Report to the Legislature

Quarterly Child Fatality Report

RCW 74.13.640

October - December 2007

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Table of Contents
Children's Administration Quarterly Child Fatality Report

Executive Summary

This is the Quarterly Child Fatality Report for October through December 2007 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 issue a report on the results of the review to the appropriate committees of the legislature and shall make copies of the report available to the public upon request.*
>
> *(3) The department shall develop and implement procedures to carry out the requirements of subsections (1) and (2) of this section.*

This report summarizes the information from 8 completed fatality reviews from fatalities that occurred in 2006. All but one was reviewed by a regional Child Fatality Review Team.

The reviews included in this quarterly report discuss fatalities from Regions 5 and 6.

Region	Number of Reports
1	0
2	0
3	0
4	0
5	1
6	7
Total Fatalities Reviewed During 4th Quarter, 2007	**8**

Child Fatality Reviews are conducted when children die unexpectedly and their families had an open case or received services from the Children's Administration (CA) within 12 months of

their death. Child Fatality Reviews consist of a review of the case file, identification of practice, policy or system issues, recommendations, and development of a work plan, if applicable, to address the identified issues. A review team can be as few as two individuals (in cases where the death is clearly accidental in nature), to a larger multi-disciplinary committee where the child's death may have been the result of abuse and/or neglect by a parent or guardian.

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

The chart below provides the number of fatalities reported to CA, and the number of reviews completed and pending for calendar year of 2006 and 2007. The number of pending reviews is subject to change if CA learns new information through reviewing the case. For example, we may learn that the fatality was anticipated rather than unexpected, or there is additional CA history regarding the family under a different name or spelling.

Child Fatality Reviews for Calendar Years 2006 & 2007			
Year	Total Fatalities Reported to Date Requiring a Review	Completed Fatality Reviews	Pending Fatality Reviews
2006	62	42	20
2007	54	0	54

The numbering of the Child Fatality Reviews in this report begins with number 06-36. This indicates the fatality occurred in 2006 and is the 36th report completed for that calendar year. The number is assigned when the Child Fatality Review and report by the Child Protective Services Program Manager is completed.

Recommendations made by the child fatality review team are included in this report verbatim.

Child Fatality Review #06-36
Region 6
Kelso Division of Children and Family Services (DCFS)

This ten-month-old white male died of homicide by abuse on October 24, 2006.

Case Overview

On October 21, 2006, Children's Administration (CA) received a call from St. John's Hospital in Longview about the decedent who presented at the emergency room with severe internal bleeding and bruises to the forehead and cheeks. He was allegedly found unresponsive by the mother's sister and boyfriend, who were providing care while the mother was at work. The child was airlifted to Doernbecher's Children's Hospital in Portland, Oregon where the seizures continued. He was later found to be brain dead. On October 24 the ventilator was removed, and the child died.

The mother's boyfriend was arrested and convicted for manslaughter after he confessed to assaulting the child.

Referral History

CA received 24 referrals on the parents of the 16-year-old mother prior to the decedent's birth. She and her siblings were placed into foster care in 1997 and later in 2002 due to physical abuse, neglect and sexual abuse. Two referrals on the decedent were made prior to his death.

On October 19, 2006, a medical provider reported three parallel marks on the decedent's face said to have been accidentally caused by a heater while the mother's boyfriend was drying him after a bath. The skin under the infant's right eye was raw and swollen, and there was a thick, dark mark around the back of his neck and a dark red mark under his chin. The mother claimed that the marks around the eyes were caused by the child rubbing his own eyes with his fists but she did not know how the other marks occurred.

The assigned social worker learned from medical professionals that the child had been seen for burns to his tongue and cheek on September 8, 2006. Some of the injuries reported on October 19 occurred in September.

On October 20, 2006, law enforcement and the assigned social worker conducted a home visit with the 16-year-old mother who said the boyfriend no longer cared for the infant. She thought the boyfriend accidentally walked too close to a heater, which caused the facial burns, but the other injuries were unexplained. The child was with the mother's own father at the time of the home visit. The social worker conducted a visit with the grandfather and infant that same day. The grandfather

had concerns about the boyfriend, and he agreed to watch his grandson more closely.

On October 21, 2006, CA was notified that the decedent arrived at an emergency room unresponsive. The mother allegedly found him in that condition when she returned home from work. The mother's boyfriend and her sister were responsible for the decedent. Physicians found intensive internal bleeding, but were unsure as to the source.

Recommendations

No formal recommendations were made by the review team.

