

**Children's Administration**  
**Executive Child Fatality Review**  
**Autumn Franks Case**  
**October 2, 2008**

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## Executive Summary

In October 2008, the Children's Administration (CA) convened an Executive Child Fatality Review<sup>1</sup> committee to review the practice and service delivery in the case involving three year old A.F. and her family.

The incident initiating this review occurred on April 30, 2008, when a hospital social worker from Mary Bridge Children's Hospital (MBCH) notified Child Protective Services (CPS) of the impending death of a young child from suspicious injuries. The referrer told CPS the child had been transported to MBCH by ambulance after the girlfriend of the child's biological father was not able to revive A.F. after allegedly being knocked off a couch by a dog. The attending physicians did not believe the story being presented by the girlfriend<sup>2</sup> and the report was accepted for CPS investigation. An initial CT scan showed two skull fractures (including an older skull fracture) with swelling and bleeding in the brain. There were no other broken bones or bruising. [REDACTED] an older sibling living in the home, was placed into protective custody and was also examined. No injuries were found upon full examination of [REDACTED]. Later that evening A.F. died after emergent brain surgery. Cause of death was determined to be from blunt force trauma, and manner of death was declared a homicide. Although criminal charges had not been made at the time of the Executive Child Fatality Review or at the time of this report, the CPS investigation resulted in a finding of founded for child maltreatment.

A review of the family's history with Children's Administration notes three previous referrals referencing A.F. and her brother. There were two information only referrals (2005, 2007) involving the biological mother. The biological mother [REDACTED] was not a caretaker at the time of the fatality in 2008. A referral was made to CPS on March 18, 2008, alleging physical abuse to A.F. by the biological father's partner L.B. (inconclusive finding). The CPS investigation was still in progress when the child suffered non-accidental trauma which resulted in death.

Committee members included a diverse group of individuals representing the community and Children's Administration (CA). Efforts to secure participation by state legislators on

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<sup>1</sup> Given its limited purpose, a Child Fatality Review by Children's Administration should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. A review is generally limited to documents in the possession of or obtained by DSHS or its contracted service providers and the panel may be precluded from receiving some documents that may be relevant to the issues in a case because of federal or state confidentiality laws and regulations. A review panel has no subpoena power or authority to compel attendance and generally will only hear from DSHS employees and service providers. The panel may not hear the points of view of a child's parents and relatives, or those of other individuals associated with a deceased child's life or fatality. A Child Fatality Review is not intended to be a fact-finding or forensic inquiry or to replace or supersede investigations by courts, law enforcement agencies, medical examiners or other entities with legal responsibility to investigate or review some or all of the circumstances of a child's death. Nor is it the function or purpose of a Child Fatality Review to take personnel action or recommend such action against DSHS employees or other individuals.

<sup>2</sup> Identification of the girlfriend will be by initials only (L.B.) as she has not been charged in connection to the incident as of this report. She is variously referenced in records as "stepmother" and "mother" but should not be confused with the biological mother A.N.

the review panel were not successful. None of the review committee members had any involvement in the A.F. case. Team members were provided case documents consisting of the following: all referrals to CPS involving the family, CPS investigator notes from the pre-fatality abuse investigation and the fatality investigation, medical information (pre-fatality and post-fatality), the initial law enforcement report, and the Pierce County Medical Examiner determination of the cause and manner of death. Additionally, committee members interviewed the CPS social worker who had been investigating the pre-fatality allegations of physical abuse. The worker's supervisor and area administrator were available for interview had the panel desired, but were not called to appear.

Following review of the documents, the case history, and interview of the CPS worker, the review committee made findings and recommendations which are detailed at the end of this report.

#### Case Overview

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Child Protective Services (CPS) history for this family began with a March 18, 2005 referral reporting concerns that biological mother [REDACTED] may have slammed a door on [REDACTED] who was nearly three years old at the time. The alleged incident did not involve the now deceased child A.F. The referent had no direct knowledge of any actual injury to the child, but had overheard the incident over the phone. The referent indicated that she would be contacting law enforcement for a child welfare check request. No confirmation was made by CPS intake as to whether a child welfare request was made. This referral was taken for information only purposes.

Two years later CPS received information that concerned possible drug use by then primary caretaker [REDACTED] (biological mother) and non-custodial father C.F. It was reported that [REDACTED] was allowing her children, ages 2 and 5, to go to their father's home on weekends even though [REDACTED] had stated that the father used drugs. According to the referent, the mother admitted to smoking marijuana. The biological mother had also mentioned that her oldest child had been touched by the father's girlfriend [REDACTED] on the bottom and "front parts." The referent did not know what was meant by "front parts." Subsequent clarification of this alleged incident was provided by a relative in 2008 who stated that the situation involved hygienic intervention. The report in April 2007 was taken as information only.

On March 18, 2008, a relative reported to CPS intake that three year old A.F. had bruises on her spine and mid-buttock area. The child reportedly stated that "mommy did it" which the referent indicated "mommy" referenced the biological father's girlfriend L.B. It was unclear as to when the bruises were first noticed, but information gathered subsequent to the referral suggests that the alleged injuries may have occurred as much as five days prior to the report to CPS. The report was accepted for investigation and law enforcement was notified the same day.

Prior to conducting an unannounced home visit the assigned CPS worker contacted a Lakewood Police Department (LPD) detective to ask his availability should the CPS investigator go to the home of the biological father and his girlfriend and find the allegations to be accurate. The CPS social worker re-contacted the detective after visiting the home to say that the detective's services would not be needed as only faint bruising was observed on the child.

The home visit by the CPS investigator occurred within 72 hours of the non-emergent referral being accepted for investigation. The "stepmother" L.B. allowed the CPS worker to view the child's back, front, legs, and arms. The CPS worker observed that A.F. had "one very faint and hardly visible bruise smaller than a dime at the base of her back." The child appeared to be a well-nourished healthy child. The social worker documented his observations of the interactions between A.F. and the "step mom" which appeared positive. When interviewed by committee members, the CPS worker recalled that the child was wary of his presence, reluctant to talk, and sought the comfort of the "stepmother." The CPS worker also stated when interviewed that his plan was to find another time when he could attempt to interview the child outside the presence of the father's girlfriend.

The CPS social worker interviewed the alleged subject L.B. who indicated that she did not know how A.F. had become bruised. She stated her discipline did not include spanking. L.B. provided the CPS worker with name of the primary care physician for the child. While at the home the social worker spoke by phone with the father who was at work. He stated that discipline in the home did not currently include spanking. The father also stated that the children's biological mother had called after her last visitation and said the kids had bumps all over. He and his girlfriend L.B. had checked the children and did not see anything. Also during the home visit by the CPS worker the paternal grandmother arrived to the home. She indicated that she saw the children regularly and she had no concerns in regard to their care.

Three days after the initial home visit and face-to-face contact with the alleged victim, a friend of the paternal grandmother contacted the CPS investigator. She stated that she had observed the alleged bruises, indicating having seen three to four bruises just above the butt cheeks and a four inch long narrow bruise on the child's back. The father's partner L.B. had told grandmother's friend that A.F. had fallen while at a local McDonald's restaurant. The caller also indicated that the child had stated that the father's girlfriend ("mommy") did spank. The friend indicated that she had taken photos of the bruises and that she would send them to the CPS worker. The worker never received the pictures which were eventually obtained post-fatality.

On March 26, 2008, the CPS social worker received a telephone call from the biological mother who said that she had also seen the bruises on her daughter's back, describing the same bruises that the paternal grandmother's friend had described to the CPS worker. The mother indicated that the child vacillated when asked about the "stepmother" and the bruises.

