Report to the Legislature

Quarterly Child Fatality Report

RCW 74.13.640

July – September 2011

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Executive Summary

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

> ***Child Fatality Review — Report***
>
> *(1)(a) The department shall conduct a child fatality review in the event of a fatality suspected to be caused by child abuse or neglect of any minor who is in the care of the department or a supervising agency or receiving services described in this chapter or who has been in the care of the department or a supervising agency or received services described in this chapter within one year preceding the minor's death.*
>
> *(b) The department shall consult with the office of the family and children's ombudsman to determine if a child fatality review should be conducted in any case in which it cannot be determined whether the child's death is the result of suspected child abuse or neglect.*
>
> *(c) The department shall ensure that the fatality review team is made up of individuals who had no previous involvement in the case, including individuals whose professional expertise is pertinent to the dynamics of the case.*
>
> *(d) Upon conclusion of a child fatality review required pursuant to 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. A child fatality review report completed pursuant to this section is subject to public disclosure and must be posted on the public web site, except that confidential information may be redacted by the department consistent with the requirements of RCW 13.50.100, 68.50.105, 74.13.500 through 74.13.525, chapter 42.56 RCW, and other applicable state and federal laws.*
>
> *(2) In the event of a near fatality of a child who is in the care of or receiving services described in this chapter from the department or a supervising agency or who has been in the care of or received services described in this chapter from the department or a supervising agency within one year preceding the near fatality, the department shall promptly notify the office of the family and children's ombudsman. The department may conduct a review of the near fatality at its discretion or at the request of the office of the family and children's ombudsman.*

During the previous quarter, SHB 1105 was passed by the legislature and signed into law by Governor Gregoire. The revised child fatality statue (RCW 74.13) was effective during the 3rd quarter of 2011. The revised child fatality statute requires the department to conduct fatality reviews in cases where a child death is suspected to be caused by abuse or neglect. This eliminates the requirement to conduct formal reviews of accidental or natural deaths unrelated to abuse or neglect. The revised statute requires the department to consult with the Office of Family and Children's Ombudsman (OFCO) if it is not clear that the fatality was caused by abuse or neglect. The department can conduct reviews of near fatalities or serious injury cases at the discretion of the department or recommendation by OFCO. The new law gives the department access to autopsy and post mortem reports for the purpose of conducting child fatality reviews.

This report summarizes information from 12 completed reviews of fatalities that occurred in 2011. All twelve of the child fatalities were reviewed by regional Child Fatality Review Teams.

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

The reviews in this quarterly report include fatalities from each of the three regions[1].

Region	Number of Reports
1	7
2	4
3	1
Total Fatalities Reviewed During 3rd Quarter, 2011	12

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

[1] DSHS implemented a reconfiguration of the regional boundaries in May 2011. The existing six regions were consolidated into three.

Executive Child Fatality Reviews (ECFR) are conducted in cases where the child fatality is the result of apparent abuse or neglect and CA had an open, active case at the time of the child's death or the child received services from the department within 12 months of his/her death. In the Executive Child Fatality Review, members of the review committee are individuals who have not had any involvement in the case and represent areas of expertise that are pertinent to the case. The review committee members may include legislators or representatives from the Office of the Family and Children's Ombudsman.

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

Child Fatality Reviews for Calendar Year 2011			
Year	Total Fatalities Reported to Date Requiring a Review	Completed Fatality Reviews	Pending Fatality Reviews
2011	41	40	1

The numbering of the Child Fatality Reviews in this report begins with number 11-04. This indicates the fatality occurred in 2011 and is the fourth report completed during that calendar year. The number is assigned when the Child Fatality Review and report by the Child Protective Services Program Manager or practice consultant is completed. The reviews contained in these Quarterly Child Fatality Reports are a summary of the actual report submitted by each region.

Notable Findings

Based on the data collected and analyzed from the 12 child deaths reviewed between July and September 2011, the following were notable findings:

- One child fatality occurred when the youth was residing in a facility licensed by the Division of Licensed Resources. This fatality was not the result of abuse or neglect by the caregivers.
- Two fatalities occurred in Department of Early Learning (DEL) facilities.
- Children 11 months or younger accounted for approximately 75% (9) of the 12 fatalities reviewed and 5 of the 9 fatalities of children under 1 year of age were female.
- Of the 12 child fatalities reviewed, 58% (7) were males and 42% (5) were females.
- Of the 12 child fatalities reviewed, 50% (9) of the children were identified as white, 17% (3) were Native American, 6% (1) was Hispanic, 17% (3) were identified as

African American, 10% (2) were identified as Asian/Pacific Islander. Some of the children are identified as being of more than one race or ethnicity.

- Natural and accidental deaths, as classified by the medical examiner or coroner, accounted for approximately 75% (9)) of the total deaths. The manner of death of the remaining cases was as follows: 17% (2) were due to unknown/undetermined causes, and 8% (1) were the result of suicides. There were no deaths as a result of homicide.
- Of the 12 child fatalities reviewed, 11 had prior contact with Children's Administration (CA). One review was conducted on a child fatality that occurred at a licensed child care facility with no prior history. Seventy-five percent (75%) of the child fatalities reviewed had between zero and four prior intakes and 25% had between five and twenty prior intakes.
- Due to the small sample of cases reviewed, no statistical analysis was conducted to determine relationships between variables.

Table 1.1

3rd Quarter 2011, Child Fatalities by Age and Gender						
Age	**Number of Males**	**% of Males**	**Number of Females**	**% of Females**	**Age Totals**	**% of Total**
<1	4	57%	5	100%	9	75%
1-3 Years	1	14%	0	-	1	8%
4-6 Years	0	-	0	-	0	-
7-12 Years	0	-	0	-	0	-
13-16 Years	2	29%	0	-	2	17%
17-18 Years	0	-	0	-	0	-
Totals	7	100%	5	100%	12	100%

N=12 Total number of child fatalities for the quarter.

