Washington State
Department of Social
& Health Services

Report to the Legislature

Quarterly Child Fatality Report

RCW 74.13.640

April - June 2005

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Children's Administration Child Fatality Report

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INTRODUCTION

This is the April – June 2005 Quarterly Child Fatality Report provided by the Department of Social and Health Services (DSHS) to the Washington State Legislature as required by RCW 74.13.640. Passed during the 2004 Legislative Session, HB 2984 (RCW 74.13.640) requires the department to report on each child fatality review conducted by the department and provide a copy to the appropriate committees of the legislature. This Quarterly Child Fatality Report summarizes the 14 reviews that were completed during the second quarter of 2005. All of these fatalities were reviewed by a regional Child Fatality Review Team.

Child Fatality Reviews are conducted when children die unexpectedly and their families had an open case or received services from the Children's Administration 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 to address the identified issues. A review team can be as few as two individuals on cases where the death is clearly accidental in nature, to a larger multi-disciplinary committee where the child's death may be the result of abuse and/or neglect by a parent or guardian.

The Executive Child Fatality Review is a special review convened by the Children's Administration's Assistant Secretary. The Executive Child Fatality Review may be requested in cases where a dependent child dies as a result of abuse and/or neglect by their parent or caretaker, or a non-dependent child dies of abuse and/or neglect on an open, active case or in a licensed facility. In the Executive Child Fatality Review, members of the review committee are individuals who did not have any involvement in the case and represent areas of expertise that are pertinent to the case. Committee members may also include legislators or others as determined by the Assistant Secretary.

It is often many months following the death of a child before the fatality review is completed. This is due to Child Fatality Reviews requiring a multi-agency effort in gathering complete reports and findings. It is necessary to wait until all information is compiled in order to ensure a thorough review of the case, even when this means having an extended timeline for completion.

The chart below displays the number of completed Child Fatality Reviews as well as those yet to be completed for the years 2004-2005. The number of reviews not yet completed is subject to change if CA learns through a record review that the fatality was anticipated rather than unexpected or if CA history on a family is later located under a different name or spelling.

Year	Child Fatality Reviews completed and submitted since July 1, 2005	Child Fatality Reviews to be completed
2004	27	23
2005	1	20

The numbering for the Child Fatality Reviews in this report begin with #04-17. This indicates the fatality occurred in 2004 and is the 17th report completed for that year. The number is not assigned until the Child Fatality Review and report by the CPS Program Manager are completed.

The reviews included in this quarterly report discuss fatalities that occurred in the following Regions:

3 reports are from Region 1—Moses Lake (1) and Spokane (2)
2 reports are from Region 2—Toppenish (1) and Yakima (1)
1 report is from Region 3—Everett
3 reports are from Region 4—Bellevue (1) and Kent (2)
4 reports are from Region 5—Bremerton (1) and Tacoma (3)
1 report from Region 6—Tumwater

In addition to the quarterly Child Fatality Reviews, CA will be completing an Annual Child Fatality Report which will provide statistical information as well as issues and recommendations from reviews on child fatalities that occurred throughout the entire year. The next annual Child Fatality Report will be for the year 2003.

Child Fatality Review #04-17
Region 1
Spokane Office

Case Overview

This two-month-old Caucasian female died on September 27, 2004 due to Sudden Infant Death Syndrome (SIDS). The mother's case was open at the time of the child's death. The mother of this child was referred to Child Protective Services (CPS) on three prior occasions.

The first referral on September 18, 2003 alleged that an older child had two head injuries possibly due to falling. The home was reported to be a "pig sty." This referral was sent to the Alternative Response System (ARS) for follow-up.

The second referral on May 28, 2004 alleged the home was "filthy." The father was out of town regularly as he is a long haul truck driver. This referral was sent to ARS for follow up.

On June 18, 2004, a referral was received alleging that the mother did not supervise her children and the home was "filthy." The referral indicated that the mother was pregnant. This referral was assigned for investigation and services as needed. Services for this family included Family Preservation Services (FPS), counseling, improved access to medical care and prescriptions, and connection with natural supports of family and church.

At the time of the child's death on September 27, 2004, the case was open for services. Due to the death of this child, the three siblings were placed into protective custody with relatives. The parents participated in services, and the children were returned by the end of November 2004.

The case was closed in February 2005.

The services offered during the history of the case include mental health, public health, parenting class, medical service, Intensive Family Preservation Service, ARS, counseling, and psychological evaluation. All of these services were accepted and engaged in by the family with the exception of parenting classes.

Issues and Recommendations

Two computer errors were identified by the review team. This information was given to the region for correction. No other issues or recommendations were reported.

Child Fatality Report #04-18
Region 1
Moses Lake Office

Case Overview

This 19-month-old child died on September 16, 2004 due to complications from a near drowning incident which occurred on June 28, 2004.

On June 28, 2004, the child was in the care of his mother. She left the child unattended near a swimming pool for an unknown duration. This child was found in the pool, and it is estimated the child was in the pool for ten minutes prior to being found. He was revived and remained in a comatose state until his death.

There were eight prior referrals alleging neglect associated with methamphetamine use. The family first came to the attention of Child Protective Services (CPS) on November 27, 2001. The allegation was that mother was using methamphetamine and was not supervising the child while living in an inadequate home environment.

On November 29, 2001, the paternal grandfather called and reported that the mother had brought the child to his home and asked that he care for her while the mother participated in drug treatment. The mother entered an in-patient program, and the paternal grandparents cared for the child. The case was closed as inconclusive on January 23, 2002.

