

**Child Fatality Review #08-59**  
**Region 4**  
**King County**

This 17-year-old Caucasian female died from asphyxiation.

**Case Overview**

On October 21, 2008, the body of this deceased youth was found in Lake Ballinger in Snohomish County. The youth was previously reported as a missing person. The police investigation determined that on October 14, 2008, the deceased youth vomited inside a vehicle while drinking alcohol with five males. One of the men allegedly became furious that she vomited. Law enforcement reports state that he walked with her to a dock on the lake, strangled her, stabbed her in the neck with a screwdriver, pulled her into the lake and held her under water until he was certain she was dead. The Snohomish County Medical Examiner's Office determined that the cause of death was asphyxiation due to strangulation and the manner of death is homicide.

The alleged perpetrator was arrested on October 28, 2008 and charged with first-degree murder. He is currently awaiting trial.

**Referral History**

On July 23, 1992, a neighbor reported to Child Protective Services (CPS) intake that the deceased youth's mother often left the deceased youth, then 14 to 16 months old, home alone while she went out for long periods of time. The child was seen pounding on the windows late a night. This referral was investigated by CPS.

On June 21, 1993, an anonymous referrer reported to CPS intake that the deceased youth's mother hit her when was a baby. The referrer saw the child with bruises to her arm and neck. The referrer was unsure how the child got the bruises. This referral was investigated by CPS.

On March 10, 1994, a doctor reported to CPS intake allegations that the deceased youth may have been a victim of sexual abuse by her father. The child made a disclosure of abuse following a visit to her father in California. The doctor said there was no evidence of abuse. This referral was investigated by CPS.

On July 11, 1997, a social service professional reported to CPS intake that the deceased youth, then five-years-old, had a congenital hypothyroid condition that required daily medication to control. The child needed to be tested twice a year to determine if her condition is under control and required medication. Her mother neglected to obtain medical care and the medication. The mother missed many appointments despite reminders by medical staff. This referral was investigated by CPS.

On February 23, 1998, a hospital staff reported to CPS intake that the deceased youth's mother has a history of medical neglect. The referrer said the child had a congenital hypothyroid condition and had complications because her mother did not attend to her medical condition. This referral was investigated by CPS for medical neglect.

On August 12, 1998, a hospital staff reported to CPS intake that the deceased youth's mother did not give the child her medication for today as instructed by the referrer. The referrer said the child was prescribed a thyroid supplement; not taking this medication can cause learning disabilities, mental retardation and poor developmental growth. This referral was screened as low-risk and was not investigated by CPS.

On September 8, 1998, a neighbor reported to CPS intake that the deceased youth's father was a drug user and dealer. The referrer said both parents use drugs. The referrer also observed the mother hitting and pushing the deceased youth, then six-years-old, and her younger brother. This referral was investigated by CPS and closed with an unfounded finding.

On May 22, 2001 a relative reported to CPS intake that the infant sister of the deceased youth had pink eye in one eye and her mother did not seek treatment for this condition. The child's father said she had this condition for three weeks and she was unable to open her eye. He took the child to the hospital for treatment. The referrer said the mother was drug involved and sold drugs out of the family home. This referral was investigated by CPS and closed with an unfounded finding.

On August 24, 2005, a youth shelter employee reported to CPS intake that the 14-year-old deceased youth came to the shelter with her five-year-old sister and said both were homeless because their mother kicked them out of the house several days prior. The youth said she was "hanging out on the Avenue." The referrer said the deceased youth left the center and her whereabouts were unknown. This referral was screened in for Family Reconciliation Services.

On December 8, 2005, a relative reported to CPS intake the deceased youth's mother uses marijuana and fights with the deceased youth. The mother admitted to the referrer that she pulled the hair of the deceased youth and beat her. The referrer said they never saw marks or bruises on the children. The referrer said the mother hung around with drug users. This referral was investigated by CPS. The investigating social worker saw no evidence of abuse or neglect and the children made no disclosures of abuse.

On March 26, 2007, school personnel reported to CPS intake the deceased youth's six-year-old sister reported her father kicked her causing pain to her toe. The child said she was knocked out of the chair. This referral was investigated by CPS and closed with an inconclusive finding.

On May 29, 2008, school personnel reported to CPS intake the deceased youth's seven-year-old sister was seen with bruises on her for the fourth time this school year. The referrer said the child's bruises were dark and purplish/blackish in color. The child said her brother pushed her into a table. About three weeks prior she gave the same reason as to how she got a bruise on her calf. She reported that her brother caused each of the four bruises. The child did not express fear of her 14-year-old brother. This referral was investigated by CPS and closed with an unfounded finding.

On October 22, 2008, the Snohomish County Medical Examiner contacted CPS intake to report the death of this youth. Her body was found in Lake Ballinger. Her death was treated as a homicide. This referral was screened out for investigation by CPS.

### **Issues and Recommendations**

**Issue:** In regards to the referral dated May 29, 2008, this was the first case for a brand-new worker. She was closely supervised and her documentation demonstrates that she not only investigated the allegations, she also focused on the family history. Her findings and risk assessment show critical thinking. There was no information that raised questions about the youth's safety. The case was properly closed following the investigation.

**Recommendation:** Continue to emphasize close support and supervision for new CPS workers.

**Issue:** The family had multiple reports of child maltreatment from 1992 to 2008. It appears that several of the intakes were not thoroughly investigated and documented. It is possible that parental substance abuse may have been more of a factor in the chronicity, but this was not examined thoroughly when it was reported as an issue.

**Recommendation:** Continue to develop tools and resources for social workers that will increase the ability to engage and assess families. This, in turn, will help to provide more effective services.

**Issue:** Regarding the referral dated August 24, 2005 screened as "Information Only" for Family Reconciliation Services (FRS): This should have been screened in for a CPS investigation. The deceased youth, then age 15, had her five year-old sister with her. The youth told a mandated reporter that their mother had kicked them both out several days ago, and they were "hanging out on the Avenue."

**Recommendation:** The regional CPS Program Manager will discuss this with the intake supervisor and worker that screened the report.