Report to the Legislature

Quarterly Child Fatality Report

RCW 74.13.640

October – December 2011

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

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Executive Summary

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

Child Fatality Review — Report

(1)(a) The department shall conduct a child fatality review in the event of a fatality suspected to be caused by child abuse or neglect of any minor who is in the care of the department or a supervising agency or receiving services described in this chapter or who has been in the care of the department or a supervising agency or received services described in this chapter within one year preceding the minor's death.

(b) The department shall consult with the office of the family and children's ombudsman to determine if a child fatality review should be conducted in any case in which it cannot be determined whether the child's death is the result of suspected child abuse or neglect.

(c) The department shall ensure that the fatality review team is made up of individuals who had no previous involvement in the case, including individuals whose professional expertise is pertinent to the dynamics of the case.

(d) Upon conclusion of a child fatality review required pursuant to this section, the department shall within one hundred eighty days following the fatality issue a report on the results of the review, unless an extension has been granted by the governor. A child fatality review report completed pursuant to this section is subject to public disclosure and must be posted on the public web site, except that confidential information may be redacted by the department consistent with the requirements of RCW 13.50.100, 68.50.105, 74.13.500 through 74.13.525, chapter 42.56 RCW, and other applicable state and federal laws.

(2) In the event of a near fatality of a child who is in the care of or receiving services described in this chapter from the department or a supervising agency or who has been in the care of or received services described in this chapter from the department or a supervising agency within one year preceding the near fatality, the department shall promptly notify the office of the family and children's ombudsman. The department may conduct a review of the near fatality at its discretion or at the request of the office of the family and children's ombudsman.

In April 2011, SHB 1105 was passed by the legislature and signed by Governor Gregoire. The revised child fatality statue (RCW 74.13) was effective July 22, 2011 and requires the department to conduct fatality reviews in cases where a child death is suspected to be caused by abuse or neglect. This eliminates conducting formal reviews of accidental or natural deaths unrelated to abuse or neglect. The revised statute requires the department to consult with the Office of Family and Children's Ombudsman (OFCO) if it is not clear that the fatality was caused by abuse or neglect. The department can conduct reviews of near fatalities or serious injury cases at the discretion of the department or recommendation by OFCO. The new law gives the department access to autopsy and post mortem reports for the purpose of conducting child fatality reviews.

This report summarizes information from completed reviews of 17 fatalities and one near-fatality that occurred in the last quarter of 2011. Thirteen of the child fatalities were reviewed by regional Child Fatality Review Teams. Four fatalities and the one near-fatality review were reviewed by an Executive Child Fatality Review team because the fatality or near-fatality was the result of suspected abuse or neglect.

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

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

Region	Number of Reports
1	8
2	3
3	7
Total Fatalities and Near Fatalities Reviewed During 4th Quarter, 2011	18

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

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

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

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

Child Fatality Reviews for Calendar Year 2011			
Year	Total Fatalities Reported to Date Requiring a Review	Completed Fatality Reviews	Pending Fatality Reviews
2011	42	42	0

Child Near Fatality Reviews for Calendar Year 2011			
Year	Total Near Fatalities Reported to Date Requiring a Review	Completed Fatality Reviews	Pending Near Fatality Reviews
2011	1	1	0

The numbering of the Child Fatality Reviews in this report begins with number 11-16. This indicates the fatality occurred in 2011 and is the sixteenth report completed during that calendar year. The number is assigned when the Child Fatality Review report is posted on the Children's Administration website.

The reviews contained in these Quarterly Child Fatality Reports are a summary of the actual report submitted by each region. Confidential and identifying information not subject to disclosure has been redacted. The executive child fatality review is as it appears on the DSHS website.

