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DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

Report to the Legislature

Quarterly Child Fatality Report

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October - December 2008

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Executive Summary

This is the Quarterly Child Fatality Report for October through December 2008 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.*

This report summarizes information from 21 completed fatality reviews of fatalities that occurred in 2008. All were reviewed by a regional Child Fatality Review Team. Two of these fatality reviews (#08-23 and #08-24) were completed as Executive Child Fatality Reviews.

This report includes three expanded Executive Child Fatality Reviews completed during the quarter. These completed reports are attached at the end of this report. These reports are also found on the DSHS website. http://www.dshs.wa.gov/ca/pubs/fatalityreports.asp

The reviews included in this quarterly report discuss fatalities from all six regions.

Region	Number of Reports
1	2
2	5
3	1
4	1
5	6
6	6
Total Fatalities Reviewed During 4th Quarter, 2008	21

Child Fatality Reviews are conducted when children die unexpectedly and their families had an open case or received services from the Children's Administration (CA) within 12 months of their 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 the identified issues. A review team can be as few as two individuals (in cases where the death is clearly accidental in nature), 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) have been conducted in cases where the child fatality is the result of apparent child abuse and neglect and CA had an open, active case at the time of the child's 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.

In June 2008, legislation passed (2SHB 6206) that expands the use of the Executive Child Fatality Review format to include this type of review for any child fatality that is the result of apparent abuse or neglect by the child's parent or caregiver and the child was in the care of the state or received any level of service in the previous year. Previously this type of review was conducted only on cases where the child died of abuse or neglect and the department had an open, active case at the time of the child's death.

The chart below provides the number of fatalities reported to CA, and the number of reviews completed and pending for calendar year of 2007 and 2008. 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 Years 2007 / 2008			
Year	Total Fatalities Reported to Date Requiring a Review	Completed Fatality Reviews	Pending Fatality Reviews
2007	59	58	1
2008	90	36	54

The remaining child fatality from 2007 still pending review is an Executive Child Fatality. The review of this fatality was postponed at the request of the county prosecuting attorney's office. An extension waiver was granted by the Governor. At the writing of this report, the review and a draft of the report was completed, though not finalized.

The numbering of the Child Fatality Reviews in this report begins with number 08-16. This indicates the fatality occurred in 2008 and is the 16th report completed for that calendar year. The number is assigned when the Child Fatality Review and report by the Child Protective Services Program Manager is completed.

The reviews contained in these Quarterly Child Fatality Reports are a summary of the actual report submitted by each region. These reports contain more detail and confidential identifying information that is not subject to disclosure.

Child Fatality Review #08-16
Region 4
King County

This four-month-old Caucasian female's cause of death was determined to be from Sudden Unexpected Infant Death (SUID).

Case Overview

On April 23, 2008, the deceased child's mother fell asleep on a couch with the child on her chest. The child had a cold and had been fussy. The mother has two older children, ages four and two years old, who slept at the other end of the couch. During the night, the four-year-old moved to a position next to his mother. When the mother woke in the morning, the deceased child was unresponsive. A neighbor called 911 and CPR was attempted. The child was declared dead at the scene.

Referral History

On January 29, 2008, a relative reported to Child Protective Services (CPS) intake that the mother was hospitalized for post-partum depression. The mother had thoughts about harming the children and herself. The relative received a phone call indicating the children were at a neighbor's house and that the mother was being hospitalized. The children were placed with relatives in Oregon.

The mother picked up the children and appeared to be under the influence of drugs. The mother did not have any information about receiving follow up services for the depression. The relative was concerned about the safety of the children. The deceased child's father was reportedly verbally and physically abusive to the mother. He used cocaine and supplied drugs to mother. He was also physically abusive to the children. The mother was involved with a domestic violence (DV) program and was not to have contact with the father of the children. However, she allowed him in the home. This referral was screened as information only.

On February 21, 2008, a CPS social worker from Oregon reported to Child Protective Services (CPS) intake that the deceased child's father was not allowed contact with the mother because of past domestic violence (DV). The deceased child's mother allowed the father to see the children, including the deceased child. The father has an extensive criminal history from gang activity to domestic violence for the past two years. He also possessed illegal weapons. There were concerns about the mother's mental health. She had been hospitalized for post-partum depression. The Oregon social worker attempted to contact the family, but was told by relatives they moved to Washington State. The mother moved into a domestic violence shelter but continued to have contact with the father. This referral was screened for Alternate Response.

On April 19, 2008, CPS received a report from the King County Medical Examiner's office that the four-month-old child had died. The mother explained that she had fallen asleep on the couch with the baby on her chest. When she awoke, the child was unresponsive. The baby was declared dead at the scene. This referral was accepted for investigation by CPS. The older children were sent by the mother to stay with relatives.

The medical examiner ruled the cause of death was Sudden Unexpected Infant Death (SUID). The manner of death is undetermined. The assigned CPS worker made collateral contacts with health care and early childhood education providers, as well as the DV advocate. Each provider consistently said that the mother and children were doing well, and that they had no concerns about her ability to raise her children. The investigation was closed as unfounded.

Issues and Recommendations

Issue: Changing a referral accepted for investigation to Information Only. The first referral had been screened for investigation. The supervisor made collateral contacts, and determined the family was residing in Oregon, where CPS was opening a case.

Recommendation: The preferred option would have been to close the case as unable to investigate (family moved out of state). Under the new computer system, FamLink (December 8), intakes cannot be changed once sent to a unit for investigation.

Issue: Downgrading the second referral from "accepted for investigation" to "low risk." The referrer was a CPS worker in the state of Oregon. Although his investigation was unfounded, he still made a referral to CPS in Washington, since the mother and children had returned here. Based on an encouraging collateral call with the mother's DV advocate, intake decided the referral could be downgraded to low risk.

Recommendation: It would have been better to have not downgraded this referral. It was made by a CPS worker. The DV advocate is trained to be very supportive to the mother. While this is good, the advocate's perspective may be just one point of view. The regional program manager will follow up with the intake unit about this referral.

Issue: Screening low risk referrals for disposition. A newly assigned supervisor's duties included reviewing all new referrals. The supervisor was unaware that the low risk referral had remained open to her.

Recommendation: The problem was corrected soon afterward by assigning a social worker who reviews all new low risk referrals. The social worker also meets with the public health nurse (PHN) who manages the Early Family Support Services program. This has worked very well in other offices in Region 4.

Issue: Responding to clients who have suffered severe grief and loss. It was very difficult to engage the mother. She was very hostile toward the social workers, who felt physically threatened by her.

Recommendation: CA should consider providing training to address ways of engaging clients who have suffered the loss of a child, or other trauma.

Issue: Collaboration with DV agencies. It would have been better for all if a staff person from the transitional housing facility had been available to be with the CPS workers and the mother. The workers were unaware that one was available and on call who could have responded. Law enforcement back-up would have been another option, considering the safety issues the workers encountered.

Recommendation: The King County Domestic Violence and Child Maltreatment oversight committee is developing a training plan for CPS and DV shelters, to be provided in the spring of 2009.

Child Fatality Review #08-17
Region 2
Klickitat County

This 14-month-old Caucasian female's died from compressional asphyxiation.

Case Overview
On June 11, 2008, the Klickitat County Coroner reported to Child Protective Services (CPS) intake the accidental death of this 14-month-old child. The child's mother reported she put the infant on her back in her crib to sleep. This infant shared a room with her three-year-old sister. The mother later went to check on the deceased child and found the three-year-old in the crib with several blankets covering the infant. The infant was blue and non-responsive. The mother called 911; medics responded but were unable to resuscitate the infant. The county coroner concluded this fatality appeared to be an accidental death. Law enforcement investigated and determined no crime or abuse or neglect was committed.

Referral History
On October 17, 2007, the deceased child's mother reported to CPS intake that her then two-year-old daughter (half-sibling to the deceased child) reported that her biological father touched her genitals. This sibling has regular, but limited contact with her father. The mother asked the father about their daughter's comment and he said he helped her use the toilet but never touched her private area. He later admitted to being sexually intimate with his girlfriend in front of his daughter. The mother is the primary caretaker of this child. This referral was screened as a low risk CPS referral.

On June 11, 2008, the Klickitat County Coroner reported to CPS intake the accidental death of this 14-month-old child. The coroner determined the manner of death was accidental. All indications are that the older child crawled into the deceased child's crib covering her with blankets and possibly sitting on her head, suffocating her. The immediate cause of death was listed as probable compression asphyxia. This referral was screened as information only.

Issues and Recommendations
Issue: None

Recommendation: None

Child Fatality Review #08-18
Region 5
Kitsap County

This seven-month-old Caucasian female died from positional asphyxiation.

Case Overview
On April 24, 2008 a Kitsap County Sheriff contacted Child Protective Services (CPS) intake to report the unexpected death of this seven-month-old infant. Law enforcement reported the deceased child's father called 911 after finding her blue, cold to the touch, and not breathing. Resuscitation efforts were attempted by adults in the home until emergency personnel arrived. The infant's mother said she fed the infant with a bottle and laid her down for a nap on her back. Approximately 45 minutes later she picked her up to changed her diaper and found her cold and stiff. There were two pillows at the head of the mattress and the infant was face down in between the pillows. The parents reported the child was able to roll from her back to her stomach. Law enforcement did not believe at the time that there were any indications of abuse or neglect. The family had been living in Kitsap County for approximately one month prior to the death of this child. The family previously lived in eastern Washington.

Referral History
On November 1, 2005, a doctor treating the deceased child's mother called Child Protective Services (CPS) intake to report concerns. The mother was 12 weeks pregnant and the doctor observed multiple bruises all over the mother's body. The mother repeatedly denied any physical or emotional abuse. This referral was screened as information only.

On January 1, 2008, CPS intake received an anonymous referral alleging the deceased child's parents left her and her older brother, then ages three months and 19 months, home alone for three hours. The parents gave a baby monitor to an intoxicated neighbor to monitor the children. The deceased children's parents returned at 3 a.m. The referrer insisted there was something wrong with the three-month-old. She appeared to shake constantly and seemed very thin. The referrer alleged this infant was not fed by her mother on a regular basis. The infant (the deceased child) vomited constantly. The referrer did not believe the mother sought medical attention for the baby. The referrer reported the infant was left in her car seat and cried herself to sleep. She was put in a darkened bedroom, in her car seat, for up to three hours, crying and screaming. The anonymous referrer also reported the house was full of cigarette butts and pop cans. The house was extremely cluttered with drug paraphernalia around. The referrer reported the deceased child's father was a drug user and was just out of prison for burglary. This referral was accepted for investigation for CPS. The social worker found the home clean and no sign of drug activity or alcohol consumption. The mother took the infant to the doctor for a well child check.

The doctor reported the child was not malnourished and her weight gain was within normal limits. This referral was closed with an unfounded finding.

On January 17, 2008, a relative called CPS intake to report the deceased child, then four-months-old, was malnourished and shook constantly. The referrer believed the shaking was drug related. The referrer stated the child was born with a low birth weight and was failing to thrive. The referrer said the mother smoked marijuana all the time and did so throughout her pregnancy. The mother was also alleged to use morphine, crank, and methamphetamine. The case was still open from the previous referral. The parents were fairly uncooperative with the social worker and would cooperate only when law enforcement was involved. The deceased child was seen by a doctor who determined she was gaining weight appropriately. This referral was closed with an unfounded finding.

Issues and Recommendations

Issue: Specific individuals were identified in the CPS investigation as possibly having more information regarding the allegation reported on January 1, 2008. The social worker did not contact those two individuals during the investigation.

Recommendation: Investigators should collect information and evidence from collateral and witness interviews.

Issue: The record does not reflect any shared decision making process prior to the case closure of the January 2008 referrals, including supervisory review.

Recommendation: Shared decision making occur prior to case closure or, at a minimum, at the supervisory review.

Child Fatality Review #08-19
Region 5
Pierce County

This four-month-old Caucasian male died from natural causes related to pneumonia.

Case Overview

On April 21, 2008, the deceased child's father found the infant in his crib pale, unresponsive, and with vomit on his face. Medics were contacted as the father attempted CPR. Upon arrival to the home medics intubated the infant and continued CPR en route to the hospital. The infant arrived at the hospital with no pulse. There were no observable signs of trauma. The infant was then transported to Mary Bridge Children's Hospital where he died. The medical examiner found no indication of child maltreatment. Both Child Protective Services (CPS) and local law enforcement investigated the circumstances surrounding this child's death. In addition, the Pierce County Medical Examiner determined that the cause of death was related to pneumonia, and the manner of death was declared to be natural.

Referral History

On April 10, 2008, a staff at a Women, Infants and Children nutritional program (WIC) program reported to Child Protective Services (CPS) intake that the deceased child, then four-months-old child, was not gaining enough weight. Additionally, his mother refused to feed him more often nor would she follow advice from the WIC dietitian to increase his food intake. This child was born premature weighing 3 pounds 9 ounces at birth. The referrer reported this baby was starving and his mother was overwhelmed by stress and financial difficulties.

This referral was initially screened out for investigation. There was on-going contact between CPS intake, the deceased child's primary care physician, WIC, and the Maternity Support Services provider. On April 22, 2008, the decision was made to screen in this referral for CPS investigation based on new information related to dietary and nutritional matters as well as a missed doctor's appointment. The child died the following day of natural causes related to pneumonia. Both CPS and law enforcement investigated and neither found evidence of child maltreatment leading to this child's death. The CPS investigation was closed as unfounded. No services were offered by the department to this family as the infant died prior to any contact by social workers.

Issues and Recommendations

Issue: Numerous community and medical providers were involved with this family prior to any reported concerns to CPS on April 10, 2008. A staff person with Women, Infants and Children nutritional program (WIC) reported concerns regarding feeding, nutritional and dietary issues, and inadequate weight gain of a four month-old-infant. A day prior to making the referral to CPS the WIC worker had faxed the client's High Risk Care Plan to

the child's doctor. The infant's growth charts were not transmitted. Following best practice, collateral contacts were made by the CPS intake worker with the primary care physician (PCP) office and the Maternity Support Services/Infant Care Management (MSS/ICM) provider. The concerns reported by the WIC staff person were not confirmed by the assessments of these other service providers.
The fact that different agencies working with the same parent and infant had differing perceptions of the child's health status made the screening decision difficult. The initial screening decision was to take the report as information only (sent to Early Intervention Program/Public Health Department) while the intake worker continued making contact with WIC and the MSS/ICM provider. On numerous occasions the information received at intake was reviewed at the supervisor level, and on April 21, 2008 the decision was made to accept the report for investigation based on new information related to dietary and nutritional matters as well as a missed (re-scheduled) doctor's appointment.

Based upon a review of records, including those from medical and community service providers, as well as on interviews conducted during the review, the panel concluded that the initial screen-out decision on April 11, 2008 appeared reasonable given the information provided at that time which included conflicting opinions about the infants health status and the mother's ability to care for the child. Overall the efforts made by the intake worker were assessed to be of excellent quality by the review participants, noting specifically the worker's documentation and her persistence in attempting to gather additional information from a variety of sources even days after the screen-out decision. The panel concluded that the decision made ten days later to screen-in the report based on new information was reasonable. As noted, the child died the following morning from pneumonia, and there was no post-mortem evidence of malnutrition or child maltreatment.

Recommendation: None
Actions Taken: The intake worker and intake supervisor were present during the review and received feedback regarding the intake decisions made.

Issue: Several practice issues surfaced during the child fatality review which provided an opportunity for discussions about improving practice for Region 5 intake as well as for the participating community providers in their collaborative role with CA.

Information from the dietician came second-hand to CPS intake through the WIC worker and a WIC supervisor, both of whom were limited in speaking to specific dietary issues and to expectations for weight gain for premature infants. The intake worker might have been more insistent with the referent in asking that the dietician contact intake directly. The delay in getting concrete statements from the dietician regarding insufficient weight gain by the infant as opposed to generalized concerns from second-hand sources might have been avoided.

While awaiting follow-up information from WIC, the CPS intake worker might have made use of medical consultation available from the CA Region 5 Child Abuse Medical Consultant.

During the fatality review questions were raised as to the reasonableness of requesting a law enforcement welfare check on a child who allegedly might be failing to thrive. The welfare check was conducted, apparently by an officer with some self-reported experience with premature infants, and he reported no concerns regarding the home environment, the caretakers, or the appearance of the baby. While child welfare check requests to law enforcement are commonly made by CA intake units across the state, such are usually done without knowledge of what training the responding officer has had regarding child maltreatment, child development, and/or child safety.

