Report to the Legislature

Quarterly Child Fatality Report

RCW 74.13.640

April - June 2007

Children's Administration
PO Box 45040
Olympia WA 98504-5040
(360) 902-7858
FAX: (360) 902-7903

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Children's Administration Child Fatality Report

Executive Summary

This is the Quarterly Child Fatality Report for April through June 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 11 completed fatality reviews from fatalities that occurred in 2005 and 2006. All were reviewed by a regional Child Fatality Review Team.

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

Region	Number of Reports
1	2
2	0
3	3
4	3
5	2
6	1
Total	**11**

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	62	0
2006	61	30	31
2007	55	0	55

The numbering for the Child Fatality Reviews in this report begins with the number 05-62 (the final child fatality report for 2005). This indicates the fatality occurred in 2005 and is the 62nd 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 #05-62
Region 5
Tacoma DCFS office

This 6-month-old Caucasian male died from accidental mechanical asphyxia.

Case Overview

On December 20, 2005, the mother of the decedent awoke to find this infant, who was sleeping with her and the biological father, not breathing. Emergency responders were called and the child was determined "dead on scene." The mother last fed the baby at 6:00 a.m. before going back to sleep. The medical examiner determined the child had died of accidental mechanical asphyxia from co-sleeping with the parents.

Referral History

The biological mother was the alleged victim of abuse and neglect referrals made to Children's Administration (CA) from 1994 to 2002. Allegations included physical and sexual abuse by her older brother and sexual abuse by her father. Both were closed as unfounded. In late 2001, a report was made that she was suicidal although no investigation occurred. She was placed in various out-of-home facilities in 2002 as a part of a juvenile court diversion program. She maintained that she had been sexually abused by her father and brother at that time.

Four allegations of neglect to the biological father occurred on 4 occasions between 2001 and 2005 during his childhood. Three of the referrals involved substance abuse allegations. The 2005 referral resulted in a methamphetamine bust when he was eighteen-years-old, although he was not known to have been involved in the illegal activity.

In January 2005, the Pierce County Prosecutor's Office reported the parents of the decedent were involved in a domestic violence incident while the mother was holding her 7-month-old daughter. Law enforcement responded to the incident, the father was arrested and a no contact order was initiated. CPS closed the investigation as unfounded because there was insufficient evidence the child had been placed in danger.

Fatality Referral

On December 20, 2005, the Pierce County Medical Examiner's Office notified CPS of the child fatality. During the investigation an anonymous referent alleged that the mother and father used methamphetamines while caring for the 18-month-old sister. The Medical Examiner determined the child died of accidental mechanical asphyxia during co-sleeping and the CPS investigation was closed as unfounded.

Issues and Recommendations

Practice Issue: There was one referral prior to the fatality, which involved a sibling as the deceased child had not yet been born. The report alleged the child was in danger during an alleged domestic violence (DV) incident.

The worker conducted face-to-face contacts with the alleged child victim and the primary caretakers. Two home visits were made during the three months the case was open, although there were 45 days of inactivity. A Safety Assessment did not require a Safety Plan but some form of safety netting would have been best practice.

The child's primary care physician was contacted but no other collateral contacts were made. The worker did not contact Women, Infants, and Children program (WIC) and Maternity Support Services (MSS) where the mother had involvement nor did the worker check with law enforcement or the prosecuting attorney's office regarding domestic violence. There was no confirmation of a No Contact Order. It appeared the worker primarily relied on the mother's statements and the worker never contacted the father who was an alleged subject.

Recommendations: None. Expected practice standards regarding subject and collateral contacts are outlined in the CA Practices and Procedures Manual.

Comments: CA has taken steps to improve practice in the area of inactivity on open cases. 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. Additionally, improvements were made in the CA data base system such that alerts to social workers and their supervisors are now provided if there has been no documented activity within the last 30 days.

CA initiated two state-wide trainings (Lessons Learned from Child Fatalities; Kids Come First Revisited) during 2005-2006, which included discussion on recognizing bias in social work practice. Caution regarding over-reliance on parent's statements was a critical part of training. Lessons Learned continues to be offered in every region for CA social work staff.

CA convened a state-wide work group in 2006 for the purpose of reviewing CA policies and practices with regard to DV. The work group is comprised of representatives from each region in CA, national experts in the field of DV, and representatives from the Washington State Coalition Against Domestic Violence. The work group currently is in the process of making recommendations to CA regarding intake and investigation/assessment practices for domestic violence.

Practice Issue: While the investigation was completed in a timely manner, the social worker was not clear in the documentation (Investigative Risk Assessment - IRA) as to the basis for a finding of 'unfounded' as to the allegations. The worker did not contact the alleged subject of the allegations (the father of the child) nor did a review of law enforcement reports occur.

Recommendations: None

Comment: Due to recurring observations of lack of adequate explanations for investigative findings within Investigative Risk Assessments (IRA) in the region, the Region 5 CPS program created a 'mock' IRA that provides social worker guidelines for best practice in completing the various sections of the IRA. This includes directions for making clear explanations for findings, whether founded, unfounded, or inconclusive. This 'mock' IRA is made available to all CPS social workers in the region as a desk reference tool and was also made available to all other regions as well.

Actions Taken: The supervisor at the time of the investigation did participate in the review and received feedback regarding this issue as it related to general supervisory practice.

Issue: In review of the intake report created at notification of the fatality incident, several issues emerged. While the cause of the child's death was unknown at the time of the report, there were noted concerns that the parents may have failed to seek medical attention in a timely manner for a sick child that subsequently died [note: the eventual cause of death was not related to the child having been ill]. It was reasonable for intake to identify possible neglect of the deceased child at the time of the notification of the fatality. However, the older sibling was also identified as an alleged victim, which was confusing to the review panel. In some cases it may be reasonable to assume that all children in the home may be victims of certain types of neglect or abuse, but in this case such assumption is questionable.

