Report to the Legislature

Quarterly Child Fatality Report

RCW 74.13.640

April – June 2011

Department of Social & Health Services
Children's Administration
PO Box 45040
Olympia, WA 98504-5040
(360) 902-7821
FAX: (360) 902-7848

Table of Contents

Children's Administration Quarterly Child Fatality Report

Executive Summary 1

Child Fatality Review #10-54 8
Child Fatality Review #10-55 11
Child Fatality Review #10-56 13
Child Fatality Review #10-57 15
Child Fatality Review #10-58 18
Child Fatality Review #10-59 20
Child Fatality Review #10-60 24
Child Fatality Review #10-61 26
Child Fatality Review #10-62 28
Child Fatality Review #10-63 30
Child Fatality Review #10-64 35
Child Fatality Review #10-65 38
Child Fatality Review #11-01 42
Child Fatality Review #11-02 46
Child Fatality Review #11-03 48

T.V. Executive Child Fatality Review 50
R.B. Executive Child Fatality Review 58

Executive Summary

This is the Quarterly Child Fatality Report for April through June 2011 provided by the Department of Social and Health Services (DSHS) to the Washington State Legislature. RCW 74.13.640 requires DSHS to report on each child fatality review conducted by the department and provide a copy to the appropriate committees of the legislature:

> ***Child Fatality Review — Report***
>
> *(1) The department of social and health services shall conduct a child fatality review in the event of an unexpected death of a minor in the state who is in the care of or receiving services described in chapter 74.13 RCW from the department or who has been in the care of or received services described in chapter 74.13 RCW from the department within one year preceding the minor's death.*
>
> *(2) Upon conclusion of a child fatality review required pursuant to subsection (1) of this section, the department shall within one hundred eighty days following the fatality issue a report on the results of the review, unless an extension has been granted by the governor. Reports shall be distributed to the appropriate committees of the legislature, and the department shall create a public web site where all child fatality review reports required under this section shall be posted and maintained.*
>
> *(3) The department shall develop and implement procedures to carry out the requirements of subsections (1) and (2) of this section.*

During this quarter, SHB 1105 was passed by the legislature and signed by Governor Gregoire. The revised child fatality statute (RCW 74.13) requires the department to conduct fatality reviews in cases where a child death is suspected to be caused by abuse or neglect. This eliminates conducting formal reviews of accidental or natural deaths unrelated to abuse or neglect. The revised statute requires the department to consult with the Office of Family and Children's Ombudsman (OFCO) if it is not clear that the fatality was caused by abuse or neglect. The department can conduct reviews of near fatalities or serious injury cases at the discretion of the department or recommendation by OFCO. The new law gives the department access to autopsy and post mortem reports for the purposes of conducting child fatality reviews. This statute went into effect July 23, 2011.

This report summarizes information from 17 completed reviews of fatalities that occurred in 2010 and 2011. Fifteen of the child fatalities were reviewed by regional Child Fatality Review Teams. Two were reviewed by Executive Child Fatality Review teams.

Regional child fatality review teams reviewed an additional 15 child fatalities not caused by child abuse or neglect, but as a result of accident or illness. In 2011, the child fatality statute was revised to require the Department to post only reviews conducted in child deaths that resulted from child abuse or neglect. The reports from child fatality reviews from non-abuse or neglect related fatalities are not posted on the public website and are not included in this quarterly report. However, this report includes analysis of data from those reports.

All prior Executive Child Fatality Review reports are found on the DSHS website: http://www.dshs.wa.gov/ca/pubs/fatalityreports.asp.

The reviews in this quarterly report include fatalities from each of the six regions.

Region	Number of Reports
1	4
2	2
3	3
4	3
5	2
6	3
Total Fatalities Reviewed During 2nd Quarter 2011	17

This report includes Child Fatality Reviews conducted after a child died unexpectedly from any cause and manner, and the child had an open case or received services from the Children's Administration (CA) within 12 months of his/her death. Child Fatality Reviews consist of a review of the case file, identification of practice, policy or system issues, recommendations, and development of a work plan, if applicable, to address any identified issues. A review team can be as few as two individuals (in cases where the death is clearly from a natural cause or accidental), to a larger multi-disciplinary committee where the child's death may have been the result of abuse and/or neglect by a parent or guardian.

Executive Child Fatality Reviews (ECFR) are conducted in cases where the child fatality is the result of apparent abuse or neglect and CA had an open, active case at the time of the child's death or the child received services from the department within 12 months

of his/her death. In the Executive Child Fatality Review, members of the review committee are individuals who have not had any involvement in the case and represent areas of expertise that are pertinent to the case. The review committee members may include legislators or representatives from the Office of the Family and Children's Ombudsman.

The charts below provide the number of fatalities reported to CA, and the number of reviews completed and pending for calendar year 2010 and pending for calendar year 2011. The number of pending reviews is subject to change if CA learns new information through reviewing the case. For example, CA may learn that the fatality was anticipated rather than unexpected, or there is additional CA history regarding the family under a different name or spelling.

Child Fatality Reviews for Calendar Year 2010			
Year	Total Fatalities Reported to Date Requiring a Review	Completed Fatality Reviews	Pending Fatality Reviews
2010	69	69	0

Child Fatality Reviews for Calendar Year 2011 January 1, 2011 to December 31, 2011			
Year	Total Fatalities Reported to Date Requiring a Review	Completed Fatality Reviews	Pending Fatality Reviews
2011	44	40	4

The numbering of the Child Fatality Reviews in this report begins with number 10-54. This indicates the fatality occurred in 2010 and is the fifty-fourth report completed during that calendar year. The number is assigned when the Child Fatality Review and report by the Child Protective Services Program Manager or practice consultant is completed.

The reviews contained in these Quarterly Child Fatality Reports are a summary of the actual report submitted by each region. Confidential and identifying information not subject to disclosure has been redacted. The executive child fatality review is as it appears on the CA website.

Notable Findings

Based on the data collected and analyzed from the 17 deaths reviewed between January and March 2011, the following were notable findings:

- One of the fatality reviews completed during the 2nd quarter required an Executive Child Fatality Review. Another review was conducted as an

executive review per the request of the Office of the Family and Children's Ombudsman and the direction of the Secretary of DSHS.

- Of the executive child fatality reviews, one fatality occurred when the case was open for child welfare services.
- Three child fatalities occurred when the children were residing in facilities licensed by the Division of Licensed Resources. None of the three were caused by abuse or neglect by the caregiver.
- Children 11 months or younger accounted for approximately 59% (10) of the 17 fatalities reviewed and 6 of the 10 fatalities of children under 1 year of age were female.
- Of the 17 child fatalities reviewed, 47% (8) were males and 53% (9) were females.
- Of the 17 child fatalities reviewed, 41% (7) of the children were White, 18% (3) were Native American, 18% (3) were Hispanic, 18% (3) were identified as African American, 5% (1) was identified as Asian/Pacific Islander.
- Natural and accidental deaths, as classified by the medical examiner or coroner, accounted for approximately 59% (10) of the total deaths. The manner of death of the remaining cases was as follows: 5% (1) was the result of homicide, 24% (4) were due to unknown/undetermined causes, and 12% (2) were the result of suicides.
- In the fatality listed as a homicide, the child died from inflicted head trauma. The perpetrator was identified as the child's father.
- Of the 17 child fatalities reviewed, 16 had prior contact with Children's Administration (CA). One review was conducted on a child fatality that occurred at a licensed child care facility with no prior history. Seventy-one percent (71%) of the child fatalities reviewed had between zero and four prior intakes and 29% had between five and sixteen prior intakes.
- Due to the small sample of cases reviewed, no statistical analysis was conducted to determine relationships between variables.

Table 1.1

2nd Quarter 2011, Child Fatalities by Age and Gender						
Age	Number of Males	% of Males	Number of Females	% of Females	Age Totals	% of Total
<1	4	50%	6	67%	10	59%
1-3 Years	0	-	3	33%	3	17%
4-6 Years	1	12.5%	0	-	1	6%
7-12 Years	0	-	0	-	0	-
13-16 Years	2	25%	0	-	2	12%
17-18 Years	1	12.5%	0	-	1	6%
Totals	8	100%	9	100%	17	100%

N=17 Total number of child fatalities for the quarter.

Table 1.2

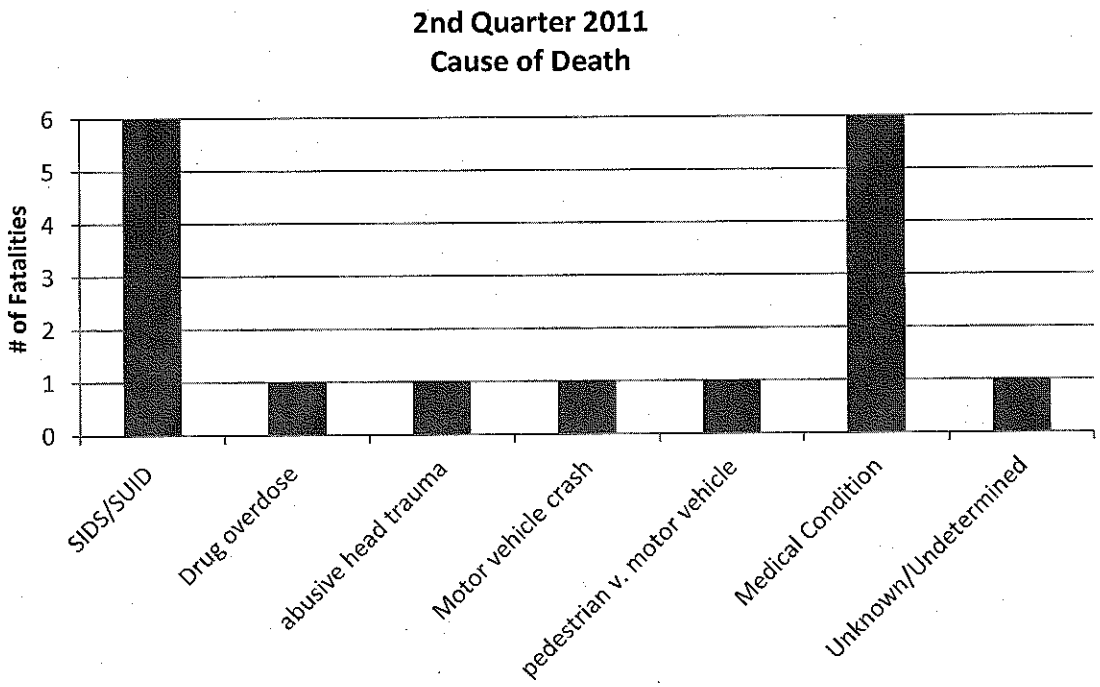
2nd Quarter 2011, Child Fatalities by Race	
Black or African American	3
Native American	2
Asian/Pacific Islander	1
Hispanic	4
White	10
Unknown	-
Total Some children may be in more than one category	**20**

Table 1.3

2nd Quarter 2011, Child Fatalities by Manner of Death	
Accident	1
Homicide (3rd party)	0
Homicide by Abuse	1
Natural/Medical	9
Suicide	2
Unknown/Undetermined	4
Total	**17**

N=17 Total number of child fatalities for the quarter.

Table 1.4



N=17 Total number of child fatalities for the quarter.

Table 1.5

2nd Quarter 2011, Number of Reviewed Fatalities by Prior Intakes						
Manner of Death	**0 Prior Intakes**	**1-4 Prior Intakes**	**5-9 Prior Intakes**	**10-14 Prior Intakes**	**15-24 Prior Intakes**	**25+ Prior Intakes**
Accident	-	1	-	-	-	-
Homicide (3rd party)	-	-	-	-	-	-
Homicide	-	1	-	-	-	-
Natural/Medical	1	6	1	-	1	-
Suicide	-	-	2	-	-	-
Unknown/ Undetermined	-	3	1	-	-	-

N=17 Total number of child fatalities for the quarter.

Summary of the Recommendations

Of the 17 child fatalities reviewed between April and June 2011, 15 (88%) identified issues and recommendations during the child fatality review process. Issues and recommendations from fatality reviews impact policy, practice and systems associated with CA. At the conclusion of every case receiving a full team review, the team decides whether any recommendations should result from the fatality review. In most instances where the death was categorized as being preventable, some recommendations were made.

Issues and recommendations that were cited during the child fatality reviews completed during the quarter fell into the following categories:

2nd Quarter 2011, Issues & Recommendations	
Contract issues	0
Policy issues	0
Practice issues	30
Quality social work	3
System issues	9
Total	**42**

Issues and recommendations were made regarding safe sleep of infants in three cases. The issues identified involved more training on safe sleep environments for child care licensors and CA staff. A recommendation was made to revise child care policies on appropriate room temperatures for sleeping infants. Three cases addressed inappropriate findings in CPS investigations. Three other cases identified issues with screening of CPS intakes. These issues were addressed through action at the local office level. Two cases identified issues with CPS social workers not meeting policy timeframes for contact with child victims. Issues identified in other cases included, Child Protection Team (CPT) staffings were not held in a timely manner, lack of documentation in case files and insufficient casework. The recommendations made regarding the practice issues identified in these areas required attention at the local office level.

An issue identified by one fatality review team related to obtaining a Do Not Resuscitate (DNR) order for legally free children. The team recommended CA update policy on obtaining DNR orders.

A recommendation made during one of the reviews advised the department to seek access to autopsy reports. Request legislation passed during the quarter authorizing the department to receive autopsy and post mortem reports from medical examiners and coroners.

Child Fatality Review #10-54
Region 6
Clark County

This two-month-old Caucasian female born in August 2010 died from congenital birth defects.