Recommendation: It is outside of the role of the review panel to make recommendations regarding practice improvements for agencies outside of Children's Administration. However, CA should continue to offer training and cross-training opportunities with private, community, and government agencies.

Action Taken: The Region 5 Child Abuse Medical Consultant recently conducted an in-service training with the local WIC program. Additionally, following this child fatality review, the MSS/ICM provider and WIC provider agreed to begin working on plans for a cross-training between their respective agencies.

Action Taken: The intake worker and intake supervisor were present during the child fatality review and received feedback suggestions for improving practice. The intake worker acknowledged awareness of access to the statewide child abuse Medical Consultant Network at the time of the intake. In March 2008, a month prior to this child's fatality, intake workers from Region 5 (Pierce and Kitsap Counties) met to discuss a variety of intake-related issues. At that time medical consultation resources available to intake workers were discussed, including contact information for the three CA child abuse medical consultants then servicing Western Washington. While the focus of the regional intake meeting was on physical injuries and medication/poisoning issues regarding infants and young children, additional topics for future intake training were discussed at that quarterly meeting.

Action Taken: Currently speakers from the local Child Advocacy Center/Child Abuse Intervention Department (CAC/CAID) have been scheduled to present to the Region 5 Intake Units on October 20, 2008. Additional cross-training with Mary Bridge Children's Hospital (MBCH) is in the planning stage, with the Regional Child Abuse Medical Consultant committing to provide training for regional intake staff on special needs infants and on newborn care, with a focus on health and safety. As part of the training plan, regional intake staff will visit the MBCH Neonatal Intensive Care Unit (NICU) in pairs over a period of several months.

Child Fatality Review #08-20
Region 5
Pierce County

This five-month-old Native American male died from complications from an enlarged heart.

Case Overview

On May 6, 2008, the deceased child was found unresponsive at the family home. Emergency medical technicians and local law enforcement were called and attempted to revive the child. This child was pronounced dead at home. Law enforcement and the medical examiner reported no obvious signs of maltreatment. The medical examiner declared the manner of death was undetermined and the cause of death was an enlargement of the heart. The child had an elevated level of diphenhydramine. Diphenhydramine is found in most common prescription and over-the-counter medications for allergy, fever, and colds. It is also found in medications for children. It is not clear if this medication, in the quantity found in his body, contributed to the death of this child. The manner of death is classified as undetermined.

This child was admitted to the Pediatric Interim Care Clinic (PICC) after birth because he was prenatally exposed to morphine. The case was monitored by state and Tribal social workers. He received aftercare from PICC after being discharged from the program. At the time of the child fatality review conducted on October 10, 2008, the cause and manner of death had not yet been determined.

Referral History

On December 21, 2007, a referral was made to Child Protective Services intake by hospital staff. It was reported the deceased child was born on December 19. His mother was prescribed morphine during her pregnancy in an attempt to ease her withdrawal from unprescribed Methadone. Both the mother and the deceased child had a positive urinalysis screen during labor for the prescribed morphine. The mother admitted to hospital staff that she used Percoset up until June 2007, when she discovered she was pregnant. She may also have used Ecstasy prior to June 2007. The mother received maternity support services during her pregnancy. The doctors were uncomfortable discharging the infant to the mother's care. However, the mother did not demonstrate any behaviors in the hospital that placed the infant at risk of harm. This referral was screened to Child Welfare Services. The mother and the deceased child received on going services. The deceased child was placed in his grandmother's care.

Issues and Recommendations

Issue: Regarding the referral dated December 21, 2007: The intake worker appears to have sought all information from the referrer necessary to make an informed screening decision.

The initial intake decision (screen out) appears to have been appropriate and followed CA Prenatal Policy (effective October 22, 2007). Although the mother was not known to be currently abusing substances, the information only (I/O) report was sent to the Public Health Department/Early Intervention Program (PHD/EIP) as a referral for community health nurse services. The report was also forwarded to the Economic Services Administration (ESA) for First Steps intervention. It is unknown whether the initial I/O referral was sent to the mother's tribe as required by CA policy, although it is known that the tribe was already involved and providing services.

Recommendation: It is known that CA has recently reviewed the legal implications of referring clients to non-DSHS programs such as PHD/EIP services following information only referrals. Such practice may violate rights of privacy in that the legal premise for sharing information is that the family is receiving services from CA, which would be questionable for a screened out referral not involving a family active with CA. It is recommended that a final determination of this matter be made prior to initiation of the new FamLink information management system in February 2009 if possible.

Issue: Regarding the referral dated December 21, 2007, revised screening: On December 24, 2007, CPS intake was notified that the hospital discharge plan was to transfer the infant to the Pediatric Interim Care Center (PICC) from the Mary Bridge Children's Hospital Neonatal Intensive Care Unit (NICU) due to escalating Finnegan scores which were indicative of withdrawal symptoms from morphine that the mother had been prescribed during pregnancy. The decision was made to upgrade the original screened out referral to accepted and then initially assigned under the CPS program.

The federal Child Abuse Prevention and Treatment Act (CAPTA) as amended by the Keeping Children and Families Safe Act (2003) requires licensed health care providers (physicians, physician assistants, nurse practitioners) to notify CPS of cases of newborns identified as being affected by illegal substance abuse. In this case the assessed drug affected status of the child was determined to be the result of morphine legally prescribed during her pregnancy and not from illegal substance abuse. Furthermore, the CA Prenatal Substance Abuse Policy defines substances (related to substance abuse and drug affected newborns) as including illegal drugs, abuse of alcohol, and abuse of prescribed medications. The CPS Referral Screening Examples published in 2007 by CA during statewide roll out for the CA Prenatal Substance Policy identifies situations where a newborn is believed to be affected by prescribed medication and what circumstances would lead to screening out or screening in such a report. In this case the drug affected status of the child was not the result of illegal drug use, use of alcohol, or prescription medication abuse. There were no allegations of abuse or neglect and no risk factors that suggested the infant was at imminent risk of harm. The decision not to take the referral under CPS (for either CPS investigation or Alternative Intervention) appears correct given the guidelines provided by CA.

Recommendation: None
Issue: Regarding the referral dated December 21, 2007, revised screening: The decision was made to channel the intake as a CWS request for services. CA policy states that referrals may come directly through intake for requests for placement of a child in cases where the request is not the direct result of a need for child protection due to abuse or neglect [see: CA Practice and Procedures Guide - Chapter 4000]. However, policy specifies that such requests for placement must come from parents or children. Intake services may, with the permission of the family, gather collateral information to make a decision regarding acceptance of the intake referral. As the placement request in this case did not derive from the parents directly or from someone on their behalf, it could be argued that the placement request from the hospital did not technically meet current CA policy.

The purpose of Child Welfare Services (CWS) intake is to determine whether the family's need for service is most appropriately addressed by the Division of Children and Family Services or by referral to another agency or family members. In this case a determination was made by medical professionals that the infant, due to the need to be weaned from morphine, required additional medical intervention available through a local Pediatric Interim Care Center. While the need for the infant to receive PICC services is recognized, the request for placement may have derived from the fact that access to PICC placement services largely comes via payment from DCFS. Accepting CWS placement requests based upon the need for payment is not consistent with CA criteria for CWS referrals.

Thus there appears to be a disconnection between policy and practice regarding CWS intake criteria. Evidence of inconsistency across the state may be found in the August 2008 state intake data that shows a disparity between regions for accepted CWS referrals. CWS intakes account for 1% of Region 5 referrals, and 5% of Region 3 referrals.

Recommendation: CA should consider reviewing CWS intake criteria (policy) and examine how it compares to actual practice around the state. At some reasonable point in time after FamLink implementation, CA should conduct a state review of CWS intake decisions

Action Taken: Within days of the reported death of the child the Regional Administrator requested an internal preliminary review of the case. The review was conducted by the Area Administrator for Family Voluntary Services (FVS) (Tacoma DCFS) in conjunction with the Tacoma CPS Area Administrator, the Regional Intake Area Administrator, and a Program Consultant with CA Headquarters. The preliminary review included a review of case documents, and interviews with the CPS supervisor, the FVS supervisor and the assigned FVS worker (in the presence of a union representative). Actions initiated from that preliminary review included:

(1) Reviewing the Prenatal Policy and the CWS intake services requirements with supervisors who assign CWS intake cases, including conducting family assessments. [Completed July 2008]

(2) Discussing with FVS supervisors prenatal substance abuse cases and developing ideas as to improving the quality of services. [Completed July 2008]

(3) Discussing at Regional Management Team prenatal substance abuse referrals that lack sufficiency for screening into CPS and where the family is not requesting CWS services but a professional involved with the family is requesting that CA open a case for services. [This occurred August 2008 with additional follow-up with CA HQ initiated]

Issue: Service Provision: The CWS case was initially assigned to a CPS Supervisor who had extensive experience with Indian Child Welfare (ICW) cases, particularly with regard to obtaining Voluntary Placement Agreements (VPA) for Native American children under the Indian Child Welfare Act ICWA). The assignment of a case to this supervisor appears to be due to the fact that there were no workers available who had familiarity with ICW casework and the VPA process required for Native American children. It is recognized that due to the rarity of the VPA process for Native American children, expertise and experience on the subject is limited to few social work staff and the expectation that all social workers would have ready knowledge may be unreasonable.

In review of the documentation, the supervisor did exceptional work in notifying all known and possible tribes connected with both the mother and alleged father of the child. Additionally the supervisor appears to have done exceptional work with the family, community, and tribes in obtaining a VPA and Court Certification for an Indian Child. All ICW requirements appear to have been met, and the quality of the ICW work and work done by the Tacoma DCFS Native American Identification Specialist appear to have been exceptional, including documentation.

During the fatality review the supervisor stated that when the case transferred to the Family Voluntary Services (FVS) worker, she had instructed the worker to monitor the case, to check on service provision (medical, PHN, WIC, substance abuse related services, tribal services) and to make sure the teen mother and her family were prepared for when the infant was discharged from PICC. The Service Episode Record (SER) was less descriptive in terms of the expectations at transfer. When interviewed by the review panel, the FVS worker confirmed the supervisor's recollection of case transfer instructions. The worker subsequently moved to a FVS unit under a new supervisor (February 2008). The case was closed by the FVS worker shortly after the child was discharged from PICC back into the mother's care and custody (March 2008), and the case remained inactive with the FVS supervisor for an additional month. The child died three weeks later. Several practice issues were identified during the review. The worker did not conduct any 30-day visits with the child as required by policy for a child in placement. The worker did not complete

a full family-focused case assessment to identify family strengths and problems [see CA Case Services Manual section 3220 and Practice and Procedures Guide section 4221]. Given the family history, the report of possible family conflict in the home, and persistent health issues with the infant, an additional visit when the child went home would have been expected practice. There is documentation showing that while communication occurred between involved entities (PICC, pediatrician, the mother's tribe, D/A counselor, family, FVS worker), there appeared to be a lack of coordination of information and a lack of case management. Best practice would suggest that a staffing with all involved parties might have occurred prior to the child returning home, although it is recognized that this case involved a CWS request for services for placement and not a situation involving child maltreatment.

The review panel discussed whether or not a Plan of Safe Care should have been developed. The federal Child Abuse Prevention and Treatment Act (CAPTA) as amended by the Keeping Children and Families Safe Act (2003) does require the development of a Plan of Safe Care for an infant born and identified as being affected by illegal substance abuse or withdrawal symptoms, and requires states to develop procedures for appropriate referrals of a child not at risk of imminent harm to a community organization or voluntary preventive service. The infant did apparently suffer withdrawal symptoms, although they stemmed from the mothers legally prescribed medication. It is noted that the CA Prenatal Substance Abuse Policy requires a Plan of Safe Care whenever a case is accepted for CPS investigation or Alternative Intervention. In this case the referral was accepted for CWS request for services and not CPS, therefore it is argued that a Plan of Safe Care would not have been required, although there would be no preclusion for doing one.

Recommendation: WORK PLAN: It is recommended that Region 5 develop an in-house specialized consultant team for cases identified as possible pre-chronic neglect cases and for cases involving young substance abusing mothers. Additionally, Region 5 should consider developing an in-house pool of peer-consultants with specialized expertise in areas such as domestic violence, substance abuse, chronic neglect, mental health, developmental delay, and various cultures/ethnicity. These individuals would be identified as resources for workers and supervisors in need of guidance in working with specific populations or specific family problems/needs.

Action Taken: CA provides ICW training annually in all regions and is available to all CA social workers. However, due to the rarity of the VPA process for Native American children, expertise and experience is limited to few social work staff in the Tacoma DCFS office. Discussion as to how this can be improved is on-going with some action already initiated or planned. A briefing paper for ICW cases has been developed by Region 5 which is available to social work staff and can be attached to any ICW referral. This fact sheet and other ICW related issues (such as the VPA process for an Indian Child) will be discussed at the next Region 5 Supervisors and Program Manager Meeting.

Action Taken: The CPS supervisor who handled the case prior to assignment to a FVS worker (post VPA) participated in the review and received feedback. The FVS supervisor was not available to participate in the review but had been given feedback previously following an earlier preliminary review initiated by the Regional Administrator. The FVS worker was interviewed by review panel members, but was not otherwise a participant and therefore did not receive any feedback on her practice at the time of the child fatality review.

Action Taken: In response to the discussions occurring during the fatality review, a Chemical Dependency Counselor working for the Tribal Community and Family Services offered to change procedures for UA testing for clients mutual to both the tribe and DCFS. The procedure will be to have primary urinalysis testing through the department, and secondary tests through the tribe. This is due to the fact that the Tribal urinalysis test results take longer for turn-around. Additionally, the Tribal Chemical Dependency Professionals (CDP) agreed to make an effort to send urinalysis results obtained through the tribe to DCFS social workers who are actively working with tribal members.

Action Taken: The CDPs out-stationed with Tacoma DCFS will continue to provide large and small training sessions on chemical dependency issues and share useful research and other information via electronic mail. For example, a recent e-mail posting from the CDPs reviewed the recommendation for workers to request a 10-panel drug test for clients who are methadone involved as lower panel tests do not capture the methadone metabolic.

Child Fatality Review #08-21
Region 5
Kitsap County

This 12-month-old Native American male died of Sudden Infant Death Syndrome (SIDS).

Case Overview
On June 6, 2008, the deceased child's father checked on him as he left for work at 6:00 a.m. The father touched his son's arm and found it cold the touch. The father called 911 and Emergency Medical Technicians (EMTs) arrived at 6:30 a.m. Both law enforcement and the county coroner were also called to the scene. The child was declared dead. The father's partner indicated she put the baby down in his playpen/crib the night before with his bottle. She reported to the medics that the baby usually slept through the night so she had not checked on him. The coroner determined cause of death was Sudden Unexplained Death in Infancy. There were no obvious signs of abuse or neglect or trauma found during the death scene investigation or during the autopsy.

The biological mother moved from Washington to Oklahoma. There were reports of neglect of the deceased child and his siblings while in her care in Oklahoma and Washington. Oklahoma Child Protective Services (CPS) completed an investigation following the birth of the deceased child. The mother admitted to prior use of methamphetamine, but denied current use. She admitted to smoking marijuana during her pregnancy. The father obtained custody of the deceased child and his siblings from their mother in February 2008. He and the four children lived together with his partner.

Referral History
On May 14, 2007, a relative reported to Child Protective Services (CPS) concerns about the deceased child and his siblings in the care of their biological mother. This relative reported the mother used marijuana and methamphetamine and did not care for the children. The mother used drugs and slept until after 1:00 in the afternoon. No one changed the 15-month-old's diaper. The mother did not obtain prenatal care. The parents separated and the father expressed concern for his children. This relative saw the mother smoking cigarettes and marijuana while holding her baby (the deceased child). The baby was hospitalized two months prior with double pneumonia. The mother was unwilling to accept help or parenting advice. The mother moved to Oklahoma on May 15, 2007. The CPS social worker met with the family prior to their move. The children were interviewed and made no disclosures of abuse. The mother was also interviewed. A referral was also made to CPS in Oklahoma with the same allegations. This referral was accepted for investigation and closed with an unfounded finding for negligent treatment.

On June 6, 2008, CPS intake was notified by the county coroner of the death of this 12-month-old child. The deceased child had a bad skin rash (eczema) all over his body which was being treated with medications. His siblings appeared healthy. They appeared bonded

to their father's live-in girlfriend. The deceased child appeared well fed and healthy. The county coroner found no signs of trauma. The home was messy, but there were no obvious health risks. The coroner did not find abuse concerns. This referral was accepted for investigation by CPS and closed with an unfounded finding for negligent treatment.

