Report to the Legislature

Quarterly Child Fatality Report

RCW 74.13.640

July - September 2010

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Table of Contents

Children's Administration Quarterly Child Fatality Report

[1]Child Fatality Review #10-16 is not subject to disclosure. The department conducted a child fatality review. However, the fatality did not meet the statutory requirement under RCW74.13.640 to conduct a child fatality review. The fatality review report is not disclosable under RCW 74.13.500.

Executive Summary

This is the Quarterly Child Fatality Report for July through September 2010 provided by the Department of Social and Health Services (DSHS) to the Washington State Legislature. RCW 74.13.640 requires DSHS to report on each child fatality review conducted by the department and provide a copy to the appropriate committees of the legislature:

> ***Child Fatality Review — Report***
>
> *(1) The department of social and health services shall conduct a child fatality review in the event of an unexpected death of a minor in the state who is in the care of or receiving services described in chapter 74.13 RCW from the department or who has been in the care of or received services described in chapter 74.13 RCW from the department within one year preceding the minor's death.*
>
> *(2) Upon conclusion of a child fatality review required pursuant to subsection (1) of this section, the department shall within one hundred eighty days following the fatality issue a report on the results of the review, unless an extension has been granted by the governor. Reports shall be distributed to the appropriate committees of the legislature, and the department shall create a public web site where all child fatality review reports required under this section shall be posted and maintained.*
>
> *(3) The department shall develop and implement procedures to carry out the requirements of subsections (1) and (2) of this section.*

This report summarizes information from 13 completed fatality reviews of fatalities that occurred in 2010. All 13 of the child fatalities were reviewed by a regional Child Fatality Review Team.

The reviews in this quarterly report include fatalities from each of the six regions.

Region	Number of Reports
1	2
2	2
3	1
4	2
5	2
6	4
Total Fatalities Reviewed During 3rd Quarter, 2010	13

Child Fatality Reviews are conducted when children die unexpectedly from any cause and manner and their families had an open case or received services from the Children's Administration (CA) within 12 months of their death. Child Fatality Reviews consist of a review of the case file, identification of practice, policy or system issues, recommendations, and development of a work plan, if applicable, to address the identified issues. A review team can be as few as two individuals (in cases where the death is clearly 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.

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

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

The chart on the following page provides the number of fatalities reported to CA, and the number of reviews completed and pending for calendar year 2010. 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 2010			
Year	Total Fatalities Reported to Date Requiring a Review	Completed Fatality Reviews	Pending Fatality Reviews
2010	62	22	40

The numbering of the Child Fatality Reviews in this report begins with number 10-10. This indicates the fatality occurred in 2010 and is the tenth report completed during that calendar year. The number is assigned when the Child Fatality Review and report by the Child Protective Services Program Manager is completed.

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

Notable Findings

Based on the data collected and analyzed from the 13 deaths reviewed between April and June 2010, the following were notable findings:

- Children four months or younger accounted for approximately 62% (8) of the 13 fatalities reviewed. The next largest group was that of teenage youth ages 13-16, representing 15% (2) of the child fatalities reviewed as shown in Table 1.1 on page 6.
- Of the 13 child fatalities reviewed, 85% (11) were males and 15% (2) were females.
- Of the 13 child fatalities reviewed, 53% (8) of the children were white, 33% (5) were Native American, and 13% (2) were Hispanic.
- Natural and accidental deaths, as classified by the medical examiner or coroner, accounted for approximately 62% (8) of the total deaths. The manner of death of the remaining cases was as follows: 15% (2) were the result of homicides, 15% (2) were due to unknown/undetermined causes, and 1 (8%) was the result of suicide.
- The two child fatalities that were the result of homicides involved two teenagers, ages 15 and 17 respectively, who were gang involved; their deaths were related to their gang involvement**.**
- Sudden Infant Death Syndrome (SIDS) or Sudden Unexplained Infant Death (SUID) was listed as the cause of death in 31% (4) of the child deaths reviewed.
- Two out of four of the infant deaths attributed to SIDS or SUID included an unsafe sleep environment; the infants were co-sleeping with their parents in both cases.
- One infant death not classified as SIDS or SUID was declared an accident in manner of death, with asphyxiation as the cause of death. The infant and the mother were co-sleeping on a couch and the infant was found in the morning with a pillow on her face.

- Of the 13 child fatalities reviewed, all had prior contact with Children's Administration (CA). Fifty-three percent of the child fatalities reviewed had between one and four prior intakes.
- One child fatality occurred in a licensed facility (child care).

Due to the small sample of cases reviewed, no statistical analysis was conducted to determine relationships between variables.

Table 1.1

3rd Quarter 2010, Child Fatalities by Age and Gender						
Age	**Number of Males**	**% of Males**	**Number of Females**	**% of Females**	**Age Totals**	**% of Total**
<1	6	55%	2	100%	8	62%
1-3 Years	-	-	-	-	-	-
4-6 Years	1	9%	-	-	1	8%
7-12 Years	1	9%	-	-	1	8%
13-16 Years	2	18%	-	-	2	15%
17-18 Years	1	9%	-	-	1	8%
Totals	11	100%	2	100%	13	100%

N=13 Total number of child fatalities for the quarter.

Table 1.2

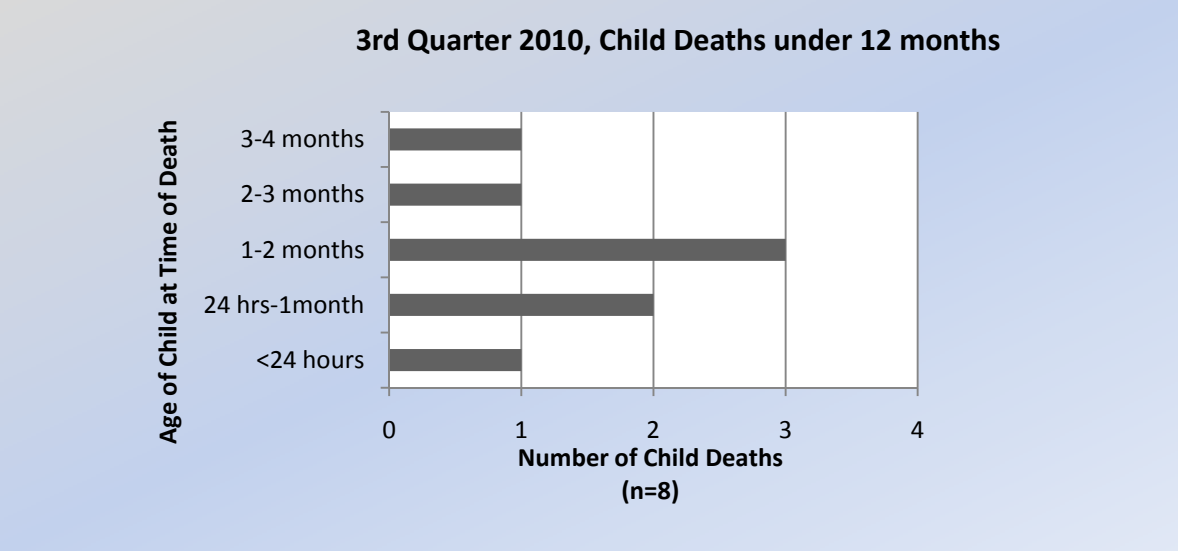


Table 1.3

3rd Quarter 2010, Child Fatalities by Race	
Black or African American	-
Native American	5
Asian/Pacific Islander	-
Hispanic	2
White	8
Unknown	-
Totals*	**15**

