



**Report to the Legislature**

**Quarterly Child Fatality Report**

RCW 74.13.640

July - September 2008

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



## Table of Contents

### Children's Administration Quarterly Child Fatality Report

Executive Summary .....	3
Child Fatality Review #06-61 .....	6
Child Fatality Review #08-02 .....	9
Child Fatality Review #08-03 .....	12
Child Fatality Review #08-04 .....	15
Child Fatality Review #08-05 .....	18
Child Fatality Review #08-06 .....	21
Child Fatality Review #08-07 .....	22
Child Fatality Review #08-08 .....	24
Child Fatality Review #08-09 .....	27
Child Fatality Review #08-10 .....	29
Child Fatality Review #08-11 .....	30
Child Fatality Review #08-12 .....	32
Child Fatality Review #08-13 .....	34
Child Fatality Review #08-14 .....	37
Child Fatality Review #08-15 .....	39

## Executive Summary

This is the Quarterly Child Fatality Report for July through September 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 issue a report on the results of the review to the appropriate committees of the legislature and shall make copies of the report available to the public upon request.*

*(3) The department shall develop and implement procedures to carry out the requirements of subsections (1) and (2) of this section.*

This report summarizes the information from 15 completed fatality reviews from fatalities that occurred in 2006 and 2008. All were reviewed by a regional Child Fatality Review Team.

This report does not include two Executive Child Fatality Reviews also completed during the quarter.

The Child Fatality Review number 06-60 from 2006 was completed prior to June 12, 2008. This completed review report was discovered during the third quarter 2008 and included in this report.

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

<b>Region</b>	<b>Number of Reports</b>
1	2
2	1
3	1
4	7
5	1
6	3
<b>Total Fatalities Reviewed During 3rd Quarter, 2008</b>	<b>15</b>

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 others as determined by the Assistant Secretary.

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 2006, 2007, and 2008. The number of pending reviews is subject to change if CA learns new information through reviewing the case. For example, we 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.

<b>Child Fatality Reviews for Calendar Years 2006 / 2007 / 2008</b>			
<b>Year</b>	<b>Total Fatalities Reported to Date Requiring a Review</b>	<b>Completed Fatality Reviews</b>	<b>Pending Fatality Reviews</b>
2006	63	63	0
2007	58	57	1
2008	54	15	39

The numbering of the Child Fatality Reviews in this report begins with number 06-61. This indicates the fatality occurred in 2006 and is the 61st 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 #06-61**  
**Region 5**  
**Kitsap County**

This 14-year-old Caucasian male committed suicide by hanging.

**Case Overview**

On May 15, 2006, this 14-year-old male was found by his mother hanging in the storage shed at the family home. His mother looked for him after he had gone to the storage shed to work on a kite at around 5:30 p.m. The parents attempted CPR and called 911. Emergency Medical Services (EMS) arrived around 6:30 p.m., five minutes after having been notified of the emergency. At that time resuscitation was terminated due to obvious lack of life signs. The forensic pathologist determined the youth died from diminished oxygen to the brain (cerebral anoxia) secondary to hanging. The youth was on several prescription medications, and drug intoxication may have contributed. The manner of death was declared to be a suicide.

At the time of the boy's death, the family was actively receiving services using their own resources. This included the deceased child receiving mental health therapy and medication management.

**Referral History**

On October 25, 2005, law enforcement reported the deceased youth was afraid to go home after school. He got in trouble at school and said he was afraid of his father. The boy disclosed that he recently had gotten into a conflict with his father resulting in the father punching him on the arm. The police officer observed a bruise on the youth's arm. Arrangements were made for the boy to temporarily stay with his grandparents. During the Child Protective Services (CPS) investigation, the youth said he was not afraid to return home and described this as an isolated incident. The youth was returned to his parents' care after a few days with a safety plan in place. This report was investigated by CPS and closed with a founded finding of physical abuse by the father.

**Issues and Recommendations**

**Issue:** On October 25, 2005, CPS was contacted by local law enforcement regarding a physical abuse incident involving the deceased youth and his father. The decision to accept the referral for investigation of abuse appears to be correct. While the designation for emergent response suggests the intake worker was aware that formal protective custody was made by law enforcement, this was not clearly indicated in the referral.

**Recommendations:** None

**Comment:** The current data system used by CA will be replaced in late 2008 by a new one (FamLink) and it anticipated that search and cross-referencing processes will be improved.

**Action Taken:** The intake worker participated in the review as did the current Bremerton DCFS intake supervisor. Both received feedback regarding the lack of clarity regarding the protective custody status of the child

**Issue:** The assigned investigating CPS worker met or exceeded policy requirements, such as timelines for face-to-face contact with the alleged victim, conducting a safety assessment, documentation standards, and completing the investigation. The assigned investigating CPS worker met or exceeded most practice expectations. Interviews with all the children in the family were conducted, as well as interviews with both parents and contact with the deceased youth's psychologist. These were well documented. The Investigative Assessment as reviewed appears to be both concise and accurate with the exception of possibly under-assessment of family stress. The finding (founded for physical abuse by the father) appears well supported by documentation. There was a delay in the notification of the finding to the subject (the father), partially due to a clerical error in sending the findings letter to the mother instead of the father.

The decision to close the case was appropriate and supportable.

Minor criticisms were noted during the review, none of which were found to have significant impact on the child's suicide six months after case closure. One minor criticism was that the worker did not make an inquiry with the state of Alaska or military social services with regard to any previous reported concerns for abuse or neglect in the family. Additionally the worker did not generate entry into the child's legal history module in the Children's Administration Management Information System (CAMIS) as to the protective custody action by law enforcement. This error was found to have no importance with regard to the subsequent suicide event.

At the time of conducting the required Safety Assessment, the CPS worker indicated that the level of abuse met the criteria for serious and immediate as defined by the CA Practice Guide to Risk Assessment. As required, such designation of a safety issue rising to serious and immediate would then necessitate a Safety Plan which the worker completed with family. While the Safety Plan as written had apparent weaknesses, it did serve as a very brief plan for temporary safety. It was discussed during the review that the injury suffered by the child during the abuse incident (arm bruising) did not actually meet the standards for what is considered to be serious and immediate as defined in the Practice Guide to Risk Assessment, and therefore a Safety Plan was not required. The fact that the worker did a Safety Plan, even if not required, was viewed as a positive action in working with the family to prevent another incident from occurring.

**Recommendation:** CA should continue with current and on-going efforts to improve Safety Assessment and Safety Planning. It is noted that a work group is being convened to look at Safety Assessment/Safety Planning for revision and strengthening of practice in CA.

**Comment:** Since 2005 changes in CA practice have occurred as to better data integrity (e.g. entry of placement and legal activity) and by the end of 2008 a new data system (FamLink) will replace CAMIS. Additionally, changes in the background check process have occurred in response to the passing of the Adam Walsh federal law.

**Action Taken:** The Kitsap County child injury protocol between CPS, law enforcement, Prosecutors Office, and other county agencies has recently been revised and updated and is in process of approval. The protocol will include guidance as to communication and collaboration. This should clarify protective custody situations and structure rapid connection between law enforcement and CPS investigators.



**Child Fatality Review #08-02**  
**Region 1**  
**Spokane County**

This 12-month-old Native American female died from septic shock.

