started working with the family.

The FPS provider had a total of 10 home based meetings from late October through the end of December 2008. The provider addressed several areas to improve including: lack of

employment, limited income, mental health that impacts the children, no furnace, water pipes frozen for a full month, and a lack of insight as to CPS concerns.

The assigned FVS worker made a home visit on December 15, 2008 and reported the home was extremely dirty with things all over the floor. The family used space heaters to heat the trailer as their furnace was not working. The assigned worker returned two days later and found the home was clean and warm. The neighbors provided water to the family.

The father had torn down an unsafe porch and disposed of the refrigerator in the yard.

The parents separated during this investigation. The mother and the two children moved from their home in Spokane County to the home of the maternal grandmother in Ferry County. The mother was offered to have services transferred to Ferry County; she declined and the case was closed in January 2009.

On November 13, 2009, CPS intake accepted for investigation a report from a medical professional alleging negligent treatment of the now deceased child and her sister due to the living environment at their apartment. The referent reported the apartment was filthy with feces and urine all over the floor, old food, clothes and garbage strewn throughout and the odor was unbearable. Both children were wearing T-shirts and diapers when the referent was in the apartment.

The assigned investigator went to the apartment on November 16, 2009 and observed the living conditions and met with the mother and both children. The home did not have foul odors or waste on the floor. The kitchen sink was full of dirty dishes. The children appeared well fed and were clean. The mother reported the children were up to date on immunizations. The social worker told the mother the children needed dental exams.

On December 21, 2009, the assigned social worker returned to the family's apartment to follow up from the previous visit. The apartment was cluttered. The assigned worker talked with the mother and grandmother about the substandard condition of their living environment and that until resolved, CPS was likely to continue receiving referrals.

The mother and grandmother complained the landlord did not provide electricity on a regular basis so hot water was not available for cleaning and showering.

The assigned worker discussed FPS, Early Head Start and parenting classes with the mother. The social worker made referrals for these services on December 22, 2009. The apartment building caught fire later that night.

The CPS investigation dated November 13, 2009 was closed without a finding.

Issues and Recommendations

Issue: Three of the five investigations involved concerns regarding the family's living environment. There were no photos taken of the living environment to support the investigative findings.

Recommendation: Social workers should take photos of conditions that are specific to the allegations. The photos can be used to support the investigative determination of findings and disposition.

Issue: The Family Voluntary Services case was closed in January of 2009 when the mother reported she and the children moved to another town. The FPS provider's exit summary included the following, "Family unable to access even the most basic community resources such as TANF. If the mother does return to live with the children's father and there is another referral I recommend that the parents receive parenting assessments and psychiatric evaluations."

Recommendation: A shared decision making process (Child Protection Team (CPT), Family Team Decision Meeting (FTDM), Administrative staffing) should be used when considering whether a case is transferred to another office or the case is closed while active interventions are being provided to a family.

Issue: There was a duplicate person as well as a duplicate case in FamLink. Partial history for the family was provided in one case (prior to FamLink) with more recent history in another case.

Recommendation: The case was identified for a case merge in FamLink to consolidate all history and records into one case.

Child Fatality Review #09-56
Region 2
Yakima County

This 16-year-old Caucasian female died from multiple stab wounds and blunt force trauma to her head.

Case Overview
On December 20, 2009, this 16-year-old youth was found dead in her home by her mother and her mother's live-in boyfriend. According to the Yakima County Coroner's report, the youth was a victim of Third Party homicide. She died from injuries related to strangulation, multiple stab wounds and blunt force trauma to the head. The medical examiner determined any of these injuries would have been fatal.

The youth's mother left her residence at 11:00 p.m. on December 20, 2009 to attend a party. The mother checked on her daughter at 12:30 a.m. and she reportedly was doing fine. The mother called a second time and her daughter did not answer. The mother and her boyfriend returned home at 4:00 a.m. and found her daughter's eight-month-old son crying on the couch unattended. They went looking for her daughter and saw her on the bedroom floor with a pillow over her face.

A 17-year-old male was arrested and charged with the murder of this youth. The mother said this 17-year-old male was a close family friend and was at times the boyfriend of the now deceased youth.

Children's Administration (CA) did not have an open case on the family of this youth at the time of her death. The most recent involvement was a Child Protective Services (CPS) investigation on July 3, 2009 following the death of the two-year-old brother of this 16-year-old youth. The brother was found deceased and he had bruising to his head. These injuries were later determined to be from a fall from a tricycle while at his daycare. However, it was also determined this child had been ill for several days prior to his death. His parents delayed in seeking medical treatment. His cause of death was acute peritonitis. Peritonitis is an inflammation (irritation) of the tissue that lines the wall of the abdomen and covers the abdominal organs. This CPS investigation was closed in November 2009 with a founded finding for neglect.

Intake History
On February 7, 2007, CPS intake received a report from a relative who alleged possible physical abuse of the now deceased youth (then age 13) by her grandmother's boyfriend. It was alleged that the boyfriend struck the youth knocking her down following an argument with her grandmother over use of the telephone. The referrer added a concern regarding the level of care and supervision this youth was receiving from her mother. Her mother was in

the hospital having a baby at the time of this incident. This intake was screened out as Third Party and referred to law enforcement.

On September 21, 2007, a teacher made a report to CPS intake alleging bruising to the six-year-old brother of the now deceased youth. The six-year-old had a small bruise above his left eyebrow and said his mother hit him for waking up the baby. This intake was screened in for Alternative Response System (ARS).

On October 9, 2007, a teacher contacted CPS intake and reported that this 16-year-old (then age 13) was found walking in a grape field visibly upset. She told the referrer her stepfather hit her and left her near the grape field. He was upset with her for talking to a friend while at the grocery store. She said he had been drinking. The referrer attempted to reach the mother at work but she was unavailable. The referrer dropped the youth off at home; the stepfather was not home. The referrer reported no signs of bruises, scratches or marks on the youth. The intake was screened as Information Only.

On December 9, 2008, a teacher reported to CPS intake that the six-year-old brother came to school with bruising. He had a bruise on his right cheek between his ear and eye and bruising on the inside of his upper lip. The brother reported his sister (then age 15) pulled on his cheeks and picked him up by his cheeks. His sister cared for him while their mother was at work. The referrer said the brother told his mother and maternal grandmother. They instructed him not to tell anyone or else he would be taken away. The referrer expressed concern for the level of supervision in the home and the child being told not to tell how he got the injury. This intake was screened as low risk and a letter was sent to the mother notifying her of the intake and services within the community which could assist her in ensuring the health and safety of her children.

On April 14, 2009, a hospital social worker reported to CPS intake that the now deceased youth, then 15 years old, gave birth to a baby boy. She told hospital staff she was unsure when she got pregnant. She identified the father as a boyfriend who was 14 years old at the time. He denied being the father. She also reported she had been intimate with a 21-year-old male between June-July 2008 and she said the relationship was consensual. The referrer reported the youth's mother was unaware of the relationship at the time, however did not allow contact between them once she learned of their relationship. This intake was screened out as Third Party and referred to law enforcement.