Case Overview
On October 5, 2010, a hospice nurse went to the foster home where this two-month-old was placed. The child was in the active stages of dying from multiple congenital disabilities. At 4:00 a.m. the child's foster mother gave her prescribed breathing medication and noticed that the child was continuing to have difficulty breathing. She appeared to be uncomfortable and was crying. Morphine had been delivered to the home the previous night at the request of the hospice nurse. At 6:00 a.m. the foster mother administered a dose of morphine. She stated that she read the dosage was 0.5ml, so she gave 0.3ml, as she was told that she did not need to give the entire dosage each time. The foster mother reported that the child appeared more comfortable.

At 8:00 a.m. the foster mother noticed that the child's breathing was becoming more erratic and she contacted the hospice nurse. The hospice nurse went to the foster home and observed the child, who appeared to be uncomfortable. The nurse took the morphine to give the child an additional dose. The foster mother observed the nurse dispense the morphine and during this time she realized that she had given her too much medication during the previous injection. The foster parent immediately notified the nurse of what had happened and realized that she gave the child 0.3mls when she should have given her .03mls. Emergency medical paramedics were called and the child was transported to a Portland area hospital for treatment. She was provided with medical intervention to counteract the administration of the morphine and was provided given assistance with breathing. According to the treating physician, the medication provided to the child should have resulted in improvements to her condition if her breathing issues were being caused by an overdose of morphine. However, since her condition did not improve it was a confirmation that the child was in the active stages of dying at the time the medication was administered. The child was later pronounced dead at the hospital.

Initially it was not known what impact the morphine may have had on the death of the infant. Following an investigation and medical team evaluation it was determined that the morphine was not a factor in her death and that she had already been in the active stages of dying as a terminally ill child at the time the morphine was administered. She died on October 6, 2010.

This two-month-old was placed into shelter care shortly after her birth due to multiple congenital disabilities and the need for intensive care that her parents were unable to provide. She was diagnosed shortly after birth with a rare malformation of the brain. She was placed into foster care and the medical team treating her had discussed with

the family about having a Do Not Resuscitate (DNR) order signed and on file as there was likelihood she would not survive long due to her medical issues.

The Clark County Medical Examiner determined the cause of death to be from her congenital condition. The manner of death was determined as natural.

Children's Administration (CA) had an open case on this child when she died. In September 2010, Child Protective Services (CPS) intake received a report with concerns of a newborn baby born with severe brain damage. She was very medically fragile and required total care. The child's mother had very late prenatal care and there were concerns about the mother's ability to parent and care for her medically fragile newborn. A case was opened and a dependency petition was filed on the child on September 9, 2010. She was placed in foster care upon discharge from the hospital. The case was open when the baby died in October 2010.

Intake History on the Foster Home

The foster parents have been licensed since June 7, 2001. There were 10 previous reports to CPS intake on these foster parents prior to the death of the two-month-old. All 10 of the reports were reported between June 2002 and July 2006. Two of the ten intakes were screened in for investigation by the Division of Licensed Resources/Child Protective Service (DLR/CPS). One investigation alleged negligent treatment or maltreatment and the other physical abuse. Both were closed with unfounded findings. There were eight separate licensing complaints on the foster home. All were investigated by licensing staff and all were reported prior to the death of the two-month-old. All eight previous licensing complaints were completed with a not valid finding.

On October 5, 2010, the assigned social worker for the two-month-old child received a report from the hospice worker reporting the child was taken to a hospital after she quit breathing. The hospice worker and the foster mother determined that the foster mother accidentally gave the child an inappropriate dosage of morphine. The child was medically fragile, born with a brain malformation and was receiving hospice care in the foster home. The child was transported to a Portland area hospital. The intake was screened in for investigation by DLR/CPS and also screened as a licensing complaint.

The investigation of improper dispensing of medication was determined by DLR/CPS to be unfounded for negligent treatment or maltreatment. But it was determined to be a valid licensing violation. The foster mother worked with her licensor to complete the requirements of the compliance plan for her license. She was required to review licensing regulations on medications and she must have the child's medical providers clarify or demonstrate correct dosage when prescribing oral medications to children in her home. At the time the foster mother improperly medicated the child, the hospice staff had the pharmacy deliver the medication to the foster home, and there was no instruction by a medical staff on how to read the syringe or how to dispense the medication.

Issues and Recommendations

Issue: The review team identified no issues or recommendations.

Recommendation: None

Child Fatality Review #10-55
Region 4
King County

This eight-month-old Caucasian female born in February 2010 died from Sudden Infant Death Syndrome (SIDS).

Case Overview

On October 8 2010, the child care provider for this eight-month-old fed her a bottle at 9:45 a.m., and the child fell asleep. The child care provider placed her on her side in the crib. The provider told law enforcement that she checked on the child an hour later and noticed her hair was wet and she was on her stomach. She picked her up and the infant was flopping around and not responsive. She called 911 and began CPR. Medics were able to get a heartbeat but she was otherwise nonresponsive. The law enforcement report noted that it was possible that the child care provider waited longer than one hour before checking on the child, based on the response time of the 911 call.

The child was taken to Seattle Children's Hospital where it was determined she had suffered a hypoxic brain injury and remained in critical condition. A hypoxic brain injury is a condition that refers to a severe decrease of oxygen supplied to the brain. The family made an informed decision to withdraw life support and the child died on October 16, 2010.

The King County Medical Examiner took jurisdiction of the body. The cause of death was determined to be SIDS and the manner of death is natural.

Children's Administration (CA) has no prior history on the family of this eight-month-old infant. This child care provider has been licensed since May 2008 and there were no prior intakes and licensing complaints on the provider prior to the death of the eight-month-old. Children's Administration has a Service Level Agreement with the Department of Early Learning (DEL) that CA will conduct child fatality reviews of fatalities that occur in licensed child care facilities. DEL staff members were present and participated in this child fatality review.

Intake History

On October 8, 2010, a King County Sheriff's deputy reported to Child Protective Services (CPS) intake the death of the eight-month-old infant at the home of a licensed in-home daycare provider. The mother dropped off her eight month old baby. The provider fed the child at 9:45 a.m. and the child fell asleep. She was placed on her side in the wooden crib. She checked on the child an hour later and noticed her hair was wet and she was on her stomach. The provider picked up the child and noticed her body was "flopping around" and she was not responding. She noticed foaming fluid coming from her nose. She called 911 and placed the child on the carpeted floor and started CPR.

The police reported the downstairs area where the daycare is located was untidy with children's toys and clothes around the floor. The temperature downstairs was 72 degrees.

Medics were able to get a heartbeat but she could not breathe on her own. Her pupils were fixed and dilated. The child was transported to Children's Hospital and her condition was listed as critical.

The treating doctor at Children's Hospital reported there was evidence of significant hypoxic brain injury and there was no evidence of trauma. The intake was screened for a Division of Licensed Resources/Child Protective Services (DLR/CPS) investigation and a child care licensing complaint. The DLR/CPS investigation was closed with an unfounded finding for negligent treatment or maltreatment. The licensing complaint was deemed valid for supervision, sleeping arrangements, and incident reporting by the child care provider.

Issues and Recommendations
Issue: Infant Safe Sleep Training

Recommendation: DEL Northwest (Bellevue) will arrange with Deborah Robinson, a recognized expert in infant sleep safety, to provide training to licensors.

Issue: Infant Safe Sleep Training

Recommendation: Region 4 DLR/CPS will arrange for Deborah Robinson to provide training to investigators and foster home licensors.

Issue: Overheating is a risk factor for SIDS. In this case the room temperature was 72 F and the outside temperature was 65 F.

Recommendation: DEL Northwest (Bellevue) will recommend that DEL consider adding a requirement that the room temperature for a sleeping infant should not exceed 68 F.

Issue: Infant Safe Sleep Training for Providers

Recommendation: DEL Northwest (Bellevue) will recommend that DEL let the licensing trainers know about training resources on this topic.

Issue: Clarifying language in WAC 296.170.1360, pertaining to sleeping infants.

Recommendation: DEL Northwest (Bellevue) will recommend that WAC 296.170.1360, define continual checks for napping infants in a day care setting as fifteen to twenty minute intervals.

Child Fatality Review #10-56
Region 2
Yakima County

This nine-day-old Caucasian male born in October 2010 died from Sudden Infant Death Syndrome (SIDS).

Case Overview
On October 15, 2010, this newborn was found at home unresponsive in bed. He was taken to Sunnyside Community Hospital and later airlifted to Seattle Children's Hospital. There were no visible injuries or bruises reported. However, there was an initial indication of internal head bleeding. There were no specific allegations of child abuse or neglect when the child was hospitalized. He died two days later on October 17, 2010. According to the King County Medical Examiner, the nine-day-old died from encephalopathy brought on by infection and sepsis. Encephalopathy is a condition characterized by altered brain function and structure. It is caused by diffuse brain disease. The manner of death is natural.

Children's Administration (CA) did not have an open case on this family when the child died. In September 2009, hospital staff contacted the Child Protective Service (CPS) intake to report the mother was unresponsive to her newborn. There was also a concern that the mother had been using drugs. The intake was screened for investigation and a case was opened on the family.

The family includes three-year-old and 16-month-old siblings.

Intake History
On November 12, 2007, a hospital social worker reported to Child Protective Services (CPS) intake that the mother had recently delivered a baby girl. The baby was born healthy. The referrer reported a concern that the mother was pregnant when she was 15 and the child's father was 20. The intake was screened as Third Party abuse.

On September 22, 2009, CPS intake received a report from a hospital social worker who reported the mother gave birth and tested positive for methamphetamine. The newborn was negative for any drugs at birth. There were no indications of health being affected by drugs. The intake was screened as Low Risk.

On September 24, 2009, CPS intake received a report from a hospital social worker who reported a doctor at the hospital where the mother gave birth placed an administrative hold on the child due to concerns that mother demonstrated at the hospital. She was sleeping and hard to wake. She was not responding to the child's cues and not tending to her child. The intake was screened in for investigation with an emergent risk tag. The CPS investigation was completed with a founded finding for negligent treatment or maltreatment and the case remained opened for services. The parents signed a voluntary placement agreement and the children were placed with relatives. The parents participated in Family Preservation Services, parenting classes and evaluations.

The three-year-old sibling was returned to the care of his biological father. The 16-month-old sibling was returned to her mother in May 2010.

On October 18, 2010, CPS intake received a report from the Medical Examiner indicating this nine-day-old infant was found unresponsive in bed at home on October 15, 2010. The child was airlifted to Seattle Children Hospital and passed away two days later. The child had no visible injuries. The referrer indicated there was sign of internal head bleeding though there were no specific child abuse or neglect allegation concerns. The intake was screened in for investigation. The Medical Examiner later determined the child died from natural causes. The CPS investigation was closed with an unfounded finding for negligent treatment or maltreatment.

Issues and Recommendations
Issue: The fatality review team did not identify any issues or recommendations.

Recommendation: None

Child Fatality Review #10-57
Region 3
Snohomish County

This nine-month-old Caucasian male born in January 2010 died from unknown causes.

Case Overview
On the morning of October 19, 2010, at approximately 9:30 a.m. Tacoma Police and the Pierce County Medical Examiner were called to the home following a report of a nine-month-old child who was unresponsive. The Medical Examiner and law enforcement arrived on the scene and both determined the child was already deceased.

The child's mother and her children were temporarily staying with the grandmother in Tacoma. The mother reported to medics and law enforcement that her nine-month-old woke around midnight. She brought him downstairs and put him on a chair and gave him some baby food and then made him a bottle of formula. He was sitting on the chair in the living room and she went to the kitchen. When she came back and attempted to pick him up, he slipped from her hands and fell from the chair to the carpeted floor. She said he landed on his face and she didn't notice any marks. He cried for a few minutes but then calmed down and was able to eat. He finished the bottle and had more food. He appeared to be tired so the mother took him back to the upstairs bedroom.

The mother reported she didn't have a crib and put a towel down on the seat cushion of the soft chair in the room. She put him down on his stomach on the chair and covered him with a blanket. She said her son liked to have the blanket all the way over his body and head. She estimated that it was about 1:15 a.m. when she put him down. The mother went to bed in the same bedroom. She said she could hear her son making noises and breathing as she went to sleep. The mother reported she was awakened by her mother at 5:30 a.m. She saw her son sleeping on the chair but didn't go to him or touch him as she thought he was still sleeping. The grandmother left the house to go to work. The mother said her son wasn't moving so she went to check on him and found him not breathing. She said he was stiff and his fists were clenched on the blanket. He was still face down. The mother immediately called 911 and the 911 dispatcher told her to administer CPR. She put her son down on the mattress on the floor and noted that fluid came out of his mouth when she pressed on his chest.

Tacoma Police Department investigated this death and closed their case with no charges. The Pierce County Medical Examiner's office stated that the final cause of death is undetermined and the manner of death is undetermined.

Children's Administration (CA) did not have an open case on this family when the child died. In July 2010, hospital staff contacted Child Protective Service (CPS) intake to report the mother was concerned that her two-year-old daughter may have been the victim of sexual abuse. The mother reported her daughter had a change in diapering habits and

reddened labia. The intake was screened as Information Only as there was no physical evidence of abuse nor any disclosure by the child.

The family includes a four-year-old, a three-year-old and two-year-old siblings.

Intake History

On February 1, 2006, a hospital social worker reported to Child Protective Services (CPS) intake concerns about the four-year-old sibling (then two-months-old) as he was born prematurely and was medically fragile. The referrer questioned his parents' ability to care for him as they were young. The referrer also reported domestic violence in the parents' relationship. The intake was screened as Information Only as there were no allegations of child abuse or neglect.

