

Child Fatality Review #09-12
Region 4
King County

This five-year-old Native American female died from asphyxiation due to fire.

Case Overview

On January 22, 2009, this five-year-old child died from the inhalation of the toxic products of combustion and thermal burns. The manner of death is accidental. A King County Fire Investigator called the Medical Examiner to report the death of this five-year-old female. She was found in an upstairs bedroom covered by insulation that had fallen from the attic with a dog nearby. Her body was badly charred. This residence was a fully engulfed structure fire.

The members of the home included the mother, her sons ages 17, and four, and her daughters ages ten and five (the deceased child). On January 22, 2009, around 4:45 a.m. to 5:00 a.m. the mother left the home to take a friend to work. 911 received a call about the fire at 5:41 a.m.

According to investigators, the 17-year-old woke to the smoke alarm. He found a fire in his mother's bedroom and his four-year-old brother in his mother's bed. He took him upstairs and tossed him out the window to the lawn. He told his 10-year-old sister to jump. He looked for the deceased child but the smoke was too thick. He jumped from the window with the 10-year-old. The four year-old brother suffered life-threatening injuries from the fire, but survived.

The King County Sheriff's Fire Investigation Unit determined that the source of the fire was an electrical event with an outlet in the mother's bedroom.

Referral History

The family has a history of eighteen reports to Child Protective Services (CPS) preceding the death of this five-year-old. These take place between October 11, 1996 and April 25, 2008. Sixteen reports were screened accepted for investigation of neglect (negligent treatment or maltreatment). Two reports were screened Information Only. Five investigations were closed with founded findings —more likely than not, abuse or neglect (as defined in the Washington Administrative Code (WAC)) occurred. Five reports were closed with unfounded findings —more likely than not, abuse or neglect did not occur); two were closed with inconclusive findings and four had no finding documented in the electronic record.

The history documents chronic neglect with multiple incidents of very young children left unsupervised, hungry, dirty and in dirty diapers. The father has a sex offense conviction. Substance abuse may have been a contributing factor to the abuse. In 2007, the deceased

child and her then three-year-old brother were badly burned when they pulled a pot of boiling water off of the stove.

The responsibility for providing services to this family has been shared between the Children's Administration Office of Indian Child Welfare (ICW) in Region 4 and the Indian Child Welfare program with the Muckleshoot Tribe. The Tribe and Region 4 have an arrangement in which CPS investigates, but the Tribe will also assign a social worker to arrange services. The Muckleshoot Tribe has a tribal court and can assert legal jurisdiction as to their children and families (at the time of this child's death, the four children were under a Tribal Court In-Home Dependency Order). Children's Administration cannot initiate dependency proceedings on children whose family is domiciled on an Indian reservation.

From 1996 to 2002, CPS received nine reports but there are few case notes in the electronic record. Only one of these reports in 1997 is listed as founded for neglect. The detailed case records begin with the intake received April 25, 2003 and screened in for investigation of neglect. The report alleged that the mother left the deceased child's older brothers to care for their younger sister while she worked evenings. (The father's teenaged son was also living with the family at this time, though no longer lived in the home at the time of the fire). She did not make adequate arrangements for their physical care and the boys had behavioral problems. The assigned CPS investigator worked closely with Muckleshoot ICW program to assess risk and develop a service plan.

On September 24, 2003, the Muckleshoot ICW social workers and the Region 4 ICW social workers met with the tribal ICW Committee (which has a similar role to Children's Administration Child Protection Teams) to discuss and review this case. It was mutually agreed that the case could be closed because the parents followed through with treatment and provided for the children's basic needs. The parents followed though with the plan and recommendations of the tribal substance abuse program. The investigation was unfounded for neglect and the case was closed.

On October 26, 2004, CPS intake received a report that the deceased child's sister, then age six, had chronic head lice, multiple school absences, and may have been left alone with a younger sibling (the deceased child). The mother had been hospitalized for complications of pregnancy and gave birth to a son in November 2004. The parents maintained that they had supportive friends who were helping to care for the other children while the mother and the baby remained hospitalized. This intake was screened in for investigation and closed with an unfounded finding for negligent treatment or maltreatment and the case remained open.

On January 27, 2005, hospital staff reported that the parents visited their premature infant twice in 11 days. Also, before his transfer from another hospital, staff there noted infrequent visits too. The parents claimed that they were ill and were told not visit if ill;

the mother said she called daily. The assigned workers made a referral for a public health nurse (PHN). On May 25 2005, this case was reviewed with the tribal ICW Committee. The team decided to have the workers visit the home one more time, then close the case. The investigation was completed with an unfounded finding for neglect and the case was closed.