**Case Overview**

This 12-month-old child was ill for several days prior to her parents taking her to be seen by a doctor on January 12, 2008. She was given an antibiotic for an ear infection. She vomited and had diarrhea after taking the antibiotic. On January 15, 2008, she became very lethargic. Her parents called 911 and the child was taken to a local hospital. After three days in the hospital the child died of septic shock.

The deceased child was born on January 1, 2007 at 34 weeks gestation. The mother has a history of substance abuse, chronic homelessness, DV, and possible mental health issues. The mother was the subject of three CPS referrals in 1996 and 1998 involving a child born to her when she was 20 to 21 years old. That case was monitored by CPS until the child's father obtained permanent custody.

There was an open CPS case on the deceased child at the time of her death in January 2008. The deceased child was in the custody of her parents, but was seen regularly at childcare and received visits from contracted providers and DCFS staff throughout December 2007 and January 2008. She attended childcare on January 11, 2008, was seen at a medical clinic on January 12, 2008, was seen by IFPS provider on January 13, 2008 and by the parent educator the morning of January 15, 2008.

On January 15, 2008 the child's mother called 911 and the child was transported to Sacred Heart hospital by ambulance. A doctor diagnosed her with shock, multi-organ failure secondary to shock, ischemic anoxic injury, and possible non-accidental trauma. The child died on January 18, 2008. The Spokane County Medical Examiner identified the cause of the child's death as hypoxic encephalopathy with cerebral infarcts (stroke) due to septic shock brought on by an ear infection and pneumonia. The manner of death was determined natural/medical.

**Referral History**

On January 2, 2007, a hospital social worker reported to CA intake that the mother gave birth to the deceased child. The mother was in jail at the time awaiting trial on domestic violence charges. She was released to deliver the child. The deceased child was born at 34 weeks gestation and spent time in the neo-natal intensive care unit. The referral was screened in for investigation by CPS and closed as unfounded. The child was placed in protective custody and a dependency petition was filed due to the mother's untreated mental health issues, instability, the father's mental health issues, and substance abuse issues. The parents were homeless at the time of the filing. The parents complied with court-ordered services

and demonstrated progress in their ability to parent their child. On July 16, 2007, the deceased child was returned to her parents' care through an in-home dependency order.

On October 26, 2007, law enforcement responded to the family home on a domestic disturbance call. The deceased child's mother reported her husband knocked her to the ground and punched her twice. The deceased child's father reported that his wife got knocked down while he was trying to prevent her from hurting the child. He reported having seen the mother shake the child. The deceased child's father was arrested for domestic violence. Law enforcement reported the incident to CPS on October 30, 2007. The CPS referral was screened as information only. The child was placed in protective custody on October 31, 2007. At a Local Indian Child Welfare Advisory Committee (LICWAC) meeting held in November 2007, it was recommended to return the deceased child to her parents' care with a safety plan. This placement was approved in court on December 3, 2007.

On January 12, 2008, the parents took the child to a doctor after she was ill for several days. The child was given an antibiotic for an ear infection. On January 15, 2008, the deceased child's parents found her non-responsive and called 911. She was transported to a Spokane area hospital. Hospital staff initially reported she had significant injuries. She had injuries to both ears. There is a bruise on the back of her right thigh, left wrist, and on her stomach. The child's vaginal area is swollen and has scratch marks. There is visible bleeding from the scratches and blood may also be coming from inside of her vagina. Law enforcement was contacted. The treating physician diagnosed the deceased child with shock; multi-organ failure secondary to shock; ischemic anoxic injury and possible non-accidental trauma. The child died on January 18, 2008. The Spokane Medical Examiner identified the cause of death as hypoxic encephalopathy with cerebral infarcts due to septic shock due to ear infections with pneumonia. The manner of death was determined natural/medical. There was no previous or current trauma to the child evidenced by the medical examiner.

### **Issues and Recommendations**

**Issue:** Four days passed from the date of the deceased child's father's DV arrest and when CPS was notified by law enforcement. The incident led to a protective custody placement.

**Recommendation:** A meeting with law enforcement to discuss delays in reporting to CPS.

**Issue:** There was a premature reunification following a DV incident between the parents and LICWAC recommended the reunification with marriage counseling and DV treatment simultaneously. The review committee opinioned this was contrary to the safety of the child and DV victim.

**Recommendation:** A practice guide with protocols be developed for social workers to reference when working a case involving domestic violence concerns.

**Issue:** The assigned social worker did not complete a reunification assessment or transition and safety plan related to the deceased child's return home in July 2007 after six months in foster care.

**Recommendation:** The social worker will receive information regarding the policy requirements for reunification of a dependent child.

**Child Fatality Review #08-03**  
**Region 4**  
**King County**

This 14-year-old African American youth died from a gunshot wound.

**Case Overview**

This 14-year-old youth was shot to death on January 10, 2008. His body was found behind a parked car the afternoon of Friday, January 11, 2008. He was shot in the abdomen. This youth had a history of substance abuse, gang involvement, and criminal activity. This case was actively investigated by Seattle Police as a homicide.

The deceased youth was not in the custody of the Department and there was not an open case as to him at the time of his death. He had lived with several different caregivers, including his mother, maternal grandmother, and his maternal aunt. He also stayed with a cousin and his father. His four younger half-siblings were the subject of an ongoing dependency case in Juvenile Court and had been removed from the care and custody of their parents and placed with relatives pursuant to a court order. The deceased youth had been living with an aunt and uncle for a number of months prior to his death.

**Referral History**

On January 9, 2001, school personnel reported to Child Protective Services (CPS) that the mother had withdrawn the deceased youth from school and did not re-enroll him in another school. There was also concern about inappropriate sexual acting out. The mother did not believe the deceased youth had been sexually abused, but agreed to counseling for him. This referral was screened in for investigation by CPS for investigation of neglect. The investigation was closed with an inconclusive finding.

On March 21 2001, it was reported to CPS intake that the deceased youth made a statement during a mental health assessment that implied his grandparents had touched him in a sexual manner. This referral was screened as a Third Party referral and referred to law enforcement.

On May 11, 2001, CPS intake received a report that the deceased youth's stepfather was angry with him and made him wear a dress on the school bus. A relative saw him at the bus stop, took him to her home, changed him into boys' clothes and took him to school. This referral was accepted for investigation of emotional abuse. It was closed with an unfounded finding.

On June 11, 2001, school staff reported they found several red marks and welts on the deceased youth's arms, shoulder and legs. This referral was accepted for investigation of physical abuse and closed with an unfounded finding.

On March 29, 2004, a mental health therapist for the deceased youth called CA intake and reported she could not locate the family. She was concerned the mother was seeing the father, who was considered dangerous. However, there was documentation to confirm he was incarcerated at that time. This referral was screened as information only.

On February 26, 2007, a referral was called to CPS intake alleging lack of supervision a 3-month-old and a 3-year-old in the home of the deceased youth's aunt and uncle. The deceased youth was living with these relatives at that time. It was reported the uncle (father of the two younger children) was the primary caretaker and was not properly supervising. This referral was accepted for investigation of negligent treatment or maltreatment and closed with an unfounded finding.

On October 23, 2007, the deceased youth's aunt called CPS intake requesting help in filing an At-Risk Youth Petition (ARY) in regards to the deceased youth. She said he was on the run, was involved in an assault incident at a bus stop, and refused to return to her home. She also said he was skipping school and was involved with a gang. This referral was accepted for Family Reconciliation Services (FRS).

