Report to the Legislature

Quarterly Child Fatality Report

RCW 74.13.640

January - March 2007

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Children's Administration Child Fatality Report

Executive Summary

This is the Quarterly Child Fatality Report for January through March 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 26 completed fatality reviews from fatalities that occurred in 2005 and 2006. All but one was reviewed by a regional Child Fatality Review Team. One case was reviewed by an Executive Child Fatality Review (ECFR) Team.

The reviews included in this quarterly report discuss fatalities from Regions 1, 2, 3, 4, 5 and 6.

Region	Number of Reports
1	1
2	4
3	1
4	7
5	4
6	9
Total Fatalities Reviewed During This Quarter	**26**

Child Fatality Reviews are conducted when children die unexpectedly and their families had an open case or received services from the Children's Administration (CA) within 12 months of their death. Child Fatality Reviews consist of a review of the case file, identification of practice, policy or system issues, recommendations, and development of a work plan to address the identified issues. A review team can be as few as two individuals (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.

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

The chart below provides the number of fatalities reported to CA, and the number of reviews completed and pending for calendar years 2005 and 2006. The number of pending reviews is subject to change if CA learns new information through reviewing the case. For example, we may learn that the fatality was anticipated rather than unexpected, or there is additional CA history regarding the family under a different name or spelling.

Child Fatality Reviews for Calendar Year 2005 – 2006

Year	Total Fatalities Reported to Date Requiring a Review	Completed Fatality Reviews	Pending Fatality Reviews
2005	62	61	1
2006	61	30	31
2007	54	0	54

The numbering for the Child Fatality Reviews in this report begins with the number 05-47. This indicates the fatality occurred in 2005 and is the 47th 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 #05-47
Region 2
DCFS Yakima

This 25-month-old Caucasian male died from drowning on May 13, 2005.

Case Overview

The 18-year-old, previously dependent mother of this child and her boyfriend stayed overnight at his mother's home in Wapato, Washington, Yakima County. The boyfriend was not the father of the child. On the morning of May 13, 2005, while the mother and boyfriend were asleep and other adults that lived in the home had left for work, the child awoke with no adult supervision. He exited through the side door of the home and fell into a back yard swimming pool where he drowned.

Police reports indicate the child was put to sleep in a first floor room by himself on the evening before his death. The mother of the child and the boyfriend slept in a separate room while the boyfriend's mother and her other two adult sons slept in their own rooms. The boyfriend attempted to check on the child after he awoke but found the bed empty. He searched the residence until finding a sliding door open and then went outside and checked the in-ground swimming pool at the residence. He did not see the child. He continued to look but did not find him. Afterward, he woke the child's mother and together they searched until the child was found floating face down just below the surface of the water on the far side of the pool. The boyfriend retrieved the child while emergency services were contacted. EMTs responded and transported the child to Yakima Regional Medical Center. Resuscitative efforts were unsuccessful, and the child was pronounced dead by ER personnel at 10:32 a.m.

Referral History

On May 1, 2003, a third party referral was received indicating that the 16-year-old mother delivered this child and that the father of the child was 22 years of age. She was 15 when she became pregnant. The referral stated that no one wanted to disclose the father's last name to protect him from prosecution. The referral was screened as Information Only.

On October 17, 2003, an anonymous caller reported that the mother was providing poor care for her then five-month-old baby. Allegations indicated that the mother neglects changing the baby's diaper on a regular basis and allows the baby to cry for long periods of time. This referral was screened as Information Only because the mother was already involved with Family Preservation Services (FPS) at that time.

On July 16, 2004 Children's Administration (CA) received a report that the 17-year-old mother ran away from her placement taking her son with her. The referral was screened as Information Only.

The mother has an extensive history with Children's Administration as a child. Her caregivers have in excess of 30 referrals made to the department from 1991 to 2003. In 1995 at age nine, she and her two siblings were placed in relative care under an in-home dependency with their biological father due to severe domestic violence between the mother's mother and her live-in boyfriend. The girls lived with him until 1998 when allegations of sexual abuse caused them to be moved. He was eventually convicted of first degree child molestation. The mother experienced multiple placements with relatives and foster care from 1998 to 2002. The dependency was dismissed when she aged out of the system in November of 2004

An internal staffing occurred when the mother gave birth to this child in April, 2003. Discussions referenced the possibility of filing a dependency petition. It was determined that there was adequate family support for the mother to keep the child in her care. On January 24, 2003, the mother was returned home on an in-home dependency (during her pregnancy). Services were provided to maintain placement. On July 12, 2004, the mother ran away from her home until picked up by the Yakima Police Department on September 16, 2004. On September 20, 2004 she was placed with her cousin by court order until her dependency was dismissed on November 3, 2004.

The mother participated and completed a three month parenting program through the Yakima Community Service Office (CSO) titled, Growing Capable Parents. She began the program when the child was approximately 1 1/2 years of age. Some of the topics taught were building family strengths, personal wellness, family commitment, communication strategies, self care, drama triangle, guidance and discipline, avoiding problems with children, acknowledging positive behavior, reducing stress, and denial. Her instructor's evaluation of her was as follows: The mother is doing very well in the class. She attends regularly and is very appropriate in the class. She is very quiet, but polite. She faces a number of obstacles with grace and dignity. She is a wonderful mother of a baby boy who is growing beautifully. Her peers see her as a "role model."

Issues and Recommendations

Practice Issue: Clearer direction for social work staff in assisting dependent teens who are expectant parents.

Recommendation: Dependent teens who are to be expectant parents should be required to successfully complete a parenting class which emphasizes all areas of safety. Social workers will continue to use current case staffings (Prognostic; Child Protective Team (CPT); Family Team Decision Making) to address issues

of concern regarding expectant teen parents who appear detached or lack the skill to parent a child. Successful completion of Independent Living Skills should be a requirement for a teen prior to Dependency being dismissed. These recommendations will be forwarded up the chain of command in Region 2.

Issue: Grief counseling after a fatality.

Recommendation: Peer support group or a contracted provider needs to be available for staff immediately after a child fatality occurs. This recommendation will be forwarded up the chain of command for Region 2.

Child Fatality Review #05-48
Region 6
DCFS Centralia

This 13-year-old Mexican-American male's remains were discovered in Riverside County California. The manner of death was homicide by abuse.

Case Overview

On December 28, 2005, Children's Administration (CA) was contacted by Child Protective Services (CPS) authorities in California indicating that the remains of this 13-year-old had been discovered in Riverside County California. Investigators concluded that he had died from homicide in Randle, Washington while living with an aunt and uncle and that his body had been transported to California after the homicide. His body was found buried in concrete at the residence during an investigation into the homicide of this 13-year-old's brother, an 11-year-old Mexican American boy who also had been living with the aunt and uncle. Law enforcement in California first became involved because the uncle reported that the 11-year-old had been accidentally fatally injured. Investigators later found that the 11-year-old died of homicide.

CPS in Washington received limited information regarding the criminal investigation because California authorities would not share information due to the pending criminal trial of the aunt and uncle.

The 13-year-old moved in with the aunt and uncle when the biological mother was sent to prison in 2004. The 11 year-old joined the family early in 2005. Information about the biological mother's criminal history was not obtained.

Referral History

On January 16, 2005, CA received a report from an anonymous caller alleging that the 13 year-old (then 12-years-old) and biological children of the aunt and uncle "are not well cared for." The caller stated that the children are subject to emotional abuse. The referral was screened as Information Only and not assigned for investigation.

On February 3, 2005, CA received second hand allegations that the 11 and 13-year-old boys were reporting to an adult sibling that the aunt and uncle were using and selling drugs and hitting the children. The referent called the boys but "they did not disclose abuse." The intake worker called staff at the elementary school asking about their impressions of care for these children. No disclosures or unusual bruising had been noted. The school agreed that they would watch the boys for indications of child abuse or neglect. The mother was said to be released from prison on May 5, 2005 and indicated that she wanted the boys back, but

there was much disagreement among family members about that. The referral was screened as Information Only.

On July 21, 2005, CA received a call from a counselor who had been to the family home that day. She stated that the family had been up all night due to the boys' behavior problems. The 13-year-old was allegedly using household items to sexually abuse his younger brother. The 11-year-old was having recurring nightmares. The 13-year-old was under 24-hour supervision and wasn't allowed out of his room until the other children were secured. The biological mother had recently been released from prison, and the 13-year-old had allegedly been placed on a train the previous day to return to California. Since the 13-year-old was believed to have been sent away, the referral was screened as Information Only and not assigned for investigation.

On August 25, 2005, CA received a call from the aunt inquiring about an At-Risk-Youth Petition for the 13-year-old. She said that he was out of control, disrespectful and that he came and went as he pleased. She said that he was gay and that he had been seen in the company of an unknown older man. The referral was assigned for investigation based on combined information of referrals to this point.

The social worker attempted to see the family at their home and left several phone messages. The family called on August 29, 2005 stating that they were moving to Oregon but they agreed to meet the social worker at a local mini-mart on their way out of town. The family was informed of the allegations. The 11-year-old was asked about abuse and neglect which he denied. The family claimed that the 13-year-old was in Seaside, Oregon, which was not true. His body was actually in the trailer with the family's possessions. The social worker checked welfare records finding that the aunt had recently alleged homelessness and would not provide an address to welfare workers. Suspicion was noted, but the case closed due to the family's departure from Washington.

Issues and Recommendations

Issue: Upon receipt of the referral in August 2005, the social worker made attempts to see the family at their home. They were not there, and the social worker later agreed to meet the family in town to interview them. The social worker met with the family together and did not interview the 11-year-old separately. The 11-year-old denied that his brother had done anything to him when he was questioned in the presence of his aunt and uncle. In addition, the social worker did not collaborate with law enforcement to see what, if anything, they were doing on the case.

Recommendation: Throughout this review process, the local law enforcement agency and the CA office worked closely together. They were cooperative with one another and shared information whenever possible. The detectives from the

Sheriffs Office have expressed an interest in attending the training social workers attend sponsored by Harborview Medical Center. They stated that they would like to be able to have a better understanding of the dynamics involved in interviewing children in CPS and make better connections with social workers in this work.

Child Fatality Review #05-49
Region 6
DCFS Vancouver

This one-day-old female child died of cardiac arrest.

Case Scenario

On October 16, 2005, this baby girl died of cardiac arrest secondary to a diagnosis of cyanotic congenital heart disease. Physicians caring for the mother detected the disease during pregnancy. Surgery was scheduled to occur on October 19, 2005. This child's death was unpreventable.

Referral History

There have been two referrals on the mother regarding other children. The first referral, dated July 14, 2005, alleged that her then nine-month-old baby had small bruises on his genitals and hips and sores on his genitals. An investigation concluded that the baby had a fungal infection that needed treatment. The mother sought appropriate medical attention, and the infection was properly treated.

The second referral was received on August 30, 2005. The referral alleged that the decedent's 10-month-old brother had a displaced transverse fracture. The referent stated that there was no way an injury of this magnitude could be self-inflicted by a 10-month old child. The mother repeatedly denied having any explanation for what could have caused the injury. Initially, the child was placed into protective custody, and a dependency petition was filed. Extensive medical testing concluded the fracture could have been accidental. Based on the results of the medical reports, the baby was returned to the care of his mother and a Voluntary Service Plan was developed and monitored by the department. The maternal grandmother was involved with the family and provided support to the mother and her three children.

Issues and Recommendations

Issue: There are many gaps in documentation in the file, and it is difficult to clearly discern what happened following the fatality and dismissal of dependency. There are notes on November 10, 2005, and then nothing until a supervisory review on April 28, 2006 stating that the supervisor instructed the worker to enter their SERs. In addition, there is an attempted contact with the family on May 15, 2006, and a staffing with the supervisor on May 31, 2006. The supervisor again entered text instructing the worker to enter their documentation and collateral contacts. On October 5, 2006 there was a supervisory review entered, but no text. It does not appear that the worker followed the instruction of the supervisor to enter the necessary information.

Recommendation: Review the policy requirements with the social worker involved for entering SERs on a case plan.

Issue: The second referral involved the fracture of a leg on a then 10-month-old baby. The baby was initially placed into protective custody, and a dependency petition was filed. Upon receipt of the medical records stating the fracture may have been the result of accidental trauma, the child was returned home. There are no records in the file that the local Child Protection Team utilized to staff the case, or other means of shared decision making were used to make the decision to return the infant home.

Recommendation: Review the policy with staff as to when and where a CPT is required for cases.

Child Fatality Review #05-50
Region 6
DCFS Kelso

This 17-year-old boy died from suicide on October 25, 2005 in Cathlamet, Washington.

Case Overview

On October 25, 2005, this teenage boy told his mother that he did not want to go to school because he was sick. His mother spoke to him later, at approximately 10:00 a.m., when he informed her that he had made a doctor's appointment at the Cathlamet medical clinic for 2:45 p.m. The child's mother returned home prior to the appointment to check on him but was unable to locate him in the house. She drove to the doctor's office thinking that he left early to his appointment. She returned home to search further after learning that he was not at the doctor's office. She found her son in the shed behind the house hanging from a rope tied to rafters. Police reports and family reflect no explanation for this child's suicide. He had contacted his girlfriend who reported no problems between them. Several drug screens were conducted during the autopsy, at the request of the mother, but no substances were found.

Referral History

Two prior referrals were reported regarding this family.

The first referral in 1990 was for physical neglect and sexual abuse. The anonymous referent reported that the oldest child, a female sibling of this boy, "Played Trick or Treat" with her father. The game was played by putting their hands down each others pants and "tickling their privates." A nanny in the home reportedly had this information about the incident, but she was not contacted. The case was closed as Unfounded.

On May 26, 1998, a referral alleged that the boys were spanked with a belt and made to stay outside all day. The children came home from visits with their father with urine stained underwear and dirty clothes. They did not appear to have been bathed. The referral alleged that the father hit the boys when he was alone with them. The case was closed as Inconclusive.