The Summary of Review section states:

The referral on October 19, 2006, was under investigation when the second referral was received. The social worker met face-to-face timeframes and appropriately inquired with medical professionals as to the injuries. The social worker saw the decedent on October 20, 2006, while he was in the care of the maternal grandfather. The family sought appropriate medical attention following the incident as verified by medical records and conversations with the medical professionals. All records indicate that the injuries leading to the October 19 referral were plausible, given the explanation by the family.

On October 20, 2006, after being seen by the social worker, the decedent was taken to the clinic to be seen. The clinic staff did not report concerns. The next referral, received on October 21, 2006, involved the severe abuse of the decedent by the mothers' boyfriend, which ultimately resulted in his death.

Child Fatality Review #06-37
Region 6
Olympia DCFS

This two-hour-old Hispanic male died from premature birth from methamphetamine use by the mother.

Case Overview

On May 16, 2006, this male infant was born at 22 weeks gestation. The mother tested positive for methamphetamines. The infant died two hours later from prematurity and chorioamnionitis, with the mother's methamphetamine use listed as a significant factor.

Referral History

A domestic disturbance between the mother and father was reported to CA in September 2002. The father claimed the mother tried to smother their baby. The mother was arrested for attempted assault, and the baby was placed with relatives while CPS investigated. Law enforcement dropped charges due to a translation error about the initial allegations. Family Preservation and Hispanic related community services were provided. The case was closed as Founded for neglect.

On May 11, 2006, the Washington State Patrol contacted Children's Administration for protective placement of two pre-school aged children of this family. Law enforcement arrested the mother and father for sale and possession of illegal drugs. The mother was admitted to the hospital for abdominal pain during the arrest. The decedent was born 5 days later. Findings as to the surviving children were Founded for neglect.

Recommendations

No recommendations were made by this team.

The summary of the review section states:

The review team discussed this case at length. During the review there were lengthy discussions regarding the use of the risk assessment tool in the three referrals that were received, and the proper use of the risk assessment process. There were inconsistencies in how staff utilized the tool and responses that were provided.

There were case notes that one of the children had been placed in out-of-home care, and had been referred for a mental health assessment. The mental health liaison attended the fatality review for this portion of the discussion. The assessment noted several things that were inaccurate, including noting that the

mother had attempted to smother the child two times. The only allegation involving smothering was from 2002. That referral was unfounded, and later determined to be the result of a misinterpretation when law enforcement was on the scene. In talking with the mental health liaison, she had reviewed the record, and did not understand the CAMIS documentation and how to read the file appropriately. The mental health liaison stated that she did not realize that the allegations were unfounded, and used this information in her mental health assessment of the child. The supervisors in attendance at the review stated that they would continue to work with the mental health liaison in understanding how to read the files and interpret the information.

No formal work plan was recommended or developed. The death was a natural death, and due to premature birth.

Child Fatality Review 06-38
Region 6
Centralia DCFS

This two-year-old Caucasian male died accidentally in a motor vehicle accident.

Case Overview

On October 16, 2006, a logging truck lost control of the trailer after it crossed the center line. Logs from the trailer fell on the family car driven by the decedent's mother. The mother's attempts to avoid the truck were unsuccessful. Law enforcement and the medical examiner concluded the fatality was an accident.

Referral History

There were seven prior referrals on this mother. Three were information only, two were alternative response services (ARS) and one was investigated by child protective services. The referrals included allegations of substance abuse, domestic violence and neglect. Services offered to the family included parenting classes, drug and alcohol evaluations and domestic violence resources. Services were not accepted by the family. The CPS investigation was closed Unfounded.

Issues and Recommendations

No formal issues or recommendations were identified.

The Summary of Review section states: "This case was closed at the time of the fatality. The death occurred on October 16, 2006, and the last referral on the family was January 27, 2006. The case was closed on February 8, 2006, with a finding of Unfounded. The mother was already connected with community resources and had cooperated fully with the department. There was little to no risk when the case was closed. No issues were identified regarding practice or policy. The automobile accident was a tragedy for the community and this family."

Child Fatality Review #06-39
Region 5
Tacoma Department of Early Learning (DEL)/ Division of Licensed Resources (DLR)

This three-month-old Caucasian male died from bronchitis-pneumonitis or RSV (Respiratory Syncytial Virus).