Table 1.2

3rd Quarter 2011, Child Fatalities by Race	
Black or African American	3
Native American	3
Asian/Pacific Islander	2
Hispanic	1
White	9
Unknown	-
Total Some children may be in more than one category	**18**

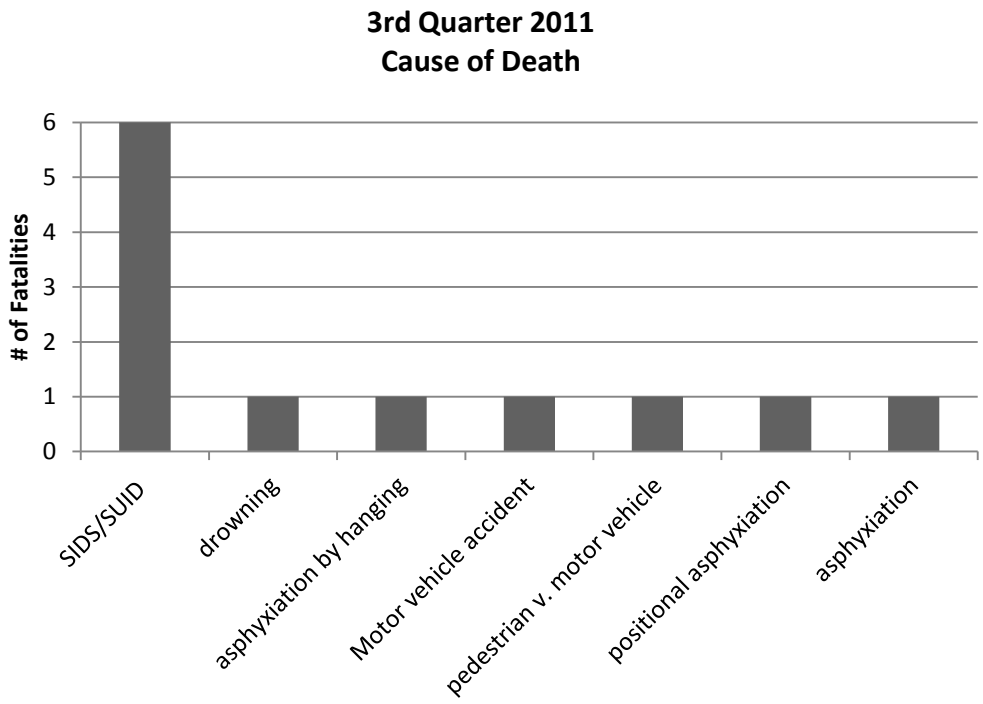
*Some children may be in more than one category.

Table 1.3

3rd Quarter 2011, Child Fatalities by Manner of Death	
Accident	5
Homicide (3rd party)	0
Homicide by Abuse	0
Natural/Medical	5
Suicide	1
Unknown/Undetermined	1
Total	**12**

N=12 Total number of child fatalities for the quarter.

Table 1.4



N=12 Total number of child fatalities for the quarter.

Table 1.5

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

N=12 Total number of child fatalities for the quarter.

Summary of the Recommendations

Of the 12 child fatalities reviewed between July and September 2011, 8 (67%) identified issues and recommendations during the child fatality review process. Issues and recommendations from fatality reviews impact policy, practice and systems associated with CA. At the conclusion of every case that receives a full team review, the team decides whether any recommendations should result from issues identified during the review of the case. In most instances where the death was categorized as being preventable, some recommendations were made.

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

3rd Quarter 2011, Issues & Recommendations	
Contract issues	0
Policy issues	0
Practice issues	8
Quality social work	3
System issues	6
Total	**17**

In two cases, issues and recommendations were made regarding thorough CPS investigations; and in two other cases issues were raised about timely documentation by social workers. In these four cases, these issues were addressed through action at the local office level. Safe sleep education was an issue raised by one review team. Poor communication with service providers and delays in a referral to a service provider were

identified issues in two separate cases. Each was addressed at the local level at the time of the review. A review team questioned the lack of reporting by mandated reporters in one case, but did not identify a recommendation from this issue.

Issues involving supervision of young children were identified in one case. These issues were identified in a fatality review of a child death occurring in a Department of Early Learning (DEL) licensed facility.

An issue identified by one fatality review team addressed covering funeral expenses for a dependent youth. The team recommended CA create a protocol to determine when CA will cover the funeral expenses for children who die when a case is open.

Child Fatality Review #11-04
Region 1
Yakima County

This 16-year-old Native American male died from injuries sustained in a motor vehicle accident. Children's Administration (CA) had an open Child Welfare Services (CWS) case on the family at the time of the youth's death.

Case Overview
On February 4, 2011, this 16-year-old youth was in a single car accident in rural Yakima County. The youth was ejected from the car even though he was wearing a seatbelt. He died at the scene. The family was immediately contacted by the Washington State Patrol. The Yakima County Medical Examiner determined that the 16-year-old died from the injuries he sustained in the accident. The manner of death is listed as accidental.

Children's Administration had an open case on this youth at the time of his death. The youth was a dependent of the Yakama Tribal Court. Children's Administration social workers provided case management during the tribal dependency.

Intake History
This family first came to the attention of Children's Administration in 2001. The family's history with Children's Administration consists of 23 intake referrals reported between the year 2001 and 2009. Of those 23 intakes, 17 were screened in for investigation by CPS. All of the 17 screened in intakes alleged negligent treatment or maltreatment. Parental substance abuse was an issue in many of the screened in intakes. Of the 17 investigations, four intakes were concluded with founded allegations of abuse and neglect; 8 were concluded to be unfounded; 5 were concluded to be inconclusive. Additionally, there were two intakes accepted for Alternative Response System (ARS); and 4 referrals screened out with no allegations of abuse or neglect.

In 2001, Child Protective Services (CPS) intake received a report that this youth had missed 55 days of school that year (he was in kindergarten). The mother was often angry and profane with school staff. There continued to be allegations of substance abuse on the part of the mother. The youth and his brother were eventually removed from their mother's home due to maltreatment after reports of physical abuse of the youth's younger brother.

In November 2004, dependency petitions were filed on the youth and his brother in Yakama Tribal Court after allegations of burns to a then 11 month old infant in the home. The youth and his brother were placed out of their home and with a grandfather. The children were made dependents of the tribal court in February 2005. The dependency was dismissed later in April 2005 and they were returned to their mother's care at that time.