On July 28, 2005, the mother requested Family Reconciliation Services (FRS) and an At Risk Youth (ARY) petition after this child refused to come home from a visit with his girlfriend in Ellensburg. A home visit occurred with the mother but she did not follow through with the petition, and there was no further contact. The social worker sent her a letter on October 12, 2005 requesting that the case be closed because follow through on the petition had not occurred.

Issues and Recommendations

This case was reviewed with the regional CPS Program Manager, the social worker, the supervisor, Prosecuting Attorney/Coroner, and the Director of the Wahkiakum County Health and Human Services. The file was reviewed at length to determine if there were any practice issues that needed to be addressed. Policies were all followed in this case. There were no previous identified concerns of mental health issues or any other areas that would have warranted further involvement by Children's Administration. The Wahkiakum County Health and Human Services Department has been working with the community on the development of materials to address suicide. The director reports that Wahkiakum County experiences 2-3 suicides per year, which is high for their population. The director stated that depression is an issue for community in the lower Columbia area. She further states that their mental health system is operated by the county government. There are no waiting lists for assessments, and people are able to access services very quickly. The county prosecutor works closely with the department on filing of At Risk Youth petitions and assists families when they need it. There is a close working relationship between the county prosecutor’s office and the department.

Child Fatality Review #05-51
Region 6
DCFS Kelso

This 16-year-old male died in his bed of unknown causes.

Case Overview

On November 25, 2005, at 11:32 a.m. the Longview Police Department and medical personnel were dispatched to the home of this family when the father found the child not breathing while attempting to wake him. The father attempted CPR but was unable to do so because the child's jaw was firmly shut. The child was pronounced dead at the scene by the county coroner. The home was searched but nothing suspicious was found. Police reports indicate that the coroner's office found no signs of physical trauma and that toxicology samples were sent to test for drugs in the child's system. The coroner's office cited confidentiality as the reason for a decision to not share results of the tests with the department.

The family reported that on the previous day the family celebrated Thanksgiving. They reported nothing out of the ordinary had occurred. A disagreement about a game system occurred between this child and one of his friends. The child reportedly called the Longview Police Department to settle the dispute. Officers responded and the matter was settled. The child watched television with the father before going to bed and asking to be awakened in the morning.

Referral History

On July 19, 1993, a referral alleged domestic violence and drinking between the parents that led to the father's arrest. The referral was screened as a low standard of risk and a letter was sent after a telephone call to the mother, who denied abuse. No allegations of abuse and neglect were made regarding this child.

On September 11, 1996, a referral alleged that police came to the home on the previous evening because the father was drunk and holding a knife on the mother. The child talked the father into putting the knife down. Referral was screened as Information Only.

On December 8, 1997, a referral alleged that the mother had a drinking problem and that she slept for long hours and was unable to speak coherently or get the child ready for school. Referral screened for low risk investigation. Parents refused services and the child denied abuse/ and neglect.

On December 9, 1997, the child called CPS crying, stating that his mother had been drinking and that he was afraid. He said she was in bed and that she had

been “getting sick.” The referral was investigated and closed as Founded for physical neglect.

On December 13, 1997, a referent alleged that the mother was being released from hospitalization against medical advice. She was admitted on December 11, 2007 “in a very intoxicated state.”

On August 1, 2000, law enforcement responded to a call of harassment by this child. Allegations were that he was throwing rocks at another child in the neighborhood. Caller alleged that the child was assaultive toward others. The referral was assigned for a low standard investigation and closed as Unfounded.

On September 27, 2000, law enforcement called about a report they received alleging that the father had assaulted and threatened to kill a neighborhood child. Referral was screened as Information Only.

On January 9, 2001, a referral alleged that the mother was not taking the child to school. The referral was screened as Information Only.

On February 8, 2001, a referral alleged that the child was stating that his father was physically abusive toward him. The child alleged that the father hit and cut his lip and that he had been striking him with a belt. The referent alleged that the lip was cut and healing. The referral was assigned for investigation and later closed as Inconclusive for physical abuse.

On September 7, 2005, allegations were made that the mother and child were at a hospital asking for pain medication. The caller alleged that both appeared incoherent and intoxicated by prescription medications. The mother had to be removed from the scene as she was interfering with treatment for the child. A hospital hold was placed on the child pending a CPS investigation. The case was closed as Inconclusive for physical neglect on November 3, 2005.

On November 29, 2005, a referral was made by the Longview Police investigating the “suspicious death” of the child. The referral was screened as Information Only because there were no other children at risk. The policy, which states that fatalities must be screened for investigation when abuse or neglect is alleged, regardless of whether another child is in the home, was clarified and communicated to staff on July 12, 2006. These referrals must be accepted for investigation.

Issues and Recommendations

Issue: The social worker interviewed the youth while he was at the hospital reportedly under the influence of prescription medications. He went to the family home later that same day, and the youth was still incoherent. No other attempts

were made to see the youth until one month later. At that home visit, the youth was not home. There were no other contacts with the youth prior to the death.

Recommendation: Since the social worker interviewed the victim when he was under the influence, best practice would have been to return within a few days to re-interview him when he was no longer incoherent. This may have provided important information in providing services to the family.

Summary of Review Recommendations: This review was a bit difficult, because the coroner's office did not release the medical findings for the youth's death. Local law enforcement did provide their reports to assist during the review. The social worker met with the family during the referral prior to the youth's death, in September of 2005. The social worker interviewed the youth at the hospital where he was reportedly still under the influence of the prescription medications he was under. The social worker later went to the home to meet with the youth. Notes reflect that the youth was still under the influence at that time and was incoherent. The social worker visited the family home approximately 30 days later. The father was home, but the social worker did not see the youth. There was no other contact with the family prior to the death of the youth.

Child Fatality Review #05-52
Region 6
DCFS Kelso

This one-month-old male infant died of cerebral anoxia, most likely the result of positional asphyxiation.

Case Review

On December 12, 2005, this 22-day-old infant died of cerebral anoxia (lack of oxygen to the brain). The mother, a 16-year-old, fell asleep with the child lying on her chest in the family home. The health department condemned the home due to deplorable sanitary conditions, no heat, water, or electricity. The 16-year-old and her mother (the decedent's grandmother), stated that they had not been living at that residence, but their claims were contradicted by other relatives and school officials who had been providing transportation for the mother. The father found the child next to the sleeping mother, having breathing problems, when an emergency 911 call was made. The child died when he was removed from life support at Emmanuel Hospital in Portland approximately 24 hours after admittance. Law enforcement did not file charges against the mother. Allegations of drug use by the mother and grandmother led to a safety assessment to include random drug testing of the grandmother. The DCFS investigation was closed as Inconclusive for neglect after the 16-year-old mother and her six-year-old brother were placed with a relative.

Referral History

There have been seven referrals to Children's Administration involving this family; two pertained to the fatality of this child.

Two of the earlier referrals were a request by the grandmother for Family Reconciliation Services (FRS) services for her daughter, (the mother of the decedent) because she was running away and not following rules.

Three referrals alleged neglect of the mother's six-year-old brother by the grandmother. Most pertained to neglectful supervision, but one referral was received on December 8, 2005, one day prior to the infant's death. Allegations were that the six-year-old arrived at school at 11:30 a.m. with arms that were red and cold. He said that there was little food, no electricity, and no running water. He said that he didn't know where his mother was and that he was residing with his 16-year-old sister and her boyfriend. The referral was screened as Information Only. Following the death of this child, the six-year-old went to live with a maternal aunt. There was no court intervention in this case because the grandmother agreed to leave the six-year-old with a relative.

Issues and Recommendations

The review team spent an extensive amount of time discussing the screening in of the referral the day prior to the infant's death. The referral was screened as Information Only, and he was not identified as a victim. The team agreed that the referral was screened appropriately, based on the information provided to the department. The discussion included support for the new practice model changes that will be happening within the department, and the potential use of structured decision making to support the work of intake in making decisions. The staff discussed their current work with schools on how to make reports of child abuse/neglect, and educating them on risk assessment and the information needed when they make referrals. All policies and timeframes were followed in this case and there are no practice or policy issues that need to be addressed as a result of this fatality.

Child Fatality Review #05-53
Region 2
DCFS Sunnyside

This 3-month old female infant died from position asphyxiation.

Case Review

On December 13, 2005 Children's Administration (CA) received a referral from the county coroner in Yakima stating that this 3 month-old infant died as a result of accidental positional suffocation. The referral was screened as Information Only because no allegations of child abuse or neglect were made.

This mother has two surviving male children, ages one and nine years old.

Referral History

Children's Administration received two prior referrals on the mother of this infant.

On July 8, 2003, allegations were made that the mother and father had been in the hospital for the birth of a previous child on June 20, 2003, but the child died after birth. The father became "out-of-control and acted very violent." The mother did not receive prenatal care, and she tested positive for amphetamine, methamphetamines, and marijuana. The caller was concerned about the 7 year-old in the home. The referral was screened as Information Only.

On September 13, 2005, a referral alleged that the mother and father had been in the hospital for the birth of the decedent and that the father had been "extremely verbally abusive to the mother and other two children." A doctor was called to calm the father who was yelling loudly and cursing. The 9-year-old had a broken femur, which the parents said was the result of falling off a ladder. The mother claims to have lost five children to miscarriage or premature birth. The referral was investigated and closed as Founded for negligent treatment on the father. The mother declined services for grief and support.

Issues and recommendations

Issue: Increasing public and community awareness of the dangers of co-sleeping with infants.

Recommendation: Actions are already being taken with television and radio educational campaigns, as well as community presentations by public health nurses.

Child Fatality Review #05-54
Region 6
DCFS Long Beach

This seven-week-old male infant died of accidental positional asphyxiation on December 26, 2005.

Case Review

On December 26, 2005, the Long Beach Police Department responded to a 911 call at 6:50 a.m. from the grandmother of this infant. She reported that her grandson was not breathing and CPR was attempted. The child was transported to the Ocean Beach Hospital where he was pronounced dead. The Long Beach Police Department reported that the mother admitted to consuming alcohol to the point of intoxication the night prior. The police reported that the step-father was also intoxicated the night prior and that he fell asleep with the child. The cause of death was ruled as an accidental death due to positional asphyxiation.

The mother was released from the hospital prior to the baby at his birth as he was jaundiced and needed additional medical attention. She initially refused to take the baby to a pediatrician but eventually did use a physician in Longview Washington. The social worker and public health nurse stated that numerous services were referred including a drug/alcohol evaluation with treatment and random urine analysis testing, Women Infants & Children (WIC) and a visiting nurse from the Health Department. The drug/alcohol evaluation recommended intensive outpatient treatment. The mother did not participate in treatment prior to her son's death. The maternal grandmother was in the home supporting the mother and baby. The social worker made a referral for parenting classes.

The public health nurse made a number of home visits and addressed concerns about the living conditions, such as smoking in the home and their pit bull dog. She advised the parents not to sleep with the infant. The public health nurse stated that she stressed the concerns about positional sleeping with both parents and the mother stated that the baby always slept in the bassinet at the end of the bed.

The maternal grandmother was in the home supporting the mother and baby. The social worker made a referral for parenting classes. The parents acknowledged using alcohol the evening prior to the death of the baby. The mother acknowledged she was ill from the alcohol and the father said he fell asleep while holding the baby and when he awoke the baby was dead. The coroner listed the cause of death as probable “Positional Asphyxia”. Law enforcement has investigated this case. The toxicology results during the autopsy were negative for drugs. Charges were not filed on the parents at the time of the review. The investigative findings were Founded for neglect.

Referral History

There were two prior referrals on the mother and three referrals regarding her as a child.

On October 31, 2005, a referral alleged that the 17-year-old mother delivered a child that tested positive for marijuana. The referral was screened as Information Only.

On November 2, 2005, a referral alleged the mother gave birth to the child who is the subject of this fatality review. Mother tested positive for marijuana. The baby was approximately 36 weeks gestation. Public health nurse services were recommended through the hospital.

The mother has a history of conflict with her own mother and was previously involved in Family Reconciliation Services (FRS) through the department. The mother attended alternative school.
The mother and grandmother previously lived with the grandmother's boyfriend. The grandmother alleged that her boyfriend had a sexual relationship with the mother in 2000 when the mother was 12-years-old. The mother indicated that her mother's boyfriend may be the father of the deceased child.

Issues and Recommendations

The review team discussed the case at length. All efforts were made to provide services to the family to alleviate the risk issues. The mother of the infant did engage in some services, but was hesitant with others. The child was very young, born positive for THC and had some minor medical problems at birth (i.e. jaundice).

The committee spent time discussing how referrals of child fatalities are received and assigned when there are no other children in the home and the initial assessment at the scene is that the child died from positional asphyxiation. It was agreed upon in the review that clarification on these issues needs to be sought from HQ and distributed throughout the region to promote consistency in this area. As a result of this recommendation, and changes made to the screening process of fatalities, an e-mail was sent out in July 2006 to all supervisors in the region explaining when to screen in and investigate child fatality referrals.

Child Fatality Review #05-55
Region 6
DCFS Aberdeen

This seven-month-old male infant died in the hospital of natural causes associated with premature birth on December 28, 2005.

Case review

This infant boy was born prematurely on May 20, 2005 at 23.5 weeks gestation. He never left the neonatal intensive care unit. Life support was removed at the recommendation of medical personnel and with the support of the family. He died shortly after the removal of life support due to severe medical complications caused by premature birth.

Referral History

On July 19, 2002, a referral alleged that this father was failing to obtain necessary medical attention for a child (with a different mother) who crashed while riding an all terrain vehicle. A social worker and public health nurse responded and examined injuries but found no reason for concern for his care.

On August 30, 2004, a referral alleged that the mother gave birth to a child weighing one pound, ten ounces and that she was on probation for felony forgery to obtain prescription medication. Hospital staff reported that the mother tested positive for opiates at birth, but this may have been a false positive due to medications provided during the child's birth. DCFS social workers removed the child from the care of parents due to substance abuse and domestic violence. Both parents had convictions for DUI. The mother has also been convicted for vehicular manslaughter. The investigation resulted in Founded findings for negligent treatment.