On October 30, 2007, staff at a Seattle area Secure Crisis Residential Center (CRC) reported to CPS intake that police brought the deceased youth to their facility after being picked up for trespassing. He had been on the run the prior four weeks. The deceased youth told CRC staff he ran away because his uncle punched him when he is in trouble. He did not have bruising and provided no further details. This referral was screened as information only.

On October 31, 2007, the assigned social worker for FRS reported he met with the deceased youth and the youth made a statement that his uncle tried to choke him, used excessive physical discipline and got drunk on the weekends. This referral was screened in for investigation of physical abuse. This investigation was unfounded.

On November 9, 2007, the deceased youth's birth father requested FRS in order to file an At-Risk Youth (ARY) petition. The father said the reasons for filing the petition were his son's criminal activities (robbery and burglary), gang involvement, drug use, aggression toward peers and possible assault on other students. It was screened accepted for FRS. The father did not respond to repeated attempts by the department to assist with the ARY petition. With no further response from the father, the FRS worker closed the case on November 29, 2007.

## **Issues and Recommendations**

**Issue:** Lack of permanency for the deceased youth. Children's Administration did not file a dependency petition as to the deceased youth when petitions were filed as to the siblings.

**Recommendation:** A petition for the deceased youth could have helped achieve a permanent plan for him. Permanency, attachment and securely belonging to a family are protective against youth violence.

**Issue:** Thorough assessments of relatives to find appropriate placements.

**Recommendation:** A Family Team Decision Meeting (FTDM) could have helped to bring extended family to the table or at least have clearly identified them to the workers involved. Finding appropriate relatives for placement resources helps with achieving child safety, permanency and well-being.

**Child Fatality Review #08-04**  
**Region 4**  
**King County**

This eight-month-old Caucasian male child died as a result of positional asphyxia. The manner of death was determined an accident.

**Case Overview**

On January 19, 2008, the King County Medical Examiner notified Children's Administration that an eight-month-old child had been pronounced dead at St. Frances Hospital. Information from law enforcement investigating the child's death noted the decedent's mother contacted 911 when she awoke and found her child not breathing. Preliminary investigation indicated the child's mother may have rolled over on top of her child while sleeping causing constriction to his airway. The cause and manner of death were to be determined following an autopsy.

**Referral History**

Children's Administration had two previous referrals referencing this family prior to the child's death. No father is listed on the deceased child's birth certificate and no other children were living in the home with the child and his mother at the time of his death.

On August 26, 2007, Child Protective Services (CPS) received a referral on this family called in by a neighbor. The referral alleged the deceased child's mother was intoxicated and left her baby home alone, while she went to the store. The referent also observed the mother heavily intoxicated and on other occasions also saw her drinking. This referral was screened and accepted for investigation of Negligent Treatment or Maltreatment.

The assigned social worker met with the mother and infant one time, in their home. The worker noted the home was very clean and neat; the infant appeared to be large, healthy and developmentally on-target. The mother was cooperative and provided the name of the child's pediatrician. She denied being drunk and denied leaving her son alone in the apartment. She further denied having any prior problems with substance use. The investigation noted the mother was employed, and had on-site daycare for her child. Unknown to the worker at the time of the investigation, the deceased child's mother had a Driving Under the Influence (DUI) conviction in 2006.

No services were offered to the family at the time and no new referrals were received while the case was open. On October 31 2007, the worker completed the investigative assessment, in which the final level of risk was moderate for neglect. The investigative finding was inconclusive. The case was closed in December 2007.

On January 19, 2008, CPS Intake received a call at 11:40 a.m. from the King County Medical Examiner's Office. The medical examiner called to report that the child was pronounced dead at the emergency room at 7:21 a.m. The Federal Way Police were investigating, and that an autopsy was to occur in the next few days. This referral was screened accepted for investigation of Negligent Treatment or Maltreatment and Physical Abuse.

On January 19, 2008, a hospital nurse called CPS intake after the medical examiner had reported the death of this child. The nurse reported the deceased child's mother called her on January 17, 2008 and expressed concern that her child was going to be taken from her. The nurse suspected the mother was under the influence of drugs. The nurse reported the child had been in the intensive care unit at birth. The deceased child's mother was referred to the hospital social worker; however, she did not contact them. There were no allegations of abuse or neglect and the referral screened as Information Only.

During the investigation of the child's death, CPS learned from the Medical Examiner's Office that the Federal Way Police had responded to an incident at the mother's home in October 2007. A loud music complaint had been received and they proceeded to investigate. Upon arriving at the home law enforcement found the deceased child's mother asleep on the couch with the baby (decedent). It was very difficult to awaken her, and when she did wake up, she was intoxicated, and dropped the baby. There was an adult male who was present, and was less intoxicated, and he agreed to watch the baby. The police did not report this incident to CPS.

During the investigation of the child's death the assigned social worker attempted to contact the child's mother, but she had gone to Texas to be with relatives. The social worker spoke with the assigned detective on several occasions and requested a copy of the investigation; however, it was not received. The social worker was unable to obtain information regarding the circumstances around the child's death or progress in law enforcement's investigation. It was during follow up with law enforcement and the medical examiner that the information regarding the previous conviction for DUI was found.

The assigned social worker received information from the Medical Examiner's office. The medical examiner ruled the cause to be positional asphyxia and the manner of death was accidental. The CPS case was closed with an unfounded finding for negligent treatment and physical abuse.

### **Issues and Recommendations**

**Issue:** Law enforcement responded to an incident in October 2007 at the mother's apartment, but did not make a report to CPS. The mother had been very intoxicated and dropped the baby.



**Recommendation:** Law enforcement agencies should provide patrol officers clear guidelines regarding protective custody of children and reporting to CPS. This incident has been discussed between the Area Administrator and a Lieutenant in the Federal Police Department.

**Issue:** A hospital nurse did not call CPS on the same day she received a call from the mother, who sounded intoxicated, and possibly paranoid. Instead she called two days later, on the day the infant died, after the nurse had learned of the death.

**Recommendation:** Encourage mandated reporters to call CPS and/or Law Enforcement whenever they believe a child may be endangered, and not wait for forty-eight hours.

**Issue:** Thoroughness of the investigation. There were a number of questions left unanswered, which likely could have been resolved by collateral contacts and a more detailed discussion with the mother. This may have lead to a voluntary service plan.

**Recommendation:** Consultation with the King South office's out-stationed Chemical Dependency Professional (CDP) would have been helpful. It may have resulted in further efforts to engage the mother around her substance abuse issues. While a criminal history check during investigations is optional, if the worker had done this, the fact of the mother's DUI conviction would have become known. This would have led to information about her treatment, as well as her probation conditions. The infant appeared healthy and developmentally on target to the investigating social worker. However, a signed consent for release of information would have facilitated a conversation between the social worker and the pediatrician. Another fact unknown to the worker, revealed when the hospital nurse called CPS intake January 19, 2008, was that the decedent had been in the newborn intensive care unit at the hospital noting possible medical issues were prevalent.

**Issue:** Safe Sleep Instruction. It is unknown whether this mother had received any instructions about safe sleep positions or environment. This baby died from asphyxia, sleeping on a couch, with his mother. This death was preventable if unsafe sleeping conditions had been discussed with the parent.

**Recommendation:** Social workers should ask parents of newborns if they have received information about safe sleep, and review safe sleeping environment options with them.

**Child Fatality Review #08-05**  
**Region 4**  
**King County**

This two-month-old African American infant's death was a result of Sudden Infant Death Syndrome (SIDS) and manner of death was determined to be natural.