The decision to accept for investigation and the designated response time (emergent) appeared appropriate. However, the 'Basis for Risk' section of the report appeared incongruent with general intake practice and included unnecessary reference to the Washington Administrative Code (WAC) and Kids Come First policies (KCF). While WAC 388-15-009 is used to make decisions about sufficiency of allegations, the 'Basis for Risk' section is to be used to assess risks associated with the severity of the current alleged child abuse and neglect (CA/N), the history of CA/N, family characteristics (including child, caretaker, and environment), and protective factors. The citing of WAC and KCF appeared unnecessary.

Additionally, physical abuse was cited in the 'Basis for Risk' section, although there was nothing in the information provided at intake to suggest physical abuse was suspected. The intake worker assessed violation of a court order as a high risk dangerous act. While violation of a restraining order or a No Contact Order may pose a risk, classifying such as a dangerous act would not be reasonable in every case.

The identified issues relating to this intake were not viewed as significant or critical, and overall the intake decisions were appropriate.

Recommendations: None. The citing of WAC and KCF policy in the 'Basis for Risk' section of an intake appears to be unique to Central Intake.

Comments: State-wide intake reviews have been conducted by CA for several years, and the results have consistently shown accuracy of intake decisions to be 97% or higher.

CA is currently in process of moving to a different risk assessment model and substantial changes to the structure of intakes and the Investigative Risk Assessment are anticipated.

Issue: In Tacoma DCFS many child fatality referrals are assigned for investigation by special social workers out-stationed at the local Child Advocacy Center (CAC). Generally, for a child fatality referral to be assigned to CPS investigators connected to the CAC there is significant suspicion that the death involved child abuse or neglect. The information provided at the time of the fatality appeared somewhat equivocal and assignment to a non-CAC CPS worker was not unreasonable in this case.

During the fatality review the social worker reported difficulty balancing agency intrusiveness with sensitivity to the family's experiencing of a child death. For example, the worker reported having experienced hesitance in sending the parents for UA testing immediately following the child's death, as the family was in process of making funeral arrangements.

Recommendations: None.

Consideration: Tacoma DCFS will explore with the local child advocacy center the development of guidelines and helpful hints for CPS investigators working with families who are in the midst of a family tragedy (fatality, near-fatality, or serious injury case).

Issue: While the fatality investigation case was still active with CPS, additional information was provided to CPS intake by an anonymous referent. The report, taken by Region 4 intake (King County), appeared to have neither an allegation nor any suggestion of imminent harm. The only new information provided was with regard to suspected drug use by the parents.

As written, the referral should have been taken as information only on an open case, with an alert provided to the assigned social worker. The intake report did not identify what, if any, specific information the anonymous referent may have had regarding how the alleged drug use by the parents was impacting the care of the surviving sibling. It is possible that more in depth questioning by the intake worker of the referrer would have clarified the situation.

In addition to the questionable screening decision, the assessment of risk at intake was debatable. The risk at intake was assessed as high. It is possible that the intake worker was familiar with the requirement that any anonymous referral, in order to be accepted for investigation by DCFS CPS, must be tagged at moderate-high or high risk. It is then speculative that the intake worker artificially assessed high risk in order to provide a basis for screening the referral in for investigation.

Recommendations: None. There is no indication of a pervasive problem within intake units across the state. The criteria for accepting referrals from anonymous reporters already exist

in statute (RCW 26.44.030) and in CA policy and practice (CA Case Services Policy Manual – Section 2131; CA Practices and Procedures Guide – Section 2210).

Issue: The assigned social worker began the investigation in a timely manner, conducting face-to-face contact with the mother, the child, and relatives within 24 hours. All documentation was completed in a timely manner.

A Safety Assessment was completed and a Safety Plan was initiated. The worker did not separate safety planning issues from service planning, which is the expected practice (see CA Practice Guide to Risk Assessment). The worker acknowledged knowing the difference, indicating the circumstances at the home had provided an opportunity to do both simultaneously. The mother and the relative with whom the mother and child were living signed the Safety Plan. During the review, the social worker indicated that the father had verbally agreed to the Safety Plan, although documentation of this was not clear in the case record.

The social worker did appear to follow through with monitoring of some of the safety issues and services outlined in the Safety Plan and Service Plan. This included contact with relatives who were monitoring the family situation and following up on random UA testing. However, the worker did not appear to follow up with the D/A assessment or the condition that everyone involved follow the No Contact Order stipulations. The worker indicated during the review that she had provided the mother with information on how to access D/A services, but documentation of this was not found in the case file.

Recommendation: None.

Actions Taken: The worker assigned to investigate this referral participated in the review and acknowledged an understanding of the difference between Safety Planning and Service Planning.

Issue: The social worker continued to require the most sophisticated type of drug screening test, which is a screen that tests for 10 substances. While the 10-screen test may be reasonable to establish an initial base-line measure, without any indication that a client may be using several drugs, reduction to a 7-screen test or 5-screen test would be indicated. In this case, the parents appear to have limited their drug use to methamphetamine, amphetamine, and THC.

The worker appeared to not recognize when UA results indicate a questionable sample. In addition to results regarding specific drugs tested, UA reports also include information as to the presence of adulterants (Creatinine, Nitrates, PH level). When a sample indicates the probability of an adulterant, the specific type is in bold print on the report from the testing lab. Both parents showed an elevated range for Creatinine for one random UA, which would suggest an invalid sample (improbable to have resulted without an adulterant).

Recommendations: None. CA offers Substance Abuse and Advanced Substance Abuse training for social workers in each region on an annual basis.

Comments: Sterling and Associates, the contracted drug/alcohol test provider for the department, offers on-going consultation for social workers relating to any questions about a client's drug test results. Social workers may directly contact Sterling Reference Laboratories and speak with a laboratory technician.