On October 10, 2002, the maternal grandmother made a referral to CPS with concerns that the mother was pregnant and using drugs. The referral was screened as informational only as the grandmother did not have an address for the mother.

On October 27, 2002, CPS received a referral from the Soap Lake Police Department. An officer reported that the parents had been arrested for possession of drug paraphernalia and weapons. Law enforcement placed the child into protective custody. On October 28, 2002, the child was moved from foster care to her paternal grandparent's home. Both parents signed a Voluntary Placement Agreement and stated they would participate with services. The case was presented to a Child Protection Team (CPT) on December 19, 2002, and a recommendation was made to keep community providers involved but to have CPS close the case. The investigation concluded with a founded allegation of physical neglect.

The next CPS referral was received on January 22, 2004 alleging that the parents were using drugs again, living in unsanitary conditions, and were not supervising their children. A male baby was born in February 2003 and was almost a year old at the time of the referral. The report included information that this baby had ingested liquid Tylenol and required medical treatment. No report of this incident was received from the medical providers. The assigned social worker attempted a home visit with law enforcement on January 29, 2004. No one answered the door although sounds could be heard coming from within the residence. The social worker attempted to contact the family by phone, but their number was disconnected. On February 3, 2004, the social worker learned that law enforcement had returned to the family home and arrested the

mother on an outstanding domestic violence warrant. Law enforcement had contacted the paternal grandparents to come get the children. Child Protective Services was not contacted or involved in the placement by law enforcement. On February 10, 2004, contact was made with the family at their home. The parents denied drug use and stated they would clean the residence. Five additional home visits were attempted through February and March 2004, but no one was ever home. The case was closed on April 30, 2004.

On May 7, 2004, CPS received a faxed report from Ephrata Police Department describing an incident that occurred on April 30, 2004. The baby had been found wandering on a road with no parental supervision. Law enforcement eventually located the parents and returned the child to their care. A social worker made contact with the mother on May 11, 2004, and a safety plan was established. Four additional home visits were attempted through May and June 2004 with no response from the parents.

On June 24, 2004, another referral was called into CPS alleging an unsanitary home environment and no food in the home for the children. On June 25, 2004, a similar referral was received and assigned to an Alternate Response System (ARS).

On June 28, 2004, the 16-month-old child was the victim of a near-drowning incident.

The services offered to this family during their history with Children's Administration (CA) include substance abuse testing and evaluation, parenting classes, child care, Alternative Response System (ARS), and anger management classes. The family accepted substance abuse services, ARS, and anger management. They refused parenting classes and child care.

Issues and Recommendations:

I. Practice Issues

A. Issue: The case was closed prematurely in December 2002. The nature of the safety and risk factors would warrant additional intervention and monitoring of services to reduce the risks to the child in the home.

Recommendation: *The recommendation is to keep cases like this one open in order to address the issues identified through the investigation. The mother was in her last trimester of pregnancy during this investigative episode, and the vulnerability of a newborn coming into the home within a couple of months needed to be considered.*

B. Issue: The intake of the referral dated January 22, 2004 was screened lower than the risk and history warranted.

Recommendation: *This referral could have been screened as high risk due to the history of the family and the critical issue of a child overdosing on medication.*

C. Issue: The June 24, 2004 and June 25, 2004 referrals received on the family are risk tagged moderate and low. The interventions utilized are for low risk cases.

Recommendation: *The history within the family and the nature of the allegations need to be considered in a larger perspective. Due to previous interventions and the continuous re-referrals, the risk to the victims would be increasing instead of decreasing. Training to this issue needs to occur with Intake workers and CPS social workers.*

D. Issue: Over the course of four months, nine parental contacts were attempted by visits to the family's residence. Contact was not made during these visits. During the investigation of the referral dated January 22, 2004, the case was closed after multiple unsuccessful attempts at parental contact.

Recommendation: *Region 1 identified a need for a practice protocol regarding attempting to locate and contact a family. The protocol was supported and implemented by the Regional Administrator on December 13, 2004.*

II. System Issues

A. Issue: On January 19, 2004, a one-year-old child ingested Tylenol. He required medical intervention and his stomach was pumped due to concern of a potential overdose. The hospital that provided medical intervention for the potential overdose did not report the incident to CPS. The supervision of the children in the home was clearly an issue.

Recommendation: *Mandated reporters need to be educated on the requirement of reporting to CPS when there is a reasonable cause to believe that a child is a victim of child abuse and/or neglect.*

B. Issue: Law enforcement faxed a report of negligent treatment to CPS seven days after an incident occurred on April 30, 2004. The incident included a 15-month-old child wandering on a street with no supervision.

Recommendation: *Law enforcement should communicate with CPS at the time a child has been identified as a victim of child abuse and/or neglect.*

C. Issue: Domestic violence was identified as an area needing to be addressed within the family system.

Recommendation: *A certified domestic violence program in the Moses Lake area needs to be identified and/or recruited.*

Child Fatality Review #04-19
Region 2
Toppenish Office

Case Overview

This Native American female child died shortly after birth on November 292004. The doctor reported that the childs death was due to the mo thers ingestion of cocaine during pregnancy.

The mother has had three prior referrals stating that the mother was using drugs during pregnancy. These referrals were founded for allegations of prenatal substance abuse. All three children were positive for cocaine at birth. The mothers drugs of choice are cocaine and alcohol.

All of the siblings to this child were placed out of home prior to the birth of this child. One child is safely placed in relative care by a dependency action with the Yakama Nation Childrens Court. The four other children resi de with their grandmother with a Voluntary Placement Agreement with the Epartment monitoring their placement.