**Case Overview**

On January 26, 2008 King County Medical Examiner's Office contacted Child Protective Services regarding the death of a two-month-old infant. According to the death scene investigator the deceased child's mother stated she put the child to bed at midnight. At approximately 2:00 a.m. one of the family's five-year-old twins woke the parents and said that something was wrong with the baby, one of two-month-old twins. The investigator reported parents started cardio pulmonary resuscitation (CPR) and called 911. It was reported there was a heartbeat but unknown if the infant was breathing. The death scene investigator said the infant died at Children's Hospital in Seattle. Sleeping arrangements for the infant were unknown at the time of the referral. It was also unknown at the time of the referral why the five-year-old awoke at 2:00 a.m. and found something wrong with the baby.

Following an autopsy the medical examiner determined the cause of death was determined to be SIDS and the manner of death was natural.

**Referral History**

This family has an extensive history with Children's Administration including the deceased child's mother having received services when she was a child. The deceased child's mother has five children, including two sets of twins. The family consisted of five-year-old twins, a three-year-old sibling, and twins born in November 2007, one of whom is the deceased child. No fathers are listed on any of the children's birth certificates.

As an adult, the mother had six referrals to Children's Administration (CA) prior to the death of this child. These cover a period of over four years, from April 2003 through August 2007. One was a request by the mother for Child Welfare Services (CWS).

On April 28, 2003, the maternal grandmother called to report the deceased child's mother as homeless and had recently moved with her twins to her home. The mother suddenly left at 10:00 p.m. three days prior and she had not had contact with her since. This referral was screened as information only.

On May 19, 2003, a First Steps service provider called CPS intake to report the family as homeless, but may have been staying with the paternal grandmother. The caller also said

the mother had informed her of a recent domestic violence incident. This referral was screened as information only.

On December 9, 2003, a worker at a homeless shelter reported the twins, ages eleven months, each had suspicious injuries. The mother had also been observed being very rough with them. The assigned worker attempted to engage the mother with Intensive Family Preservation Services (IFPS), and to enlist her cooperation in obtaining medical care and diagnosis for the boys. It screened in as accepted for investigation of Negligent Treatment or Maltreatment

On December 31, 2003, as a result of the earlier referral and subsequent investigation a dependency petition was filed. The court ordered the twin boys be placed in out-of-home care. The case record reflects the children were placed with the maternal grandmother, but they also lived with their paternal grandmother.

Prior to the dismissal of the dependency of these children in March 2005 a number of referrals were received regarding the grandparents while the children were in care.

On April 14, 2004, the children were removed from their paternal grandmother's care and placed with their maternal grandmother. The children were removed from their paternal grandmother's care after repeated concerns of medical neglect. The deceased child's siblings and mother were reunited in September 2004 after an in-home dependency was established with multiple services. The mother was in compliance with all court ordered services and the in-home dependency was dismissed on March 23, 2005.

The fourth referral as to the mother was received on April 8, 2005 shortly after dismissal of the dependency. It was screened accepted for investigation of negligent treatment or maltreatment. The assigned CWS social worker reported that the maternal grandmother informed her that the deceased child's mother allowed a man in the home in which a No Contact Order existed between and he and the deceased child's mother. Domestic violence (DV) occurred and both the deceased child's mother and this man had been arrested. The investigation resulted in an unfounded finding.

On March 25, 2006, a neighbor reported seeing a three-year-old boy on the front porch of his home, wet, cold, dirty and crying. An adult was very hostile to her inquiries. The referral was accepted for investigation of negligent treatment or maltreatment and closed with an unfounded finding.

On August 9, 2007, the mother of the deceased child called requesting assistance with paying her bill for electricity and gas. The assigned social worker helped her to pay the bill and provided community resources information. It was accepted for Child Welfare Services and closed on August 28, 2007.

On November 7, 2007, the deceased child and her sister were born. No other referral was received until notification of the death of a two-month-old infant in January 2008. Following an investigation into the death of the two-month-old infant it was determined the child died as a result of SIDS. Though risk factors existed regarding unsafe sleeping arrangements, the investigation did not indicate an abuse or neglect condition was a contributing cause.

Subsequent to this child's death there were two additional referrals received concerning neglect of the surviving children and the mother's response to the loss of her infant. The investigations were founded and the children were placed in protective custody by law enforcement. A dependency petition has been filed and the children are currently in out-of-home care.

### **Issues and Recommendations**

**Issue:** The mother's participation in services. The record documents that the mother had participated in multiple services, (for example IFPS, FPS, and, First Steps). She appeared to be able to engage and participate in services, but she is a single parent with four very young children and a recent infant death. There is a legitimate concern about her ability to sustain changes and meet the basic needs of her children.

**Recommendation:** There should be frequent monitoring and contact with the mother. The decision to reunite should be carefully considered in regards to the needs of her children.

**Issue:** There needs to be a consistent message from all providers to this mother about the safety needs of her children.

**Recommendation:** From safe sleep environment to preschooler safety, every provider working with this family needs to give the same, consistent messages about safety and developmental needs for all of the children. If the children are returned, a Public Health Nurse from the Early Intervention Program (EIP) is recommended.

**Child Fatality Review #08-06**  
**Region 4**  
**King County**

This nine-month-old African American female died of compressional asphyxiation.

**Case Overview**

On February 4, 2008, the King County Medical Examiner reported to Children's Administration (CA) the death of this nine-month-old child. The Medical Examiner reported the deceased child and her mother slept in the same bed that consisted of a mattress and box springs without a bed frame. This bed was pulled away from the wall and away from a heater to allow for circulation. The mother reported she and her daughter went to bed around 10:30 p.m. The mother reported she woke up when her brother came into her room shortly before midnight and asked her where the baby was. The mother found the deceased child face down (prone) in the gap between the wall and the head of the bed. The baby was lying on top of a pillow that had fallen down in the gap. The Medical Examiner determined that the cause of death was compressional asphyxia. The Medical Examiner determined the manner of death was accidental, but there were also several risk factors that may have contributed to this child's death including cigarette smoke in the home environment and the baby co-sleeping with her mother on a soft surface.

**Referral History**

There are 18 referrals to Child Protective Services (CPS) intake on this family prior to the birth of the deceased child. The first referral was reported in February 1997. Four of the referrals alleged lack of parental supervision of the oldest brother. Several of the referrals were called in by school personnel on the same boy (the deceased child's older brother) alleging he had frequent poor attendance and had poor hygiene when he did attend school. There are three referrals that alleged the deceased child's mother assaulted non-family members and all were screened out as 3<sup>rd</sup> party. One referral alleged domestic violence between the mother and a former boyfriend. Two referrals alleged substance abuse by the mother, including information that she attended, but did not complete, inpatient drug/alcohol treatment. Six of the 18 referrals were investigated by Child Protective Services (CPS) or opened for services. None were closed with a founded finding. Three referrals alleged the oldest brother ran away from home and was caught trespassing on private property. This same child was placed in foster care under a Voluntary Placement Agreement (VPA). These referrals were accepted for Family Reconciliation Service (FRS). The brother ran from his foster care placement.

On January 28, 2008, CPS intake received a referral from law enforcement reported they were placing the deceased child's brother in protective custody for runaway and taking him to the SCRC. The deceased child's mother was charged with selling property her son had stolen. The brother threatened to assault the assigned FRS social worker and also stole from a staff member at Spruce Street. He was placed in foster care, but ran away from this placement. This referral was screened accepted for FRS. The FRS social worker met with the

deceased child, her brother, mother and grandmother. The mother's newborn infant (the deceased child) seemed healthy and normal. The social worker went to the home with a Chemical Dependency Professional (CDP) who screened the mother to determine her need for further treatment.