Case Overview

On March 2, 2006, the child care provider for the decedent called Children's Administration to report that she found him limp and unresponsive. At 8:50 a.m. Cardio Pulmonary Resuscitation (CPR) was administered by the provider and calls were made to the mother and aunt of the child. The aunt immediately responded went to the care provider's home where she found the provider administering CPR. The aunt instructed the provider to call 911 while she resumed CPR. Paramedics were unable to revive the infant, who was later pronounced dead at Mary Bridge Hospital in Tacoma.

The medical examiner determined bronchitis-pneumonitis or RSV (respiratory syncytial virus) as the cause of the death.

Referral History
Licensing Complaint History:

07/23/04: Licensing Complaint - Non-CPS
A day-care client alleged that the girlfriend of the father of her children picked up her children often, despite a request to the contrary. The results of the complaint were not documented until October 2005. Findings for character and report/record keeping were Invalid.

10/19/04: Licensing Complaint - Non-CPS
The mother alleged that her 11-month-old son had a red mark around his neck and a bite mark on the arm when picked up from the day care. The injuries were believed to have occurred from another child. Findings for lack of supervision were Inconclusive.

12/20/04: Division of Licensed Resources/Child Protective Services (DLR/CPS)
The mother reported that she asked her son if he had been "popped" at the day-care because he had been upset when she picked him up. The child answered to the affirmative. The mother alleged that her son had two bruises on his right shoulder, which she said may have been inflicted at the day care. The DLR/CPS investigation was Inconclusive as to physical abuse. The licensing complaint findings for discipline and supervision were determined to be Inconclusive.

12/15/05: Licensing Complaint - Non-CPS
A child welfare social (CWS) worker reported concerns about the condition of the daycare. The daycare home was allegedly cluttered and messy, which the caller believed to be dangerous. The caller also alleged that the daycare provider was frustrated because the child was not sleepy at nap time. Licensing issues of "facility environment" and "nurture/care" were found to be Not Valid.

12/29/05: Licensing Complaint - Non-CPS
Additional information and concerns from previous report. Investigation of licensing issues for facility environment, discipline, and nurture/care were all found Not Valid for this referral.

The biological mother and father of the decedent have no CA history.

Issues and Recommendations
Issue: The screening decisions appear correct. The information provided by the complainant on licensing issues at the daycare was designated as "licensing only" and therefore correct.

However, the intake worker appears to have inadvertently related the referral to the business identification number for the daycare provider's previous license application that was closed in early 2003. It appears that the Children's Administration (CA) intake worker selected the first business identification number that appeared in the Children's Administration Management Information System (CAMIS) under the provider's name. Thus the alert that routinely goes to the assigned daycare licensor when a referral is taken did not go to the current licensor assigned to the daycare provider under the new license and new business identification number, but rather to the previous licensor and supervisor under the old license application. The current licensor did not become aware of this licensing complaint from July 2004 until October 2005.

The previous business identification number for the day care provider should have been merged with the new business identification number issued in mid-2004. Primary responsibility for merging old with new business identification numbers for licensed day care resides with the Department of Early Learning (DEL) and not with Children's Administration. It is not known how many daycare providers licensed in the State of Washington have multiple business identification numbers that have not been merged. Thus it is difficult to gauge the potential of similar incidents to occur.

Recommendation for DEL: Consideration should be given by DEL to review statewide the issue of unmerged business identification numbers.
Actions Taken: Both DEL supervisors from the Tacoma office participated in the fatality review and indicated that currently the Tacoma DEL licensors are directed to merge closed business identification numbers when a provider obtains a new business identification number for a new license.

The current Tacoma DLR/CPS supervisor, who participated in the review, noted that she also merges and connects duplicate daycare license business identification numbers in CAMIS when such becomes apparent during her intake review process.

Issue: As noted, because the referral was not related at intake to the correct business identification number, the current licensor was not notified and did not become aware of the licensing complaint until October 2005. Thus the licensing investigation was not initiated nor completed in a timely manner. The DEL licensor did document the delay when the error was discovered and proceeded to conduct the licensing investigation. The licensing investigation activities were consistent with expected practice, and the resolution appears to be supportable ("Not Valid" for both reports/record keeping and character issues).

It was noted during the review that because the originating intake was connected in the data base to the previous (closed) business identification number, the Service Episode Record narratives (SERs) documenting the licensor's activities, were therefore also connected to the wrong license.

Recommendations: None.

Actions Taken: Both the licensor and supervisor participated in the discussion regarding the licensing investigation activities.