Services offered during the history of this case include mental health, substance abuse, public health, parenting class, and Intensive Family Preservation Services (IFPS). The family engaged in substance abuse, public health, and IFPS services.

Issues and Recommendations

No issues or recommendations were identified by the review team.

Child Fatality Review #04-20

Region 4
Bellevue Office

Case Overview

This five-year-old Caucasian/Hispanic girl died on October 1, 2004 due to medical issues she had since birth. This child was born at 24 weeks gestation and was diagnosed as having "cerebral palsy, seizures, developmental delay and serious chronic lung disease." She was at risk for aspirating food into her lungs. The child required oxygen and constant care. She also received case management services through the Department of Social and Health Services (DSHS) Division of Developmental Disabilities (DDD).

There were five prior referrals for neglect and physical maltreatment, four of which were accepted for investigation. The four accepted referrals were unfounded by the investigators.

During the last accepted referral in July 2004, the child was placed voluntarily in a group home for medically fragile children. While at school on September 30, 2004, her class was sitting in a circle on the floor. The child collapsed and stopped breathing. Cardio-pulmonary resuscitation (CPR) was performed and 911 was called. She was transported to Children's Hospital and died on October 1, 2004.

There were no complaints about the quality of care the child received at the group home. The mother visited with her daughter often.

The services offered and accepted by the family were mental health, domestic violence, medical, and DDD.

Issues and Recommendations

No issues or recommendations were identified by the review team.

Child Fatality Review #04-21

Region 4
Kent Office

Case Overview

This three-month-old boy died on October 24, 2004. The medical examiner has classified this death as Sudden Infant Death Syndrome (SIDS). On October 24, 2004, the mother found the child unresponsive after laying him down for a nap at approximately 3:00 pm. The family was napping together in the same bed. There was no evidence of trauma or abuse. The case was open at the time of this infant's death.

Prior referrals had been received alleging that there were problems between the mother and the father. The father had threatened to kill the mother and take the child to Alabama. The second referral indicates that the parents are using crack cocaine, and the children are exposed to the smoke. This referral indicates that the crack cocaine is within reach of the children, as well as dangerous tools. It also relates that the children are found wandering around the neighborhood unattended. The case was open at the time of this second referral.

The two-year-old sibling was placed into protective custody, and a dependency was established. She continues to reside outside of the home, and her case remains open.

Services offered during the history of the case include mental health, domestic violence, substance abuse, child care, and Intensive Family Preservation Services (IFPS). The family refused domestic violence and IFPS/FPS services.

Issues and Recommendations

No issues or recommendations were identified by the review team.

Child Fatality Review #04-22
Region 4
Kent Office

Case Overview

This two-month-old Caucasian child died on November 8, 2004. The medical examiner's office related that the child's death was due to Sudden Infant Death Syndrome (SIDS). The mother and child went to sleep on a futon at 2 am. The mother woke up at 10:30 am and found the child unresponsive. Emergency services were called and the child could not be revived.

This baby was born four to five weeks premature and required medication to assist with breathing.

This family has one prior referral for domestic violence. Law enforcement had been to the home several times due to domestic violence. The case was open at the time of the death of this child. The mother is 18-years-old, and the father is 17-years-old. Both parents have a history as victim children in their extended families.

A surviving sibling remains with the parents. Services such as Childhaven, urinalysis, and public health nurses were offered to the parents, but were refused. The father has anger problems and is a possible methamphetamine user (this could not be determined because he refused to do urinalysis). The father was very irate with the Child Protective Services (CPS) social worker. It was determined after the death of the baby that there were on-going risk factors, but not enough to file a dependency petition.

Issues and Recommendations

I. Practice Issues

A. Issue: The assigned worker's face-to-face contact was delayed due to an unusually lengthy dependency proceeding on another case.

Recommendation: *It would be best in such a situation for the supervisor to re-assign the referral to another worker who would be available to make contact sooner.*

Child Fatality Review #04-23
Region 5
Tacoma Office

Case Overview

This three-month-old Caucasian male died due to "death during infancy, no identifiable cause" on June 12, 2004. Allegedly the infant had fallen asleep on his mother's chest after breastfeeding. The mother also fell asleep and awoke to discover her infant face down on her chest and unresponsive.

The manner of death was listed as "undetermined" by the medical examiner. There was no evidence of injury. Toxicological evidence of exposure to methamphetamine was found, but the level would not usually be considered toxic or lethal. Thus whether or not the drug exposure contributed to the determined cause of death could not be stated with reasonable medical certainty by the medical examiner.

There is one prior referral on this family in December 2003. It was alleged that the mother was neglecting her two children by not meeting medical care needs, the children having diaper rash, and blowing marijuana smoke in the children's faces to get them to go to sleep. Other concerns were methamphetamine use by mom who was pregnant and due in three months, an unclean home, and the mom not making herself available to the children. The report was accepted for investigation by Child Protective Services (CPS).

The social worker conducted a home visit and found the residence to be clean, as were the children. The social worker addressed the concerns in the referral such as prenatal care, prenatal drug and alcohol use, health care for family members, and domestic violence. The mother indicated that she was a high risk pregnancy (thin uterus, uterine cancer cells), and acknowledged drug and alcohol use, anorexia, and domestic violence victimization. She was advised to seek information from a physician as to the effects of prenatal exposure to drugs and smoking. The mother stated that she did not want to keep the baby initially, but it was too late to terminate the pregnancy. A referral was made for Intensive Family Preservation Services (IFPS) to help mom connect with medical services, drug/alcohol services, domestic violence services, and housing.