On May 12, 2009, a school counselor called in a report that the brother of the now deceased youth said she continued to pinch and hit him causing injury. The referrer said this information was reported in the past and the referrer was concerned that the youth continued to lie to their parents about their interactions. The referrer further reported the brother was defiant and had disciplinary problems at school. This intake was screened in for ARS. A referral as made to the Early Family Support Services (EFSS) program. An EFSS exit summary received on July 10, 2009 indicated the family refused services.

On July 3, 2009, law enforcement contacted CPS intake to report the death of the two-year-old brother of this 16-year-old. After receiving a 911 call, police officers and Emergency Medical Technicians responded to the home where this child was found non-responsive, not breathing and cold to the touch. He was transported to a local hospital and pronounced dead shortly after arrival in the emergency room. He had bruising to his head. It was determined this was an accidental injury and not the cause of this child's death. The final autopsy report received indicated the cause of death was acute peritonitis. The intake was screened in for investigation. The CPS investigation was completed with a founded finding for negligent treatment or maltreatment by the child's parents. It was determined during the CPS investigation that this child was ill for several days prior to his death. The parents delayed in seeking medical treatment.

Law enforcement did not place the other children in the home into protective custody during this investigation. However, it was recommended the children stay with their maternal grandmother until the investigation was completed. The family complied with CA and law enforcement in this request.

On December 22, 2009, CPS intake was notified of the death of this 16-year-old youth. She died on December 20, 2009 from multiple stab wounds and head trauma. There was evidence that she was strangled. This intake was screened in for investigation and closed with an unfounded finding for negligent treatment or maltreatment regarding the youth's parent. A 17-year-old male, who was a close family friend, was arrested and charged with murder.

The family case continues to remain open with Children's Administration under Family Voluntary Services (FVS). The eight-year-old brother has moved in with his biological father, who has indicated he will pursue permanent custody of his child. This child is in mental health counseling to deal with his behavior issues. The infant child of the deceased youth has been residing with his great grandmother. She is interested in obtaining guardianship of this child.

Issues and Recommendations
Issue: None

Recommendation: None

Child Fatality Review #09-57
Region 4
King County

This one-month-old Caucasian female died from Sudden Infant Death Syndrome (SIDS).

Case Overview
On December 21, 2009, the mother of this one-month-old infant stated she gave her daughter over-the-counter Dimetapp at 11:00 p.m. The mother reported her daughter had "sniffles and congestion." She then fed her one to two ounces of Similac formula. The mother and baby slept in the same bed; they both woke up and fed again and fell back to sleep. When the mother awoke in the morning, her daughter was unresponsive.

According to the King County Medical Examiner, this infant was last placed in bed with her mother at 11:00 p.m., and was last known alive at an undetermined time. She was found at 6:00 a.m., unresponsive. The mother claimed that she placed her daughter to sleep on her back and she was found on her back.

The mother and infant were bed-sharing on an adult mattress and box spring placed on the floor. The child's sleep surface included two adult pillows and a comforter underneath her. There was a crib in the bedroom.

The mother informed the Medical Examiner's staff that she had used methamphetamine three days prior to her daughter's birth, causing abruption of the placenta. The child was born five weeks prematurely.

The Medical Examiner determined there was no evidence of overlaying and made a diagnosis of SIDS, noting the risk factors of bed sharing with an adult and soft sleeping material. The Medical Examiner has listed the manner of death as natural.

Children's Administration (CA) had an open case on the family of this child at the time of her death. On November 16, 2009, Children's Administration (CA) opened a case following the birth of this child. The child tested positive for amphetamines at birth and was placed in a facility to help her through the withdrawal process. The case was still open when this child passed away.

Intake History
On August 20 2008, CPS intake received a report from a relative who had concerns for the welfare of the sister of the now deceased child. The sister was then six years old. The referrer claimed to see the child's mother smoke something from a straw. The referrer added the mother was very underweight, and there were people in the home that "looked real retarded." This intake was screened as Information Only.

On July 6, 2009, a DSHS Work First social worker contacted CPS intake to report the mother was pregnant. She was using methamphetamine and was homeless. A copy of the intake was sent to Public Health Nursing for Maternity Support Services. This intake was screened as Information Only.

On November 16, 2009, a hospital social worker reported to CPS intake the birth of this child. Doctors at the hospital where she was born placed her on an administrative hold. She was born at thirty-five weeks; both she and her mother tested positive for amphetamines. The mother was brought to the hospital emergency room the day prior, but left against medical advice. She refused to do a urinalysis at that time. The infant was delivered by emergency caesarian section. The mother told hospital staff she used methamphetamine six days prior to giving birth. The intake was screened as Risk Only.

The child was placed at the Pediatric Interim Care Center (PICC) facility while going through the withdrawal process.

The child was moved from the hospital to PICC on November 21, 2009. The parents signed a Voluntary Placement Agreement (VPA) to place her in PICC. The case was transferred from CPS to a social worker in the Family Voluntary Services (FVS) unit. The assigned social worker discussed substance abuse assessments and treatment. This worker also arranged to have Homebuilders Intensive Family Preservation Services (IFPS) for the family. The plan was for the parents to pick up their daughter from PICC on December 10, 2009 and to take her to their home, ending the VPA.

On December 16, 2009, a Family Team Decision Meeting (FTDM) was held. The parents attended, as did the Homebuilders therapist and her supervisor. The worker also had collateral contacts with other providers for the family. The outcome of the meeting was that the parents agreed to continue to participate in services; they agreed to enroll their daughter in Childhaven. On December 21, 2009, the Homebuilders therapist informed the social worker that the parents and the baby were doing very well, and there was evidence of strong bonding. The therapist also described the safety plan that she had made with the parents in regards to maintaining each other's sobriety.

On December 22, 2009, the King County Medical Examiner reported that this child had died unexpectedly while sleeping with her mother. An intake was created and screened in for investigation of negligent treatment or maltreatment. The CPS investigation was completed with an unfounded finding based on the Medical Examiners' findings.

The case remained open to offer services. The focus of services included continuation of Homebuilders, grief support, and facilitating outpatient substance abuse treatment for both parents. The case was closed at the end of February 2010. However, Children's Administration also had a case on the father as to his eight-year-old daughter from a prior

relationship. The case on this child remained open with a Child and Family Welfare Services (CFWS) worker.

Issues and Recommendations

Issue: This family had risk factors that were concerning for neglect, and the social workers and supervisors were thorough in their decision-making. They learned that the mother and father interacted very well with their daughter at PICC; PICC staff were not concerned about her release to her parents.

The social worker arranged for the family to have Homebuilders IFPS, and the therapist found the parents had numerous strengths and abilities to nurture the mother and her daughter.

The parents received safe sleep instruction from their Public Health Nurse, as well as from the social worker, who also provided them with a safe, portable crib and safe sleep literature.

The Kent Office has recruited community professionals for a new Child Protection Team that will meet at PICC, specifically to review cases with infants placed at PICC. This team will begin to meet in June 2010.

Recommendation: None.

Child Fatality Review #10-01
Region 4
King County

This 15-year-old African American female died from a gunshot wound.

