

**Child Fatality Review #10-65**  
**Region 5**  
**Pierce County**

This 12-month-old African American female died from complications of a chromosomal disorder.

**Case Overview**

On December 14, 2010, the mother of this 12-month-old medically fragile child reportedly heard a cough and went to check on her. The child had been fed around midnight. The mother reported that she observed what she described as prolonged seizure activity, with her daughter going limp soon after being held. Following a call to 911 at 12:46 a.m., Fire Department EMS arrived on scene at 12:51 a.m. The child was in "full code" and without a pulse. Resuscitative efforts were continued and the child was transported to Mary Bridge Children's Hospital where she was pronounced dead.

The Pierce County Medical Examiner determined that manner of death was natural, and most likely due to complications of the child's chromosomal disorder. The child had multiple and complex medical conditions including hypertrophic cardiomyopathy (thick heart muscle with outflow obstruction), microcephaly (small head) with lobar holoprosencephaly (lack of normal brain development/birth defect), and diabetes insipidus (kidneys cannot conserve water). Given the extensiveness of her medical disorders, early death was not unexpected.

According to the Medical Examiner, the actual mechanism of death may have been a seizure, a primary cardiac dysrhythmia, an endocrine abnormality such as hypernatremia (elevated sodium), or aspiration. There was no evidence that physical injury played a role in the death and the autopsy did not show evidence of any recent injury. There was no evidence of rib fractures. Toxicology testing was conducted and the results were negative for alcohol and drugs.

Children's Administration (CA) had an open case on this child. In June 2010, the 12-month-old was seen by doctors and appeared to have two healing fractured ribs and other possible injuries. The 12-month-old and her older sibling were placed into protective custody and dependency actions initiated. The sisters were eventually moved to relative care. The children were found dependent in Pierce County Juvenile Court, and the CPS investigation was completed with founded findings.

**Intake History**

On December 12, 2005, CPS intake received a report from a hospital social worker that the older sister of the 12-month old was seen at a Tacoma area hospital with bruises on her cheeks and a scraped nose. The child was a year old at the time of this report. She was in the care of her father for several days. The referrer reported the injuries were not consistent with the explanation given by the father. The father had a prior arrest for assaulting a child of a former girlfriend. The CPS intake was screened in for investigation

for physical abuse by the father and neglect by the child's mother. The CPS case was closed in March 2006 with an inconclusive finding. The father was eventually convicted of Domestic Violence Assault in the Fourth Degree of the assault of his former girlfriend's child.

On May 19, 2008, CPS intake received a report that the mother was allowing the father contact with the child who was injured in the December 2005 intake report. This report was screened in for investigation and closed with an unfounded finding. The child's father was in jail and not around any children.

On June 20, 2010, CPS intake received a report from hospital staff who reported the 12-month-old child (six months old at the time of this report) was seen at a hospital emergency room. She had healing rib fractures, an injury to her wrist and a possible spinal injury. The physician at Seattle Children's Hospital described the injuries as possibly the result of "squeezing or rough handling." The spinal injury was later determined to be from a mass or a congenital malformation.

Both the 12-month-old and her older sibling were placed into protective custody and dependency actions initiated. The children's father was arrested for aggravated assault and jailed while awaiting trial. The 12-month-old had continued medical issues not related to the alleged abuse and remained hospitalized until mid-September 2010 when she was discharged into relative care. Her older sibling had already placed in relative care. The children were found dependent in Pierce County Juvenile Court and the CPS investigation was completed with founded findings for physical abuse as to the father and neglect as to the mother.

In preparation for reunification, unsupervised overnight visits were court approved for the mother and her children. On December 14, 2010, the 12-month-old had a seizure during an overnight visit at her mother's home. The child's mother called 911 but emergency responders were unable to revive the child.

### **Issues and Recommendations**

**Issue:** Regarding the CPS Investigation of the December 1, 2005 intake report: There were two concerns identified for the 2005-2006 CPS investigation. (1) The worker did not contact the Burien Police Detective that was investigating the alleged physical abuse by the father. (2) The "Inconclusive" finding as to the physical abuse allegations was questionable and appeared to be largely based on the fact that the father avoided being interviewed. The medical evidence and physician opinion that the child's injuries were non-accidental would have been sufficient for a finding of "Founded." Additionally, the fact that the father was charged and later convicted of Domestic Violence Assault in the Fourth Degree stemming from the abuse event would have supported a "Founded" finding.