Issue: The information provided by the referent (complainant) to Tacoma CPS intake related to concerns that her child may have been injured by other children at the daycare she had used on a weekend (the daycare). The decision was made by DLR/CPS to change the initial assignment from a DLR/CPS for investigation to that of a licensing complaint (non-CPS). It was noted by the DLR/CPS supervisor that two weeks prior Kent CPS had accepted for investigation a report from another daycare provider that the now complaining parent may have caused injuries to her own child that the parent was now attributing to having occurred at the daycare. It was noted during the fatality review that the result of the Kent CPS investigation on the parent was "Inconclusive" for child maltreatment.

Similar to the July 2004 referral, CA intake again related the referral to the business identification number for the daycare provider's previous license application that was closed in early 2003. Again the alert that routinely goes to the assigned daycare licensor when a referral is taken did not go to the licensor assigned to the daycare provider under the new license and new business identification number, but rather to the previous licensor and supervisor under the old license application. The DLR/CPS supervisor reviewing the referral immediately noticed the error and connected the referral to the correct license and business identification number. Thus the licensing investigation was initiated and completed in a timely manner. However, the old business identification number remained unmerged with the new business identification number.

Recommendation for DEL: As noted previously in this report, consideration should be given by DEL to review statewide the issue of unmerged business identification numbers.

Actions Taken: Both DEL supervisors from the Tacoma office participated in the fatality review and indicated that currently the Tacoma DEL licensors are directed to merge closed business identification numbers when a provider obtains a new business identification number for a new license.

The current Tacoma DLR/CPS supervisor, also participating in the review, noted that she also merges and connects duplicate daycare license business identification numbers when such becomes apparent during her intake review process.

Issue: Overall the licensing investigation activities were consistent with expected practice, and the resolution appears to be supportable (Inconclusive for supervision issues). However, the licensor did not contact the CPS worker investigating the allegations against the parent who had complained about the daycare. The licensor did not review the CPS investigation documentation which included additional concerns from the parent about other licensing issues at the daycare which would have been sufficient to generate a new licensing complaint referral. The Kent CPS social worker who investigated the parent was not contacted for this review. It is unknown why that worker did not contact intake following the allegations by the parent as to multiple concerns (licensing issues) regarding the daycare.

Recommendation: None.

Actions Taken: The licensor and licensing supervisor both participated in the review and received feedback regarding the licensing investigation activities. The licensor acknowledged her oversight in not contacting the Kent CPS worker who was simultaneously investigating the complaining parent. The licensor and licensing supervisor agreed that the information obtained from the parent by the Kent CPS worker would likely have been sufficient to cause an additional licensing complaint referral.

Issue: A parent alleged that her 2-year old son may have been intentionally injured while attending the daycare. The decision to accept the report for investigation by DLR/CPS appears correct.

However, CA intake again related the referral to the business identification number for the daycare provider's previous license application that was closed in early 2003. And once again the alert that routinely goes to the assigned daycare licensor when a referral is taken did not go to the licensor assigned to the daycare provider under the new license and new business identification number, but rather to the previous licensor and supervisor under the old license application.

DLR/CPS did contact the contact the current licensor, and thus both the DLR/CPS investigation and the DEL licensing complaint investigation occurred in a timely manner.

Recommendation for DEL: As noted previously in this report, consideration should be given by DEL to review statewide the issue of unmerged business identification numbers.

Actions Taken: Both DEL supervisors from the Tacoma office participated in the fatality review and indicated that currently the Tacoma DEL licensors are directed to merge closed business identification numbers when a provider obtains a new business identification number for a new license.

The current Tacoma DLR/CPS supervisor, also participating in the review, noted that she also merges and connects duplicate daycare license business identification numbers when such becomes apparent during her intake review process.

Issue: Overall the DLR/CPS investigative activities were consistent with expected practice, and supervisor involvement in the case was exceptional. Together the DLR/CPS investigator and the DEL licensor made an unannounced visit to the daycare to co-conduct interviews and checking the daycare records. The DLR/CPS finding regarding the daycare was supportable (Inconclusive for physical abuse).

Due to the unavailability of the parent and child involved in the allegations against the daycare provider, the investigating social worker was not able to meet some required timeframes (e.g., face-to-face with victim; completion of the investigation within 45 days). The DLR/CPS supervisor, following policy, noted the granting of timeframe waivers, although the documentation was not made in a timely manner.

Based on information from the daycare as well from statements the parent made to the DLR/CPS investigator, DLR generated a separate CPS referral on the parent. Information gathered during the investigation suggested there was reasonable cause to believe that the mother's boyfriend may have caused past and current bruising to the child, and that the mother may have suspected it. It was noted during the review that the results of the CPS investigation on the parent and her partner were Inconclusive as to maltreatment.