The mother was not cooperative with the service engagement. The social worker spoke with the doctor who had also provided transportation information to the mother as well as shared concerns with the patient about prenatal care, drug use during pregnancy, and the nature of her high risk pregnancy. A community Child Protection Team (CPT) staffing occurred March 9, 2004. The recommendation was to place the baby in protective custody when delivered, and consider removal of the other two children. The social worker alerted local hospitals to put the newborn into protective custody, and was notified when the baby was born. Drug tests were negative at delivery for both mother and baby, therefore, the baby was not placed on hold. A

Safety Plan was put into place in lieu of removal and an agreed upon service plan, but by April the mom had left the relative's home with the children and apparently began to avoid CPS.

On June 11, 2004, the bio-father of the two older children came to Washington and returned with them to Connecticut on June 12, 2004. Later he was notified by the mother that the baby had died. A welfare check/home visit to his home in Connecticut was conducted post fatality. The Connecticut social worker did not find any reason to believe the two children were not being cared for by their bio-father and his fiancé. The father is now seeking custody in Connecticut court. The children will be examined by a physician and counseling will be provided.

After the fatality, it was reported by a friend of the mother that the mother was using methamphetamine regularly while breastfeeding the baby.

The father of the deceased child has no known CPS history as a child nor has he been identified as an alleged subject on any CPS report. He reportedly has been on probation for domestic violence charges involving a woman in Oregon and one in Washington. He is known to have engaged in domestic violence with the mother of the deceased child. He appeared to use drugs, including methamphetamine.

The mother of deceased child reports having parents who were heavy drug addicts, and she and her siblings were severely abused and neglected by her parents. All the children were removed and placed with relatives or into foster care. The mother was placed at approximately age two with paternal relatives in California. Despite having what the mother described as a "good life" with the relatives, she became out-of-control and a runaway as a teen, was gang-raped on the streets, and into drugs and alcohol. She went into a chemical dependency treatment program while in high school, and attended an eating disorder clinic as well.

Issues and Recommendations

I. Practice Issues

A. Issue: The investigation for the referral on December 18, 2003 was not initiated within ten calendar days as prescribed by policy. The worker assignment was significantly delayed, and thus the worker was unable to meet the 10-day face-to-face contact requirement. There was no evidence of supervisory waiver in the service episode record (SER).

Recommendations: *Policy and practice standards for initiating investigations and for conducting face-to-face contact with alleged victims are already in place. The policy regarding supervisory waivers already exists and is available on the Children's Administration (CA) intranet web site.*

Comments: The supervisor was present during the review and acknowledged a waiver was granted but not documented.

B. Issue: Regarding the investigation of the referral on December 18, 2003, the social worker's activities during the initial 90 days of the investigation period were found to be a combination of good practice and areas where practice could have reasonably been improved. The worker appears to have addressed the concerns identified in the referral during an unannounced home visit, but did not document having checked for diaper rash or the alleged poor dental hygiene. The documentation shows the alleged victims, although very young, were interviewed. The fact the mother was reluctant to confront critical risk factors was documented. Additionally, the issue of "parental ambivalence" was documented (the mother initially did not want to continue the pregnancy). Signed "Exchange of Information" documents were attained, and both family history and Native American heritage information was sought by the assigned worker.

The mother provided information regarding an office visit to an Enumclaw clinic and although the children verbally corroborated having recently seen a doctor, the worker did not follow-up with the clinic. However, there was collateral contact with the doctor and medical records were requested and received. There was an opportunity to contact the TANF worker and possibly coordinate a cross-agency staffing, but this was not done.

In anticipation of a possible positive toxicity screen on a newborn child, the worker notified various local hospitals, prepared a referral to Pediatric Interim Care Services (PICS), and scheduled a CPT staffing. These activities were reasonable and reflected good practice. The worker did not obtain the medical record of the meconium test results from the hospital, or if obtained verbally, did not document it. Furthermore, there is no evidence of any follow-up contact with the newborn's medical provider post delivery (e.g., well child exams).

Recommendations: *Both the worker and supervisor were present during the review and received both positive and critical feedback. The failure to contact the Enumclaw clinic or the TANF worker was acknowledged by both the worker and the supervisor to not reflect best practice.*

The narrative recording for the initial home visit did not indicate whether it was an announced or unannounced visit. While there is no policy or practice standard for specifying such, this issue will be included in the annual High Standard of Investigation training by the Region 5 CPS Coordinator.

C. Issue: The initial safety assessment and corresponding safety plan were completed in a timely manner although were not converted from NCR form to CAMIS within the prescribed timeframe. The safety plan relied too heavily on "promise keeper" pledging, with no outside people involved in monitoring child safety. Additionally, the safety plan looked more like a service plan than safety plan. An incident of significant domestic violence occurred on February 2, 2004 in which the father allegedly assaulted the mother, trashed the residence, and stole money and the family TANF food card. A revised safety plan should have been initiated at that time.

A revised safety plan was done in late March 2004 (NCR form only – parents signed) at the time of the delivery of the newborn. The revised safety plan again relied too heavily on "promise keeper" pledging and contained some service plan goals. This revised safety plan, initiated in March 2004, minimally addressed the safety issues related to domestic violence even though the father was actively in contact with the mother and the children.