Issues and Recommendations
Issue: None identified

Recommendation: None

Child Fatality Review #08-22
Region 6
Mason County

This 15-year-old Caucasian female died of a drug overdose.

Case Overview
On May 20, 2008, this 15-year-old female was found dead in her home by her mother. Law enforcement arrived on the scene and found the youth on her back on a mattress on the floor. Law enforcement determined she had been dead for some time before they arrived at the home. Law enforcement found a prescription bottle next to her. The medication (Methylin) was prescribed for the youth's mother. Methylin is used for treating attention deficit disorder (ADD) and periods of daytime sleep (narcolepsy). The pills in the bottle were not Methylin according to the mother. A bent Coke can with a burn mark in the center, a broken pipe with burn residue and aluminum foil containing tobacco were located near the youth's body. The coroner was also on the scene and reported nothing seemed suspicious. An autopsy was performed and toxicology tests were conducted.

Referral History
On June 1, 2004, hospital staff reported to Child Protective Services (CPS) intake that on April 9, 2004, the deceased youth, then 11-years-old, was taken to a hospital following a suicide attempt where she swallowed a number of cold/allergy pills. The youth was in therapy but had only two sessions with a therapist. The youth's mother was reported to misuse prescription pills in the past. This referral was screened as information only.

On August 5, 2004, CPS intake was notified by school administrators that the deceased youth missed 48 days of school during the 2003-2004 academic year. The school was unable to file a Becca Bill petition against the mother because she wrote excused absence notes to each of these days. It was also reported that the mother may have a significant alcohol or substance abuse problem, although no details were provided to the department. This referral was screened as information only.

On October 8, 2004, the Department of Corrections contacted CPS intake and reported the mother of the deceased youth abused alcohol and methadone. The mother's paramour was on probation and was not allowed to consume alcoholic beverages. Department of Corrections staff tried to keep their client away from the deceased youth's mother due to her substance abuse issues. This referral was screened as information only.

On February 27, 2007, a relative reported to CPS intake on numerous occasions the deceased youth had attempted suicide. The first attempt was in 2005 and second incident was in December 2006. The deceased youth attempted suicide by taking prescription drugs. The referrer reported the youth had only marginal attendance at school. The youth was home-schooled, but the relative felt her mother did not meet any of the child's

academic needs. The relative also reported the mother lived with her parents in the main part of the house while her daughter lived in the mother-in-law apartment attached to the house. This apartment was filthy. This referral was screened as information only.

On March 1, 2007, a therapist reported to CPS intake that the deceased youth, then 14-years-old, was not participating in counseling services with her mother. The youth refused to answer questions and claimed she was forced to participate. The youth was physically assaultive toward her mother. The mother admitted to punching her daughter on the face and head. The referrer said the youth used drugs and alcohol and was sneaking boys into her separate apartment. The mother wanted the youth to live in the main house with her but the youth refused. The youth was not cooperating with any home-schooling. The mother was advised about pursuing an At-Risk Youth petition and engaging court intervention. The information in this referral was forwarded to law enforcement. This referral was screened for Family Reconciliation Services (FRS). FRS referrals are opened for services when one of the family members in conflict requests this service from Children's Administration (CA). In this referral, neither the mother nor the deceased youth made such request.

On March 6, 2007, a fireman reported to CPS intake his unit responded to a fire in the apartment occupied by the deceased youth. The referrer said the apartment was extremely cluttered with stacks of dirty clothes up to four feet high. The referrer was most concerned about the combustible materials in close proximity to space heaters and that the home smoke detectors were disconnected. The referrer called the interior of the apartment "a fire trap" and the mother was advised to take corrective measures. This referral was screened in for investigation by CPS. The CPS social worker's investigation revealed the youth was participating in mental health counseling and drug/alcohol treatment. The child denied active suicidal thoughts and said she was taking her antidepressant medications. The social worker offered Family Preservation Services (FPS) to the family and the mother initially accepted though did not respond to the FPS provider's attempts to contact her. Eventually the mother agreed to grant third party custody to a relative and the youth moved from the mother's home. The CPS case was closed with an inconclusive finding.

On April 3, 2007, it was reported to CPS intake that the deceased youth's mother was seen acting like she was going to hit the youth with a closed fist. It appeared as though the mother was unable to control her temper. The youth was not hit. The mother also called her daughter names and told her she had to walk home from a mall. This referral was screened as information only.

On November 27, 2007, a relative reported to CPS intake she took the youth in for an eye exam because the youth said she could not remember the last eye exam she had. She needed glasses. The youth reluctantly participated in a drug/alcohol aftercare program but refused to attend Alcoholic's Anonymous (AA) or Narcotic's Anonymous (NA) meetings. The relative stated the youth was being neglected by her mother in the past. Relatives had

third party custody of the youth, but she recently returned to her mother's care. The youth did not return to the separate apartment, rather she moved into the main house with her mother. This referral was screened as information only.

On November 28, 2007, a relative reported to CPS intake that the deceased youth returned to her mother's care after living with another relative for several months. The youth was asked to move from the relative's home due to behavioral problems. The referrer felt that Child Protective Services should re-open the case since the youth returned to her mother's care. This referral was screened as information only.

On February 13, 2008, a relative reported to CPS intake that the youth returned to her mother's care in November 2007 and her mother did not enroll her in school. It was also reported the mother had problems with narcotics or prescription drug misuse and did not participate in a recommended treatment program. The referrer added the deceased youth went to inpatient treatment on two occasions but exhibited little change in her behavior. The youth assaulted her mother. The mother was informed of the At-Risk Youth process. This referral was screened as information only.

On May 27, 2008, a Mason County newspaper reported the death of this youth. She was found in her home on the night of May 20, 2008 by her mother. An autopsy was conducted. It was determined this youth died of a drug overdose. This referral was screened as information only.

Issues and Recommendations

Issue: The fatality review team looked at the screening decisions for all nine referrals called in to CPS intake regarding the youth and her family. The team agreed with the screening decisions on all referrals except for the referral dated February 27, 2007. This referral was screened as information only and the team felt this referral should have screened in for investigation. However, a referral with similar allegations was called in to CPS intake seven days later (on March 6, 2007) that did meet the screening criteria for investigation.

Recommendation: None. The allegations were investigated during a referral screened in one week later. The Intake/CPS supervisor at the time of the 2007 intakes no longer works in this CA office. There is a new Intake/CPS supervisor in the office who closely reviews intake decisions and addresses issues with the intake workers when she disagrees with a decision made at intake.

Child Fatality Review #08-23
Region 6
Thurston County

This five-year-old Caucasian male drowned in a boating accident.

Case Overview
On June 12, 2008, the Thurston County Sheriff's Office reported a boating accident had occurred on the Nisqually River. Two children, the deceased child, age five and his nine-year-old brother, drowned. There were five occupants in the boat. The deceased child's mother and the driver of the boat made it to shore safely. The boyfriend of the deceased child's mother also drowned.

The five and nine-year-old boys and their mother along with her boyfriend were at the river when a man, unknown to the family, asked if they would like to go on a boat ride. The mother observed the man driving the boat had a beer in his hand and more beer in the boat. Despite this, they agreed to a ride in the boat. No one in the boat wore a personal flotation device. The driver of the boat drove the boat in reverse down the river. At some point the boat struck a jog jam causing the boat to capsize. All of the passengers in the boat were thrown overboard. The body of the deceased child was found later that evening. The body of his nine-year-old brother was found on June 30, 2008. The boat driver's blood alcohol level was .193. The coroner has ruled this death an accident however law enforcement charged the driver of the boat with homicide by watercraft. The driver later pled guilty to three counts of homicide by watercraft.

The fatality review was conducted as an executive child fatality review. Executive child fatality reviews are conducted whenever a child dies of apparent abuse or neglect and the family has an open case with the department or there have been services provided to the family in the previous 12 months. In this instance, there was an information only referral called in on the deceased child's mother approximately six weeks prior to the children's deaths.

Referral History
On April 28, 2008, law enforcement reported to Child Protective Service (CPS) intake an incident between the deceased child's mother and her boyfriend. The mother disclosed to law enforcement that she threw herself from her boyfriend's car and was bleeding from her head. The mother was intoxicated and had an argument with her boyfriend. The car was reportedly moving forty-five miles an hour when the incident occurred. The mother requested medics to treat her injuries. The police officer determined the boyfriend did not assault the mother or cause the alleged incident. None of her children were present during this incident. This referral was screened as Information Only.

On June 12, 2008, CPS intake received a report from law enforcement about the death of this five-year-old child. Law enforcement reported the family was involved in a boating accident on the Nisqually River. The person operating the boat was intoxicated. The boat capsized. This five-year-old, his older brother, and their mother's boyfriend all drowned. The operator of the boat was charged in their deaths. The children were not wearing life preservers. This referral was screened in for investigation by CPS of negligent treatment or maltreatment and closed with a founded finding.

Issues and Recommendations

Issue: The social worker assigned to this case did an excellent job investigating this case. She investigated the death of two children and provided support services to the mother, father and sister of the deceased children.

Recommendation: During the review the worker was commended for her work on this case.

Committee Members

- Kris Tweet-Goheen, Social Worker, Division of Children and Family Services (DCFS) Region 6
- Frank Odell, Supervisor, Division of Children and Family Services (DCFS) Region 6
- Edith Hitchings, Regional CPS Program Manager, Children's Administration Region 6 Headquarters
- Steve Fretts, Sergeant, Hoquiam Police Department

Child Fatality Review #08-24
Region 6
Thurston County

This nine-year-old Caucasian male drowned in a boating accident.

Case Overview
On June 12, 2008, the Thurston County Sheriff's Office reported a boating accident had occurred on the Nisqually River. Two children, the deceased child, age nine and his five-year-old brother drowned. There were five occupants in the boat. The deceased child's mother and the driver of the boat made it to shore safely. The boyfriend of the deceased child's mother also drowned.

The five and nine-year-old boys and their mother along with her boyfriend were at the river when a man, unknown to the family, asked if they would like to go on a boat ride. The mother observed the man driving the boat had a beer in his hand and more beer in the boat. Despite this, they agreed to a ride in the boat. No one in the boat wore a personal flotation device. The driver of the boat drove the boat in reverse down the river. At some point the boat struck a jog jam causing the boat to capsize. All of the passengers in the boat were thrown overboard. The body of the younger brother was found later that evening. The body of this nine-year-old was found in the river on June 30, 2008. The boat driver's blood alcohol level was .193. The coroner has ruled this death an accident, however, law enforcement charged the driver of the boat with homicide by watercraft. The driver later pled guilty to three counts of homicide by watercraft.

The fatality review was conducted as an executive child fatality review. Executive child fatality reviews are conducted whenever a child dies of apparent abuse or neglect and the family has an open case with the department or there has been services provided to the family in the previous 12 months. In this case, there was an information only referral called in on the deceased child's mother approximately six weeks prior to the children's deaths.

Referral History
On April 28, 2008, law enforcement reported to Child Protective Service (CPS) intake an incident between the deceased child's mother and her boyfriend. The mother disclosed to law enforcement that she threw herself from her boyfriend's car and was bleeding from her head. The mother was intoxicated and had an argument with her boyfriend. The car was reportedly moving forty-five miles an hour when the incident occurred. The mother requested medics to treat her injuries. The police officer determined the boyfriend did not assault the mother or cause the alleged incident. None of her children were present during this incident. This referral was screened as Information Only.

On June 12, 2008, CPS intake received a report from law enforcement about the death of this nine-year-old child and his brother. Law enforcement reported the family was involved

in a boating accident on the Nisqually River. The person operating the boat was intoxicated. The boat capsized. This nine-year-old, his younger brother, and their mother's boyfriend all drowned. The operator of the boat was charged in their deaths. The children were not wearing life preservers. This referral was screened in for investigation by CPS of negligent treatment or maltreatment and closed with a founded finding.

Issues and Recommendations

Issue: The social worker assigned to this case did an excellent job investigating this case. She investigated the death of two children and provided support services to the mother, father and sister of the deceased children.

Recommendation: During the review the worker was commended for exceptional work on this case.

Committee Members

- Kris Tweet-Goheen, Social Worker, Division of Children and Family Services (DCFS) Region 6
- Frank Odell, Supervisor, Division of Children and Family Services (DCFS) Region 6
- Edith Hitchings, Regional CPS Program Manager, Children's Administration Region 6 Headquarters
- Steve Fretts, Sergeant, Hoquiam Police Department

Child Fatality Review #08-25
Region 2
Walla Walla County

This 12-month-old Caucasian male died from respiratory arrest.

Case Overview
On June 6, 2008, the 14-year-old sister of this 12-month-old boy found him not breathing. Medics were called to the home and the child was taken to a local hospital where he was pronounced dead. The deceased child's mother reported he was suffering from medical conditions prior to his death. He had seizure-like symptoms, a cold, ear infection and the onset of pneumonia just prior to his death. Law enforcement was notified and investigated this fatality. Police reported no suspicious criminal activity involving the death of this child. According to the forensic pathology report the manner of death is undetermined. The cause of death is listed as respiratory arrest of unknown origin.

Referral History
On September 25, 1998, it was reported to Child Protective Services (CPS) intake that the deceased child's mother would leave his older sister (then age five) home with teenage babysitters for days. It was alleged the home was filthy and the mother was using drugs. This referral was screened to Alternate Response System (ARS).

On February 15, 2000, CPS intake received an anonymous referral alleging unspecified neglect of the deceased child's sister. This referral was screened as Information Only.

On February 22, 2000, law enforcement notified CPS intake they received a complaint that the deceased child's mother left her child home alone and did not leave sufficient food in the home. This referral was investigated by CPS and closed with an unfounded finding.

On June 19, 2006, CPS intake received an anonymous report of possible sexual abuse of the 12-year-old sister of the deceased child by their mother's boyfriend. The boyfriend did not live in the family home. This referral was screened out as a third party referral and the information was forwarded to Walla Walla Police for further investigation.

On April 25, 2008, the mother of the deceased child called CPS intake to request Family Reconciliation Services (FRS). The mother reported her teenage daughter, sister of the deceased child, was on a truancy petition, was sneaking out of the house, was verbally aggressive at home, and was physically aggressive with peers. The mother alleged drug use by her daughter. This referral was accepted for Family Reconciliation Services.

Issues and Recommendations
Issue: There were no issues or recommendations made by this review team.

Recommendation: None

Child Fatality Review #08-26
Region 5
Pierce County

This two-year-old Native American female died from an accumulation of fluid around her heart.

Case Overview

On June 3, 2008, a social worker went to the home of the deceased child to do a health and safety visit of this child. The child was returned to her parents' care a week earlier. The child was in foster care since her birth until one week before her death. She was placed in her parents' home on an in-home dependency.

The parents told the social worker the deceased child was not feeling well, sleeping more, and not eating much. The following day the mother contacted the child's former foster parent who came over to the family home. The child had an elevated temperature, leg swelling, and leg pain. The foster parent took the family to a hospital emergency room. The child had fluid around her heart and an enlarged liver. The child was transported to Mary Bridge Children's Hospital where she received surgery. While in the recovery room the child's blood pressure dropped and heart stopped. Attempts to revive her were unsuccessful. She passed away on June 4, 2008. The medical examiner indicated the death was related to a pericardial effusion (accumulation of fluid around the heart).

Referral History

On November 2, 1999, it was reported to Child Protective Services (CPS) intake the neglect of the, then five-year-old, brother of the deceased child. It was alleged the family home was very dirty and had a bad smell. This referral was screened as Information Only.

On June 6, 2000, CPS intake received second hand information that the then six-year-old brother of the deceased child was witnessing sex between his mother and stepfather. This referral was screened in for investigation by CPS and closed with no finding.

On August 26, 2005, CPS intake received information from hospital staff reporting the deceased child's mother was 22 weeks pregnant and tested positive for amphetamines and marijuana. There were no other concerns documented. It was unknown if she received regular prenatal care or any community resources. The doctor who treated her did not believe it was necessary to offer services. This referral was screened as Information Only.

On November 16, 2005, hospital staff reported to CPS intake that the deceased child was born prematurely on November 15, 2005. The mother tested positive for cocaine and admitted to her drug use. The child tested positive for amphetamines. The child was removed from the mother's care and placed in foster care. A dependency was established. The parents remained drug free and complied with all court orders. The child was

eventually returned to their care on an in-home dependency. This CPS investigation was closed with an inconclusive finding.