Notable Findings

Based on the data collected and analyzed from the 17 deaths and one near fatality reviewed between October and December 2011, the following were notable findings:

- Four of the fatality reviews completed during the 4th quarter required an Executive Child Fatality Review. Two of these child fatalities occurred on an open case. Another case was closed and the family had moved to another state. One of the reviews was conducted at the request of the Office of the Children and Family Ombudsman. The child did not die from suspected abuse or neglect.
- The near fatality review was the first of its kind conducted under the revised statute.
- Of the 18 child fatalities and near fatalities reviewed, 9 were open cases with Children's Administration at the time of the child's death.
- Of these 9 open cases, 4 child fatalities and the 1 near fatality were determined by CA staff to be the caused by abuse or neglect by the children's parent(s).
- Children 11 months or younger accounted for approximately 33% (6) of 18 child fatalities and near fatalities reviewed and 4 of these 6 children were male.
- Of the 18 child fatalities and near fatalities reviewed, 56% (10) were males and 44% (8) were females.
- Of the 17 child fatalities reviewed, 14 of the children were Caucasian, 4 were Native American, 1 was Hispanic, 4 were African American, and 1 was Asian/Pacific Islander. Note that these numbers reflect that some children are identified as being of more than one race.
- In the two fatalities listed as a homicide, both children were Caucasian.
- Natural and accidental deaths, as classified by the medical examiner or coroner, accounted for approximately 59% (10) of the total deaths. The manner of death of the remaining cases was as follows: 12% (2) were the result of homicide, 23% (4) were due to unknown/undetermined causes, and 6% (1) were the result of a suicide.
- In the two fatalities listed as a homicide, one child drowned. The child's father was later convicted of negligent homicide in the death of his son. Another child died from blunt force trauma to her head. The perpetrator was identified as the mother's boyfriend.
- Children's Administration had intake reports of abuse or neglect in all 17 child fatality cases prior to the death of the child. Forty-seven percent (47%) of the child fatalities reviewed had between one and four prior intakes and 24% had between five and nine prior intakes. Six cases (29%) had between 10 and 24 intakes reported to CA prior to the child's death. Of these six child fatalities, four (4) were classified by a medical examiner or coroner as accidental; the other two were undetermined.
- Due to the small sample of cases reviewed, no statistical analysis was conducted to determine relationships between variables.

Table 1.1

4th Quarter 2011, Child Fatalities and Near Fatalities by Age and Gender						
Age	**Number of Males**	**% of Males**	**Number of Females**	**% of Females**	**Age Totals**	**% of Total**
<1	4	40%	2	25%	6	33%
1-3 Years	3	30%	2	25%	5	28%
4-6 Years	2	20%	0	-	2	11%
7-12 Years	1	10%	2	25%	3	17%
13-16 Years	0	-	2	25%	2	11%
17-18 Years	0	-	0	-	0	-
Totals	10	100%	8	100%	18	100%

N=18 Total number of child fatalities and near fatalities for the quarter.

Table 1.2

4th Quarter 2011, Child Fatalities and Near Fatalities by Race	
Black or African American	4
Native American	4
Asian/Pacific Islander	1
Hispanic	1
Caucasian	13
Totals*	**23**