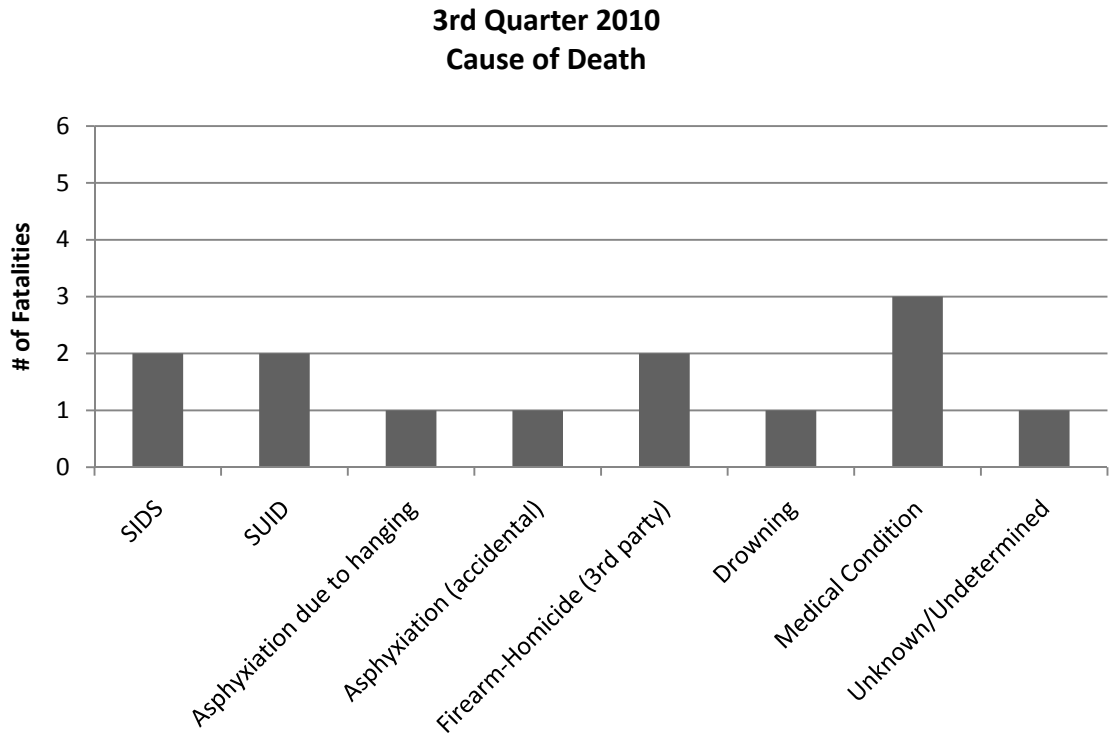
*Some children are in more than one category.

Table 1.4

3rd Quarter 2010, Child Fatalities by Manner of Death	
Accident	2
Homicide (3rd party)	2
Natural/Medical	6
Suicide	1
Unknown/Undetermined	2

N=13 Total number of child fatalities for the quarter.

Table 1.5



N=13 Total number of child fatalities for the quarter.

Table 1.6

3rd Quarter 2010, 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	-	-
Homicide (3rd party)	-	1	1	-	-	-
Natural/Medical	-	4	1	1		-
Suicide	-	1	-	-	-	-
Unknown/ Undetermined	-	1	-	-	-	1

N=13 Total number of child fatalities for the quarter.

Summary of the Recommendations

Of the 13 child fatalities reviewed between July and September 2010, 10 (77%) had issues and recommendations identified 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 receiving full team review, the team decides whether any recommendations should result from the fatality review. 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 2010, Issues & Recommendations	
Contract issues	1
Policy issues	1
Practice issues	15
Quality social work	-
System issues	4
Total	**21**

Issues and recommendations were made in area of intake in six cases (46% of child deaths during the quarter). The issues identified had to do with screening decisions, a lack of quality information contained in intakes, and a failure to consider family history and/or a pattern of reported concerns at intake. The recommendations made regarding the practice issues identified in the area of intake require attention at the local office level and statewide. For example, in one review where concerns were noted regarding a lack of consideration of the family's history, the team recommended that more shared decision making occur between the intake worker, supervisor and area administrator specifically on

intakes that are questionable. In another review where there was some disagreement about intake screening decisions, the team recommended that Children's Administration consider resuming an annual statewide intake review, as well as reinforcing through training or other means, the expected practice at intake of assessing for patterns of reported concerns.

Child Fatality Review #10-10
Region 4
King County

One-month-old Native American male died from Sudden Infant Death Syndrome.

Case Overview
On February 15, 2010, the mother of the one-month-old woke at 8:20 a.m. and found her son non-responsive. He was on his back lying face up. She called 911 and her partner performed CPR until an aid unit arrived.

The mother reported that her son slept in the bassinette. The family bedroom consisted of a crib on one side, a bassinette, and a bed. The family included the one-month-old infant, his parents, and his 14-month-old brother. The bassinette was next to the bed. The mother told police that she breastfed him and placed him back to sleep at 6:00 a.m. She placed him in a bassinette, and swaddled him in a receiving blanket. She went back to sleep with the father of the baby.

The home was noted to be clean and orderly. There were no other risk factors noted in the Medical Examiner's report. The Medical Examiner determined the child died from Sudden Infant Death Syndrome (SIDS). The manner of death is listed as natural.

The baby was apparently a healthy infant who had a well baby exam on February 1, 2010. The mother and infant also received services from a Public Health Nurse.

Children's Administration (CA) had an open case on the parents of the one-month-old baby at the time of his death. CA intake received a report on December 16, 2009 alleging the father was in violation of a no-contact order with the mother. There was prior history of domestic violence between the parents.

Intake History
On December 16, 2009, a staff member with the tribal housing authority reported to Child Protective Services (CPS) that the mother allowed the child's father to be in the home. There was a protection order preventing the father from being around both the mother and the child (an older sibling, then one year old). The father has a history of domestic violence against the mother. He reportedly had kidnapped and held her against her will. This intake was screened as Risk Only.

The mother told the assigned CPS social worker that the domestic violence occurred over one year prior and she did not fear the father of her child. The social worker made contact with a relative who reported the mother and her child moved in with her. The father had moved to eastern Washington.

On January 11, 2010, the assigned social worker staffed the case with the Muckleshoot Indian Child Welfare case workers. The mother was staying with her mother pending the delivery of child. The father had left the area. The mother was receiving Women, Infant, and Children (WIC) services. There was consensus that the case could close, but the case was open when the one-month-old infant died on February 15, 2010.

Issues and Recommendations
Issue: Grief and loss resource information for clients.

Recommendation: The Regional CPS Program Manager will follow up with the King County Medical Examiner's Office, and obtain a packet of resource information that can be shared with clients and with Muckleshoot Indian Child Welfare. This information was requested on July 8, 2010.

Issue: Screening decision of the intake dated December 16 2009. This intake was screened in as Risk Only based on a reported violation of a no contact order. However, there was no information about any harm to the older sibling, the only child in the home at that time.

Recommendation: The Regional CPS Program Manager will follow up with the Intake Program Manager to discuss this screening decision.

Child Fatality Review #10-11
Region 6
Clallam County

Two-month-old Native American male died from a medical condition.

Case Overview
On February 28, 2010, the parents and children were out to eat at a restaurant approximately 10 minutes from their home. Upon arriving at their home, the parents discovered that their two-month-old son was not breathing. They called 911 and the police arrived at the home within five minutes and started CPR. The medics arrived at the home a few minutes later and took over CPR. The infant was transported to the hospital in Forks where continued lifesaving measures were attempted. The infant was pronounced deceased approximately three hours later. The attending physician signed the death certificate indicating the child died from a medical condition. The manner of death was listed as natural.

The child was seen at the emergency room on February 26, 2010 for a cough and congestion. He was sent home, and the mother was told to return to the emergency room if there were further concerns.

The family consisted of the parents and their four children ages, 10 years, 4 years, 2 years, and 2 months.

Children's Administration (CA) did not have an open case on the parents of the two-month-old baby at the time of his death. CA received a report on December 18, 2009 alleging the child was born at a local hospital and his mother tested positive for marijuana at the time of his birth. He was born two weeks premature and had a low birth weight (five pounds). This intake was screened for the Alternate Response System (ARS).

Intake History
On January 3, 2008, a social worker from the Forks Community Hospital called CPS intake to report the birth of a newborn female. The mother tested positive for marijuana at birth. The referrer stated that the mother's primary care physician had warned her not to use marijuana during her pregnancy. The newborn female was healthy and doing well. The mother had no other complications other than the positive toxicology screen. This intake was screened as Information Only.

On December 18, 2009, staff from the Forks Community Hospital called CPS intake to report the birth of this male infant. The infant's mother tested positive for marijuana at the time of her delivery. The mother had no prenatal care. The infant was born at 40 weeks gestation. The infant had minor medical issues at birth that included high blood sugars and low birth weight (five pounds). The intake was screened for the Alternate Response

System. A letter was sent to the mother discussing the risk of marijuana exposure to an infant and encouraging her to take her infant son to well child exams. The letter also contained a list of local community agencies that could assist the mother including tribal social services, Public Health Nurse, and chemical dependency services.