In June 2007, the youth was again made a dependent of the Yakama Tribal Court following reports that the children had been severely neglected both medically and emotionally. The youth and his brother have been Tribal Court dependents since that time. CA staff participated in regular review hearings conducted every six months. The youth and his brother were placed with extended relatives. The youth participated in services including mental health counseling. The youth participated in substance abuse treatment in June 2009, but aborted treatment before its completion.

In October 2010, Children's Administration (CA) staff requested a special hearing because the relative placement requested to have the youth removed from his care because he became defiant and had run away to his grandfather's home. CA staff recommended that the youth stay with his grandfather temporarily as he appeared to be the only relative who had a positive impact on the youth's behavior.

After two months of placement, the grandfather failed to follow the safety plans, including random urinalysis for both he and his grandson. The youth was not attending school and the grandfather did not require the youth to obey household rules. A Family Group Conference was held in December 2010 and the family agreed that the grandfather's home was not a safe and productive placement for the youth at that time. He was not able to provide the structure, stability, sobriety, consistency and discipline that the youth needed at that time. The family further recommended that the youth be placed in a non-relative foster placement out of the area in an attempt to keep him safe from the familial influence that was undermining his progress.

The CA social worker requested removal of the youth from his grandfather's care in December 2010. The youth and his grandfather did not attend the Family Group Conference and left the area together. Children's Administration staff were unable to locate them from November 2010 until February 3, 2011. At the dependency court hearing on January 20, 2011, the court agreed that the youth needed to be moved to a different placement. The judge agreed to a pick up order for the youth. CA staff were unable to locate them.

On February 3, 2011, a relative reported seeing the youth at a convenience store. The relative reported that he appeared intoxicated. The department contacted police and requested that the youth be placed in a detention facility. Yakama Tribal Police found him at this grandfather's home on February 4, 2011, but he ran when police attempted to talk to him.

On February 5, 2011, CA staff were notified that the youth was killed in a single car accident. The youth was under a dependency court order to complete a drug/alcohol evaluation at this time of his death.

Issues and Recommendations

Issue: Complex cases that involve high risk child behavior have become more prevalent among social worker caseloads. Because of this child's defiant and difficult behavior, relative placement was difficult to maintain as well as managing overall safety.

Recommendation:

1. Social work staff will be reminded of resources available to relative caretakers that would assist them in maintaining these children in their care, i.e. Resource Family Training Institute, Casey Family Kinship Care Program, CA Service Providers. This will be completed at the next all staff meeting by the Area Administrator or designee by July 31, 2011.

2. The Area Administrator or designee will meet with newly appointed Children's Tribal Judge to discuss the challenges in meeting the health and safety of these children. This will be completed by July 31, 2011.

Child Fatality Review #11-05
Region 1
Kittitas County

This 9-month-old Caucasian female drowned. Children's Administration (CA) did not have an open case on the family at the time of her death.

Case Overview
On February 11, 2011, Ellensburg Police and emergency medical technicians responded to a report of a 9-month-old who drowned in a bucket of mop water. The child's mother told law enforcement that she and her 10-year-old son were in the kitchen washing dishes and the counters. She placed a bucket of mop water in the living room. She was unable to see the bucket from the kitchen. The mother later went into the living room to check on her 9-month-old daughter and found her in the bucket.

The police officer noted the home was very clean and counters cleared off. There was vomit both inside and outside of the bucket on the floor possibly outside from mother pulling the child out of the bucket. The child was transported to an area hospital and was later moved to Seattle Children's Hospital and placed on life support. She died on February 14, 2011. Law enforcement reported this incident appeared to be an accident. No other injuries or concerns were found during the autopsy. Additionally, the criminal investigation was completed by the Ellensburg Police Department and no criminal charges were filed.

The King County Medical Examiner determined that the 9-month-old died from the drowning. The manner of death is listed as accidental.

Children's Administration did not have an open case on this child or her family at the time of her death. In October 2010 Child Protective Services (CPS) intake received a report alleging the nine-year-old brother occasionally cared for his infant sister. The intake also alleged the home was unsanitary. This intake was screened for an Alternate Intervention.

Intake History
On August 1, 2002, a relative of the mother reported to CPS intake that the mother was incapable of caring for her 22-month-old son (now 9 years old). The referrer reported the mother was abusing drugs and alcohol and leaving him with inadequate caretakers. The intake was screened in for investigation and closed with an unfounded finding for negligent treatment or maltreatment.

On December 15, 2005, a Head Start teacher contacted CPS intake to report the mother's nine-year-old son (five years old at the time of this report) had not attended Head Start for two to three weeks. The referrer was informed by relatives that the mother did not think it was important to have him in Head Start. The child also disclosed

to a Head Start teacher that his mother hit him on the abdomen. The intake was screened in for investigation and closed with an unfounded finding for physical abuse.

On January 11, 2010, a relative reported to CPS intake that the mother had a new boyfriend and he was verbally abusive to the mother's nine-year-old son. The referrer also reported the mother has a two-year-old daughter and her hygiene was poor. The intake was screened out for investigation as there was no allegation of abuse or neglect.

On August 12, 2010, law enforcement contacted CPS intake to report the 15-year-old brother told police that he was in conflict with his mother's husband and the youth was shoved to the floor during an argument. Police reported he was not injured. The youth lived with his biological father and was visiting his mother's home. The intake was screened out for investigation.

On October 29, 2010, CPS intake received a report that the nine-month-old (four months old at the time of this report) was being cared for by her nine-year-old brother. The referrer reported the older brother would occasionally miss school to care for her. The outside and inside of the home were described as unsanitary. The intake included an allegation of poor hygiene of a 23-month-old sibling. The intake was screened for Alternate Intervention. A social worker conducted a home visit to the family home and completed a face to face with all identified children. The home was found to be clean and appropriate with no identified safety concerns.

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

Recommendation: None

Child Fatality Review #11-06
Region 3
Kitsap County

This six-month-old Native American female died from asphyxiation. Children's Administration (CA) did not have an open case on the family at the time of her death.

Case Overview
On February 17, 2011, the mother of this six-month-old child went into a bedroom to check on her daughter. The mother screamed to other family members that her daughter was not breathing. A call to 911 was made with both emergency medical and law enforcement responding to the home. Law enforcement and emergency medical technicians noted that the child was already deceased; therefore, the infant was not transported until after a death scene investigation was completed. Witnesses interviewed by law enforcement included the 17-year-old daughter and a family friend who had arrived shortly before the deceased child was discovered. The biological father of the deceased child did not appear to have been present in the home at the time of the fatality incident.