On June 5, 2008, a medical examiner called CPS intake to report the death of this two-year-old child. The medical examiner stated the child died from a mass of fluid that accumulated around her heart. Her mother had taken her to a hospital because the child had a fever and swelling in her legs. The child died in the hospital after undergoing surgery. There are no allegations of neglect by the mother. This referral was screened as Information Only.

Issues and Recommendations
Issue: None indicated

Recommendation: None

Child Fatality Review #08-27
Region 6
Cowlitz County

This three-month-old Caucasian female died from positional asphyxiation.

Case Overview
On June 3, 2008, law enforcement was dispatched to the family home of this deceased child on a report that she was not breathing. Officers attempted CPR. Officers spoke to the mother who said that she found her husband sleeping on the couch, her daughter lying on his body with her face toward his arm. The deceased child's mother pulled her from her husband and noticed that she was not breathing. She called 911. The coroner's report indicated that the cause of the child's death was probable positional asphyxia with the manner of death being undetermined.

The autopsy also revealed the child suffered a broken bone in her right arm. The child's father was seen handling her in a rough manner shortly after she was born. The police officer reported there are indications the child may have been abused.

The deceased child's father reported the broken arm when it occurred on May 31, 2008. He called 911 and reported he heard a "pop" when he shifted his daughter in his arms. Her arm became caught under his armpit, authorities said. The child was taken to a doctor for this injury. Doctors did not detect an injury at that time. According to the police report, the coroner said the broken arm could not have happened in the manner the father explained. The coroner determined the child's arm was broken on or around May 31st.

The father was later charged with first- and second-degree assault of a child. He has not been charged in the child's death. There is no indication this child's death was the result of abuse or neglect.

This is the second baby to die in this family. The couple's 34-day-old son died in January 2006 of Sudden Infant Death Syndrome.

Referral History
On March 13, 2008, staff at a hospital reported to Child Protective Services (CPS) intake concerns about the behavior of the father toward his newborn daughter (the deceased child). The referrer reported the father was seen feeding the deceased child and said, "Come on, just eat the food!" The father's affect at the time was impatient and not playful. The father handled the baby roughly. The child's mother told hospital staff she had a baby die of SIDS about one year prior. The parents had good family support at the hospital. The baby was fine medically. There was no suspicion of drug or alcohol use by either parent. The Women, Infants, and Children (WIC) program was already involved with this family.

The parents refused referrals to other local services. This referral was screened as Information Only.

On June 3, 2008, CPS intake received a report from law enforcement about the death of this child. There were no allegations of abuse or neglect reported. This referral was screened as Information Only.

On June 27, 2008, CPS intake received a report from law enforcement. During the autopsy, they found this child had a fractured arm that occurred three days prior to her death. The child was taken to the doctor for this injury, but the x-rays were taken incorrectly. After several interviews and gathering of evidence, police arrested the father for 2nd Degree Assault of a Child. There is no indication that this injury had a connection to this child's death. The investigation into this child's death continued. The medical examiner reported there was no indication that this injury was inflicted intentionally. This CPS investigation was closed with an inconclusive finding.

Issues and Recommendations
Issue: None indicated

Recommendation: None

Child Fatality Review #08-28
Region 1
Spokane County

This six-month-old Caucasian female died from hypoxic encephalopathy (a lack of oxygen to the brain).

Case Overview
On June 18, 2008, the father of the deceased child found her face down in her crib. She was not breathing. Her parents called 911 and were instructed how to perform CPR. The child was revived and taken to a local hospital. The treating doctor reported it appeared to be interrupted SIDS episode. He did not suspect neglect or abuse. The father said she was placed on her back when put to sleep, but found her on her stomach. Doctors did not seem to be concerned that the child's death was suspicious.

On June 20, 2008, the deceased child died from hypoxic encephalopathy (a lack of oxygen to the brain) due to cardio-respiratory arrest. There was no evidence of acute injury to the child. Posterior rib fractures were discovered during the autopsy. These fractures were aged between 4 to 8 weeks old. Law enforcement was consulted about investigating the fracture to the ribs. Law enforcement would not investigate unless the injury to the ribs contributed to the fatality. The medical examiner determined conclusively that the rib injury in no way contributed to the child's death.

The mother agreed to discuss the rib injury with the investigating social worker. The mother was surprised to learn of the injury. She stated that many adults including babysitters, relatives, and the child's parents all spent time alone with the child. Any of these individuals had opportunity to inflict the injury. The investigating social worker was unable to determine who fractured this child's rib. The father refused to cooperate with the investigation. He and the deceased child's mother ended their relationship.

Referral History
On April 24, 2008, an anonymous referent called Child Protective Services (CPS) intake and reported both parents smoke marijuana. This same source also reported that the baby appears healthy and well care for. This referral was screened as information only.

Issues and Recommendations
Issue: None identified

Recommendation: None

Child Fatality Review #08-29
Region 1
Asotin County

This 17-year-old Caucasian female died of a drug overdose.

Case Overview
On June 23, 2008, this deceased dependent youth went to a drug store before school, bought a bottle of Tylenol and swallowed 50 Tylenol tablets. She became ill and on the morning of June 24, 2008, she told her foster mother what she had done. The foster mother took the youth to the hospital emergency room. The youth was eventually transported to Harborview Hospital in Seattle. She died on June 30, 2008 as a result of the Tylenol overdose. Her death was ruled a suicide by the medical examiner.

This dependent youth was paralyzed from the chest down from injuries suffered in car accident in 2003. She made prior suicide attempts including overdosing on medications. She was in counseling and was admitted to the psychiatric ward at local hospitals. She threatened suicide in early June 2008. Her Division of Child and Family Services (DCFS) social worker made an immediate referral for her to be assessed by a County Designated Mental Health Professional (CDMHP). The CDMHP completed a safety plan with the youth in an attempt to avoid further suicidal ideation and suicide attempts. The youth committed suicide despite actions taken by the department and the CDMHP. The supervisor of the mental health agency was contacted and asked to participate in the child fatality review conducted by Children's Administration. The agency supervisor declined to participate and said the agency completed its own internal review of the child's case.

Referral History
On March 11, 2005, Child Protective Services (CPS) intake received a licensing complaint that the deceased youth's foster parents were investigated for possible fraud. There was concern that the deceased youth would have to leave this long term placement because of the investigation. This referral was screened as information only.

On April 10, 2006, the foster parents for the deceased youth reported to her assigned DCFS social worker that she accidentally spilled scalding water on her lap while attempting to pour some water for herself. The foster parents took her to the hospital and the youth had blisters on her thighs from the water. This referral was screened as information only.

On November 1, 2006, CPS intake received a report from school staff that another foster child in the home had bruising, scratches and a rug burn that were concerning to this educator. The foster parent had no explanation for these injuries. This referral was investigated by the Division of Licensed Resources/Child Protective Services section (DLR/CPS) and closed with an unfounded finding.

On February 24, 2007, CPS intake received an anonymous report that the foster home where the deceased youth was living had too many children. It was alleged there were seven children in the home, two of the foster children were disabled. Some of the children were seen running around the yard with no supervision. This referral was screened as information only.

On October 10, 2007, CPS intake received an anonymous report that the foster home where the deceased youth lived was over capacity. It was alleged there were seven children in the home, two of the foster children were disabled. Some of the children were seen running around the yard with no supervision. The deceased youth, then 16-years-old, was left to watch all the other children. This referral was investigated by DLR/CPS and closed with an unfounded finding.

On October 30, 2007, CPS intake received a report from another foster parent that the foster mother of the deceased youth was sharing confidential information about the deceased youth. This referral was screened as information only.

On November 21, 2007, CPS intake received a report from a social service professional working with the deceased youth. The deceased youth told the referrer she took too many of her pills at 6:00 p.m. the previous day. The deceased youth was evaluated by an on-duty CDMHP. She was later referred to a hospital in Spokane for evaluation because of her suicide threats. The foster mother set the youth's medications on the counter and allowed her to administer them herself. The foster mother agreed to stop giving medications this way. The deceased youth reported she had access to her medications which were left in an open drawer in the foster home. The youth said she also stabbed herself in the abdomen with a knife. She added her foster parents were unaware of the self inflicted knife wound. This referral was investigated by DLR/CPS and closed with an inconclusive finding.

On March 5, 2008, CPS intake received a report from a social service professional who reported finding the deceased youth, then 17-years-old, left home alone by her foster parents. The referrer was unsure how long the teen had been left home alone. The deceased youth was wheelchair bound and physically disabled. The referrer did not feel she should have been left home alone and unsupervised. This referral was screened as information only.

On April 29, 2008, CPS intake received a report from school staff that the nine-year-old son of the foster parents was caring of the deceased youth, then 17-years-old, and a 14-year-old special needs child. The nine-year-old was alleged to have kicked and hit the teens in his care. This referral was investigated by DLR/CPS and closed with an unfounded finding.

On June 24, 2008, the foster mother of the deceased youth called CPS intake to report she took the youth to the emergency room. The youth got sick at school. She told her foster

mother she went to a drug store before school and bought a bottle of Tylenol and took 50 pills. The deceased youth was allowed to leave the classroom and be unattended for short amounts of time. The youth died on June 30, 2008 after being transported to Harborview Hospital. This referral was investigated by DLR/CPS and closed with an unfounded finding.

Issues and Recommendations
Issue: None identified

Recommendation: None identified

Child Fatality Review #08-30
Region 3
Snohomish County

This 17-year-old Caucasian female died from injuries sustained in a motor vehicle accident.

Case Overview
On June 30, 2008, the deceased youth was driving her car and turning onto a busy highway in Snohomish County. Her car was struck broad-side by a motorcycle traveling at a high rate of speed. The force of the impact caused her car to roll over on its side. The deceased youth and a passenger were riding with her were transported to Harborview Medical Center. The deceased youth was pronounced dead at the hospital.

The youth was living with her grandmother at the time of her death. Her immediate family participated in an extensive array of services that were provided by the department over the years. The referral history on this family spans the years 1993 through 2007. Most of the early referrals concerned issues of parental drug use and neglect of the six children. Many of the more recent referrals relate to the serious behavior issues of a sibling of the deceased youth. The services provided by the department were aimed at maintaining this child in the home.

Referral History
On November 4, 2005, a mental health therapist called Child Protective Services (CPS) intake to report a family altercation in which the nine-year-old brother of the deceased youth, who had serious behavioral problems, had lost control and was throwing things. Several family members were scratched in this altercation. This referral was screened as information only.

On December 29, 2005, the mother called Child Protective Services (CPS) intake to request in-home services for her family. She reported her daughters had difficulty getting along with their brother, age nine. The brother was diagnosed as conduct disordered and was actively involved in services. This referral was accepted for Child Welfare Services (CWS).

On February 2, 2006, CPS intake received a report alleging the then six-year-old brother of the deceased youth received a minor injury when his mother threw him against a wall. The mother explained she reacted after her son jumped on her back from behind and bit her on the head. The injury was not serious. The referral was resolved with this explanation and the case remained open for services. This referral was screened as low risk.

On February 9, 2006, a referral was made to CPS intake alleging the then six-year-old brother of the deceased youth was seen with a slight injury above his eye. He told his

therapist his younger sister threw a shoe at him and it hit his eye. This referral was screened as information only.

On April 21, 2006, a referral was made to CPS intake by school staff who observed a two-inch long bruise on the deceased youth's brother's ribs. The boy said he got it when his father hit him on the head, knocking him into a chair. It was determined the injury was accidental and occurred while the father was attempting to separate two of the children who were fighting. This referral was screened in for investigation by CPS and closed with an inconclusive finding for physical abuse.

On October 25, 2006, school staff reported to CPS intake alleging the seven-year-old brother of the deceased youth said his aunt locked him into the shed at his home and nailed it shut. When interviewed, the boy did not confirm this to the social worker. This referral was screened in for investigation for negligent treatment or maltreatment and closed as unfounded. The family still had an open case under CWS.

On May 14, 2007, school staff reported to CPS intake alleging the eight-year-old brother of the deceased youth choked their six-year-old sister. There were no injuries. This referral was screened as information only.

On June 29, 2007, a referral was made to CPS intake alleging the mother of the deceased youth left her ten-year-old and five-year-old children alone in an alley while she was high on methamphetamine. It was also alleged she was a daily drug user and was transporting her children while under the influence. The mother denied drug use and this was confirmed by a negative urinalysis (UA). This referral was screened in for investigation for negligent treatment or maltreatment and closed as unfounded.

On July 8, 2007, hospital staff contacted CPS intake and reported the mother was pregnant with twins and had not received prenatal care. Her due date was November 13, 2008. The treating doctor noted the mother got out of detox three weeks prior. She was offered services from Women, Infant & Children (WIC) or a referral with a public health nurse, but she refused. The mother said she was homeless and living in her car. This referral was screened as information only.

On July 7, 2008, hospital staff contacted CPS intake and reported the mother of the deceased youth brought her six-year-old daughter to a local hospital for an exam. The child was out with a neighbor family and was not brought home until 2:00 a.m. The child's mother thought she might have been injured and took her to the hospital for an exam. No injuries were apparent, nor was there a disclosure of any child abuse or neglect by anyone. This referral was screened as information only.

On October 12, 2007 school staff reported to CPS intake the nine-year-old brother of the deceased youth came to school with a bruise above his right eye. The boy said he was

having a tantrum and his father attempted to grab him by the ankle. The boy pulled his legs into his chest and in doing so hit himself in the eye with his own knee. This referral was screened for the Alternate Response System (ARS).

On June 30, 2008, law enforcement reported the deceased youth was killed in an accident in which her car was struck by a speeding motorcycle. No abuse or neglect was alleged in this accident. This referral was screened as information only.

Issues and Recommendations
Issue: None identified

Recommendation: In review of the file and discussion of activity on this case some of the areas explored were attention to child safety, staffings, supervisory overview, appropriate screening of referrals, timely responses, engagement of the family in services, and adequate and effective monitoring of services. No issues or concerns as to policy or practice were identified in any of the areas addressed.

Child Fatality Review #08-31
Region 2
Yakima County

This one-day-old Caucasian male died shortly after being born prematurely. He and his twin brother were born at 21 weeks gestation.

Case Overview
NOTE: this report is a duplicate of report # 08-32.
On July 10, 2008, the mother of the deceased child gave birth to twin boys at 21 weeks gestation. Earlier that day she was at the hospital with complications during her pregnancy. She left the hospital against medical advice before seeing a doctor. She later returned to the hospital after her water broke. She admitted she had been spotting blood on and off for the previous three days. She had no prenatal care. She tested positive for methamphetamines. The mother insisted on proceeding with the delivery of her babies. Doctors talked with her so that she would understand the risks of a premature birth. She was encouraged to continue with her pregnancy and deliver closer to viability. It was explained to the mother that if her children were delivered nothing would be done except administer antibiotics. She was told that resuscitation would not be appropriate for fetuses of this gestational age.

The twins were delivered and died later that day. This information was forwarded to Yakima Police Department and the Yakima County prosecutor for their review and consideration of criminal charges.

This mother also had a premature delivery in 2007. This child also died shortly after delivery. The mother's toxicology screen was positive for six illegal substances. She refused medications that would slow her labor knowing this child would not survive if born. Hospital staff reported she showed no remorse about the death of this baby. This mother has given birth to seven children. Three of these children, including the twins referenced in this report, were born drug exposed and died prematurely. Two of the children are being raised by their father. Her parental rights to the other two children were terminated and they have been adopted.

This mother has an extensive history with the department. There are at least eight documented attempts by Children's Administration social workers to get her to complete drug/alcohol evaluations or enter and complete inpatient treatment starting in 2000. She did participate in some evaluations, but never completed inpatient treatment. In 2006, she was again referred for a drug/alcohol evaluation, but failed to show for the scheduled appointment.

Referral History

On June 24, 2003, a hospital social worker called Child Protective Services (CPS) intake to report the mother of the deceased children was 29 weeks pregnant and tested positive for marijuana. This referral was screened as information only.

On September 14, 2003, a hospital social worker called CPS intake to report the mother of the deceased children delivered a baby on this date and tested positive for marijuana and opiates. The mother admitted smoking marijuana. This baby was born in good health and delivered at full term. The mother received prenatal care. This referral was screened in for investigation by CPS and closed with a founded finding for negligent treatment or maltreatment. The department opened a case on this family at the time of the child's birth. Services were offered and eventually the department removed this child from the mother's care. The mother's rights were eventually terminated and this child was adopted.

On March 29, 2004, CPS intake received a report from a DSHS Community Services Office alleging the mother of the deceased children had a nervous breakdown or may have been using drugs. The mother had her then six-month-old daughter in her care. The department had an open case on the family and was providing services and case monitoring. This referral was screened as information only.