On May 18, 2005, a referral was made when the mother's twelve-month-old dependent daughter stopped breathing during a supervised visit with the mother. The child was resuscitated and hospitalized. The mother had been instructed repeatedly to not feed the infant on her back since she had severe reflux. The child remained in out-of-home care; findings were Founded for negligent treatment.

On May 21, 2005, the mother gave birth to the decedent that resulted in a referral. The referral alleged the mother had not received prenatal care and medical records reflect "extreme prescription drug seeking" behavior by the mother, although a urine analysis test was negative. The case remained open for Child Welfare Services; findings were Inconclusive for negligent treatment.

Division of Child and Family Services (DCFS) social workers referred the mother to the following services: parenting classes, domestic violence services, chemical dependency treatment, a mental health evaluation and treatment, Women Infants & Children (WIC), First Steps home health nurse, Alcoholics Anonymous, Narcotics Anonymous (available daily), and a psychological evaluation with a parenting component. The social workers focused on maintaining family connections and utilizing relative placements whenever possible.

Issues and Recommendations

The death of this child was due to extreme prematurity. He lived in a hospital from the time of birth until the time life support was removed, 7 months later. The department was involved with his parents, providing services and placement, and later for a different son born in 2006. The department attempted to provide services which would minimize the risks to other children in the family. Unfortunately, the mother ingested contradicting medications during her pregnancy, and refused to enter into treatment services. These medications may have caused the premature birth of this child, which later was the cause of his death.

It is obvious that the social workers involved in this case worked very hard to provide services to this family. Family team meetings were used to develop safety plans with the family. Parenting classes, domestic violence services, chemical dependency treatment and a variety of other services were provided to this family. The social workers focused on maintaining family connections and utilizing relative placements whenever possible.

Child Fatality Review #05-56
Region 6
DCFS Port Townsend

This 5-month-old Caucasian male infant died from accidental asphyxiation.

Case Overview

On December 31, 2005, Children's Administration (CA) received a call that this child had died on the previous evening after the father fell asleep with him on the couch after having fed him at 3:00 a.m. He told law enforcement officers that he awoke to the mother's screaming she entered the room and found his feet on top of the infant. The child was not breathing. No injuries were found and after an investigation and autopsy it was determined that the child died of accidental asphyxiation.

Referral History

On July 31, 2001, a welfare worker called asking for available services for the mother who was homeless at the time. The mother and father were told that a foster home was available for her and the baby, but she declined. The parents had been kicked out of the father and mother's home. The referral was screened as Information Only.

On June 28, 2005, a referral from a medical provider alleged that the mother did not obtain prenatal care. The referrer had suspicions of substance abuse and mentioned that the mother appeared ambivalent about keeping the baby. Referral was screened as Information Only.

On August 15, 2005, a referral alleged that the mother had been seen entering a "drug house" while leaving her two children (ages 2 and 4) in the car for 2 hours. The two-year-old began choking and appeared to stop breathing. He was revived and rushed to the hospital. Hospital staff indicated that they suspected the child was actually having a seizure due to an illness and high fever. The referral was assigned for investigation. The mother claimed that her 12-year-old brother was in the car with her children while she visited a friend for 30 to 40 minutes. The 12-year-old brother verified the claim that he was in the car but law enforcement named the man living at the residence the mother was visiting as a known drug seller. The social worker requested a urine analysis test (UA) but the mother declined. A public health nurse and a babysitter stated that the couple was violent with each other and both parents used meth-amphetamines. Law enforcement were considering charges of vehicular assault on the mother since she rammed her car into the father's, forcing him off the road. The children were in the mother's car when this incident occurred. The incident was investigated and closed as Unfounded.

On August 23, 2005, a referral alleged domestic violence in the presence of the children. A visiting nurse from the Department of Health alleged that she was met in the driveway by the 4 year-old, whom she said was frantically yelling, "My Daddy's got a gun and he's going to kill himself in the front of me." The mother met the public health nurse and 4 year-old outside claiming that everything was fine. Upon entering the house the referent alleged that the father appeared from a back room looking very upset, drug impaired and moving about the room in a threatening manner.

The investigations from August 15, 2005 and August 23, 2005 were combined and closed as Unfounded for physical neglect with "moderately high" risk.

The mother did agree to Alternative Response Services, enrolled the older child in Head Start, and assured staff that medical needs and wellness child medical examinations were being met. The father was in and out of the house sporadically, but did meet with the social worker just prior to the case closure and was referred to a substance abuse program along with mother. Both were referred to couples counseling and anger management.

Issues and Recommendations

System Issues:

Issue: The medical examiner was brought in from Seattle to do the autopsy. The death was ruled as accidental. No unusual trauma found. The local coroner's office worked with the medical examiner and local law enforcement.

Recommendation: Local protocol/agreements should be reviewed to ensure timely reports are provided to DCFS in cases of child death when the department has a case open or had a case open within the last 12 months.

Issue: Prosecutor's office reported to be unhappy with the investigation within the coroner's office. No evidence was found to indicate anything other than an accidental death. The parents both were reported to have drug issues but nothing was ever substantiated.

Recommendation: DCFS to provide prosecutors office with file information when requested.

Issue: The supervisor responded quickly and did consult with Area Administrator. He did open the case to himself and did many follow up visits, calls, and saw the deceased baby. He worked closely with law enforcement and the coroner's office and the Department of Health. This

community was greatly impacted by this child's death. The supervisor went above and beyond to respond to the family and community.

Recommendation: In cases when the supervisor is the social worker for the case, staffing and oversight are to be completed by the area administrator including case reviews.

Practice Issues

Issue: Children were not initially placed in out-of-home care but with the recommendations of the Child Protective Team (CPT) children were placed with the grandparents. The parents both continued to live with the grandparents with the children but the grandparents were very responsible and followed the social worker's guidance. Legal status was by Voluntary Placement Agreement (VPA).

Recommendation: Find creative ways to ensure child safety and continue to support the child/parent bonding. Recommendation is to maintain an open case until completion of the reunification plan.

Issue: The case was closed at the time of the child's death. It had been opened in the past twelve months and therefore, subject to review. The referral came to Central Intake on New Years Eve day. The Area Administrator was notified immediately. The Area Administrator responded within the 24 hour standard.

Recommendation: Central Intake should notify both the area administrator and the local supervisor in cases of child death. All intake policies and procedures in place were followed and response was within the required time frames.

Issue: Community involvement and oversight of this family has been on-going since the birth of the first child. Those agencies having contact with this family included: Economic Services for food stamps and medical coupons, Women Infants and Children (WIC) for the baby, Department of Health through the First Steps and visiting nurse program, Head Start, law enforcement, medical physicians, grandparents, and the Division of Children and Family Services (DCFS). The Department of Health nurse had seen the baby after the birth and had several failed appointments with the mother. The last time the nurse saw the mother or baby was October 3, 2005. At that time the baby appeared healthy. From October 3, 2005 to December 31, 2005, there were no contacts with the family, and there were no referrals from the community. Prior to the death there were two accepted DCFS referrals (August 15, 2005 and August 23, 2005). Both were investigated and were Unfounded and closed. There was no one who could have predicted this accident.

Recommendation: Death ruled an accident.

Issue: Central Intake staff questioned the response of the local law enforcement and asked that the two older children be placed into custody and placed out of the home. Children were traumatized by the death of a sibling and went home with grandparents and their parents. The police found no danger for the older child and did not place outside of the home.

Recommendation: A review by Central Intake staff regarding law enforcement decision to take a child into custody or release to parents.

Child Fatality Review #05-57
Region 2
DCFS Yakima

This 15-year-old Hispanic male died of homicide from a gunshot wound.

Case Overview

On March 24, 2006 Yakima County Coroner's office notified Children's Administration (CA) about the December 31, 2005 killing of this 15-year-old male child. An investigation was underway and preliminary indications were that the incident was gang related. No details regarding the incident were provided. The referral was screened as Information Only.

Referral History

All referrals pertaining to the mother of this child were investigated and closed as Unfounded or Inconclusive unless otherwise noted.

On November 20, 1991, a referral alleged that the mother was using cocaine and that she had struck one of the children in the face with her fist.

On December 17, 1991, a referral alleged that the mother was away from home all night leaving the children in the care of an adult who slept with the 11 year-old.

On November 30, 1991, a referral alleged that the mother left the children alone for two days while she was out partying. The 11 year-old was responsible for taking care of the children and feeding them. Referent claimed that the mother was using drugs. Ages of the children were 1, 4, 6, 9, and 11.

On January 13, 1992, law enforcement called CPS because they were unable to locate the mother to discuss the 15-year-old daughter's suicide attempt. CPS responded and the mother was located at 3:00 a.m.

On January 29, 1992, the school reported that a child of this mother had been absent 22 out of 28 days. One of the children had a cut that was not healing and the other had bruises of unknown origin.

On July 24, 1992, a referral for Family Reconciliation Services (FRS) was made because one of the children had allegedly been running away, skipping school, and using cocaine.

On September 13, 1992, a referral alleged that one of the children had scratches around her eye that resulted from a physical altercation with the mother. The child returned home and the referral was screened as Information Only.

On January 18, 1994, a referral alleged that the mother and her boyfriend were selling drugs from the home. The referral screened as Information Only.

On January 13, 1995, a referral alleged that the mother and children were being evicted. They had no food, medical coupons, or utilities. The referrer alleged that the mother stayed out all night and left the children home alone. The youngest child was two-months-old.

On March 17, 1995, a referral alleged that the mother threw garbage out the back door and that there were health concerns such as rats and other animals.

On May 1, 1995, a referral alleged that the mother left the children home alone and that there was inadequate food.

On May 2, 1995, a referral alleged that a caller from the school reported that one of the children was repeatedly sent home for head lice.

On June 29, 1995, a referral alleged that the teenage daughter in the home was pregnant and bleeding, but the mother refused to take her to a doctor. Follow up contact with the doctor revealed that a doctor's visit did occur on June 30, 1995.

On October 30, 1995, a referral alleged that the mother was leaving the child alone overnight while she was out drinking. The home was allegedly filthy and strewn with garbage and there was little food. The referent alleged that windows had been broken out of the house.

On September 25, 1997, a referral alleged that the children were being left alone frequently and that they missed a lot of school. The referral stated that the children were sent home from school on this date due to head lice.

On February 6, 1998, school staff reported that this child (subject to this review) was "very sad, depressed, and unmotivated." The mother allegedly told staff that his older sister "beats" him while the mother worked at night. Attempts by the school to get this child counseling for his depression were unsuccessful because the mother allegedly would not follow through. School staff reported that the child "cries incessantly" when the older sibling was unavailable and that they had concerns for the level of depression regarding this six-year-old.

On April 15, 1998, a referral alleged that a child in the home had missed 60 days of school that year.

On November 30, 1998, law enforcement called to report that they could not locate the mother to pick up a child who had been a runaway. Efforts to locate the mother were unsuccessful and the child was placed at a secure crisis residential center.

On April 7, 1999, a referral alleged that the mother hit one of the children with a frying pan and that she was threatening to kill two of the children who were staying with relatives. The caller alleged that the mother's husband was selling drugs.

On March 13, 2000, an anonymous referent alleged that the mother screamed at the children and threatened to kill them. Allegations were also made that the mother had a warrant out for her arrest for domestic violence.

On September 23, 2000 a law enforcement officer called regarding the runaway child that had been taken into custody. Law enforcement was requesting help since the mother was in jail on felony charges (not listed) and the step-father would not allow the child to return home. Child was placed in a secured crisis residential center. Allegations included assault of the child by the mother. Referral was screened as Information Only.

On October 8, 2001, a referral alleged that a daughter of this mother was pregnant because her boyfriend was living in the home. Referral was screened as Information Only.

On September 27, 2002, a referral alleged that a two-year-old was playing outside by herself "all day." The child told referent that she was locked out of the home. Police were called after the referent attempted to contact an adult at the residence. Allegations also stated that the child had a burn on her hand that she said was caused by the mother. Police entered the residence after no one answered the door and found the mother, and then they left. The callers reported that she had seen the two-year-old outside alone often, and that she had seen her attempting to get back into the residence by beating on the door while crying.

On January 5, 2004, a referral alleged that the mother was physically abusive toward the children and that the oldest son committed suicide in March of 2003. The caller also reported that this child had been "shipped" to Mexico on more than one occasion to avoid CPS intervention.

On August 10, 2004, a referral alleged that the mother called requesting At Risk Youth (ARY) services for the child subject to this review because he was not attending school and because he had been running away. She claimed that he was "on the streets" late into the evenings. The mother allegedly admitted that she "smacked" him upon his return and the police were called. The mother said that this child broke out windows in the garage and that he was spending time with drug users. The referral was screened as Information Only.

On September 22, 2004, a caller from school reported that this child was not coming to school and family members did not know how to find him. The referral was screened as Information Only.

On October 28, 2004, the mother called CPS requesting Family Reconciliation Services (FRS) because she believed that the decedent was using and selling drugs. He was reportedly gang-involved as well. The referral was accepted for FRS.

On May 6, 2005, a referral alleged that law enforcement reported they responded to a domestic disturbance call between the mother and a teenaged daughter. The mother alleged the daughter was gang-involved and using drugs. The referral was screened as Information Only.

On June 1, 2005, law enforcement reported this child was placed at a secure crisis residential center by police after they responded to a domestic disturbance call. The mother was charged with fourth degree assault. The referral was screened as Information Only.

The Family Reconciliation Services Program (FRS) assisted the mother in filing an At Risk Youth Petition (ARY) due to the child's out of control behavior. An ARY was granted on November 29, 2005. The following services were proposed for the family in this order: Drug/alcohol evaluation for this child, a mental health evaluation for both the child and his mother, and an anger management evaluation for the child. The Department closed the case at the At Risk Youth Fact Finding Hearing.