**Comment:** It was noted during the review that significant policy and practice expectations have occurred within Children's Administration (CA) over the five years since the 2005-2006 investigation, such as improvements in safety planning, clearer expectations for collaboration with law enforcement, and elimination of "Inconclusive" as a finding option (2008). It should be noted also that neither the CPS investigator nor the supervisor from the 2005-2006 investigation is currently employed by CA and did not participate in the review.

**Recommendation:** None

**Issue:** Regarding the CPS Investigation of the June 20, 2010 intake report: There were several practice issues identified for the CPS investigation of the alleged abuse to the child six months before her death from medical causes. (1) While the CPS worker did request the family case file from record retention, the file was misplaced and not located until after the Child Fatality Review. (2) The CPS worker might have considered contacting and obtaining records from the child care provider. (3) The documented basis for the "Founded" finding on the father for physical abuse was not well written and appeared to be partly based on the father's refusal to be interviewed. The medical evidence and physician opinion that the child's injuries were non-accidental would have been sufficient for a finding of "Founded." Additionally, the fact that the father was charged with aggravated assault of a child stemming from the abuse event in June 2010 would have supported a "Founded" finding.

**Action Taken:** The CPS investigator was not able to participate in the Child Fatality Review due to emergency placements of children on her current case load. The CPS supervisor was unable to participate due to medical leave. Both received feedback post review regarding the identified practice issues. The worker's current CPS Supervisor and the CPS Area Administrator did attend the review and participated in the discussions as to the issues identified.

**Comment:** Noted during the review is the fact that refresher CAPTA (findings) training has been offered annually for CPS investigators in Tacoma and Bremerton DCFS offices for the past few years, the most recent being in November of 2010.

**Recommendation:** None.

**Issue:** Overall the Child and Family Welfare Services (CFWS) worker appeared to demonstrate good practice in most areas of social work and case management. Two issues noted during the Child Fatality Review were that some case notes by the CFWS worker were not entered in a timely manner, and that the legal record for the deceased child was never updated from initial Shelter Care status. Another identified practice concern was the failure to utilize the CA Reunification Assessment tool per practice expectations [see CA Practice and Procedure Guide - Section 43051]. The decision in early December 2010 to proceed towards reunification/trial return home with the initiation of unsupervised overnight visits between mother and her two daughters appears

reasonable and utilized available shared decision making venues (e.g., Child Protection Teams, Family Team Decision Meetings, court). However, the Reunification Assessment tool was not utilized prior to coming to the reunification decision, but rather after the transition process (overnight visits) had already begun. While there is evidence of a completed Reunification Assessment for the older sibling, no Reunification Assessment was ever initiated in FamLink for the medically fragile child who died while on overnight visitation with her mother.

**Action Taken:** Both the CFWS social worker and her supervisor participated in the review and received feedback regarding quality work as well as where practice needed improvement. The CFWS Area Administrator also attended the review and participated in the discussions about practice improvements.

**Action Taken:** The legal record for the now deceased child was updated following the Child Fatality Review to reflect correct legal history. Currently the Tacoma and Bremerton DCFS offices are in process of moving FamLink input of children's legal history from a clerical function to CFWS supervisor function to improve immediacy and accuracy of legal action documentation.

**Action Taken:** Refresher training on Reunification Assessment and Transition & Safety Planning was initiated prior to this Child Fatality Review. The refresher opportunity was required for all CFWS social workers and CFWS supervisors in Pierce West, Pierce East, and Bremerton DCFS offices. The first of the four hour training sessions occurred on March 21, 2011. The fourth and final training session occurred on May 12, 2011. Additionally, CFWS supervisors have been notified that effective June 1, 2011, completion of the Reunification Assessment and Transition and Safety Plan will be expected on all cases where return home is the primary plan and must be shared at Permanency Planning and CPT staffings.

**Recommendation:** None.