On March 30, 2006, a hospital social worker contacted CPS intake and reported the mother's four-year-old child (then three months old) could die in the care of his parents if he was discharged from the hospital due to the parents' immaturity, and the mother minimizing the seriousness of her child's medical condition. The child required feeding through a gastric tube and had a condition that left his bones weak and susceptible to breaking. The intake was screened in for investigation. The parents were also working with staff with the Division of Developmental Disabilities (DDD). They worked with their assigned DDD social worker to voluntarily place their son in a group home for medically fragile children. The CPS investigation was closed with an inconclusive finding.

On October 23, 2006, CPS intake received a report from a hospital social worker who reported the mother gave birth to another child. The child was healthy and there were no concerns about abuse or neglect. The referrer reported there was domestic violence in the parents' relationship. The intake was screened as Information Only.

On May 17, 2008, CPS intake received a report from a hospital social worker who reported the mother gave birth to another child. The referrer reported the father of the child was charged with child molestation in the third degree. The child was healthy and there were no concerned about abuse or neglect. The intake was screened as Information Only.

On January 29, 2010, CPS intake received a report from a public health nurse who reported the mother and her children moved into the grandmother's home. The referrer reported the maternal grandmother provided primary care for the oldest child (age four). The referrer reported the father had previously threatened the mother (the referrer was unaware of specific threats). The referrer observed the father to the youngest child being "overly stern" with the older children. The intake was screened as Information Only.

On May 12, 2010, CPS intake received a report from law enforcement. The father of the two-year-old contacted police and said the mother attempted to give the child up for adoption, but she did not follow through with this attempt. The father told police that

the mother gave him custody of their daughter, and she later wanted the child returned to her. The intake was screened as Information Only.

On May 19, 2010, CPS intake received a report from an anonymous referrer reporting the mother allowed her two children, ages four and three years old, to be watched by a relative whom the referrer described as "a low functioning autistic man." The intake was screened as Information Only.

On July 18, 2010, the mother brought her two-year-old daughter to a hospital with concerns that she may have been sexually abused. Hospital staff found no evidence of sexual abuse and the intake was screened as Information Only.

On October 19, 2010, the Pierce County Medical Examiner contacted CPS intake to report the death of this nine-month-old child. The referrer suspected the child died of Sudden Infant Death Syndrome during the night. The cause of death was unknown. The mother put the child face down on a chair the previous night and found the child not breathing the next morning. A call to 911 was made, but the child was already deceased when law enforcement arrived. The intake was screened as Information Only.

Issues and Recommendations

Issue: More safe sleeping education is needed throughout the department's administrations and for the families served by the Children's Administration.

Recommendation: Feedback about safe sleeping education will be provided by the Safety Program Manager to the past and current CPS social workers working with this family. Children's Administration staff will continue to learn more about safe sleeping. The Safety Program Manager will invite Deborah Robinson, Acting Director of the Northwest Infant Survival and SIDS Alliance, to the next quarterly Intake/CPS/Family Voluntary Services (FVS) Supervisors meeting to train on the topic of safe sleeping.

Child Fatality Review #10-58
Region 3
Snohomish County

This two-month-old Caucasian female born in August 2010 died from Sudden Infant Death Syndrome (SIDS).

Case Overview

On October 22, 2010, the father of this two-month-old child fed her at approximately 8:00 a.m. He then wrapped her in a baby blanket and propped her up on a bed with some pillows and comforters so her head was elevated. He placed a comforter over her and then he went back to sleep in a separate room. At approximately 11:30 a.m., the parents woke up and the mother went to check on her daughter. She discovered the child was not breathing and face down on the bed. The mother told law enforcement that her daughter's face was purple, she was wrapped in her pink blanket, and there was a funny smell in the room like an old diaper. The mother turned her over and called for her husband. He ran into the room and began CPR while the mother called 911. An aid car responded but was unable to resuscitate the child. The law enforcement report indicates that there was a face print and lip marks in the sheet on the bed where the child was found.

The Snohomish County Medical Examiner's office reported to Children's Administration that this two-month-old child died on October 22, 2010. The Medical Examiner stated that the official cause was "unexpected infant death" and the manner was ruled as "undetermined."

Children's Administration (CA) did not have an open case on this family when the child died. In September 2010, hospital staff contacted Child Protective Service (CPS) intake to report the child (then four weeks old) was brought to an emergency room with an injury to her face. Her father dropped her while giving her a bath. The injury was deemed accidental, and the intake was screened as Information Only.

Intake History

On September 29, 2010, a hospital staff member reported to CPS intake that the two-month-old (then four weeks old) was brought to the emergency room by her father and mother. The father was giving his daughter a bath and he reached to get a towel and the child twisted and slipped through his arm causing her to strike her face on the side of the bathtub. As she was falling he managed to grab her foot; she didn't hit the ground but did hit her face on the tub. The father put ice on the child's face. The mother came home and insisted the child be taken to the hospital. She was examined and had a soft tissue injury on the left side of her head around her cheek. The doctor said the child would recover and that the father's explanation was consistent with how the injury could have happened. The doctor suggested the child remain overnight for observation.

The intake was screened as Information Only as there were no allegations of child abuse or neglect.

On October 23, 2010, the Snohomish County Medical Examiner called CPS intake to report the two-month-old child was discovered by her mother at 11:00 a.m. on October 22, 2010 not breathing and lying face down on a bed. The Medical Examiner stated the child's father reported that he got up and fed his daughter a bottle of formula at approximately 8:30 to 9:00 a.m. and then propped her up on some pillows and comforters and put a comforter over her and left the room and went back to sleep. The parents woke again at around 11:00 a.m. and discovered their daughter not breathing. The mother called 911; emergency medical technicians arrived and attempted to revive the child but were unsuccessful. The Medical Examiner stated he would obtain all the medical records concerning the child's prior head injury. The intake was screened in for investigation. The CPS investigation was closed with an unfounded finding for negligent treatment or maltreatment and physical abuse. The parents were offered information on a SIDS support group, and the case was closed.

Issues and Recommendations

Issue: The CPS social worker did not share Safe Sleeping information with the grieving parents until after the child's death.

Recommendation: At the review, feedback was provided to the CPS Supervisor and Area Administrator. Feedback will also be provided to the CPS social worker by the Safety Program Manager. Children's Administration staff will continue to learn more about safe sleeping and supervisors will discuss this topic at unit meetings and during their supervisor review meetings. The Safety Program Manager will invite Deborah Robinson, Acting Director of the Northwest Infant Survival and SIDS Alliance to the next quarterly Intake/CPS/FVS Supervisors meeting to train on the topic of safe sleeping.

Child Fatality Review #10-59
Region 1
Whitman County

This 16-year-old Caucasian male died from a drug overdose.

Case Overview
On October 23, 2010, the body of this 16-year-old youth was found under a bridge in rural Whitman County. He had run away from home on October 11, 2010. The Whitman County Coroner determined that the youth died from multiple drug intoxication resulting in respiratory failure. The manner of death is listed as suicide.

Children's Administration (CA) did not have an open case on this family when the youth died. In November 2009, Child Protective Service (CPS) intake received a report of domestic violence between the parents. The intake was screened for alternate intervention.

Intake History
On July 7, 1999, a social service professional reported to CPS intake allegations of physical abuse of the 16-year-old (then five years old) and his younger brother, then nine months old. It was also alleged that the two children appeared underdeveloped. The house was reported to be filthy and the mother had previously lost custody of four children. The intake was screened in for investigation.

The assigned social worker made a referral to the Early Intervention Program (EIP) through the Whitman County Health Department. The CPS investigation was closed with a founded finding for physical abuse by the father. The negligent treatment allegations were unfounded as to both parents of the children.

On February 8, 2000, a school teacher called CPS intake to report the youth, then six years old, had gone several weeks without bathing. He had tantrums and "melt downs." The intake was screened for Alternate Intervention. The case was referred to EIP.

An EIP disposition report to CPS dated April 27, 2000, identified lack of participation in EIP by the family. The mother denied there were any problems and the school reported improvement in the youth's behaviors. The family was referred to the Women, Infant and Children (WIC) program and counseling services. The mother did not follow through with the appointments and the EIP was closed in May 2000.

On September 22, 2000, a teacher contacted CPS intake and reported the youth (then seven years old) smelled like feces and smoke. He soiled his pants regularly at school. He said his mother wouldn't wash his clothes. The referent helped him get cleaned up and noticed that he had feces on his bottom that appeared to have been there a while. The intake was screened in for investigation alleging negligent treatment. The mother agreed to have the Home Support Specialist (HSS) come to the home. The family

continued participation with HSS in-home services for three months. In January 2001, the investigation concluded with inconclusive findings and the case was closed.

On June 3, 2004, a police officer contacted CPS to report the younger brother (then age five) was assaulted when he got between his parents who were fighting. The mother was arrested for fourth degree assault. The mother participated in substance abuse treatment and mental health services. The case was closed in September 2004 with an inconclusive finding.

On August 19, 2005, CPS received a police report referencing a domestic dispute from August 15, 2005. The intake was assigned for investigation. The mother reported she was sleeping when her husband grabbed her by the hair and yelled at her about the location of his money. The mother said her husband pulled her down the stairs by her hair, hitting her head on the wall all the way down. Police were called to the home.

The police report indicated the house was in horrible condition. The children said they saw their father chase and push their mother. The 16-year-old youth (10 years old at the time of this report) climbed out a second story window to get away. The police charged the father with 4th degree domestic violence assault.

The intake was screened in for investigation. The supervisor directed the social worker to see the condition of the home and ask the mother for a urinalysis and substance abuse evaluation. The review also stated the safety plan may need to be revised and the children should be seen at school. There is no documentation to indicate the supervisor's direction was followed.

On March 15, 2006, the Community Service Office (CSO) worker called CPS intake to report information she received from a hospital social worker. The hospital worker saw an exchange between the father and his children that was concerning. He appeared to have significant anger and rage. The mother was hospitalized for an extended period of time and he was the sole caretaker of the children. The intake was screened in for investigation and closed with an unfounded finding for negligent treatment or maltreatment.

On May 7, 2008, CPS intake received an anonymous report. The referrer reported the 16-year-old (then 14 years old) was helping his father work on a car and the car fell on his arm. On another occasion, the youth went to a neighbor's house with blood on his pants and said he fell. He also reported in the past that his father had beaten him. A low risk letter was sent to the parents describing the intake information and a phone contact was made with the family. The case was closed in June 2008.

On May 12, 2009, the mother contacted CPS intake to request Family Reconciliation Services (FRS). The 16-year-old youth (then 15 years old) was calling his parents names, challenging them to fight and picking on his younger brother. The intake was accepted for FRS.

Services were provided to the family from May to July 2009 for Crisis Family Intervention. The contracted provider's service summary documented the family's progress in family functioning including increased communication between family members, the youth's compliance with house rules, willingness to complete household chores as well as improved positive interactions between the 16-year-old and his younger brother. The case was closed at the conclusion of this intervention.

On November 3, 2009, CPS intake received a written police report with information that included domestic violence with no arrests made. The intake was screened for alternate intervention and a letter was sent to the family offering services. On November 30, 2009, a case note documents that the social worker did not hear back from the family. The case was closed.

On October 27, 2010, CPS intake received a report that the 16-year-old youth had committed suicide the week prior. The intake also indicated the living conditions in the home were inappropriate for the surviving 12-year-old sibling. It was also alleged that the parents were using Oxycontin. The intake was screened in for investigation. The home was found to be cluttered but not unsanitary. The intake was closed with an unfounded finding.

Issues and Recommendations

Issue: The response time for face-to-face contact with the victim by the social worker was outside the ten day timeframe indicated in the policy that was in effect at the time of the September 22, 2000 intake.

Recommendation: There is policy that addresses contact requirements. The social worker should meet the policy expectation.

Issue: A victim interview was not attempted with the indentified child victim. Documentation in the case indicates the child was available and capable of participating in an interview related to the September 22, 2000 intake.

Recommendation: There is policy that addresses investigation requirements. The social worker should meet the policy expectation.

Issue: Information in the case record supports a finding determination of founded findings based upon a preponderance of evidence for the investigation of the June 3, 2004 intake. The documented finding is inconclusive.

Recommendation: The social worker should base the investigative findings on all evidence gathered and use a preponderance of evidence standard for the findings decision.

Issue: Documentation in a supervisory review case note dated January 20, 2006 gives clear direction to the social worker regarding additional actions needed for the family.

There is no documentation or other evidence to support the assigned social worker followed the supervisor's direction.

Recommendation: The social worker should follow direction provided by their supervisor.

Issue: The face-to-face contact with the child victim was not completed within the required 24 hour timeframe for the March, 23, 2006 intake. There is no documentation that supports an extension was provided by the supervisor.

Recommendation: There is policy that addresses contact requirements. The social worker and supervisor should meet the policy expectation.

Issue: There is no documentation that a subject interview was conducted through the investigation for the March 23, 2006 intake.

Recommendation: There is policy that addresses investigative requirements that includes an opportunity for the subject to be interviewed. The social worker should meet the policy expectation.

Issue: Information was available to each of the social workers assigned to this case referencing the mother's four previous children and their removal from her care prior to the 1999 intake. This historical information was never researched and the review committee stated that additional information may have influenced decision making at particular points in time throughout the case, such as intake screening decisions, interventions and services offered and potentially court involvement.

Recommendation: Social workers should gather and evaluate historical information as it pertains to current circumstances for immediate child safety as well as identifying and prioritizing interventions and services.

Child Fatality Review #10-60
Region 1
Spokane County

This one-month-old Caucasian female born in October 2010 died from Sudden Unexplained Infant Death (SUID).

Case Overview
On November 5, 2010, the parents of this one-month-old infant were co-sleeping with her. At approximately 3:30 a.m., the mother awoke to feed her and noticed that she was not moving or breathing. The father started CPR while the mother called 911. Resuscitation efforts continued while the child was transported to a Spokane area hospital where she was declared deceased.