The autopsy revealed no signs of trauma or injuries on the body or to the internal organs. The medical examiner concluded that the child likely died within hours of being fed and put down to sleep. The time of death is estimated to be around 2:00 a.m. The mother denied co-sleeping with her baby. According to law enforcement and the Deputy Coroner, the mother's account of the incident is consistent with the findings of the autopsy. Post-mortem toxicological test results were negative.

The cause of death was ascribed as probable asphyxiation secondary to suffocation or smothering as a result of the baby becoming entangled in multiple bedding in the crib.

Children's Administration did not have an open case on this child or her family at the time of her death. In October 2010 Child Protective Services (CPS) intake received a report alleging the mother occasionally had inappropriate caretakers watch her 16-month-old son. This intake was screened for an Alternate Intervention.

Intake History
On July 24, 2006, an anonymous referrer reported to CPS intake that the mother and her teen daughter were living with relatives in a home that had no running water. The water had been shut off, and the bathroom facilities were reportedly not operable. There were additional concerns for possible lack of supervision of the children by the adults living in the home. The report was screened out per the anonymous referent policy and RCW 26.44.030. It is known that local law enforcement did go to the home but did not find sufficient reason to intervene. The intake was screened out for investigation.

On September 6, 2006, a family friend reported to CPS intake that the mother dropped off her 13-year-old daughter over one week prior and didn't return. The referrer was unable to keep the youth. The intake was screened for a Child Welfare Services (CWS) case. Family Preservation Services (FPS) was initiated to help the mother and daughter stabilize their housing situation, to obtain necessary household items (e.g., furniture, washer and dryer), and to facilitate the child getting into school (enrollment, school supplies, school clothes). Additionally the FPS therapist worked with the family on parenting and improving communication between mother and daughter. FPS closed out services in late December 2006.

On April 9, 2010, CPS intake received a report that the mother was allowing her son (then 16 months old) to be occasionally babysat by a friend whose children were removed by CPS. The report was determined to be low risk (Alternate Intervention) and was referred to Early Family Support Services (EFSS) which was unable to connect with the family.

On February 12, 2011, law enforcement contacted CPS intake to report the death of the six-month-old. The intake was screened in for investigation and CPS investigated the allegations in conjunction with law enforcement. The autopsy revealed no signs of trauma or injuries on the body or to the internal organs. The post mortem evidence confirmed that the infant had died within hours of being fed and put down to sleep. The child's mother denied co-sleeping with the baby.

There were no criminal charges regarding the fatality incident, and the CPS investigation has been closed with an unfounded finding for neglect.

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

Recommendation: None

Child Fatality Review #11-07
Region 1
Chelan County

This three-month-old Caucasian female died from Sudden Infant Death Syndrome (SIDS). Children's Administration (CA) did not have an open case on the family at the time of her death.

Case Overview
On February 23, 2011, this three-month-old child was found unresponsive in an infant swing while she was at the home of her licensed child care provider. A child care staff reported to law enforcement that the child care owner placed the three-month-old in the stationary swing for a nap at 9:00 a.m. It was further reported the infant was checked on approximately every 15 minutes and at 10:30 a.m. was discovered not breathing. The child care provider called 911 and attempted resuscitation efforts until medical personnel arrived.

The Chelan County Coroner determined the cause of death was Sudden Infant Death Syndrome (SIDS). The manner of death is natural/medical.

Children's Administration did not have an open case on this child or her family at the time of her death. She was in the care of a licensed child care provider when she died from SIDS.

Intake History on the Child care Provider
The family child care provider was provisionally licensed on September 10, 2003. She received a full license for family child care in her home on April 5, 2004 from the Department of Early Learning (DEL).

The first licensing complaint was received on April 25, 2007. An unidentified individual contacted a DEL licensor in Wenatchee describing the child care provider as a good provider, however had concerns regarding the use of a second story porch overlooking a steep drop off. The caller was concerned that the porch railing was not tall enough and the children had been seen using a chair to look over the edge.

Two DEL licensors went to the family child care home to discuss the concern reported. The provider agreed to not have any children on the upper porch until the floor was replaced and the railing with slats was a minimum of four feet tall.

Additional deficiencies were identified at this same contact and additions were made to the compliance agreement. Other areas noted by DEL licensors included no fire drills, expired fire extinguishers, incomplete child files, infants sleeping in car seats and swing, unlocked medication, unlocked shed and freezer, expired CPR card by an employee and the climbing toys in the yard were in need of ground cover. A compliance agreement to

remedy the deficiencies was agreed to on May 7, 2007. On May 15, 2007 the complaint was closed as valid for the use of unlicensed child care space referencing the porch.

On April 1, 2008, an anonymous reporter called in a licensing complaint alleging the child care provider was out of the country and left a minor in charge of the child care facility. The reporter stated this was not the only time this has occurred.

The original screening decision was accepted for Division of Licensed Resources/Child Protective Services (DLR/CPS) investigation with an emergent response.

On April 2, 2008 a DLR/CPS investigator and DEL licensor made an unannounced site visit to the child care. The child care provider's 17-year-old daughter was in charge of the child care and reported her mother went to Mexico for a family emergency and was expected to return on Aril 11, 2008. There were nine children present who all appeared healthy and supervised.

The DEL licensor consulted a DEL supervisor and the decision was made to allow the child care to remain open with a compliance agreement. The DLR investigator consulted a DLR/CPS supervisor and a decision was made to change the intake from a DLR/CPS investigation to a DEL licensing complaint based upon the absence of any child abuse and neglect victims.

A written agreement was completed with three child care assistants that all three would remain on site during the hours of child care operation, complete background checks that had previously been rejected and arrange for immediate tuberculosis tests. A compliance agreement could not be completed due to the provider not being available for signature.

An unannounced site visit was made on April 7, 2008. Following the visit the licensor called the child care and requested that all the blinds in the child care be removed as they posed a safety hazard. On April 8, 2008 the licensor returned to the child care and all blinds had been removed.

