Report to the Legislature

Quarterly Child Fatality Report

RCW 74.13.640

July - September 2006

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Children's Administration Child Fatality Report
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INTRODUCTION

This is the July – September 2006 Quarterly Child Fatality Report 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. This report summarizes the four reviews that were completed during the third quarter of 2006. All four of these cases were fatalities that occurred in 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 (CA) within 12 months of their death. The Reviews are also completed when the fatality occurs in a licensed child care or foster care facility. 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 (in cases where the death is clearly accidental in nature), to a larger multi-disciplinary committee where the child's death may have been the result of abuse and/or neglect by a parent or guardian.

An Executive Child Fatality Review by policy is a special review convened by CA's Assistant Secretary. The Executive Child Fatality Review may be requested when 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 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 provides the number of fatalities reported to CA, and the number of reviews completed and pending for calendar year 2005-2006. The number of pending reviews is subject to change if CA learns new information through reviewing the case. For example, we may learn that the fatality was anticipated rather than unexpected, or there is additional CA history regarding the family under a different name or spelling.

Child Fatality Reviews for Calendar Year 2005 – 2006			
Year	Total Fatalities Reported to Date	Completed Fatality Reviews	Pending Fatality Reviews
2005	58	29	29
2006	26	0	26

The numbering for the Child Fatality Reviews in this report begins with #05-26. This indicates the fatality occurred in 2005 and is the 26th report completed for that year. The number is assigned when the Child Fatality Review and report by the CPS Program Manager is completed.

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

Region 1 (2 reports)
- 1 Moses Lake
- 1 Spokane

Region 2 (1 report)
1 Yakima

Region 3 (1 report)
- 1 Day Care Center

Region 4 (0 reports)

Region 5 (0 reports)

Region 6 (0 reports)

In addition to the quarterly Child Fatality Reviews, CA completed the 2004 Annual Child Fatality Report, which provides statistical information on child fatalities that occurred throughout 2004. This report can be accessed at; http://www1.dshs.wa.gov/ca/pubs/reports.asp.

Child Fatality Review #05-26
Region 3
DCCEL Child Care Center

Case Overview

This five-year-old Caucasian female died on February 24, 2005 from cardiac arrest at her licensed kindergarten/day care center.

The child was on the playground with the rest of the children. She was seen by a teacher running and then simply collapsed, "crumbling to the ground." She did not appear to have fallen, tripped, or otherwise injured herself. She appeared to have stopped breathing immediately. The staff at the center stated she had been fine all day prior to the incident. She had eaten well and did not appear to be ill. Cardio Pulmonary Resuscitation (CPR) was begun immediately by center staff and continued until taken over by the aid unit, which arrived within four minutes and began use of a defibrillator. The aid unit medics reportedly worked on the child for forty minutes without success. The child and her mother, who arrived during the course of the on-site medical attention, were transported to the hospital in separate units. The Medical Examiner's office reports that an autopsy was conducted. It showed that this was a natural death, due to cardiac dysrhythmia. The medical examiner speculated that the child may have had an undetected heart condition since birth.

The decedent's little sister still attends this day care. Her parents have set up a web site in their daughter's memory. In addition to memorializing their daughter's life, its purpose is to facilitate awareness and education about sudden cardiac arrest, and establishing public access defibrillation programs targeting education and response.

In consultation with the Division of Licensed Resources (DLR)/CPS Program Manager, the referral was screened out for CPS because there were no allegations of child abuse/neglect related to the incident, nor was there history with the department regarding this family. The Division of Child Care and Early Learning (DCCEL) conducted an inquiry into the occurrence. They determined that the center was in compliance with all licensing regulations at the time of the child’s death. In fact, the child care staff had just completed their annual CPR training. Their history with licensing compliance was good. After the fatality, the center provided grief counseling for the children and staff.