In 2006, Chemical Dependency Professionals were out-stationed throughout every region in CA. Since April 2006, the Tacoma DCFS office has had at least one chemical dependency professional (CDP) on site. Currently, Tacoma DCFS has two out-stationed CDPs available to provide consultation to social workers including how to read UA results. Recently a summary "cheat sheet" was distributed to all social workers in the Tacoma office which provides guidance for reading UA test results.

Actions Taken: The out-stationed CDPs in the Tacoma DCFS office are currently in process of scheduling "brown bag lunch" presentations for social workers on a variety of substance abuse issues, with an overview on how to read UA results scheduled for April 2007.

The investigative social worker participated in the review and indicated a desire to get additional training on UA testing and other substance abuse topics.

Child Fatality Review #06-21
Region 5
Tacoma DCFS office

This 9-month-old Caucasian male died on March 27, 2006, from unknown causes while sleeping between his father and his father's girlfriend.

Case Overview

This infant died during a visit with his father. The father reported that around 1:30 a.m. the decedent awoke, was given a bottle, and went back to sleep. At 9:30 a.m. the child was found unresponsive. Lividity was already present in the child's head area. The medical examiner's autopsy found the cause of death unknown/undetermined. CA screened the referral as information only because there were no other children in the home and because there was no allegation of child abuse or neglect.

Referral History

On June 24, 2002, Children's Administration (CA) received an anonymous handwritten letter that alleged the mother (then 18) was not cleaning or properly dressing the child and that there were "signs of abuse" although specifics were not provided. The referral was screened as low risk and an Alternative Response Services (ARS) case was opened with public health nurse services.

On October 18, 2004, allegations were made that the father, who lived with the mother at the time, had kicked and pushed their 2-year-old daughter. Allegations also stated that the father had driven with the child while intoxicated. The referent stated that the mother "makes excuses" for the father. The referral was accepted for investigation. The father and mother agreed to no physical discipline of the oldest child, parenting classes, and the father would not drive the children if he had been drinking. The worker also referred the father for a chemical dependency assessment but he did not complete it. The investigation was closed as unfounded.

On February 11, 2005, a referral alleged there was inadequate food in the home and the kitchen smelled of garbage, vomit and stale beer. Mildew and garbage were alleged to have been strewn throughout the apartment. The referrer claimed there was a lot of traffic in and out of the home and the parents were abusing alcohol. The investigation found the home to be in the condition as described. Public health nurse services ensued, and the case was closed as unfounded.

The social worker assigned to the October 18, 2004 referral attempted later contact with the mother to verify the status of the agreed contract. She told the social worker that she and the child had since moved to Gig Harbor without the father to be nearer to her family. The social worker closed the case inconclusive.

On September 11, 2005, allegations were made that the mother and her friend (who lived at the residence and was the mother of a one-year-old and a 2-week-old) were leaving their children alone and unsupervised several times a day for up to 30 minutes at a time. The decedent was 3-

months-old at the time. The sibling was 3-years-old. The referral was assigned for investigation as high risk and services were offered but refused. The mother denied that the father was in the home, claiming that she lived in Gig Harbor, although neither appeared to be correct. Collateral contacts indicated she had been living in the apartment in Lynnwood for several weeks, at least. The children appeared supervised and in good condition at the social worker's unannounced home visit. The case was closed as inconclusive on October 19, 2005, and submitted to the supervisor for review and approval. The case was returned by the supervisor for additional investigation and contact with the family and collateral sources. By the time the case was assigned for this follow-up it was December, and the mother had moved to Tacoma. The worker was unable to locate the mother, and the case was closed as unfounded.

On March 27, 2006, CA received the referral related to the death of the decedent. The referral alleged the father's girlfriend's own children had previously been removed from her by CA, which was missed at intake. The referral was screened as information only as there were no allegations of abuse.

Issues and Recommendations

Issue: There was scant documentation of supervisory review in the three referrals investigated by the Lynnwood office. The only evidence of monthly supervisory review was one review on the 2004 referral. There was also documentation of review at the closure of the case after the last investigation.

Recommendation: The issue of monthly supervisory reviews of all cases has been addressed with all of the supervisors in the Lynnwood office. This has now been re-emphasized in accordance with standards for accreditation, for which the office has since been preparing.

Issue: There were some concerns with practice issues in regard to the investigation of the most recent CPS referral prior to the death:

1. The team saw this investigation as superficial--the investigation of this referral consisted of one home visit, which included conversations with the adults and observations of the children. There was no documentation of any collateral contacts made to verify parents' statements.

2. The safety plan agreed to at the time of the home visit consisted of the parents saying they would maintain supervision of the children, with no mechanism for monitoring.

Action Taken:

1. The necessity for comprehensive investigations has been addressed with this worker and appropriate action taken.

2. Office-wide training was held shortly after this fatality, giving workers additional information and support in formulating more effective safety plans.

In the inputting of the last referral (related to the fatality) the father's girlfriend was coded as ‘collateral’ rather than ‘client.’ The effect of this was that her full history with the department (her children were placed under a dependency) did not attach to the referral. Had she been coded appropriately as a client, the mother's Child Welfare Services social worker would have been automatically alerted and pertinent information may have been offered.

This issue has been addressed with the intake worker.

Child Fatality Review #06-22
Region 3
Division of Licensed Resources/CPS facility investigations

This 14-year-old medically fragile Caucasian female died of natural/medical causes of an unknown nature.

Case Overview

The licensed foster/adopt home first responded to this child's medical concerns on April 11, 2006 by taking her to an emergency room. She had a fever of 104 degrees. ER physicians diagnosed tonsillitis and an ear and sinus infection. She was prescribed antibiotics, which the adoptive parents filled and administered that day. The next day the child's fever subsided, and she appeared better by bedtime. The next morning the adoptive mother found this child unresponsive in her bed. Emergency responders were called, and CPR administered but she was not revived.

Referral History

This family adopted two children from social services in the State of Virginia in 2000; a boy and a girl (the decedent).

The family requested assistance from Children's Administration (CA) in Washington, asking for placement of their adopted son due to mental health/behavior issues. The issue was resolved in October of 2003 when social services in Virginia arranged an out-of-home placement.