The Spokane County Medical Examiner's office stated that the final cause of death is Sudden Unexplained Infant Death (SUID) and the manner of death is natural.

Children's Administration (CA) did not have an open case on this family when the child died. In October 2009, an anonymous referrer contacted Child Protective Service (CPS) intake to report the mother was driving under the influence with her son in the car. The intake was screened in for investigation and the CPS investigation was closed in November 2009 with an unfounded finding.

The family includes a three-year-old sibling.

Intake History
On September 6, 2007, an acquaintance of the mother reported to CPS intake concerns about the mother and her three-year-old son (five months old at the time of this report). The referent reported the mother had overdosed sometime in the previous year. The caller reported the mother rear ended another car. A police officer responded to the scene. The mother was outside the vehicle following the accident and left her five-month-old in the car.

CA intake made a collateral contact to the responding police officer. He stated the mother appeared presentable and her son looked very healthy. The intake was screened as Information Only as there were no allegations of child abuse or neglect.

On October 23, 2009, CA intake received an anonymous letter reporting the mother was seen driving her car, with her son, after she had been drinking alcohol at a bar. Her former boyfriend allegedly found evidence of intravenous drug use. The letter explained that the mother appeared under the influence of drugs and the referrer witnessed track marks on her arms. The intake screened in for an investigation. The assigned social worker made contact with the mother and her son. The child appeared to be in good health. The mother denied the allegations and denied drinking and driving with her son in the car. The social worker observed the home and found no health or safety hazards

and no evidence of intravenous drug use. The social worker asked the mother to submit to random urinalysis (UA). The allegations were determined to be unfounded and the case was closed in November 2009.

On November 8, 2010, CA intake received a law enforcement report referencing a 911 call on November 5, 2010, in which the one-month-old was found not breathing. The child was co-sleeping between her parents; the mother woke in the middle of the night and found the child not breathing. She was taken to a Spokane area hospital and where she was pronounced deceased. The Spokane Medical Examiner's office completed a death scene investigation and an autopsy. The cause of death was Sudden Unexplained Infant Death and the manner was determined natural. The intake was screened as Information Only.

Issues and Recommendations

Issue: The review committee had several questions regarding the death scene investigation and information regarding the three year old sibling. Children's Administration does not have access to autopsy reports, including the death scene investigation report.

Recommendation: The review committee recommends legislation to allow Children's Administration access to autopsy reports to include the death scene investigation report. (Note: HB1105 was passed by the Washington State Legislature during the 2011 legislative session. A provision in this bill gives Children's Administration staff access to autopsy and post mortem reports for the purposes of conducting child fatality reviews).

Issue: The review committee determined the October 23, 2009 investigation met the minimum policy requirements for an investigation however additional information from collateral contacts would have provided information helpful to determining if services would have been appropriate for the family. Examples are a collateral contact to the prescribing physician of medications the mother was prescribed, collateral to the child's physician and a collateral contact to the WIC program in which the child was receiving services.

Recommendation: The review committee recommends social workers complete a global assessment of safety beyond the incident focused investigation. The review committee is aware that Children's Administration is currently consulting with the National Resource Center for Child Protection and is working to develop and implement a global assessment of safety.

Child Fatality Review #10-61
Region 5
Pierce County

This 17-day-old Caucasian female born in October 2010 died from Sudden Unexpected Infant Death (SUID).

Case Overview
On November 6, 2010, the mother of this 17-day-old infant nursed her early in the morning. The mother then fell asleep with the infant in the middle of the bed with the father asleep on the other side of the bed. The mother reportedly woke four to five hours later at which time she discovered her daughter was not breathing. Emergency response was requested (911) but responders were unable to resuscitate the child.

A death scene investigation was conducted by the King County Medical Examiner. The death scene information suggests the possibility that weight distribution on the mattress may have caused the infant to roll toward the mother. Based on the post-mortem examination and ancillary studies, the King County Medical Examiner was "unable to determine if external conditions contributed to the death" and ruled the cause of death to be SUID (Sudden Unexpected Infant Death). The manner of death is Undetermined.

Children's Administration (CA) did not have an open case on this family when the child died. In June 2010, Child Protective Service (CPS) intake received a report the mother was pregnant and the father of her unborn child has history with CPS for physical abuse of a child of a former girlfriend. The mother of the unborn child also had a four-year-old son in her care. The referrer expressed concern for the safety of the four-year-old. The intake was screened in for investigation and the CPS investigation was closed in July 2010.

Intake History
On February 27, 2006, CPS intake received information that a three-year-old child was in critical condition in a Lewis County hospital with facial bruising and subdural hematoma. The father of the 17-day old infant was in a relationship with the mother of this three-year-old. He was caring for the child at the time of the injuries and his explanation (the child fell) was not consistent with the injuries. The intake was screened in for investigation and completed with a founded finding for physical abuse. There is no record of any criminal charges regarding the matter. He had no further involvement with his former girlfriend or her children.

On June 8, 2010, CPS intake received a report from a relative with concerns about the father of the 17-day-old infant being around a four-year-old child. The mother of the 17-day-old infant had a four-year-old son from a prior relationship. The mother was living with the father of the 17-day-old and was pregnant at the time of this report. The

referrer reported that in the past the father was allowed only supervised visits with his children from a prior marriage. The intake was screened as Risk Only and was accepted for CPS investigation. The information gathered by the CPS social worker from a variety of sources did not support any current indicators of imminent risk or child maltreatment in the home. The investigation was completed in July 2010.

Three months later the 17-day-old infant was born and 17 days later, on November 6, 2010, the infant was found unresponsive while co-sleeping with her parents. CPS intake was notified of the child fatality by the King County Medical Examiner's office. First responders were unable to resuscitate the neonate. There were no reported suspicions regarding the circumstances of death and the notification of death was recorded and screened out by Central Intake. Following autopsy and ancillary study results, the King County Medical Examiner was unable to determine if external conditions contributed to the death and determined the cause of death to be SUID (Sudden Unexplained Infant Death). The manner of death is listed as Undetermined.

Issues and Recommendations

Issue: While no substantive practice, policy, or system issues surfaced during the review, two issues were discussed and are included here for the limited purpose of documenting the discussions occurring during the Child Fatality Review.

(1) The June 2010 intake screened in as a Risk Only investigation based largely on the father's history from 2006. While the panel reached general consensus that the intake decision was reasonable, a decision to screen out would also have been supportable based on the lack of any clear implications of imminence of serious harm by the father to his unborn child or to the four-year-old child of his new partner.

(2) While the CPS worker assigned the June 2010 Risk Only intake completed his work in a timely manner (July 2010), there was a slight delay in supervisory closure in FamLink (September 2010). The delay appears to have been the result of the supervisor having been on leave for most of August. While day-to-day supervision and support is provided to workers by other Pierce West unit CPS supervisors covering for fellow supervisors on leave, functions such as closing out cases in FamLink are not viewed as a priority for coverage.

Action Taken: The supervisor for the 2010 Risk Only investigation was not able to participate in the review, but was given feedback post-review. The supervisor acknowledged the delay in completing final approval for closure in FamLink, noting his extended leave time in the month of August 2010.

Recommendation: None

Child Fatality Review #10-62
Region 1
Stevens County

This 13-month-old Caucasian female died from injuries sustained in a car accident.

Case Overview
On November 5, 2010, the mother of this 13-month-old child was driving on Highway 395 in rural Stevens County. She had stopped and was preparing to make a left hand turn when her car was struck from behind by another car. The mother and her two children, the 13-month-old and three-year-old brother, were all appropriately restrained according to Washington State Patrol. The mother and her 13-month-old daughter were airlifted to Sacred Heart Hospital and the three year old was taken to St. Joseph's Hospital by ambulance. The 13-month-old died on November 6, 2010 from hypoxic encephalopathy (brain is deprived of an adequate oxygen supply) due to mechanical compression of the chest with rib fractures. The manner of death is accidental.

Children's Administration (CA) did not have an open case on this family when the child died. In October 2010, Child Protective Service (CPS) intake received a report that the children were not receiving regular meals while the children lived with their mother, the 13-month-old fell from the porch, and the mother slept frequently leaving the 13-month-old to cry. The intake was screened as Information Only as the children were in the care of their father.

The family includes a three-year-old sibling.

Intake History
On November 3, 2007, an acquaintance of the mother reported to CPS intake that the mother of the 13-month-old appeared agitated and dressed inappropriately for the weather and presented as emotionally unstable. She had just given birth and hospital nurses expressed concerns about her behavior. The intake was accepted for Alternate Intervention. A CPS social worker confirmed that the mother was working with the First Steps program and had been referred to counseling services. A contact was made with the hospital social worker who reported no suspicion of drug use and did not have concerns for the infant in the mother's care.

On December 13, 2007, a CPS social worker met with the parents and their newborn. The family agreed to participate in the Women, Infant and Children (WIC) program and keep regular medical appointments for their infant son.

A contact with the infant's doctor was made and the doctor stated the infant had been at all recommended well child exams, had gained weight, and there were no concerns regarding the parents' ability to care for the child at the time. The social worker confirmed participation with WIC and closed the case in December 2007.

On February 25, 2009, staff with a housing assistance office called CPS intake to report the parents self-reported that their living conditions were unsafe and they were staying at another individual's home. The referent believed the other individual had a volatile temper. The parents were seeking assistance finding more permanent housing for the family. The intake was screened Information Only.

On October 8, 2009, a hospital nurse called CPS intake with concerns following the birth of the 13-month-old. The child's mother did not appear able to care for herself. She was actively participating in mental health counseling and refused in-home interventions referred by the hospital. The intake was screened Information Only.

On October 28, 2010, a relative contacted CPS intake and reported while the children were in their mother's care, they did not receive regular meals. The 13-month-old fell from the front porch step and her three-year-old brother almost fell out a window after pushing on the screen. It was alleged that the mother slept much of the day and left the 13-month-old in a crib to cry. At the time of this report, the children were in their father's care. The intake was screened as Information Only.

Issues and Recommendations

Issue: The review committee identified the intake dated October 8, 2009 may have screened in for alternate intervention or a CPS investigation had more information been obtained by the intake worker. Information that may have influenced the screening decision includes specific descriptions of the mother's lack of care for herself, additional information related to the stated ongoing issues with the pregnancy that required hydromorphone and oxycodone (pain relievers) use, specific descriptions of the type of nurse instructions that the mother was resistant to, descriptions about the mother's quality of care for her infant when she visited the newborn in the hospital, and for what mental health issues the mother was receiving treatment.

Recommendation: The review team did not make a recommendation related to the identified issue.

Child Fatality Review #10-63
Region 1
Grant County

This nine-month-old Caucasian female died from Sudden Unexpected Infant Death (SUID).

Case Overview
On November 26, 2010, the father of this nine-month-old child put her to bed. He reported placing her on her stomach on a pillow with a blanket covering her back and legs. The father reported he gave his daughter a bottle at approximately 5:00 a.m. and put her back to bed. At approximately 8:35 a.m. he found her unresponsive and not breathing. He yelled for help and 911 was called. The Grant County Coroner determined the child died from Sudden Unexpected Infant Death. The child also had myocarditis (an inflammation of the heart wall). The manner of death is natural/medical.

Children's Administration (CA) had an open case on this family when the child died. CA received an intake from another parent who alleged that her 16-month-old child ingested methamphetamine while visiting the home of the mother of the nine-month-old. A ten year old child reported seeing the 16-month-old put what appeared to be crystals in her mouth. The intake was screened as alternate intervention. The alternate intervention case was still open at the time of the child's death.

The family includes siblings ages two and three years old.

Intake History
On January 1, 2007, a hospital nurse reported to Child Protective Service (CPS) intake that the mother of the nine-month-old just gave birth to her first child and the hospital nurse expressed concerns that the mother appeared overwhelmed. The intake social worker contacted the mother and she stated she was overwhelmed and wasn't getting any assistance from the baby's father. The intake worker suggested services but she declined. The intake was screened in for investigation.

On January 17, 2007, an intake was received from hospital staff. The mother had brought her oldest daughter to the hospital where she was diagnosed with Respiratory Syncytial Virus (RSV) and was admitted. The mother told hospital staff that the child's maternal grandmother wouldn't stop smoking in the house. The mother was 17 years old and living with her mother at the time of this report. The referrer expressed concern that the grandmother was putting the child at medical risk. The intake was accepted for investigation.

A shared planning meeting occurred on January 22, 2007. The family declined all services. The investigative assessment was completed as unfounded for neglect on both intakes. The case was closed.

On March 26, 2007, CPS intake received a report from a former neighbor stating the mother may be evicted from her apartment due to disruptive behavior. The mother was described as loud and verbally abusive to her neighbors. The mother and maternal grandmother argued frequently. The intake was screened as Information Only.

On June 14, 2007, an anonymous reporter contacted CPS intake to report the mother was seen hitting the six-month-old infant in the face with a cell phone. The baby didn't respond to the action. The mother was also heard calling the baby "stupid" and "ugly." The referrer saw the baby earlier on June 14 but did not see any bruising to the baby. The intake was screened in for investigation of physical abuse.

The assigned social worker notified law enforcement of the intake report. The social worker made initial contact with the family and saw a bruise under the child's eye. The mother agreed to take her daughter to a pediatrician to be medically evaluated which she did on June 18, 2007. The investigation concluded unfounded finding for physical abuse.

On July 9, 2007, CPS intake received an anonymous report alleging the mother was using drugs and that the maternal grandmother provided most of the care for her baby. The intake was screened as Information Only.

On July 24, 2007, CPS intake received a report from a relative who stated that the mother and her paramour took the mother's oldest child and moved to the Mount Vernon area. The intake was screened as Information Only.

On August 27, 2007, CPS intake received a report from a friend of the mother who reported observing her and another friend smoke methamphetamine from a pipe in the presence of the mother's oldest child, who was eight months old at the time. The intake was screened as Information Only.