This fatality was reviewed with the Regional Administrator and Safety Program Manager, as well as DCCEL and DLR/CPS. In reviewing the available documentation and post-fatality information from other sources, no violations of policy, procedure, or practices surfaced that would suggest recent or previous action taken or not taken by the department or by the daycare contributed in any way to this child fatality.

The facility staff training was current. The private kindergarten and day care have been in operation since their initial license was issued in 2001. The facility remains open and operating. There is no indication that the staff or the physical environment played a role in the child's death.

There was only one referral on this facility prior to the fatality. That involved a child who broke his arm landing on the ground after jumping quickly down the slide. It was screened out for CPS and referred to licensing. DCCEL determined it to be inconclusive for supervision issues. The licensor reported that new wood chips had been laid just the week before and the equipment was in generally good repair. The child had run ahead of the rest of the group to the slide, and the teacher did not actually see him go down the tunnel slide. When he complained that his arm hurt, the facility responded appropriately.

Issues and Recommendations

No issues or recommendations were identified.

Child Fatality Review #05-27
Region 2
Yakima Office

Case Overview

This two-year-old Caucasian male died on May 13, 2005 due to drowning in a swimming pool.

The child's mother went to stay with her boyfriend at his mother's home in Wapato, Washington, Yakima County. Her boyfriend was not the father of the decedent.

On the morning of May 13, 2005, while the mother and her boyfriend were asleep and other adults that lived in the home had left for work, the child woke up with no one to supervise him. He went out the side door of the home and fell into a back yard swimming pool, where he drowned. Per the police report: "The mother and boyfriend had come to the West Wapato residence of the boyfriend's mother last night. They had spent the night. The decedent was put to sleep in a first floor room by himself. The mother and boyfriend slept in another room and the boyfriend's mother and her two other adult sons slept in their normal rooms at the residence. The boyfriend indicated that he woke and went to check on the decedent. The boyfriend said that he went to the room that the decedent was sleeping in and found the bed empty. He quickly searched the residence and did not find the decedent. He then found a back sliding door standing open and went outside. He immediately checked the in-ground swimming pool that is immediately adjacent to the back door, but did not notice the child. He looked into the driveway and, not seeing the child, went back inside to alert the mother. They both began looking, and came back out the back door. At that point they observed the decedent floating face down just below the surface of the water on the far side of the pool. The boyfriend pulled the decedent out and they called for help at that time. AMR Ambulance responded to the call and transported the decedent to Yakima Regional Medical Center. Resuscitative efforts were not successful, and the decedent was pronounced dead by emergency room personnel at 10:32 am."

The mother has three referrals as a caretaker:

1. On July 16, 2004, an information only referral indicated that the mother ran away from her placement and took her son with her.

2. On October 17, 2003, an anonymous referrer reported that the mother was providing poor care for her (then five-month-old) baby. Specifically, the referrer said that the mother neglected changing the baby's diaper on a regular basis and allowed the baby to cry for long periods of time. This referral was screened as information only. At the time of the referral the mother was involved with Family Preservation Services and was attending a parenting class.

3. On May 1, 2003, a third party referral was made indicating that the mother delivered a baby on April 26, 2003 and that the father of the child was twenty-two-years of age. The mother was 15 years of age when she conceived the child. The referral also indicated that no one wanted to disclose the father's last name in an attempt to protect him from prosecution.

In addition, the mother has a long history with Children's Administration as a child. The mother's caretakers have in excess of 30 referrals made to the department from 1991 to 2003. In 1995, when she was 9-years-old, the mother and her two siblings were placed in an In-home Dependency with their biological father due to severe domestic violence between their mother and her live-in boyfriend. The children lived with their biological father until 1998, when there were allegations that he sexually abused the mother of the decedent. From 1998 to 2002, the mother had multiple placements with relatives and foster care. Ultimately her dependency was dismissed when she turned 18 in November of 2004.