The foster parents applied for a foster care license with the CA Division of Licensed Resources (DLR) in March 2004. A foster home license was signed September 10, 2004. The approved capacity was for 3 children (female only) from the ages 7 to 12. The license was amended shortly thereafter for girls up to age 18. The parents provided "equine therapy" for disabled children in their community. The father's adult daughter from a previous marriage and her 2-year-old son moved into the home in November 2004 but the family did not submit a required background clearance for her.

In June 2005, the parents submitted a request for a background check on the foster mother's adult sister. The licensor discovered that the sister had previous child abuse or neglect allegations that were founded, and the clearance for unsupervised access to children was denied.

There were a total of 21 girls and one boy placed in this foster home for the 18 months prior to the fatality. Prior to the decedent's death in April of 2006, there were six licensing administrative approvals to allow for overcapacity/age/gender exceptions. There were five licensing complaints, none rising to the level of accepted a CPS referral. All licensing complaints were resolved as invalid for licensing violations.

In February 2005, licensing granted an administrative approval for continued placement of a female foster child (not the decedent) who became older than the licensed age limit. The foster

parents indicated they wanted guardianship of that child, as well. In February 2005, the social worker visited the home and found the family preparing to move from their home to travel in a motor home while home-schooling the children. The social worker stated that licensing was aware of the plans and that the foster parents agreed to communicate by e-mail and telephone, although the licensor denied knowledge that the family had ever left. The family agreed to return in April 2005 for a court date and visitation with the biological family. The family returned as planned. The decedent died the day after her foster sister's April visitation with relatives. The foster child then asked to be moved to another foster home and was moved less than a week later.

On July 11, 2006, the foster child that had been moved allegedly told her new foster sister that the previous foster father (above) had sexually abused her while on their trip. The referral was assigned for investigation. The foster child disclosed details of sexual abuse that included statements that she had also witnessed the foster father sexually abusing the decedent during their travels. The Snohomish County Sheriff's Office investigated. A monitored telephone call was arranged between the foster father and the foster child in which the sex abuse was discussed. The foster father acknowledged the sexual abuse during the call. Law enforcement referred the case for prosecution.

Quarterly health and safety visits with the foster child were completed as required. An application for a renewal of the foster home license was denied by the Division of Licensed Resources.

Issues and Recommendations

Issue: Information was not requested from two other states in which the foster parents had reported that they had been adoptive parents.

Recommendation: Region 3 DLR will remind licensers that best practice would be to contact any state in which they are aware that applicants had previous history of foster care licensure or adoption.

The foster parent's sister, who had a history of founded child abuse with CPS, was found to be living on the property. This information should have been treated as a licensing referral and investigated.

Issue: The foster parents purchased a motor home in which they planned to travel throughout the country with their adopted daughter and one foster child while home-schooling the children on the road. They planned to give up the property on which they had been operating their foster home and a horse ranch. Their intent was to return in two months for the child's court hearing. This intent to quit their established residence was known to the foster child's social worker and supervisor. The supervisor had a very brief conversation with the DLR Area Administrator about it and had the mistaken impression that it would be permissible under licensing regulations. The information about the plan was never communicated to the home's licenser, who was unaware of their absence until the child's death, just a few days after their return to Snohomish County.

Recommendation: DLR staff will be meeting with DCFS staff in each office in a series of all-staff meetings. They will be presenting information about licensing regulations in general and also about the types of information that may be learned by the social workers in their work with foster children that needs to be reported to the licenser.

Issue: There were five licensing complaints on this home during the time they were licensed. Three of those licensing referrals were very late in response and completion. In referral #1654773 (received September 23, 2005), there was one contact, and the complaint was closed as invalid July 13, 2006. Referrals #1666636 and #1654773 (both received in November 2005) had no response until July 13, 2006. The complaints were closed out as invalid. The investigations were limited to contact with the foster parents only. The standard for investigation of these 'priority one' referrals is that the licenser begin the investigation within two work days, and complete the report within 45 days.

Recommendation: DLR is in the process of realigning the workload in regards to licensing complaints on facilities. These will be handled by staff particularly designated for this task. There is training scheduled for staff on the handling of these cases, including time frames.

Child Fatality Review #06-23
Region 4
Seattle King Eastside DCFS office

This 3-month-old African-American male died from either Sudden Infant Death Syndrome (SIDS) or accidental asphyxiation.

Case Overview

On October 22, 2006, the King County Medical Examiner (ME) reported the death of this 3-month-old child. The fatality was treated as a SIDS death but the ME reported the death could be the result of "overlying." The ME reported the mother may have accidentally lain on this child while sleeping with him.

Referral History

Child Protective Services (CPS) received three reports concerning the mother of this child and her children. The first, dated August 12, 2005, came from a Registered Nurse (RN) at a hospital who called to report that medics had responded to the home because a sibling, then age sixteen months, was having a seizure. The medics observed drug paraphernalia and crack cocaine lying around the home and accessible to children. The child's seizure was not related to drugs. The referral was screened in for investigation with a risk tag of 4.

CPS went to the home on August 15, 2005, with a police officer and interviewed the 2 children in the home. The mother denied using crack but admitted that she had smoked marijuana in the past. The worker did not offer services to the mother or her children. On March 3, 2006, the assigned worker wrote a closing summary for the case. On May 8, 2006, the supervisor returned the case to the worker to complete the investigation.

The worker gathered information from St. Francis Hospital, Kent Police Department, South King Fire and Rescue, and from Group Health. The child's seizure was related to a fever, not drug ingestion. According to a police officer, the pipe was for marijuana, not crack cocaine. First responders did not actually see crack cocaine, but there were foil packets that an unrelated woman had gathered when they arrived at the scene. The worker concluded that the investigation was founded for negligent treatment/maltreatment with no services offered.