Recommendations: *The worker and supervisor have both attended the Region 5 training on Safety Assessment and Safety Planning, as well as follow-up consensus building activities at the unit level. Safety Assessment/Safety Plan training is scheduled to be offered on an annual basis for social workers in the Tacoma Division of Children and Family Services (DCFS) office.*

Both the worker and supervisor were present during the review and acknowledged the feedback.

D. Issue: The worker initiated IFPS in February 2004. IFPS was not able to provide services due to the mother's reluctance to be engaged in services. The criteria for using IFPS rather than Family Preservation Services (FPS) are based on placement prevention in high risk cases. If the selection of IFPS rather than FPS was the correct choice, then a parent refusing to engage would suggest the need to consider out-of-home placement of the children. However, in reviewing the case, the panel concluded that while the gate-keeping process for IFPS/FPS was followed, the choice of IFPS was questionable, and FPS would have been more applicable for the circumstances of the case. A parent refusing to engage with FPS, while concerning, would not necessarily result in consideration to remove children from the home.

Recommendations: *None*

E. Issue: A CPT was held on March 9, 2004 in anticipation of a possible positive toxicology screen on the newborn child. The CPT recommendations were not well written. The CPT agreed with the department's plan to place the newborn when delivered, and to consider removing the other two children as well. "Out-of-home" was checked on the placement recommendation section of the CPT Staffing Recommendation form. During the internal review, the worker indicated that when the baby was born negative for drugs, the worker did not feel placement was necessary. However, as the CPT recommendations for placement were not written as conditional, failing to follow the CPT placement recommendations would have required a waiver, per policy. While the worker's thinking process was understandable given the circumstances, the review panel found that the worker failed to contact the regional CPT Coordinator per policy to initiate the waiver process when the intention was to not follow the CPT placement recommendation.

Recommendations: *The regional and state CPT policies are already in place and reminders of the policies are disseminated via all staff emails or individual unit meetings at least once a year. Following this review on December 30, 2004, the Region 5 CPT*

Coordinator sent a Region 5 all CA staff e-mail explaining the required actions should CPT placement recommendations not be followed by the department.

Action Taken: The Region 5 CPT Coordinator participated in the review and agreed to provide feedback to the contracted CPT facilitators regarding the way the recommendations had been written.

Actions Taken: Both the worker and supervisor were present during the review and acknowledged the error.

F. Issue: The worker did attain a signed Voluntary Service Agreement at the 90-day mark, but did not complete the Investigative Risk Assessment (IRA) in the prescribed timeframes. The IRA for the referral received on December 18, 2003 was not completed until August 2004, seven months after the referral was accepted. Therefore the Notification of Findings did not get sent out in a timely manner.

Recommendations: *The policies regarding completing investigations and notifying alleged subjects of the findings are already in place.*

Action Taken: Both the worker and supervisor were present during the review and acknowledged the error.

G. Issue: In April 2004, the case plan changed. The mother and children were to reside with an aunt with services such as public health nurse (PHN) involvement. While there appears to have been some informal discussions with the relative and mother about the conditions of this arrangement with regard to the health, welfare, and safety of the children, there was no structured agreement. The worker, when questioned during the internal review, stated she had failed to document additional contacts and conversations with the mother and the aunt. The review panel concluded the documentation was inadequate, and there was no evidence the relative understood the contingencies. Reasonable practice standards would suggest that informal family arrangements require documentation of clear agreements or understanding by all parties involved and the Region 5 Informal Placement Agreement form would have better satisfied such practice expectation and been appropriate for the circumstances of this case. This error became apparent when the mother and children disappeared while the assigned social worker was on medical leave, and the relative did not immediately contact the department.

The assigned worker became aware of the situation while on medical leave, and did contact her supervisor who sent out a worker to try to locate the mother and children. It is not clear as to any specified coverage for this case while the assigned worker was on medical leave. Additionally, the consensus of the review panel was that the supervisor should have considered consulting with the Area Administrator and others when the mother turned up missing with the children.

Recommendations: *Region 5 has guidelines already in place regarding "formal" and "informal" family arranged relative placement situations, and all CPS supervisors in the*

region are aware of these regional guidelines. Within the last year, CPS workers were given copies of these regional guidelines. These guidelines are referenced at each annual High Standard of Investigation review/training conducted in Region 5. The Informal Placement Agreement form is available to all workers.

Action Taken: The Tacoma CPS Area Administrator, who participated in the review, offered to initiate discussion with the Tacoma CPS supervisors as to case coverage when staff are on extended or medical leave. This discussion will serve not only to raise awareness, but also to problem-solve on how to avoid this problem in the future.

Action Taken: The worker was given positive feedback for having alerted her supervisor while on medical leave as to the information regarding the mother having disappeared with the children. The worker and supervisor both acknowledged the concern that the relative and parent may not have had a clear understanding of what was expected regarding the mother and children living with the relative, and what the department's response would be if the plan was not followed.

Action Taken: The supervisor acknowledged the panel's recommendation that shared decision-making be considered in similar situations in the future.

Child Fatality Review #04-24
Region 6
Tumwater Office

Case Overview

This five-month-old Caucasian male child died due to Sudden Infant Death Syndrome (SIDS). This child's mother and father separated in November of 2003. The mother went to Utah with the children to visit her family. While in Utah, the mother ingested controlled substances and passed out while caring for her own and several other children. She reports having been unconscious for approximately six and a half hours. During that time, five and six-year-old children "wrestled" with her three-month-old resulting in a subdural hematoma. The mother pled guilty to misdemeanor child abuse/neglect charges and returned to the State of Washington to reside with her child's father's parents. The mother and father cooperated with the assigned social worker in developing a safety and service plan to correct parental deficits and reduce risk to the children. Both parents were initially compliant with their contract.