The mother of the decedent participated and completed a three month parenting program through the Yakima Community Services Office entitled “Growing Capable Parents.” She began the program when the decedent was approximately a year and a half old. Some of the topics taught included: building family strengths; personal wellness; family commitment; communication strategies; self care; drama triangle; guidance and discipline; avoiding problems with children; acknowledging positive behavior; reducing stress; and denial. Her instructor gave this evaluation of her: "She is doing very well in the class. She attends regularly and is very appropriate in the class. She is very quiet, but polite. She faces a number of obstacles with grace and dignity. She is a wonderful mother of a baby boy who is growing beautifully. Her peers see her as a role model."

In June 2002, the decedent’s mother became pregnant while she was placed in her aunt’s care. An internal Department staffing occurred when the child was born to consider whether it was necessary to file a dependency petition for the child. It was determined that there was significant family support to allow the mother to keep the child in her care without filing a Dependency Petition. On February 26, 2003, the mother and her child were returned home to an In-Home Dependency with the decedent’s maternal grandmother. Services were provided to his grandmother to help maintain placement.

On July 12, 2004 the decedent’s mother ran away from home. She was picked up by the Yakima Police Department on September 16, 2004. On September 20, 2004 the court placed the mother and the child with the mother’s cousin until her dependency was dismissed on November 3, 2004. In the ensuing 6 months that lead to this child’s death, there was minimal contact between the Department and the mother.

Issues and Recommendations

I. Practice Issue

A. Issue: Clearer direction for social work staff in assisting dependent teens who are expectant parents to succeed.

*Recommendation: *Dependent teens who are expectant parents should be required to successfully complete a mandatory parenting class which emphasizes all areas of safety. Social workers will continue to use current case staffing (Prognostic; CPT; Family Team Decision Making) to address issues of concern regarding expectant teen parents who appear detached or lack the skill to parent a child. * Successful completion of*

Independent Living Skills should be a requirement for a teen prior to dependency being dismissed. These recommendations will be forwarded to CA management in region 2.

B. Issue: Grief counseling after a fatality.

Recommendation: Peer support group and or contracted provider needs to be available for staff immediately after a child fatality occurs. This recommendation will be forwarded to CA management for region 2.

Child Fatality Review #05-28
Region 1
Moses Lake Office

Overview

This two-year-old African American male died on September 25, 2005 from marked degeneration of the brain.

He incurred unexplained injuries in his parent's custody in August, 2003. At that time he was presented to the hospital with anoxic brain injury, bruises on his left arm and foot as well as petechia. His death is a direct result of these injuries. He survived much longer than his physicians expected.

The child was placed in foster care after he was released from the hospital. His foster parents provided quality care and appropriate medical interventions on the day of his death.

The mother and her family first came to the attention of Child Protective Services (CPS) on February 4, 1996. The family was residing in Ephrata, Washington, when a third party referral was reported by a Samaritan Hospital nurse. The referral alleged that the mother brought her six-month-old daughter to the hospital with a concern that the daughter had been sexually abused by a babysitter. Grant County Sheriff investigated.

An emergent referral was accepted on July 8, 1998, in Burien, Washington. A neighbor at an apartment complex reported that the mother's children, a three-year-old female and a five-month-old male, were left unattended. Law Enforcement responded and found the three-year-old wandering the parking lot screaming and the five-month-old asleep on a couch inside the family's apartment. Law Enforcement waited at the apartment for 90 minutes before the mother returned. The mother reported that she went to another apartment to get diapers and lost track of time. Both children were placed into protective custody. The mother's family was involved in developing a safety plan with the mother, so she would not leave the children alone again. They were returned to their mother's care that same day by the assigned CPS social worker. The case was closed on July 22, 1998 with a founded finding of neglect and an overall low risk. The plan was for a Public Health Nurse to stay involved with the family. Although the case was closed, Service Episode Records (SERs) were entered in October 1998 indicating concerns from Children's Hospital that the mother was not following through with medical care for the five-month-old. He had lost weight over time. The hospital social worker stated that he was scheduled for an appointment on October 26, 1998. The social worker said she would call in a referral if the doctors had concerns following that appointment, or if the mother failed to show for the appointment. There was not another referral made until May 1999.