Issues and Recommendations

Issue: Family had multiple referrals (32) with minimal interventions and services provided.

Recommendation: Policy needs to better address chronic referring families at the intake level and to better assess family and individual needs. The ability to provide concrete resources to families needs to be more easily accessible.

Child Fatality Review #05-58
Region 4
DLR/CPS King Eastside Office

This 18-month-old Caucasian girl died from asphyxia.

Case Overview

On December 1, 2005, this child died from asphyxia after becoming entangled in a cord from a rolled up bamboo window blind while in an in-home day care. She was found slightly suspended in a portable crib in the bedroom where she had been sleeping.

Referral History

This provider became a licensed day-care home for six children, ranging from 0 to 11 years, on October 12, 1993.

On October 7, 1997 allegations were made that the caregiver left three children alone in a truck while picking up her other children. There were allegedly no seatbelts for the children. The report alleged safety hazards in the home as well. The Division of Licensed Resources and CPS investigation was Unfounded for neglect. The day care licensor found "valid" license complaints that this provider was overcapacity by two children and the environment was cluttered. A referral was made for a childcare resources consultant to assist with transitions and environmental design. A compliance agreement was completed on October 10, 1997.

On April 11, 2000 a licensing compliant alleged overcapacity (twelve children). The Licensor found this licensing allegation to be Invalid.

On November 24, 2003 a school bus driver reported concerns about supervision and the environment. Staff and health/sanitation issues were found to be Valid and there was a compliance agreement made concerning some environmental concerns.

On April 7, 2004 a three year-old broke his leg while on a swing in this home. This complaint was Valid for overcapacity and supervision and a compliance agreement was completed.

Issues and Recommendations

Issue: The Division of Licensed Resources/Child Protective Services (DLR/CPS) investigation is very thorough and complete.

Recommendation: Children's Administration should consider having Division of Children and Family Services (DCFS) write investigative summaries in a format similar to DLR.

Issue: The Department of Early Learning (DEL) licenses family child care homes. Providers are granted licenses based on meeting minimum licensing requirements.

Recommendation: The Department of Early Learning (DEL) should consider strategies to raise the level of licensing requirements to focus on the quality of nurture provided to the children by the provider.

Issue: Licensor monitoring - the DEL licensor has about 140 homes to monitor. Homes are monitored every 18 months, at renewal, or if there are any complaints received. The latter often result in unannounced home visits. In this case the childcare provider did have a history of being out of compliance with regulations more than once. However, the safety hazard of the crib next to a blind cord did not exist during any prior visit by the Licensor.

Recommendation: DEL should consider adding blind cord safety hazards to the Washington Administrative Code (WAC), which would allow them to add that item to the safety checklist.

Managers from DEL were present and signed off on this review.

Child Fatality Review #05-59
Region 4
DCFS Tacoma

This 17-year-old African-American female child died unexpectedly from a blood clot that traveled to her lungs while hospitalized for other illnesses.

Case Overview

This 17-year-old was admitted to Mary Bridge Children's Hospital for pneumonia and dehydration. She remained in the hospital for evaluation and tests for suspected Lupus. While in the hospital, the child died unexpectedly when a blood clot traveled into her lungs. Hospital staff were unable to revive her and she was declared dead on July 21, 2005.

Referral History

In November of 2000, a counselor for siblings of this child reported that the boys had disclosed that while on a recent court ordered visit with their sisters at the grandmother's (the licensed foster parent for these children), they were left home alone with no adult supervision for a significant amount of time. All the children were dependents of the state. One of the assigned social workers confirmed the allegation that the grandmother may have been leaving children home alone for periods of time. The report was accepted for CPS investigation of physical neglect (low risk), and appeared to have been addressed by the social worker.

In 2004, CPS was contacted with allegations that the 11-year old sibling had been assaulted by her 18-year old sister while the grandmother was at work. The report was accepted for investigation by the Division of Licensing Resources (DLR). The DLR/CPS investigative results indicated the allegations were Unfounded regarding child abuse/neglect. However, DLR/Licensing conducted a facility complaint investigation (as to licensing regulations) which resulted in Valid findings for discipline and facility environment concerns, and Inconclusive for supervision issues. The 11-year old sibling was removed from the grandmother's care and placed in a foster-adoption home.

On July 18, 2005, DCFS intake received a licensing complaint (non-CPS). The decedent was in the hospital for pneumonia. Lab work indicated the child tested positive for an opiate. She claimed to have taken one of her grandmother's pain pills, but the grandmother denied having any pain medications. The licensing complaint investigation found supervision and other non-specified licensing issues Not Valid.

While in the hospital, the child died unexpectedly when a blood clot traveled into the child's lungs and she went into arrest. Medical personnel determined that the death was neither related to pain medication nor Lupus.

Issues and Recommendations

No recommendations made by the child fatality review team.

Child Fatality Review #05-60
Region 5
DCFS Bremerton

This 19-month-old African-American male child died in the hospital while being treated in a hospital for accidental scalding injuries.

Case Overview

On September 28, 2005, CPS intake was notified by a Harrison Hospital social worker of a scalding incident of this child. The teen mother of the deceased child was lying down at the time of the incident. Another child in the home was boiling water and sugar for tea and went into the bathroom, leaving the kitchen area. Members of the household heard a child's scream from the kitchen where the child was discovered to have been scalded. The child was transported to Harrison Hospital by emergency response and then airlifted to Harborview Medical Center for burns to the chest, neck and arm.

This child was transported from Bremerton to Harborview Burn Center (King County) following an accidental scalding incident at his home. He had burns on approximately 12% of his body. The child remained in the hospital for observation with the plan to discharge him back to his parent as the burns were not severe enough to require extended hospitalization.

The child died unexpectedly on October 3, 2005 while under observation at the hospital. The suddenness of the death resulted in an extensive medical review at Harborview and a comprehensive post-mortem examination including autopsy and extensive ancillary studies (toxicology, serology, metabolic, and histology). The burn incident did not appear to be related to the child's death since the burns were healing and without gross evidence of infection. No anatomic, microbiologic, toxicologic, or metabolic cause of death was identified, and the cause and manner of death were deemed undetermined.

Referral History

The teen mother of the deceased child experienced significant child abuse and neglect as a child.

In February of 2004 a hospital social worker reported that the 15-year-old mother had given birth. The alleged father of the baby was a 25-year-old, who no longer lived in the state of Washington. The report was taken as "third-party sex abuse" with the mother and assumed father identified as the subjects. The information was forwarded to law enforcement. Other information provided to CPS intake was that the teen had admitted to having smoked marijuana early in her pregnancy, but

she stopped when she realized she was pregnant. There were no allegations of neglect to the newborn.

In April of 2004 a public health nurse reported to CPS that the mother had discontinued PHN services after only one visit. There were no allegations or risk of imminent harm and the information was taken as an Information Only report. The assigned CPS worker continued to investigate, but was unable to locate the subject or victims. Contacts included relatives, the school district, Community Service Office, and a letter to a possible residence in Spokane.

In March of 2005 CA was contacted by a federal probation officer who reported that the grandmother had used the decedent as part of a shoplifting scheme. It was believed that the mother was not involved and she was not identified as a subject. The information was accepted for Alternative Response Services but efforts to contact the grandmother were not successful.

The assigned CPS investigator conducted interviews and home visits. A safety plan was created in anticipation of the child's discharge from the hospital. The child was initially scheduled for discharge from Harborview two days after the incident, but the decision was made to keep him over the weekend for observation. The mother had been staying at the hospital with her child. Hospital staff reported no concerns regarding her behavior while at the hospital.

On October 3, 2005 CPS was notified that the child had unexpectedly died at Harborview Hospital. The hospital immediately conducted a multidisciplinary conference but the cause for the patient's death could not be determined. Conclusions were that the death did not appear to be directly related to the burn incident. Law enforcement also investigated the incident. The final determination by the King County Medical Examiner was that the cause and manner of death were undetermined. The CPS case was closed in January 2006 as Inconclusive. The law enforcement investigation was also closed with no charges filed.

Issues and Recommendations

Issue: Intake. The grandmother of the infant was identified at intake as the primary caretaker for her two children and a grandchild. She was also listed as the subject of neglect allegations. The teen parent and primary caretaker of the infant should have had a separate referral created under her name for concerns about her ability to meet her child's needs. CA procedures allow for a minor to be listed as a subject in a CPS referral if that minor is also a parent of an alleged child victim. Due to the referral only being taken under the grandmother's name, all documentation relating to the incident and the teen mother and her child is found only in the grandmother's file.

While the referral was initiated by Central Intake, the error should have been caught and corrected by the local office assigning the referral.

This particular issue was viewed by the review panel as ancillary rather than critical, and did not appear to have any significance to the scalding incident a year later.

Recommendations: None. Identification of 'primary caretaker' can be found in CA Operations Manual – Chapter 15. Action Taken: The issue has been placed on the April 10, 2007 agenda for the state Intake Leads and CPS Program Mangers meeting. Additional discussion is planned for the next scheduled Region 5 intake meeting.

Issue: CAMIS case assignment. The date of the case assignment was confusing. The referral was assigned for investigation on June 4, 2004. The assigning supervisor provided the master file clerk with the date of case assignment, but the clerk entered the case assignment date as June 10, 2004, which was the date the case file was created in Case and Management Information Service (CAMIS), which is the electronic information system currently being used by Children's Administration (CA). The master file clerk should have used the actual date of assignment. This particular issue was viewed as superficial rather than critical, and did not appear to have any significance to the scalding incident a year later.

Recommendation: None. Actions Taken: A pattern of similar procedural errors was recognized at the Bremerton DCFS office and was corrected in 2006. Master file clerks are now entering the actual date of case assignment.

Issue: Investigation/supervision. Documentation by the investigating social worker and supervisor indicated that the worker was unable to locate the family. Efforts reported and reviewed by the supervisor appear to be consistent with the "unable to locate" Region 5 practice guidelines for CPS workers conducting a high standard of investigation. The guidelines were initiated in the Tacoma and Bremerton DCFS offices in September 2002. Under the guidelines, workers were expected to perform a specific set of activities for a minimum of 45 days. The worker and supervisor well exceeded the 45 day standard. However, the case appears to have been kept open for a much longer period than necessary. The case then went inactive with no activities for 6 months (see issue below for more detailed discussion). Additionally, Service Episode Records (SERs) were not entered until nine months after the referral was assigned, which raised concerns regarding accuracy of the documentation (see issue below for additional discussion).

Recommendation: None.

Comments: In July 2005 CA implemented 'Guidelines for Reasonable Efforts to Locate Children and/or Parents' which was based on the Region 5 guidelines initiated in 2002. No minimum timeframe was provided in the CA guidelines.

Actions Taken: The social worker assigned to investigate referral #1524332 was not present during the review as he left state service in 2005. The supervisor at the time of the investigation did participate in the review by phone, and received the feedback. It should be noted that the supervisor currently holds another DCFS position (non-supervisory) in another region.

Issue: Investigation/supervision. Documentation by the assigned investigation social worker was not timely and was not consistent with CA policies for entering documentation into CAMIS/GUI. All social worker SERs were created on March 4, 2005 which was nine months after the investigation was initiated. Several dates and timeframes appear to be questionable. The inconsistencies may be a natural consequence of delayed documentation taken from handwritten notes or from memory. Additionally, one of the social worker's narratives indicated a letter had been sent to the last known residence, but the case file does not contain either a copy of the letter or post office confirmation of an inability to deliver.

During the fatality review, the worker who had been the supervisor at the time recalled being aware of the lack of any SER entries by the social worker. The failure to follow the SER policy was partially attributed by the supervisor to a workload crisis at the time. The panel did not agree with the prior supervisor's claim of a larger system issue within the Bremerton DCFS office. Failures to follow documentation policy may have been largely an issue with that particular unit and social worker. Pervasive practice deficits by the particular worker, such as failing to document social work activities in a timely manner had been of historical concern. Additionally, bias by the supervisor may have been a barrier to adequate supervision of the worker.

The documentation issues during this investigation were concerning to the fatality review panel, but did not appear to have any significance to the scalding incident or fatality over a year later.

Recommendation: None. Policies regarding documentation requirements for activities are already in place.

Comment: CA initiated two state-wide trainings (Lessons Learned from Child Fatalities and Kids Come First Revisited) during 2005-2006, which included discussion on recognizing bias in social work practice. Lessons Learned training continues to be offered in every region for CA social work staff.

Actions Taken: The social worker assigned to investigate referral #1524332 was not present during the review as he left state service in 2005. The supervisor at the time of the investigation did participate in the review by phone, and was provided the opportunity to discuss the panel's concerns with supervision during the time of this investigation in 2004.

Issue: Investigation/supervision. There were no apparent investigative activities between October 2004 and March 2005, a period of six months. Monthly supervisory case reviews did appear to have been conducted, consistent with CA policy. During the fatality review, the supervisor involved with the investigation acknowledged his awareness that the investigation had not been completed in a timely manner, and had gone "inactive" for an extensive period of time.

The lengthy "inactive" issue during this investigation was concerning to the fatality review panel, but did not appear to have any significance to the scalding incident or fatality which occurred in October 2005.

Recommendation: None.

Comment: CA has already taken steps to improve practice in this area, and it would be significantly less likely for such a long period of case inactivity to occur at this time. Following the high profile deaths of two children in late 2005, CA became aware of a large number of "inactive" cases within DCFS which remained "open" but without any documented activities for several months or longer. At that time CA initiated a directive for all offices to review inactive cases and expedite closures where needed. Bremerton DCFS conducted such "clean-up" which resulted in the closure of this case in March 2005. Additionally, improvements were made in CAMIS/GUI such that alerts to social workers and their supervisors are provided if there has been no documented activity (SERs) within the last 30 days on an open case.