On February 2, 2004, the five-month-old was found dead in his crib. A safety plan was developed with the family for the surviving sibling pending the results of the autopsy. The autopsy results showed the death to be SIDS.

This family had prior history in the State of Utah. Washington State had an open case at the time of the fatality due to the referral received from Utah.

Utah had an open case, filed a Dependency and had the child placed in shelter care. However, they allowed the mother to move to Washington and closed the case in Utah. It appears that Interstate Compact on the Placement of Children (ICPC) was not followed or utilized at the time the mother was allowed to move to Washington State.

The services offered to this family were mental health, domestic violence, public health, parenting class, child care, medical services and Intensive Family Preservation Services (IFPS)/Family Preservation Services (FPS). The family refused domestic violence, parenting class and IFPS/FPS services.

Issues and Recommendations

I. System Issues

A. Issue: The State of Utah had an open case, filed a Dependency and had the child placed in shelter care. However they allowed the mother to move to Washington and closed their case out in Utah. It appears that ICPC was not followed or utilized at the time the mother was allowed to move to Washington State.

Recommendation: *Headquarters reviewed this case and corresponded with Utah on ICPC rules, and how this case was handled.*

Child Fatality Review #04-25

Region 1
Spokane Office

Case Overview

This almost 17-year-old Caucasian male died by shooting himself in the head with a .38 caliber hand gun at his high school. He was airlifted to a Spokane hospital where he died four hours later. He was the biological son of licensed foster parents.

Information received by Children's Administration (CA) indicated the foster parents were aware their son was suicidal, and they left a hand gun accessible to him. The investigation that was conducted by Child Protective Services (CPS) with Licensed Resources determined that the foster parents did not have reason to believe their son was suicidal or that he would harm himself.

The foster home was licensed for foster care on September 17, 2002. This home received placement of their first foster child on December 13, 2002. On February 18, 2003, the foster father reported to CPS that his two youngest children and the foster child were found exposing their genitals to each other. The licensing complaint was reviewed and screened out due to no licensing violations. On March 7, 2003, a referral was made to CPS that following the February 18, 2003 incident, the foster father had pulled the foster child off his bed and slammed him into the wall. Licensed Resources CPS investigated this referral and determined that the allegation was unfounded. The licensor did find that the complaint was valid for a licensing violation due to inappropriate discipline (by intimidation). On March 19, 2003, the foster child was moved to another placement. The foster family did not have any other foster children placed in their home.

Issues and Recommendations

I. Practice Issues

A. Issue: The foster home was not utilized for one year and nine months, but continued to have an active license for foster care. There was a valid licensing complaint and a determination that the family would not receive other foster child placements.

Recommendation: *It was recommended a meeting occur between the Licensing Supervisor, Licensing Administrator, and/or the Placement Supervisor with the foster parents about continuing with an active license if one or both parties do not believe there will be foster children placed in the foster home in the future.*

B. Issue: The social worker assigned to the foster child placed in this foster home had multiple concerns regarding the foster parents.

Recommendation: *The Division of Children and Family Services (DCFS) social workers will communicate concerns regarding foster families to the foster care licensor for the home.*

C. Issue: The review participants raised questions regarding inconsistencies between social workers addressing the storage and safe keeping of firearms when conducting health and safety visits in foster homes.

Recommendation: *Children's Administration should review practice expectations for social workers completing health and safety checks of foster children in a home that has a firearm on the premises.*

II. Policy Issues

A. Issue: Although WAC 388-148-0190 addresses the safekeeping of firearms in a licensed foster home there is no specific signed policy statement regarding firearms within CA.

Recommendation: *When a firearm is on the premises of a licensed foster home, the licensor will review a specific policy statement with the foster parents and obtain their signatures.*

Child Fatality Review #04-26

Region 5
Tacoma Office

Case Overview

This sixteen-year-old Caucasian female died on November 1, 2004 due to a "penetrating contact gunshot wound to the chest." The manner of death is listed as suicide.

There were three prior information only referrals regarding this family. The first two referrals indicated there was domestic violence between the mother and the step-father. The last referral indicated that the child and her mother had an argument and the child was kicked out of the house. The child was on her way to the grandparent's house, when law enforcement noticed her walking along the street in her pajamas. A report was made to Child Protective Services (CPS) and was classified as informational.

Upon investigation of this fatality, it was found that the child in question was taking medication for depression. Her medication was increased two weeks prior to her death. This child was a good student that had difficulty with several of her classes, bullied at school, and had problems at home.

The gun that was used in this incident was locked in a gun cabinet and the ammunition was locked separately from the gun.

The CPS investigation of this incident resulted in "unfounded" findings for negligent treatment.

Prior to the fatality, no services had been offered to the family by CPS as all referrals had been taken as information only. The school counselor involved with the child did provide resource referrals to the family. The child was seen at a local clinic for depression and was prescribed medication prior to the suicide.

Issues and Recommendations

No issues or recommendations were identified by the review team.

Child Fatality Review #04-27

Region 5
Tacoma Office

Case Overview

This two-week-old Caucasian male died on June 1, 2004 due to pneumonia. This child was born on May 12, 2004 at 28 weeks gestation.

The mother tested positive at birth for oxycodone and marijuana. The child did not test positive at birth. The child remained hospitalized after birth and was placed in the Tacoma General NICU.