On October 25, 2007, CPS intake received a call that the mother and maternal grandmother allowed a registered sex offender to move into their home. The intake was screened as Information Only.

On March 1, 2008, an anonymous reporter contacted CPS intake and said she observed the then 15 months old child's milk bottle to be moldy and had mildew around the top. The intake was initially accepted for investigation and later changed to an alternate response intervention.

On November 19, 2008, a friend of the mother called CPS intake to report she observed the mother smoke methamphetamine. The mother had two children at the time, a two-year-old and a two-month-old. Neither child was with the mother when she smoked methamphetamine. The intake was screened as Information Only.

On August 12, 2009, CPS intake received a police report of an incident in which the mother's oldest child, then two years old, was found playing in the neighborhood

unsupervised. Her mother was four houses away and the grandmother was inside the residence. The child was wearing just a diaper and was covered in dirt. The intake was accepted for an investigation. The mother reported that several people were outside. She denied a lack of supervision. The social worker observed both children who appeared healthy and adequately cared for.

A supervisory case note was entered for September 22, 2009, indicated that collateral contacts were made, there was no need for a Child Protection Team meeting and the children appeared healthy. The case was closed with no finding of neglect.

On November 16, 2009, CPS intake received a report that the mother's home was described as having several dogs that used potty pads that are in different parts of the home. It was a mess with the children walking over the soiled pads. The mother allegedly yelled at the children. The intake was accepted for investigation.

The assigned social worker made contact with the mother and her children on November 19, 2009. The home environment was not as described in the intake. The mother told the social worker that she was pregnant and seeing a physician. An investigative assessment was completed with unfounded finding for neglect.

On February 1, 2010, Moses Lake Police contacted CPS intake to report the mother's two oldest children were briefly placed in protective custody due to allegations of sexual abuse by the mother's boyfriend. The children were immediately seen by a medical professional who determined the children had diaper rashes and that there was no evidence of abuse. Law enforcement was requesting CPS to follow up on the situation. Law enforcement returned the children to the care of the mother. The intake was assigned for investigation.

The assigned social worker made contact with the two children at the mother's home. She denied her daughters had been sexually abused. The children were regularly seen by their doctor. Contact was made with the doctor's office and no concerns were noted.

On February 8, 2010, CPS intake received a report from hospital staff that the mother had given birth to her third daughter, the now deceased child. The hospital nurse stated concerns that the infant would be at risk in the mother's care. The intake was screened as Information Only.

On July 28, 2010, CPS intake received a report from a mental health professional (MHP) that the mother sought medications for her three-year-old daughter in order to help manage her behavior. The MHP denied medications. The intake was screened Information Only.

On October 12, 2010, CA received an intake from a parent alleging her 16-month old baby ingested methamphetamine while visiting the family home of the now deceased child. A ten-year-old child reported seeing the 16-month-old put what appeared to be

crystals in her mouth. The crystals came from a back room. The intake was screened as Alternate Intervention.

Issues and Recommendations

Issue: The January1, 2007 intake did not include an allegation of child abuse or neglect or imminent risk of serious harm. The original intake screening decision by Central Intake was to screen out for investigation. The local office changed the screening decision and the intake was screened in for investigation of neglect.

Recommendation: Current policy exists and intake screening decisions should follow the intake policy and intake sufficiency screen.

Issue: The January 17, 2007 intake information alleges neglect for a teen parent by her mother (the maternal grandmother was smoking in the home and refused to stop). The intake was accepted for investigation with the teen parent listed as the subject and her infant daughter as the victim.

Recommendation: The intake creation should have identified the teen parent as the victim and her mother as the subject based on information the teen and her infant had been kicked out of the family home by the teen's mother.

Issue: The July 24, 2007 intake required more information to determine the screening decision. The maternal grandmother reported law enforcement had just left her residence. Her granddaughter was taken from the local area by her daughter's paramour several days previous and her daughter had just left the area.

Recommendation: The documented information did not include allegations or concerns the grandmother was reporting. A collateral contact with law enforcement would have assisted in understanding why they had just been at the family residence. It was through the fatality review process that the committee learned law enforcement had a search warrant and located drugs and paraphernalia in the teen mother's possession. Additional information regarding the mother's paramour would have likely increased the risk to the infant left in his care.

Issue: The August 27, 2007 intake was the eighth intake received in eight months regarding this teen mother and her infant daughter. Based on the report this teen parent was smoking methamphetamine in the presence of her infant and was the primary caretaker to the infant the intake should have screened in for an investigation based upon imminent risk of serious harm.

Recommendation: The review committee agreed that Children's Administration's current requirement that all information only intakes receive a supervisory review is best practice.

Issue: The February 8, 2010 intake required more information to make a screening decision. This was the fifteenth intake in three years. A nurse called to report the birth

of this mother's third child. The intake states the infant will be at risk if left in the mother's care.

Recommendation: Questions regarding the specific risks posed to the infant if in the mother's care should be explored with the referrer and documented.

Issue: There were six investigations conducted involving this family prior to the child's death. The review committee determined additional information from collateral contacts would have provided information helpful to determining safety, risks and if services would have been appropriate for the family. Examples for this case includes calling the referrers for additional information, contact with law enforcement and obtaining copies of law enforcement reports as well as collateral contact with the children's health care providers.

Recommendation: The review committee recommends social workers complete a global assessment of safety beyond the incident focused investigation. The review committee is aware that Children's Administration is currently consulting with the National Resource Center for Child Protection and is working to develop and implement a global assessment of safety.

Issue: The investigation from the February 1, 2010 intake did not have any case activity documented beyond the initial subject and victims contact. The case was open for seven months with no activity.

Recommendation: Close the case at the conclusion of the investigation if no interventions are offered.

Issue: The Structured Decision Making (SDM) risk assessment tool completed on November 6, 2009 was not completed accurately based upon information available in the case record.

Recommendation: Use the SDM tool accurately based upon the definitions provided for each area of risk assessed.

Issue: The SDM risk assessments completed on November 19, 2009 and February 15, 2010 indicate moderate high risk for the children in the household. These results require a Child Protection Team meeting.

Recommendation: Follow current policy for convening required Child Protection Team meetings when the risk assessment indicates moderate high or high risk households.

Child Fatality Review #10-64
Region 3
Snohomish County

This two-year-old Native American female died from an infection caused by aspiration pneumonia.

Case Overview
On December 2, 2010, the foster father of this two-year-old child went to check on her. She was in bed and was late to wake up. He noticed that she appeared lethargic, limp and unresponsive, and in obvious respiratory distress. Her breathing was very shallow. The child continued to be non-responsive with "glazed over" eyes. He thought it may be helpful to feed her so he fed her through her gastric tube. When she didn't respond to the feeding he immediately called 911. An ambulance arrived and started CPR on the two-year-old and transported her to Providence Hospital in Everett. The two-year-old coded in the hospital and was placed on life support. She was then transported by ambulance to Children's Hospital and continued to be resuscitated. She later died at Children's Hospital.

The King County Medical Examiner reported that the two-year-old died from sepsis (infection) due to aspiration pneumonia. Down Syndrome and dysphagia (difficulty swallowing) were listed as contributing conditions. The manner of death is natural.

Children's Administration (CA) had an open case on this child. She was born in November 2008 and remained hospitalized due to cardiac and feeding issues. She was medically fragile. She was diagnosed with blindness and hearing loss. The department filed a dependency petition while she was hospitalized. Her three older siblings were already dependent when she was born. Their mother had a history of neglect and failing to protect her children from dangerous individuals. The child was discharged from the hospital in May 2009 directly to the care of the foster home where she lived most of her life. She became legally free in July 2010.

Intake History on the Foster Home
The foster parents were originally licensed through Children's Administration (CA) in October 2003. They became licensed through a private child placing agency in 2004 and remained licensed until October 2010, at which time they became licensed by Service Alternatives, another private child placing agency.

There were seven previous reports to CPS intake on these foster parents prior to the death of the two-year-old. All seven reports were made between January 2009 and November 2010. Three of the seven intakes were screened in for investigation by the Division of Licensed Resources/Child Protective Service (DLR/CPS). Two investigations alleged negligent treatment or maltreatment and the other physical abuse. All three were closed with unfounded findings. There were four separate licensing complaints on

the foster home. All were investigated by licensing staff and all were reported prior to the death of the two-year-old.

In February 2009, a licensing complaint investigation was closed with a valid finding for training. The foster parents' CPR training had expired and they allowed a babysitter who had not completed CPR training to watch the children in their care.

In October 2009, a licensing complaint was closed with a valid finding after the foster parents had unapproved contact with the biological parents of another child placed in their home. In November 2009, a licensing complaint was closed with a valid finding after the foster parents used an improper car seat to transport a foster child. This two-year-old medically fragile child was listed in one of the intakes to Child Protective Services (CPS) on this foster home. It was screened as a licensing complaint investigation.

On March 12, 2010, CPS intake received a call from the foster mother stating that this two-year-old (then 16 months old) was suffering from a fever, cough, and cold. The foster mother took her to the doctor on March 11, 2010 and the doctor said she had pneumonia. The x-rays revealed that she had a coin stuck in her esophagus that she had apparently swallowed. The foster mother was referred to Children's Hospital for assistance. On March 15, 2010, this provider infraction was concluded as not valid regarding services provided by foster parents. The foster parents sought medical care when the child was sick and it was found that she had a dime in her esophagus. The foster parents further sought help at Children's Hospital for removal. The child's pediatrician was contacted; the doctor was unable to determine how long the coin had been in the child's esophagus. There was no correlation with the coin in her esophagus and the child's illness. The family went through their home ensuring there were no little objects or choking hazards in their home environment.

Issues and Recommendations

Issue: The two-year-old was resuscitated several times on December 2, 2010, the day of her death. Because she was legally free, CA staff tried to obtain a Do Not Resuscitate court order that day by staffing this situation with the Attorney General's office. At 4:20 p.m., the medical professionals made the decision to stop resuscitation.

Recommendation: The Adoption Area Administrator will bring up this scenario at the Snohomish County Table of 10 meeting she attends with attorneys general, mental health professionals, and foster parents for discussion to ensure legally free children with severe medical problems have adequate legal protection in case of a life threatening medical crises. The Adoption Area Administrator discussed this case with the Regional Management team right after the two-year-old died. The Safety Program Manager will suggest to the Children's Administration Health Program Manager updating the medically fragile children policy that is currently under revision to include guidance for CA staff regarding legal protection for medically fragile children.

Issue: The conflict of interest that occurs when private agency licensors are responsible for investigating the Provider Rule Infraction/Facility Complaint intakes about foster parents.

Recommendation: The team recommended that Children's Administration hire more staff to work in the DLR/CPS unit or hire more regional licensors to complete these investigations instead of the private agency licensors.

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 the 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.

Child Fatality Review #11-01
Region 4
King County

This four-year-old Caucasian male died from sepsis and peritonitis (infection in the intestines). Children's Administration did not have an open case on the family at the time of the child's death.

Case Overview

On January 2, 2011, this four-year-old boy was in the care of his mother's boyfriend while his mother was at work. The child became ill and was vomiting. The mother was contacted at work by her boyfriend to alert her that her son was sick. She called the Nurse Line at Mary Bridge Hospital and was advised to not bring him in to the hospital unless he had a fever. On January 3, 2011 the mother called the child's primary care physician, who advised her to bring him in immediately. He became unresponsive in the family vehicle en route to Valley Medical Center. He was revived at the hospital and airlifted to Mary Bridge Children's Hospital.

At Mary Bridge, surgeons found perforations in the duodenum (the first section of the small intestine), the jejunum (the middle section of the small intestine) and the esophagus (the first digestive organ). These perforations were repaired, but the child was unable to recover and he died on January 6, 2011 at Mary Bridge Hospital. Doctors initially believed that the injuries were inconsistent with a natural process.

The King County Medical Examiner conducted the autopsy. The cause of death was determined to be from sepsis and peritonitis due to duodenal and esophageal perforations of unknown etiology. (Sepsis is a systemic inflammatory response to infection. Peritonitis is the inflammation of the peritonium, a membrane that lines part of the abdominal cavity.) The Medical Examiner could not conclusively determine if the perforations were caused by physical injury or by a medical condition. The manner of death is undetermined.

Children's Administration (CA) did not have an open case on this child at the time of his death. On January 2, 2011, Child Protective Services (CPS) intake received a report that the four-year-old expressed fear of his mother's boyfriend. The referrer reported no physical evidence of abuse and the child said nothing about being hit. The referrer was aware that the child had a medical condition (Henoch-Schonlein Purpura) that caused lesions that looked like bruises on the child. The intake was screened as Information Only.

A child fatality review was conducted in May 2011. The review team included two pediatricians, a Sudden Infant Death Scene investigator, the director of the Office of the Family and Children's Ombudsman, a public health nurse, a CPS Intake supervisor from outside King County, a CPS Program Manager from outside King County, and a

pathologist from the King County Medical Examiner's Office. A CPS medical consultant Pediatrician provided post-review medical consultation.

Intake History

On January 2, 2011, CPS intake received a report from a babysitter who reported that in December 2010, the child's genitals were black and blue and swollen. The child was diagnosed with Henoch-Schonlein Purpura (HSP). The caller says that the condition has also shown up in his face and eyes. The referrer babysat the child over New Years Eve. He did not want to go home with his mother and asked where her boyfriend was at the time. The referrer speculated that the boyfriend presented a danger to the boy and may have hit him in the past. However, there was no physical evidence of abuse and the child said nothing to the referrer about being hit. The CPS intake was screened as Information Only.