On July 14, 2006, CA was contacted by a social worker from University Hospital who reported the mother was pregnant and was to be induced the following week. In June, she was hospitalized for pre-term labor. A toxicology screen was positive for marijuana. The mother claimed she was depressed. Group Health had prescribed antidepressants but she did not use them. University Hospital made a public health nurse (PHN) referral and a worker from an outreach organization was assigned. The CA referral was screened as information only. The PHN visited the mother and baby in the home on July 25, 2006. She included information about safe sleep environment in her discussion with the mother. She made several follow-up telephone calls but the mother did not return the calls and the PHN closed her case.

On October 18, 2006, CPS received a referral that alleged neglect, drug use, no food and people in and out of the home with guns. The next day, the assigned CPS worker interviewed the 8-year-old sibling at school. The school had no concerns about his care as they stated he was clean and well groomed and that he always had food at home.

On October 20, the worker went to the home and learned for the first time that the mother gave birth to the decedent. The worker and co-worker observed that he and siblings appeared clean and well cared for. The worker noted that the carpet was dirty and it was dark in the home but the living/dining and kitchen area did not pose safety concerns. The mother denied drug use or neglect of her children in any way.

On October 22, 2006, CA received a call from the King County Medical Examiner, concerning the death of this child as a possible SIDS or accidental asphyxiation fatality. The investigator reported the condition of the home as "atrocious" due to a foul smell of cigarette butts mixed with uncooked and cooked meat all over the kitchen counters. The report was assigned for investigation. The responding CPS social worker found that the family was not residing at the apartment, but rather, they lived at the maternal grandmother's home.

Over the next two months the assigned worker saw the family and had telephone contact with school staff. The mother stated she had moved and was in counseling at Group Health. She expressed interest in daycare for the youngest child but did not follow through with further information for the social worker. The investigation was unfounded, and the case was closed January 3, 2007.

Issues and Recommendations

Issue: There was no referral for a Public Health Nurse (PHN) either time that the case was open to CPS. When the case was open the first time in 2005-2006, one sibling was just a toddler - a PHN could have helped the family with health care resources, understanding child development, parenting, etc. A PHN had been involved in July 2006 through the UW Hospital, but the family could have used these services again in October 2006.

Recommendation: When CA opens any case for services and the family has infants and or children three years old or younger, we should always make a referral for a PHN through the Early Intervention Program (EIP).

Issue: The mother was not screened for substance abuse and/or mental health problems, during either time the case was open. CA was not aware that she had ongoing problems in both areas.

Recommendation: The mandatory use of the Global Appraisal of Individual Needs - Short Screener (GAIN-SS), effective January 1, 2007, should help workers better identify clients who may need further assessments and services.

Issue: The condition of the home changed dramatically within forty-eight hours - the difference in time when the assigned CPS worker and a co-worker visited the home and the Medical Examiner's staff arrived to respond to the report of the fatality.

Recommendation: Social workers should be mindful that the families we serve often have lots of social chaos and stress in their lives, and conditions can change rapidly.

Issue: The investigation of the first referral in the Office of African American Children's Services (OAACS) was profoundly incomplete and delayed by months, yet offered by the social worker as a case to be closed. It was through an office-wide review of cases that this worker was directed to complete the investigation.

Issue: The investigation of the first referral in the Office of African American Children's Services (OAACS) was delayed for many months. The case manager submitted the case for closure, however, prior to the child's death, the case was returned to the case manager to perform more collateral contacts and to correctly write the investigative risk assessment, which was completed.

Recommendation: This matter was addressed in Region 4 by moving CPS investigations from OAACS.

Issue: The investigation of the first referral was founded for negligent treatment/maltreatment. However, the social worker from OAACS did not offer or provide any services to help the family.

Recommendation: Current policy does not mandate an offer of services on founded investigations, although one would expect an offer in nearly all such instances. The CA Practice Model design team should consider whether an offer of services should follow all founded investigations.

Child Fatality Review #06-24
Region 6
Olympia DLR/CPS

This 4-month-old Caucasian female died from Sudden Infant Death Syndrome (SIDS).

Case Scenario

On January 18, 2006, this infant, while in sitting up in full view of care providers at a licensed day care home, began to turn blue. The provider's spouse performed CPR until EMT workers arrived but the child could not be revived. The provider's spouse has extensive CPR experience as a trainer. The coroner's office determined the cause of the death due to SIDS. The Division of Licensed Resources (DLR) and law enforcement investigated and found nothing suspicious.

Referral History

No referral history exists on the family or the licensed day care home.

Issues and Recommendations

None.

Action taken: The Department of Early Learning (DEL) gave the licensed providers an email link to the SIDS website which includes group information. The providers were already connected with counseling services due to their biological adult son's suicide. DEL staff will explore training from the SIDS foundation for licensed day care providers. DEL staff will explore grief support for providers and social workers when a child dies in a provider's care.

Child Fatality Review #06-25
Region 4
Kent DCFS – King South

This 1-month-old Caucasian male died of Sudden Infant Death Syndrome (SIDS).

Case Overview

On November 13, 2006, a call was received from the King County Medical Examiner regarding the death of this infant. Allegations were that the mother and father laid down for a nap with the baby and later awoke to find the child dead. They called the police and fled the scene. The house was cold, dirty and smelled of smoke and investigators found the baby had been dead for "a while." There was no obvious trauma to the baby. The referrer indicated that there were ten other transients living in the home and that it was a drug house. The father had been reportedly in and out of jail, and the mother a substance abuser. An autopsy concluded that the child had died of SIDS.

Referral History

On September 22, 1999, a hospital social worker called to report that the mother of the decedent had tested positive for amphetamines during the birth. The report also indicated the mother had tested positive on her first (and last) prenatal visit 3 months earlier. The baby was irritable, and he had trouble feeding. The hospital placed an administrative hold on the baby, and the referral was assigned for investigation.