On April 11, 2008 the provider had returned from Mexico and initiated contact with the licensor. The concerns were reviewed with the provider and the licensing complaint was closed as valid on May 19, 2008.

This family child care completed licensing renewals on July 17, 2008 and again on April 16, 2010.

On February 23, 2011 DEL and DLR were notified of the infant fatality in this family child care.

Issues and Recommendations

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

Recommendation: None

Child Fatality Review #11-08
Region 2
King County

This 15-month-old African American male died from injuries sustained when she was run over by a car. Children's Administration (CA) did not have an open case on the family at the time of her death.

Case Overview
On March 23, 2011, this 15-month-old child got out of his parents' home and crossed yards to the driveway of neighbor's house. The 15-month-old followed his four-year-old brother out the front door of his parents' home. A neighbor was leaving her home and observed several children playing in the vicinity of her vehicle She instructed them to move off of the driveway and to her left, on the driver's side of the car, where she could keep an eye on them. Unknown to the driver, the 15-month-old was behind her car, near the driver's side rear wheel. Apparently the child was bending over and the driver did not see him. She started backing out of the driveway and ran over him. This incident occurred at around 7:00 p.m.

The King County Medical Examiner determined the cause of death was a skull fracture and brain lacerations due to blunt force injury of the head. The manner of death is accidental.

Children's Administration did not have an open case on this child or her family at the time of the child's death. The child was in the care of his parents. The child's mother was a licensed child care provider.

Intake History on the Child Care Provider
The mother was first licensed as a child care provider on June 24, 2010. She renewed her license on December 23, 2010. Prior to this incident, there were no licensing complaints or Child Protective Services (CPS) intakes on this child care provider. The Department of Early Learning (DEL) suspended her license and filed a licensing complaint after receiving the report of the death of this child.

On March 24, 2011, the King County Medical Examiner's office reported to CPS intake that the 15-month-old got out of his parents' house the evening of March 23 and crossed yards to the next door neighbor's house. The neighbor was backing out of their driveway and ran over the child. The incident occurred around 7:00 p.m. The child was pronounced dead at 7:30 p.m. apparently as a result of injuries received in the accident. Law enforcement also investigated the incident. The intake screening decision was accepted for Division of Licensed Resources/Child Protective Services (DLR/CPS) investigation and accepted as a licensing complaint. The DLR/CPS investigation was closed with an unfounded finding for negligent treatment or maltreatment. The licensing complaint was determined to be not valid.

Issues and Recommendations

Issue: Supervision of young children. This 15-month-old toddler quickly followed his four-year-old brother out the door. The incident illustrates the need for parents to be vigilant at all times.

Recommendation: None

Issue: Improving safety before driving a vehicle. The national "Spot the Tot" campaign is designed educate drivers to walk around a vehicle before getting in, so that fatal incidents such as this can be avoided.

Recommendation: None

Child Fatality Review #11-09
Region 2
Whatcom County

This 16-year-old Hispanic male died from asphyxiation caused by hanging. His death was ruled a suicide. He was a dependent youth at the time of his death.

Case Overview
On April 7, 2011, in the early morning hours, officers with the Lynden Police Department responded to a foster home in the area. The foster father told police he woke up that morning to get ready for work and went into the family room. He saw the 16-year-old foster youth near the patio door and appeared to be standing at the door. He also noticed a chair sitting near the door. He then approached the youth and touched him. He was cold and stiff with a dog leash around his neck. The other end of the leash was tied to a curtain rod above the patio door. The foster parent said he unhooked the leash and lowered the youth to the floor. He immediately called 911 with police and fire department personnel responding.

Whatcom County Medical Examiner's office completed the autopsy. The autopsy report indicated the cause of death was ligature hanging and the manner of death was suicide.

Children's Administration had an open case on this youth. He was removed from the care of his mother in December 2010 and made dependent in March 2011. He was in the care of licensed foster parents when he died.

Intake History on the Foster Care Provider
These foster parents have been licensed since December 2006. Prior to this incident, there were no licensing complaints or Child Protective Services (CPS) intakes on these foster parents.

On April 7, 2011, the Division of Licensed Resources/Child Protective Services (DLR/CPS) opened an investigation into the death of this 16-year-old youth. The investigation was closed with an unfounded finding for negligent treatment or maltreatment. The youth had substance abuse issues. He had no prior suicidal ideations or self harming behaviors. Additionally, he was not on a specific supervision plan. His assigned social worker saw him the day prior and he was in good spirits. He was in counseling and saw his counselor the day before he died.

Issues and Recommendations
Issue: The team agreed that there was quality social work by the staff assigned to the case of the youth's mother and staff assigned to the DLR licensed foster home provider. The team also agreed that the licensed foster parents were excellent caregivers to him.

Recommendation: None

Issue: The team agreed there was poor communication between some of the involved systems (Chemical Dependency (CD) Treatment Providers, Children's Administration staff, and probation officer) regarding information about the youth's increased substance abuse issues. The CD professional stated that there are no WACs in the CD field that mandate chemical dependency professionals to contact Children's Administration when a client they share has a positive urinary analysis (UA) test.

Recommendation: The CFWS social worker, supervisor, and area administrator were present at this review and said this was a good reminder for them to reach out to the chemical dependency experts to get reports and results of UA's regarding shared clients.

Issue: The team reported that there was a lot of frustration and confusion by foster parents, biological parent, and CA staff regarding who covers the costs of the youth's funeral expenses, what funding was available, and how to authorize those funds.

Recommendation: The team recommended that Children's Administration headquarters staff create a protocol to address funeral expenses of both dependent and non-dependent children when a child dies on an open CA case.

Child Fatality Review #11-10
Region 2
King County

This one-month-old Caucasian female died from Sudden Infant Death Syndrome (SIDS). Children's Administration (CA) had an open case on the family at the time of her death.

Case Overview
On April 5, 2011, the King County Medical Examiner (ME) reported to CA intake that this one-month-old infant was found unresponsive in her bassinet by her mother. The ME stated that the child's mother and her boyfriend woke up at around 7:00 a.m. to find the one-month-old unresponsive. Paramedics were summoned to the home and the infant was pronounced dead at 7:25 a.m.

The Medical Examiner determined the cause of death to be SIDS, and the manner of death to be natural. There were no other children in the home. Grief and loss counseling was offered to the mother.