The Hoh Tribe had been working with the family through tribal court. Her surviving children were placed in out-of-home care through tribal court. Since the death of her son, the mother started to comply with the court orders and had clean urinalyses.

Issues and Recommendations

Issue: There were no issues or concerns raised during the review. The tribal social worker stated that she felt as though she was getting the support needed from the state on this case and felt that the state had responded appropriately to the intakes received on this family.

Recommendation: None

Child Fatality Review #10-12
Region 2
Yakima County

Two-month-old Native American male died from Sudden Infant Death Syndrome (SIDS)

Case Overview
On March 1, 2010, detectives with the Yakama Nation Police Department reported the death of a two-month-old child. The detective reported his mother woke at 8:20 a.m. and found him nonresponsive. He was on his back lying face up. She called 911 and her partner performed CPR until an aide unit arrived.

The child was transported to the Toppenish Hospital by ambulance and did not have a heartbeat upon arrival. The coroner reported the child died in the early morning hours of March 1, 2010. The infant was pronounced dead at Toppenish Community Hospital. The coroner reported that the child was born with a loud murmur and was diagnosed with a respiratory infection on February 17, 2010. It is reported that the cause of death was respiratory arrest due to probable SIDS. The manner of death was natural.

The Yakima County Coroner reported there are no allegations of abuse or neglect related to this child fatality.

Children's Administration (CA) did not have an open case on the parents of the two-month-old baby at the time of his death. CA intake received a report dated January 29, 2010 that was screened out for investigation. This intake documented the birth of the now deceased child. The delivery was without complication and there were no reports of substance abuse or other allegations of neglect.

The mother has a total of eight intakes reported to Children's Administration from 1998 to January of 2010. Four intakes were screened in for investigation and completed with founded findings for negligent treatment or maltreatment. Her children in her care at the time of these intakes were all placed out of the home due to the high risk behavior associated with the mother's substance abuse. The mother refused to make herself available to social work staff and refused to comply with court ordered services.

The mother has seven children. None of her children are currently in her care and custody. Her children include the two-month-old infant who passed away on March 1, 2010, a 20-month-old son in 3rd party custody with his maternal grandmother; a three-year-old son and a six-year-old daughter in a guardianship with a maternal aunt; an eight-year-old son, a 14-year-old son and a 15-year-old daughter all placed in guardianships with their maternal grandmother.

Intake History

On October 16, 1998, a staff member with the tribal housing authority reported to Child Protective Services (CPS) intake that housing authority workers went to the home and found the mother passed out on the couch. Her two-year-old son (now 14 years old) was wandering around the house. The housing authority received complaints from neighbors there were a lot of people in and out of the home and wild parties. The child was placed on a Voluntary Placement Agreement (VPA) with his maternal grandmother. The grandmother already had custody of the older sister (now 15 years old). The mother completed a drug and alcohol assessment. The intake was screened in for investigation and closed with a founded finding for negligent treatment or maltreatment.

On December 1, 2003, hospital staff contacted CPS intake to report the birth of a newborn girl who tested positive for cocaine. The baby was born six weeks premature. The mother had no prenatal care. The mother admitted to hospital staff that she used cocaine. The infant was placed with a maternal aunt and a dependency petition was filed on the child, her nine-month-old brother, and seven-year-old brother. She remained in the care of her aunt under a guardianship order. The brothers, now eight and 14 years old, were placed in a guardianship with their maternal grandmother. The intake was screened in for investigation and closed with a founded finding for negligent treatment or maltreatment.

On June 24, 2007, CPS intake received a report from a nurse who reported the mother gave birth to a male child in a car in the hospital parking lot in Seattle. The infant tested positive for barbiturates and amphetamine. The mother admitted to hospital staff that she used cocaine. The infant was placed with a maternal aunt and a dependency petition was filed in tribal court on the child. The child has remained in the care of his aunt under a guardianship order. The intake was screened in for investigation and closed with a founded finding for negligent treatment or maltreatment.

On November 26, 2008, a nurse at a Yakima area hospital reported to CPS intake that a baby boy was born three days prior and was a month premature. The mother's drug screen was negative. No drug screen was conducted on the infant. The infant had respiratory distress at birth. The intake was screened out for investigation.

On October 25, 2009, a hospital social worker reported to CPS intake that the mother was involved in a car accident. Her 11-month-old son (now 20 months old) was not with her. The mother tested positive for opiates and marijuana. She reported she was taking non-prescribed Oxycontin for tooth pain and admitting using marijuana. She was approximately 22 weeks pregnant. She told hospital staff that she received prenatal care and agreed to a referral for a Public Health Nurse. The intake was screened out for investigation.

On January 29, 2010, a hospital social worker called CPS intake to report the mother gave birth to a baby girl (the now deceased child). The social worker reported the delivery went

fine and there were no reported substance abuse issues. The intake was screened out for investigation.

On March 1, 2010, a detective with Yakama Tribal Police called to report the death of the two-month-old infant. The detective reported there were no suspicions of abuse or neglect related to the child's death. The County Coroner determined the cause of death was SIDS. The intake was screened in for investigation as Risk Only. There was a 20-month-old surviving sibling in the home (though he was later removed from his mother's care following a new intake reported to CPS intake after the death of his brother). The parents initially chose to participate in Family Preservation Services. The social worker attempted to engage the parents in services. However, the parents chose later to decline participation in services and the case was closed.

On May 17, 2010, the mother was involved in a high speed chase with law enforcement that resulted in her crashing her vehicle. Her now 20-month-old son was in the vehicle. He escaped injury. The mother was arrested on charges of attempting to elude, reckless endangerment and driving with a suspended license. The child was placed with his maternal grandmother and she was granted custody of him in the Yakama Tribal Court.

Issues and Recommendations

Issue: Family Child Abuse/Neglect history was not considered when making screen out decisions on intakes received between November 26, 2008 and January 29, 2010.

Recommendation: The Toppenish office will continue with standard practice of looking at and assessing family history when making screening decisions. Shared decision staffing will occur between intake worker, intake supervisor and Area Administrator on those intakes that are questionable.

Issue: According to the detective from the Yakama Nation Police Department, field officers (Patrol) often do not understand Child Protective Services policy and protocols as it relates to risk and safety of children.

Recommendation: A designee from DCFS Toppenish office will provide a thorough CPS presentation to Yakama Nation Police (Patrol) to be followed by a question and answer session. This presentation will be completed by October 31, 2010.

Child Fatality Review #10-13
Region 4
King County

Sixteen-year-old Caucasian male died from hanging.

Case Overview
On March 1, 2010, the 16-year-old was last seen by his family at 9:30 p.m. when he went to his bedroom. He was found in his room the next morning on March 2, 2010 partially suspended by a rope.

His parents reported that he was their adopted son and he had anger management issues and a history of smoking marijuana. In 2009, he assaulted his adoptive mother which resulted in his arrest and court-ordered juvenile detention. He was also court-ordered into therapy. He also took medication for depression. His parents told police that he had a recent breakup with a girlfriend. He did not leave a note.

According to the King County Medical Examiner's report, the 16-year-old died as a result of asphyxiation due to ligature hanging. The manner of death is suicide. The toxicology report was negative.

Children's Administration (CA) did not have an open case on the family at the time of his death. CA opened a Family Reconciliation Services (FRS) case on May 22, 2009 at the request of the parents who were struggling with their son's behaviors. The FRS case was closed on July 13, 2009.

Intake History
On May 22, 2009, the parents of the 16-year-old youth called Child Protective Services (CPS) intake to request an assessment for an At-Risk Youth Petition and crisis counseling. The parents also requested FRS. The parents told intake that their son threatened to kill students and a teacher at school. He has been expelled for his actions. The parents said he had recently attacked his mother and choked her. The youth's father had to intervene. Police were called to the home and the youth was arrested and placed in juvenile detention. The parents feared for the safety of their 12-year-old daughter.

The parents tried to get their son to participate in mental health therapy, but he refused. He has been working with a school counselor, but his behavior had gotten worse during the past year.