Issue: Intake. CPS intake received a report of a child having been scalded. The referral was accepted for investigation of possible neglect. When an incident is reported to CPS that involves possible abuse and neglect of a child and/or a possible crime against a child, CPS is required to notify law enforcement. This is usually done by initiating a referral to law enforcement. There is no evidence in CAMIS/GUI that this referral was referred to law enforcement. Copies of faxed referrals to law enforcement are routinely held by the Bremerton intake supervisor for one year.

Records obtained by CPS during the investigation of the incident and the subsequent fatality, showed that emergency response personnel did notify law enforcement at the time of the scalding incident, although law enforcement did not become involved until after the child unexpectedly died while in hospital. Thus both CPS and law enforcement were notified of the incident around the same time.

This particular issue was viewed by the review panel as unrelated and did not appear to have any significance to the CPS response to the scalding incident.

Recommendation: None.

Actions Taken: Bremerton CPS intake workers have now received new directions regarding documentation of referrals to law enforcement which stem from CPS reports not initiated by law enforcement. For any referral on an open case, the "referral to law enforcement" (known as the LE report) will be routed to the assigned worker to go into the case file. If the referral is not accepted for investigation and relates to a closed case, the law enforcement referral will be routed to master files for inclusion in the case file. Bremerton intake will continue to keep for one year all copies of law enforcement referrals on non-accepted referrals with no prior CPS history.

Child Fatality Review #05-61
Region 5
DCFS Tacoma

On August 31, 2005 this 14-month-old Caucasian female died naturally from complications of the bowel necrosis due to a dilated colon and chronic constipation.

Case Scenario

The medical examiner concluded that this child's death resulted from medical problems not related to care of the child and that the necrosis likely existed throughout her life. She had been seen by numerous medical professionals between June and August, prior to her death. These medical visits included hospital, ER, and doctor office visits, Early Periodic Screening and Diagnostic Treatment (EPSDT), Well Child visits, special evaluation for physical therapy, and physical therapy sessions.

Referral History

The foster home was licensed in July 2003. There were no facility complaints prior to the fatality incident in August 2005.

Subsequent to the fatality there were three referrals (2006), two of which were non-CPS complaints, resulting in non validated issues. The third referral was a DLR/CPS investigation for possible physical abuse on a foster child that was concluded with a finding of Unfounded and no licensing issues validated.

Issues and Recommendations

The review team had no recommendations for CA regarding this fatality.

Child Fatality Review #06-10
Region 6
DCFS Port Townsend

This 18-month-old female died of Sudden Infant Death Syndrome (SIDS).

Case Overview

On January 20, 2006, Port Townsend Child Protective Services (CPS) received a call from law enforcement regarding a possible child death. The father stated he fed the baby at two a.m. then returned to bed placing a pillow between him and child to avoid rolling onto her. The child was found unresponsive when the father awoke. Emergency services were called and CPR was administered. The child had been seen two days prior by the family physician who found her to be healthy, at good weight gain, and with only slight upper respiratory problem. No medications were prescribed. The medical examiner concluded that the cause of death was SIDS.

Referral History

Two low risk referrals were received regarding this mother. On December 26, 2004, a caregiver of this mother and her first child reported that the mother and father were yelling at each other, failing to properly feed and bathe the child, and that the mother was not seeking housing assistance or a job. The family was referred to family court, the Community Services Organization, and to the Health Department for Alternative Response Services.

On December 22, 2005, a public health nurse called requesting services for the mother and this infant because the mother was hospitalized for ulcerative colitis. She was also experiencing post-partum depression. The father had been in and out of the mother's life but was back and was providing care for the infant. Alternative Response Services were initiated with the Department of Health on December 28, 2005.

Issues and Recommendations

Practice

Issue: Staffing was completed as required. Staffing was completed by the Health Department that had on-going contact with the child. The supervisor consulted with the area administrator. This was an open Alternative Response Services (ARS) case although the service was on hold while the mother was in the hospital.

Recommendation: DCFS should review policy regarding when an ARS case should be open or closed.

Issue: Health Department, Police Department and Medical Examiner. The process was slowed because it was necessary to speak directly with the Medical Examiner for information.

Recommendation: DCFS should add to the local office protocol agreement with community partners that they would provide requested records and be received by DCFS in a timely manner.

Issue: Referral for ARS came to the local DCFS office from the Health Department who is an ARS provider. This case had previously been open to ARS when the first child was born but currently is closed. The Health Department had concerns about the mother and the birth of the second child which led the Health Department to request a second ARS referral for the second child. The case was open in DCFS for ARS for the second child. The mother remained in the hospital due to extreme ulcerated colitis and post partum depression, services had not yet begun. There was no intent to use ARS services for the birth father.

Recommendation: The health department should refer suspected abuse or neglect (high or low risk) to DCFS intake and DCFS will screen for the appropriate services.

Issue: Due to the size of the community, the community partners work together to help families with children at risk of abuse and neglect, for example, this case. The DCFS supervisor and assigned worker were in close contact with the health department and worked closely with the police department. This close work enables the community to react quickly when there is a crisis. The DCFS office and supervisor, in particular, did an outstanding job of ensuring all the community partners were contacted. He spoke personally with the father of the baby, the detectives, the medical examiner and the health department worker. This was a tragic case of SIDS.

Recommendation: Community partnerships are good within the Port Townsend area. The recommendation is to continue building and maintaining community partnerships.

Child Fatality Review #06-11
Region 3
DCFS Everett

This medically fragile 20-month-old female died naturally from congenital heart disease.

Case Overview

On July 30, 2006 this one year, eight-month-old-female died from complications of a heart surgery performed two days prior to her death. Physicians deemed the surgery medically essential to her survival. She had been medically fragile since birth with congenital heart disease and DiGeorge Syndrome, which required use of a ventilator and feeding tube. The child remained at Children's Hospital from birth to seven months of age.

Referral History

On May 26, 2005 and May 31, 2005 Children's Administration received referrals from medical personnel at Children's Hospital. The referrals indicated that this child was nearing discharge from the hospital but the parent disabilities prevented them from meeting her extensive medical needs, even with home health nurses. She was placed by Voluntary Placement Agreement (VPA) at the Children's Country Home (CCH) on June 16, 2005. A dependency was later established because her long-term needs would result in specialized foster care, to which the parents were opposed. She remained at CCH for approximately one year until the surgery that preceded her death on July 30, 2006.

Issues and Recommendations

The Regional Administrator authorized a waiver of the remainder of the review because the department and the child's parents agreed to the medically advised surgery that led to the unpreventable death of this child.

Child Fatality Review #06-12
Region 1
DCFS Spokane

This three-year-old Caucasian female died accidentally during a fire in her aunt's home.

Case Overview

On December 3, 2006, a fire started in the home of this child's aunt, where she was spending the night. The aunt's biological children awakened the aunt and they escaped. The aunt indicated that she was unable to save this child. Law enforcement did not investigate because the fire department investigators found the fire to have been accidentally caused by a pillow falling against a space heater. The medical examiner's manner of death was "accidental."

Referral History

An Information Only report was received by Child Protective Services (CPS) on April 14, 2006 regarding the mother of this child. The allegations were that the mother was allowing the child to ride in a car with a person with CPS history, who did not have a driver's license.

The mother has extensive history of abuse and neglect as a child. She was placed out of her own mother's care and lived in foster care and with relatives while growing up.

The aunt was the caretaker only on the night of the house fire. She has a history with CPS that includes four Information Only referrals that were not investigated by CPS because allegations of child abuse or neglect by a caregiver were not made. Those were on May 12, 1994; November 11, 1997; September 13, 2001 and April 8, 2002.

Three high risk referrals dated August 18, 1993, October 13, 1993 and February 2, 1995 were investigated by CPS. One investigative assessment documents a Founded finding. Allegations pertained to substance abuse, neglect, and sexual abuse by the aunt's husband.

A referral on February 12, 1997 alleged that teenagers were drinking alcohol at the residence. No documentation detailed CA response.

Issues and Recommendations

No issues and recommendations identified.

Child Fatality Review 06-13
Region 4
DCFS King West Office

This three-month-old Hispanic male died from diffuse brain injury due to blunt force trauma.

Case Overview

The King County Medical Examiner called the cause of this child's death "diffuse brain injury, with new and old rib fractures, due to blunt force injuries of the head and torso" and determined "homicide by abuse" as the manner of death. The father confessed to causing the fatal injuries during an episode of rage.

Referral History

Child Protective Services received three reports concerning this family prior to the incident that caused the death. The first report, dated April 10 2005, was screened Information Only. A social worker at Highline Hospital reported that the mother had given birth to her daughter and both tested positive for marijuana. There was no prenatal care according to the report.

On April 11, 2005 a hospital worker reported that the mother had agreed to accept the services of a public health nurse (PHN). The referral was screened Information Only.

On April 19, 2006 an elementary school counselor called to report that four of the children had chronic lice. Alternate Response Services (ARS) were referred and a public health nurse was assigned and visited the home. The family was receptive to ARS and the nurse referred them to community resources for head lice supplies, an infant car seat, and medical needs.

On May 15, 2006 the King County Sheriff's Office (KCSO) reported that the decedent was at Harborview Hospital with head trauma. CPS initially placed all the other children into protective custody but they were returned to the mother after the father's arrest and a determination that the mother would be protective. The child died May 18, 2006. The mother and other children subsequently moved to California to be with relatives. According to KCSO, the father pleaded guilty to murder in the second degree.

Issues and Recommendations

Issue: Shaken baby prevention strategies. Currently there is no universal, constant strategy employed toward primary prevention in the whole population. Nor is

there a universal application of secondary prevention efforts toward families with identified risk factors.

Recommendation: Public policy makers and health care officials should consider employing primary and secondary prevention strategies on a broad scale, where the message reaches those most likely to shake an infant. It should provide caregivers with clear, easy alternatives.

Issue: The Child Abuse/Neglect Medical Consultation Network (MEDCON) is available 24 hours a day 7 days a week for CPS, Law Enforcement and other health care providers.

Recommendation: Encourage broad use of the Child Abuse/Neglect Medical Consultation Network (MEDCON).

Issue: The family moved from California. Obtaining criminal histories from other states is difficult.

Recommendation: This issue should be resolved because federal law will soon allow CPS to access the National Crime Information Center (NCIC), managed by the FBI.

Child Fatality Review #06-14
Region 4
DCFS King West Office

This four year-old medically fragile female died of natural causes due to complications from a medical procedure.

Case Overview

On April 21, 2006, the King County Medical Examiner's office ruled this four year-old girl's death as natural, caused by "complications of hypoxic ischemic encephalopathy (brain damage due to lack of blood flow), due to neonatal hypoxic episode due to cardiac tamponade following umbilical catheter perforation for the right heart.

This child was placed into foster care on March 29, 2006 after referrals alleged that she was severely malnourished and that she was being neglected by her mother.

Referral History

There were 16 referrals on this family prior to the child's death. Additionally, the mother's family of origin had 7 referrals reported while she was a child.

On May 13, 1999, allegations were made that the mother's home was "very dirty" and that the electricity and water had been shut off all winter. The five-month-old allegedly was covered in rashes and looked like she had a yeast infection for over a month. The referent stated that the mother spent welfare funds on drugs. The referral was screened as Information Only.

On June 6, 1999, allegations were made that drug paraphernalia was strewn throughout the home and that about 40 empty bottles of alcohol were lying around the house. There was also a weapon allegedly visible in the home despite the fact that the mother is a felon on parole. The case screened in for investigation. The investigating social worker found the home to be unkempt with dirty clothing, drug paraphernalia and empty beer containers. The mother refused access to the child and left the home with no forwarding or contact information and the investigation was closed as Inconclusive but only after the social worker testified on behalf of the father in a custody hearing. The judge awarded the father custody of that child.

On April 3, 2002, a referral was made on the birth of the child subject to this review. She tested positive for marijuana at birth. The referent indicated that the other children appeared healthy and that "the situation had resolved itself." The referral was screened as Information Only.

On August 14, 2002, hospital staff reported that this child was in need of immediate medical care that would require a flight to Spokane. The parents had not visited the child in 2 days and their whereabouts were unknown. The parents had missed doctor's appointments previous to this hospitalization, which occurred on August 7, 2002, but they "had appropriately brought the child into the emergency room" on that date. The referral was screened as Information Only.

On August 17, 2002, a landlord reported that the mother and her boyfriend were abusing substances and neglecting the children. Allegations were that the children had been seen standing against a screen at a third-floor window and that the children and infant had been left unattended at a wading pool. The boyfriend was allegedly violent with the mother and children and had been seen dragging the children around by their arms. The home was described as filthy. The mother and boyfriend admitted to marijuana use but refused services from the department. The investigation was closed as Inconclusive.

On October 2, 2002, allegations were made that the family was homeless due to eviction but they were staying with a friend temporarily. The referent, a Community Services Office (CSO) worker, was concerned because the child had severe developmental problems and the mother was not pursuing recommended treatment. Attempts to get the mother in for substance abuse and anger management services were unsuccessful though she had been ordered to do so by Tacoma Municipal Court for a history of multiple assaults on other adults. The mother said that she would not stop smoking marijuana. The referral was screened as Information Only.

On October 7, 2002, a referral was received by a CSO worker concerned about this child (seven months old at the time). Allegations were that the special needs of this child were not being met by the parents. She had a gastric feeding tube, seizure activity and developmental delays. Third hand information was that the mother was not correctly feeding the child. A follow up telephone call by CA intake to the nutritionist revealed that she did not share specific feeding concerns reported by the referent, but she was concerned about the child losing weight. The referral was investigated and closed as Unfounded for child abuse or neglect.

On April 16, 2004, allegations were made that the parents "smoke marijuana excessively" and that they were dealing drugs from the home. Allegations were that the child was mostly confined to a crib in the bedroom. The referral was screened as low risk and was not investigated.