Children's Administration had an open case on this child or her family at the time of her death. The day before her death (April 4, 2011), CPS intake received a report of neglect of this child. The intake was screened in for investigation with a 72 response time. The CPS supervisor assigned the case to a social worker, however the child died before contact was made with the family.

Intake History
On April 4, 2011, CPS intake received a report regarding concerns for this one-month-old infant. The referrer reported the infant was not gaining weight sufficiently and seemed lethargic (not moving much and or crying). The referrer speculated that this was due to drug use by the child's mother and also stated that the mother and boyfriend were prescription drug addicts. The referrer said that the mother and her boyfriend sleep long hours and are often drowsy or will fall asleep while the child is in their care. It was also reported this infant had recently rolled off the bed while co-sleeping with her mother.

It was also reported that the mother's boyfriend drives under the influence of drugs with the infant in the car.

There were no criminal charges regarding the fatality incident, and the CPS investigation was closed without a finding as there was no indication of abuse or neglect related to the child's death.

Issues and Recommendations
Issue: The intake dated April 4, 2011 was properly screened, and assigned for investigation. The worker was on his way to see the family and provide infant safe sleep information, when CA learned of the child's death that morning.

Recommendation: None
Issue: There were no reports to CPS from health care professionals concerning the child.

Recommendation: None

Child Fatality Review #11-11
Region 1
Walla Walla County

This four-month-old Caucasian female died from positional asphyxiation. Children's Administration (CA) did not have an open case on the family at the time of her death.

Case Overview
On May 24, 2011, the father of this four-month-old brought her with him to visit family members in Oregon. He fell asleep on a couch with his daughter and reports his arm was across the top edge of the couch. When he awoke on May 25, 2011 his arm was across the child's chest; she was not breathing or responsive. CPR was initiated but was unsuccessful.

An autopsy was conducted and the medical examiner found nothing of concern and the child had no injuries. The medical examiner ruled the manner of death accidental and the cause of death was positional asphyxia.

The parents were separated and had no other children. The four-month-old lived with her mother who allowed the father to bring their daughter to Oregon to visit paternal family members.

Children's Administration did not have an open case on this child or her family at the time of her death. CPS intake received one report of neglect of this child, but the intake was screened out for investigation as the report did not contain an allegation of abuse or neglect.

Intake History
On February 22, 2011, Child Protective Services (CPS) received contact from the child's mother regarding her then six-week-old infant daughter. The mother was concerned because she and her daughter's father had separated the previous night and he refused to return the child back to the care of her mother. The child's mother said she was breast feeding the infant so she was unsure how the father was feeding the infant. She also reported that he used and sold marijuana. The referrer contacted law enforcement who reported there was no action for them to take. The father was contacted and arranged to return the child to her mother's care. The intake was screened as information only as there were no allegations of child abuse or neglect and any risks indicated did not rise to the level of imminent risk or serious and immediate harm to the infant.

Issues and Recommendations
Issue: None

Recommendation: None

Child Fatality Review #11-12
Region 1
Franklin County

This one-month-old African American male died from unknown causes. Children's Administration (CA) had an open case on the family at the time of his death.

Case Overview
On May 16, 2011, Child Protective Services (CPS) received an intake report from Pasco Police regarding the death of this one-month-old infant. The mother and her son were staying at her father's house. She reported to law enforcement that she and her 12-year-old brother went to bed at approximately 10:30 p.m. and she put her son to sleep in the same room in a bassinet next to her bed. In the middle of the night, she placed him in the bed between her and her brother with a blanket over them. The mother woke at around 4:00 a.m. and found her son not breathing. She yelled for her father to get help. He called 911 and performed CPR until medics arrived. The child was declared dead at the scene approximately five minutes after medics arrived. Police did not see any signs of trauma including any marks or bruising.

Police contacted the child's father and informed him of his son's death.

The Franklin County Coroner has classified this child's death as unknown cause and unknown manner following a complete autopsy and toxicology tests.

Children's Administration had an open case on this child at the time of his death. CPS received one report of neglect of this child shortly after the child was born and the investigation of this report was still open when this-one-month-old died. This intake was screened in for investigation.

Intake History
On April 26, 2011, a doctor called CPS intake and made a report regarding the safety and well-being of this child. The child had breathing difficulties immediately following his birth and was admitted to the Special Care Nursery. There were concerns that the child was born drug-affected. The child's father was arrested and charged with possession of marijuana and selling marijuana to middle school-aged children. The mother was arrested the day before she gave birth on old outstanding warrants. The referrer expressed concern about the possible risks/dangers related to both parents and having a newborn baby with some birthing complications. The intake was screened in for CPS Risk Only pursuant to a Children's Administration policy to screen in intakes reported by a licensed physician or medical professional on children ages birth to five years old.

A social worker met with the mother and developed a plan of safe care. The plan provided that the child would sleep in a crib and his parents would not have illegal drugs in the home. The mother was referred to Women, Infants, and Children (WIC), Safe

Babies Safe Moms, and Crisis Response. She agreed to attend counseling. The child was tested for drug exposure and all tests had returned negative.

On May 16, 2011, the department received the report of the death of this one-month-old. The intake was screened in for investigation. The CPS investigation was completed with a founded finding of negligent treatment are founded against the mother. The mother was non-compliant with the plan of safe care by not allowing her son to sleep in his own crib. The mother was also instructed regarding the concerns of co-sleeping with her baby. The case was closed in June 2011. The parents had no other children in their care.

Issues and Recommendations
Issue: The review committee discussed that a home visit to the family residence to assess preparedness and physical safety for the infant was a missing investigative element.

Recommendation: None
Issue: The review committee discussed that during the post fatality investigation the social worker did not interview the decedent's uncle who was sleeping in the same bed with the infant. The social worker also did not interview the infant's maternal grandfather who was present and performed CPR on the infant. These were determined missed elements in the investigation.

Recommendation: None
Issue: The Director of the Office of the Children and Family Ombudsman observed the review process and acknowledged the thorough and detailed work completed by the intake social worker for the intake received on April 26, 2011. The review committee concurred that the intake included detailed and significant information that was relevant to the assigned social worker's investigation.