On May 27, 2004, a referral was made to CPS intake alleging the eight-month-old sister of the deceased twins was being left in a car seat with a bottle propped in her mouth. It was further alleged that drug users were in and out of the home and both parents were active drug users. This case was already open to CPS. This child was placed in foster care. This referral was screened as information only.

On August 11, 2006, a referral was made to CPS intake by a doctor seeing the mother of the deceased children for prenatal care. The mother did not show for prenatal appointments. The doctor reported 16 documented visits to hospitals seeking drugs. On this date the mother arrived at a hospital in full labor. The mother was going to leave against medical advice until the doctor convinced her to stay. Her baby was born at 35 weeks gestation. The mother had a positive drug screen and said she wanted to relinquish the baby. This was her fourth child. The doctor felt it was unsafe to discharge the baby to the mother. This referral was screened in for investigation by CPS and closed with a founded finding for negligent treatment or maltreatment. The child was discharged to the care of foster parents and never placed in the mother's care. A dependency petition was filed and the mother's parental rights to this child were later terminated.

On June 23, 2007, a referral was made to CPS intake alleging the mother of the deceased children arrived at an emergency room on this date. She was 15 weeks pregnant and was bleeding and had painful cramps. The mother was drug tested and found to be positive for amphetamine, benzodiazapines and canabinoids. The mother was abusive to hospital staff when told she would not get anymore pain medication. She left the hospital against

medical advice. Nurses said the fetus' heart beat was quite a bit faster than is considered within normal range. By this time the mother had four children, but none lived with her. This referral was screened as information only.

On August 22, 2007, CPS intake received a report from staff at a Klickitat County hospital. Staff reported the mother of the deceased children came to the hospital on this date due to complications in her pregnancy. She told hospital staff she was four months pregnant and had received no prenatal care. She tested positive for amphetamines, methamphetamine, opiates, benzo-diazapines, marijuana, and anti-depressants. The mother refused treatment for a urinary tract infection. The mother told hospital staff she would most likely kill her baby because of her lifestyle. The referrer was concerned not only because of the unborn child but also because the mother said she has her youngest child living with her, which was not true. She went into labor later that same day and refused treatment to delay the delivery of her child. The child was born and died the same day. Hospital staff reported the mother's drug use contributed to his premature delivery and death. This referral was screened in for investigation by CPS and closed with a founded finding for negligent treatment or maltreatment.

On May 8, 2008, a worker from a DSHS Community Service Office reported the mother of the deceased children was pregnant with twins and has extensive CPS and drug histories. This referral was screened as information only.

On June 16, 2008, hospital staff contacted CPS intake and reported the mother was pregnant with twins and not receiving prenatal care. Her due date was November 13, 2008. The treating doctor noted the mother had gotten out of detox three weeks prior. She was offered services such as WIC or a referral with a public health nurse, but she refused. The mother said she was homeless and living in her car. This referral was screened as information only.

On July 7, 2008, hospital staff contacted CPS intake and reported the mother of the deceased children was admitted on July 5, 2008 and tested positive for methamphetamine. She was treated for an abruption of the placenta. The mother was described as a "frequent flyer" in hospital emergency rooms. She was seen at the hospital about 30 times within the past two years. She had little or no prenatal care, except for what was given to her during hospital visits. Her due date was November 13, 2008. This referral was screened as information only.

On July 15, 2008, hospital staff contacted CPS intake to report the mother gave birth to twin boys at 21 weeks gestation. Earlier that day the mother was in the hospital with complaints of spotting, however left the hospital against medical advice before seeing a doctor. She later returned to the hospital after her water broke. She had no prenatal care and tested positive for amphetamines/methamphetamines. The mother declined treatment

to stop the delivery of her twins. The twins were delivered and both are deceased. This referral was screened as information only.

Issues and Recommendations

Issue: Children's Administration intake was not notified by hospital staff when the mother delivered the twins. A referral was generated by a DCFS staff co-located at the hospital six days after the babies were born.

Recommendation: The Region 2 Area Administrator (and other staff) will meet with hospital administrators to discuss mandatory reporting laws. This meeting will take place the first quarter of 2009.

Issue: There is a deep concern over the mother's mental health condition. She has had repeated pregnancies in which she has delivered prematurely due to substance abuse. The callous behavior and statements made are extremely concerning. She has made statements to her friends and hospital staff that she does not care if her babies live or die.

Recommendation: The Region 2 Area Administrator (and other staff) will meet with hospital administrators to discuss possible voluntary/involuntary mental health assessment and or additional resources for the mother in the event she re-admits with another medical condition or unplanned pregnancy. This meeting will take place the first quarter of 2009.

Child Fatality Review #08-32
Region 2
Yakima County

This one-day-old Caucasian male died shortly after being born prematurely. He and his twin brother were born at 21 weeks gestation.

Case Overview
NOTE: this report is a duplicate of report # 08-31.
On July 10, 2008, the mother of the deceased child gave birth to twin boys at 21 weeks gestation. Earlier that day she was at the hospital with complications during her pregnancy. She left the hospital against medical advice before seeing a doctor. She later returned to the hospital after her water broke. She admitted she had been spotting blood on and off for the previous three days. She had no prenatal care. She tested positive for methamphetamines. The mother insisted on proceeding with the delivery of her babies. Doctors talked with her so that she would understand the risks of a premature birth. She was encouraged to continue with her pregnancy and deliver closer to viability. It was explained to the mother that if her children were delivered nothing would be done except administer antibiotics. She was told that resuscitation would not be appropriate for fetuses of this gestational age.

The twins were delivered and died later that day. This information was forwarded to Yakima Police Department and the Yakima County prosecutor for their review and consideration of criminal charges.

This mother also had a premature delivery in 2007. This child also died shortly after delivery. The mother's toxicology screen was positive for six illegal substances. She refused medications that would slow her labor knowing this child would not survive if born. Hospital staff reported she showed no remorse about the death of this baby. This mother has given birth to seven children. Three of these children, including the twins referenced in this report, were born drug exposed and died prematurely. Two of the children are being raised by their father. Her parental rights to the other two children were terminated and they have been adopted.

This mother has an extensive history with the department. There are at least eight documented attempts by Children's Administration social workers to get her to complete drug/alcohol evaluations or enter and complete inpatient treatment starting in 2000. She did participate in some evaluations, but never completed inpatient treatment. In 2006, she was again referred for a drug/alcohol evaluation, but failed to show for the scheduled appointment.

Referral History

On June 24, 2003, a hospital social worker called Child Protective Services (CPS) intake to report the mother of the deceased children was 29 weeks pregnant and tested positive for marijuana. This referral was screened as information only.

On September 14, 2003, a hospital social worker called CPS intake to report the mother of the deceased children delivered a baby on this date and tested positive for marijuana and opiates. The mother admitted smoking marijuana. This baby was born in good health and delivered at full term. The mother received prenatal care. This referral was screened in for investigation by CPS and closed with a founded finding for negligent treatment or maltreatment. The department opened a case on this family at the time of the child's birth. Services were offered and eventually the department removed this child from the mother's care. The mother's rights were eventually terminated and this child was adopted.

On March 29, 2004, CPS intake received a report from a DSHS Community Services Office alleging the mother of the deceased children had a nervous breakdown or may have been using drugs. The mother had her then six-month-old daughter in her care. The department had an open case on the family and was providing services and case monitoring. This referral was screened as information only.

On May 27, 2004, a referral was made to CPS intake alleging the eight-month-old sister of the deceased twins was being left in a car seat with a bottle propped in her mouth. It was further alleged that drug users were in and out of the home and both parents were active drug users. This case was already open to CPS. This child was placed in foster care. This referral was screened as information only.

On August 11, 2006, a referral was made to CPS intake by a doctor seeing the mother of the deceased children for prenatal care. The mother did not show for prenatal appointments. The doctor reported 16 documented visits to hospitals seeking drugs. On this date the mother arrived at a hospital in full labor. The mother was going to leave against medical advice until the doctor convinced her to stay. Her baby was born at 35 weeks gestation. The mother had a positive drug screen and said she wanted to relinquish the baby. This was her fourth child. The doctor felt it was unsafe to discharge the baby to the mother. This referral was screened in for investigation by CPS and closed with a founded finding for negligent treatment or maltreatment. The child was discharged to the care of foster parents and never placed in the mother's care. A dependency petition was filed and the mother's parental rights to this child were later terminated.

On June 23, 2007, a referral was made to CPS intake alleging the mother of the deceased children arrived at an emergency room on this date. She was 15 weeks pregnant and was bleeding and had painful cramps. The mother was drug tested and found to be positive for amphetamine, benzodiazapines and canabinoids. The mother was abusive to hospital staff when told she would not get anymore pain medication. She left the hospital against

medical advice. Nurses said the fetus' heart beat was quite a bit faster than is considered within normal range. By this time the mother had four children, but none lived with her. This referral was screened as information only.

On August 22, 2007, CPS intake received a report from staff at a Klickitat County hospital. Staff reported the mother of the deceased children came to the hospital on this date due to complications in her pregnancy. She told hospital staff she was four months pregnant and had received no prenatal care. She tested positive for amphetamines, methamphetamine, opiates, benzo-diazapines, marijuana, and anti-depressants. The mother refused treatment for a urinary tract infection. The mother told hospital staff she would most likely kill her baby because of her lifestyle. The referrer was concerned not only because of the unborn child but also because the mother said she has her youngest child living with her, which was not true. She went into labor later that same day and refused treatment to delay the delivery of her child. The child was born and died the same day. Hospital staff reported the mother's drug use contributed to his premature delivery and death. This referral was screened in for investigation by CPS and closed with a founded finding for negligent treatment or maltreatment.

On May 8, 2008, a worker from a DSHS Community Service Office reported the mother of the deceased children was pregnant with twins and has extensive CPS and drug histories. This referral was screened as information only.

On June 16, 2008, hospital staff contacted CPS intake and reported the mother was pregnant with twins and not receiving prenatal care. Her due date was November 13, 2008. The treating doctor noted the mother had gotten out of detox three weeks prior. She was offered services such as WIC or a referral with a public health nurse, but she refused. The mother said she was homeless and living in her car. This referral was screened as information only.

On July 7, 2008, hospital staff contacted CPS intake and reported the mother of the deceased children was admitted on July 5, 2008 and tested positive for methamphetamine. She was treated for an abruption of the placenta. The mother was described as a "frequent flyer" in hospital emergency rooms. She was seen at the hospital about 30 times within the past two years. She had little or no prenatal care, except for what was given to her during hospital visits. Her due date was November 13, 2008. This referral was screened as information only.

On July 15, 2008, hospital staff contacted CPS intake to report the mother gave birth to twin boys at 21 weeks gestation. Earlier that day the mother was in the hospital with complaints of spotting, however left the hospital against medical advice before seeing a doctor. She later returned to the hospital after her water broke. She had no prenatal care and tested positive for amphetamines/methamphetamines. The mother declined treatment

to stop the delivery of her twins. The twins were delivered and both are deceased. This referral was screened as information only.

Issues and Recommendations

Issue: Children's Administration intake was not notified by hospital staff when the mother delivered the twins. A referral was generated by a DCFS staff co-located at the hospital six days after the babies were born.

Recommendation: The Region 2 Area Administrator (and other staff) will meet with hospital administrators to discuss mandatory reporting laws. This meeting will take place the first quarter of 2009.

Issue: There is a deep concern over the mother's mental health condition. She has had repeated pregnancies in which she has delivered prematurely due to substance abuse. The callous behavior and statements made are extremely concerning. She has made statements to her friends and hospital staff that she does not care if her babies live or die.

Recommendation: The Region 2 Area Administrator (and other staff) will meet with hospital administrators to discuss possible voluntary/involuntary mental health assessment and or additional resources for the mother in the event she re-admits with another medical condition or unplanned pregnancy. This meeting will take place the first quarter of 2009.

Child Fatality Review #08-33
Region 2
Yakima County

This 17-year-old Hispanic female died from a gunshot wound.

Case Overview
On July 4, 2008, the body of the deceased youth was discovered floating in a Yakima County irrigation ditch. Her death was ruled a homicide. According to the autopsy report, she suffered a single shotgun wound to her chest. Her identity was not immediately known. On July 24, 2008, dental records were used by the coroner's office to confirm her identity. The deceased youth was reported as a runaway on May 27, 2008 by Grandview Police.

Referral History
On January 19, 2007, the mother of the deceased youth called Child Protective Services (CPS) intake to request Family Reconciliation Services (FRS) services. The mother reported the deceased youth was gang affiliated, had a history of using drugs and mental health issues. The mother was scared to send her to school due to gangs being upset with her and possible retaliation. FRS was not offered to the family due to mother not making contact with DCFS after repeated attempts by social workers to schedule an appointment.

On July 30, 2007, CPS intake received a report that the deceased youth disclosed during a counseling session that she had been raped on two different occasions by two different men who were not household members. This information was forwarded to law enforcement for follow up investigation. The referral was screened out as a third party referral.

Issues and Recommendations
Issue: None

Recommendation: None

Child Fatality Review #08-34
Region 6
Lewis County

This nine-year-old Caucasian male died in a car accident.

Case Overview
On July 26, 2008, the deceased child was riding in a loaded dump truck driven by his father. The child and his father were on a forest road when the truck's brakes failed to slow the truck enough to negotiate a turn. The vehicle rolled over and came to rest on the passenger side. The child died from massive head injuries. The child was wearing a seat belt at the time of the accident. No child abuse or neglect was suspected; no drug or alcohol use was detected by investigating law enforcement officers.

Referral History
On October 24, 2003, allegations of sexual abuse were reported to Child Protective Services (CPS) intake. The then 11-year-old sister of the deceased child reported to a friend that her father touched her breast while helping her bathe. The girl also alleged physical abuse. CPS social workers and law enforcement investigated. The girl denied the abuse. This referral was closed with an unfounded finding.

On January 16, 2008, law enforcement reported to CPS intake the arrest of the deceased child's father for assaulting his 15-year-old daughter. The teen had bruising across her legs and on her hand from being struck with a board. The father admitted to the abuse. The deceased child, then nine-years-old, was placed in the care of his mother. His sister was placed with relatives. A protection plan was put in place and the children were returned home. The father agreed to services. This referral was closed with a founded finding for physical abuse.

On July 29, 2008, CPS intake received a report of this nine-year-old boy being killed in a motor vehicle accident. Law enforcement determined the father was not negligent. The referral was screened as information only.

Issues and Recommendations
Issue: None

Recommendation: None

Child Fatality Review #08-35
Region 5
Pierce County

This two-year-old medically fragile Caucasian male died after accidentally pulling out his tracheotomy tube.

Case Overview

On June 13, 2008, this two-year-old child accidentally disconnected his tracheotomy (trache) tube, losing his ability to breathe. At the time of his death, he was in a voluntary placement at Ashley House (Brown's Point) through the Division of Developmental Disabilities (DDD). Ashley House is a licensed group home specializing in the care of medically fragile children. The deceased child had severe disabilities and was considered medically fragile. Ashley House staff reported he often pulled out his trache tube which was difficult to re-insert as the child had scar tissue growth around the incision. The nurse attending to the child had finished giving him a bath and left the room to prepare his meal. The child's monitoring alarm was disconnected. The nurse estimated she was out of the room less than five minutes when she returned and found his trache tube underneath him. Unable to re-insert the trache tube, staff initiated artificial breathing and administered CPR until emergency medical technicians (EMTs) arrived on scene. The EMTs were also unable to re-insert the trache tube and initiated intubation with difficulty. The deceased child was transported to Mary Bridge Hospital where he was declared dead.

The medical examiner was notified but declined to conduct any post-mortem review of the death of this medically intensive child. The child had multiple medical issues and although his death was not expected at the time it occurred, his condition was deteriorating and his death was anticipated and imminent.

The Division of Licensed Resources (DLR) declined to accept for investigation the fatality notification due to insufficient allegations regarding lack of supervision by facility staff. The notification regarding the child fatality was routed to the DLR licensor who conducted a licensing investigation and concluded that staff carried out their duties within the parameters of agency protocol and procedure. There were no valid licensing complaint issues.

Information gathered post-fatality suggests that the child accidentally disconnected his trache, lost consciousness from loss of airflow, and due to the closure of his airway hole (related to extensive scar tissue), nursing staff and emergency responders were unable to re-insert the trache tube.