After testing positive at delivery for marijuana and unprescribed pain medication, the mother was referred for substance abuse evaluation and urinalysis (UA) testing. The father was also asked to do UA testing. There was only partial compliance with requested services. A community Child Protective Team (CPT) staffing was scheduled to discuss hospital discharge and the parents assuming care of the infant. However, the child passed away weeks prior to the CPT, which was then cancelled. At case closure in July 2004, the Child Protective Services (CPS) social worker sent a letter to the parents regarding counseling and other resources.

Issues and Recommendations

In reviewing the case history and the circumstances surrounding the child fatality (non-child abuse/neglect related), no significant issues were identified.

Child Fatality Review #04-30
Region 5
Bremerton Office

Case Overview

This 16-year-old Caucasian female was killed on August 23, 2004 in a motor vehicle accident. On August 23, 2004, she was one of eight teenagers riding in a Sports Utility Vehicle (SUV) driven by a 14-year-old girl. The teens had taken the vehicle without permission. The estimated speed at the time of the crash was 75 or more miles per hour. The teen driver pled guilty to vehicle homicide and has been sentenced. This child was killed and pronounced dead at the scene having suffered multiple blunt force traumas.

In September 2003, there were two calls made to Children's Administration (CA) intake regarding concerns for the now deceased child and her twin sister. The biological father, who was living in Montana, reported that this child had been kicked out of her home by her biological mother in Washington State after a series of arguments and fights. This child reportedly was dropped off by her mother at the house of one of her friends. The intake worker discussed options with the non-custodial parent, including the availability of Family Reconciliation Services (FRS) if the teen or her mother requested such, or the father (a licensed attorney in both Montana and Washington) could revisit the parenting plan. The reported concerns from the non-custodial parent were taken as information only for FRS.

Soon after, the paternal grandmother (living in New York) reported that this child and her sister had been kicked out of their house by their mother. Allegedly the step-father did not want the girls in the home due to their disruptive behaviors. The girls were reportedly dropped off to the maternal grandmother in Bellevue who allegedly did not want the girls. This child ended up with a friend of her bio-father. The twin sister, who had recently returned from a boarding school in Colorado, was threatening to run away if her bio-father tried to gain custody of her. The report was taken as information only.

On February 4, 2004, the biological mother requested FRS. The deceased child reportedly was defiant of rules/punishments and had violent outbursts (screams, yells, threatens to run away). The twin sister reportedly had a more stable temperament but was cutting herself. Both girls reportedly had experimented with drugs. Previously, after the twin girls threatened the family with knives, they had been sent to stay elsewhere (boarding school, relatives, etc.). The mother was asking for information on accessing services, such as Crisis Residential Center (CRC), At-Risk-Youth petition process (ARY), and accessing other appropriate services. The referral was accepted for FRS.

The assigned FRS worker discussed (by phone) an overview of the FRS program and service options. The worker suggested the parents consider having the now deceased child do a drug and alcohol evaluation. The mother indicated she would discuss things with her husband and call the worker back to schedule an appointment for further family assessment. The mother never called back, and the FRS worker submitted the case for closure with supervisory review completed at the end of March 2004.

Issues and Recommendations

There were no issues or recommendations identified by the review team.

Child Fatality Review #04-31

Region 3
Everett Office

Case Overview

This nine-month-old Native American male died on October 22, 2004 due to Shaken Baby Syndrome.

This case originated in Region 3 (Everett). When the child died the case was being monitored by the Puyallup Tribe. The child was placed in a Puyallup Tribal foster home in Region 5 (Pierce County) at the request of the Puyallup Tribe liaison and Indian Child Welfare worker. The tribal foster home was located in Region 4 (King County).

The initial call from the foster mother indicated that the foster child had fallen off of a trundle bed into a bean-bag chair and had lost consciousness. The baby was taken to the hospital and later diagnosed as having suffered Shaken Baby Syndrome. The physical indications of this were that the child had brain shift and a head bleed. It was later admitted that the child had been shaken and hit by the unauthorized babysitter. This person had been babysitting the child in the foster home since August 17, 2004 unbeknownst to the tribe or licensor. The baby died later in the hospital as a result of his injuries.

The only surviving child in the home was removed from the facility immediately after the incident was reported. The tribal private agency and Division of Licensed Resources (DLR) will not allow further placement into the home. DLR is moving toward revocation of the license of this foster home.

During the King County Sheriff's Office investigation, the babysitter admitted to the investigator at the time of the child's hospitalization that he had shaken the child on one occasion about a month prior. He also made a statement that he was responsible for the child's current injuries. He admitted to using blunt force and shaking the child, causing his injuries. He was referred by law enforcement for prosecution for this act of abuse, and pled guilty to homicide for this incident.

The Child Protective Services (CPS) DLR investigation of this incident concluded with a finding of "founded" against the babysitter for his role in this incident.

The foster mother had been advised in June or July 2004 by director of Tribal Social Services that she was not to allow anyone who was not approved by the tribe to care for children placed in her home. Despite this, she allowed the babysitter to reside in her home and care for the children without advising Tribal services. The foster mother admitted that she had not informed anyone of the babysitter's presence in the home because of her belief that he would not have passed a background check.

It is not clear how much the foster mother knew or did not know of this babysitter's capacity for violence. Although she had known him for about five years, it is not clear what she knew of any violence he may have perpetrated in his family of origin. There were six CPS referrals regarding

violence among his siblings, but his role was not clear from CPS records. His criminal history check, completed at the time of this incident, revealed a July 26, 2001 arrest for marijuana possession and an arrest for resisting arrest on April 27, 2002. There were no convictions recorded. It was also not known what, if anything, the decedent's five-year-old foster brother told the foster mother about what happened in her absence.