The assigned FRS social worker kept the case open while the youth was in detention. He was in detention for twenty days. The family arranged for mental health services. The youth was court ordered to participate in the Step Up program through juvenile court services. This is a program for youth who have been convicted of assaulting a parent.

The mother and the FRS social worker had a telephone conversation on July 8, 2009. At that time, the mother decided she would not pursue an At-Risk Youth petition; instead, she wanted to continue with the outpatient mental health services.

The FRS case was closed on July 13 2009.

On March 2, 2010, the King County Medical Examiner called CPS intake to report the death of the 16-year-old. The Medical Examiner reported the youth committed suicide by hanging. The intake was screened in for investigation for negligent treatment or maltreatment. It was completed with an unfounded finding. The assigned social worker provided the family with grief and loss resources.

According to the youth's probation officer, the parents were very involved in getting their son into every service he needed. The probation officer reported the youth had identified all the positive changes he had made in the latter part of 2009 including substance abuse recovery, mental health treatment, and taking medication for depression. The probation officer reported the 16-year-old was looking forward to the New Year (2010).

Issues and Recommendations
Issue: None identified

Recommendation: None

Child Fatality Review #10-14
Region 3
Skagit County

Four-month-old Native American male died from Sudden Unexpected Infant Death.

Case Overview
On March 5, 2010, the four-month-old had surgery at Seattle Children's Hospital to repair a cleft palate. The surgery took eight hours. The child was released from Children's Hospital on March 6, 2010 at 3:00 p.m. to the care of his grandparents. At 6:00 p.m., his grandmother administered the prescribed pain medication and immediately the child went limp and stopped breathing. The grandparents called 911. Medics were unable to resuscitate the child.

The child had just returned to the home of his paternal grandparents after a brief hospitalization to repair the cleft palate. He had been home just a few hours when he was fed and given his pain medication as prescribed.

The autopsy showed the child had early bronchopneumonia and a mild chronic aspiration. The Medical Examiner determined these were not severe enough to cause the child's death. Toxicology results showed that the four-month-old had the appropriate amount of medication in his system at the time of his death. The Skagit County Coroner determined the cause of death to be Sudden Unexpected Infant Death. The manner of death is natural.

Children's Administration (CA) had an open case on the family at the time of the death of the four-month-old. A case was opened on November 12, 2009 after a report to Child Protective Service (CPS) intake that the child and his mother tested positive for several drugs at his birth. The child was residing with the paternal relatives since birth, initially on a voluntary basis, and continued in this relative placement after the shelter care status was obtained.

Intake History
On November 12, 2009, a hospital social worker called CPS intake to report the mother gave birth to the now deceased child. The baby was transferred to Children's Hospital in Seattle. The baby was born full term, but was born with a cleft palate. The mother tested positive for methamphetamine. The hospital did not test the baby. The mother did not have prenatal care. The intake was screened as Risk Only and a CPS social worker was assigned to address the concerns.

The infant was given morphine to address withdrawal symptoms. The infant was discharged from Children's Hospital to the care of his grandparents. The parents were allowed to live with the grandparents; however the grandparents were the primary caregivers. The case was transferred to the Family Voluntary Services (FVS) Unit. Both

parents completed drug and alcohol evaluations. A dependency petition was filed when the parents did not follow through with the evaluation recommendations and had minimal compliance with other agreed upon services. The dependency petition was filed on January 14, 2010 and the infant remained in his grandparents' care. The child was in Shelter Care status when he died.

Issues and Recommendations

Issue: The four-month-old went with his parents into the home of his paternal grandparents upon his release from the hospital in November 2009. This outcome was decided at a Family Team Decision Meeting. However, there was no documentation in the record of a criminal background check being done on the paternal grandparents until the department was formally placing the child in that home with the filing of the dependency petition. The team agreed that there was a lack of clarity amongst social workers in the office concerning when and how to access criminal background checks on clients.

Recommendation: An office-wide training has been scheduled for the Mount Vernon office on the use of criminal background checks. This training is scheduled for August 27, 2010.

Issue: The intake that was produced when the four-month-old was born was screened out originally, as there were no allegations, only risk factors for the future. The situation was not seen to rise to the level of needing an immediate response on the basis of risk factors. Had it been accepted as originally written, the intake would have been a "Risk Only" and would not have required that findings be made. When the intake reached the CPS unit supervisor, the concerns appeared to her to be great enough that a decision was made to assign the intake. The intake was changed to "accepted." However, the current computer system (FamLink) requires an intake to include allegations when a supervisor changes the initial intake screening decision. Risk Only intakes do not require findings, but intakes with allegations of abuse or neglect do require a finding. The social worker chose to close the case with a founded finding, despite the intention of this intake to be Risk Only. The "founded" was then made, in error, on the allegations at the end of the investigation.

Recommendation: This issue of how to treat "risk only" intakes that need to have screening decision changed, along with the feasibility of making new intakes, will be on the agenda for discussion at the next CPS/FVS supervisors' meeting in the region. The issue of making findings in cases being investigated for prenatal drug use will also be discussed.

Issue: There was no Plan of Safe Care delineated in the case notes for this intake, as required by policy.

Recommendation: Plans of Safe Care for infants born with drug issues will be addressed at the next CPS/FVS supervisors meeting and the next Intake Specialists' meeting. This training is scheduled for August 25, 2010.

Child Fatality Review #10-15
Region 1
Grant County

Seventeen-year-old Caucasian male died from a gunshot wound.

Case Overview

On March 7, 2010, just after 6:00 p.m. the 17-year-old youth and two companions were walking alongside the road outside of the town of Mattawa when they were shot at by individuals in a passing car. The 17-year-old was killed and one companion was injured in the shooting. Two adults and one juvenile were arrested on March 18, 2010 as suspects in the shooting. Grant County Sheriff's deputies believe the shooting was gang related. The youth died from a gunshot wound to the chest. The Grant County Coroner determined the manner of death to be Third Party Homicide.

Children's Administration (CA) had an open case on the mother of the 17-year-old at the time of his death. The case was open in October 2009 when the youth was being released from Juvenile Detention due to assault charges and his mother could not be located to pick him up. Police placed him in protective custody. His mother was out of town during that particular weekend and was unaware of her son's arrest or his release from detention. The youth was placed in foster care for two days and released to his parents. The case was inactive for services at the time of the youth's death.

Intake History

On October 26, 2009, staff from Grant County Juvenile Detention contacted Child Protective Services (CPS) intake to request placement for the 17-year-old. He was in detention for three counts of third degree assault and one count of intimidating a public servant. He was to be released from detention but no adult could be located to accept him from detention. The intake was accepted for investigation as a neglect allegation. The youth was placed in a licensed foster home for two days and was released to his mother on October 28, 2009 when she returned from a trip to California. The intake was screened in for investigation and closed with an unfounded finding for negligent treatment or maltreatment.

The assigned social worker spoke to the youth and his mother about Family Reconciliation Services (FRS). The mother stated that family was not interested in FRS at that time. The mother was informed she could request FRS at a later date.

The youth's mother was out of town over that particular weekend and did not know of the arrest or the release from detention. The participants in the child fatality review contend that had intake staff had this information, the intake screening decision would likely be a Child Welfare request for placement and not a negligent treatment allegation against the youth's mother.

Issues and Recommendations

Issue: The review committee identified limits of Juvenile Detention as a potential safety issue when youth are being released and no parent is available or capable to respond. Children's Administration is frequently contacted to place youth being released from detention when there are no child abuse or neglect allegations. The committee discussed concerns that these youth may be placed into foster homes where there are other vulnerable children without sufficient information about the youth such as risk factors, their crimes or social history. At this time detention centers cannot keep a youth post detention release and Children's Administration has limitations on placements defined in WAC 388-25-0020.

Recommendation: The review committee recommends a provision be added to RCW 13.40 that gives Court Administrators the ability to extend into the next business day the youth's detention stay when parents or other responsible adults cannot be contacted for the youth's release from detention.

Issue: Minimal information was documented by intake staff in the accepted intake on October 26, 2009 when Juvenile Detention staff called to request placement of the 17-year-old.

Recommendation: Intake staff conduct an interactive interview with the referent when placement requests are being made by Juvenile Detention Centers. Information about the youth obtained from Detention Center staff should include previous criminal history, when the youth was arrested, alleged crimes committed, time served, parental contact from time of arrest through release date and any additional risk factors known in order to provide the safest placement decision possible. Intake should acquire all available information so that if a youth released from a detention center is placed in foster care, the department is doing so with as much information as possible to assist in safety to all.

