

Child Fatality Review #08-38
Region 6
Wahkiakum County

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

Case Overview

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

Referral History

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Issues and Recommendations

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

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

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

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

Issue: Using barcode at intake to see if clients are open with other DSHS administrations.

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