The assigned social worker met with the parents, the hospital physician, a public health nurse (PHN) and the hospital social worker. The parents signed a voluntary service plan that included PHN services, random urinalysis tests (UAs) for the mother and an assessment for substance abuse. The evaluation recommended treatment, and the mother cooperated with three months of UAs that were all negative. She did not enter treatment. Follow-up appointments for the baby with the primary care pediatrician were noted to be unremarkable, and the PHN did not have concerns about the mother's ability to care for the baby. The case was closed as inconclusive.

On October 13, 2006, a hospital social worker called to report the birth of this child. Allegations were that the mother claimed she had lost custody of her previous children, and that there was history of substance abuse. There was, however, no documentation that CA had removed her children. The mother tested negative for substances at birth. The referral was screened as low risk and referred to the Alternate Response System (ARS) and a PHN was assigned.

The PHN attempted contact at the home and by phone on numerous occasions. After several weeks the mother returned a phone call stating that she would be out of town but agreed to meet with the PHN on November 15, 2006. On November 13, 2006, the maternal grandmother of this child called the nurse to inform her that the infant had died. ARS was closed on November 15, 2006.

On November 13, 2006, the King County Medical Examiner called CA asking that a CPS investigation occur regarding this child's death. The referral was assigned for investigation. The mother stated that her two older boys lived with their custodial fathers – one in California and one in Federal Way. The autopsy results confirmed the death was SIDS, and the CPS case was closed as unfounded.

Issues and Recommendations

Issue: From the case episode in 1999: No treatment for the mother, despite a diagnosis of methamphetamine dependency. A Chemical Dependency Professional (CDP) conducted an assessment on October 22, 1999. She found the mother to be methamphetamine dependent and recommended she participate in intensive out-patient treatment. The mother was referred but did not attend, apparently due to difficulties arranging care for her children. The mother did participate in multiple UAs and was always negative - but did miss some appointments initially.

Recommendation: Whenever a client has a diagnosis of drug dependency, CA should be more assertive in helping the client participate in services.

Child Fatality Review #06-26
Region 4
King County DCFS African-American Unit

This 2.5-year-old African-American female died naturally in a relative's home of Streptococcus Pneumonia and Haemophilus Influenzae Pneumonia.

Case Overview

On December 6, 2006, this Children's Administration (CA) dependent child died while in a relative's home. She was born with Down Syndrome and heart defects that required surgery when she was 7-months-old. She also had a history of respiratory difficulties. A referral to CA on the day of her death alleged that family members at the relative home had flu symptoms and that the decedent had been sick as well. An aunt placed the decedent for a nap and noticed that she had shallow breathing. 911 was called and CPR was administered but the child could not be resuscitated. The King County Medical Examiner determined the cause of death as Streptococcus Pneumonia and Haemophilus Influenzae Pneumonia.

Referral History

The family has a history of seven referrals preceding the fatality. The mother was the subject in four referrals with founded findings on two for neglect. The mother has an extensive history of substance abuse.

On February 20, 1991, a doctor reported that a sibling had fallen from an open window at a theatre in Spokane while with his grandmother. The referral was screened as information only.

On November 5, 2003, a referral alleged that the mother was using drugs after completing treatment. CPS found that the mother had relapsed and encouraged her to follow treatment recommendations. The finding was inconclusive for neglect.

The next two reports were Family Reconciliation Services (FRS) referrals, dated January 30, 2004 and March 10, 2004. The mother requested help with her teenage son due to difficult behaviors via an At-Risk Youth (ARY) petition.

On November 23, 2005, a Public Health Nurse (PHN) reported that the mother had only two or three prenatal visits with her obstetrician and that she had tested positive for drugs. The mother had lost thirteen pounds. The case was investigated and closed as inconclusive.

On November 27, 2005, CA received a report that the mother had given birth to a boy and that both tested positive for cocaine. He was born prematurely and was not feeding well. CPS placed the baby at the Pediatric Interim Care Center (PICC). The mother's sister came from Spokane to help and Intensive Family Preservation Services (IFPS) were provided. A Family Team Decision Meeting (FTDM) convened to build a plan. The investigation was closed as founded.

On May 2, 2006, CPS received a report that the mother was missing while the children were staying with a relative. This investigation was founded for negligent treatment/maltreatment.

Voluntary services were frequently offered and provided to the family that included substance abuse evaluations and treatment, random urinalysis tests, mental health services, a PHN, and Childhaven. CA eventually filed a petition for dependency and relative placement based on the mother's mental health disorders and substance abuse. The children were placed in relative care.

Issues and Recommendations

Issue: Substance abuse services for pregnant and parenting women. The highest priority for treatment for all chemical dependency treatment agencies in our publicly-funded system is supposed to be pregnant women and mothers. This mother has been in and out of treatment multiple times. She is currently under a court order to be in treatment and is non-compliant. This mother may also have mental health problems.

Recommendation: The Office of African-American Children's Services (OAACS) should consult with the out-stationed Chemical Dependency Professional (CDP) for its office and determine the best intervention strategy.

Child Fatality Review #06-27
Region 3
Everett DCFS office

This 3-month-old Caucasian male died from Sudden Infant Death Syndrome (SIDS).

Case Overview

The mother and father of this infant were sleeping with him in their bed when they awoke at 10:30 a.m. to find him not breathing. They denied rolling over on him, and there were no signs of trauma. The child was transported to the hospital where he was pronounced dead. The cause of death was later determined as SIDS.

Referral History

In 2005 the mother was 16-years-old when her father requested assistance from the Family Reconciliation Services (FRS). An At-Risk-Youth (ARY) petition was obtained through the juvenile court because she skipped school, argued, ran away, used drugs, and was in danger of being dismissed from school. She continued to run away and was arrested for possession of drug paraphernalia. Her father claimed that she used marijuana frequently and that she had used methamphetamine.