Death certificate information obtained from the Department of Health (DOH) in mid-November 2008 shows the child died from cardiac arrest secondary to respiratory failure. Manner of death is listed as natural.

Referral History

On November 16, 2005, a hospital social worker and staff from Ashley House called Child Protective Services (CPS) intake concerned about the deceased child, then two-months-old. He suffered from Saethre-Chozen Syndrome, a genetic disorder. He had multiple facial anomalies, a feeding tube, colostomy and required oxygen. He could not manage his secretions. The referrers requested placement at Ashley House until the parents were competent to care for him. The parents were homeless. This referral was accepted for Child Welfare Services (CWS).

On January 11, 2006, a hospital social worker called CPS intake and reported a doctor put the deceased child on a medical hold because he had respiratory problems and required immediate treatment at Children's Hospital. The parents were unable to give consent as their whereabouts were unknown at the time. Ashley House staff had no contact with the child's mother since January 4, 2006. The deceased child's parents were homeless. This referral was screened as low risk CPS.

On April 27, 2006, a hospital social worker called CPS intake and reported the deceased child, then seven-months-old, needed an evaluation of his skull in preparation for surgery. The child had to be sedated for the evaluation and the hospital needed parental consent. The parents could not be located to give consent. The child was taken to a cranio-facial clinic on April 10, 2006 by a nurse from Ashley House. The parents did not show to the appointment. This family had an open case in the Tacoma DCFS office. This referral was screened as information only.

On February 5, 2007, a referral was made to CPS intake by a staff at Ashley House. A former employee (fired by Ashley House) alleged concern about the care of children at the facility. This former employee alleged another employee put the deceased child's trache tube back in after it become entangled in toys. It was also alleged this same staff was not careful in handling a child with a bone condition. It was alleged this may have contributed to this child's fractures. This referral was screened in for investigation by the Division of Licensed Resources, CPS unit (DLR/CPS) and closed with an unfounded finding for negligent treatment or maltreatment.

On March 13, 2007, a referral was made to CPS intake alleging staff at Ashley House wanted to send the deceased child home. Ashley House staff were unable to work toward this goal as his parents did not cooperate in training and did not come to visit him. The parents were not available to consent to medical care. The deceased child was seen for outpatient treatment, but could not have any type of potentially risky treatment as his parents were not available to consent. The parents did not attend medical appointments. They were given assistance with transportation. This referral was screened in for investigation by CPS and closed with an unfounded finding for negligent treatment or maltreatment.

On June 13, 2008, CPS intake received a report the deceased child died earlier this day. The child lost his airway after he pulled out his trache tube. CPR was administered and 911 called. He was sent to Mary Bridge via ambulance. Mary Bridge staff contacted the medical examiner who declined to review the death. The child was an active two-year-old who pulled on his trache tube. The nurse had just finished giving him a bath and his medications. The nurse returned from preparing his meal and found the trache underneath him. The nurse was out of the room not more than five minutes. This referral was screened as information only.

Issues and Recommendations

Issue: Fatality Notification Intake dated June 13, 2008: Notification to CA intake of the child fatality was initially screened out and referred to licensing as a Licensing Complaint (Non-CPS). The intake decision was amended the same day following supervisory reviews and assigned to DLR/CPS for investigation. The basis for this upgrade of the intake appears to be based on possible lack of supervision given the child's history of previous decannulations and being left briefly unattended at the time of the initiating event.

A DLR/CPS worker was assigned to the case on Monday, June 16, 2008. However, it appears that prior to any investigative activity other than the DLR/CPS worker leaving a voice mail message for the Brown's Point Ashley House Program Services Director, the intake was again amended, screened out, and re-referred to licensing as a Licensing Complaint (Non-CPS). The Region 5 DLR/CPS Supervisor documented the intake decision change the following day, based on information provided to her by the Regional DLR Area Manager who had consulted with CA DLR Deputy Administrator who reports having discussed the incident with CA Critical Incident/Risk Management. The basis for the amended screening decision was documented as "the allegations do not rise to the level of CA/N." It is not unusual for Region 5 DLR to amend decisions made by CA intake, and more often than not the basis for change is sufficiently documented with supporting information. In this case the basis for change appears to be minimally documented.

The review panel was unable to reach full consensus regarding the final screening decision. Based on information available at the time of the intake, the fatality referral could arguably have remained assigned to DLR/CPS rather than screened out and re-referred back to licensing. However, the decision to screen out for DLR/CPS and refer the matter to licensing was also deemed to be a supportable resolution.

When the facility licensor later obtained more details regarding the circumstances surrounding the child fatality, additional consultation with the DLR/CPS supervisor and Regional DLR Area Manager might have been considered. The critical additional piece of information obtained by the licensor was that the child had been left in the room without reconnection to his alarm which would have alerted staff to a problem.

However, it is noted that while decannulation was the precipitating event, the death appears to be the result of an inability to re-insert the trache tube due extensive scar tissue collapsing the child's airway. It is not recommended that DLR open an investigation at this point.

Recommendation: None

Action Taken: The Regional DLR Area Manager and the Region 5 DLR/CPS supervisor participated in the child fatality review and received feedback regarding the lack of written clarity as to the basis for screening out to licensing the fatality notification report. Additionally, following the panel review, the DLR Deputy Administrator was briefed on the panel review discussion surrounding the intake decision process. While such deficiency appears to be an anomaly, the importance of clear documentation was acknowledged by all involved.

Action Taken: The DLR facility licensor participated in the review and acknowledged that she might have reviewed with DLR/CPS the additional information obtained during her licensing investigation for possible reconsideration for a DLR/CPS investigation. Additionally the licensor, in reflection of the child fatality review, indicated that in the future she would (1) seek consultation with either a Child Protection Medical Consultant or Regional Medical Consultant when medical issues surface during a licensing investigation, and (2) work more collaboratively with DDD staff.

Issue: Facility - Circumstances surrounding the child fatality:

Information obtained post fatality suggests that in preparation for a bath the deceased child's alarm was disconnected, his VPAP (variable positive airway device to assist breathing) was removed, and his cardiac monitor was also removed. Such would be routine for bathing. A therma vent (called a "nose") was placed on the child's trache and secured. The child's trache itself was also secured with ties (Velcro). The attending nurse left the room to prepare breakfast for the child. She reportedly was gone for a period of approximately five minutes, leaving the deceased child unattended in his room about ten feet away. At some point just prior to the nurse returning to the child's room there was decannulation. The two most likely possibilities are that the child pulled out his trache tube, or that the Velcro trache ties became attached to the flannel sheet in the bed and when the child moved the trache decannulated. Regardless of how the trache became decannulated, efforts to re-insert the tube were unsuccessful due to scar tissue collapsing the child's airway hole and he subsequently went into cardiac arrest due to respiratory failure.

The child's medical care plan did not require direct line of sight according to Ashley House, but the physician order was for the child to be connected to an alarm when sleeping or when left unattended. The issue of what constitutes "unattended" as it relates to "line of

sight" and "required monitor/alarm" was discussed during the review, and reportedly was not specified by the child's physician. The provider agency indicated that "unattended" parameters vary depending on the patient's individual needs. Furthermore, the provider stated that it was not unusual for the deceased child to be unmonitored (no alarm) during awake time when staff were in close proximity to the child such as occurring at the time of the fatality incident.

The vagueness of the terms "unattended" and "close proximity" resulted in the panel not being able to agree as to whether the incident involved a reasonable medical judgment or a medical misadventure. There was no disagreement, however, that the medically intensive child had been disconnected from his monitor/alarm and left alone in his room, and such would be inadvisable given the child's history of occasional decannulation. Had the alarm been connected, it would have alerted nursing staff to the trache being removed. It would not have prevented the decannulation, but would likely have affected the response time. Given the severe scaring around the child's airway which prevented re-insertion of the trache, there is no way to know if an earlier response would have made any difference regarding re-insertion attempts.

Recommendation: None

Comment: Given the absence of any medical definition of "unattended" and the varying descriptors in the medical literature (ranging in meaning from "unwatched" to "neglected"), consideration could be made as to requiring an operational definition of "unattended" for each medically fragile/medically intensive child in facility care. This would be based on their individual behavioral, medical, and/or observational needs, and made clear in the child's medical care plan or physician orders. However, it is not clear as to which system would be responsible for this requirement in terms of inclusion into law, policy, licensing expectations or service contracts.

Action Taken: The DLR licensor has committed to initiating a meeting with the new facility licensor for Ashley House and the Ashley House Program Services Director to discuss facility procedures. The main focus of the discussion will center on what "unattended" means for each individual child with regard to any physician orders or Medical Care Plans in place.

Action Taken: Following the child fatality review, the DDD Case Manager whose case load includes numerous children at Ashley House indicated his commitment to closer scrutiny of physician orders regarding medically fragile and medically intensive children during his on-site visits.

Action Taken: Following the child fatality review, the Medically Intensive Children Program Manager indicated consideration will be made to consult with Aging and Disability Services Administration contracts staff as to possible revising of expectations

for facilities contracted to provide medically intensive program services with regard to leaving a child "unattended."

Child Fatality Review #08-36
Region 6
Clallam County

This two-month-old Caucasian male died from Sudden Infant Death Syndrome (SIDS).

Case Overview
On October 11, 2008, medics were dispatched to the family of the deceased child on a report of a two-month-old infant not breathing. CPR was performed at the home by the father. The father told law enforcement he woke up around 3:30 a.m. to feed his son. The father said nothing appeared out of the ordinary when he was feeding the child. After feeding his son, he put the baby in bed with him and both went to sleep. The father reported he surrounded his son with pillows to keep him from rolling around and/or to keep him from rolling onto the infant overnight. The father woke up around 8:25 a.m. and checked on his son who was warm but not breathing. The father called 911 and immediately began CPR. The medics arrived and found the father in the back bedroom on the floor performing CPR. The deceased child was transported to the hospital where he was pronounced dead at approximately 9:49 a.m.

This child was born with a positive toxicology screen for Methadone. His mother was on a prescribed Methadone program during her pregnancy and at the time of the child's birth. An Alternate Response System (ARS) service provider continued to be involved with this family throughout the life of the child. The King County Medical Examiner conducted the autopsy and ruled the child died as a result of Sudden Infant Death Syndrome; a factor contributing to the death is bed sharing. The autopsy also revealed the child had a healing rib fracture. The Medical Examiner determined the rib fracture occurred during child birth.

Referral History
On February 4, 2003, Child Protective Services (CPS) intake took a report that the father of the deceased child was in jail for using and dealing methamphetamine. The referrer was also concerned that his 14-month-old son was being neglected as evidenced by a diaper rash because his diapers were not changed regularly. This referral was screened as information only.

On December 1, 2003, police reported to CPS intake to report a domestic violence (DV) incident between the mother of the deceased child and her former husband. The mother was grabbed by the shirt and the shirt was torn. Law enforcement searched the residence for the mother's ex-husband but did not find him. Law enforcement reported there have been several incidents of DV between them. This referral was screened as information only.

On April 30, 2006, CPS intake received a report from hospital staff who reported the mother of the deceased child tested positive for Methadone and Prozac after giving birth to

another child. Both medications were prescribed. This referral was screened as information only.

On February 28, 2008, a referral was made to CPS intake from local law enforcement. It was reported there was a DV incident between the parents of the deceased child. One of the mother's children was present during the altercation between the parents. The mother was pregnant with the deceased child at the time. The father of the deceased child was arrested after police determined he was the aggressor in this incident. The mother had marks on her arm and back from being pushed and grabbed. The father reported he was hit and denied being the aggressor. He had no marks and was arrested. This referral was screened as information only.

On July 16, 2008, a nurse at a local hospital reported to CPS intake that the deceased child's mother was pregnant with twins. The referrer reported the mother had a significant history of substance abuse and was on Methadone while pregnant. The referrer noted the mother was very consistent with her prenatal care. This referral was screened as information only.

On August 29, 2008, a nurse at a local hospital reported to CPS intake alleging the deceased child's mother was not capable of caring for twins born on August 21 and was addicted to Methadone. The deceased child was one of the twins. The infants were born drug effected and were placed on morphine for withdrawal of Methadone. It was believed the mother took more than her prescribed amount of Methadone. The mother was discharged from the hospital but was believed to be going through withdrawal. The father of the children visited regularly and stated he did not know the mother was taking Methadone. Another child in the home, then two-years-old, was in the care of a maternal grandmother. This referral was screened as information only.

On September 3, 2008, law enforcement reported to CPS intake the siblings of the deceased child, ages 2 and 10, were left unattended. Police contacted the mother who reported the grandmother was watching the children and left thinking another adult would be home soon. Law enforcement investigated and closed their case as unfounded. This referral was screened in for Alternate Response System (ARS). Services were offered by a local First Steps provider. The family actively participated in this service.

On September 5, 2008, CPS intake received a report that the deceased child and his twin siblings were taken to Children's Hospital by their mother because they suffered from withdrawal. The mother used Methadone during her pregnancy. The referrer noted the mother was attentive and involved in the care of her twins. The twins stayed at Children's Hospital and later transferred to a local hospital. This referral was screened as information only.

On October 13, 2008, law enforcement contacted CPS intake to report the deceased child's death. The child's father reported he, the child's mother, and twin sister were the only persons in the house during the time of the incident. It is believed the child died between 3:30 and 8:30 a.m. Law enforcement reported there was no sign of foul play and all indications were the death was most likely associated with SIDS. The mother informed the deputy that during her pregnancy she was prescribed Prozac and Methadone by her doctor. The deceased child slept with his father in the father's bed and was surrounded by pillows. This referral was screened as information only. The family was actively involved in ARS services with a local provider at the time of this death. This provider assisted the parents in accessing grief counseling.

Issues and Recommendations

Issue: The referral dated August 29, 2008 was taken by Region 3 and screened in for investigation. When the Port Angeles office received the referral they reviewed it with the Area Administrator and changed the screening decision to information only as the information contained in the referral was not new information. The information regarding the mother possibly taking more than the prescribed Methadone was not backed by any medical evidence or testing and was not new information. There were concerns regarding how the allegation section of the referral was written as the majority of this section contained narrative from previous referrals. Region 3 agreed with these statements.

Recommendation: None identified

Children's Administration
Executive Child Fatality Review
Jordyn Moses case

October 10, 2008

Committee Members

- Jessica Gurley, Community Services Supervisor, Snohomish County Superior Court
- Sherry Guzman, Senior Manager for Behavioral Services, Tulalip Tribes
- Cammy Hart-Anderson, Coordinator, Snohomish County Division of Alcohol and Other Drugs
- Sandra Kinney, Area Administrator, Division of Children and Family Services (DCFS) Region 3
- Linda Tosti-Lane, Supervisor, Division of Licensed Resources in Children's Administration, Region 5
- Betsy Tulee, Indian Child Welfare (ICW) Program Manager, Children's Administration Headquarters

Observer

Rachel Pigott, Office of the Family and Children's Ombudsman

Facilitator

Susan Welch, Program Consultant, Division of Children and Family Services (DCFS) Region 3

Case Overview

In October 2008, the Children's Administration (CA) convened an Executive Child Fatality Review[1] committee to review the practice and service delivery in the case involving six-month-old Jordyn Moses and his family.

On November 26, 2007 CA received a referral from the Tulalip Tribal Court reporting that the Tulalip Police had responded the day before to the Walmart on Tulalip lands. It was reported that there had been an incident of domestic violence involving [redacted], and Gregory Aaron Moses, [redacted] (both enrolled Tulalip members), that endangered [redacted], Jordyn Moses, then just seven weeks old.

[redacted] was shopping with a female relative and had Jordyn and her three year old daughter with her. [redacted] confronted [redacted] in the parking lot. Arguing loudly and accusing [redacted] of going out with other men, it was alleged [redacted] pulled Jordyn out of [redacted] grocery cart in his baby carrier and "threw" him into his van, failing to belt him in. It was further alleged that he then "slammed" [redacted] against the vehicle, causing bruising, and then left with Jordyn in the van. Police were called, and they later arrested him and returned Jordyn to [redacted]. The tribal court put a "no-contact" order in place, barring [redacted] from having contact with either [redacted] or their child Jordyn.

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[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.

The case was assigned to a Child Protective Services (CPS) worker and also to a worker in the Tulalip Tribal child welfare agency. There was a joint response that resulted in agreements with [redacted] and [redacted] to engage in a voluntary service plan.

On November 27, 2007, [redacted] entered into a service agreement with the social worker, in consultation with the assigned tribal worker, to participate in domestic violence awareness counseling and parenting classes. [redacted] also agreed to abide by the restrictions of the restraining order. At that time, [redacted] was living with Jordyn and her oldest child, then three-years-old, in the home of her father and stepmother on Tulalip Tribal lands.