DLR CPS in Region 4 investigated the allegation of neglect against the foster parent. They completed the investigation at the time of this review and found there was not sufficient information known regarding what the foster parent knew at the time of the incident to make a finding. Therefore, the investigation is being concluded as "inconclusive" as to neglect by the foster parent. The King County Sheriff's Office is not pursuing a criminal case against the foster parent.

There were eight previous accepted referrals listing the birth mother as subject. They date back to April 1994, and were concerned primarily with the bio-mother's use of drugs and alcohol and the consequent effects on her children. Most of the referrals were regarding the decedent's older siblings, who also had been involved with the Department and were not living with their mother. There was one prior referral on this foster home alleging medical neglect. It was investigated by the tribal agency and determined to be unfounded. As this was investigated by the tribe, there is not a CAMIS record.

The bio-mother was incarcerated at the time of the decedent's birth. When CPS received notification of his birth, they met with bio-mother and her parents and developed a safety plan. The safety plan stated that the bio-mother would stay with the decedent in her parents' home after her release and engage in chemical dependency treatment. When she failed to comply with this agreement and left the home with the child, the Department filed a dependency petition and placed the child in care. He was placed with the maternal grandparents initially. When the maternal grandparents were unable to continue caring for him, he was placed in foster care.

Issues and Recommendations

I. Practice Issue

A. Issue: There was unclear understanding of jurisdiction versus intervention.

Recommendation: *The updated agreement will identify and clarify these issues.*

B. Issue: Casework services were not maintained during the transfer process of this case from state CPS unit to Child Welfare Services (CWS) unit in Region 3.

Recommendation: *State workers will follow established policy in this area.*

Region 3: Recommend an action plan be devised for this section that includes training in this area.

C. Issue: The policy regarding requests for courtesy supervision and delineation of responsibilities for case management was unclear to social workers.

Recommendation: *Clarification of the issue of courtesy supervision will be included in an update of tribal/local agreement.*

Region 3: Recommend an action plan for this section to include training in this area.

D. Issue: The Puyallup tribe seeks to improve its tracking of CPS referrals investigated by tribal services.

Recommendation: *The tribe will continue their work on attempting to track CPS referrals investigated by tribal social services.*

E. Issue: There was insufficient understanding in this incidence of the respective roles of the tribal liaison.

Recommendation: *The Region 5/ tribal agreement needs to be updated to clarify these areas of responsibilities.*

Region 3: Recommend action plan for this section to address training in this area.

F. Issue: The tribe identified a commitment to monitor its foster homes more closely.

Recommendation: *The tribe has begun a practice of making unannounced home visits to their foster homes.*

G. Issue: The team identified a need for DCFS social work staff to have an increased awareness and understanding regarding effects on social work practice and decision-making in cases where a tribe legally intervenes in a case.

Recommendation: *The review team recommended having language inserted in the updated Region 5/Puyallup agreement to clarify the legal ramifications of tribal intervention.*

Region 3: Recommend section training in tribal legal interventions and ramifications in social work practice.

II. Policy Issue

A. Issue: The review team identified a need for a more global reporting system for serious incidents of child abuse. This should include tribes within the state and among states.

Recommendation: *A work group should be convened to study ways to establish a mechanism to address the need for a global reporting system for serious incidents of child abuse.*

III. System Issue

A. Issue: The tribal-state agreement may be insufficient to address identified issues.

Recommendation: *The recommendation is that the Region 5/Puyallup Tribe agreement be updated to incorporate the issues identified by the review team.*

Action Plan

This action plan would incorporate the issues raised between the state and the tribe in this review into a revision of the Region 5/Puyallup Tribe agreement. Region 5 Area Administrator will oversee the revision of this agreement.

Region 3 will address the issues that include training for the section as identified previously in this report.

Child Fatality Review #05-01
Region 2
Yakima Office

Case Overview

This one-month-old Caucasian male child died on February 20, 2005 due to Bronchopneumonia or Respiratory Syncytial Virus (RSV). The child had been recently released from the hospital. The child was sleeping in the same bed as the parents. The parents smoke in the house. The father noticed the child had stopped breathing. All efforts to revive the child were unsuccessful.

This family had five prior referrals alleging physical neglect, medical neglect, and sexual abuse. Two of the five referrals were information only and three were assigned for investigation. Of the three referrals assigned for investigation regarding the older sibling of the deceased child, one was founded for physical abuse and negligent treatment. The family was provided services, and they accepted them. The family worked with the service providers. Those services included parenting assessments, substance abuse evaluations and Family Preservation Services (FPS).

After the fatality of the one-month-old, services were again initiated. After agreeing to services the family was contacted by the service providers. The family refused to engage in the services. The family felt that if services were accepted, it meant a deficiency on their part which led to their child's death. The assigned social worker informed the family that this was not the case and that no one was faulting them, but the family still refused.

The mother in this case has a history as a dependent child within Children's Administration from 1984 to 1997. This current family has CPS history in Missouri. The investigations in Washington addressed the issues identified in Missouri.

Issues and Recommendations

I. Practice Issues

A. Issue: Timely reporting of child abuse and/or neglect reports to Children's Administration by the law enforcement agencies. The referral was faxed by law enforcement to the local office on a weekend rather than calling Central Intake. As a result, the referral was not known to the department until two days after the child died.

Recommendation: *The Intake Supervisor will have a meeting with a representative of the Yakima Police Department to remind the local office of the reporting requirement/protocol for after hours regular business hours and on weekends.*