Case Overview
On December 31, 2009, this 15-year-old youth was shot by her 16-year-old boyfriend. It was reported that he was jealous and angry over a message another boy had posted on her MySpace page.

The incident occurred in the youth's home. A witness in the home reported she heard the two teenagers arguing over the MySpace posting, followed by a single gunshot. The witness then saw the 16-year-old assailant shoot himself in the shoulder, apparently as a ruse to claim there was another assailant that shot them both.

The 16-year-old was charged as an adult, with second-degree murder and unlawful gun possession. He had prior convictions for unlawful gun possession, burglary and witness tampering. He was also reported to have been on electronic home monitoring at the time of the murder.

According to the King County Medical Examiner, this youth was transported to Harborview Medical Center by medics at 10:00 p.m. on December 31, 2009. She was pronounced dead at 1:55 a.m. on January 1, 2010. The autopsy revealed that she had been shot at close range through her left cheek resulting in a fatal injury to her brain. The cause of death is a gunshot wound to the face and the manner of death is Third Party homicide.

Children's Administration (CA) did not have an open case on the family of this child at the time of her death. On November 5, 2009, Children's Administration (CA) received an intake following an alleged physical confrontation between this 15-year-old youth and her mother resulting in an injury to the youth's lip. The Child Protective Services (CPS) investigation was completed and the case closed on December 18, 2009.

Intake History
On October 15, 1996, CPS intake received a report from a relative alleging the now deceased child, then two years old, had a bad skin condition and mother was not taking her to see a doctor. It was also alleged the mother may have a drug problem as she was unable to provide a stable place for her daughter or provide her with medical care. This intake was screened in for investigation. There is no finding in the electronic record.

On July 7, 2009, the mother of this youth contacted CPS intake and reported multiple concerns about her daughter's defiant, aggressive behavior. She had been expelled from school for fighting. She was staying out very late or not returning until the next day. There

were also concerns of substance abuse. The mother enrolled her daughter in counseling, but she refused to attend. This intake was accepted for Family Reconciliation Services (FRS).

The assigned FRS social worker contacted the mother the next day to discuss how FRS could help the family. The mother did not want to file an At-Risk-Youth (ARY) Petition as she thought this would make matters worse. The social worker offered Crisis Family Intervention (CFI), a contracted in-home service. The mother agreed to this and the worker scheduled an appointment for a family assessment on July 10, 2009.

The family did not keep the appointment. The FRS social worker attempted to contact the mother two more times to reschedule with no success. On July 23, the social worker reached the mother who reported her daughter was not available. She said the behavior problems had continued. The mother said she would call the worker back, but did not. On July 28, 2009, the worker wrote the mother a detailed letter, explaining that she was closing the case, but also providing her with resource information and encouraging her to request FRS in the future.

On November 5, 2009, a school nurse reported to CPS intake an incident between this 15-year-old youth and her mother. It was further reported that the youth received bloody lip during a physical fight with her mother. There was a report of chaos in the home. The intake was screened in for investigation of physical abuse. The youth, her mother and another sibling in the home denied the physical altercation occurred. The youth said she got the bloody lip in a fight at school. The mother said her daughter was not complying with curfews and was having behavior problems at school.

The worker explained the results of the CPS investigation and that it would be completed with an unfounded finding. The social worker encouraged the mother to have the case remain open for transfer to the Family Voluntary Services unit. The mother declined, stating she had other resources available.

On January 1, 2010, the King County Medical Examiner’s office reported the death of this 15-year-old youth from a gunshot wound. The alleged perpetrator is her former boyfriend. The incident occurred in the family home. This intake was screened as Information Only.

Issues and Recommendations

Issue: A minor with multiple offenses, including illegal possession of firearms, was released to home detention instead of remaining confined on pending charges.

Recommendation: None

Issue: Additional services for the surviving siblings. Seattle Children's Hospital offers a grief program, “Journeys”, for children who have lost a sibling.

Recommendation: The most recently assigned worker will contact the nurse at the elementary school where the surviving siblings (twins) attend, and provide the nurse with the information about the grief program. The nurse can then provide the information to the mother, who would likely receive it more positively than if Children's Administration were to provide it to her directly.

The most recently assigned worker completed the follow-up on this recommendation, May 27, 2010.

Child Fatality Review #10-02
Region 2
Benton County

This 10-month-old Caucasian male died from Sudden Infant Death Syndrome (SIDS).

Case Overview
On January 1, 2010, the mother of this 10-month old infant woke to find him unresponsive. The mother told responding police officers that she spent the night at a relative's home. The 10-month-old was fussy throughout the day, likely from teething. He had a slight fever of 99.6 and was given Children's Tylenol throughout the day. The mother and her son went to bed around 9:00 p.m. He woke up around 1:00 a.m. fussy so the mother gave him half a bottle of formula. He was put back to bed in his portable playpen. He awoke again at 3:00 a.m. At that time, his mother fed him and put him in bed with her. They both went back to sleep. She nudged him with her elbow at 10:30 a.m. and she noticed that he was not breathing. He was lying on his back with his head turned to the right toward her. His lips were blue. Paramedics were dispatched to the relative's home.

An autopsy was performed on January 1, 2010. The coroner's report indicated co-sleeping with an adult is a risk factor for infant death, but the death scene investigation does not strongly suggest that this occurred. The cause of death listed in the coroner's report is Sudden Infant Death Syndrome (SIDS). The manner of death is natural. In the coroner's report it indicates the child had no bruises, injuries, or fractures. Police did not suspect abuse or neglect in the death of this child.

Children's Administration (CA) had an open case on the family of this child at the time of his death. On December 28, 2009, CA received an intake with concern about the child's low birth weight, a burn on the child's cheek, and domestic violence in the parents' relationship. This intake was screened in for investigation and the Child Protective Services (CPS) investigation was open when this child died four days after receiving the first intake on this family.

Intake History
On December 28, 2009, CPS intake received a report from a social worker from another state. The mother and her son had moved to Washington State days prior to the intake. The mother had relocated with the assistance of a domestic violence advocate to be near relatives. The child was examined at a hospital emergency room prior to the mother moving to Washington. The doctor was concerned about the baby's weight as he was only in the fifth percentile. The child also had what appeared to be a cigarette burn to his cheek and other bruises on his head.

The intake also alleged that this child was put in the bathroom so the mother could sleep. The child was seen by the assigned CPS social worker the day after the intake was

received. The medical records from the prior state were obtained and reviewed with a medical consultant specialist in abuse and neglect. The CPS investigation was completed with an unfounded finding for negligent treatment or maltreatment.

On January 6, 2010, CPS intake received a report that this 10-month-old child died on January 1, 2010. The mother and her son spent the night at a relative's home that evening. The mother reported her son was fussy throughout the day, likely from teething. He was given children's Tylenol throughout the day. The aunt rubbed whiskey on his gums as well. The mother and her son went to bed. The mother fed him several times throughout the night. At 3:00 a.m. she put him in bed with her. At 10:30 a.m. she noticed he was not breathing and paramedics were called. This intake was screened in for investigation. The CPS case was closed with an unfounded finding for negligent treatment or maltreatment.