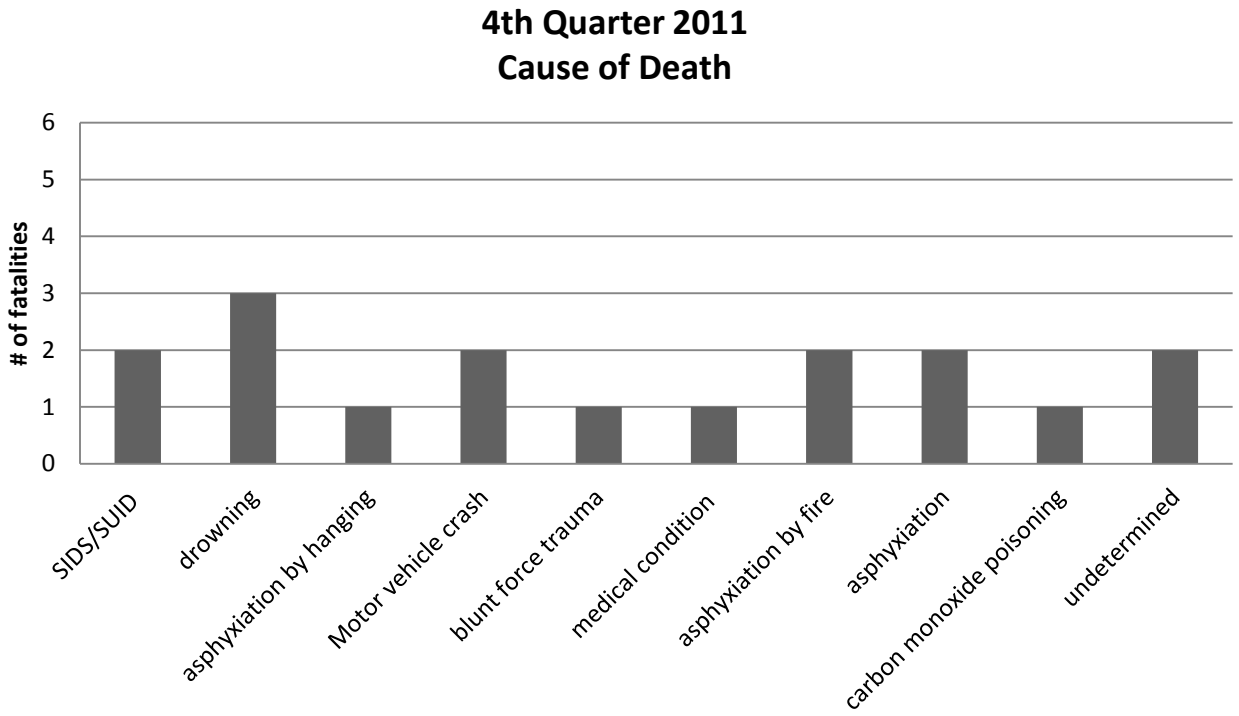
*Children may be from more than one race.

Table 1.3

4th Quarter 2011, Child Fatalities by Manner of Death	
Accident	8
Homicide (3rd party)	0
Homicide by Abuse	2
Natural/Medical	2
Suicide	1
Unknown/Undetermined	4

N=17 Total number of child fatalities for the quarter.

Table 1.4



N=17 Total number of child fatalities for the quarter.

Table 1.5

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

N=17 Total number of child fatalities for the quarter.

Summary of the Recommendations

Of the 17 child fatalities and the one near fatality reviewed between October and December 2011, 12 (67%) identified issues and recommendations during the child fatality review process. Issues and recommendations from fatality reviews impact policy, practice and systems associated with CA. At the conclusion of every case receiving a full team review, the team decides whether any recommendations should result from issues identified during the review of the case by the fatality review team. In most instances where the death was categorized as possibly 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:

4th Quarter 2011, Issues & Recommendations	
Contract issues	1
Policy issues	3
Practice issues	16
Quality social work	2
System issues	3
Total	**25**

In three cases, recommendations were made regarding domestic violence. Specifically, the fatality review teams made recommendations for ongoing training for social workers in the area of domestic violence. It was also recommended that a domestic violence advocate be co-located in CA offices for consultation. In two cases, recommendations were made regarding thorough CPS investigations. Issues were raised about timely documentation by social workers and supervisors, delays in notifying the subject of CPS investigations and reporting new abuse and neglect allegations.

In four cases, the review teams identified issues related to case supervision. In one case, the team identified an issue that the monthly supervisory reviews were not completed or documented. The teams made recommendations to provide training on clinical supervision and to revise the curriculum for supervisors at the CA training academy. Teams also recommended that supervisors received monthly reports on open cases in their units.

Review teams identified issues with intake screening in three cases. In one of these cases, the team recommended that low risk or screened out intakes be screened in for investigation if the report is made by a contracted provider who is working with the family. In another case, the team questioned the screening decision of an intake. This issue was addressed through action at the local level and involved more oversight in screening decisions by regional management.

In another case, the review team recommended that headquarters staff create a protocol and provide continuous Peer Support for CA staff impacted by a child death.

This team also recommended closer monitoring of medically fragile children placed in one foster home and training on the placement of medically fragile children.