On October 22, 2004, allegations were made that the mother was not following through with medical recommendations on a newborn including phenylketonuria (PKU) testing, which is a test to check if a newborn baby has the enzyme needed to use phenylketonuria in their body. Medical staff allegedly attempted to engage the family by phone and were told that medical follow up would occur, but it did not. The referral was screened as Information Only.

On April 18, 2005, a referral was received alleging this child was terminally ill and that the mother was unwilling to take her in for immunizations because the mother's regular physician had retired and she did not want to find a new doctor. A public health nurse had been assigned but the mother refused to engage in services. The referral was investigated, referred for physical therapy services and the mother agreed to procure a doctor for the child. The case was closed as Unfounded.

On May 9, 2005, a referral was received indicating that this child had been hospitalized. The parents had "fired" the latest doctor for the child and were using the emergency room for regular medical care. The caller indicated "the child was being well cared for" and the referral was screened as Information Only.

On May 11, 2005, medical staff of a new physician for the family reported that medical records indicate multiple "no-shows" for the last physician (since November 2004). The child allegedly presented with multiple cavities and dime sized bruises on her forearm though the child was bedridden. The child was diagnosed with pneumonia that could be fatal if the mother didn't follow through with medications. Antibiotics were prescribed but the mother said that she would not fill it. The referral was investigated and assessed conjointly with the April 18 referral and closed as Unfounded.

On June 17, 2005, a home health care provider (dietician) reported that she had been working with the family since 2004, but she had been unable to contact them since November of 2004. An appointment was later made when contact was made in May of 2005. On the date of the home visit, the dietician was not allowed in the home and the mother told her that she was not welcome any longer. The referral was investigated but the family refused services and the case was closed as Unfounded.

On September 14, 2005, allegations were made that the father/boyfriend had been violent in the home and that he was being evicted because there had been a "brawl" at the home. The referral was assigned for investigation and closed as Unfounded after the parents refused services.

On February 27, 2006, a caller alleged that the mother was living in the home of a gang member who had just served 10 years in prison for murder. The referent stated the home was "filthy" and that this child was not being fed with clean feeding tubes. The mother allegedly was not feeding the child according to schedule and was leaving the child unattended in a bedroom for up to 6 hours. The mother was alleged to be drug involved. She was allegedly supposed to have taken the child to Children's Hospital, but she had not "because she would never see the baby again." The child's teeth were alleged to be rotting. Referent was "concerned that the child would die" if she didn't see a physician soon. The child

was already hospitalized when an assigned social worker attempted a home visit to investigate.

On March 3, 2006, a call was received by medical providers, informing CA that this child had been sent to Children's Hospital in Seattle (from Moses Lake, Washington). The allegations were that the child "was suffering from extreme malnutrition" and that she had dropped from 8.12 kilograms to 5.97 kilograms since November of 2005. The caller indicated that the malnutrition may have been the result of the child's medical problems. The referral was assigned for investigation and the children were placed into foster care and the case was later closed as Inconclusive.

Children's Administration was informed that this child died in a foster home of natural causes on April 21, 2006.

Issues and Recommendations

Issue: The social worker did an excellent job of investigating the most recent referral prior to this child's death. She did her best to provide a nurturing, skilled foster mother as well as arranging services for the rest of the family.

No recommendation.

Issue: Serving families with a medically fragile child and child maltreatment. The investigations that occurred prior to March 2006 did not include close coordination with health care professionals.

Recommendation: In cases such as this, do refer for the Public Health Nurse Early Intervention Program (PHN-EIP) A PHN could have arranged health care services for the other children in the family who were not getting regular care. In addition, arrange for the regional medical consultant (MedCon) to review the case. Consultants can review cases and medical reports to help workers make the best plans for children with special medical needs.

Issue: Chronic Referrals. There were seventeen referrals and a primary caretaker with simultaneous substance abuse and mental health problems.

Recommendation: The family could have benefited from comprehensive case reviews that focused on patterns of neglect and more effective interventions. The new neglect legislation, effective January 1, 2007, that the Department may intervene where "a pattern of neglect has been shown to cause damage to the health and well-being of the child subject to the neglect; In cases of chronic neglect where health, safety, or welfare of the child is at risk; And if a parent fails to comply with offered necessary and available services, the Department may intervene to protect the child." Current policy and new

neglect legislation should help intake staff in making better decisions when dealing with chronic neglecting referrals.

Child Fatality Review #06-15
Region 5
DCFS Tacoma

This 14-year-old Caucasian/Asian female died from homicide after being shot by a young adult male during a rave party.

Case Scenario

With parental permission, this female went with friends to Seattle to attend a rave party on the night of March 24, 2006. After the party, the 14-year old failed to connect with her ride back to Pierce County and subsequently went to an after-party. Later, a young adult returned to the party heavily armed with weapons and proceeded to kill six people, including this child. The perpetrator killed himself. Details were unknown as the case file had been destroyed per record retention policy.

In June 2005, CPS was contacted by the Pierce County Prosecuting Attorney's Office (PCPAO), which had received a request for a courtesy sex abuse interview of this child. The State of Utah was reporting a sex abuse allegation (historical, reportedly occurring in Utah seven years prior). A child (age 14) stated that while in second grade she and this child were taking a bath together and that the father (referred to above) sexually abused them. The PCPAO reported that this child was interviewed at school by Pierce County law enforcement, but she did not disclose sexual abuse victimization. According to PCPAO, the father took a polygraph test regarding the historical allegations and did not pass. A report was then made to CPS (Pierce County), which was accepted for investigation of sexual abuse despite being historical and the incident having allegedly occurred in another state. CPS was cleared by law enforcement to pursue the CPS investigation that resulted in a finding of Inconclusive.

Issues and Recommendations

The Child Fatality Review (CFR) panel found no issues directly related to the third party homicide of this child in March of 2006. The issues and recommendations emerging from the review and detailed below relate to general practice and policy matters stemming from a previous CPS investigation in June 2005. None of the practice issues involving the investigation of the alleged sex abuse from seven years ago had any apparent relationship to the circumstances of the child fatality.

Issue: Intake. The report was taken by a Children's Administration (CA) Case and Management Information System (CAMIS) trainer briefly deployed to an intake field assignment. The worker had no recent intake experience and this may account for the lack of ample clearness of the report.

Recommendation: CA Program Managers re-assigned to field positions during work force deployments should be placed into positions for which they have experience or receive training for the work they assume in their temporary field assignments.

Actions Taken: The intake worker was later re-assigned back to CA Headquarters and did not take part in the Child Fatality Review (CFR) process. The intake supervisor did take part in the CFR and agreed that she had not closely checked the reports taken by the field deployed worker who had assumed temporary intake duties in the Tacoma office.

Issue: Intake. The alleged sex abuse event reported to Tacoma CPS appears to have taken place seven years prior in Utah. Before making contact with CPS, local law enforcement did conduct a courtesy interview for Utah officials of the alleged child victim living in Washington State. The child did not disclose any past or current sexual abuse by the alleged subject (her father) with whom she was living in Pierce County. Given the facts that the alleged event was historical (that is, not recent), had allegedly occurred in another state, and the alleged victim in Washington State did not disclose being a victim when interviewed by local law enforcement, it would have been reasonable to screen out this referral rather than accept it for a CPS investigation.

According to RCW 74.13.031 the Department is given authority to investigate complaints of any "recent" act that results in sexual abuse or other types of serious child maltreatment. There is a lack of clear definition as to what "recent" means. In this case, the sexual abuse event being alleged by a person in Utah occurred seven years prior. Such a time lag between alleged event and the reporting of the said event would not fit well with the concept of "recent." A dissenting view presented during the CFR was that the disclosure by another victim living in Utah was "recent" and therefore the allegation could be viewed as "recent." The term "recent" therefore appears to be open to interpretation and not applied consistently. There also appears to be a difference as to what is considered a recent enough event to initiate an investigation of physical abuse or neglect as opposed to what is recent enough to initiate a sexual abuse investigation. No such differentiation exists in the RCW.

Recommendation: CA should define what is considered "recent" for the purposes of carrying out the statutory authority provided in RCW 74.13.031. This will require providing guidance for intake as to screening decisions for reported historical abuse of a child when there is no current allegation, no behavioral indicators suggesting current victimization, and no reason to believe that the child is currently at risk. This may include integrating department response to suspected sexual abuse that occurred in the past (i.e., not recent) into the proposed changes in the CA Practice Model to move toward a "differential response model." That model allows for an "assessment

track" as well as an "investigative track." This would allow for historical abuse reports to be accepted for "assessment" rather than investigation.

Issue: Issues regarding the alleged sexual abuse investigation. The unusual circumstances of the report to CPS regarding the alleged historical sexual abuse caused several problems for the assigned CPS investigator. The initial interview of the child was done by local law enforcement on June 15, 2006 which was six days before the referral was made to CPS. This led to the worker being confused as to whether or not the law enforcement interviews would suffice as the initial face-to-face (IFF) interview of an alleged victim. The CAMIS system does not allow the documenting of any event prior to the date the referral was created, and this led to confusing documentation in the Service Episode Record (SER) in the case file. The assigned worker did interview the alleged victim and adequately documented that interview.

Law enforcement and the County Prosecutor conducted a courtesy interview of the alleged victim for Utah, and determined no evidence of victimization. Due to concerns stemming from the polygraph results of the father, the case was referred to CPS. The worker was then put in a position of making a finding as to alleged sexual abuse that was not recent and did not occur in the State of Washington. An opinion from an Assistance Attorney General had previously stated that CPS could not make findings of abuse or neglect that occurred in another state. However, in order to "complete" an investigation a CPS worker is required to complete the CAMIS Investigative Risk Assessment that includes making a finding as to the alleged abuse or neglect. The assigned worker was forced to make a finding (Inconclusive) on an alleged incident occurring in another state seven years ago.

Recommendation: None. The unusual circumstances surrounding the investigation do not lend themselves to any broad practice or policy recommendations. It should be noted that SER coding for IFFs has been recently clarified by the department. Problems with CA's data system (CAMIS) have been noted in previous CFRs and plans are already in place to replace the system.

Actions Taken: The CPS investigator was present during the review as was his supervisor.

Child Fatality Review #06-16
Region 4
DCFS King West Office

This 17-year-old Caucasian male died from a self-inflicted gunshot wound to the head.

Case Scenario

The King County Medical Examiner's Office reported that this male had been found dead in a park in Shoreline, near Shoreline Community College with a self-inflicted gunshot wound to the head.

Referral History

Nearly all the referrals for this child's mother pertained to his sisters. He is listed as a member of his father's most recent family constellation and his stepmother had two Information Only referrals in 2006 concerning her then-unborn daughter. On that basis, the fatality review is required.

On March 08, 1993, allegations were made that the father sexually abused his niece who was living with their family. The Service Episode Record (SER) does not document a CPS investigation or finding but does state he pled guilty to rape of a child in the third degree on May 12, 1993. He was sentenced to 78 months in prison.

On November 30, 1993, a referral alleged that the decedent's 5 year-old sister may have been abused by an older cousin. The referral was screened for Third Party.

On May 7, 1999, a referral alleged an altercation between the stepmother and a sister. The referral was screened as Information Only since an active FRS case was already open.

On August 9, 2000, allegations were made that a sister was being left alone for several days. The child subject to this review was not listed as a victim. Findings were Unfounded.

On October 1, 2000, a referral alleged that the mother would not buy this child new school clothes. The referral was screened as Information Only.

On May 5, 2001, allegations were made that the fourteen year-old sister was pregnant by a 21 year-old. The referral was screened with a risk tag of 2 (on a five-point scale - referrals rated 1 or 2 do not require an investigation). A report was made to Law Enforcement.

On September 20, 2001, allegations were made that the mother allowed the twenty-one year-old (see previous referral) to live in the home with them. The referral was screened as Third Party.

On July 8, 2003, a report alleged that the teen sister moved back into the home and that she admittedly brought methamphetamine and alcohol into the home, where her mother has custody of the older sister's infant daughter. The investigation is Inconclusive for neglect.

On August 7, 2003, allegations were made that the sister was again using drugs and that she removed the infant from the mother (of this child), but then returned. The referral was screened as Information Only. This is the last referral in the mother's home while this child is listed as a family member.

On March 3, 2006, hospital staff reported that the stepmother of this child screened positive for cocaine and methadone, and that she was twenty weeks pregnant. The referral was screened as Information Only.

On May 11, 2006, the stepmother called CPS intake to explain her prior history and current circumstances as well as to seek guidance about the man who previously was convicted of sexual abuse (see first referral). The referral was screened as Information Only.

On August 10, 2006 a report was made that the decedent was found dead in a park, having shot himself. The death was ruled a suicide. CPS and law Enforcement investigated the matter and found no negligence on behalf of the parents.

Issues and Recommendations

Issue: No services. The decedent seemed to be on the periphery of every referral in which he was mentioned. Nearly all focused on his older sister, (she committed suicide as an adult in November 2006). Before his death, he is never listed as a victim, and there is no documentation of any attempt to engage him in services either within DSHS or by any social service agency.

Recommendation: Develop ways of engaging and assessing all family members, and offer services as appropriate.

Child Fatality Review #06-17
Region 4
DCFS Indian Child Welfare Unit

This 13-year-old Native American male died from acute ethanol intoxication.

Case Scenario

On April 15, 2006, this child was out driving and drinking with his sister when he became unresponsive. The sister thought he had passed out when she transported him home where he was laid on the couch. The child was taken to bed around 10:00p.m. Family members checked in on him an hour later and found that his lips were blue and he was not breathing.

The medical examiner's official cause of death is acute ethanol intoxication and the manner of death is accidental.

Referral History

The family lived on the Muckleshoot Reservation during this referral history. Children's Administration (CA) in Region 4 and Indian Child Welfare (ICW) were assigned the CPS investigations while Muckleshoot and Quinault Tribes provided social services and treatment. There were 31 referrals made to CPS from June of 1997 to April of 2006. Some referrals were child welfare service alerts that had no allegation.