Recommendation: None

Child Fatality Review #11-13
Region 2
King County

This one-month-old Caucasian male died from Sudden Infant Death Syndrome (SIDS). Children's Administration (CA) had an open case on the family at the time of his death.

Case Overview
On April 26, 2011, Child Protective Services (CPS) intake received a report from the King County Medical Examiner regarding the death of the four-month-old child. The child woke at 7:30 a.m. and was fed four ounces of formula by his mother. She held him until he fell asleep and then placed him lying face down on top of a circular pillow in a smaller crib that was in the dining area of the family home. His parents checked on him soon after and he was unresponsive.

The death was reported to the Medical Examiner at 11:36 a.m.; the Medical Examiner's staff arrived at 12:45 p.m. The child was pronounced dead at 2:45 p.m. The Medical Examiner noted during his investigation that the Medical Examiner found soft bedding, a dirty and cluttered home environment, with empty beer bottles under the crib where the infant was found. The child also slept in a prone position. The parents told police and Medical Examiner investigators they son placed their son in the prone sleep position because they were concerned he was developing a flat spot on the back of his head.

The mother received pre- and post-natal care.

The autopsy report noted that the child was found in a prone position with his head and face within the crook of a soft "boppy" type cushion. The cause of death was determined to be SIDS, with the risk factors of soft bedding and prone sleep position noted. The manner of death is natural.

Children's Administration had an open case on this child or his family at the time of his death. CPS received one report of neglect of this child shortly after the child was born. This intake was screened in for investigation.

The family included a two-year-old sister to the one-month-old.

Intake History
On February 1, 2011, Child Protective Services (CPS) intake received a report alleging that the mother did not get up with her children and was a poor housekeeper. It was also reported that the older sister was covered in flea bites. The case was screened in for Alternate Intervention and was referred to the Public Health Nursing - Early Family Support Services (EFSS) program. A public health nurse was assigned on February 7, 2011. However, a second intake was received on the family on that same date. The second intake was screened in for investigation. Per the EFSS contract, this service

closes whenever there is a new report that is opened for investigation, so the EFSS was closed before it had the opportunity to make contact with the family.

On February 7, 2011, CPS intake received a report that the one-month-old was born premature and weighed less than four pounds at birth. It was also alleged that the mother was breastfeeding and drinking alcohol. The referrer reported the living conditions were hazardous to the health and safety of the children. The intake was screened in for investigation of negligent treatment or maltreatment.

The social worker found the home to be acceptable. The CPS worker found the parents were attentive and appropriate with both the infant and their daughter, who appeared to be healthy and well cared-for.

The case remained open but was later closed with an unfounded finding.

On April 26, 2011, the King County Medical Examiner contacted CPS intake to report the death of this one-month-old child. The intake was screened in for investigation of negligent treatment or maltreatment. The Medical Examiner reported the initial finding was that the child died from SIDS. The final autopsy revealed no physical trauma and there were no suspicious circumstances. The Medical Examiner determined that the parents did not place their son in a higher risk sleeping position. There was no evidence found during the CPS investigation that supported the allegations of neglect and the investigation was closed with an unfounded finding.

Issues and Recommendations

Issue: It appears that there was no contact between the worker and the family, between February 10, 2011 and the date of the child's death on April 26; a period of 76 days. Per policy, investigations are to be completed within 45 days.

Recommendation: If a case remains open to CPS, there should be a case plan and ongoing contact. The Program Manager and Area Administrator reviewed this with the assigned worker and he understands the importance of timely case management.

Issue: The case notes of the assigned worker's contact with the family from February 10, 2011 were not entered in FamLink until April 27, the day after the infant died.

Recommendation: Case notes are to be entered within three days of a contact or case activity. While this involved just one case note, an untimely entry subsequent to the death of a child can raise the question of accuracy. Program Manager and Area Administrator discussed this with the assigned worker and he understood the importance of timely case notes.

Issue: Timeliness of the referral to Public Health Nursing/Early Intervention Program (EIP). The referral was made on May 11, 2011, focusing on the family's grief and loss. However, the family was eligible for EIP on February 7, 2011 as an open case with an infant. In-home safe sleep instruction may have made a difference.

Recommendation: Use EIP at the earliest possible point of intervention.

Issue: Public Health records verify that the mother did receive safe sleep instruction.

Recommendation: Encourage workers to always ask about safe sleep for families with infants. If the family needs safe sleep information provide it, and also make an EIP referral.

Child Fatality Review #11-14
Region 1
Spokane County

This six-month-old Native American male died from Sudden Unexplained Death in Infancy (SUDI). Children's Administration (CA) had an open case on the family at the time of his death.

Case Overview
On May 5, 2011, the mother of this six-month-old child found him unresponsive. They were living in the home of the maternal grandmother. The grandmother attempted CPR while the child's mother called 911. The first responders continued attempts to revive the child while transporting him to a Spokane area hospital. He was pronounced dead on May 6, 2011.

The Spokane Medical Examiner determined the child's cause of death to be sudden unexplained death in infancy with contributing factors of bi-lateral haemophilus influenza (a bacterial infection often infecting eyes, ears, throat and lungs) and ear infections in both ears. The manner of death was natural. The family included a four-year-old sister to the six-month-old.

Child Protective Services (CPS) intake had received a report on the day the child died alleging injuries to the child sustained during a domestic violence incident between his parents. The Medical Examiner reported that the autopsy did not detect any injuries to the child related to the child's death.

Children's Administration had an open case on this child or his family at the time of his death. CPS received a report of possible abuse of this child. The investigation was still open when the report of the child's death was made to CPS intake.

Intake History
On June 2, 2008, CPS intake received a report of a response to domestic violence at the home of the child's mother. She had her daughter, then 10 months old, in her care. The family was reportedly living in Seattle at this time. The family included the mother, her former boyfriend and her daughter. The mother had an Order of Protection against her former boyfriend. Police reported they had responded to the home on three separate occasions in 2008 for domestic violence. The law enforcement reports indicate the 10-month-old was present during all of the domestic violence altercations. The intake was screened in for investigation. The assigned CPS social worker made multiple attempts to locate and see the family but was unsuccessful. At the time it appeared that the family was not residing in Seattle.