Refresher training for mandated reporters was recommended in two cases. The training was arranged with the mandated reporters in each case.

Child Fatality Review #11-16
Region 1
Kittitas County

This six-year-old Caucasian male died from asphyxiation in a house fire. Children's Administration (CA) did not have an open case on the family at the time of his death.

Case Overview
On April 16, 2011, a mother and her two children, ages six and four, died in their home in the early morning hours as result of a fire in their home. The fire is believed to have been caused by food left cooking on the stove. Neighbors saw flames and called the fire department. Fire personnel arrived and were able to get the six-year-old and his mother out of the house. They were taken to a local hospital, but could not be resuscitated. The body of the four-year-old was later found in the home. There were no batteries in the smoke detectors in the house. The Fire and Rescue personnel reported that it appeared that the mother and children collapsed after breathing in smoke.

No autopsies were completed at the request of surviving family members. The Kittitas County Medical Examiner determined that the six-year-old died from asphyxiation due to smoke.

Children's Administration did not have an open case on this child or his family at the time of his death. Eleven months prior to the child's death, a Child Protective Services (CPS) intake received a report alleging physical abuse of the six-year-old by his father. The child's mother was operating an unlicensed child care. The intake was investigated by CPS.

Intake History
On September 21, 2007, CPS intake received a report alleging there were beer bottles strewn all over the home. The children, including a six-month-old child, had poor hygiene. There were also reports of many people passing through the home. The intake was screened in for investigation. The assigned social worker went to the home and observed it to be clean. The children were clean and receiving regular medical care. The family received WIC services. The CPS investigation was closed with an unfounded finding.

On February 24, 2010, the six-year-old was observed with a bruise on his face that he attributed to his father. The CPS intake was screened in for investigation. The child, father, and mother all explained that the injury was accidental and occurred when the child and his father were playfully roughhousing. The CPS investigation was closed with an unfounded finding for physical abuse.

Issues and Recommendations
Issue: The review team discussed at length all available information on the family and did not express any issues or recommendations from this child fatality. This review team

commented on statewide and local ongoing media campaigns reminding the community of periodically changing smoke alarm batteries.

Recommendation: None

Child Fatality Review #11-17
Region 1
Kittitas County

This four-year-old Caucasian male died from injuries sustained in a house fire. Children's Administration (CA) did not have an open case on the family at the time of his death.

Case Overview
On April 16, 2011, a mother and her two children, ages six and four, died in their home in the early morning hours as result of a fire in their home. The fire is believed to have been caused by food left cooking on the stove. Neighbors saw flames and called the fire department. Fire personnel arrived and were able to get the six-year-old and his mother out of the house. They were taken to a local hospital, but could not be resuscitated. The body of the four-year-old was later found in the home. There were no batteries in the smoke detectors in the house. The Fire and Rescue personnel reported that it appeared that the mother and children collapsed after breathing in smoke.

No autopsies were completed at the request of surviving family members. The Kittitas County Medical Examiner determined that the six-year-old died from asphyxiation due to smoke.

Children's Administration did not have an open case on this child or his family at the time of his death. Eleven months prior to the child's death, a Child Protective Services (CPS) intake received a report alleging physical abuse of the six-year-old by his father. mother was operating an unlicensed child care. The intake was investigated by CPS.

Intake History
On September 21, 2007, CPS intake received a report alleging there were beer bottles strewn all over the home. The children, including a six-month-old child, had poor hygiene. There were also reports of many people passing through the home. The intake was screened in for investigation. The assigned social worker went to the home and observed it to be clean. The children were clean and receiving regular medical care. The family received WIC services. The CPS investigation was closed with an unfounded finding.

On February 24, 2010, the six-year-old was observed with a bruise on this face that he attributed to his father. The CPS intake was screened in for investigation. The child, father, and mother all explained that the injury was accidental and occurred when the child and his father were playfully roughhousing. The CPS investigation was closed with an unfounded finding for physical abuse.