On May 10, 2006, CPS intake received a report that the deceased child, then 2-years-old, and her brother, then 17 months of age, were found unsupervised on a playground next to the Muckleshoot Tribal Housing Office. They were very dirty and appeared to have respiratory problems. A housing worker brought them to the office and no parent inquired about them—even after three hours had passed. A sheriff's deputy found the father and brought him to the housing office.

The workers decided that the children could return home with a safety plan. The plan included medical exams, the Birth to Three programs at daycare, PHN, and a back-up plan for help with supervision. The father signed this plan. This intake was screened in for investigation of negligent treatment or maltreatment and closed with an unfounded finding. The Muckleshoot ICW program and Region 4 ICW mutually agreed to close the case.

On July 11, 2007, CPS intake received a report that the deceased child, then age three, and her two sibling, age eight and two, were left home alone for over five hours. The children went to neighbors several times asking for food and even when the father returned in the evening he did not provide care. They did not look well cared-for. The two girls' hair was matted and needed to be brushed. The three-year-old had visible tooth decay. The two year-old was wearing only a diaper all day. The intake was accepted for investigation by CPS and closed with a founded finding for negligent treatment or maltreatment.

On August 10, 2007, two separate reports were made to CPS intake. Muckleshoot Tribal Housing Authority staff reported during a routine inspection that the three youngest children were observed to be filthy; there was an odor of spoiled food and garbage, and the residence was a health hazard.

Another intake alleged that the deceased child and her younger brother pulled a pot of boiling water off the stove and suffered severe burns. The brother had burns covering 22 percent of his body and the deceased child was burned on 7 percent of her body. They were airlifted to Harborview Hospital. The father claimed he had answered the door or had a phone call when this incident occurred.

The social workers arranged for contracted Intensive Family Preservation Services (IFPS) and for more PHN services. The parents cleaned up their apartment and discarded many of the children's items due to lice infection. They replaced clothing and bedding items.

These intakes were screened in for investigation of negligent treatment or maltreatment and closed with founded findings.

The parents followed through on medical appointments but were slow to respond to the IFPS and PHN services. They were initially compliant, then stopped engaging in services and conditions in the home appeared to deteriorate again. A shared planning meeting on October 15, 2007 with the service providers resulted in a decision to continue the voluntary services plan.

On November 13, 2007, an IFPS provider reported that she came to the home for an appointment and found the deceased child in her underpants and her younger brother with no clothes on. The father was asleep and the kids had to wake him. The house smelled of garbage. The kids were not attending tribal day care because they were behind in immunizations again. This intake was accepted for investigation and closed with an inconclusive finding. The case remained open with an extensive voluntary service plan, with little compliance or progress.

On April 25, 2008 CPS intake was again contacted after the deceased child and her younger brother were found outside, in diapers, unsupervised. The parents were not home, the house was dirty. There were no clothes for the children. The deceased child had head lice. Law Enforcement was contacted and placed them in protective custody with a grandmother in Tacoma.

This intake was accepted for investigation and was eventually closed with a founded finding. The Muckleshoot ICW social worker filed a dependency petition in Muckleshoot Tribal Court and arranged for an aunt to move into the family home while the parents moved out. This allowed the children to continue with school and services without disruption. The Children's Administration case was subsequently closed, but the Muckleshoot ICW case remained open.

The case was still open with the Muckleshoot ICW Unit at the time of the house fire that resulted in this child's death and severe injuries to her brother. The legal status of the children at that time was in-home dependency as ordered by the Muckleshoot Tribal Court.

The report of the fire and death was received on January 22, 2009. This intake was screened in for investigation of negligent treatment or maltreatment. The King County Medical Examiner reported the death of this child in a house fire at the family residence. The preliminary information was that the mother left the house around 5:00 a.m. to take a friend to work. Two children woke to the smoke alarm. Three of the children were able to get out of the house. The oldest brother attempted to find the deceased child, but could not find her due to smoke. Her body was later found by investigators. The King County Medical Examiner determined this fatality to be an accident due to faulty electrical

wiring. The CPS investigator was waiting for the fire investigator's final report to make a finding in the case. The worker's supervisor approved of this action. The case remained open with both Region 4 ICW Office and Muckleshoot ICW Unit.

Issues and Recommendations

Issue: Addressing families with repeated referrals for child maltreatment.

Recommendation: Region 4 will offer a meeting with the tribe to discuss the state-tribal partnership in addressing families with repeated referrals for maltreatment.

Issue: There currently is not a signed Memorandum of Understanding between Muckleshoot Tribe and Region 4, pertaining to each agency's roles and responsibilities for Indian Child Welfare cases.

Recommendation: Region 4 and Muckleshoot Tribe should consider finalizing a Memorandum of Understanding.

Issue: The CPS investigation has not been completed. This is an unusual case and the investigator needed information from other sources in order to make a finding.

Recommendation: Now that the social worker has this information, he should complete the investigation.