Issues and Recommendations
Issue: Understanding dynamics of domestic violence.

Recommendation: As best practice, cases where domestic violence is an identified issue, Children's Administration social workers should consult with domestic violence experts in understanding dynamics to help write up safety and service plans.

Child Fatality Review #10-03
Region 3
Whatcom County

This 14-year-old Caucasian female died from a gunshot wound.

Case Overview
On January 7, 2010, this 14-year-old youth was at home with her mother and her mother's boyfriend. The mother's boyfriend shot and killed this youth before killing himself. Prior to the shooting, the mother and her boyfriend consumed a large amount of alcohol and had been fighting. The youth's mother was shot but survived her injuries.

There were two other children living in this home at that time. The mother's nine-year-old son and the boyfriend's 12-year-old daughter also lived in the home, but were with their non-custodial parents when this incident occurred.

Children's Administration (CA) did not have an open case on this youth or her mother at the time of the incident. CA had an open Child Family Welfare Case (CFWS) case on the mother's boyfriend following a Child Protective Services (CPS) investigation that was completed in October 2007. The CFWS case remained open for case monitoring. The boyfriend's teenage son had been a dependent since June 2008. The dependency was dismissed on January 4, 2010.

Intake History
On October 8, 2007, Child Protective Services (CPS) intake received a report from a school counselor who reported allegations that the now deceased youth (then 11 years old) was inappropriately touched by the teenage son of her mother's boyfriend. The intake was screened in for investigation of both parents for lack of supervision. The CPS investigation was completed with an unfounded finding for negligent treatment or maltreatment. The parents agreed to a safety plan not to allow the teenager to be unsupervised around the younger children in the home. He moved from the home in December 2007 and did not return.

On March 22, 2008, a relative contacted CPS intake to report an incident of domestic violence between the now deceased youth's mother and her boyfriend. It was alleged that the youth's mother was the aggressor; her boyfriend pushed her in an attempt to defend himself. She fell to the ground breaking her arm. This intake was screened as information only.

On March 28, 2008, a staff member at a juvenile rehabilitation facility contacted CPS intake to report the pending release of the teenage son of the mother's boyfriend. He was unable to return to his father's home as he had victimized younger children still in the home. This intake was screened as Information Only.

On January 7, 2010, CPS intake received a report of the death of this 14-year-old youth. She was shot and killed by her mother's boyfriend.

Issues and Recommendations
Issue: Lack of coordination with local enforcement to ensure all family members received timely notification of the murder of this youth and suicide of her mother's boyfriend.

Recommendation: Bellingham office administrator will contact local law enforcement agencies to discuss best practices for notification of family members.

Issue: How to ensure safety when youth placed out of the home return to their family home for weekend visits.

Recommendation: Social work supervisors will be reminded by the regional CPS program manager to utilize afterhours staff to conduct weekend visits when concerned about child safety.

Issue: The need to obtain timely background checks on all adults living in the family home.

Recommendation: The Regional Background Check Coordinator will continue ongoing work with the statewide background check coordinator to improve the timeliness of the background process and support field staff's efforts to ensure child safety.

Issue: Conflict presented by having an individual as both a victim and perpetrator of domestic violence and the need for awareness of gender bias when determining safety risk to children when domestic violence is occurring in a family.

Recommendation: Domestic violence experts will be invited by the Regional Safety program manager to a CPS supervisor's meeting to provide domestic violence training.

Issue: The tendency of the investigative social worker to become focused on the identified victim and lose sight of the safety concerns for all children in a family.

Recommendation: The local office administrator will provide training and ongoing reminders to staff on the need of maintaining safety for all children involved in a family.

Child Fatality Review #10-04
Region 2
Yakima County

This seven-month-old Native American female died from positional asphyxiation.

Case Overview
On January 4, 2010, this seven-month-old child was co-sleeping with her grandfather. She had been placed on a Native American baby board when she was put to bed. The grandfather placed a rolled up blanket underneath one side of the baby board, thereby allowing the child to sleep on her side. Sometime during the night, the child's baby board rolled over causing her to be face down on a blanket. At 1:30 a.m., the grandfather woke and noticed the child face down on the bed. The child was found not breathing and 911was called immediately. The emergency medical response team transported the child to Toppenish Hospital where the child passed away at 3:10 a.m. According to the Yakima County Coroner, this child died as a result of respiratory arrest due to positional asphyxia.

Children's Administration (CA) had an open case on the family of this child at the time of her death. This child was placed in her father's care on an in-home dependency through the Tribal Court. The father and his daughter lived with the paternal grandfather. The father was in jail on the night his daughter passed away. The grandfather was caring for the child. The father was released from jail upon the news of his daughter's death.

Intake History
Children's Administrations (CA) has history with this family dating back to 1999 which includes nine intakes prior to the report of the death of the seven-month-old. The mother of the now deceased child gave birth to four children, though none are in her care. The oldest two children live with their father and another is placed with relatives on a dependency action through Tribal Court.

The history includes a founded finding for negligent treatment or maltreatment in 1999. On February 21, 2009, Child Protective Services received an intake after the mother was involved in a motor vehicle accident. Her two oldest children, who were six weeks and three years old at the time, were in the car and received minor injuries. The mother was arrested for DUI. The children were initially placed with relatives and their father reported he obtained temporary custody and would seek permanent custody of his two children. The mother obtained an assessment and treatment for substance abuse issues.

On April 13, 2003, law enforcement officers contacted CPS intake to report the mother was intoxicated and unable to care for her 11-month-old child. The child was temporarily placed in foster care. The child was not in need of medical care. Social workers met with the mother and developed a service contract with the mother. Family Preservation Services

(FPS) was put in the home and the child was returned to the mother's care. The CPS investigation was completed with an inconclusive finding.

On April 12, 2004, CPS intake received a report that the mother left her then two and five year old children with a daycare provider before enrolling the children with this provider. The two-year-old had blood on her face from a bloody nose. The five-year-old did not have shoes on. The mother later came back and picked up the children. The CPS investigation was closed with an unfounded finding for negligent treatment or maltreatment.

On May 9, 2007, school personnel contacted CPS intake to report the then eight year old brother of the now deceased child had an untreated wound on his leg. The referrer checked the leg the following day and it appeared to be healing. The child said his mother put medication on the wound. The intake was screened as Low Risk.

On January 14, 2008, CPS intake received a call that the mother of the children was no longer in the home and an uncle was caring for the children. This intake was screened as Information Only.

On January 23, 2008, police spoke with the 12-year-old brother of the now deceased child at his school. He told police he has not seen his mother in a week and he was caring for his younger siblings. He said this happens regularly. He added that aunts and uncles routinely check on them. The CPS investigation was closed with a founded finding. In March 2008, relatives were granted temporary custody of all three children.

On October 1, 2008, a relative reported concerns of physical abuse, sexual abuse and neglect of the two oldest children in the home. The children were observed playing with a doll and were inappropriately touching the doll. The referrer believed this suggested sexual abuse. The intake was screened as Low Risk.