On February 4, 2008, CPS intake was informed of the deceased child's death the day before. The Medical Examiner determined the manner of death was accidental, but there were also several risk factors that may have contributed to the child's death. There was cigarette smoke in the environment; the infant co-slept with her mother on a soft surface (adult pillow and adult mattress), and there was a gap between the wall and the mattress into which the baby slipped, head-first. The mother's state of impairment, if any, was unknown. This referral was accepted for investigation by CPS but closed without a finding.

### **Issues and Recommendations**

**Issue:** There were no referrals from the hospital, or other health care providers, concerning the mother's pregnancy or the deceased child's birth. A CPS social worker did make an information only report to intake about the mother's pregnancy, but the case was closed before the deceased child was born. The mother entered inpatient treatment for severe cocaine dependence when she was eight months pregnant, and left after eight weeks, against the treatment plan. She did seek WIC formula and as a result received Maternal Support Services (MSS) from Public Health Nursing.

**Recommendation:** The Program Manager will discuss mandatory reporting with the DSHS Division of Alcohol and Substance Abuse (DASA).

**Issue:** The death scene investigation. While it is usually the medical examiner who reports child deaths to CPS, law enforcement typically arrives first. A call from law enforcement to CPS intake could have provided them with more information about the mother, including substance abuse issues. That may have led to information about whether she had been using drugs or alcohol.

**Recommendation:** Follow the CPOD Guidelines for First Responders: Child Deaths and Serious Physical Injury Cases (Collaboration, Preservation, Observation and Documentation), produced in 2006 by the Washington State Criminal Justice Training Commission.

**Child Fatality Review #08-07**  
**Region 6**  
**Clallam County**

This three-year-old Caucasian male drowned in a pond on his parents' property.

**Case Overview**

On March 3, 2008, this three-year-old child wandered away from his parents' residence. The deceased child's father reported last seeing his son at his grandparents' home who are neighbors. Law enforcement was contacted and a search was conducted. A shallow pond on the parents' property was drained and the body of the deceased child was found. Law enforcement determined that it was an accidental death and did not suspect child abuse or neglect. The department did not have an open case on this child or his family at the time of his death.

**Referral History**

The first referral on this family was received on April 24, 2007. This referral alleged Negligent Treatment or Maltreatment by the deceased child's mother. The deceased child, then age two, was found sleeping in a car alone in a parking lot. Law enforcement was dispatched to the location and found the child's mother. She was told of the dangers of leaving her child alone in a car. The mother said the car was always in view. She was already involved in services in the community including parenting classes and childcare at the time of this referral. This referral was investigated by Child Protective Services (CPS) and closed with an inconclusive finding.

The second referral on this family received March 4, 2008 was in reference to the child's drowning. This referral was not screened in for investigation. CA intake spoke with police officers who investigated the death. They determined that it was accidental and did not suspect child abuse and neglect.

No services were offered by the department to this family.

**Issues and Recommendations**

**Issue:** In reviewing the investigation of referral dated April 24, 2007, it was determined that the allegation was not fully investigated. The team felt that the allegation was founded rather than inconclusive as the worker had determined.

**Recommendation:** During the course of the review the social worker was counseled on the importance of completing thorough investigations. The worker indicated that he did not thoroughly document his contact with the mother and service providers working with her.

**Child Fatality Review #08-08**  
**Region 6**  
**Thurston County**

This 11-year-old medically fragile Caucasian male died from acute bronchopneumonia.

**Case Overview**

On July 17, 2008, staff at the Thurston County Health Department informed Children's Administration (CA) staff of the death of this 11 year old boy. He passed away on January 9, 2008. CA staff were unaware of this child's death until notified by the county health department. The child was medically fragile and had Lissencephaly: a rare brain malformation characterized by the absence of normal convolutions (folds) in the cerebral cortex and an abnormally small head. Children with Lissencephaly rarely live beyond the age of five and often die from aspiration of food or fluids, or from respiratory disease. He was fed through a feeding tube and was developmentally delayed. The official cause of death is listed as bronchopneumonia. The child's pediatrician reported this child far outlived his life expectancy and that his parents did a good job providing care for him. The department was previously involved with this child's family due to referrals regarding the alleged filthy condition of the family home. There were no child abuse and neglect allegations in relation to this child's death. The department did not have an open case on this child or this family at the time of his death.

**Referral History**

On November 18, 2004, a social worker from the Division of Developmental Disabilities (DDD) reported to CA intake that the deceased child, then age eight, appeared extremely malnourished. This DDD social worker visited the child and found the child's feeding pump was not hooked up. The deceased child spent all day on a low cot mattress close to the floor. The feeding tube was on the floor and the floor was very dirty. The mother reported her son received five cans of Pediasure during the day. His room smelled strongly of urine. The floor to his room was covered with debris. This referral was screened as low risk for Child Protective Services (CPS) and referred to the Alternate Response System (ARS).

On December 1, 2004, the ARS provider working with this family contacted CA intake with concerns. The child's bedroom smelled of urine and a dirty diaper was lying on the floor. The bedroom floor was covered with garbage and toys. The child's bedding area was in the corner of a room on the floor and the room was cold. His mother reports that the room is one of the colder rooms in the house. She reported the child's condition was terminal and he outlived his life expectancy. The ARS worker believed the child was left to lie in bed most of the day and that his contact with the rest of the family was minimal. This referral was investigated by CPS and closed with an unfounded finding.

On October 19, 2005, a teacher reported the deceased child, then 9-years-old, had a sore on his left thigh approximately five inches long. The sore looked like a burn or a blood blister. The child returned to school after being absent since October 5<sup>th</sup>. The child was non-



ambulatory and non-verbal. The child's mother said she had no knowledge of this sore. The sore appeared older than 24 hours. This referral was investigated by CPS and closed with an inconclusive finding.

On November 16, 2005, school staff reported the deceased child had sores on his back which were bleeding and oozing. There was no indication the sores were suspicious in nature. It was unknown if these sores were the same sores mentioned in a prior referral. This referral was screened as low risk CPS and no finding was required.

On December 8, 2005, a school bus driver reported to CA intake the deceased child was left outside in the cold waiting for the bus in his wheelchair. This referral was screened as information only.

On October 18, 2006, a social worker from DDD reported to CA intake that the deceased child, then age 10, weighed 32 pounds. He had scars from heeled pressure sores. A nurse was sent out to the home and found nothing to report regarding the deceased child's skin condition. This referral was screened as information only.

On October 25, 2006, a social worker from DDD reported to CA intake ongoing concerns about the deceased child. He was blind, non-functioning and heavily contracted (curled up in a fetal position). The mother was not following through with appropriate medical care. The mother reported her son was seen by doctors at Children's Hospital and Mary Bridge Hospital. Staff at both hospitals denied treating this child in the recent past. The deceased child was seen by a doctor at a local clinic in April of 2006 for problems with his gastric tube, feeding difficulties, and seizure issues. This doctor asked the mother why her son was not on medications to address his contracting issues. The mother said her son's former doctor did not believe it was necessary. This former doctor was contacted and denied making this statement. The deceased child was on prescribed medication requiring regular checks of his blood levels. Those checks did not occur. The child's most current pediatrician said he saw no evidence of neglect and spoke positively of the mother's care for her son. This referral was investigated by CPS and closed with an unfounded finding.