In December 2007, the case transferred to the Family Voluntary Services (FVS) unit. It was reported to the review committee that caseloads in that unit at that time were in the high 20s, and that a change in supervisor occurred in the unit in January, 2008. On January 3, 2008, the FVS worker went to the [redacted] home and met with [redacted] and her family. Together they completed the Family Assessment.

The worker told the review committee that [redacted] and her family discounted the incident and strongly advocated for the lifting of the restraining order prohibiting contact between [redacted] and herself and child. [redacted] did, however, agree to abide by it for as long as it was in force.

The social worker then met with [redacted] on January 11, 2008 and entered into a service agreement with him in which [redacted] agreed to complete a domestic violence assessment and follow the recommendations of that assessment, as well as abide by the conditions of the order barring him from contact with Jordyn and [redacted]. He requested that his services be completed through the Tulalip Tribe. At that time, [redacted] said that he was living with his grandmother [redacted], also on the Tulalip reservation.

Over the course of the next several weeks, there were several phone conversations between the social worker and [redacted], as well as between the social worker and the Tulalip case manager, and [redacted] attorney's office. It was clear from the documentation of these contacts that the primary activity of the family was in efforts to get the restraining order lifted. There

was little in the way of progress on the service plans. [redacted] had some contact with a domestic violence service worker from the tribe. [redacted] had not engaged in any services.

On February 28, 2008, the FVS social worker made another visit to the [redacted] home to check on the children. She reported to the review committee that she was told then by the maternal grandparents that [redacted] and the children had moved out. When she asked where they had moved, the family refused to tell her. The worker stated that she had suspicions at that time that the family may not be abiding by the court order, but did not have actual "proof."

On March 14, 2008, the social worker attempted to visit [redacted] and the children at the address where she found her listed as receiving [redacted] The worker documented in the record that she was unable to locate that specific address and returned to the office. It was only after the death of this child that this address was identified as the home of [redacted] and his grandmother. There is no indication that the grandmother or aunt provided any significant care of the deceased child while this family lived in their home. There is also no information the aunt and grandmother had any connection to the death of Jordyn Moses. However, law enforcement continues to investigate this fatality and has not shared any information with department or tribal social workers. The full extent of grandmother or aunt's knowledge of the fatality or their roles as caretakers is still unknown.

On this same day, March 14, 2008, the social worker attended the regularly scheduled twice-monthly staffing with the Tulalip Family Services staff. At that staffing, the possibility of closure of the state's case was discussed, as the family had identified that they wanted their services to come through the Tulalip Tribe. The worker reported to this review committee that she learned at this staffing that the tribe did not have the ability to conduct domestic violence assessments, and would need to keep the state case open until that contracted service could be paid for, and then the tribe could provide the treatment, if indeed that was recommended by the assessment.

There had been some discussion during February and March, 2008 between the Tulalip case manager and the state social worker regarding the possibility of Tulalip Family Services closing their case. However, on April 1, 2008, the assigned Tulalip Family Services case manager left a voice mail for the state

social worker saying that Tulalip had staffed this case the day prior, and decided to take over the case from that point on, and the state could close their case, as the parents were following the court order. There were voice mail exchanges only on this issue, and not a full discussion of the case.

The social worker stated to the review committee that she did not have a copy of the restraining order from the Tulalip Court, and there appeared to be some lack of clarity about the content of the order and whether or not it remained in effect.

On April 10, 2008, CPS received a referral from Children's Hospital saying that Jordyn was on life support, having suffered a cardiac arrest. He was non-responsive.

It was reported that early in the morning of April 10, 2008 emergency aid was called to the home of [redacted]. [redacted] told the first responders that she and the children had been living in the house with [redacted], and that she had come home in the early morning hours after taking a relative to the hospital and found [redacted] and her three year old asleep. She reported that she saw Jordyn, not breathing and non-responsive, suspended by his neck from an "exer-saucer" with his feet not touching the floor. She said that he had evidently fallen between the bed and the wall, and immediately called 911.

The detectives interviewed both parents and reportedly expressed some doubt at that time, believing that the physical and medical evidence did not support [redacted] version of the events. Jordyn remained in the hospital until April 23, 2008 and after it was clear he had suffered brain death, he was taken off life support and was officially declared dead.

An autopsy was performed. The conclusion of the autopsy was that the circumstances of the injury as reported to medical personnel and the investigating police agency were not consistent with Jordyn's injuries. He had blunt force injury of the head and the manner of death was classified as homicide.

[redacted]. Although this referral was assigned for a CPS investigation, it was reported to the review committee that the Federal

Bureau of Investigation (FBI), which had jurisdiction in the case, directed the department social worker not to interview [redacted], [redacted] [redacted], or [redacted] [redacted] three year old child until cleared to do so.

As of the date of this report, the investigation is ongoing and no arrests have been made. The department has not conducted interviews on this matter with the family. It was reported to this committee that several subsequent attempts by the assigned CPS worker to contact the assigned FBI agent and tribal law enforcement to discuss this case were not successful.

It was later determined that the home in which Jordyn was injured was a licensed foster home. [redacted] and her adult daughter, [redacted] [redacted] (the grandmother and paternal aunt, respectively, of [redacted]) were licensed by a private agency as a foster home. Three of [redacted] grandchildren were placed in that home in a tribal guardianship. The [redacted] foster home had previously (2007) had a referral alleging that they had allowed a relative to temporarily reside in the home without notifying licensing. They subsequently signed a compliance agreement in which they agreed to notify licensing if a relative were to be in the home for more than two weeks.

Findings and Recommendations

The committee met on September 29, 2008 and on October 6, 2008 and made the following findings and recommendations based on interviews, review of the case records, and department policy and procedures.

Findings

- Personnel transitions and workload issues may have affected the worker's ability to closely follow and monitor this family's activities. (The Children's Administration has, since this incident, implemented a policy requiring face to face contact with children every thirty days in voluntary service cases.)
- The standard format currently used for the writing of voluntary service plans does not lend itself to identification and documentation of specific timeframes for completion of service activities. The newer information system for documentation of case activities (FAMLINK), which is to be implemented in December

2008, has a complete Family Assessment section that will require specific timeframes to be included in service plans.

- Communication issues among the FBI, CPS, and the tribe impeded the timely identification of the home in which this child was injured as a licensed foster home.

Recommendations

- It is recommended that the Smokey Point Office management make outreach to Tulalip Tribes to begin discussions on the possibility of developing a joint working protocol that would more clearly delineate roles and responsibilities in shared cases.

- It is recommended that Children's Administration continue work on the development of a practice guide for domestic violence and that the training on this practice guide be offered to tribal child welfare workers as well as state social workers.

It is recommended that the Division of Licensed Resources (DLR) explore the possibility of establishing a standardized format for the Licensing Health and Safety Checklist, to include questions about significant changes of circumstances in the home, particularly the composition of the household.

Children's Administration

Executive Child Fatality Review

Autumn Franks Case

October 2, 2008

Committee Members
Michelle Terry, MD, Medical Consultant Region 5
Kevin Crane, Detective, Bremerton Police Department
Bolesha Johnson, Area Administrator, Division of Children and Family Services (DCFS) Region 4
Kui Hug, CFWS/CHET/Adoption Support Program Manager Supervisor, DCFS Region 6
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Paul Smith, Critical Incident Program manager, Children's Administration (CA)
Lynette Young, MSW intern, Division of Children and Family Services Region 5

Facilitator
Bob Palmer, Child Fatality Program Manager, CA Region 5

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Executive Summary

In October 2008, the Children's Administration (CA) convened an Executive Child Fatality Review[2] committee to review the practice and service delivery in the case involving three year old A.F. and her family.

The incident initiating this review occurred on April 30, 2008, when a hospital social worker from Mary Bridge Children's Hospital (MBCH) notified Child Protective Services (CPS) of the impending death of a young child from suspicious injuries. The referrer told CPS the child had been transported to MBCH by ambulance after the girlfriend of the child's biological father was not able to revive A.F. after allegedly being knocked off a couch by a dog. The attending physicians did not believe the story being presented by the girlfriend[3] and the report was accepted for CPS investigation. An initial CT scan showed two skull fractures (including an older skull fracture) with swelling and bleeding in the brain. There were no other broken bones or bruising. [redacted]., an older sibling living in the home, was placed into protective custody and was also examined. No injuries were found upon full examination of [redacted] Later that evening A.F. died after emergent brain surgery. Cause of death was determined to be from blunt force trauma, and manner of death was declared a homicide. Although criminal charges had not been made at the time of the Executive Child Fatality Review or at the time of this report, the CPS investigation resulted in a finding of founded for child maltreatment.

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

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

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

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

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

Case Overview

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

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

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

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

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

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

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

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

On April 23, 2008, the CPS worker spoke with the "stepmother" seeking to find out what school the oldest child was attending and whether or not A.F. was in any day care. When interviewed by committee members the CPS worker indicated his intent was to conduct follow-up interviews with the alleged victim and the older sibling. An interview with the sibling did occur on April 23, 2008, at the boy's school in the presence of the school principal. The child gave permission for the interview to be recorded. [redacted] stated during the interview that everything was fine at home and that he and sister did not get in trouble at home. There were no disclosures of child maltreatment. The social worker checked the boy's arms and legs and torso for bruises and found no marks or bruises. When asked about his sister ever getting hurt or having marks on her back, [redacted] stated that his sister had gotten tangled up with the leash of a dog while at the home where his mother lived. When asked by the CPS worker the school principal indicated the school had no concerns about [redacted].

Five days later the CPS investigator contacted L.B. to discuss the alleged incident at McDonald's whereby A.F. had reportedly gotten hurt. L.B. stated that a week prior to the March referral to CPS that A.F. had been pushed down a slide by another child resulting in marks on her back. The social worker informed L.B. that he intended to do another home visit later in the week. Two days later CPS received information that A.F. had been brought to MBCH with suspicious injuries and was not expected to survive.

Upon receiving notification that A.F. had been admitted to the hospital with serious injuries from suspected non-accidental trauma, CPS initiated an investigation in conjunction with local law enforcement. Extensive medical examination had revealed old and new skull fractures. The older sibling was placed into protective custody by law enforcement and was interviewed at the Tacoma Child Advocacy Center (CAC). When interviewed the boy stated that his sister had been throwing up for several days. He stated that he recently had been in trouble at school and his father had spanked him, indicating he had bruises and his "bones hurt." A medical examination was conducted at the CAC and no injuries were found and he was found to be in good health. A dependency petition was initiated and juvenile court ordered the child to remain in out-of-home placement.

A specialized CPS worker out-stationed at the CAC conducted the investigation of the fatality. While the earlier allegation regarding bruises on A.F.'s back was found to be inconclusive, the investigation of the fatality incident resulted in a determination that more likely than not A.F. had been physically abused by L.B. which led to the child's death. Furthermore, a finding of founded for abuse was made on both L.B. and the father given evidence of a prior skull fracture. Given the medical opinion that the child had suffered the earlier injury which would have been severe enough for both L.B. and the child's father to have noticed and sought medical intervention, a finding of founded was made for negligent treatment/maltreatment on both caregivers. It is unknown whether the subjects of the allegations have sought to overturn the CPS findings.

At the time of the Executive Child Fatality Review and of this report, criminal charges had not yet been filed against either L.B. or the father C.F. The surviving sibling remains in out-of-home care in relative placement.

Findings and Recommendations

The committee made the following findings and recommendations based on interviews, review of the case records including obtained medical documents, department policy and procedures, Child Sexual and Physical Abuse Investigation Protocols for Pierce County Washington, Revised Code of Washington (RCW), and Washington Administrative Code (WAC).

Findings

CPS Intake:

- The report to CPS in March 2005 should have been screened in for investigation rather than taken as information only. Additionally the intake worker should have contacted law enforcement to confirm whether the referent had indeed requested a child welfare check. These noted intake issues were found to have no direct impact upon the child fatality that occurred three years later as the allegation in 2005 involved the biological mother who was not the caretaker of the deceased child at time of the fatality incident.

- The decision at intake to screen-out the report made to CPS in 2007 was found to be reasonable. The referral was not passed onto law enforcement as it was taken for information only. However, because there was a vague reference to possible inappropriate touching of a child by a non-related adult, a minority view among committee members was that consideration could have been made by CPS intake to send the screened out report to law enforcement even if not accepted for investigation by CPS. This issue was determined to have no direct impact upon the child fatality that occurred three years later.

- The physical abuse allegation reported to CPS intake on March 18, 2008, was accepted for investigation and designated for non-emergent field response rather than emergent[4]. The committee was unable to reach full consensus as to which response time was most reasonable given the information provided at the time of the intake and given the lack of clarity as to when the bruises first appeared. Although it appears that the alleged victim may have already returned to her father from visitation with her biological mother, the intake worker might have encouraged the referent (relative) to speak to the non-custodial parent (biological mother) about taking the alleged victim for a medical exam.

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[4] An intake designated for emergent response requires a worker to conduct initial face-to-face contact with any alleged victim within 24 hours from the time of the referral. This was implemented by CA in April 2005. An intake designated for non-emergent response requires a worker to conduct initial face-to-face contact with any alleged victim within 72 hours from the time of the referral. This practice was implemented by CA in August 2005.

CPS Investigative Activities (pre-fatality):

- While recognizing the fact that the investigation was still in process when the child fatality occurred, the interviews of the caretakers as conducted and documented by the CPS worker appear to be deficient. The only contact with the biological father was a brief phone contact occurring while conducting the initial home visit (father was at work). After the initial interview of the father's partner (L.B.) at the home, the worker received additional information that would suggest a need to re-interview her. There is some indication in the case record that the CPS worker had intended to re-interview the girlfriend but that plan was interrupted when the child fatality incident occurred. There was also minimal contact with the biological mother. While the mother was a non-custodial parent at the time, there were indications in the case documentation that suggest she could have been a source of more specific information regarding suspected non-accidental injuries to A.F.

- Subsequent to the initial contacts with the alleged victim and the family, there was a 30 day period without any significant investigative follow-up activity by the CPS worker. This included a delay in interviewing the sibling and re-interviewing the alleged subject of the allegations. The worker's ability to meet best practice expectations appear to have been compromised by his case load at the time.

- The CPS worker might have considered giving the family information on available community services such as the local Family Support Center and/or making a referral for Public Health Nursing services.

- The CPS worker did conduct an informal criminal court history check on the child's caretakers (biological father and his girlfriend). Although it was later determined that neither caretaker had any significant criminal history, the worker might have considered checking with local law enforcement for a more in depth local criminal history check earlier in the case.

- The CPS worker should have put forth a more assertive effort to get photographs of bruises on A.F. that had reportedly been taken. It is noted that the person who initially offered the photos to the CPS worker stated in a post-fatality e-mail to the CPS worker that she had decided not to send the photos fearing the children would be taken away and placed with strangers. On March 21, 2008, when the CPS investigator saw the child, there was no significant bruising observed. The photographs obtained post-fatality, which had been taken on March 14, 2008, did show observable bruising.

- After considering the family history, interviewing the pre-fatality CPS worker, and reviewing all available documents the committee reached consensus that the subsequent death by abuse did not appear to be predictable in any obvious way. However, the issue of preventability of the outcome does allow for conjecture and rests on not having obtained the photos from mid-March 2008. Had the worker

seen the photographs, it is possible that the caretakers would have been asked by the CPS worker to have A. F. examined. It is unknown as to whether such a medical examination by the child's PCP or other professional would have led to a recommendation for full body radiographs which then may have identified an old skull fracture.

Workload:

- As noted, the ability of the CPS worker to meet both basic and best practice expectations appeared to be compromised by his case load. The worker was experienced and typically was assigned the most serious physical abuse and sexual abuse cases through his out-stationed position at the local Child Advocacy Center[5]. Due to unit vacancies, social workers attending CA Academy Training (and unable to be assigned cases), and the number of referrals needing to be assigned for investigation, the worker was getting as many as four assigned cases a week, some of which would have normally gone to regular (non-CAC) CPS workers in the unit had workers been available. Thus while working numerous exceptionally serious child maltreatment cases which required intensive investigative activities, the worker was also assigned more routine cases such as this case. At the time of assignment it was the ninth case assigned to him that month, with three more assigned by the end of March. Total number of active cases being worked by the CPS investigator was 26 at the end of March. Additionally, the worker received 11 new investigative assignments in April 2008, ending the month with 30 total active cases.