On June 17, 2009, a report was made to CPS intake documenting the birth of the now deceased child. The mother had minimal pre-natal care and used methamphetamine days prior to giving birth. The child's father was in jail at the time. The CPS investigation was completed with a founded finding for negligent treatment or maltreatment

The newborn also tested positive for methamphetamines. The child was placed in protective custody and then placed in foster care and relative care. In July 2009, arrangements were made for the parents and the child to enter a treatment facility that allowed children to be with their parents. The mother left the facility after six days. The father and his daughter remained. The father transferred to another facility and remained there until November 2009 when he was asked to leave for violating the rules of the facility. His daughter was placed in foster care.

On December 4, 2009, a Family Team Decision Making (FTDM) meeting was conducted. The placement recommendation of this meeting was to return the child back to her father. The department conducted the necessary background checks on the persons identified living at the father's residence and also conducted a walkthrough of the home. There was no disqualifying information that would prevent placement.

On January 4, 2010, CPS intake was notified of the death of this seven-month-old infant while being watched by her grandfather. The child was placed on a Native American baby board. She was propped on her side. During the night she rolled over face down. The County Coroner determined the child died from positional asphyxiation. The intake was screened in for investigation and closed with an unfounded finding.

Issues and Recommendations

Issue: After the death of this child, it was discovered by the assigned Children's Administration social worker that there were other individuals that resided in the father's home than what was originally reported to the worker at the time of placement.

Recommendation: When considering returning a child home on an in-home dependency, best practice by the Children's Administration social worker is to verify all occupants in the home and complete background checks prior to return. Utilizing the ACES system will assist in identifying residents who require BCCU clearance. In addition, the social worker shall conduct and document a thorough walk through of the home. The Toppenish office will implement this practice immediately.

Issue: This child died while on a Native American baby board which did not have the proper safety hardware that could have possibly prevented this tragic death.

Recommendation: Whenever Children's Administration hands out baby boards to caretakers, they need to be trained on the proper use and safety. The Toppenish office has identified someone from their office staff that is knowledgeable on the proper use of baby boards to provide this training. This practice will begin immediately.

Issue: Although Shared Decision Making was practiced by conducting a Family Team Decision Making (FTDM) meeting on December 4, 2009, a balanced team membership was not reflected at this meeting given the dynamics of the case and the recommendations that were given.

Recommendation: The FTDM team from the December 4, 2009 meeting should have included others such as providers, other family support and direct supervisor. Postponing the meeting would have been appropriate given the placement of the child was not imminent or emergent. The Area Administrator has agreed to conduct reviews of shared decision making policy and practice with her area supervisors by September, 2010.

Child Fatality Review #10-05
Region 6
Grays Harbor County

This three-week-old Caucasian female died from unexpected death during infancy.

Case Overview
On January 18, 2010, the mother of the three-week-old infant woke at around 3:00 a.m. and heard her daughter making a "gurgling" noise and it appeared she was not breathing. The mother called 911 and another adult living in the home started CPR. Medics arrived at the home and transported the child to the hospital where she was declared deceased. An autopsy was completed and no trauma was observed. The manner of death is natural.

According to relatives, the baby was healthy, though she was fussy throughout the day on January 18, 2010.

Children's Administration (CA) had an open case on the mother of this child at the time of her death. The mother was a dependent youth living in the home of a court approved suitable placement. CA intake received a report on December 29, 2009, documenting the birth of this child. It also documented that the mother smoked marijuana during her pregnancy. This intake was accepted as a Risk Only case.

Intake History
On December 29, 2009, Child Protective Services (CPS) intake received a report from a social service professional who reported on the birth of this infant. The mother smoked marijuana during her pregnancy. The father had a history of minor law violations related to alcohol. He was also a minor when his daughter was born. This intake was screened in as Risk Only and a case was opened. A Family Team Decision Meeting was held on January 4, 2010. The parents agreed to participate in services. The mother actively participated in the Women, Infants and Children (WIC) and the First Steps programs. The father had completed all court ordered services.

On January 19, 2010, a report was made to CPS intake documenting the death of the three-week-old infant. The referrer was a social service professional and reported the death appeared to be Sudden Infant Death Syndrome (SIDS). The intake was screened as Information Only. The parents and family were offered assistance with grief and loss services.

Issues and Recommendations
Issue: None

Recommendation: None

Child Fatality Review #10-06
Region 4
King County

This eight-year-old Caucasian male died from injuries sustained in a motor vehicle accident.

Case Overview
On January 16, 2010, an eight-year-old boy and his 11-year-old brother were seriously injured in a motor vehicle accident. The brothers were critically injured and transported by Tacoma Fire paramedics to Mary Bridge Children's Hospital. The 11-year-old died a short time later. The eight-year-old was taken into surgery and died on January 17, 2010. According to a Tacoma Police Department report, these boys were riding in a car with their mother after they attended a monster truck show. Tacoma police report the mother was traveling at excessive speed and failed to negotiate a curve in the road. Her car veered into oncoming traffic and crashed into another vehicle. She told Tacoma police she drank a couple of beers at the show. Her blood-alcohol level was .07 approximately three hours after the accident.

According to the Pierce County Medical Examiner, the cause of death is cranial cerebral trauma and blunt force impact to the head. The manner of death is accident.

The mother was later charged with vehicular homicide. The Pierce County Prosecuting Attorney charged her with two counts of Vehicular Homicide.

Children's Administration (CA) did not have an open case on the parents of this child at the time of his death. The boys lived with their father who was the custodial parent. CA intake received a report on October 23, 2009 alleging physical abuse of the 11-year-old and 17-year old sister at the father's home. The investigation was closed in December 18, 2009 with an unfounded finding.

Intake History
There are nine prior reports made to Child Protective Services (CPS) intake on the parents of the eight-year-old child. The parents separated sometime around 2006. The family included this eight-year-old, his 11-year-old brother and their two sisters, now ages 17 and 19. The CA intake history on the father dates from September 2006 to October 2009. There were five intakes with the father as a subject called in to CPS intake during that time. Four of these intakes were investigated by CPS.

There were two investigations into allegations of physical abuse and both were closed with unfounded findings on the father. These intakes were investigated in September 2006 and October 2009 and neither resulted in any legal action or services provided to the family. The family was already participating in counseling during the 2006 investigation.

There were two investigations into allegations of negligent treatment or maltreatment of the children while in the care of their father. In October 2007, a CPS investigation was closed with an unfounded finding. The intake alleged the older sister was physically and verbally abusive toward the younger sister and the father did not intervene. The investigation did not result in legal action or services. The family was still participating in family counseling.

In April 2008, a teacher reported the teenage daughter had an ear infection and her father was not seeking treatment. The investigation was completed with an unfounded finding after it was determined the father did take his daughter to see a doctor and agreed to take her to an ear specialist.

An intake received in April 2009 was screened out for investigation. It alleged the father was verbally abusive and threatening toward his children. He was also rough with his son.

The intake history below identifies the mother as the subject of abuse or neglect intakes. She had her two boys in her care for weekend visitation and was driving the car in which they were killed.

On June 8, 2006, a teacher reported that the sister (then 13 years old) of the now deceased child reported she and her siblings stayed home from school because their mother and a female friend came home at 3:00 a.m. intoxicated and turned on loud music.