Issues and Recommendations
Issue: The review team discussed at length all available information on the family and did not express any issues or recommendations from this child fatality. This review team

commented on statewide and local ongoing media campaigns reminding the community of periodically changing smoke alarm batteries.

Recommendation: None

Child Fatality Review #11-18
Region 3
Pierce County

This nine-day-old African American male died from Sudden Unexplained Infant Death (SUID). Children's Administration (CA) had an open case on the family at the time of his death.

Case Overview
On April 21, 2011, the father of this nine-day-old infant woke around 4:30 a.m. to feed and diaper his son. He then rested on the living room couch with the baby. He fell asleep sometime around 5:30 a.m. with his infant son. Several hours later the father woke to discover the child unresponsive. He attempted CPR and then called 911.

Upon arrival to the apartment the responding paramedics were handed the infant by the distraught father. The baby was placed into the Aid Car and resuscitation efforts were made but were unsuccessful.

Kitsap County Sheriff's Deputies arrived and detectives began the death scene investigation, joined shortly thereafter by the Kitsap County Deputy Coroner. Evidence was collected, photographs taken, and interview of the father was conducted on site. The father's original description of the sleeping position was inconsistent with the evidence. He later admitted that the actual position could have been different. He also admitted to detectives that the hospital had told him he should not sleep with the baby. He said he was scared and panicked at the thought he may have accidentally caused the death of his son by co-sleeping on the couch.

The child's mother had no involvement with her newborn following hospital discharge and was not present at the time of the fatality incident.

The post-mortem examination revealed no signs of injuries or trauma, and preliminary indication from the forensic pathologist was of possible positional asphyxia. The final determination was Sudden Unexplained Infant Death (SUID). While the manner of death could not be determined, the forensic pathologist did indicate a possibility of asphyxia secondary to chest and abdominal compression from the father's heavy arms placed across the baby's chest during co-sleeping on the couch.

Children's Administration had an open case on this infant at the time of his death. Immediately following his birth, Child Protective Services (CPS) intake received a report from the hospital reporting the child's mother was interested in adoption for the child, or he be given to his father. She left the hospital without making proper arrangements for her newborn. The hospital requested CPS involvement to assess the safety of the child with his father. The intake was investigated by CPS.

Intake History
On April 12, 2011, CPS intake received a report from the hospital social worker shortly after this child was born. Reportedly the mother of the newborn was refusing to see the baby and indicated a desire to give him up for adoption. The mother said the child's biological father may want custody of the baby, but the hospital had no information regarding the father. The hospital was unwilling to release the baby to him without a court order, but was willing to discharge to CPS. The intake was accepted on the basis of possible intent of the mother to abandon the child and CPS responded within 24 hours. The CPS investigation was closed with an unfounded finding.

On April 21, 2011, CPS received notification of the death of this nine-day-old infant. Given that the case was still active with CA, a CPS investigation was initiated in collaboration with local law enforcement, with the baby's father identified as the subject of the intake. Investigations by both law enforcement and CPS did not reveal any evidence of neglect or abuse by the father. Law enforcement closed the criminal investigation. Likewise, the CPS investigation was completed and closed out in late June following release of the coroner's report. The post-mortem examination revealed no signs of injuries or trauma. The final determination was Sudden Unexplained Infant Death (SUDI). The CPS investigation was closed with an unfounded finding for physical abuse.

Issues and Recommendations
Issue: Regarding the intake dated April 12, 2011
Upon review of the intake, the decision by the hospital to refuse to release the newborn to the father appeared presumptive and premature, resulting in CPS becoming unnecessarily involved. There has been recurring issues with this particular hospital in terms of questionable hospital holds and strategic use of information in order to get CPS involved.

Action Taken: The Bremerton DCFS Area Administrator has planned a meeting for August 2011 with the supervisors to discuss identification of specific workers or office units that would function as liaisons to specific community partners including but not limited to local hospitals. The intent is to strengthen relationships and lines of communication with community partners who share the goals of child safety and child protection.

Recommendation: None

Child Fatality Review #11-19
Region 2
Snohomish County

This nine-year-old Caucasian female died from complications of a genetic disorder. Children's Administration (CA) did not have an open case on the family at the time of her death.