On May 18, 1999, Seattle CPS received an informational report from a hospital social worker. The male sibling (15 months) had surgery for cleft lip and palate on April 27, 1999. The parents did not keep the pre-operative appointment which postponed his surgery. Additional concerns were the mother's refusal of Public Health Nursing services. The social worker contacted the mother again and offered a Public Health Nurse. The mother asked the hospital social worker for

mental health services for depression and childcare. It appears that these needs were not addressed.

On June 15, 1999, Seattle CPS received a moderate-low risk referral with concerns that the mother was not following through with medical appointments and recommendations related to the male sibling's surgery. Additional information reported was the mother's statements of domestic violence in the home and her depression. The referral was screened for an alternate response, and the department sent the family a letter on June 30, 1999. The mother was referred to the public health nurse and the case was closed.

On July 13, 1999, Seattle CPS received a referral that was accepted as moderately high risk due to the mother's failure to follow through with medical appointments for this male sibling and refusal of Public Health Nursing services. This referral for medical neglect was founded. There had been five referrals made for Public Health Nursing services and the mother did not follow through.

In August 1999, the CPS social worker received information that the mother and her family had moved. The investigation was closed on October 12, 1999. There was speculation that the family may have moved to Moses Lake because the mother had extended family members in that area.

On May 19, 2003, the Moses Lake CPS office received a referral indicating the mother was pregnant at the Quincy Valley Medical Center. The mother reported that she didn't have her other children in her care. Her explanation was that the children's father had kidnapped them. The mother tested positive for cocaine, cannibinoids, and methamphetamine. She was dehydrated and malnourished. An Alternate Response Service (ARS) nurse attempted to intervene, but the mother refused assistance.

On June 19, 2003, the ARS provider made a referral and the previous referral's risk increased for negligent treatment due to the mother's refusal of any services or interventions. The case was assigned to a CPS worker.

The decedent was born on July 25, 2003. He presented as a healthy infant. The mother's urinalysis was negative for drugs. The CPS social worker held a staffing which resulted in a recommendation for a safety plan.

On July 28, 2003, CPS received a referral alleging that the mother failed to comply with services and medical attention during her third trimester of pregnancy and had tested positive for cocaine, methamphetamine, and cannibinoids. The case was referred to an Alternate Response System (ARS) Nurse. On July 30, 2003, CPS received an emergent referral for negligent treatment. Samaritan Hospital received the results of the baby's meconium screen. It was positive for methamphetamine and cannibinoids. The CPS social worker updated the safety plan.

On July 31, 2003, the assigned social worker held a meeting with an Assistant Attorney General (AAG), ARS nurse, 2 CPS workers, and the supervisor. They decided that there was not legal sufficiency to place the baby outside the home. The social worker and the mother's community services worker developed a plan for the mother to meet the needs of the baby and comply with

her Work First requirements. The recommendations included: substance abuse evaluation and any recommended treatment, mental health treatment, maternity support services, and developmental screening for the baby. The case was closed as Inconclusive for negligent treatment on August 8, 2003.

On August 10, 2003, CPS accepted an emergent referral. The seventeen-day-old baby was brought to the hospital with bruises on his left arm, petechia, bruising on his left foot, and anoxic brain injury. He was ventilated and kept in the hospital. The etiology of the baby's injuries has not been determined.

On August 28, 2003, a CPT recommended out of home placement of the baby. The investigative assessment was completed on October 14, 2003, with a founded finding for negligent treatment and inconclusive for physical abuse. The baby remained in foster care until his death on September 25, 2005.

Throughout this case Mental Health, Domestic Violence, substance abuse, public health, medical, Alternative Response, Maternity Support services were offered, but refused by this mother.

The decedent's older siblings were not in their mother's care at the time of the incident that preceded the child's death.