The only CPS referral on this mother as a parent came in July of 2006, when she was 17-years-old. A maternal relative reported that the mother and her boyfriend had been "cooking crack" in their apartment with their 2-month-old infant present. The caller was also concerned about the father, whom she described as an "alcoholic" who "beats" the mother when he's drunk. The referral was assigned and a home visit conducted the following day. The officer present arrested the mother on two outstanding warrants and the decedent was placed with the maternal grandmother by law enforcement on a 72-hour protective placement. The mother said that she planned to live with her parents and the baby after her release from jail due to conflict between her and the infant's father. DCFS allowed the protective custody to lapse without court intervention based on this plan.

A week afterward the social worker received a call from the maternal grandmother indicating that the mother had left with the baby and returned to the father. The social worker contacted the mother and asked her complete a urinalysis test (UA) and to meet with her the next day. The UA was clean. The safety plan included actions to keep the child safe if the father became violent and anger management classes for the father. Both parents refused a drug/alcohol assessment that was offered. The social worker closed the case afterward and submitted to the supervisor for approval. Prior to the supervisor's approval, however, CA received a referral indicating that this child had died. The referral was not assigned for investigation because no allegations or suspicions of child abuse or neglect were made.

Issues and Recommendations

Issue: There was no information in the record on the father. There were several allegations and risk factors that may have prompted the social worker to investigate his background more thoroughly. These included the mother's statement that the father was on SSI for "mental problems" and the caller's allegation that the father is an "alcoholic" and that he "beats" the mother. Additionally, the father angrily stated that he was in foster care most of his life and the mother communicated fear of leaving the infant alone with him. Without a date of birth or other identifying information for the father, it was not possible to link his history with CA to the current situation.

Recommendation: Attempts to identify all subjects in a referral and connect them to their history should be made and documented in the file. This issue should be discussed/addressed in the next meeting of CPS supervisors.

Issue: Documentation of case activity in this referral was scant. It was unclear from the record how the social worker learned that the mother had left her own mother's house and returned to the father with the baby.

Recommendation: This issue has been addressed with the worker involved.

Issue: This child was identified by the investigating worker as non-Indian, based on the mother's statement that she had no Indian heritage. The question was not asked of the father. However, the earlier record of the mother as a juvenile FRS client in March 2005 contains a statement from her father that he was 1/8 Chippewa and eligible for enrollment, although he was not planning to enroll. The mother may be eligible for enrollment as well. This information should have been incorporated into the mother's and her father's person cards at that time.

Recommendation: This issue has been addressed with the worker, and the information in the computer system has been amended to reflect the Indian heritage of the family. Recent peer and case reviews have shown that since the time of this case, this office has shown increasing improvement in performance in the area of documentation of Native American ancestry.

Issue: Caseload pressures contributed to the early, perhaps premature, closure of this case. This family may well have benefited from continued work with the mother on services.

Recommendation: A re-design of unit organization in this office now allows for transfer of cases such as this into a unit specializing in designing and monitoring service plans for families at risk.

Child Fatality Review #06-28
Region 3
Everett DCFS office

This 12-year-old Caucasian male died from a pedestrian motor vehicle accident.

Case Overview

The child was skateboarding with friends near his home in the Lowell neighborhood of Everett the evening of Monday, August 21, 2006. At approximately 9:30 p.m. he was struck by a vehicle that left the scene. He was taken to Harborview Hospital where he was pronounced dead at 1:30 a.m. the following day. The driver of the vehicle was later identified. The manner of death was determined accidental.

Referral History

There were 18 referrals on this family prior to the child's death.

The first two referrals about this family came in February of 1993. Head Start staff reported that the older sibling (4-years-old at the time) to the decedent had a scab on his wrist that he said was caused when the mother hit him with a stick. The following day a second referral was received from the Everett Police alleging that the father hit a sibling with a stick and caused a bruise. CA records indicate that there may have been a short term placement with the maternal grandparents after this incident, although records from that time are not complete.

In June 1997 a report was made by the Snohomish County Prosecutor's office that alleged the decedent (then 3-years-old) played naked and unsupervised in the street. The investigation was concluded as founded for negligent treatment.

A referral that alleged injuries to this child was made by his school in 1999. He told the school that his older brother had burned him and that his maternal grandfather had hit him. The referral was investigated and closed as unfounded. This child was unable to give a consistent explanation of what happened, and the mother denied the allegations.

In 2000 a referral alleged that the mother's boyfriend was physically abusive of the mother. The mother told CPS during the investigation that she was no longer involved with the boyfriend and that he was no longer around the children. A few days later, another report was made with the same information. The investigations were closed as founded for physical abuse. Three months later a referral alleged that the youngest sibling, aged two, was playing in the street unsupervised. It was investigated and closed as inconclusive.

In May 2003 allegations of physical abuse to the 15-year-old sibling by the boyfriend were made. CPS learned that he had not left the home as previously purported by the mother. The child was injured as he attempted to intervene in a domestic violence incident between the mother and boyfriend. The mother admitted that he had remained in the home but said there were new house rules about when and where the boyfriend could drink alcohol. Three months

later she called the social worker to report that another episode of domestic violence and that she had obtained a restraining order against the boyfriend.

In January 2004 the school reported injuries to the 6-year-old sibling who had been beaten by the decedent. The mother, while home at the time, did not take action according to the victim. Services were offered and the case was closed as unfounded.

In October 2004 a referral was received that alleged the boys were fighting and hurting each other with less severe injuries this time. CPS was unable to reach mother, and the case was closed.

There were five additional referrals that followed, two in November 2004, one in January 2005 and two more in March 2005. Allegations from each alleged that the decedent physically abused the youngest sibling. All five were closed as unfounded in May 2005. The worker negotiated an "aftercare plan" with the mother who agreed to closer supervision of the boys, counseling and door alarms.

In August 2005 allegations were made that the younger sibling arrived at day care with a substantial burn to his arm that was blistered. He allegedly told the caller that the decedent had poured lighter fluid onto his arm and set it on fire. The mother reported that she was not sure how it had happened since the boys were frequently left home alone. The investigation was closed as founded for negligent supervision. and the mother signed an agreement that she would not leave the children unsupervised.