Recommendation: None.

Issue: Most of the licensing investigation activities were consistent with expected practice, and, as previously noted, the DEL licensor conducted a site visit with the assigned DLR/CPS investigator. However, there is no documentation that the licensor contacted the parent who had called in the complaint. While the licensing

resolution appears to be supportable (Inconclusive for supervision and discipline) based on the DLR/CPS investigation (which included contact with the parent and an interview with the child), the licensor's failure to contact the parent is viewed as a significant oversight of expected practice.

Recommendations: None.

Actions Taken: The licensor and licensing supervisor both participated in the review and received feedback regarding the licensing investigation activities. The licensor acknowledged the apparent failure to contact the parent to discuss the alleged concerns at the daycare. The licensor and supervisor stated that such oversight was not typical of the licensor's practice when investigating licensing complaints.

Issue: The first referral in December 2005 stemmed from observed concerns for the general environment (potential hazards) and nurture/care provided by the daycare provider. It is unclear whether observations were actually made by a DCFS social worker or by a case aide while returning a dependent child from a visitation session. The second referral appeared to be a reiteration of the concerns reported two weeks prior and an additional concern for discipline at the daycare. While generating a second referral does not appear to be unreasonable, another option would have been to add the new concern to the recent referral. The intake decisions to assign the reports as licensing complaints (non-CPS) appear to be appropriate.

Unlike previous referrals, these referrals were correctly connected to the active business identification number under the active daycare license, and the DEL licensor and supervisor were alerted.

Recommendation: None.

Actions Taken: Discussions by CA Program Managers and Intake Leads across the state have occurred over the last two years regarding unnecessary creation of multiple referrals. The issue has been the artificial inflation of referral histories when new referrals are created on information already documented in previous referrals or which could be added to a recently created intake report. This has resulted in more referrals now being documented as "addendum to allegations" rather than additional (duplicated) referrals being generated on a family or facility.

Issue: Overall the licensing investigative activities were consistent with expected practice. This included making two site visits following each licensing complaint referral, contacting the referent, interviewing the daycare provider, and contacting the guardian of the child. The resolutions appear to be supportable (Not Valid for facility environment, nurture/care, and discipline).

Recommendations: None

Actions Taken: The licensor and licensing supervisor both participated in the review and received feedback regarding the licensing investigation activities.

Issue: Following the death of a child attending the daycare, concern surrounding the provider's delayed response in calling for emergency medical response was reported by the DEL licensor. The report was accepted for DLR/CPS investigation, and that decision appears correct.

A review of the documented DLR/CPS investigative activities showed exceptional work by the assigned social worker. The investigator actively sought information from law enforcement and the Pierce County Medical Examiner's Office, as well as consultation with medical professionals. Practice expectations were met or were exceeded. Documentation was detailed and comprehensive. Collaboration with DEL demonstrated best practice. The finding at completion of the investigation ("Unfounded for negligent treatment or maltreatment") was supported by the facts of the case and medical opinion regarding the circumstances surrounding the child's death.

Noted in the DLR documentation was the inability of the DLR/CPS investigator to obtain autopsy information from the Pierce County Medical Examiner's Office.

Recommendations: For CA: While RCW 26.44.030 authorizes CPS to obtain records from all mandated reporters (including Medical Examiners and Coroners) when there is an active investigation of child abuse and neglect, 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 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 legislative change so that CA may be authorized to obtain autopsy and investigative records from Medical Examiners and County Coroners. It is recommended that CA continue to pursue this matter with the legislature.

Issue: Two DEL licensors conducted the site visit to the daycare following the fatality, and this is routine practice for the Tacoma DEL office. The DEL licensor and supervisor worked collaboratively with the DLR/CPS social worker staffing the case twice. The decision to issue a temporary summary suspension of the license after the fatality appears to be reasonable. As additional information surfaced (as noted above), the decision to lift the summary suspension also appears to be reasonable.

Overall the licensing investigative practices met expected practice. The Facility Complaint Record indicated a single licensing issue, that of "failing to report" (which was found to be Not Valid). In reviewing the concerns surrounding the circumstances of the child fatality, it would have been reasonable to have identified nurture/care as the more accurate licensing issue. The panel concluded that based on the information documented by both DLR/CPS and DEL, a finding of Valid for nurture/care would have been reasonable.

Recommendation: None.

Actions Taken: Tacoma DEL is currently working on training for licensors that addresses the need to improve accuracy of licensing issue identification so that the complaint record reflects the concerns presented in licensing referrals.