Child Fatality Review #10-16 is not subject to disclosure. The department conducted a child fatality review. However, the fatality did not meet the statutory requirement under RCW 74.13.640 to conduct a child fatality review. The fatality review report is not disclosable under RCW 74.13.500.

Child Fatality Review #10-17
Region 1
Spokane County

One-day-old Native American male infant died after aspirating on meconium during delivery.

Case Overview
On March 23, 2010, the mother gave birth to this infant via Caesarian section (C-section). The infant aspirated on meconium during the C-section. The Spokane Medical Examiner's initial finding indicated that there is no information that substance abuse by the mother was an additional factor causing the death of the child. The Medical Examiner reported that mother was a known heroin user. The infant was born at approximately 37 weeks gestation. The Medical Examiner did not have information on whether the mother received prenatal care. There is no report of trauma or injury to the infant.

The Medical Examiner did not conduct an autopsy. There is no official cause and manner of death at the time of this report.

Children's Administration (CA) had an open case on the family at the time of the infant's death. The mother gave birth to an older sibling in March 2009. This child was placed with relatives at birth. A dependency petition was filed leading to the termination of the parents' parental rights in December 2009. The case was still open to complete the adoption of this child when the one-day-old infant passed away.

Intake History
On July 26, 2005, medical personnel contacted CPS intake to report that the mother of this one-day-old infant was five months pregnant with another child and tested positive at a medical clinic for methamphetamine, marijuana and amphetamine. An ultrasound showed fetal anomalies and lab tests were positive for syphilis. The mother reported decreased fetal movement and was advised to return to the hospital. She did not. The intake was screened as Information Only.

On August 17, 2005, CPS was contacted to report the mother was arrested and was transferred to the Purdy Correctional facility. She was pregnant and due to deliver on October 7, 2005. It was unknown if she was still incarcerated at that time, but concerns noted were the mother's sporadic prenatal care and history of IV drug use. The intake screened as Information Only.

On September 21, 2005, staff from the Purdy Correctional facility contacted CPS intake to report the mother went into labor and was about to deliver a child. The facility was seeking assistance in having the infant placed with a relative. The intake was screened as Child Welfare Services request.

On September 28, 2005 staff from the Purdy Correctional facility contacted CPS intake to report the infant had not been born yet but the mother was to be released from prison the following day. After collateral contacts were made, the report was accepted for negligent treatment investigation and the case assigned. The CPS investigation was later completed with a founded finding for negligent treatment or maltreatment.

On October 5, 2005, the mother gave birth to a baby girl. The infant was healthy with no sign of withdrawal. The infant was released from the hospital on October 8, 2005 to the mother's care. A case was already open and the social worker was working with the mother to establish stable housing for her and her baby.

On October 14, 2005, a doctor made a report to CPS intake alleging the infant was diagnosed as failure to thrive after losing 12 ounces following her birth. The infant was hospitalized for three days and upon discharge, hospital staff said the mother did a good job of caring for the baby. The mother was referred to First Steps. The CPS investigation was completed with an unfounded finding for negligent treatment or maltreatment.

In late November 2005, the mother admitted to her social worker that she had used methamphetamine. Her infant daughter was placed with relatives on December 14, 2005 by court order and a dependency petition was filed at that time.

The mother did not complete any of the court ordered services and continued drug use throughout the dependency. The mother was court ordered to participate in services to address substance abuse issues and parenting. She did not comply with any services nor did she demonstrate any progress related to the identified concerns. The parents' parental rights to the child were terminated on May 4, 2007. An adoption was finalized on December 14, 2007 and the dismissal of dependency was on January 8, 2008.

On March 19, 2009, a hospital social worker called CPS intake to report the mother gave birth to a second baby girl. The mother admitted to using methamphetamine, marijuana, and alcohol during her pregnancy. She did not receive regular prenatal care during her pregnancy. The intake was screened in for investigation as Risk Only and a CPS case was opened.

A dependency petition was filed on this child shortly after her birth. Both parents were arrested for felony charges shortly after this child's birth. The child was placed with the same relatives who have the older sibling. Neither parent completed the court ordered services; they continued to use drugs throughout the dependency. Both parents stopped communication with social workers and were unable to be located. Their parental rights were terminated in December 2009. The child was later adopted by her relatives.

On January 29, 2010, CPS intake received a report that the mother was pregnant and was using heroin. Her two other children were no longer in her care. This intake was screened as Information Only and no investigation was conducted.

On February 2, 2010, staff from Community Corrections called to report the mother was seven months pregnant and was using methamphetamine and heroin during her pregnancy. The mother did not receive prenatal care. The intake was screened as Information Only and no investigation was conducted.

On March 22, 2010, hospital staff called CPS intake to report the mother gave birth to a child via C-section. The child had aspirated meconium. He died seven hours after birth. There was no indication of injury to the newborn. There was no autopsy performed. The intake was screened as Information Only and no investigation was conducted.

Issues and Recommendations

Issue: The case of the mother's second child (who is Native American) does not have documentation that a Local Indian Child Welfare Advisory Committee (LICWAC) staffing occurred prior to termination of parental rights nor was there clear documentation that decisions were case managed by a Tribe in lieu of the LICWAC. This documentation was located for the older sibling, who is also Native American.

Recommendation: The Area Administrator and Tribal Liaison will provide education and training to the supervisor and social workers involved with this case.

Child Fatality Review #10-18
Region 6
Mason County

Three-week-old Caucasian female infant died from Sudden Unexplained Infant Death (SUID).

Case Overview
On March 26, 2010, the mother of the three-week-old infant called medics to her home after she found her daughter non-responsive. Medics arrived at the home and the infant was intubated at the scene. The medics administered CPR and transported her to Mason General Hospital. Efforts to revive the infant were unsuccessful. The Mason County Coroner reported there were no signs of abuse and neglect. The manner of death is listed as undetermined. The cause of death is Sudden Unexplained Infant Death (SUID).

Children's Administration (CA) had an open case on the family at the time of the infant's death. This case was an open Child Protective Services (CPS) case as the result of an intake received on February 27, 2010 alleging physical abuse and neglect by the parents of the seven-year-old brother in the home. CPS intake received another report on March 2, 2010, when the three-week-old infant was born at home and then transported to Mary Bridge Children's Hospital. The baby was born positive for marijuana and methadone. The mother was enrolled in a methadone treatment program at the time of the baby's birth. The infant was in the hospital from March 2, 2010 to March 14, 2010 for methadone withdrawal. The case was to be transferred to the Family Voluntary Services (FVS) unit the week of March 29, 2010.

Intake History
On September 22, 2008, a neighbor contacted CPS intake to express concern about the mother and her six-year-old son. The child was not attending school. There were a high number of people staying in the home. The referrer believed some of the visitors had criminal histories. It was suspected that the mother and her husband were using drugs as both had lost weight. The intake was screened as Information Only and not investigated by CPS.

On September 29, 2008, a relative contacted CPS intake to report the older brother of the three-week-old infant was not enrolled in school and was wearing dirty clothes, sleeping in dirty linen, and was living with his stepfather as his mother was incarcerated. The stepfather was believed to be heavily medicated. The intake screened as Information Only and was not investigated.

On February 19, 2009, CPS intake was contacted by a relative because the six-year-old was not attending school. He had open wounds with a staph infection. The untreated wounds were on his face, lip, cheek, nose, stomach and on his buttocks. The mother was

told to take her son to see a medical professional, but she wasn't concerned. The referrer admitted that he had not personally observed the child. The intake was screened in and investigated by CPS. The mother did take the child to the doctor and he was diagnosed with impetigo. The mother obtained medication for the impetigo. The CPS investigation was closed with an unfounded finding for negligent treatment or maltreatment.

On March 30, 2009, a neighbor reported to CPS intake that the six-year-old child was not being adequately supervised. The child was burned in the past while playing with a lighter. The mother and stepfather were both in methadone treatment programs. They both smoked marijuana daily. The stepfather would fall asleep and drop lit cigarettes onto the floor. The child would occasionally wet the bed. The bed and mattress both smelled of urine. The intake was screened in for investigation. The CPS investigation was closed with an unfounded finding for negligent treatment or maltreatment. The parents were asked about the child being burned while playing with a lighter. They reported the incident occurred approximately three years prior when he was able to get the mother's lighter while she was in the shower. The mother confirmed the child had bed wetting accidents; she obtained a rubber mattress cover to address the soiling of the mattress.