Issues and Recommendations

1. System Issue

    A. Issue: The May 18, 1999 information reported to CPS by a medical social worker did not indicate if the surgery and medical needs of the child were elective or essential.

    Recommendation: Information reported to CPS needs to be specific to the potential consequences to the child and risk of harm for not having the medical procedure done.

    B. Issue: Alternative Response System (ARS) do not have the ability to document work with families in the CAMIS system.

    Recommendation: The review team recommends that documentation by ARS occur through Children's Administration database. This allows CA social workers immediate access to information that may be critical for future investigations and/or interventions.

2. Practice Issue

    A. Issue: The July 13, 1999 investigation was closed due to parents moving from the area. No attempt was made to locate the family prior to case closure.

Recommendation: Children's Administration has developed best practice standards and implemented guidelines for reasonable efforts to locate children and/or parents on April 20, 2005.

B. Issue: Serious and immediate harm was indicated on a safety assessment in July 2003 with some documentation by the social worker exploring out of home placement for the decedent.

Recommendation: A Child Protection Team meeting may have been beneficial to lend some shared decision making to the case.

C. Issue: The review team believes the case was closed prematurely on 8/8/03. There was evidence that the mother needed intervention regarding substance abuse, mental health treatment, and maternity support services. Her infant was 15 days old and extremely vulnerable.

Recommendation: The supervisor who was involved in this case no longer works for the agency and the worker has transferred to a different region. This issue has been discussed with all of the supervisors and area administrators in the region, noting the vulnerability of a young child in this situation.

D. Issue: The safety assessments completed on July 25, 2003 and July 31, 2003 did not adequately address the immediate safety needs of the infant but rather focused on services to be offered to the mother.

Recommendation: Continued training by Children's Administration for writing effective safety plans for children.

Child Fatality Review #05-29
Region 1
Spokane Office

Case Overview

This six-year-old Caucasian male died in the Spokane area on December 7, 2005 from a gunshot wound to his head.

On the evening of December 6, 2005, at approximately 5:00 p.m., an eleven-year-old reportedly shot his younger brother, age six. They were at their home alone when the eleven-year-old shot the six-year-old in the head with his father's gun. The six-year-old was airlifted to the hospital where he died the next morning.

The parents did not adequately provide supervision for their children. This was a recurring theme in several previous referrals. Child Protective Services (CPS) had received a total of 12 referrals regarding this family.

The parents were offered substance abuse evaluations and marital counseling following the first referral received by CPS in May 2001. The parents refused to participate in these services. In January 2002, substance abuse evaluations were offered again following a new investigation by CPS. The father complied and was diagnosed as alcohol dependent with recommendations for intensive outpatient treatment and community support groups. The mother also completed an evaluation and was diagnosed as alcohol and cannabis dependent. She was recommended to participate with intensive outpatient treatment and sexual assault counseling. Neither of the parents followed through with the treatment recommendations.

The siblings were also referred to individual counseling because of reports that they were engaged in sexualized behavior. There was not an opening available when the referral was made. The counseling center only had one counselor available in the parents' community. Due to a possible conflict of interest, at least one of the children would need to participate in counseling in Spokane. The parents stated this posed a hardship due to their hours of employment and transportation issues.

In March 2002, a referral was received for Sexually Aggressive Youth (SAY) treatment for the older boy. The Spokane County Prosecutor made the request for services. The parents did not respond to the services offered for their oldest son.

In February 2003, following a protective placement by Law Enforcement, the assigned social worker attempted to engage the parent's in intensive outpatient treatment, counseling, and counseling for their children. For five months the parents failed to follow through with any services.

In February of 2003, the older brother was placed in a behavioral intervention classroom and the decedent was accepted in a pre-school through the school district. The school provided the

transportation for pre-school. The school counselor contacted the parents to offer school based mental health services to the children. The parents refused to allow the children to participate.