Recommendations

Intake:

- CA should continue efforts to standardize intake decisions across the state to promote better consistency. The development of an intake "decision tree" as part of FamLink, the new CA data management system which is due for implementation in December 2008, should improve consistency. However, within the first six months post implementation of FamLink, CA should conduct a review of intakes to evaluate if the implementation of the intake "decision tree" improved consistency across the state.
- It is recommended that CA consider adding at intake the task of asking referents who report physical abuse of a child as to the existence of any known photographs of marks, bruises, or injuries.

[5] CAC refers to the Children's Advocacy Center of Pierce County, a child-friendly facility in Tacoma, made up of representatives from law enforcement, prosecution, CPS, medical, mental health, advocacy, and other disciplines within Pierce County. The team's primary goal is to coordinate efforts to offer a comprehensive and collaborative approach to the investigation, prosecution, and treatment of child victims of alleged sexual and severe physical abuse.

- While the FamLink system includes a chronically referred family indicator[6] for intake, consideration should be made by CA to establish specific criteria for additional intake review when a family has multiple "information only" but not multiple accepted referrals. This recommendation does not derive specifically from elements of this case, but from a general discussion occurring among the committee members during the fatality review regarding "red flags" for child maltreatment for which a pattern of report history is an important consideration.

Training/Practice:

- CA should consider developing a basic checklist guideline ("cheat sheet") that would be available to all CPS investigators in the state. This would include listing both what is required by law, policy and best practice for conducting CPS investigations. It would include noting such activities as contacting the child's doctor, seeking child medical records, seeking any photographs that may be available, consideration for consultation with the Child Abuse Medical Consultant, and other practice guidelines. Such a one-page tool could serve as a task-reminder to workers in the field as well as serve as a supervisory review tool. It is recognized that such efforts have been made previously by individual CA offices across the state as well as by CA program staff, and it is strongly recommended that this be revisited.
- CA should continue the current practice of conducting state-wide "Lessons Learned" presentations that address issues surfacing during Child Fatality Reviews. This includes continuing to present issues relating to non-biologically related caretakers and social worker bias.

Workload

- CA social worker caseloads need to be reduced in order for workers to meet current basic practice expectations. CA should consider putting a cap on the number of cases a CPS investigator can be assigned per month and can have active at any point. This should be in the range of no more than 2-3 new investigative assignments per week, 8-10 new cases per month, and no more than 18 at any given time for a CPS caseload. It is understood that smaller CA offices across the state most often have social workers with mixed case loads (CPS, FVS, adoption). It is further understood that meeting such recommendation would be contingent upon exceptional budgetary considerations that would need to be approved by the state legislature.
- The documentation requirements for social workers, which currently involves time consuming "desk time" by social workers while inputting case notes into the CA data management and information system, could be lessened by making available

[6] The Chronically Referred Person Indicator will be incorporated into the new CA data management web-based system called FamLink due to go on-line in December 2008. An indicator will automatically be triggered when a participant in a case meets any of the following criteria: (1) three accepted CPS referrals in the prior year; (2) four accepted CPS referrals in the prior two years; (3) five accepted CPS referrals in the prior three years; (4) two or more founded allegations in the past two to six CPS referrals.

dictation devices, transcription services, and subsequent entry into the CA data base by support/clerical staff. CA should continue to seek improvement and/or new technology that may help support less time consuming data processing by case carrying social workers.

Access to law enforcement and court data bases

- CA should continue pursuing measures to give workers simple ready access to the numerous information management systems used by various law enforcement and court jurisdictions.
- Although RCW 26.44.030[7] authorizes law enforcement and CPS to exchange information on cases being investigated for child maltreatment, there is a need for clarity regarding any limits to what information can be provided and if such information can be provided "informally" by law enforcement without violation of rights of privacy or other rights of protection under the law. This would include whether information such as criminal histories of members of a household (including arrests that did not involved convictions) or prior child welfare checks on a residence can be provided routinely to CPS informally by law enforcement officers. It is recognized that some law enforcement jurisdictions may require formal requests while others may provide such information informally on a routine basis and may be doing so at risk of violation of rights of privacy. CA, in conjunction with the Attorney General's Office should review this issue, and if deemed necessary, pursue changes in the current RCW that would clarify authority and limits of authority.

[7] Section 12 of RCW 26.44.030 states that "In investigating and responding to allegations of child abuse and neglect, the department may conduct background checks as authorized by state and federal law."

Children's Administration

Executive Child Fatality Review

Michael Ravenell

September 16, 2008

Committee Members:
*Lanelle Anderson, Detective, Pierce County Sherriff's Office
*Yolanda Duralde, MD, Child Protective Services (CPS) Medical Consultant, Region 5
*Senator Rosa Franklin, Washington State Senate - 29th District
*Amy King, Detective, Olympia Police Department
*Yen Lawlor, Area Administrator, Division of Children & Family Services (DCFS), Region 3
*Tami Mistretta, Social Worker 4, DCFS, Region 6

Observers:
*Mary Meinig, Director, Office of the Family and Children's Ombudsman
*Bob Palmer, CPS Program Manager, DCFS, Region 5
*Jennifer Strus, Senior Coordinator/Counsel, Senate Human Services & Corrections Committee
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Executive Summary

In September 2008, Children's Administration (CA) convened an Executive Child Fatality Review[8] committee to review the practice and procedures in the case of three-year-old, African-American/Native Hawaiian, Michael Ravenell (M.R.) and his family. M.R.: Date of Birth: December [redacted] 2004 Date of Death: May 28, 2008.

On May 28, 2008, CA Central Intake (CI) accepted a referral reporting the death of M.R. The referent, M. R's father, told CI the mother and other family members brought the child to the St. Clare Hospital emergency room. The mother reported that he fell off toys at the playground. M.R. received cardiopulmonary resuscitation and died despite resuscitative efforts. The referent said the Pierce County medical examiner found the death suspicious, and Tacoma Police Department (TPD) was investigating.

A review of the family's history with CA noted one prior referral on April 2, 2008 reporting bruising to the child's chest and eyes. The April 2, 2008 report was assigned for a Child Protective Services (CPS) investigation, however no finding had been made in regards to this referral prior to M.R.'s death. The CPS case was open at the time of the child's death.

Fatality review committee members included CA staff and community members who had no involvement in the case. The review committee addressed issues related to investigative practice and procedures, Region 5 hiring practices, social worker (1, 2, and 3) job classifications, supervision, and training protocols for social work staff.

Committee members received case documents including the following:

- CPS referrals regarding Ravenell family
- Ravenell case chronology
- Noah Thomas (mother's boyfriend)[9] case chronology
- CA Practice and Procedure Manual – Chapter 2000 Child Protective Services
- Case Service Policy Manual – Chapter 3000 Assessment

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[8] 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.

[9] The full name of Mr. Noah Thomas 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.

- Operations Manual Chapter - 5100 – Health and Safety
- Operations Manual Chapter - 5500 Criminal History and Child Abuse and Neglect History Checks
- Class Specifications for Social Worker 1, 2, and 3[10].

The committee interviewed the social work supervisor on this case. While the CPS program manager and Region 5 Regional Administrator attended the review as observers, the team asked them questions regarding hiring, training, and supervision expectations for the region.

The team determined several important steps in the investigative process were missed by the assigned social worker. The review committee noted that the CPS social worker on the case had little child welfare or social services experience prior to being hired and identified concerns about hiring candidates with limited professional work experience to work with families at high risk of abuse and/or neglect. The review committee explored current system limitations and constraints facing CA managers accessing qualified candidate pools. The review committee also noted newly hired, inexperienced social workers are assigned CPS investigations after completing their mandatory academy training.

The committee felt assigning high risk investigations to newly hired and inexperienced CPS social workers may present risk issues for CA. Academy training and other mandatory training provided by CA for these social workers cannot by itself compensate for a lack of direct child welfare or investigative experience. Supervisors do not have the time to provide the level of supervision that inexperienced staff require. It was noted the lack of qualified candidates and the transfer of social workers from other departments within DSHS who do not possess child welfare practice experience may affect the quality of practice and increase the risk of liability to CA.

Region 5 may not be the only region within CA facing these hiring challenges. If this challenge is faced by other regions, it is expected the quality of practice may be impacted throughout the agency, creating system vulnerability. The committee recommended additional training, mentoring, and extended on-the-job training. The committee also recommended developing pools of trained social workers to fill vacancies as they occur. Further detail on these recommendations, additional findings and recommendations are found at the end of the report.

Case Overview

CPS history for this family noted one referral prior to the child's death. A referral received on April 2, 2008, reported that M.R had bruising near his left eye area and that he had bruising several weeks prior on his chest. According to the referent, M.R.'s father, the child's mother admitted inflicting the bruises on M.R.'s chest. The referent noted the child's maternal aunt confirmed the child had a bruise on his chest and that she did not report the bruising. The referent said when he asked M.R. about the bruise around his eye,

[10] Source: Washington State Department of Personnel Class Specifications 351O, 351P and 351Q

the child told him "Noah did it." The referent did not know "Noah's" last name at time of referral but said he was the mother's boyfriend. The referral was assigned for a CPS investigation. The referral notes the referent said a report was made to the Pierce County Sheriff's Office. (CA later determined the correct jurisdiction was Tacoma Police Department [TPD]).

The case record reflects that the CPS social worker responded and had initial face-to-face contact with M.R. on April 4, 2008 within mandatory timelines. Despite the child's young age, he was able to participate in an interview and told the investigating social worker that his mother had punched him in the stomach. When questioned about "Noah" M.R. stated he did not like him. M.R. did not report any injury inflicted by "Noah." The social worker noted no discernable bruising to M.R.'s chest or face at the time of the initial contact. The social worker did not take photographs during the contact.

The initial interview with M.R. was conducted at his maternal aunt's home, who provided regular child care for him. Additional investigative steps were completed including an interview with the maternal aunt, M.R.'s mother, his maternal grandmother, and his father. The maternal aunt told the social worker she and the maternal grandmother saw the bruise on M.R. and that M.R.'s grandmother took a picture of the bruise with her cell phone, which was later deleted. She also told the social worker she suspected illicit drug use by both M.R.'s mother and "Noah." She said she did not know "Noah's" last name.

On April 7, 2008 the social worker interviewed M.R.'s mother and asked about her son's bruises. The social worker documented that M.R.'s mother said she was aware of the bruise to her son's eye and explained her 16-month-old daughter may have caused the injury. Regarding the bruise to M.R.'s chest, his mother stated she had poked him in the chest, but did not realize she had hit him so hard until the bruise began to appear. She justified her action as discipline, indicating the child was being punished for soiling himself and trying to blame his sister for messing up his room. The social worker asked M.R.'s mother if "Noah" was ever alone with her children, and she replied "no."

An interview with M.R.'s father took place on the same day. Mr. Ravenell confirmed his report in the referral and that photographs were taken of M.R. He said they did not come out well and were deleted off the maternal grandmother's cell phone. The social worker also interviewed M.R.'s maternal grandmother regarding the bruising to his chest. She said she saw the injury during bath time and asked both her husband (the maternal grandfather) and the maternal aunt if they had noticed the bruising. She stated no one was overly concerned because M.R. did not report that anyone had hit him or how he had gotten the bruise. She stated given the family's ethnicity and the tendency to bruise easily, she did not think the bruising was significant at the time.

On April 9, 2008, the CPS social worker completed a safety assessment per CA policy. The assessment documents an incident of high-risk physical abuse in the family in the last 90 days, and that the child was expressing fear of people living in the home. CA policy

requires the development of a safety plan when preliminary facts in the case indicate threats to child safety are evident. During the development of the safety plan, M.R.'s mother disclosed the full name of "Noah" as Noah Thomas. With the identity of Mr. Thomas now known, the social worker included him in the safety plan. M.R.'s mother agreed in the safety plan that she and Mr. Thomas would use no corporal punishment on the children, and she would continue to use her family for support and child care. The social worker planned to refer the family for services.

The social worker made several attempts to speak with Mr. Thomas through M.R.'s mother. She asked that the mother request Mr. Thomas call the social worker. It is not known if Mr. Thomas received the request, and he did not contact the social worker for an interview.

On May 22, 2008, M.R.'s father left a message on the social worker's voice mail. He reported he had seen more bruising on both his children and that he had continued concerns regarding Mr. Thomas and the mother's care of the children. The social worker returned his call and left a message suggesting he contact law enforcement and make a referral to CPS intake reporting his concerns. There is no record of these concerns being reported to CPS intake by the father, social worker, or anyone else involved.

On May 28, 2008 CA was notified of M.R.'s death by St. Clare Hospital staff. The next contact CA had with M.R.'s father was on May 29, 2008 when he left a voice mail message for the assigned worker reporting M.R.'s death.

Three-year old M.R. died from severe trauma resulting from physical abuse inflicted by Mr. Thomas. TPD noted on May 29, 2008 that Mr. Thomas was arrested and charged with second degree murder in the death of M.R. In the charging documents, Mr. Thomas admitted to inflicting the injuries resulting in M.R.'s death.

Findings and Recommendations

The committee made the following findings and recommendations based on an interview with the CPS supervisor, review of case records, CA policies, procedures and protocols, and Washington State Department of Personnel Class Specifications for Social Worker 1, 2 and 3.

Findings

- Important CPS investigation steps were not completed.
    - Upon learning "Noah's" last name on April 9, 2008 the social worker did not conduct a Children's Administration Management Information System (CAMIS) search of Mr. Thomas. Mr. Thomas had three prior founded findings of physical abuse against his biological children. The CAMIS search should have led to a criminal history check which would have

revealed a prior criminal conviction for 3rd degree assault of a child against his biological children.

- There was no coordination between CPS and law enforcement regarding the April 2, 2008 referral. The CPS social worker did not establish contact with law enforcement to determine what information they had or what they intended to do regarding the referral.

- Information regarding possible bruising to the chest to M.R should have prompted CPS to recommend an examination by his primary care physician or prompt consultation with the Regional CPS Medical Consultant.

- When interviewed by the review committee the CPS supervisor noted supervisory consultation was done with the assigned social worker on several occasions during the course of the investigation. However, case notes do not reflect any documentation of supervisory consultation or staffing. The supervisor said interruptions to case staffings were commonplace due to unit workload and at times a thorough review of cases was not possible.

- The CPS social worker was employed with CA for approximately three months at the time of case assignment. The social worker had completed CA Social Worker Academy training and Harborview interviewing training. Her caseload at the time of the investigation and M.R's death was 30 cases.

- The review committee noted the level of experience of the assigned social worker and her assigned workload supported the need for close supervision and consultation. Region 5 best practice expects supervisors to develop initial on-the-job training plans and meet with their staff monthly to review work. Supervisory workload does not allow supervisors to spend 100% of their time training and supervising new staff. It is not reasonable to expect a CA supervisor to provide enough training to educate and remediate an employee's gaps in knowledge or lack of child welfare experience.

- Related to this, it is difficult for a supervisor to provide quality clinical supervision to a unit of social workers 1, 2, or 3's who present with and demonstrate varied levels of competencies relevant to child welfare practice.

- The current academy and initial mandatory trainings for new employees are not sufficient to teach and train new employees who have no direct experience, education, or knowledge of child welfare. While CA social workers are required to have a social work or equivalent degree, it should not be assumed that a social work curriculum or degree provides a good foundation for the skills or knowledge required by CA social workers.

- Current training provided by CA is not designed for social workers with no experience or education in child protection and /or child welfare issues. During

initial training, new social workers should be able to demonstrate the capacity to understand and apply basic child welfare concepts of safety, permanency, and well-being. At the end of the initial training social workers should be able to demonstrate the acquisition of key child protective/child welfare competencies.

Recommendations

- Develop training models to ensure demonstration and retention of core competencies. Examples:
    - Law enforcement has been successful with a Field Training Officer (FTO) training model. The FTO model partners and mentors new staff with experienced officers to develop and ensure demonstration of core competencies. New officers are partnered with field officers for six months before they are allowed to work on their own. This model appears suited to child welfare where new social workers can learn from senior workers as they do their work. This may reduce exposure to liability, share workload and decision making, improve morale, and reduce need for the high level of oversight required of supervisors on day-to-day work.

- Create training units where new staff can be supported by close supervision until they are able to demonstrate the key competencies affiliated with child protective/child welfare practice.

- Establish a pool of experienced social workers or a statewide support unit to step into vacancies as they occur. This will relieve the immediate stress of vacancies, may decrease the likelihood of supervisors having to carry caseloads, and allow supervisors more time to negotiate the hiring process, seek out, and hire qualified candidates.