On January 3, 2011, CPS intake received a report that the 4-year-old child was airlifted from Valley Medical Center to Mary Bridge Hospital. According to the child's mother, he had been sick with vomiting and diarrhea for the past 36 hours. They were en route to Mary Bridge Hospital from Enumclaw when he went into full cardiac arrest. The initial assessment was severe shock and multi-organ system failure. A CT scan revealed the possibility of a duodenal perforation. Further examination revealed a tear in the esophagus and possible acute anoxic brain injury. He was described as a gravely ill 4-year-old with multi-organ system failure including acute kidney injury secondary to shock. He appeared to have had a catastrophic abdominal event and was in guarded condition.

A hospital social worker's progress note in the hospital chart on January 3, 2011 read there was no new information to give CPS or a reason to call police to report abuse. It appeared that there was a medical reason for the child's medical status and non-accidental trauma was not suspected. A social worker from Mary Bridge Hospital related concerns for child maltreatment to Intake, but stated there was no evidence of that yet. The intake was screened as Information Only.

On January 4, 2011, CPS intake received a report from a relative which was screened in for investigation of child maltreatment and child abuse. The relative reported that in September 2010, the child accidentally consumed some sort of unknown illicit substance/narcotic. (This information was not reported to CPS intake prior to the January 4, 2011 report.) The child was taken to an Enumclaw area hospital because of the accidental consumption. The CPS intake worker made a collateral call to Mary Bridge Hospital. The hospital social worker reported the child had surgery for internal injuries and the medical consensus is that the injuries were suspicious for child abuse. The King County Sheriff's Office was informed and detectives were assigned.

The assigned CPS social worker obtained medical records on the child during the course of the CPS investigation of the January 4, 2011 intake report. The medical records

revealed that in December 2010, the child's mother brought him to Mary Bridge Children's Hospital for bruising around his groin and buttocks. The child was diagnosed with HSP and was discharged home with advice to give Ibuprofen for discomfort and to follow up with primary care.

On another occasion in December 2010, the mother took her son to Seattle Children's Hospital emergency department. He was examined, HSP was noted, and he was released to home again.

On a third occasion in December 2010, the child's mother again took him to Mary Bridge Hospital. Since his diagnosis in early December 2010, he continued to develop a lot of bruising. The scrotal swelling worsened. He also had developed swelling in the left temporal scalp area. The mother mentioned that in the week before his diagnosis, he had bruising and also lost four molars. He was admitted to the hospital for treatment. An urologist noted that the scrotal swelling and buttock rash were typical for HSP, but the facial bleeding was unusual. A CT scan suggested a cellulitis of the left temporal scalp. This area was described in the discharge examination as bruising around the left eye, left temporal area extending down around the ear and behind the left ear, bruising also within the left ear. The child was discharged to home on December 21, 2010. There were no reports to CPS intake regarding the child's medical treatment he received in December 2010. The first report to CPS intake on this family was on January 2, 2011.

The child was evaluated on January 5, 2011. It was noted that non-accidental trauma was considered. He was pronounced brain dead on January 5, 2011 and died on January 6, 2011.

The King County Medical Examiner concluded the manner of death was undetermined. The criminal investigation is still active. The CPS case remained open pending the conclusion of the criminal investigation.

Issues and Recommendations

Issue: Review of the CPS intake received on January 2, 2011 and screened out. The caller was a friend of the family who had provided care for the child.

Recommendation: The fatality review team discussed the screening decision. While not unanimous, the most persuasive reason to screen this in was the caller's description of the child's fear of his mother's boyfriend. The team believed it may have been more informative if the intake worker had asked follow up questions with respect to the caller's knowledge of the child's diagnosis, the mother's partner, and their drug use. It could have been screened in as risk only. Another option would have been to screen in based on physical abuse (black and blue marks on the child and swollen genitals), although this was described as being a symptom of the child's diagnosed condition, HSP.

Issue: Review of the CPS intake received on January 3, 2011 and screened out. The referrer was a social worker at Mary Bridge Hospital in Tacoma where the child had

arrived that evening via airlift. He was in septic shock and very critical. There was no evidence of abuse at the time this report was made to CPS Intake.

Recommendation: The review team felt this intake was correctly screened out given the information reported.

Issue: Review of the CPS intake received on January 4, 2011 and screened in for investigation: The caller was a relative who reported the child had an accidental overdose of an illicit drug in September 2010 and recounted his recent health crisis. Collateral calls to Mary Bridge Hospital confirmed the child had internal injuries consistent with inflicted injury.

Recommendation: This intake was correctly screened in for investigation with a 24-hour response time.

Issue: There are differing medical opinions about the diagnosis of HSP and whether the child's external and internal injuries were inflicted.

Recommendation: Children's Administration will offer to meet with two of our contracted medical consultants who will provide input post review.

Child Fatality Review #11-02
Region 4
King County

This nine-month-old Asian male died from anoxic encephalopathy (brain damage due to lack of oxygen), due to an interrupted Sudden Infant Death (SIDS) event. Children's Administration had an open case on the family at the time of the child's death.

Case Overview
On January 15, 2011, the King County Medical Examiner's Office reported death of this nine-month-old child. He died while hospitalized at Seattle Children's Hospital.

The child had a near fatal SIDS incident when he was two months old on May 7, 2010. His parents transported him to St. Francis Hospital in Federal Way. He was later transferred to Mary Bridge Children's Hospital. When he arrived at the hospital he had not been breathing for at least 20 minutes and he sustained serious brain injury; reportedly there was no neural activity. Detectives with the Federal Way Police Department investigated. Since the child's hospitalization in May 2010, the child's prognosis for survival had been very poor. The lack of cerebral cortex functioning had impaired the child's ability to regulate his breathing and temperature. The child had multiple hospitalizations due to these complications and was eventually placed at Ashley House on July 15, 2010. Ashley House is a licensed home that specializes in caring for medically fragile children.

Children's Administration (CA) had an open case on this child at the time of his death. On August 25, 2010, Child Protective Services (CPS) intake received a report that while the child was placed at Ashley House, he had bi-lateral fractures of both femurs and tibias and was found with a subdural hematoma. Intakes were reported on the child's parents and on Ashley House staff. The intake on Ashley House was investigated by the Division of Licensed Resources/Child Protective Services Section (DLR/CPS). The case was open to the child's parents when their son died.

Intake History
On June 9, 2010, CPS intake received a report from a nurse with the Division of Developmental Disabilities (DDD). The child, then two months old, was hospitalized at Mary Bridge Hospital. In May 2010, his father found him facedown in his crib, not breathing. The parents did not perform CPR on their son or call 911. They put him and the other three children into the car and drove him to a local hospital. The child had no brain or neural activity when he arrived at the hospital. Law enforcement was notified and began an investigation. The CPS intake was screened in for investigation. The investigation was completed with an unfounded finding for negligent treatment or maltreatment. The child was discharged to a placement at Ashley House. The case remained open for services to provide child care assistance and counseling support for the parents and older children due to the serious medical condition of the child.

On August 25, 2010, CPS intake received a report that the child, then four months old, had been hospitalized and during his hospitalization it was discovered that he had fractures of both femurs and tibias and had a subdural hematoma. Police were notified of the injuries to the child and placed him into protective custody. The intake was screened in for investigation on the parents as they had access to their son while he was in the hospital and at Ashley House. A DLR/CPS intake was also screened in to investigate physical abuse by staff at Ashley House concerning the same injuries.

Tacoma Police Department placed the child into protective custody and opened a case for investigation of assault. Subsequent medical consultation with a pediatrician and child abuse expert and her review with two radiologists determined that the leg fractures were most likely due to extreme weakening of the bones and the hematoma was from brain atrophy. This investigation was determined to be unfounded on the parents and Ashley House staff for physical abuse.

Issues and Recommendations

Issue: Two hospitals and law enforcement did not regard the initial incident (reported on June 9, 2010) as something to report to CPS. A nurse/contractor for DDD made a report after the incident occurred. With such a delay, it was difficult to determine what really occurred in the family home.

Recommendation: None

Child Fatality Review #11-03
Region 6
Cowlitz County

This 17-year-old Caucasian male died from hypertrophic cardiomyopathy. Children's Administration (CA) had an open Family Reconciliation Services (FRS) case on the family at the time of the youth's death.

Case Overview
On January 26, 2011, the Longview Police Department reported that the 17-year-old youth and his friends were engaged in Mixed Martial Arts (MMA) fighting when he was placed in a chokehold. He collapsed and never recovered. The police report said there was no evidence of foul play or head trauma.

The Cowlitz County Coroner determined that the 17-year-old died from hypertrophic cardiomyopathy (a congenital heart condition that results in the thickening of the heart muscle). The manner of death is listed as natural.

The Children's Administration had an open case on this youth at the time of his death. On November 30, 2010, the youth's mother contacted Child Protective Services (CPS) intake to ask for assistance with filing an At Risk Youth Petition (ARY) on her 13-year-old daughter and her son. The mother reported that the children fought a lot and had problems at school. The case was assigned to an FRS social worker.

Intake History
On November 30, 2010, the mother of the 17-year-old contacted CPS intake to request assistance with filing an At-Risk Youth Petition (ARY) on her daughter and son. The mother reported that her children fought a lot and had problems at school. The intake was screened in for Family Reconciliation Services (FRS).

A family assessment was completed on December 13, 2010. The assessment indicated that the 17-year-old had previously run away from home and both children had problems in school including sporadic attendance. The children fought a lot at home.

The family agreed to participate in counseling before filing the ARY. The mother agreed to set up counseling for her family.

The social worker met with the mother on January 26, 2011. She reported there was no change in her children's behavior. The social worker assisted the mother with filling out the ARY petition for both children and was going to file them with the court. The mother acknowledged that she did not follow through with setting up a family counseling appointment.

On January 28, 2011, a police officer contacted CPS intake and reported that the 17-year-old collapsed while engaged in martial arts with friends and later died. The autopsy revealed he died of hypertrophic cardiomyopathy, a thickening of the heart muscle.

The social worker contacted the mother after her son's death and she agreed that her daughter would benefit from counseling. She also decided not to file the ARY on her daughter as her daughter's behavior had improved since her son's death. A letter was sent to the family providing them with counseling resources and the intent to close the case. The case was closed on May 19, 2011.

Issues and Recommendations

Issue: The review team noted that the social worker met all of his timelines in responding to this case and also provided excellent culturally appropriate services to this family. He ensured that he had an interpreter when meeting with the mother and also made sure that documents were translated into her language. The worker kept the case open four months after the youth's death and provided support services to the family during that time.

Recommendation: The worker was at the review and was commended for his work on this case.

Children's Administration

Executive Child Fatality Review

T.V. Case

Date of Birth: 05/05/2010
Date of Death: 10/05/2010
Date of Review: 02/04/2011

Committee Members
Steve Shumate, Sergeant, Grays Harbor County Sheriff's Department
Steve Hutton, M.D., Pediatrician Aberdeen
Hieu Dang, Area Administrator, DCFS, Region 6
Angela Coulter, Director, Grays Harbor Child Advocacy Center
Kui Hug, Program Manager Supervisor, Region 6
Nancy Liedtke, Grays Harbor County Child Protection Team Member
Sharon Bailey, Director, Family Birth Center

Observer
Debbie Lynn, Area Administrator, DCFS, Region 6

Facilitator
Edith Hitchings, Deputy Regional Administrator, Region 6, Children's Administration

Table of Contents

Executive Summary 52
Case Overview 54
Findings by the Review Team 56
Recommendations 57

Executive Summary

On October 3, 2010, Children's Administration (CA) accepted an intake from a social worker with Grays Harbor Hospital reporting that four-month-old T.V. was admitted to the hospital after his father, Michael Vanderveur,[1] called 911 when T.V. became unresponsive. Mr. Vanderveur told the treating emergency room doctor that the previous night (October 2) his son fell off a sofa and hit his head on table. He stated he observed his son that night and didn't feel he needed medical attention. The next morning he picked up his son and noticed that he arched his back, his eyes rolled back, and his stopped breathing. Mr. Vanderveur reported he called 911 and started CPR. T.V. was taken to Grays Harbor Hospital and was intubated. He was later transferred to Mary Bridge Children's Hospital.

Upon arrival at Mary Bridge, hospital staff noticed that T.V. had bruises on his chin, cheeks, chest, and abdomen. A CAT was completed and found significant bleeding in the brain and retinal hemorrhaging in both eyes. The scan also revealed bleeding in the brain that doctors reported was consistent with abusive head trauma. According to the medical record, the father's report that T.V.'s injuries were caused by the fall off a couch was not consistent with the severity of his injuries. T.V. remained hospitalized at Mary Bridge.

On October 4, 2010, Michael Vanderveur was arrested by Grays Harbor County Sheriffs and charged with Assault 1.

On October 5, 2010, Michael Vanderveur admitted to a detective with the Grays Harbor County Sheriff's Office that he shook T.V. the night of October 2, 2010. He reported he was frustrated as T.V. woke him with his crying. He stated he went to T.V.'s crib and picked him up and shook him. T.V. became quiet and was quiet for the remainder of the night. Mr. Vanderveur observed that T.V. was unresponsive the next morning and called 911.

On October 5, 2010, doctors at Mary Bridge conducted several neurological tests on T.V. and each examination found no evidence of brain function. Doctors determined T.V. was brain dead and the decision was made, with his mother's consent, to take him off mechanical ventilation. T.V. died later that day.

Given that T.V. was in at Mary Bridge Children's Hospital when he died, the Pierce County Medical Examiner conducted the autopsy to determine the cause and manner of death. The autopsy was completed and the Medical Examiner determined the cause of death was physical trauma due to abuse. The manner of death is homicide.

The criminal charges against Michael Vanderveur were amended and he was charged with homicide in the first degree. The criminal case is pending.