Issue: Discussion occurred during the fatality review regarding multiple DEL licensing and/or DLR/CPS referrals involving individual daycare providers (daycare home or daycare center). The question was raised in the context of a specific daycare provider having received six complaints in just over a two year period (July 2004 – December 2006), including the child fatality at the daycare in March 2006. However, the discussion was broadened to the recognition of possible "red flags" regarding licensed daycare providers who have an exceptional number of complaints.

Recommendations: None.

Actions Taken: Since 2005 DEL's Licensed Child Care Information System (LCCIS) "automatically triggers" a notification when a daycare receives 10 or more complaints within 3 year period. The daycare provider then is called into the DEL office to address the referral history. Similarly, following a child fatality in a licensed foster home, DLR/CPS has initiated as review process for licensed foster homes which appear to have a pattern of reported concerns.

Issue: Previously DEL was a division within DSHS and was called the Division of Child Care and Early Learning. Currently DEL is a separate department and no longer a division within DSHS.

CPS Program Managers from each of the six DSHS regions continue to be responsible for conducting reviews for child fatalities occurring in licensed daycare facilities, even when the family of the deceased child has no known CA history. This includes responsibility to review DEL records, facilitating the actual review, and writing the CA Child Fatality Report (CFR) with identified issues and recommendations.

Recommendation: DEL should consider conducting an independent child fatality review when there is a death of child in a licensed daycare home or center. This could be facilitated by DEL risk management staff.

Child Fatality Review #06-40
Region 6
Stevenson DCFS

This 14-year-old Native-American female died from suicide.

Case Overview

The parents of the decedent sent this teenager to live with relatives in Omaha, Nebraska. She attempted suicide twice after the age of ten, when she first started using several drugs. On January 31, 2006, she stepped in front of a moving train and was killed.

Referral History

On June 6, 2005, the decedent called Children's Administration twice to report that she was in a crisis residential center due to an attempted suicide. She said that she did not want to return to her mother's home because her mother was physically abusive and had been striking her in the face with her fist for two years. She had no injuries at that time. Allegations were that the mother was a recovering alcoholic and that the father was a practicing alcoholic. One referral was screened to Family Reconciliation Services (FRS) for a Child In Need of Supervision (CHINS) petition and the other was screened as moderately low risk. Services with mental health providers were monitored for several months until the child returned home.

On November 21, 2005, allegations were made that the decedent had bruises on her right hip allegedly caused by the mother after an argument. CPS found bruises and placed the child into foster care until November 28, 2005. She was then moved to Vancouver, Washington to live with her older sister. She moved to Nebraska to live with relatives shortly thereafter.

Issues and Recommendations

Issue: It is reported in the referral from June 2005 that the decedent was Native-American, and specifically from the Yakama tribe. There are no indications in the file that attempts were made to involve the Tribe in the case.

Recommendation: Social worker staff will be reminded by the supervisor that they need to make contact and work with the Tribe when a child is identified as being Native-American.

Issue: In June 2005 the mother contacted the department to request FRS services. At the same time, the decedent made allegations of physical abuse. The referrals clearly stated that she was hospitalized then for mental health issues. The records

from the mental health facility were not requested until after the case was closed and reviewed by the supervisor.

Recommendation: Review with staff the importance of gathering all information to fully assess the service needs of the family prior to determining the case to be closed.

Summary of Review: This case was very difficult, as the decedent had extreme mental health issues and repeated suicide attempts. Although the department was not involved with the case at the time of the death, the case remained open, only waiting for the closing paperwork.

During the review several practice issues were discussed. The two that needed follow-up in the office involved the Tribe for Native-American children, and requests for the medical records. Neither occurred. It does not appear from the record that any attempts were made to contact the Yakama Tribe, even when the decedent was placed into foster care. The mental health records may have been helpful for a service plan and support for the mother, who sought assistance. The records were not requested until several months after the decedent's death when the case was being reviewed for closure by the supervisor.

Child Fatality Review #06-41
Region 6
Vancouver DCFS

This 20-month-old Caucasian male died from multiple stab wounds.

Case Overview

On May 19, 2006, the mother of the decedent repeatedly stabbed him in the stomach and back with a large knife. The father, who was outdoors at the time, called 911 when the body was discovered. The child was pronounced dead by responding emergency medical professionals.

Referral History

The following referrals pertain to the mother and father of the decedent. Other children in the home include a five-year-old sister and a three-year-old brother.