On April 6, 2009, a neighbor called CPS intake to report that the mother owned a gun that she kept under the seat of her car and inside the house. The gun was loaded but it was unknown if the six-year-old had access to the gun. It was also reported that the six-year-old goes unsupervised. The intake was screened as Information Only as the information reported was not a new allegation and the case was open and under investigation at the time of this intake. The social worker asked about allegations in this intake. The parents denied they had a gun in the house. The child later went to stay with his biological father in Tennessee for several months. The father considered filing an amended parenting plan to get custody of his son.

On April 7, 2009, CPS intake received a report that the mother was pregnant and due in June 2009. This intake was screened as Information Only. A referral was sent to DSHS First Steps as to the pregnancy. Local area hospitals were alerted in case the mother arrived to give birth. The department was later notified that the mother had suffered a miscarriage.

On July 24, 2009, a relative contacted CPS to report that the mother was using drugs (methamphetamine). The referrer reported the mother was observed to be under the influence but was not incapacitated and had been functioning. The child had returned from an extended visit with his biological father. It was believed that the mother and her seven-year-old son moved to the Spokane area. The intake was screened as Information Only and was not investigated by CPS.

On February 27, 2010, a family friend contacted CPS intake to report the mother and her partner spank her seven-year-old son a lot. The referrer reported an incident that he witnessed where the partner used a belt on the child and he saw a bruise. He also told of an

incident where the partner hit the child's head, causing the child to hit his head against the wall. The referrer stated the mother spanked the child with an open hand. This information was reported in February 2010 but the referrer said it occurred between March 2009 and September 2009. The referrer also reported that the house was filthy. There are piles of dirty clothes everywhere and dirty dishes in the sink for a week at a time. There were two dogs in the home with dog hair everywhere. The dogs defecated in the house and it was later cleaned up. The mother smoked cigarettes and marijuana and was pregnant. There were periods of time where there was no electricity or water in the home due to lack of bill payment. The intake was screened in for investigation and was completed with an unfounded finding for physical abuse and negligent treatment or maltreatment.

On March 2, 2010, a hospital social worker reported the mother gave birth to her daughter at home. The newborn was taken to Mary Bridge Children's Hospital in Tacoma. The referrer reported the mother has a history of methamphetamine use. The mother called an ambulance after she went into labor at home, but delivered five minutes before the ambulance arrived. The mother had sores all over her body. Her urinalysis test was positive for THC. The child's father was falling asleep in the waiting room. Both parents smelled strongly of cigarettes. The intake was screened in for investigation and completed with an unfounded finding for negligent treatment or maltreatment. The case remained open. The mother was working on relapse prevention with the Family Preservation Services (FPS) provider.

On March 29, 2010, CPS received a report of the death of the three-week-old infant. Medics were called to the home at approximately 9:00 a.m. and found the infant non-responsive. The medics arrived at Mason General Hospital at 9:13 a.m. and administered CPR. The infant was intubated at the scene but was unresponsive. The coroner's preliminary report indicates the child may have suffered from an accidental smothering. The report was changed to SUID. The coroner reported there were no signs of abuse and neglect. The intake was screened as Information Only. The family has support within the community and support from the paternal grandparents. The case remains open under Family Voluntary Services with FPS in the home. The parents requested grief counseling.

Issues and Recommendations
Issue: None identified.

Recommendation: None

Child Fatality Review #10-19
Region 6
Clark County

Four-year-old Caucasian male died after contracting E. coli poisoning

Case Overview
On April 8, 2010, this four-year-old boy died at a Portland, Oregon area hospital after contracting E. coli poisoning. The four-year-old was receiving child care at a licensed child care home in Clark County. Thirteen children and one staff member eventually tested positive for E. coli. The four-year-old was hospitalized and had part of his colon removed on April 2, 2010. He later had his entire colon removed and developed subsequent problems with his kidneys and central nervous system. He was removed from life support and died at the hospital on April 8, 2010.
Children's Administration (CA) does not have prior history on the family of the four-year-old. The child care provider had an open child care license through the Department of Early Learning (DEL). The provider was licensed to provide child care since July 1990.

Intake History on the Childcare Provider
On April 19, 1994, a report to CPS intake alleged the biological child of the child care provider had a mark on his face after being slapped by his mother. The intake was screened in for investigation was closed with an inconclusive finding for physical abuse.

On August 21, 1995, a parent contacted CPS intake to report the child care provider was providing care for too many children at one time. There were no concerns about the quality of care. The overcapacity occurred when the biological child of the child care provider had a friend over to play. The provider agreed not to allow more children in the home over the license capacity. The intake was screened as a licensing complaint and closed with a not valid finding by the child care licensor.

On August 29, 1996, CPS intake was contacted by a neighbor who reported there was too much noise coming from the child care facility. The child care licensor made two unannounced visits, tried to reach a compromise with the neighbor, who expected that there be no noise and no family gatherings outside. The licensor determined there were no licensing violations. The intake was screened as a licensing complaint and closed with a not valid finding.

On April 20, 1998, a staff from a youth shelter reported to CPS intake that the teenage daughter of the child care provider ran away from home and alleged that both parents were addicted to heroin. The child care license was suspended during the investigation. The teen was interviewed and reported she made up the allegations in the intake. The intake was screened as a licensing referral and closed with a not valid finding by the child care licensor.

On April 16, 2010, a report was made to CPS intake that the four-year-old died following surgery. The child care facility was shut down by DEL and the Department of Health. The child care provider accepted another child for child care while the facility was shut down. The child did not come down with E. coli. The intake was screened in for investigation by the Division of Licensed Resources/Child Protective Services (DLR/CPS) and accepted as a licensing complaint. The DLR/CPS investigation was closed with an unfounded finding. The licensing complaint was closed with a valid finding. DEL revoked the child care license of this provider.

Issues and Recommendations

Issue: Inter-agency communication was an issue on this case. The County Public Health Department is unable to share protected health information (PHI) with DEL, and this hindered DEL's ability to have all the required information needed to make appropriate decisions. DEL staff relied on the provider to accurately convey information and did not verify the accuracy of that information. DEL was unaware of recommendations made to the provider by the county health department. During the CPS investigation, the DLR investigator had difficulty obtaining information from the Department of Health. An Assistant Attorney General became involved which resulted in obtaining needed information for the DLR investigation.

Recommendation:

1. The Clark County Health Department will request the presence of the licensor when making a visit to a facility that may involve serious health issues in that facility whenever possible.

2. This recommendation should be conveyed to all county health departments or to the Washington Health Officer's Association.

3. DEL and the Clark County Public Health Department will continue to work on communication barriers, including clear notification when recommendations are made to close a facility based on issues involving communicable diseases or other serious health concerns.

Issue: Child care home providers are not required in Washington Administrative Code (WAC) to notify their licensor of concerning health issues involving communicable diseases, as do child care centers. If this had been a requirement, it is possible that DEL would have been able to take action on an earlier date.

Recommendation: WAC changes should be considered to require reporting of serious health issues or communicable diseases, consistent with the requirements for child care centers.

Child Fatality Review #10-20
Region 6
Clark County

Two-month-old Caucasian female infant died from asphyxiation.

Case Overview
On April 11, 2010, Vancouver Police reported to Child Protective Services (CPS) intake the death of this two-month-old infant. Her mother told police the child had been ill with vomiting and diarrhea earlier in the evening. The mother reported she fell asleep with her daughter on the couch, getting up once at around 1:00 a.m. to change her diaper. The child was fine. When the mother awoke in the morning, she found her daughter with a pillow on her face and she was not breathing. The mother took her daughter to a next door neighbor who had medical training. The neighbor called 911 and started CPR. The child was not revived. Law enforcement conducted a forensic interview of the mother's six-year-old son. From all reports, the child's death appeared to be an accident.