On November 14, 2006, a social worker from DDD requested a child welfare check of the deceased child, then age 10. The social worker was concerned that the deceased child's parents were not caring for him appropriately. A deputy from Thurston County Sheriff's Office went to the home. The deputy noted that the home was messy, but did not appear to be unsanitary. The deputy noted a strong smell of urine in the home. The deputy found the deceased child connected to a feeding tube in his room. He appeared thin and pale. The mother told the deputy her son was to see his doctor in two weeks time and that CPS was involved with her family. This referral was screened as information only.

On November 16, 2006, school personnel called CA intake and alleged the deceased child was not properly buckled into his wheelchair, had bad body odor, and bad oral hygiene. This referral was screened as information only.

On October 10, 2007, a relative reported she went to the home and found the deceased child's medication on the bathroom counter with the cap off and that at times she finds the medication in the deceased child's bedroom. The house was dirty. Bugs and fruit flies were present because of old food and garbage lying out. The refrigerator contained food that was expired and molded. The relative said she saw the home in this condition in May 2007 and was unaware of the condition of the home when she called intake five months later. This referral was screened as information only.

On October 22, 2007, a relative reported to CA intake she went to the family home on August 20, 2007. She stated the home smelled of urine and rotting food. The garbage, including food and dirty diapers, was overwhelming. She observed old food on the floor. Flies and gnats were visible on old food and in open food containers. There were dirty dishes scattered throughout the house. This referral was investigated by CPS and closed with an inconclusive finding.

### **Issues and Recommendations**

**Issue:** None identified

**Recommendation:** None

**Child Fatality Review #08-09**  
**Region 4**  
**King County**

This 15-year-old Native American female died from strangulation.

**Case Overview**

On February 17, 2008, this 15-year-old female was found dead by her father, her custodial parent. This teen girl arrived at her home around 2:30 a.m. She was intoxicated. Her father told law enforcement he got angry with her. She ran out of the house and hid under a vehicle in the driveway. Family members brought her back home and put her to bed. Family members reported sitting with her until she fell asleep (approximately 6:30 a.m.). The deceased youth's father reported he woke up about 12:00 noon. He checked on her at 1:30 p.m. and discovered she was dead. The county coroner initially determined that she likely died from acute toxicity from drugs and alcohol. Tests confirmed the youth had alcohol and drugs in her system. However, the King County Medical Examiner determined this was not the cause of death. There was evidence of mechanical asphyxiation and strangulation. The death has been certified as a homicide. The law enforcement investigation continues. No person has been arrested for this child's murder.

**Referral History**

The youth's mother is listed as the primary caretaker on 21 referrals, from April 14, 1998 through May 10, 2002. Fourteen referrals were screened accepted for investigation, and seven were screened information only. The deceased youth is not listed as a victim in any of these referrals as she was raised by her paternal grandmother and later lived with her father. The referral history is on her father's home where the youth was living at the time of her death.

There was one referral on the father's home. This referral was received on April 16, 2007. The father contacted Children's Administration intake requesting Family Reconciliation Services (FRS). The father called reporting his daughter was out of control. The deceased youth was not attending school and was a chronic runaway. The father suspected she was using drugs. He reported she had attempted suicide. The father and grandmother requested assistance to file an At Risk Youth (ARY) petition for the youth. The department opened the case for FRS. The assigned social worker made attempts to contact the family to address the at-risk issues. The father and grandmother (legal guardian) did not respond to the social worker's repeated phone calls and the case was closed.

**Issues and Recommendations**

**Issue:** The pending criminal investigation - there is no primary suspect identified at the time of the review. Several people, including the father, had an opportunity to harm the youth.

**Recommendation:** If this investigation results in the identification of the alleged perpetrator, Children's Administration will take appropriate action.

**Issue:** Sending letters to families to explain programs and resources.

**Recommendation:** In this case, the worker left phone messages, but did not send a letter to the family. In May or June 2008, this office decided to begin sending letters to families who requested FRS, but were not responding to phone calls from the assigned worker. The letter explains this voluntary program, as well as other resources. This is now the standard for the FRS program in the King South office. Children's Administration should consider implementing this practice statewide.

**Child Fatality Review #08-10**  
**Region 1**  
**Grant County**

This three-year-old Hispanic female drowned.

**Case Overview**

This three-year-old child was visiting her grandmother and was left alone in the yard for approximately six to seven minutes. The grandmother's property was adjacent to an irrigation canal. A fence guarding the canal was removed. The deceased child's body was found in the irrigation canal downstream from her grandmother's home.

**Referral History**

On August 21, 2007, a police officer reported to CPS intake that on August 20, 2007, the deceased child left her house and was found wandering unsupervised throughout the neighborhood. The child was returned home that morning by the police officer. On August 21, 2007, the deceased child was again found wandering the neighborhood unsupervised. These incidents were investigated by a CPS social worker. The social worker worked with the mother to address how the child was getting outside unattended. The CPS investigation was closed with an unfounded finding.

On April 18, 2008, CPS intake received a report from law enforcement that the deceased child drowned in an irrigation canal. A CPS case was opened on the mother based in part on history of the child wandering away unsupervised. However, there is no information to indicate the child was in the mother's care at the time of her death. Law enforcement and the investigating CPS social worker determined this fatality was an accident. The CPS case was closed with an unfounded finding.

**Issues and Recommendations**

**Issue:** None

**Recommendation:** None

**Child Fatality Review #08-11**  
**Region 3**  
**Snohomish County**

This 10-year-old Caucasian male died from asphyxiation.

**Case Overview**

On March 10, 2008, this 10-year-old and his peer-aged friends were playing in a neighbor's backyard sandbox. The deceased child asked his friends to bury him headfirst in the sand. His friends buried him from his head to his chest. He started to thrash around, but the friends thought he was playing. Eventually they figured out that something was wrong, quickly dug him out and sought help. Adults performed CPR until an aid car and law enforcement arrived. He was taken to a hospital and declared brain dead. Two days later his parents made a decision to terminate life support. The primary cause of death was listed as anoxic brain injury (his brain was deprived of oxygen) and secondary cause was asphyxia.

**Referral History**

On February 14, 2003, school staff reported concern about the behaviors of the deceased child and his siblings. The oldest sister disclosed that her adolescent cousin molested her and possibly other children. The deceased child's parents contacted law enforcement and did not allow contact with the cousin. This referral was screened as a Third Party referral.

On December 8, 2003, school staff reported to CPS intake that the three oldest children (including the deceased child, then age six) disclosed that they get frequent spankings from their father with a wooden paddle. The school staff believed the children were bruised, but were unable to examine them. School staff were also concerned about the supervision of the youngest child, then age three, in the mornings as she was no longer in day care and the parents had overlapping shifts. Although the referral was assigned for CPS investigation, the interviews and investigation were done by law enforcement and it was determined that no crime had been committed. The CPS case was then closed as unfounded.

On March 8, 2005, CPS intake received a referral from CPS in New Mexico. The deceased child and his sister, then 10-years-old, stayed with their biological mother for the school year. The children disclosed to their mother the sexual abuse by their cousin, which was previously reported in February 2003. This referral was screened as a Third Party referral.