On June 6, 2002, allegations were made that the mother left her 18-month-old child by the road for 1.5 hours. The caller took the child to her home until the father arrived. The child screamed when he arrived and did not want to leave with him. Allegations included recent episodes of "severe domestic violence" that led to bruises to the mothers face. The referral was investigated and closed as Inconclusive.

On July 28, 2003, allegations were made that the mother left her 4-month-old infant in the middle of a parking lot at a public library and then drove away. CPS found that the mother had been involuntarily committed for psychiatric reasons three weeks prior. The mother said she committed the act because someone had put methamphetamines in her water supply. CA filed a dependency petition and placed the children with grandparents while the mother received services. On October 17, 2003, the mother admitted herself for psychiatric care. While hospitalized she had hallucinations and was described as psychotic and depressed.

The father obtained custody of the children, and the case was dismissed in April, 2004. A voluntary service agreement with the father required that he not leave the children alone with the mother.

On May 20, 2004, CA was called about concerns for the mother's mental health and care for the children. The caller alleged that the mother went to a neighbor's home at 3:00 a.m. because she feared someone with a knife was in their home. The referral was screened as Information Only.

On July 8, 2004, the father called CA alleging that the mother was involuntarily admitted for an unspecified psychotic disorder. He stated that the mother's mental health symptoms had worsened. He claimed she had become assaultive since the

birth of their second child and that she was currently pregnant (with the decedent). The referral was screened as Information Only.

On September 3, 2004, CA was notified of the decedent's birth. Medical staff alleged the mother was depressed with episodes of psychosis. The mother allegedly attacked a nurse in July during a prenatal visit. The referent said the family has significant stress due to the mother's mental health but the grandparents had provided strong support. The caller said that the mother was alone with the children at times. The referral was investigated and closed as Inconclusive.

On January 23, 2005, a mental health professional called 911 because the mother was suicidal. She spoke about "taking her children with her." Day care services were offered and the case was closed in April 2005 as Unfounded. An official supervisory review occurred in September 2005.

On May 19, 2006, CA was notified about the murder of the 20-month-old decedent. Family Preservation Services (FPS) was contacted and with help from the maternal and paternal grandparents the father was able to relocate the two surviving children. The home was found to be unsanitary and the father negligent because he allowed the mother to have unsupervised access to the children.

Issues and Recommendations

Issue: In September 2004, the previous social worker entered a note in the case file about retiring and that the next social worker assigned would need to follow-up to make sure that the mother received appropriate mental health services. The next social worker was assigned the case but did not attempt to make contact with the family until December 2004. The first meeting between the new worker and the family was January 2005.

Recommendation: The local management team should develop a process for how to re-assign cases in a timely manner when a worker leaves the agency.

Issue: There were numerous referrals in the file alleging neglect of the children by the mother, due to incapacitation from mental health issues. It did not appear that the mother was asked to sign a release of information or that efforts were made to obtain copies of her mental health records. This information may have been useful to plan for services to the family and protection for the children.

Recommendation: The Area Administrator has initiated meetings with the county mental health agency to revise the MOU. In addition, work was initiated to set up regular meetings with the county mental health agencies to conduct staffings and promote communication. It is recommended that the Area Administrator continue to work on these two processes and complete the MOU with the county mental health agency. The local staff needs to be reminded to coordinate with mental

health to obtain the proper records of parents when they pertain to the care and welfare of their children.

Summary of Review

The review for this fatality was conducted on October 11, 2006. Due to the criminal investigation, it took longer than usual to get the necessary information. This case revealed several areas of practice that could be improved, in addition to positive case practice that needs to be recognized. The Vancouver DCFS office prides itself on utilizing relative resources whenever possible. In this case, although one child had been in placement for a while, they were always placed with the relatives. In an attempt to keep this family together, there were many efforts to provide in-home services. Unfortunately the mental health issues of the mother were far more in-depth than the agency was aware. Local mental health providers had been working with this mother for several years as well.

In the case file there was an Investigative Risk Assessment for each of the cases that were investigated. The Investigative Risk Assessment includes a summary of the history of child abuse and/or neglect, the description of the most recent child abuse and neglect, and an assessment of the risk levels of the caregivers and the children. The Investigative Risk Assessment was utilized inconsistently in this case. The rankings for the individual risk ratings were not consistent with the overall level of risk. In many areas there would be indications of high risk in certain categories, but then the overall rating would be low. This tool is a very subjective tool, and has not been shown to have high inter-rater reliability.