Children's Administration (CA) had an open case on the family at the time of the infant's death. This case was open with Child Protective Services (CPS) in response to an intake received on December 18, 2009. This intake alleged the mother's six-year-old son was fed by neighbors nightly because he was hungry. The neighbors also reported the child had poor hygiene. The CPS investigation was completed with an unfounded finding for negligent treatment or maltreatment. However, multiple risk factors for this family resulted in a Family Voluntary Services (FVS) case being opened. The FVS case was still open when the infant passed away.

Intake History
On October 9, 2003, a social worker with DSHS contacted CPS intake to express concern that the mother and her boyfriend were unable to care for their newborn son. The mother had a history of drug use and running away as a teenager. The intake was screened in for investigation by CPS. The investigation was completed with an unfounded finding for negligent treatment or maltreatment. The mother reported she was receiving parenting classes through the Women, Infant and Children (WIC) program. She was offered public health nurse (PHN) services, but declined. She was in substance abuse treatment when she learned she was pregnant. The mother was receiving appropriate medical services for her newborn son.

On August 18, 2008, a Head Start teacher contacted CPS intake to report the mother was taking a nap with her boyfriend when her five-year-old son left the apartment and was missing. When the child eventually returned to the apartment complex from the street, the mother was alleged to have spanked him leaving a bruise on his buttocks and his hand. The intake was screened in for investigation by CPS. The investigator determined that it was the mother's boyfriend who spanked the child and left the marks. The CPS investigation

was completed with a founded finding for physical abuse on the mother's boyfriend and a founded finding for negligent treatment on the mother. The case was closed after the department arranged for parenting classes for both the mother and her boyfriend. Criminal background checks were completed on the mother and her boyfriend with no concerns noted.

On June 9, 2009, CPS intake was contacted by an anonymous referrer who reported the mother was using marijuana, methamphetamine and cocaine around her five-year-old son. The referrer also stated there was very little food in the home. The intake was screened as Information Only and was not investigated by CPS.

On November 24, 2009, an elementary school counselor contacted CPS intake to report that the six-year-old disclosed that his mother and an unnamed boyfriend verbally fight every night, and the boyfriend says things that leads the six-year-old to feel that he might kill the mother. The mother and boyfriend are intoxicated when they fight. The child reported his mother would give him "sleeping pills" when the adults argued. The referrer was unsure what the child was given to help him sleep. The child also disclosed that his mother was pregnant. The intake was screened as Information Only and was not investigated by CPS.

On December 18, 2009, an elementary school staff reported that a neighbor to the family sent information to the school that the six-year-old was frequently fed by neighbors. The child was at the neighbor's home for up to 12 hours without a check-in by his mother. The child was usually hungry, never wore socks, and had poor hygiene. The mother was suspected to be a methamphetamine user. The intake was screened in for investigation by CPS. The investigation was completed with an unfounded finding for negligent treatment or maltreatment. Contact was made with the child's doctor, and he was up to date with well child checks. The case remained opened and transferred to the FVS unit due to multiple risk factors being present during the investigation. Those risk factors included drug use, depression, history of domestic violence in relationships, and parenting deficiencies.

On February 23, 2010, a hospital social worker called CPS intake to report the mother gave birth to a female child. The mother admitted to hospital staff that she smoked marijuana during her pregnancy. The newborn tested positive for marijuana at birth. The mother had prenatal care, though late in her pregnancy. She refused public health nurse services. The child's father was present at the hospital. He and the child's mother had split up prior to the birth of their daughter. Hospital staff reported he appeared to be under the influence of drugs while at the hospital. The intake was accepted for investigation as a Risk Only intake.

The case remained opened and the mother was referred to, or offered, a number of services. The services included a drug and alcohol evaluation, a referral to maternity

support services, a parenting evaluation for the mother, and helping her arrange counseling for her six-year-old son. If the father was to return to the home, he was to also have a drug and alcohol evaluation.

The mother initially engaged in services but had difficulty showing consistent progress. She missed appointments for urinalysis and counseling sessions. Some of the urinalysis samples she submitted were positive for marijuana. The mother completed the drug/alcohol evaluation and agreed to participate in outpatient treatment.

On April 7, 2010, CPS intake received a report from a neighbor who reported the mother's seven-year-old son had a large bump/bruise on his forehead. The child has had different accounts of how he got hurt. He has said that he and his mother fell after they tripped on a blanket, that he didn't know how he got hurt, that he fell on a bedpost, and that he ran into a wall. A neighbor has told school personnel they smell drugs in the home. The intake was screened as Information Only. The case was still open when this intake was received.

On April 11, 2010, law enforcement called CPS intake to report the death of the two-month-old. Police reported the mother and infant were sleeping on a couch. In the morning the mother woke and found a pillow on her daughter's face and she was not breathing. Police officers interviewed the mother's six-year-old son. The infant's death appeared to be an accident, according to police. An afterhours social worker was sent to the home to assess the safety of the six-year-old. The intake was screened in for investigation by CPS. The CPS investigation was completed with an unfounded finding for negligent treatment or maltreatment.

A Family Team Decision Meeting (FTDM) was held following the death of the infant. The team debated whether to recommend placement of the surviving sibling. The team decided to leave him in the care of his mother. In May 2010, a dependency petition was filed on the six-year-old sibling, though he remained in his mother's care. He was removed from her care less than two weeks after the dependency petition was filed after the mother submitted another positive urinalysis sample.

Issues and Recommendations

Issue: The mother was advised about safe sleeping by the department when her oldest child was an infant. This discussion was documented in the case record. However, when the department became involved following the birth of her daughter in 2010, there is no record of another discussion with the mother about safe sleeping or a caution about co-sleeping. The mother told law enforcement that sleeping on the futon couch with her infant daughter was a nightly routine, as the mother did not want to sleep in her bed without her boyfriend (the father of the newborn) and felt placing her daughter in a bassinet at night was a danger. No investigative inquiry was made about the sleeping arrangement of the newborn because it was believed that this was not the focus of the concern with this

family. Although the mother was instructed about safe sleeping in the past, it was over six years ago and the mother was 16 years old at the time.

Recommendation: Recommend that the department remind social workers to routinely educate parents of every newborn with department involvement about safe sleeping including information about the dangers of co-sleeping. This is especially important for caregivers who have substance abuse issues. Recommend that staff receive information related to concerns with co-sleeping with parents who are using marijuana and opiates in particular. Recommend that workers are reminded that it is best practice to observe and assess the sleeping arrangements of infants on cases in which the department is involved.

Issue: The review team believed that the transfer process in the Vancouver office is not working as efficiently as it might. The CPS social worker forwarded the case for approval to his supervisor on March 16, 2010. The supervisor was unable to review the case until March 26, 2010. The office had an unusually high CPS caseload at the time. The case was not assigned to the FVS social worker until March 31, 2010. At that point, the social worker had a difficult time making contact with the mother, despite trying repeatedly. Because of the transfer process as well as difficulty making contact with the family there was no face-to-face contact between the department and the mother from March 15, 2010 until April 12, 2010 which was after the infant's death. This issue generated a discussion on the review team with regard to what was best practice for case transfers for CPS cases. Some believed that the receiving unit should make contact and get involved with the family as soon as possible despite the fact that the CPS social worker had not completed the investigative assessment and the worker may not have all the information. Others believed that the receiving social worker needed to wait for the investigation to be completed when they have all the available information in order to best assess and meet the family's needs.

Recommendation: DCFS management indicated they have already made some changes in the case transfer process to maximize information sharing in case transfers. The office has meetings weekly to staff cases that are transferring and there are frequent case staffings between supervisors. There is now an expectation that there is a case staffing between social workers when a case transfers.

The review team recommends that the Vancouver office continue to improve the case transfer process to minimize the amount of time cases are inactive in the transfer approval process and maximize information sharing between workers.

The review team recommends that all cases transfer within 24 hours of Area Administrator approval of the transfer.

The review team recommends that, whenever possible, the receiving social worker make a field visit with the social worker transferring the case in order to facilitate a smoother transition between staff for the family.

Issue: The review team discussed the intake that was received and screened out regarding a bruise and bump injury on the six-year-old brother. Information was shared that in other staffings of this case it was believed that this intake should have screened in for investigation. Through the fatality review process the fatality review facilitator reviewed another intake that was screened out on this case and also believed this was an intake that was appropriate to screen in. This was a disclosure by the six-year-old son that his mother and her boyfriend verbally fight and the six-year-old was afraid the boyfriend would kill his mother. It was also alleged the mother gave her son "sleeping pills." This intake would have been appropriate for an alternate response or a 72-hour investigation.