On November 15, 2005, a school nurse reported the deceased child then eight-year-old disclosed that his head hurt because his father slid him across the floor the night before and he hit his head. He said it was all in play. He had a small mark on his forehead. The deceased child also reported that his dad "tortures" him and his siblings. This "torture" was related to tickling. The school counselor said the home life was chaotic. The referral was screened for low-risk CPS. The assigned social worker contacted the father. He said the deceased child had an issue telling lies. He added the injuries happened during play. The case was closed with no further intervention.

On January 17, 2007, a school teacher called to report the deceased child, then age nine, said his wrist hurt, but did not know how it had happened. He also said his father and stepmother had been arguing and he may have to move in with his mother as a result. A month later, the teacher called intake again and reported the deceased child said his sister, then age 12, drank half a glass of rum and coke at a family party. He said she drank it on a dare from their father and acted "weird." Both referrals were screened as information only.\

On February 20, 2008, CPS intake received a report from the Snohomish County Sheriffs Office. Law enforcement investigated a complaint that the deceased child's father held a gun to the head of a 13-year-old neighbor child'. The report indicated the father may have been intoxicated when he pointed a gun at his daughter and her friend. Law enforcement was unable to determine if a crime had occurred. The referral was screened as information only.

### **Issues and Recommendations**

**Issue:** There were two noteworthy points in the history of this case. The first was the investigation of the CPS referral received in December of 2003, and the second was the agency's consideration of the CPS referral that was received from law enforcement in February 2008. In both of these situations, it appears the agency relied unduly on the separate investigations conducted by law enforcement. The purpose of those law enforcement investigations was to determine if there had been a violation of criminal law, rather than the agency's purpose, to assess the risk of child abuse/neglect.

**Recommendation:** Region 3 should address this issue in their upcoming "findings" training.

**Issue:** The screening decision on the last referral received by CPS in this case may have changed with additional information from the referrer. A call back to the law enforcement agency that made the referral may have elicited that information.

**Recommendation:** Making a telephone call to the referrer for clarification of purpose and additional information when law enforcement sends a report to CPS that appears to be intended as a CPS referral. It is recommended that consideration be given to this practice at the next Region 3 Intake Specialist meeting.

**Child Fatality Review #08-12**  
**Region 2**  
**Benton County**

This one-month-old Hispanic female's death was attributed to Sudden Infant Death Syndrome (SIDS).

**Case Overview**

On April 3, 2008, this one-month-old Hispanic female was brought to a hospital in cardiac arrest. The mother told law enforcement she fell asleep with the infant on her lap and when her boyfriend woke up, he found the child face down on the floor not breathing. The deceased child's aunt and mother's boyfriend started CPR and called 911. Detectives reported there was probable cause the death resulted from possible neglect issues. In the Benton County Coroner autopsy report, it was reported the child was found on the floor after co-sleeping between her mother and the mother's boyfriend on a twin bed. The autopsy revealed no trauma, infection, or other apparent cause of death. It is not known how the child ended up on the floor. The coroner's report listed the cause and manner of death as undetermined. The coroner reported Sudden Infant Death Syndrome or overlay asphyxia were both reasonable possibilities.

**Referral History**

On October 13, 2007, staff at a doctor's office reported to Child Protective Services (CPS) intake that the deceased child's mother was four months pregnant and admitted to ongoing methamphetamine use. It was unknown if she received pre-natal care. The mother was homeless at the time of this referral. CPS intake sent notices to area hospitals alerting them that the mother may arrive to deliver her child. The referral was screened as information only. The referral was screened as information only according to CA intake policy. A referral to a local First Steps agency was made by CA staff. This referral notified the First Steps agency that the mother was pregnant and possibly used illegal drugs and/or other controlled substances while pregnant.

On December 4, 2007, the deceased child's mother disclosed to a CA social worker that she was six months pregnant and over the past year used methamphetamine on an ongoing basis during her pregnancy. The mother admitted using methamphetamine on December 2, 2007. The mother said she received prenatal care through a private doctor and did not receive care or services through the Public Health Department. The referral was screened as information only according to CA intake policy and a referral to First Steps was made by CA staff.

On April 3, 2008, CPS intake received a report from law enforcement about the death of the deceased child. Law enforcement reported there was probable cause that the death may have resulted from neglect. The mother's boyfriend reported finding the baby on the bedroom floor. The baby was co-sleeping with the mother and her boyfriend. The coroner's reported the manner of death was undetermined and likely from SIDS or overlay asphyxia. This



referral was investigated by CPS and closed with an unfounded finding for negligent treatment or maltreatment.

**Issues and Recommendations**

**Issue:** None

**Recommendation:** None

**Child Fatality Review #08-13**  
**Region 6**  
**Clark County**

This nine-day-old Caucasian male died from a severe infection.

**Case Overview**

On March 14, 2008, a hospital social worker reported to Children's Administration (CA) intake that this child passed away due to a severe infection caused by a communicable disease passed onto the baby at birth. The mother gave birth to this child and his twin sister earlier in the month. Both the mother and the infants tested positive for methamphetamine and Cannabinoids at the time of the birth of the twins. A dependency petition was filed on the surviving twin. She was in foster care for approximately two months and then placed with her father under an in-home dependency. The mother had five other children removed from her care and did not engage in services.

**Referral History**

On September 10, 2006, a police officer placed three siblings of the deceased child in protective custody. The officer reported the living conditions in the home were real bad. There were feces in the home and no running water. The 14-year-old was made to do pushups as a form of discipline and her father kicked her in the back for not doing them correctly. The children were put in protective custody and placed in foster care. This referral was investigated by Child Protective Services (CPS) and closed with an inconclusive finding. The children were returned to their parents' care days later with a service plan in place.

On September 16, 2006, the deceased child's mother contacted CA intake to request Family Reconciliation Services (FRS). This referral was screened for FRS.

On November 1, 2006, a family friend reported to CPS intake concerns for the safety of the deceased child's three older siblings. The children called from a neighbor's home and said their father held the 13-year-old down by her throat. The 14-year-old sister tried to stop their father from hitting the 13-year-old and he hit the older sister in the face. The referent was not sure if both girls were hit. The referent did not see the girls in person so was unclear if there were injuries. This referral was investigated by Child Protective Services (CPS) and closed with an inconclusive finding. The family was actively involved in services monitored by the department.

On November 7, 2006, school staff reported the older two sisters in the family were runaways. Once they returned they had to stay in the bedroom at all times. The parents put a container in the room for them to go to bathroom. They were not allowed out of their room to eat nor could they speak to the other children. The referral was screened for low-risk CPS.

On June 4, 2007, a family friend said one of the children came to her door and did not want to go home because her mother was a methamphetamine addict and the home was filthy and rat infested. The child also reported dirty laundry was three feet high and the utilities were about to be shut off. The referral was screened for low-risk CPS.

On July 5, 2007, the 15 and 13 year-old siblings of the deceased child told a neighbor their mother kicked them out of the house. They added their mother was gone for three days and they took care of their younger siblings. This neighbor said the deceased child's mother hung out with a bad group of people and she was into drugs. The neighbor called FRS intake to see how she could help the girls. The referral was screened for low-risk CPS.

On July 10, 2007, a police officer reported the house was filthy and unfit for human habitation. There were eight dogs with both animal and human feces in every room of the house. The officer placed the five children in protective custody. Dependency petitions were filed on each child. They were out of their parents' care when their mother gave birth to twins (including the deceased child). They remain out of their parents' care. The referral were screened in for investigation by CPS and closed with founded findings.