The sister indicated that there was a domestic violence disturbance between the mother and her friend resulting in bruising to the mother. The teen sister told the referrer the mother would blame her for the bruises. This intake was screened as Information Only.

On June 22, 2006, a mental health counselor reported that the sister (then 15 years old) of the now deceased child told the referrer that two years prior her mother used to pull her hair and slap her across the face. However, she no longer disciplined her that way. This intake was screened for Alternate Intervention and a letter was sent to the mother.

On June 29, 2006, a mental health counselor reported that the 13-year-old sister and her mother had a confrontation. The mother removed the youth's bedroom door as a consequence for misbehavior and hit her on the leg with the door. The youth received a red bump on her leg. Law enforcement was called and determined this incident was an accident. This intake was screened for Alternate Intervention and a letter was sent to the mother informing her of the CPS report and an offer of assistance to address the concerns.

On January 20, 2010, a report from law enforcement was received by CPS intake reporting on the accident and death of this eight-year-old and his 11-year-old brother. The accident occurred on January 16, 2010 and the mother was arrested. The mother veered into oncoming traffic and crashed into another vehicle. The mother was arrested and eventually

charged with vehicular homicide. The mother was under the influence of alcohol at the time of the accident. This intake was screened in for investigation by CPS and completed with a founded finding for negligent treatment or maltreatment against the mother and unfounded for negligent treatment or maltreatment by the father —the custodial parent.

Issues and Recommendations
Issue: The roles assigned to family members on the intake received on January 20, 2010.

This is the report of the deaths of these two boys. The father and the mother were identified as the subjects. The boys and their 17-year-old sister were identified as victims.

Staff in the King South office thought that only the mother should have been labeled the subject and that only the boys should have been listed as victims. That would have avoided the very difficult circumstance of having to contact the father as a subject and the older sister as a victim when they were both in extreme grief.

The regional CPS program manager followed up with the Intake Unit and learned that the decision to add the father as a subject and the sister as a victim was made jointly between the Intake Supervisor and the CPS Supervisor.

Recommendation: CPS supervisors have the authority to change the roles of family members through the FamLink Investigative Assessment. When workers obtain clarifying information about the roles of family members, it is appropriate to modify the roles. It appears that in this case, removing the subject code for the father and the victim code for the daughter would have been appropriate.

Child Fatality Review #10-07
Region 4
King County

This 11-year-old Caucasian male died from injuries sustained in a motor vehicle accident.

Case Overview
On January 16, 2010, an 11-year-old boy and his eight-year-old brother were seriously injured in a motor vehicle accident. The brothers were critically injured and transported by Tacoma Fire paramedics to Mary Bridge Children's Hospital. The 11-year-old died a short time later. The eight-year-old was taken into surgery and died on January 17, 2010. According to a Tacoma Police Department report, these boys were riding in a car with their mother after they attended a monster truck show. Tacoma police report the mother was traveling at excessive speed and failed to negotiate a curve in the road. Her car veered into oncoming traffic and crashed into another vehicle. She told Tacoma police she drank a couple of beers at the show. Her blood-alcohol level was .07 approximately three hours after the accident.

According to the Pierce County Medical Examiner, the cause of death is blunt force trauma to the head and trunk. The manner of death is accident.

The mother was later charged with vehicular homicide. The Pierce County Prosecuting Attorney charged her with two counts of Vehicular Homicide.

Children's Administration (CA) did not have an open case on the parents of this child at the time of his death. The boys lived with their father who was the custodial parent. CA intake received a report on October 23, 2009 alleging physical abuse of this 11-year-old and his 17-year old sister at their father's home. The investigation was closed in December 18, 2009 with an unfounded finding.

Intake History
There are nine prior reports made to Child Protective Services (CPS) intake on the parents of the 11-year-old child. The parents separated sometime around 2006. The family included this 11-year-old, his eight-year-old brother and their two sisters, now ages 17 and 19. The CA intake history on the father dates from September 2006 to October 2009. There were five intakes with the father as a subject called in to CPS intake during that time. Four of these intakes were investigated by CPS.

There were two investigations into allegations of physical abuse and both were closed with unfounded findings on the father. These intakes were investigated in September 2006 and October 2009 and neither resulted in any legal action or services provided to the family. The father and his children were already participating in counseling during the 2006 investigation.

There were two investigations into allegations of negligent treatment or maltreatment of the children while in the care of their father. In October 2007, a CPS investigation was closed with an unfounded finding. The intake alleged the older sister was physically and verbally abusive toward the younger sister and the father did not intervene. The investigation did not result in legal action or services. The family was still participating in family counseling.

In April 2008, a teacher reported the teen-aged daughter had an ear infection and her father was not seeking treatment. The investigation was completed with an unfounded finding after it was determined the father did take his daughter to see a doctor and agreed to take her to an ear specialist.

An intake received in April 2009 was screened out for investigation. It alleged the father was verbally abusive and threatening toward his children. He was also rough with his son. The intake history below identifies the mother as the subject of abuse or neglect intakes. She had her two boys in her care for weekend visitation and was driving the car in which they were killed.

On June 8, 2006, a teacher reported that the sister (then 13 years old) of the now deceased child reported she and her siblings stayed home from school because their mother and a female friend came home at 3:00 a.m. intoxicated and turned on loud music.

The sister indicated that there was a domestic violence disturbance between the mother and her friend resulting in bruising to the mother. The teen sister told the referrer the mother would blame her for the bruises. This intake was screened as Information Only.

On June 22, 2006, a mental health counselor reported that the sister (then 15 years old) of the now deceased child told the referrer that two years prior her mother used to pull her hair and slap her across the face. However, she no longer disciplined her that way. This intake was screened for Alternate Intervention and a letter was sent to the mother.

On June 29, 2006, a mental health counselor reported that the 13-year-old sister and her mother had a confrontation. The mother removed the youth's bedroom door as a consequence for misbehavior and hit her on the leg with the door. The youth received a red bump on her leg. Law enforcement was called and determined this incident was an accident. This intake was screened for Alternate Intervention and a letter was sent to the mother informing her of the CPS report and an offer of assistance to address the concerns.

On January 20, 2010, a report from law enforcement was received by CPS intake reporting on the accident and death of this 11-year-old and his eight-year-old brother. The accident occurred on January 16, 2010 and the mother was arrested. The mother veered into oncoming traffic and crashed into another vehicle. The mother was arrested and eventually charged with vehicular homicide. The mother was under the influence of alcohol at the

time of the accident. This intake was screened in for investigation by CPS and completed with a founded finding for negligent treatment or maltreatment against the mother and unfounded for negligent treatment or maltreatment by the father —the custodial parent.

Issues and Recommendations
Issue: The roles assigned to family members on the intake received on January 20, 2010.

This is the report of the deaths of these two boys. The father and the mother were identified as the subjects. The boys and their 17-year-old sister were identified as victims.

The King South office thought that only the mother should have been labeled the subject and that only the boys should have been listed as victims. That would have avoided the very difficult circumstance of having to contact the father as a subject and the older sister as a victim when they were both in extreme grief.