On February 13, 1992, a referral indicated that the mother was hostile and indifferent to her child during a medical examination for heavy wheezing. She was angry and slammed things around before leaving with the child prior to conclusion of treatment and prescriptions. The referral was screened as Low Standard.

On December 18, 1992, allegations of sexual abuse were made regarding an uncle to these children. The caller was asked by the mother to not report the matter. The caller was certain that the mother would protect the child. The referral was screened as Third Party and not assigned for investigation.

On August 5, 1993, allegations of sexual abuse were made regarding a child in this home. The mother was hostile toward questions and would not allow a doctor to finish an examination. The referral was screened for Investigation.

On June 15, 1997, a referral was received regarding a nine month-old infant girl of this mother who was presented at the hospital with a fractured arm, which medical staff called "questionable." This was the child's fourth hospitalization since birth. The referral was investigated and closed as Unfounded for physical abuse.

On July 11, 1997, allegations were made that the mother had missed important medical appointments for an infant girl and that the parents abuse alcohol. The referral was investigated and closed Unfounded for physical neglect.

On July 27, 2001, allegations were made that the parents were involved with cocaine and that food stamps were being used for drugs. Allegations also indicated that the family was homeless and that the mother was physically and emotionally abusive. The children were voluntarily placed with the grandmother and services were referred for substance abuse. The case was closed as Inconclusive for abuse and neglect.

On November 16, 2001, a relative contacted CPS because the parents were abusing substances and using public assistance for illegal drugs. The referral was received while the children were voluntarily placed with the grandmother and it was screened as Information Only.

On November 19, 2001, a referral was generated because the father asked that the children be moved to another relative. This occurred immediately after an altercation between the father and other adult relatives. The referral was screened for investigation and later closed as Unfounded.

On January 2, 2002, a referral was made that the parents had moved in with the grandmother and children and that they were selling drugs in front of the children. Both parents allegedly were abusing substances. No investigative risk assessment was completed.

On June 7, 2002, the grandmother reported that she believed the 12 year-old sibling to the child subject to this review was involved in a sexual relationship with an 18 year-old girl. The referral indicates that she sounded intoxicated. CA referred the grandmother to law enforcement and forwarded this referral to the Muckleshoot Tribe Indian Child Welfare unit and it was screened as Third Party.

On June 10, 2002, the grandmother reported the same information as above, stating that the young girl was now residing in the grandmother's home. She indicated that the mother was in drug treatment. The referral was screened as Information Only.

On June 14, 2002, a referral alleged that the mother had left the Muckleshoot Reservation with some of the children after a positive urine analysis (UA) test for substances. Her whereabouts were unknown. The referral was screened as Information Only.

On August 27, 2002, allegations were made that the 12 year-old sister to the child subject to this review, a dependent of the Muckleshoot Tribal Court, acknowledged a sexual relationship with an older teenaged girl. Previously, the older girl was said to be 18 years old. This referral alleged that she was 17, though CA did not know.

The referral was faxed to law enforcement and the Muckleshoot ICW and subsequently screened as Information Only.

On October 17, 2002, a referral was received because a sibling to this child was extremely angry with school staff who told him that they were going to report an incident of misbehavior to his father. The child stated that his father hit him and made him care for the younger children. Callers did not believe the child was in danger. The referral was screened as Information Only.

On October 30, 2002, allegations of physical abuse were made regarding the mother's boyfriend. The 12 year-old sister of this child stated that she had been struck in the face, grabbed by her hair, struck with objects and she had a bump on her head. The referral was screened for investigation. No investigative risk assessment and service episode reports were completed as to the findings.

On November 27, 2002, allegations were made that the 12 year-old sister to the child subject to this review was drug involved and that she ran away. Previous allegations of a sexual relationship between this child (subject to the review) and an 18 year-old girl were reiterated. The referral was screened as Third Party and the allegations were passed on to Muckleshoot social services.

On December 4, 2002, the grandmother reported the 12 year-old Muckleshoot dependent sister, referred to above, was brought home by a Muckleshoot social services worker and another woman. All were allegedly intoxicated. The social worker allegedly told the referrer that she had found the young girl at the home of an elderly man known to the community as a place where children abuse substances. The child was covered in mud and missing clothing. After the social worker left, the child admitted to drinking with the two adults on this and prior occasions. The referral indicates that the next day, Muckleshoot social services transported this child to a group care facility for five days.

On September 26, 2003, a medical professional reported the 13 year-old sister to this child acknowledged sexual relationships with two persons. Both were boys older than herself, one being 16 and the other 18. The referral was screened as Third Party.

On June 25, 2004, allegations were made that the 13 year-old was abusing drugs and not being adequately protected because the father, who had custody, was not home most of the time due to long work hours, mostly at night. CPS investigated and offered services, which were refused. The case was closed as Unfounded.

On August 12, 2004, a referral alleged that a six year-old sibling broke her leg during a powwow. The father sought emergency medical treatment at an emergency room, having the child's leg placed into a splint. The mother did not have the leg placed into a cast as needed the following day. The referral was screened as Information Only.

On September 14, 2004, a referral was made alleging out-of-control behavior by the children in this family. The information was relayed to the Muckleshoot social services, rated as Low Standard investigation and later closed.

On September 20, 2005, a referral alleged physical abuse to one of the children by the father. No specifics or injuries were noted. The referral was screened as Information Only.

On April 6, 2006, allegations were made that the father was giving alcohol to the children and not adequately supervising their behavior. The referral was screened as Information Only.

On April 16, 2006, the referral regarding the fatality of this child was received from the King County Medical Examiner's Office regarding possible alcohol poisoning.

Issues and Recommendations

Issue: There are no findings on Investigations prior to 2001.

Recommendation: The issue is resolved with the current Investigative Risk Assessment tool.

Issue: Referral dated April 6, 2006 was screened as Information Only, in which the father allegedly gave alcohol to his children. The reason for screening it as "information only" was that the caller did not know the current address of the family. The referral notes that a call was made to Muckleshoot ICW on the same day, with no answer.

Recommendation: Leave a message with Muckleshoot ICW. They would have known how to locate the family and the report could have been investigated.

Issue: The family has had many risk factors and stresses, especially substance abuse, that contributed to chronic child maltreatment. The response, up to the time of the child's death, was to focus on each new report and not on the history and patterns of neglect.

Recommendation: The 'Chronic Neglect Legislation' (ESSB 5922, effective January 1, 2007), provides authority and resources to address chronic neglect. Children's Administration should offer training to tribes on this topic.

Issue: A working agreement between Children's Administration in Region 4 and the Muckleshoot Tribe would help to define roles and responsibilities on Indian Child Welfare cases.

Recommendation: Region 4 and Muckleshoot should begin the process for a working agreement.

Issue: An adult in the Muckleshoot community purchased and provided the liquor to the decedent that resulted in his death.

Recommendation: All communities should develop strategies to minimize the likelihood of minors having access to alcohol.

Child Fatality Review #06-18
Region 4
DCFS King South Office

This 2-year-old African-American male died after accidentally being run over by a vehicle in front of the family home.

Case Scenario

On April 21, 2006, the mother of this 2-year-old male was dropped off by friends at the family home. While the car was backing out, the child was knocked off balance and run over by the front wheel as the car backed down the driveway.

Referral History

The mother of this child was fifteen-years-old when he was born. The father listed on the birth certificate was twenty-two. The mother was not yet at the age of consent and the father was nearly seven years older, making the mother a victim of rape.

The mother grew up with several siblings and her mother. The family had multiple stresses and risk factors. There were fifteen referrals to Children's Administration (CA), mostly pertaining to neglect. This mother also committed crimes causing placement into juvenile detention and there was a great deal of conflict with her own mother. She was under the supervision of a juvenile probation officer.

On September 22, 2005, the mother requested Family Reconciliation Services (FRS) and help with filing a Child in Need of Services (CHINS) petition. She wanted to move out on her own with this child. On October 18, 2005 she requested child welfare services to assist her move to a teen parent program as soon as she was released from detention. On October 31, 2005 she was placed by law enforcement at the Secure Crisis Residential Center.

On January 5, 2006, the manager of the teen program reported to Region 4 CA that the mother had accidentally locked herself out of her apartment. The child was inside and she had food cooking on the stove. The apartment was filled with heavy smoke by the time the fire department responded. The child was not injured. Other allegations involved the mother not making curfew. The DCFS Office of African American Children’s Services investigated and opened for services. The findings were Unfounded, but the case had been open for services at the time of the child’s death.

Issues and Recommendations

Issue: There was a significant delay before the referral on January 5 2006, was investigated. It was not investigated until the referral was transferred from one office to another.

Recommendation: Follow policy concerning face-to-face contact with child victims, and investigative timelines.

Issue: The mother signed a voluntary service plan with the social worker who completed the investigation, but none of the services were ever arranged after the case was transferred.

Recommendation: Follow through with service arrangements as planned.

Issue: Subsequent to this child's death, CA received two referrals. One was the report of his death and had been screened as accepted for investigation; the other was a request to offer services to the mother, a minor. That referral was also screened and accepted for investigation. The second referral could have been screened for Child Welfare Services (CWS) since it was not an investigation. The first referral was treated as if it were the same as the second, although there is no documentation about a decision not to do an investigation.

Recommendation: Document decisions carefully so that there is a rationale for taking a different course of action.

Child Fatality Review #06-19
Region 4
DCFS African-American Unit

This six-week-old African-American male infant died of Sudden Infant Death Syndrome (SIDS).

Case Scenario

This child's grandmother checked on him at 5:00 a.m. on July 21, 2006, and found him unresponsive. The King County Medical Examiner's Office determined that he died of Sudden Infant Death Syndrome.

Referral History

The first referral Child Protective Services (CPS) received was on July 10, 1998. Prenatal Treatment Services reported that the mother, then pregnant, was due within thirty days and in need of in-patient treatment. She refused treatment and left the facility, despite testing positive for cocaine.

This referral was accepted for investigation and assigned to the African American CPS Unit. The worker maintained contact with the mother and child for about ten months. The mother and infant were living with the maternal grandmother at that time. A Public Health Nurse (PHN) was assigned to the mother and child and they had a primary care pediatrician. The social worker completed three CPS Risk Assessments on the family. The first on November 30, 1998, concluded Founded for Pre-Natal Abuse. The second assessment on April 28, 1999, describes the mother's substance abuse problems. The third assessment, on May 25, 1999, describes risk factors for future child maltreatment, as well as her strengths. The mother showed some ability to realize her problem, but would not follow through on treatment. A decision was made that the child would be safe since the grandmother was also in the home and the case was closed.

On June 9, 2006 CPS received a referral regarding this child's birth. The mother had not received pre-natal care and she refused a drug toxicity screen. The screen on the baby was pending. The report was screened as Information Only with instructions to the hospital to call back if the infant's report was positive.

On June 10, 2006, the hospital called back to confirm that the baby had tested positive for cocaine. The referral was investigated and CPS made arrangements for the baby to be placed with his maternal grandmother using a Voluntary Placement Agreement (VPA). The mother and grandmother signed a voluntary service plan that included random urine analysis testing, substance abuse assessment/treatment, parenting classes, and supervised visits at all times by the grandmother. A PHN was also serving the infant and mother. The case was

originally in the King East office but because the family is African-American, it was transferred to the Office of African American Children's Services (OAACS) on June 15, 2006.

The next contact with the child and grandmother occurred on July 14, 2006. A Children's Health and Education Tracking social worker visited the grandmother and child. The report notes the infant's well-child exam and his newborn course and prenatal exposure to cocaine. He appeared to be developing normally and was noted as a beautiful baby. The assigned social worker also visited during that time period. No other CA contact occurred prior to the child dying from SIDS.

Issues and Recommendations

Issue: Timeliness of case assignment after transfer from one office to another. The King East DCFS office transferred the case to OAACS on June 16, 2006. The worker in OAACS was assigned the case on July 10, 2006.

Recommendation: Each office should assure that there is clear communication among supervisors and master files staff when cases are sent to and from offices. The assignment of incoming cases needs to be completed within policy timeframes.

Issue: No referral to a Public Health Nurse (PHN) via the Early Intervention Project (EIP). This mother and infant did have a PHN since he was born at University Hospital. However, had the social worker completed an Early Intervention Program referral, a PHN would have been assigned that works closely with DCFS.

Recommendation: Always make a referral for an Early Intervention Program PHN for children birth to three years-old or any child with an ongoing health issue.

Child Fatality Review #06-20
Region 2
DCFS Yakima
(Executive Child Fatality Review)

This 23-month-old Native-American male died from internal injuries caused by abuse.

Case Scenario

On August 3, 2006, this child was brought to a Spokane hospital for vomiting after "falling in the bathtub." A CT scan of the child's head was interpreted as negative with a closed head injury and the child was released. The following day he was again brought to the hospital after he began seizing. There was swelling in the left temporal and forehead but no lacerations could be found. A new CT scan showed subdural hematoma and he was hospitalized. On August 6, 2006, he was pronounced brain dead and life supports were removed.

CA initiated an executive child fatality review regarding this child's death. The following narratives come directly from the final report.

Referral History

The deceased child was born on November 12, 2004. He was born prematurely at 38 weeks and tested positive for cocaine at birth. Throughout his life, social services were provided by Division of Child Family Services (DCFS) but legal authority for case management and legal oversight was in Yakama Nation Tribal Court.

The child was made a ward of tribal court and placement responsibility was given to the department. The child was placed from the hospital with his mother at Isabella House, a drug rehabilitation center in Spokane on November 16, 2004. The mother aborted treatment on December 6, 2004, and Spokane DCFS placed the child in foster care in Spokane. He was later moved to a foster home in the Yakima area and remained in that home until December of 2005.