On July 27, 2009, CPS in the Office of Indian Child Welfare in Seattle reopened the original investigation from the previous year based upon a case review that occurred in

that particular office. A supervisor identified concerns that the 10-month-old was never seen by a CA social worker.

The newly assigned social worker learned that the family had moved to Spokane and were residing with relatives. The case was transferred to the Spokane office. Relatives reported the mother's boyfriend was in jail due to a domestic violence assault. The case was closed as he was expected to be sentenced to prison. There was no face-to-face contact made with the child or mother by a CA social worker. The case was closed on August 21, 2009.

On September 22, 2009, an intake was accepted for investigation with concerns that the mother's older daughter, then 12 months old, appeared malnourished and was treated cruelly by the mother. It was also reported that she was left unsupervised for extended periods of time and her mother was drinking alcohol on a daily basis and smoking marijuana. The mother completed a urinalysis (UA) which was negative. She agreed to participate in the Women, Infants, and Children (WIC) services and child care. The mother's boyfriend was in jail. The case was closed on December 8, 2009 after consultation with the social service agency with the mother's tribe. The case was closed with an unfounded finding for negligent treatment or maltreatment.

On May 25, 2010, an intake was accepted as an imminent risk of harm investigation. There were no allegations of child abuse or neglect. A police report was received from Spokane Police documenting the arrest of the mother for assault (domestic violence) against her new boyfriend, the father of the now deceased six-month-old child. The mother was pregnant with his child at the time. It was alleged they argued over his drug use.

On May 27, 2010, the mother and her boyfriend came to the CPS office. The worker met with the family and requested both adults submit a UA. The mother's boyfriend refused and the mother said she would and then failed to comply.

It was learned through the investigation that the child's father had a founded finding for physical abuse for using a belt on his 10-year-old stepdaughter during a previous marriage.

On June 16, 2010, the mother attended a meeting with social service workers with the mother's tribe. The tribal social services worker recommended a safety plan in which the mother's boyfriend not have any contact with the mother or her children and the mother would check in once per week with the assigned social worker.

The case was kept open with a Voluntary Service Plan that included individual counseling, a parenting program, and a safety domestic violence (DV) assessment for the both parents. The older daughter was referred to Head Start. The mother participated in many of the services, demonstrated progress and increased parenting skills. Her boyfriend did not follow through with the recommended services. On

September 15, 2010, tribal social services recommended case closure when the Voluntary Service Plan expired on September 22, 2010.

On February 18, 2011, an intake was accepted for investigation of alleged physical abuse. The previous day the mother contacted a case manager at her supported living apartment and reported domestic violence by her boyfriend. The case manager reported the incident to law enforcement. On the morning of the February 18, 2011, the case manager observed what appeared to be a small bruise under the eye of the now deceased child. He was three-months-old at this time. The case manager did not know how the infant obtained the mark.

A CPS afterhours social worker observed the child the two days later and observed that the child had a small red spot on his cheek. The worker described the mark as a rash or eczema. The child was taken to a doctor who confirmed that he had some type of infant rash on his cheek and his mother was provided cream to treat the rash.

The assigned social worker continued to assess the risk of the children in the home primarily due to domestic violence issues.

The case was being prepared for case closure when, on May 6, 2011, an intake was accepted based on information that the six-month-old had died earlier that morning at the hospital.

Information obtained after the child's death included he had attended his well-child exams and received his recommended immunizations.

The Spokane Medical Examiner determined the child's cause of death to be sudden unexplained death in infancy (SUDI) with contributing factors of haemophilus influenza and ear infections. The manner of death was natural.

Issues and Recommendations

Issue: The investigation from June 2008 was reviewed as part of an internal Indian Child Welfare office review in King County during 2009. The investigation was closed as unable to complete based on the family moving from the area. The decision from the internal review was for the case to be reopened and a thorough investigation occur. The case was reopened in July 2009 in King County. The family was reported to be in Spokane at this time. The assigned worker made telephone contact with an extended family member who confirmed the mother and child were living with the relative and the case was closed. There was no contact made with the child or parents either in person or in any other manner. There is no documentation that any contact had been made with the Spokane Tribe regarding the case being reopened or an inquiry as to the status of the family with the tribe.

Recommendation: None

Child Fatality Review #11-15
Region 1
Spokane County

This six-month-old Caucasian male died from Sudden Unexplained Infant Death (SUID). Children's Administration (CA) did not have an open case on the family at the time of his death.

Case Overview
In the evening of May 25, 2011, the father of this three-month-old son put him down to sleep. The father reported he woke at 4:15 a.m. on May 26th and noticed that his son had kicked his blanket off so the father put the blanket back over him. At 6:00 a.m. the father woke again and noticed his son was not breathing and he could not find a pulse. The child's mother ran next door to her grandmother's home to get help. Emergency medics were called and paramedics responded to continue life saving efforts. The child was transported to a Spokane area hospital where he was declared dead.

The death scene investigator from the medical examiner's office reported this was not a suspicious death for child abuse or neglect and an autopsy was completed. Upon completion of the death scene investigation and an autopsy the Spokane County Medical Examiner determined the death of this three-month-old to be sudden unexplained infant death with the manner of death being natural.

Child Protective Services (CPS) intake had received a report on the day the child died alleging injuries to the child sustained during a domestic violence incident between his parents. The medical examiner reported that the autopsy did not detect any injuries to the child related to the child's death.

Children's Administration did not have an open case on this child or his family at the time of his death. Nine months prior to the child's death, CPS intake received a report alleging the child's mother was operating an unlicensed child care. It was also alleged she used physical discipline on children in the child care. The intake was not screened in for investigation.

Intake History
On June 2, 2008, CPS intake received a report alleging the mother was running an unlicensed child care and the children were spanked with a metal spatula. There was no indication that any of the children sustained any injury. It was unknown whether or not the children were still attending the unlicensed child care. It was determined that this mother did not require licensure for the type of child care she was providing. The intake was screened out for investigation.

On May 27, 2011, CPS intake was notified by the Spokane Medical Examiner's office reporting the death of this three-month-old child. There was nothing suspicious regarding the infant's death and the intake was screened as an information only report.

Issues and Recommendations

Issue: No issues or recommendations were made at the conclusion of the fatality review.

Recommendation: None