The regional CPS program manager followed up with the Intake Unit and learned that the decision to add the father as a subject and the sister as a victim was made jointly between the Intake Supervisor and the CPS Supervisor.

Recommendation: CPS supervisors have the authority to change the roles of family members through the FamLink Investigative Assessment. When workers obtain clarifying information about the roles of family members, it is appropriate to modify the roles. It appears that in this case, removing the subject code for the father and the victim code for the daughter would have been appropriate.

Child Fatality Review #10-08
Region 5
Pierce County

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

Case Overview
On January 25, 2010, the mother of this five-month-old infant dropped him off at the home of his child care provider around 7:00 in the morning. That afternoon he was put down to sleep on his back on an adult bed in a back bedroom. The child care provider reports that she and her adult daughter (who is an approved assistant) did visual checks on this child five times. When the infant exceeded his normal afternoon sleep routine, the provider asked her daughter to check on him. The daughter went to check on the child and then alerted her mother that something was not right with the infant. The provider entered the room and found this child cold to the touch, not breathing, with mucus around his mouth and face. Contact was made with 911 and the provider initiated CPR.

Emergency responders from East Pierce County Fire and Rescue arrived within minutes, soon followed by a Pierce County deputy at 4:26 p.m. The child was pronounced deceased on site at 4:36 p.m. The child's father arrived on the scene later and reported his son had been to the doctor the week before and he was in good health.

The Pierce County Medical Examiner determined the death to be a natural death (SIDS).

Children's Administration (CA) did not have an open case on the parents of this child at the time of his death. This child died in the care of a licensed child care provider. This provider was licensed since September 2009.

Intake History
There is no prior history on the parents of this child. There are no prior licensing complaints or Child Protective Services (CPS) complaints on this licensed child care provider.

On January 26, 2010, this child care provider contacted CPS intake to report the death of this five-month-old infant on January 25, 2010. The child care provider reported the child was a bit sleepy when his mother dropped him off, but he still wanted to play a bit and then he had a bottle. The child care provider reported she put him down for an afternoon nap. He usually sleeps about 2½ hours, waking at around 2:45 p.m. The provider noted that he was not awake after 3:00 p.m., so she sent her daughter to go check on him. She came and reported the child was not breathing. The child care provider then checked on him and also noticed he was not breathing. The provider said she called 911 and started CPR. The provider reported the child was sleeping on his back, with no blankets around him other than a light receiving blanket. This intake was not screened in for investigation by CPS.

This intake was screened as a licensing complaint. The licensing investigation was completed with a valid finding for supervision, failure to report, facility environment, and character. The Department of Early Learning (DEL) has started the licensing revocation process on this provider.

Issues and Recommendations
Issue: Documenting discussions between agencies.

Shortly following the child fatality intake, discussion occurred between supervisory staff from Tacoma DEL and Tacoma DLR/CPS, with supplemental consultation with CA Headquarters administrative staff. The intake decision was to screen out the report due to being a non-suspicious death with regard to child abuse or neglect. The intake was deferred to DEL for licensing complaint investigation. As more information was obtained by DEL staff, a re-review of the screening decision occurred between DEL and DLR/CPS with the intake decision remaining unchanged. These collaborative discussions were reflective of positive inter-agency partnership. However, the discussions that occurred were not fully documented by either DEL or DLR/CPS personnel.

Action Taken (local offices): Tacoma DEL and the Tacoma DLR/CPS supervisor participated in the review and received feedback regarding lack of documentation of the discussions that occurred between agencies. Tacoma DEL and DLR/CPS supervisor agreed in the future to fully document such local inter-agency discussions.

Recommendation: None

Issue: Licensing Investigation

Overall the licensing investigation met or exceeded DEL standards. Interviews and other information gathered by DEL staff were deemed sufficient to support the validations of multiple licensing issues regarding the fatality situation. The documentation in general was excellent. A minor practice issue noted during the review was that case notes by one of the licensors responding to the fatality incident were entered over 60 days after the activities occurred. The current DEL policy is for documentation to be electronically recorded within five days from activity. The delay in entering case notes appeared to be an isolated situation and not reflective of any on-going pattern in the DEL Southwest Service Area or as to the individual licensor.

Action Taken (DEL): Participating in the review and receiving feedback were numerous DEL staff (licensor, supervisor, Assistant Service Area Manager, and Southwest Service Area Manager).

Recommendation: None

Issue: Lack of DEL staff training regarding responding to child deaths in licensed child care facilities.

When there are child maltreatment concerns involving a child death in licensed child care, DLR/CPS assumes primary role in the investigation. However, when a reported child death in a licensed child care facility does not involve suspicions of child abuse or neglect, DLR/CPS may not initiate an investigation. During the review DEL staff expressed discomfort in taking on the role of primary investigator of child fatality situations even if the issues appear to be solely licensing violations. This apprehension stemmed largely from perceived lack of training. Review participants were in full agreement that DEL licensors need to be prepared to respond to child deaths not being investigated by DLR/CPS (i.e., those involving non-suspicious deaths).

Recommendation: DEL should consider offering training for selected staff from each DEL office or larger service area regarding responding to child fatalities in licensed child care. This might include Sudden Unexplained Infant Death Investigation (SUIDI) training or First Responders and Collaboration-Preservation-Observation-Documentation (C-POD) Training from the Washington State Criminal Justice Training Commission.

Issue: Expanding infant care curriculum and SUID/SIDS training for child care providers and DEL child care licensors.

From September 2002 through April 2010 there were ten total identified SIDS deaths that occurred in DEL Southwest Service Area (R5 and R6) licensed child care centers or homes. While such incidents are relatively infrequent, the same licensing violations appear to be occurring (failure to follow safe sleep requirements).

Actions Taken (DEL): In response to this SIDS death, training by the Washington State SIDS Foundation was conducted at the Vancouver DEL office for all Southwest Service Area licensing staff on June 1, 2010. Additionally, mass mailing of SIDS information was sent to all Southwest Service Area child care providers.

Recommendation: DEL should consider changing the training infrastructure for child care licensing to include expanded Infant Care curriculum. This could involve incorporating SIDS training as part of 20 hour State Training and Registry System (STARS) training or as pre-service training.

The DEL Southwest Services Area Manager stated during the review that DEL is currently exploring options for conducting state-wide on-going education opportunities for DEL staff regarding infant death and sleep environments. It is recommended that DEL continue with such efforts, possibly utilizing resource information as made available on-line by the National Sudden and Unexpected Infant/Child Death & Pregnancy Loss Resource Center which offers materials specific to child care (www.sidscenter.org/child care).

Issue: Development of a child fatality review process within DEL

DCFS had no involvement with the family of the deceased child and CA Division of Licensed Resources/Child Protective Services (DLR/CPS) was only involved in a consulting role regarding this SIDS death in a licensed child care family home. The primary focus of the Child Fatality Review was on DEL policy and practices. The responsibility for conducting a Child Fatality Review, even though no CA involvement either pre or post fatality, currently remains with CA.