[1] The full name of Mr. Michael Vanderveur is being used in this report as he has been charged in connection to the incident and his name is a part of the public record. During the course of the law enforcement investigation it was found through DNA testing that Mr. Vanderveur is not the biological father of T.V. as noted on the birth certificate. The biological father of T.V. is not known. However, Mr. Vanderveur was recognized as T.V's father prior to his death. For this purposes of this report, Mr. Vanderveur will be referred to as T.V.'s father.

T.V. was in his father's care when he was injured. Mr. Vanderveur and Ms. E. did not have an established parenting plan. Ms. E. told law enforcement that she allowed Mr. Vanderveur to visit T.V. on September 8, 2010 and Mr. Vanderveur refused to return T.V. to her care. Ms. E. as told by police to file a parenting plan to regain custody of her son. Ms. E. filed a parenting plan on September 11, 2010. A court date was scheduled for October 11, 2011.

On February 4, 2011, CA convened a multi-disciplinary committee to review intake screening decisions, policy and practice in this family's case.[2] This was done pursuant to RCW 74.13.640 because T.V. and his parents had been the subjects of referrals to CA within the twelve months prior to his death. The fatality review team was represented by disciplines associated with the case and had no involvement or limited involvement with this family. The fatality review team members included, a medical professional, law enforcement, staff from a child advocacy center, director of the family birth center and a local Child Protection Team member. The team also included CA staff who had no direct connection to the case. Relevant case documents were made available to the fatality review team. These documents included: medical reports, law enforcement reports, family history including all intake information and a chronology of the case upon assignment of the case on October 4, 2010.[3]
The social worker on the case was interviewed by the review team. In addition, the investigating supervisor was also interviewed by the team. The Children's Administration Intake supervisor for Grays Harbor and Pacific Counties was also interviewed by the fatality review team.

During the course of the review, team members discussed screening decisions on intakes received prior to T.V.'s death, and intake screening policies. The team also discussed information sharing between CA and referring parties. In addition, the review team addressed issues related to information provided to CA intake by medical professionals and the impact that the lack of comprehensive information has on the screening of CPS intakes.

Following review of the case histories, medical and law enforcement records and discussion, the review team made findings and recommendations. The findings and recommendations are detailed at the end of this report.

---

[2] 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.

[3] The criminal case was pending at this time of the fatality review; therefore limited information regarding the criminal investigation is contained in this report to preserve the criminal proceedings of this case.

RCW 74.13.500

RCW 13.50.100

Case Overview

The review team was provided with CA case information for two families; the deceased child's mother's case and the case related to T.V. [redacted] The review team also reviewed and discussed the intakes regarding Mr. Vanderveur's care of T.V. Intakes referencing the families were reviewed in regards to screening decisions and interventions.

[redacted]

On September 12, 2010, an intake was received by CA Central Intake from staff at Grays Harbor Hospital. T.V. was taken to the hospital by his father Michael Vanderveur. Mr. Vanderveur told hospital staff that Ms. E. was allowing small children to carry T.V. and he thought T.V. had been dropped by the other children. He also reported that there was a pit bull in the home that was unsupervised around the children. T.V. was previously diagnosed with esophageal reflux and the mother refused to give the father T.V.'s medication. Hospital staff reported that T.V. had old scratches on his head and one on his arm. None of these scratches required medical attention. The hospital staff reported that T.V. appeared healthy. This intake was initially screened in by the intake worker for alternate intervention. The intake supervisor changed the screening decision and screened out the intake because a medical professional reported that the child was okay.

During the fatality review it was discovered that law enforcement spoke to the father about this incident and did not generate a report of abuse and neglect. It was also discovered that T.V. had been seen at the hospital approximately three months prior to this intake after he had been stepped on by a dog. T.V. would have been a little over a month old at the time of this incident. Ms. E. followed up with getting T.V. medical treatment and no intake was received by the department regarding this incident. This information was provided to the review team by law enforcement who is investigating the death of T.V. The Grays Harbor Hospital staff who reported the intake on September 12, 2010, did not mention any history of seeing T.V. prior to September 2010. It is unclear from the intake if the intake worker asked the hospital staff if they had a history of seeing this child. The review team agreed with the initial screening decision by the intake worker and would have left the intake screening decision as alternate intervention.

[4] M is T.V's half brother and Michael Vanderveur is not M's father.

An intake was received on September 13, 2010 by Central Intake. This intake was called in by Ms. E. who reported that five days earlier T.V. had bruises "covering his back" after he had a visit with his father. Ms. E. stated that she took photos and took her son to a doctor. Ms. E said the doctor " didn't do anything." There was no report from the doctor taken by CA intake. Ms. E. reported that earlier that evening Mr. Vanderveur took T.V. and would not give him back to her. Ms. E. told intake staff that police were talking to Mr. Vanderveur while she was calling in this report to intake. Central Intake staff contacted law enforcement who reported the parents were having a custody dispute, T.V. was fine, and the officer was ready to clear the scene. Law Enforcement did not make a report to CA intake on this incident. The review team agreed with the intake screening decision based on the information received at intake. Law enforcement went to the home and saw T.V. and did not believe that he was in danger. T.V. had been seen at the hospital the previous day and hospital staff did not indicate that T.V. had bruising on his back and also stated that the child looked fine.

Two intakes were received during the month of October 2010; the first intake was received on October 1, 2010. This call came in from HeadStart staff reporting that T.V.'s grandmother picked him up for a visit with his father. The father then called the mother and told her that he was not bringing the child back to the mother. The mother told HeadStart that she had photos of bruising on T.V.'s back between his shoulders. Central Intake screened this intake out indicating that the bruising had been previously reported. During the review of this intake it was stated that the HeadStart worker felt that she was dismissed by the Central Intake worker and was informed by the intake worker that this was a custody issue between the parents. The review team felt that this intake was screened properly based on the information provided at intake. However it was unclear if further questions were asked of the referrer regarding the bruises and whether they were seen by the referrer.

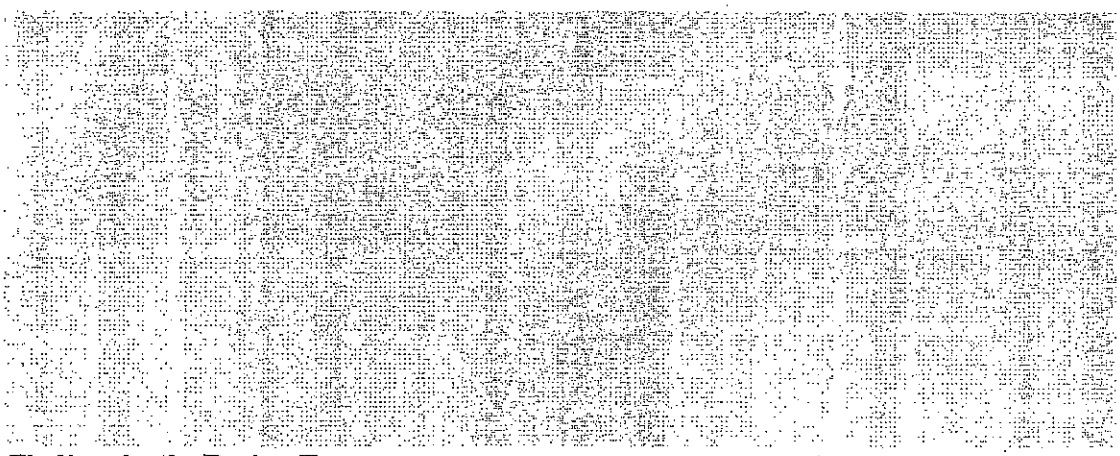
The final intake on this family was received by Central Intake on October 3, 2010. The report indicated that T.V. was taken to the hospital from his father's home via ambulance. Mr. Vanderveur told Grays Harbor Hospital staff that T. V. had fallen off the couch and hit his head on the table the previous night and that he did not feel that T.V. needed medical attention. The next morning T.V. stiffened and arched his back and eventually went limp. Mr. Vanderveur reported he then called 911. T.V. was taken to Grays Harbor Community Hospital where he was intubated and transported to Mary Bridge Children's Hospital in Tacoma. The social worker from the Grays Harbor Community Hospital initially reported that there was no indication of child abuse and neglect. Central Intake called Mary Bridge Children's Hospital who indicated that T.V. had a purple bruise on his chin and additional bruising to his forehead. He also had older bruising to his arms and knees. A CT scan of the brain revealed that brain bleeding was consistent with abusive head trauma. The intake was screened in for investigation with a 24 hour response time. The review team agreed with the screening decision on this intake.

October 2010 Fatality Investigation

On October 3, 2010, CA received a report that T.V. was taken to Grays Harbor Hospital after he became unresponsive. He was in the care of his father, Michael Vanderveur, at this time. Information provided by medical staff and law enforcement noted bruising to T.V. and a brain injury consistent with being shaken. The intake identified Mr. Vanderveur as the subject of physical abuse. A review of the medical reports by Dr. Yolanda Duralde, Director of the Child Abuse Intervention Department at Mary Bridge, indicated that T.V. received a life-ending injury due to abusive head trauma while in the care of Mr. Vanderveur.

Based on information from Ms. E. and the police officer's interview with Michael Vanderveur, it can be concluded that Mr. Vanderveur took physical custody of T.V. on September 8, 2010 without the consent of the child's mother. On the night of October 2, 2010 T.V. suffered a severe injury to the brain which resulted in his death three days later. A hearing on custody was pending in family court at the time of the child's death. The Pierce County Medical Examiner subsequently determined the cause of T.V.s death was physical trauma caused by abuse and that the manner of death was homicide. Mr. Vanderveur was arrested and has been charged with homicide in the first degree.

Mr. Vanderveur admitted to law enforcement officers he shook his son the night before he was hospitalized. Mr. Vanderveur declined to be interviewed by a CA social worker during the CPS investigation of T.V.'s fatal injuries. The CPS investigation was closed with a founded finding for physical abuse of T.V. by Michael Vanderveur.



Findings by the Review Team

Intake Decisions

The review team discussed the screening decisions related to intakes involving this family. The team also discussed information sharing by mandated reporters. The findings include the following:

- In the October 1, 2010 intake, the review team felt the intake was screened appropriately based on the information that was provided to intake by the referrer. The review team felt it was unclear if the referrer was asked additional questions about the

alleged bruising on the child, specifically if the referrer had seen pictures Ms. E reports she had of the bruising.

- In the September 12, 2010 intake, the review team agreed with the initial screening decision by the intake worker to assign the case for alternate intervention. The intake supervisor changed the screening decision to Information Only and was screened out.

- While the review team agreed with most of the intake screening decisions they felt that significant information regarding T.V.'s medical care was not properly conveyed at the time intakes were called into the department. Law enforcement discovered that T.V. was seen in June 2010 at both the Grays Harbor Community Hospital and Mary Bridge Hospital when he was stepped on by a dog. Neither hospital called in an intake regarding abuse and neglect of T.V. at the time he was treated in June 2010. T.V. was also seen on September 3, 2010 at Providence Hospital in Centralia; there was no call from Providence Hospital regarding concerns of abuse and neglect.

- The review team felt that intake staff did not get specific enough information regarding T.V.'s medical treatment and whether the callers had concerns regarding the safety and care of T.V. while in his parent's care.

Recommendations

Intake Decisions

- The review team recommended that mandatory reporting training be provided to staff at the Grays Harbor Community Hospital and that this training should be completed by April 15, 2011.

- The review team recommends that Region 6 and Central intake supervisors review and discuss the new intake policy that goes into effect on March 1, 2011 regarding intakes reported by a licensed physician or medical professional on "the physician's behalf" or a non-mobile infant (birth to 12 months) with bruises, regardless of the explanation for how the bruises occurred. A meeting is scheduled with all Region 6 intake supervisors on March 1, 2011. The new policy will be discussed with supervisors at that meeting.

Children's Administration
Executive Child Fatality Review

R.B.

January 21, 2011
Date of Child's Death

June 2, 2011
Executive Review Date

Committee Members
Larry Caranza, Social Worker, Nak Nu We Sha, Yakama Nation
Bob Cox, Mental Health Professional, Behavioral Health, Yakama Nation
Jackie Davidson, Greater Columbia Regional Support Network
Nancy Dufraine, Indian Child Welfare Program Manager, Children's Administration
Berta Norton, Area Administrator, Children's Administration
Robert Rodriquez, Child Protective Services Program Manager, Children's Administration
Nate Sitton, Behavioral Rehabilitative Services Program Manager, Children's Administration
Stella Washines, Tribal Council Member, Yakama Nation

Observer/Invitee
David Lees, Prosecutor, Yakama Nation Office of the Prosecutor, Yakama Nation
Mary Meinig, Director, Office of the Family and Children's Ombudsman

Facilitator
Marilee Roberts, Practice Consultant, Field Operations, Children's Administration

Table of Contents

Executive Summary 61
Case Overview 62
Service and Placement Information 62
Team Discussion and Findings 64
Recommendations 66

Executive Summary

On June 2, 2011, the Department of Social and Health Services (DSHS), Children's Administration (CA) convened an Executive Child Fatality Review (ECFR)[1] of the case involving the death of a 15-year old Yakama Nation Tribal member, R.B. (DOB 12/[redacted] 1995). R.B. was a dependent of the Yakama Nation with case management services provided by the state of Washington. A committee[2] that included Tribal representatives, community professionals, and CA staff reviewed the case documents and interviewed CA staff in an effort to examine child welfare practices, system collaboration, and service delivery.

On January 21, 2011 at approximately 7:40 p.m., Cypress House[3] staff reported to CA they were contacted by the Snohomish County Medical Examiner (SCME) and Washington State Patrol (WSP) requesting information (fingerprints) regarding R.B.; WSP notified Cypress House that they believed R.B. had jumped off a freeway overpass (Interstate 5) at approximately 2:30 p.m. and died. At the time of his death R.B. was residing at Cypress House, a staffed residential facility for youth in Snohomish County, Washington.