Recommendation: The Vancouver office recently underwent an intake review with a team from outside the office. There were no significant findings regarding screening decisions. The intake supervisor met with his staff and discussed the findings of the review.

Consensus building training occurred with supervisors on July 28, 2010 to strengthen intake screening decision making. Further consensus building training will be scheduled for regional supervisors.

Child Fatality Review #10-21
Region 5
Pierce County

Three-week-old Caucasian male died from renal failure.

Case Overview
On April 9, 2010, this three-week-old infant died at a Tacoma area hospital. His mother was admitted to the hospital on March 21, 2010 for gastric pain at which time fetal distress was also diagnosed resulting in the immediate decision to proceed with a Cesarean (C-Section) delivery. At delivery the infant weighed four pounds, five ounces with noted poor tone, poor color, and no respiratory effort. The infant was born at 34 weeks gestation and was diagnosed with numerous medical problems believed to be primarily related to birth asphyxia (oxygen deprivation) that may have occurred as the result of an undetermined in-utero event.

The infant was then transferred to Mary Bridge Children's Hospital and placed in the Neonatal Intensive Care Unit (NICU) where he remained until his death 19 days later. No autopsy was performed and the death was certified by the attending physician as a natural death due to "renal failure due to respiratory failure due to necrotizing entercolitis."

Necrotizing enterocolitis is a serious bacterial infection in the intestines primarily affecting sick or premature newborn infants. It can cause the death of intestinal tissue. Necrotizing entercolitis is the most common and serious gastrointestinal disorder among hospitalized preterm infants. Premature infants have immature bowels which are sensitive to changes in blood flow and prone to infection. They may have difficulty with blood and oxygen circulation and digestion which increases their chances of developing necrotizing entercolitis.

Hospital staff reported the parents visited their son and were appropriately bonded with him.

The mother tested positive for prescribed opiates at birth. During her pregnancy she was in the hospital emergency room twice for abdominal pain. She was prescribed pain medications. Doctors questioned if the mother was falsifying pain symptoms in an attempt to get pain medications.

Children's Administration (CA) had an open case on the family of the three-week-old at the time of his death. The department opened a Risk Only case following his birth and a report that his parents would be unable to meet the needs of a newborn with serious medical issues.

Intake History
On December 16, 2008, a hospital social worker reported to Child Protective Services (CPS) intake that the mother gave birth to a baby boy at 39 weeks gestation. The newborn was in the Neonatal Intensive Care Unit. He had positive urine toxicology screen for opiates and marijuana. The newborn did not have withdrawal symptoms.

The intake was screened as Information Only and was not investigated by CPS. The information in the intake was forwarded to the First Steps Program.

On May 16, 2009, CPS intake received notification from the Pierce County Medical Examiner of the death of the newborn identified in the December 16, 2008 intake. The Medical Examiner reported there was nothing suspicious regarding the circumstances of the death. The child was born with numerous medical problems including brain damage from a lack of oxygen at birth. The intake was screened as Information Only and was not investigated by CPS.

On March 24, 2010, a social worker from Tacoma General Hospital called CPS intake to report the birth of another child. The child was born at 34 weeks gestation. The mother had a positive toxicology screen for prescribed opiates. The mother took pain medications for abdominal pain during her pregnancy. Doctors report it appeared that the mother engaged in drug seeking behavior. The intake was screened as Risk Only and a case was opened on the mother and newborn.

The newborn was born with the following diagnosis: acute renal failure, asphyxia (oxygen deprivation), brain injury with severe cerebral damage and internal hemorrhage. Doctors reported the infant had an unfavorable neurological prognosis.

The mother was referred to a substance abuse evaluation. The father had a prior conviction for Assault IV and was referred for a domestic violence assessment.

On April 12, 2010, CPS intake was notified of the death of the three-week-old infant. The hospital reported the child died from renal failure and an infection. The infant was medically fragile born at 34 weeks gestation. The infant never left the hospital. The intake was screened as Information Only as there was no allegation that either parent abused or neglected this child after he was born.

Issues and Recommendations
Issue: None identified

Recommendation: None

Child Fatality Review #10-22
Region 2
Yakima County

Fifteen-year-old Caucasian male died from a gunshot wound.

Case Overview
On April 28, 2010, this 15-year-old youth was a passenger in a car that was shot at by a group standing near the side of a road. The youth was stuck in the head. He was flown to Harborview Medical Center and died from his injuries on May 1, 2010. Yakima Police believe the youth was a gang affiliate. It is suspected that the 15-year-old and his friends drove through a rival neighborhood when someone from a rival gang shot at their vehicle. A 17-year-old youth was later arrested and charged with murder for the shooting of the 15-year-old.

Children's Administration (CA) did not have an open case on the family of this youth at the time of his death. An intake received on November 2, 2009 alleged the mother left the 15-year-old in charge of his younger siblings while she was away at work. It was reported that the 15-year-old was not attending school, used drugs and had gang involvement. This intake was screened for the Alternate Response System (ARS) and closed on November 4, 2009.

Intake History
On February 27, 2004, a school staff member contacted Child Protective Services (CPS) intake to report the 15-year-old youth (nine years old at the time of this report) said his stepfather hit him with a belt on the legs and the arms. The youth said he had a circular bruise about the size of a dime on his calf. The youth also reported that the stepfather hit his two-year-old sister. The intake was screened for the Alternate Response System (ARS).

On March 23, 2004, a relative reported to CPS intake that the 15-year-old (nine years old at the time of this report) was seen with a bruise on his bicep two weeks prior and that he had a bruise on his left thigh eight days prior. The youth reported his stepfather hit him. It was alleged that the two-year-old sister was spanked by her mother, leaving no marks. The referrer reported seeing the two children every weekend and would call CPS or the police if the children had non-accidental injuries. The intake was screened for the Alternate Response System (ARS).

A contracted ARS provider met with mother and children and discussed the allegations. The youth was in counseling at his school. The mother denied hitting her children with a belt. The mother was offered services, but she stated she did not need services at that time. The children appeared healthy, well developed and nourished. The home was clean and organized. There were no bruises or injuries on the children.

On September 16, 2005, school personnel contacted CPS intake to report concern for the 15-year-old (then 10 years old). The referrer reported the youth's stepfather hit his mother. The youth told the referrer his mother lost a baby because of domestic violence. The youth said he tries not to be around because of the fighting. He didn't give any indication when the last time the domestic violence occurred. The youth said he was not afraid to go home and denied that he has been harmed. The intake was screened in for investigation by CPS and the investigation was closed with an unfounded finding for negligent treatment or maltreatment.

On January 30, 2007, the youth's mother called CPS intake to report he had skipped 15 days of school. She was not told by the school that he was truant. The mother said she was not having any problems with him at home. The mother also stated that her son was not involved in gang activity or in drug activity. The intake was screened in for Family Reconciliation Services (FRS). The mother inquired about filing an At-Risk Youth (ARY) petition, but did not qualify for an ARY petition because the only family issue was school attendance. The mother was informed to contact the school to address the truancy issue.

On September 29, 2008, the youth's mother called CPS intake to request help filing an ARY petition. The mother said her son refused to go to school. She suspected that he was now using drugs. The mother did not think her son was involved in gangs. The intake was screened in for Family Reconciliation Services. The assigned FRS social worker completed the family assessment and helped the mother completed ARY petition. The FRS social worker recommended that the youth get a mental health assessment, submit to random urinalysis and engage in gang education.

On November 2, 2009, a report was made to CPS intake by a relative who reported the 15-year-old was left in charge of his younger siblings while their mother is at work. The referrer reported the 15-year-old was not attending school due to drug use and gang involvement. The referrer stated that the school frequently called her to have her pick up the five-year-old sibling. The three-year-old sibling told a relative that his 15-year-old brother was hitting him. The home had dirty dishes, old food, toys and clothing everywhere. The five-year-old had several teeth removed due to decay. The referrer stated the children do not eat healthy meals. The intake was screened as low risk Alternate Intervention. An afterhours social worker was sent to the home to assess the situation. The social worker made two attempts to contact the family at the address provided by the referrer. The address provided was incorrect.

Issues and Recommendations
Issue: None identified.

Recommendation: None