

**Child Fatality Review #08-73**  
**Region 4**  
**King County**

This 17-year-old Caucasian female died after suffering a stroke.

**Case Overview**

On December 12, 2008, this 17-year-old youth died at Harborview Hospital. Earlier, she was taken to another hospital for a fever. While at the hospital she suffered a stroke and was airlifted to Harborview Hospital where she died. There were no suspicions regarding child abuse or neglect.

It was determined that the immediate cause of death was a bacterial infection leading to intercerebral hemorrhage (stroke). The teen was found to have infectious endocarditis, an infection of the lining of the heart chambers and heart valves that is caused by bacteria, fungi, or other infectious substances. The manner of death was determined as natural, and a medical condition is listed as the official cause of death.

**Referral History**

On September 20, 2000, a teacher called Child Protective Services (CPS) intake and reported the then six-year-old sister of the deceased youth said her privates hurt when she walked. She made no further comment. This referral was screened for the Alternate Response System (ARS). The ARS provider was unable to locate the family.

On June 17, 2002, a teacher called Child Protective Services (CPS) intake and reported the then four-year-old brother of the deceased youth said his mother hit him on the nose. There appeared to be a bruise on the child's nose. This referral was screened in for investigation by CPS. The social worker was unable to locate the family. The referral was closed without a finding.

On February 9, 2007, a teacher called Child Protective Services (CPS) intake and reported the then 13-year-old sister of the deceased youth said her stepfather hit her two years prior. This referral was screened as Information Only.

On March 22, 2007, a teacher called Child Protective Services (CPS) intake and reported the then nine-year-old brother of the deceased youth said his older brother, then age 15, woke him up by hitting and kicking him on the head and the legs. The older brother also pulled his ear. The nine-year-old said his mother is always sleeping when his brother is doing this. There was indication that the mother drank a lot. The nine-year-old said his mother got mad at him for telling and did not do anything about it. Mother denied to the teachers yesterday that there was abuse between her sons. Referrer stated there were a lot of bruises on his right front leg from the knee down. This referral was screened in for investigation by CPS and closed with an unfounded finding.

On December 4, 2007, a teacher called Child Protective Services (CPS) intake and reported the then 13-year-old sister of the deceased youth said her stepfather pushed her and threw a cup of water with maggots in it at her. The child had no marks or bruises. This referral was screened as Information Only.

On May 2, 2008, a report was made to CPS intake that the 15-year old brother of the deceased youth inappropriately touched his 10-year-old brother. The information was sent to law enforcement. The 10-year-old was interviewed at a sexual assault clinic and made disclosure of abuse. This referral was screened out as Third Party abuse.

### **Issues and Recommendations**

**Issue:** All six intakes (2000-2008) were reviewed. In examination, the panel agreed that the intake decisions were appropriate and reasonable with the exception of the first intake from September 2000. In review it appears that the referral dated September 20, 2000 should not have been accepted even as a low risk referral assignment to Alternative Response System (ARS). The single concern that was reported did not appear to meet legal sufficiency for CPS services. It was noted during the panel discussion that such assignments to ARS as a means to offer services to families were part of accepted practice in the Bremerton DCFS office in 2000. It is currently not the practice.

**Recommendation:** None

**Issue:** Six years prior to this youth's death Bremerton intake received information that the younger brother of the deceased youth disclosed being hit in the nose by his mother. The referral was appropriately assigned for investigation. Although Children's Administration (CA) policy and practice requirements for conducting CPS investigations have changed significantly since 2002, full consensus was reached by the Child Fatality Review panel that the CPS investigator failed to meet basic practice standards. The review panel found no credible evidence of any attempt to conduct an investigation. Documentation of reported attempts to contact the alleged victim, the family, and the child's school was made in a single case note in November 2002 just prior to closing the case as "unable to locate."

Following the Child Fatality Review the CA "Guidelines for Reasonable Efforts to Locate Children and/or Parents" was electronically disseminated to the Bremerton Area Administrator and supervisors overseeing the CPS program. This was not in response to any indication of a current problem within the CPS units, but rather in recognition of an opportunity to update and reinforce Region 5 practice expectations in the Bremerton DCFS office regarding "unable to locate" situations.

**Recommendation:** None

**Issue:** In March 2007, Bremerton intake received information that the deceased youth's younger brother disclosed being physically abused by his older brother on a frequent basis. This child indicated that he had told his mother but she was not doing anything about the situation. The referral was appropriately assigned for investigation of negligent treatment (parent not adequately intervening in sibling-to-sibling abuse). The CPS worker met or exceeded most practice and policy. The field response time was immediate. The alleged victim was interviewed at school using a sign language interpreter. The investigator conducted an unannounced home visit and both parents were interviewed. The deceased youth and her siblings were also interviewed although none were identified as victims. The CPS worker made contact with the schools of all the children as well as spoke with a relative who lived nearby the family home. The investigation was completed in a timely manner and the finding (unfounded) appears to be supportable upon review. Overall the investigative activities and documentation were of excellent quality. The CPS worker participated in the review and received feedback regarding her investigative practice and documentation.

**Recommendation:** None