In October 2007, the entire Children's Administration will discontinue the use of the Investigative Risk Assessment and use the new evidence based tool: Structured Decision Making (SDM). This tool is more concise and will not require a worker to enter individual risk categories for each characteristic for the caretaker and child, but will ask the worker to answer a series of questions related to the circumstances of the case. The overall result will be a computer generated score which will help the social worker determine what cases will need to be opened for services.

Child Fatality Review #06-42
Region 6
Kelso DCFS and DLR

This 16-year-old Caucasian male died in an automobile accident.

Case Overview

On February 20, 2006, this male was killed while riding as a passenger in a friend's vehicle. The 19-year-old driver of the vehicle was intoxicated at the time of the accident. The medical examiner determined the manner of death as accidental.

Referral History

The decedent and several siblings were adopted by this foster family while they were licensed. There were six referrals on this foster/adoptive family prior to the fatality. Five were reported when this was a licensed foster home from 1998 to 2003. One referral occurred after closure of the license in 2005.

On October 8, 1998, a caller reported that a foster child was squeezing a kitten to the point the animal was in pain. The foster father instructed her to stop, since the kitten was crying out in pain, but she refused. The foster father then pushed her and she fell to the ground and shouted, "You hurt me." No injuries occurred. The referral was screened to licensing, where no licensing violations were found.

On September 29, 2002, allegations were made that the foster father punched an adopted son in the chest to stop an altercation with another child. The referral was assigned to the Division of Licensed Resources/Child Protective Services (DLR/CPS) and closed as Founded for abuse.

On October 2, 2002, allegations were made that an altercation occurred between the foster parents, and the foster father was asked to move out. The referral was screened to licensing and concluded as "Valid" for licensing complaints.

On October 9, 2002, allegations were made that the foster father struck the adopted daughter in the face which left a bruise. The referral was assigned to DLR/CPS for investigation and closed as Unfounded for abuse/neglect.

The foster family requested closure of their foster family license in October, 2002, during the DLR/CPS investigations.

On November 14, 2002, DLR investigated allegations of sexual abuse by the foster father and closed the investigation as Unfounded.

In January 2003 the Division of Licensed Resources closed the foster home license.

On June 1, 2005, allegations were made that one of the adopted males in the home sexually abused a younger adopted daughter. The incident was alleged to have occurred while the family was licensed. CA policy requires that DLR/CPS investigate allegations of abuse or neglect when the event was alleged to have occurred while the home was licensed. DLR/CPS closed the case as Unfounded.

Issues and Recommendations

No recommendations were made. The Summary of Review section stated the following:

"The fatality of this child was due to an automobile accident, where the driver had been drinking and using excessive speed. This case involved a tragic car accident where two young teenagers lost their lives. The previous foster parents are now actively involved in the local community on educating teens on drinking and driving. The vehicle the decedent died in was placed on display in the local community as a reminder of what can happen when the choice is made to drink and drive."

Child Fatality Review #06-43
Region 6
Kelso DCFS

This 3-month-old Caucasian female died from homicide by abuse.

Case Overview

On January 22, 2006, emergency services were called because the mother found the decedent unconscious in her crib. The father had been caring for the child prior to the mother's return from work. Several small bruises and an abrasion on the left side of the face were noted by emergency medical technicians. The child was transported to St. John Medical Center where resuscitation attempts failed and she was pronounced dead.

The autopsy later revealed non-accidental trauma as the cause of death. The father admitted to snapping the child's head backward, although he denied that it was with enough force to kill her. He was charged with murder and is awaiting the criminal trial.

Referral History

The only referral received on this family was the referral regarding the fatality and the bruising to her twin sister. CPS placed the twin sister with a relative. Injuries found on the surviving sibling included bruises to the face, mouth, left ear and left eyebrow. The case was closed as Founded for abuse by the father.

Issues and Recommendations

Issue: An after hours worker was not dispatched when this child died, per policy, since the surviving child was placed on an administrative hospital hold. The decision proved to be a hardship on the relationship with law enforcement, since they wanted a social worker present while they investigated at the hospital.

Recommendation: The local office is working on a protocol with local law enforcement regarding after hours responses in fatality situations. The protocol will include a special team trained to respond to high risk and intense situations.

Issue: Cowlitz County borders the state of Oregon, where many children in high risk situations are seen. The issue of jurisdiction is handled on a case by case basis and there are concerns for Washington children in care in Oregon.

Recommendation: A meeting will be planned with after-hours in Oregon to discuss jurisdiction issues, practice issues and how to work cooperatively in these types of situations.