Several referrals were received in 2005 that required CPS investigation. The father had agreed to a voluntary service plan that included Family Preservation services (FPS), counseling for the older children, as well as appropriate childcare whenever the father was not home. The father quit participating after three contacts by the FPS provider. The FPS provider reports that she addressed gun safety at a meeting with the family on July 9, 2005. The father said that all of his guns were locked up and he wouldn't allow his oldest son to have a gun because he hadn't completed a gun safety course. The FPS provider also identified childcare resources for the father. He never arranged for the children's counseling and did not have adequate supervision for the children on the day the shooting occurred.

On September 29, 2005, a Child Protection Team (CPT) recommended that the children remain in the home. The team expressed concerns for the children's safety and suggested that the Department staff the case with an Assistant Attorney General (AAG) and the father should get a substance abuse evaluation. According to the Social Worker, the AAG said that there was not sufficient information to pursue a dependency petition.

On November 1, 2005, the school reported to CPS that the oldest boy smelled of alcohol at school. They had reports that the children use alcohol and drugs at home and that the daughter had pulled knives and pellet guns on the boys. CPS investigated these allegations, which were founded for negligent treatment. The school helped develop a safety plan for the children to be supervised by a friend's parents after school.

On November 2, 2005 CPS received an informational report that the daughter had snorted oxycontin.

On December 7, 2005, CPS received information that the youngest boy had been shot by his older brother and died.

A safety plan was implemented in the father's home immediately after the child's death. However, both siblings were informally placed shortly thereafter. The older daughter was placed with a relative and her brother was placed with a friend of the father's. A dependency on the two children was granted in March, 2006. The brother is currently in a BRS placement and the daughter is in a foster home.

Issues and Recommendations

1. System Issues

A. Issue: The review team identified an issue for cases referred to Child Protective Services (CPS) from the Prosecuting Attorney's office for Sexually Aggressive Youth (SAY). CPS can offer services for the child/ren but there is no process for cases when the parents don't follow through with services for their child/ren.

Recommendation: The review team recommends that the Prosecuting Attorney's office and CPS develop a process for the SAY referrals in which the families do not follow through with services.

B. Issue: The review team identified that Children's Administration, Attorney General's Office, and Judicial officers do not appear to have a common definition of when chronicity with cumulative harm meets the criteria for a Dependency filing.

Recommendation: The review team encourages broad dissemination of this report to judicial officers, Assistant Attorneys General, and Guardians Ad Litem and discussion of this issue between those systems and Children's Administration.

C. Issue: The Child Protection Team that heard this case felt influenced in their decision making by the social worker and supervisor indicating that there was not sufficiency for a Dependency filing.

Recommendation: Region 1 provides multiple volunteer trainings annually for Child Protection Team members. CPT volunteers will be encouraged to attend and the curriculum in the future will address this issue.

2. Practice Issues

A. Issue: The review team identified an intake worker that prevented intervention for the family by inaccurately assessing a situation that was reported by a school.

Recommendation: The recommendation is for the Spokane Intake unit to have additional training specific to chronically referred families as well as customer service. It is anticipated that Children's Administration will release a policy regarding chronically referred families with a process for assessing those in the near future.

B. Issue: The safety plans completed were more specific to services instead of immediate safe guards for the children.

Recommendation: Region 1 provided 11 training opportunities for staff that addressed safety assessment and safety planning as part of the Kids Come First refresher trainings during the Fall and Winter of 2005/2006.

C. Issue: In June 2005 all three children were placed in protective custody by Law Enforcement. The return home of the children was premature.

Recommendation: The supervisor will discuss practice expectations related to protective custody, reunification, and safety assessments. Region 1 provided 11 trainings in the past year related to the risk assessment model and each tool. The assigned social worker attended this training.

D. Issue: The investigative risk assessment for referral # 1628029 was completed on 12/13/05 and dated for 8/9/05.

Recommendation: Supervisor to speak with worker regarding policy requirements for investigations and documentation.