On January 7, 2008, a relative reported the deceased child's mother was pregnant and using methamphetamine daily. The mother planned to have the baby at home to avoid detection by law enforcement and CPS. She did not receive prenatal care. This referral was screened as information only.

On March 6, 2008, a hospital social worker and a social worker with Home and Community Services reported the mother gave birth to twins (one being the deceased child). The mother received no prenatal care during her pregnancy and was not aware that she was having twins. The mother tested positive for methamphetamine prior to the birth of these twins. The mother told hospital staff she used methamphetamine to relieve stress. The hospital social worker reported the babies were stable. The mother lost custody of her five other children and did not engage in court ordered services. This referral was accepted for investigation by CPS and closed with a founded finding.

On March 14, 2008, a hospital nurse reported the death of this nine-day-old child. The child died from a severe infection caused by a communicable disease passed onto the baby at birth.

## **Issues and Recommendations**

**Issue:** None

**Recommendation (Comment):** The death of this infant was an unfortunate result of exposure to a communicable disease carried by his mother. The department had been working with the mother prior to his birth, but she refused to engage in services. The older

siblings are in care and remain in care. The office and social workers involved in this case worked very closely with the parents and had frequent and ongoing access to them. The social workers have also worked very closely with all of the children to identify their needs and provide them with the necessary services. The office worked with both fathers involved in this case and has sought out relatives to utilize for placement and support in this case. The social workers were diligent and worked hard to provide the safest environment for these children while promoting reunification plans with the parents. This case was full of excellent documentation of all of the efforts and services that have been provided to this family.

**Child Fatality Review #08-14**  
**Region 4**  
**King County**

This three-month-old African American male's death was attributed to Sudden Infant Death Syndrome (SIDS).

**Case Overview**

On April 5, 2008, the King County Medical Examiner reported to Children's Administration intake that the deceased child's mother was co-sleeping with her twins (one of the twins is the deceased child) in her bed. She reported she woke four times during the night to feed them. When she woke in the morning, she noticed the deceased child had mucus and blood coming from his nose and mouth. The Medical Examiner reported this is common with SIDS fatalities. The mother tried to clear the area with a small pump but the child was already deceased.

In 2007, another infant died in the mother's care. The mother's four-month-old daughter died from injuries from being shaken by her birth father. He did not live in the family home and harmed this child during a scheduled visit. The father was charged with Murder. There was no evidence the mother was aware of the injuries to this child.

**Referral History**

On May 31, 2007, the King County Medical Examiner reported to Children's Administration intake the death of a four-month-old female child in the mother's home. This child would be the sister to the deceased child. The initial cause of death was suspicious and the Medical Examiner's office investigated this fatality. This sibling died from a skull fracture with bleeding on the brain. The police were notified and two other older siblings, ages five-years-old and 16-months-old, were placed in protective custody. The child's father admitted to shaking the child and was charged with Murder. Dependency petitions were filed on the two surviving siblings and they remained in relative care. By March 14, 2008, the mother had complied with all services and court orders, and there had been no new referrals to Child Protective Services (CPS). A Child Protection Team (CPT) recommended the dependency be dismissed; the dependency was dismissed on March 24, 2008 and the CA case was closed on March 27, 2008. The CPS case was closed with a founded finding as to the father and an inconclusive finding as to the mother.

On April 5, 2008, the King County Medical Examiner reported to Children's Administration intake the death of the deceased child died from unknown causes. The mother told law enforcement that she woke and found the deceased child's nose plugged (he had a cold) and attempted to clear the nostrils of mucus with a small pump. The Medical Examiner reported the baby was already dead at that time. The referral was screened in for investigation by CPS and closed with an inconclusive finding. According to the autopsy report, the cause of death was SIDS. There were no signs of physical trauma.

## **Issues and Recommendations**

**Issue:** Each of the social workers helping this family were effective in engaging mother and other family members in services. The decision to file a dependency petition after the first child death, and to monitor closely while the family received services, was very appropriate, as was the decision to dismiss the dependency and close the case near the end of March 2008.

**Recommendation:** None

**Issue:** The risk factor of co-sleeping with premature twins on an adult bed, with soft objects present. There was no documentation that the mother had received safe sleep instruction when the twins were born. The surviving twin was apparently on or near a pillow when his mother awoke.

**Recommendation:** Health care providers and Children's Administration should consider strategies for emphasizing a safe sleep environment.

**Issue:** Coordination of investigations with law enforcement. The social workers had difficulty engaging the same police department in both investigations, in the first case, causing a delay in contact with the children and the caregivers; in the second case, coordinating the need for physical exams to rule out child maltreatment.

**Recommendation:** The recent revision to the King County Special Assault Network Protocol, addressing serious physical abuse, helps to clarify each agency's role.

**Child Fatality Review #08-15**  
**Region 6**  
**Grays Harbor County**

This one-day-old Caucasian male died from respiratory distress syndrome due to acute drug toxicity.

**Case Overview**

On April 7, 2008, this deceased child was born at home, delivered by a midwife. Both the mother and the midwife claim the birth went fine and the baby cried when born, but when the umbilical cord was cut the infant's condition immediately deteriorated. There was approximately a 35 minute delay before 911 was called. The infant was transported to Grays Harbor Community Hospital via ambulance. Tacoma General transport team was called to the to the hospital in Grays Harbor to pick up the infant and transport to Tacoma. The Tacoma General staff arrived at the hospital and took over treatment at approximately 11:30 p.m. They were unable to revive the infant.

**Referral History**

The department received four referrals on this family since 1999. The first three referrals were screened out. Two of these referrals alleged substance abuse by the parents, the most recent alleged the eight-year-old sister had a burn on her leg. The fourth referral received on July 17, 2008 was the report from the Grays County Health Department to the Aberdeen DCFS office regarding the death of this child. The hospital, the midwife, and law enforcement did not make a referral to the department at the time of the child's death in April 2008.

On July 17, 2008, the Grays Harbor Health Department reported to Child Protective Services (CPS) intake the death of this infant. The cause of death was listed as neonatal death with respiratory distress syndrome due to acute drug toxicity (methamphetamine, opiates, and meprobamate) as a result of the mother's drug use. The deceased child was brought to the Grays Harbor Community Hospital just after being born and died in the hospital emergency room. The coroner's report confirmed the information from the Health Department. This referral was investigated by Child Protective Services (CPS) and closed with an inconclusive finding for Negligent Treatment.

There was a nine-year-old sister of the deceased child still residing in the home. The deceased child had two other siblings who live with their biological father. The CA social worker offered services to the family, but they refused. The social worker considered filing a dependency petition on the nine-year-old sister, but there was insufficient evidence to support this action. This case was staffed at CPT in September 2008, and the CPT

recommended closure with risk. The nine-year-old sibling's school counselor was contacted and reported no concerns for her well-being.

### **Issues and Recommendations**

**Issue:** At the time of the review, the Structure Decision Making (SDM) Risk Matrix was not completed. It was noted that staff try to get the SDM completed at the time they determine services will be offered to the family however that doesn't always happen.

**Recommendation:** The Aberdeen office will review their practice and work towards completing the SDM in a timely manner. They understand that the SDM should be completed prior to the completion of the investigative assessment.

**Issue:** The department was not notified of this incident until three months after the child's death. This case has been reviewed by the Health Department and it was agreed that they will begin making notification to CPS on all child deaths in Grays Harbor County.

**Recommendation:** No recommendation as a plan has already been established.