In the time between the child's birth and December 2005, there were a number of Local Indian Child Welfare Advisory Committee (LICWAC) staffings. In these staffings, recommendations were made for service provision for the mother and the alleged father in order to have the child returned to their care. These recommendations included filing a dependency on the child in tribal court, drug treatment, parenting classes, day care, visitation, and fostering a stable living situation. The tribe encouraged enrollment of the child if the child qualified.

In March, 2005, a fact finding hearing was held in the Yakama Nation Tribal

Court. The court ordered a chemical dependency evaluation as well as domestic violence counseling for the mother. Throughout this period of time, the mother and alleged father moved back and forth between Spokane and Toppenish. Neither fully engaged in any services. Relative placement was sought for the child through the maternal great-grandmother. She was not able to care for the child but provided names of several maternal family members as possible placement options.

The Toppenish DCFS social worker visited the child in the foster home at regular intervals and was involved with medical service providers in the Yakima Valley. The child experienced developmental delays in hearing, speech, and gross motor ability as a residual effect of the mother's drug involvement throughout the pregnancy.

In July 2005, a referral was made on the child's Yakima foster home. The room where the child slept was allegedly cluttered and out of listening distance of the foster parents. This created concern about the supervision provided for the child. This referral was investigated, and the finding was Unfounded.

In December 2005, a CPS referral was submitted by the DCFS social worker who was managing the case. It alleged the birth mother was seven months pregnant and using drugs. The mother entered treatment in November of that year, but left a week later. She missed most of her prenatal appointments and had neglected to take prenatal vitamins. This referral was screened as Information Only because did not meet the criteria for assignment and field investigation.

On January 7, 2006, the mother prematurely delivered (36 weeks gestation) a female baby. Both the mother and baby tested positive for cocaine. A hospital hold was placed on the baby who was later placed in the same foster home as her brother, the deceased child.

On January 11, 2006, a shelter care hearing for the newborn was held in Yakama Nation Tribal Court (YNTC). The tribal court ordered that the newborn baby be placed in the physical custody of DCFS and that the matter be set for a Fact Finding hearing. A number of paternal relatives were present at this hearing including the aunt and uncle from Spokane who expressed strong interest in having the baby, as well as her brother (the deceased child), placed in their home. Criminal background checks were submitted on the aunt and uncle, and Toppenish DCFS staff requested that the Spokane DCFS office conduct a home study to determine if their residence was appropriate and suitable for the placement of the two children.

On January 13, 2006, a tribal staffing was held in Toppenish. There was agreement by all parties at this staffing that the children should be placed with the aunt and uncle, provided the background checks were completed and approved. The parties present were informed that the baby's doctor did not want her moved

out of the area until two weeks after her hospital release. The doctor indicated that the baby may have "inner **[**sic**]** utero retardation."

The background information received indicated that the uncle had five convictions - 2 misdemeanors, 2 gross misdemeanors, and a Class C felony drug conviction. His record documented a 2003 gross misdemeanor Theft 2. Under DSHS policy, this offense should have precluded the placement of the children in the home of the aunt and uncle for at least 5 years after the date of conviction. The aunt and uncle would have been eligible for consideration as placement resources in 2008. This information was not well articulated in the YNTC proceeding which was held to determine placement of the children. However, the state social worker, in an affidavit presented to the court on January 17, 2006, did advise the court of the criminal history of the aunt and uncle known to the department at the time.

It was later discovered that the uncle had been charged in federal court with Involuntary Manslaughter in Nevada in 1991. This charge was reduced to Reckless Driving in 1996. The Toppenish social worker had no knowledge of this crime until after the death of the child. Although the Reckless Driving charge would not have precluded placement of the child with the relatives, it is concerning that the complete criminal history was not available to the social worker at the time of the placement hearing. They did not reveal this information to the department.

On January 17 and 18, 2006, two referrals were received on the Yakima foster family with whom the children were placed. Both referrals alleged that the home was inappropriate for the children, and that the decedent was sleeping in the bed with the foster parent. The referent indicated that the child had access to houseplants that he ate as well as the houseplant dirt. These referrals were investigated and found to be Valid. The foster mother corrected the situation and also relinquished her day care license as part of the compliance plan developed by the Division of Licensed Resources (DLR).

On January 20, 2006, a Spokane DCFS worker responded to the Toppenish DCFS worker's request for a home study of the aunt and uncles home. The response consisted of an email to the Toppenish DCFS social worker indicating that the Spokane worker had been to the home and approved it for placement of the children. The email also stated that the Spokane office would accept courtesy supervision of the case.

The Spokane social worker later stated that he could not recall whether the information on the criminal history of the aunt and uncle had been shared with him. On January 20, 2006, the YNTC ordered the placement of the decedent and his younger sister in the home of the relatives. The children were placed with the aunt and uncle shortly thereafter.

On January 26, 2006, the mother entered inpatient treatment for substance abuse at Casita Del Rio in Kennewick.

On March 14, 2006, dependency was established on the newborn in YNTC. A recommendation was made to move the children to the treatment center with their mother on April 15, 2006. This was based on information from the provider at the treatment center. The aunt, through her attorney, opposed placement with the mother on the basis that it was too soon. The tribal court set another hearing for April 25, 2006 to discuss this placement.

On April 14, 2006, the mother left treatment without completing it.

Three health and safety visits were completed in the home between February and July 2006. Documentation in the case record reflects that the children were healthy and interacted well in the home. No reference was made to the ongoing developmental delays experienced by the children as a result of the in utero drug exposure. These developmental delays are documented elsewhere in the file, but it is not clear they were observed or known to the Spokane staff conducting the home visits**.** It is also unclear who the primary caregiver of the children was during that time.

On August 3, 2006, the decedent was brought to Holy Family Hospital in Spokane by the aunt and uncle. The child had been vomiting for 24 hours. The aunt told the doctor that the child had fallen in the bathtub the previous day and had struck the left side of his head. A CT scan completed on the child was interpreted as negative. The hospital's assessment at the time was a closed head injury. The child was discharged in stable condition but the relatives were instructed to return to the hospital immediately if any problems occurred.

On August 4, 2004, the child was once again brought to the emergency room at Holy Family Hospital. He was actively seizing at the time. There was swelling in the left temporal and forehead region but no laceration. A new CT scan showed a left frontoparietal acute subdural hematoma. The child was airlifted to Sacred Heart Hospital in critical condition. The child's condition continued to deteriorate throughout the following day.

On August 6, 2006, the child was pronounced brain dead and life supports were removed.

Issues and Recommendations

Practice Issue

Background Checks: The child's paternal relatives were not truthful in completing the criminal background check form. Section 2 - Item 11 on the form specifically asks: "Have you ever been convicted of, or do you have

any charges pending for any crime?" Both denied any prior criminal activity. The results of the inquiry forms returned from the Background Check Central Unit (BCCU) showed otherwise. There was no consequence assigned to the relatives, and the department did not take any steps to address this issue.

The criminal history background check received by the Toppenish office indicated that the uncle had a disqualifying crime which would preclude him from having a child placed in his care. This 2003 conviction for the crime, Theft 2, was a gross misdemeanor. Under Children's Administration (CA) policy, this crime would disqualify the subject from having a child placed in his/her home for five years from the date of the conviction.

It was later discovered that in addition to the criminal history, he had a 1995 charge of involuntary manslaughter in Reno, Nevada. This charge was later reduced to a conviction of reckless driving. This information was not available to the requesting social worker who received the background check in Washington State. The information was available through a check with the National Crime Information Center (NCIC). At the time of this case, Children's Administration social workers did not have access to this database, unless the individual had lived in the state of Washington for less than three years.

Recommendations: The department should mandate that deliberately providing false information on the Criminal Background Check form automatically disqualifies the applicant for placement of any child in his/her home. The potential for disqualification on this basis should be explicitly and prominently stated on the form.

Enable tribal and state staff to access the National Crime Information Center (NCIC), Juvenile Court Information System (JUVIS), and Superior Court Information Management System (SCOMIS).

Issue: Communication with Tribal Court. The communication of the criminal background information by the department to the Yakama Nation Tribal Court (YNTC) which had the legal jurisdiction of this case was not clear.

This information appeared to be confusing to the social worker who informed the court of the uncle's complete criminal history of convictions but indicated that the background check had cleared. Source documents were not provided to the court but the list of convictions for the relatives as well as the outstanding warrants on him were outlined in an affidavit presented to YNTC by the Toppenish DCFS social worker.

In the affidavit to YNTC, there was an emphasis on reviewing the relative's substance abuse issues and trying to determine if these were still a relevant factor in this home. There was no formal mention of the Theft 2 conviction that was the disqualifying crime unless an administrative waiver was granted.

Recommendations: Recommendations to the court should be clear and concise with supporting source documents.

The cover letter from Background Check Central Unit BCCU that accompanies returned criminal background checks should clearly and prominently state which listed crimes are disqualifying under department policy so that there is no confusion when there are multiple crimes on a criminal history report.

The Individual Safety and Service Plan (ISSP), which is the document used by the department to update the court on the current status of a case should be reformatted. The top page should completely embody, in very clear, brief form, the recommended service plan for the next review period.

Several practice issues became evident as this case was reviewed.

Issue: The Colville tribe was not notified of the dependency action on the children. According to the Department's Indian Child Welfare policy all tribes involved with a family should be notified of children placed out of the care of their parents in the state child welfare system.

The Indian Child Welfare manual Section 03-30 (D) states:

> If the child is affiliated with more than one Tribe, the social worker contacts each Tribe by telephone and sends each Tribe a written request for verification of the child's Indian status.

The child was placed in the Yakama Nation child welfare system. Yakama Tribal Court had legal custody of the child from the beginning of the placement. Although this child had heritage from both the Yakama Nation and the Confederated Tribes of the Colville Reservation, only the Yakama Nation knew that the child was dependent.

Issue: Pressure from the tribal court and some family members impacted the decision making on the case. Throughout the month of January 2006, there was pressure placed on the Toppenish social workers by the tribal court and the extended paternal family to place the child and his sister in the home of the relatives in Spokane.

During this time, as well, the workers were called to meetings with the

family and members of the tribal legal system to update them on the progress of the potential placement. At these meetings the family expressed that they wanted the child and his infant sister placed in the home. On one occasion, the mother was also present and expressed her desire to have the children placed in this home.

Throughout these meetings and in all tribal court hearings, the DCFS social workers did not have legal representation. Social workers who appear in state court are represented by assistant attorneys general.

Issue: The home study completed on the relatives was hurried and incomplete. The desire for a relative placement and the need to change the placement of the children, coupled with pressure from the tribe and the family, caused the Toppenish placement without that information.

The home study was incomplete with little information regarding the living situation of the relatives. The Spokane supervisor who received the referral did not assign the case but completed the home study himself. He stated that the home study was not in depth because his unit was inadequately staffed at the time.

Chapter 5000-Section 5231 of the Children's Administration Practices and Procedures Guide states that in addition to the general requirements for the completion of a home study the social worker shall document an assessment of appropriateness, including:

> A formal criminal history and background inquiry, using the DSHS 09-693 to the Washington State Patrol and to local law enforcement.

In this case, the criminal history background check was completed but not considered in the assessment for the appropriateness of the placement.

Issue: There was confusion about the roles and responsibilities involved with cases sent from one office to another for courtesy supervision. Along with a request for courtesy supervision of a case from one DCFS office to another, the sending office should provide the receiving office with all pertinent documentation on the child as well as inform the office of any outstanding concerns about the case. This case indicates that the social work staff in the Spokane office were not totally informed regarding the child's special needs or behavioral problems. Both of the children placed in the home were born premature and drug exposed. The deceased child had been involved with medical providers in the Yakima area, but the social workers in the Spokane office seemed unaware of the medical issues of the child and no mention was made of them in the completed 90-day health and safety reports.

Recommendations: To ensure that ICW policy is thoroughly followed in cases involving Native American children, staff should receive regular ICW training.

Placements of children should not occur unless policy is followed.

Tribal and/or LICWAC staffing shall be completed prior to a change of placement of Native American children unless immediate placement is court ordered in which case the staffing should occur as soon thereafter as possible.

CA needs to clarify the roles and responsibilities in the process of home study requests and subsequent courtesy supervision placements.

Issue: There appeared to be confusion by staff around a number of departmental policies and procedures in this case. The criminal history background check specifically stated that the uncle had a disqualifying crime but workers seemed unsure as to what the crime actually was.

The form that lists these crimes divides them into groups of permanent disqualifiers and those which disqualify the subject for five years. It also categorizes them into misdemeanor, gross misdemeanor and felony. The Toppenish worker focused on the uncle's drug history and emphasized this in the affidavit to the tribal court when reporting his criminal history. She did not address a conviction for Theft 2 which was a five-year disqualifying crime committed in 2003. The worker also seemed unaware of the current department policy and cited the Revised Code of Washington (RCW) as her source of information on disqualifying crimes. The RCW does not specifically detail disqualifying crimes for potential placement options for children. The categories of disqualifying crimes are set out in the Washington Administrative Code (WAC). The WAC is not identical to the agency policy.

Recommendation: The department should provide regular training to all staff on the disqualifying crimes and the time frames that outline them.

This case was unique in that it was involved in tribal court, and the court was an integral part of the placement of the child with the relative. The committee made several findings and recommendations for the Yakama Nation Tribal Court to consider:

There was not a Guardian ad Litem (GAL), Court Appointed Special Advocate CASA, or other individual at court to speak on behalf of the best interest of the child.

There is not consistent information sharing and discussion between the

department, the tribe, and the legal parties involved with cases administered through the YNTC. This can lead to situations which result in decisions that are less than optimal for tribal children or place those children at significant risk.

Recommendations: The YNTC should appoint a GAL for children in dependency cases.

Regular meetings should be established which involve the Yakama Nation staff, judges, tribal prosecutor, Nak-Nu-We-Sha staff, Children's Administration staff, and supervisors appearing in YNTC in order to discuss procedures, issues, communication, and other items of mutual concern. The Assistant Attorney General (AAG) representing the CA in state court should be invited to attend these meetings.