From May 1998 until his death, R.B. had been in the care and custody of the Yakama Nation pursuant to Tribal Court jurisdiction and had been placed in out-of-home care. During this time he had been in 22 placements with the most recent placements, those between June 2009 and January 2011, being in staffed residential facilities. In early January 2011, R.B. had been accepted and was awaiting placement in a Children's Long-Term Inpatient Program (CLIP)[4] when he was placed at Cypress House.

Committee members received case documents including a case summary regarding R.B.'s family. In addition, un-redacted copies of the family's case file, summary information regarding R.B.'s recent placements, Division of Licensed Resources investigation regarding R.B.'s death in a licensed facility and information from CA's Behavioral Rehabilitation Services (BRS) handbook were made available. Committee members also had the opportunity to meet and interview two CA staff members; the social worker and social work supervisor assigned to the case at the time of R.B.'s death.

---

[1] 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.

[2] Ms. Washines was unavoidably called away and was not able to attend the full review, however was provided a copy of the final document for review and approval. Mr. Lees was invited by Ms. Washines to the review.

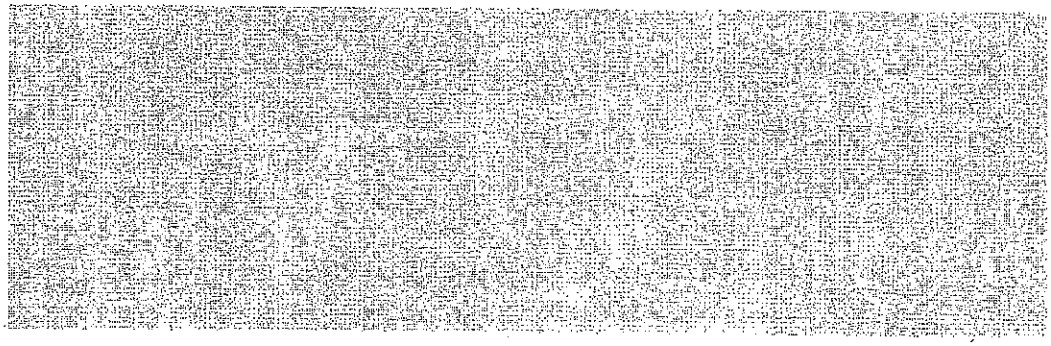
[3] Cypress House is an unlocked staffed residential facility in Snohomish County licensed by Children's Administration, Division of Licensed Resources.

[4] CLIP provides psychiatric inpatient services for the children and youth of Washington State. There are 91 CLIP beds in the state of Washington located at Child Study and Treatment (47 beds), a state operated psychiatric hospital for children and three contracted Residential Treatment Facilities (44 beds).

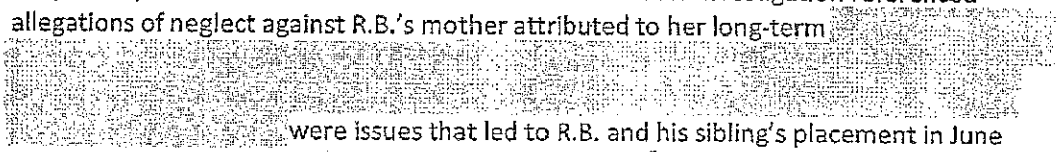
During the course of the review, committee members discussed issues related to the coordination of communication between service providers, foster parents, and other professionals involved. In addition, the committee members addressed issues related to accessibility of services within a youth's own community, training and support for foster parents and residential facility staff, and delivery of mental health services.

Following review of the family's history, case records and discussion, the committee members made findings and recommendations that are detailed at the end of this report.

Case Overview



R.B.'s CPS history as a child victim includes six intakes between April 1997 and May 1998 where his mother is identified as the subject of abuse or neglect of her children. Five of the six intakes were screened in for investigation with one intake identified as CPS Risk Only and opened for services. The five intakes screened for investigation referenced allegations of neglect against R.B.'s mother attributed to her long-term



were issues that led to R.B. and his sibling's placement in June 1997 (temporary) and then again in May 1998. FamLink[5] does not identify investigative findings for the five intakes; however this family's case remained opened for services during this time (April 1997-May 1998) until protective custody was granted in May 1998.

Service and Placement Information

A dependency was established as to R.B. in May 1998 in Yakama Tribal Court. This family was provided services prior to placement in out-of home-care and throughout the dependency by the Yakama Nation, as well as by CA under a local agreement with the Yakama Nation. Unfortunately, R.B.'s parents failed to consistently access identified services intended to address

Active efforts to encourage parental engagement in services occurred prior to the death of R.B.'s mother in 2001. In June 2005, the Yakama Tribal Court vacated R.B.'s father from the service plan because he could not be considered a placement

[5] FamLink is Children's Administration's management information system. FamLink became operational in January 2009 and replaced CA's previous information system, CAMIS.

option due to his incarceration. This order released CA from the responsibility of offering or providing remedial services to R.B.'s father.

After entering out-of-home care in May 1998, R.B. and his sibling were placed in four foster homes within three years. The duration of each of these placements varied, with the longest placement being 2 years. However, in June 2001 R.B. and his siblings were placed in a Yakama Nation foster home where they remained for 3½ years. In October 2001 while placed in this home, the children's mother committed suicide. The stability of this placement, assisted the young children in dealing with their mother's death while remaining in a stable environment. Placement was stable in this two-parent home until the unexpected death of the foster father in September 2004. At the request of the grieving foster mother, the children were removed and placed in a relative's home.

From September 2004 to June of 2009 R.B.'s placement changed thirteen times. During this five year period Children's Administration worked in partnership with the Yakama Nation and Service Alternatives[6] to find a placement that would best meet his needs. Despite the stability of the previous placement (June 2001-September 2004), R.B. struggled significantly in new homes,

In June 2005, R.B. began receiving additional Services were intended to address

In December 2006, after another disrupted placement, R.B. was assessed for Behavioral Rehabilitation Services[7] (BRS) and placed in several Service Alternatives homes. In June 2009, led to placement in a more supervised environment at Northwest Idaho Children's Home (NICH). While at NICH, R.B. was monitored closely by staff as well as involved in Continued concerns regarding led CA to initiate an application to support placement in a Children's Long-Term Inpatient Program (CLIP) facility in August 2010[8].

[6] Service Alternatives is a multi-faceted human services agency providing services which include residential services, wraparound/kinship services, and therapeutic foster care among others.
[7] Behavioral Rehabilitation Services is a temporary intensive wraparound support and treatment program for identified youth. Services are intended to increase a child's behavioral and placement stability in order to increase potential to reach permanency.
[8] Application was evaluated and accepted by the state CLIP committee in early January 2011.

Placement at NICH disrupted in November 2010 after an incident which led to R.B.'s placement at the Nez Perce Juvenile Detention facility until mid-December 2010. On November 29, 2010 a CLIP staffing was held with the local Regional Support Network (RSN)[9]. R.B. was found to be eligible for a CLIP bed; however he was placed on a wait list pending bed availability. In addition to review and approval by the local RSN, the social worker shared the plan and received support from the Local Indian Child Welfare Act Committee (LICWAC). The LICWAC committee also encouraged CA to continue researching other options and resources for R.B.

On December 17, 2010, R.B. was returned to his home community and placed in a secure crisis facility, EPIC. Lack of availability of CLIP beds and program parameters at EPIC necessitated the placement of R.B. at Cypress House in Lynnwood, WA in early January 2011. The Cypress House placement was intended to be a temporary placement until a CLIP facility was available. R.B. was told of the plan and according to documentation, understood and was prepared to enter the CLIP facility when available. This information along with LICWAC's knowledge of the plan was presented to and approved by the Yakama Nation's Tribal Court on January 18, 2011. However, a CLIP bed did not become available prior to R.B.'s death on January 21, 2011.

Team Discussion and Findings

- Communications – At various times during the dependency, information regarding family history such as mental health, child protective services, cultural preferences, and service outcomes did not appear to be consistently conveyed to all providers or caregivers. Committee members noted specific information regarding a youth's behaviors or special needs must be conveyed to providers and caregivers in order to assist in developing safety and service plans critical to child safety and placement success.

  Complex cases require diligent efforts to ensure communication and coordination of services. Service providers and caregivers need information regarding past and current service successes and outcomes for purposes of future case planning and development. This concept was referred by the committee members as 'bringing history forward' to ensure continuity and consistency in care.

- Case Coordination (Safety Planning) - During a document review and in speaking with the assigned social worker and supervisor, questions arose concerning whether critical information referencing the youth's recent behavioral issues[10] was made available to Cypress House residential staff.

[9] In 1989 the Washington Legislature passed legislation creating county-based Regional Support Networks to design and administer local mental health systems to meet the unique needs of people with mental health issues.

[10] Information specific to [redacted] and CLIP bed application.

A review of the BRS packet sent to Cypress House (an unlocked staffed residential facility) and e-mails between CA staff and Cypress House indicates that information regarding [redacted] and an incident at NICH in which R.B. [redacted] was provided. As a result, the safety plan for R.B. while in care at Cypress House identified [redacted] and running away as key issues. Frequency of supervision while in the program included constant visual and earshot[11] supervision. The safety plan developed by Cypress House with CA's approval referenced a staff/client ratio of 1:3 when traveling with no other additional supervision recommended. The safety plan was developed in collaboration with CA as required by policy.
The review committee felt the safety plan could have been enhanced to include additional supervision given R.B.'s [redacted]
Current BRS funding supports programs, when determined necessary, to request additional funding to allow for increased supervision. Exploration of CA policy and additional funding sources to support additional supervision could have been included during the development of the safety plan.

- Case Complexity – Committee members discussed the complexity of cases where placements are affected by a youth's special needs and where multiple systems (mental health, child welfare, and juvenile justice) are involved.
Committee members noted that a significant number of services were provided to R .B. which included multiple [redacted] and structured group care among others. The discussion included the complexity of this case and limited services within R.B.'s home community that precipitated CA to explore and identify more intensive services outside his home community.

  As a result of this discussion the committee also considered decision-making regarding the timing for CLIP placement applications. The review committee suggested CA may want to consider accessing more secure placement settings for youth with complex behavioral and mental health needs earlier in the case as issues are identified. They found the use of unlocked staffed residential facilities[13] (e.g. NICH or Cypress House) or psychiatric hospitalization outside a youth's home community is accessed only after all other local resources have been exhausted regardless of a youth's needs. Given limited community resources for youth who present with complex mental health and behavioral issues, placement in such facilities at the time of diagnosis may provide the most comprehensive and

[11] 'Constant visual and earshot supervision' is the term used in the Individual Behavior Management/Safety Plan utilized by Cypress House.
[12] Evaluations included [redacted]
[13] Washington State does not allow dependent non-adjudicated youth to be placed or housed in a locked facility.

effective services for a youth. This could support early intervention and placement in a secure environment that maximizes treatment options and success.

- Providers - Mental Health Training and Support – Committee members discussed the training and education needs for foster parents, residential facility, and CA staff when working with youth with intensive mental health and behavioral issues. The committee identified a need to develop a range of care providers who, coupled with additional training and added supports, are able to sustain placement of youth who have special needs. With added case and behavior management support for least restrictive[14] setting providers, a youth may be able to receive services within his home community.

Recommendations

- Communications and Case Complexity – CA must ensure a complete case history is conveyed to care givers and service providers (e.g. medical providers, mental health professionals, care providers, etc.) to provide a baseline for case planning. When multiple agencies and service providers over time have worked or are working with a youth and family or have referred them for intervention; a thorough overview of the case must be shared. In addition to the packet of information forwarded to a care provider[15], information provided must include a comprehensive summary of the case history, service intervention and significant events to date.

  The review committee suggested this discussion should occur in person or telephonically prior to placement to ensure appropriate case plan development in the proposed home/facility. CA can utilize several existing venues where this information can be shared (e.g. Multiple Disciplinary Teams, Shared Planning Meetings, Family Team Decision Making Meetings) and assist in developing communications across systems and ensure a comprehensive plan of care is developed[16]. At minimum staff participating in such staffings should include the assigned CA social worker and supervisor, BRS facility staff and the CA Regional BRS Program Manager. As noted above a comprehensive staffing may have led to a request for additional supervision supported by BRS funding sources.

- Provider Training –Currently CA offers training to foster parents regarding Sexually Aggressive Youth (SAY) and Physically Aggressive and Assaultive Youth (PAAY). In order for a care provider to care for youth who has been identified as SAY or PAAY, they must attend training referencing these topic areas.

---

[14] Least Restrictive Care refers to family based care options such as relative placement or foster care as opposed to residential or group care.

[15] Foster parent receives a Child Placement Referral form. Residential facilities receive a Behavioral Rehabilitation Services packet. Both documents provide information regarding a youth and his/her family's history with CA.

[16] A plan can include additional funding to allow for increased supervision.

CA may choose to consider the development of additional training opportunities that address the complexity of mental health and behavioral issues in children and adolescents. This enhanced training will support care providers, CA staff and its partners in addressing issues related to youth with special needs and may support and assist in sustaining least restrictive placements for youth.

Training opportunities which introduce and provide specific information related to mental health and their related behavioral issues can support care providers and social workers in caring for youth diagnosed with such issues. Training such as medication management, accessing community resources such as the Designated Mental Health Professional[17] (DMHP), intervention strategies, redirecting behaviors, safety planning and monitoring[18] were several topics suggested by the review committee.

[17] Provides assessment to determine if a person is a danger to self or others or suffering from grave disabilities.

[18] CA has initiated a new safety assessment and safety planning framework for all staff. Child Safety Framework training is scheduled for August 2011 through November 2011 and is mandated for all CA staff.