Recommendation: As a separate department within state government, DEL should consider assuming primary responsibility for conducting reviews in cases where there is no CA involvement and the child death in licensed child care is not attributable to child abuse or neglect.

Child Fatality Review #10-09
Region 4
King County

This 13-month-old African American female died from a muscle disorder.

Case Overview
On February 1, 2010 the King County Medical Examiner reported the death of this 13-month-old female. She was found at home not breathing and was sent to Seattle Children's Hospital where she died after being removed from life support. There was no initial explanation as to why she stopped breathing.

The mother explained to investigators from the Medical Examiner's office that after dinner this child and her two-year-old brother were upstairs in their bedroom they share and their 10-year-old sister was cleaning her bedroom. The mother was downstairs studying. The 10-year-old went into the other bedroom and found the 13-month-old face down on the pillow unresponsive. She ran downstairs with her sister in her arms and alerted their mother who called 911 and began CPR.

As of June 25, 2010, there is still no official cause and manner of death. A laboratory report is pending. However, the Medical Examiner reports no evidence of child maltreatment associated with this death. The Medical Examiner informed the assigned Child Protective Service (CPS) social worker that this child had a non-inflammatory muscle disease and that is what likely caused her death. The Medical Examiner reported this is an organic problem not caused by any person.

Children's Administration (CA) did not have an open case on the parents of this child at the time of her death. In August 2009, CPS intake received a report of physical abuse of this child and neglect of her two siblings by their mother. The intake was screened in for investigation and closed in November 2009.

Intake History
On February 24, 2004, a nurse at a sexual assault clinic called CPS intake to report the sister of the now deceased child (then three years old) was sexually assaulted by an adolescent friend of the family. The child's mother missed two appointments to bring her daughter to the sexual assault clinic. The mother did eventually follow through and got her daughter to the clinic. This intake was screened for the Alternate Response System (ARS).

On March 22, 2004, CPS intake received a police report into the investigation of the sexual assault of the sister. A church pastor told the investigating officer the child's mother was involved in illegal activities and he thought she was into drug trafficking. The pastor reported different men brought the child to school. She would be dirty, with no socks, no shoes, and sometimes in pajamas. The pastor said the child complained of being alone and

going without breakfast. The intake was screened in for investigation and closed with an unfounded finding for negligent treatment or maltreatment.

On December 23, 2004, CPS intake received a report from a social worker who reported the older sister of the now deceased child claimed her mother left her alone at home when she exercised, spoke to her in a harsh manner, and had not obtained sexual assault counseling for her. The intake was screened in for investigation. The assigned worker determined that the mother did enroll her daughter in counseling and the investigation was closed with an unfounded finding for negligent treatment or maltreatment.

On August 22, 2006, a child care provider contacted CPS intake after she observed marks on the arms of the older sister. The child said she got the marks from a belt and also said her mother had choked her. This intake was screened in for investigation and closed with an unfounded finding for physical abuse.

On August 24, 2006, a law enforcement report was sent to CPS following the investigation that the sister of the now deceased child was left home alone by her mother. She was seven years old at the time of this report. This intake was screened in for investigation and closed with an inconclusive finding for negligent treatment or maltreatment. .

On September 19, 2006, a teacher called CPS intake and reported the older sister came to school on September 18, 2006 with a fat lip. She told other children at school that her mother hit her because she was angry and caused the injury. When school officials asked her about the injury, she changed her story and reported that she fell off the monkey bars and hit her lip on the ground. This intake was screened in for investigation and closed with an unfounded finding for physical abuse.

On March 15, 2007, a teacher called CPS intake to report the sister of the now deceased child was absent from school for many days and the school could not get in touch with the child's mother. This intake was screened as Information Only.

On May 11, 2007, a teacher contacted CPS intake to report the sister of the now deceased child and her mother were homeless and living in a motel. The child did not show up for school and school staff contacted the motel manager to inquire about her. The motel manger reported the day before the child was left alone and was hungry, but the motel manager did not call CPS. On May 11th, the motel informed the school that the mother and child checked out and left no forwarding address. This intake was screened as Information Only.

On May 19, 2007, a child care provider reported to CPS intake concerns about the sister of the now deceased child. She was eight years old at the time of this report. The child care provider reported the child had poor hygiene. She also had bruising and red flaking skin on her arms. Child care staff tried to talk to the child about the marks on her arms but she

responded that she would be in trouble if she talked about the marks. The child would show up at times without a packed lunch. The family was homeless. This intake was screened in for investigation.

The child was interviewed and made no disclosure of abuse. Her hygiene was good. The mother denied the allegations and refused to participate in offered services. She and her daughter moved to California. The assigned CPS social worker contacted social services workers in California and made a report of on-going concerns regarding this mother and her daughter. The case in Washington State was closed with inconclusive findings for physical abuse and negligent treatment or maltreatment.

While in California, the mother gave birth to another child, a boy, in December 2007. CPS became involved on medical neglect issues. This boy and his older sister were eventually placed in foster care following the filing of a dependency petition. The children were returned to the mother's care in January 2009.

The mother gave birth to the now deceased child in January 2009. Social workers in California did not file a dependency petition on this child.

In May 2009, this mother and her two children returned to Washington State. The children were still dependents of California. An Interstate Compact on the Placement of Children (ICPC) request was submitted by social workers from California and approved by social workers from Washington. The case was assigned to a social worker in Washington for case monitoring and supervision.

In August 31, 2009, the director of a transitional housing shelter reported other residents reported hearing the mother yelling at her children. There was a report the mother hit her son, then 20 months old, on the chest, though it was unknown when this occurred or caused an injury. Another resident mentioned that mother kicked her daughter, then age 10, on the back. There was no report of injury. Two weeks prior the mother swatted her seven-month-old daughter (the now deceased child) on the leg.

The referrer said the mother could potentially lose her housing because of her temper and behavior toward other residents. The mother was later told to leave the shelter because she had a shotgun in the trunk of her vehicle.

ICPC in Washington decided that the mother violated the agreement with California and the open ICPC case was closed September 10, 2009.

The assigned CPS worker interviewed/observed the children, met with the mother, and contacted multiple collaterals involved in the case. It was determined that the allegations were unfounded and the case assignment was closed November 7, 2009.

On February 1, 2010, CPS intake received a report from the King County Medical Examiner regarding the death this 13-month-old child. She was found in bed unresponsive by her mother. The Medical Examiner determined the child died from a lack of oxygen to the brain. The intake was screened in for investigation. The case was closed with an unfounded finding for negligent treatment or maltreatment. At the writing of this report, the Medical Examiner has not issued an official cause and manner of death. The Medical Examiner is reporting the child died from an undiagnosed muscle disorder and the death is unrelated to abuse or neglect.

Issues and Recommendations
Issue: Chronicity and resistance to services.

Children's Administration received nine reports from 2004-2007 concerning abuse or neglect of the older sister of the now deceased child — who was then the only child. There was a documented pattern of avoiding CPS and the agency was not able to engage the mother in shared planning to learn more about the underlying issues or to develop a strong service plan.

Recommendation: Workers and supervisors should pay close attention to families that chronically refer. These should be thoroughly reviewed and efforts made to engage them in services.