Two information-only referrals were received afterward. Both alleged injuries to this child. Information was not clear as to how those injuries occurred. Both were addressed by the assigned worker.

Issues and Recommendations

Issue: In the Investigative Risk Assessment on referral #1418028, the case was closed at a moderately high level of risk (4). The victim was 6-years-old at that time; therefore, the case should have been staffed with a Child Protection Team per policy. Policy also requires that CPS referrals are to be closed within 90 days of the date received. It was almost one year from date of referral to date of finalization of assessment.

Recommendation: Action Taken: These issues have been addressed with the unit supervisor. A recent re-design of the units' organization now allows for considerably shortened time frames on closing of investigations.

Issue: The two referrals assigned in November 2004, the one in January 2005, and the two in March 2005 were all closed in two assessments in May 2005 which was six months after the November referrals were received. All were unfounded. Instead of a monitored service plan there was an "aftercare plan" developed with the mother just prior to the closing of the case in May 2005. It was essentially a parental promise for better supervision and insufficient to assure the safety of the children.

Recommendation / Action Taken: At the time this aftercare plan was developed and the case was closed, caseload pressures were intense in this office's CPS units, and timely response to referrals was taking priority over monitoring contracts. Since that time there has been a redesign of the CPS units that allows for both timely response to referrals and much greater attention to developing and monitoring voluntary service contracts.

Issue: In referral #1568912, received in November 2004, the allegation was that the younger sibling was injured by the decedent. When he told the mother about this, it is alleged that she then hit this child in the face with a spatula. Both boys should have been listed as victims in this referral on the negligent treatment/maltreatment allegation, not just the younger child.

Action Taken: This has been discussed with the Intake supervisor on this referral.

Issue: The review team was concerned that there may be some bias among workers regarding sibling physical abuse--a bias that might tend to minimize the effects of physical abuse by a sibling. There was agreement that particularly when this abuse occurs over a long period of time, the effects can be extremely damaging.

Recommendation: It is recommended that the issue be explored through the use of a speaker with expertise on this topic for a meeting of CPS supervisors.

Child Fatality Review #06-29 and #06-30
Region 1
Spokane DCFS office

This 16-month-old Caucasian male and 5-year-old Caucasian female died in an automobile accident.

Case Overview

On September 12, 2006, Children's Administration received information that the mother and her three children were in a car versus train collision in Montana. These two children were killed in the collision while the third and the mother survived. The mother was charged with reckless driving by Montana State Police. On September 15, 2006, a referral was received from a medical provider in Minnesota with concerns that the mother had intentionally placed her children in harm's way. Montana State Police conducted the investigation but refused to share information with CA for this review.

Referral History

On October 17, 2005, a mental health counselor called Child Protective Services (CPS) to allege negligent treatment of this mother's three children. The children included the male decedent (5 months), the male sibling (2 years) and the female decedent (4 years). The referral alleged that the mother was depressed and that she had not filled her anti-depressant prescription. The mother told the referent that she had met the children's basic needs (two of which are special needs) but she spent a lot of time in her bedroom. She claimed to monitor the children with a baby monitor. The father was a fulltime student and was on medication for bi-polar disorder.

The assigned social worker was immediately concerned by the small size of the male decedent. The house was cluttered and the children were in the care of a babysitter who appeared overwhelmed. The social worker returned to the CPS office, staffed her concerns with her supervisor and both conducted a second home visit that same day. The supervisor saw the child and agreed the child appeared small, but did not believe the situation was emergent.

The parents signed a safety plan that included a medical appointment for the male decedent as soon as possible.

On October 19, 2005, the children's physician reported that the five-month-old weighed 10 lbs. 15 oz. and was Failure-to-Thrive like his older sibling. The older sibling gained weight when he was placed on a G-tube.

On October 20, 2005, the social worker spoke with the physician who stated that he would like to monitor the 5-month-old and that he believed that CPS did not need to file a dependency petition.

The female decedent received special education pre-school. She required physical therapy, occupational therapy, speech therapy and academic skills. She was considered delayed across the board.

On October 27, 2005, a Family Team Decision Meeting was convened. It was attended by the parents, relatives, friends and church supports. A safety plan was developed which included the family moving in with the maternal grandmother.

On November 17, 2005, CPS learned that the male decedent to this review had gained weight while in the hospital but that weight loss was occurring in the grandmother's home.

On November 18, 2005, a dependency petition was filed. The petition sought placement for all three children. The male decedent was the only child placed into foster care.

On January 18, 2006, the social worker spoke to the doctor who stated that this boy was not gaining significant weight in foster care, and he recommended that the child be returned to his parents' care. He believed support services mitigated risk to the children.

On January 19, 2006, a multidisciplinary team meeting recommended the return of this boy to his parents' home that occurred that day after completion of a safety plan.

On January 30, 2006, the former foster mother for this boy baby saw all the children and reported that this child had lost 6 oz. since his return home. The dependency petition was dismissed on this date.

On February 1, 2006, the physician reported that there was an autosomal dominant condition affecting the male decedent but he was unable to see a pattern and make a diagnosis. The case was closed with information that the mother was taking her antidepressant medication and the following supports for the family: Guild school for both boys; Early Head Start with in-home visits; Public Health Nurse services in the home; a dietician for the oldest boy; physicians continued to monitor the children; counseling for the mother; extended family and church support and continued residence with the maternal grandmother.

On September 15, 2006, a referral was received from a medical provider in Minnesota with concerns that the mother had intentionally placed her children in harm's way. The referral was investigated and concluded founded for negligent treatment.

Issues and Recommendations

Recommendations: The review committee discussed systems issues that impacted the original investigation in 2005 as well as investigation post-death of these children. The lack of exchange of information between Montana State Police created barriers for the social worker to investigate allegations and assess safety and risks for the surviving child. The committee discussed anticipated improvements with interstate collaboration when the Adam Walsh Legislation is implemented.