Case Overview
On May 1, 2011, the Snohomish County Medical Examiner called Child Protective Service (CPS) intake to report the death of the nine-year-old developmentally delayed child. The child was at her home and was playing when her mother heard her scream and found her unresponsive on the floor. The mother called 911 then attempted to revive the child unsuccessfully. Medics arrived and continued to work on her. They used a defibrillator on her three separate times but she could not be revived. She was later pronounced dead at the hospital emergency room.

The hospital reported no trauma nor suspected child abuse related to the child's death. The medical examiner declined to perform an autopsy due to the nature of the child's developmental disability. She was born with Trisomy 13, a rare and severe genetic disorder that is often fatal. More than 80% of children with Trisomy 13 die in the first month of life. Complications begin almost immediately and most children with Trisomy 13 have congenital heart disease (according to the National Institute of Health).

This nine-year-old was adopted by her former foster parents. These licensed foster care providers often took in very medically fragile children.

Children's Administration did not have an open case on this family at the time of the child's death. A CPS investigation was opened in February 2011 on allegations of physical abuse of the 13-year-old brother. The investigation was closed prior to the death of this nine-year-old girl.

Intake History
This nine-year-old child was born several weeks premature and with a heart defect. She was removed from her biological mother's care immediately after birth. She was placed with her adoptive parents when she was about two months old. Her adoptive parents were licensed foster parents from 1997 to 2009.

There have been three licensing complaints on this former foster home from May 2001 to February 2008. The licensing complaints identified hygiene issues, inappropriate discipline of foster children and cleanliness of the home. Two licensing complaint investigations were determined to be not valid and one was closed with an inconclusive finding.

There have also been four investigations conducted by the Division of Licensed Resources/Child Protective Services (DLR/CPS). The investigations looked into allegations of improper hygiene of foster children, supervision issues and physical abuse. All were closed with unfounded findings. In addition to the four CPS investigations, a Family Reconciliation Services (FRS) case was opened in February 2011. The FRS case and a CPS investigation into allegations of physical abuse of this nine-year-old's 13-year-old brother were closed in April 2011.

A prior licensing complaint was reported in February 2008 regarding the death of a very medically fragile child placed in this home. Emergency medical personnel reported that the child died from complications relating to the respiratory distress. The referent said there was no abuse or neglect for the child. The referrer said the child's state of health was affected or influenced by the condition of the home. It was alleged that the home was dirty and the foster mother appeared overly tired and lethargic. This foster home had ongoing nursing care for medically fragile children in their home and the nurses had no such concerns. The licensing complaint was closed as inconclusive.

On May 1, 2011, a CPS information only intake was received from the Snohomish County Medical Examiner's office reporting the death of this nine-year-old from a genetic disorder. The hospital reported no trauma on the child and did not suspect child abuse.

Issues and Recommendations

Issue: The team raised concerns about not having a statewide protocol to follow when CA staff receives a call about a child's death regardless of the current case assignment status.

Recommendation: The team recommended that CA headquarters staff create a statewide protocol and identify regional contacts to provide guidance and consultation to CA staff impacted by a child death. The team also recommended the continuous need for Peer Support and for professional debriefing and grief counseling. The team recommends that the regional Safety Program Manager be a consultant for staff assigned to cases involving child deaths.

Issue: The team raised concerns about our current overcapacity process regarding medically fragile children residing in foster homes. The Washington Administrative Code (WAC) for DLR has minimal requirements. There were several overcapacities completed over the years in this foster home.

Recommendation: The team recommends that headquarters review the current overcapacity approvals system so there aren't too many medically fragile children placed in one foster home. The Safety Program Manager will follow up with the regional representatives of the upcoming placement coordinators statewide training to ensure the training includes information on special considerations of medically fragile children. The safety program manager will also ensure that staff are aware of the recently

updated Medically Fragile Child policy. The policy specifically directs staff to develop a caregiver support plan to ensure medically fragile children's day to day needs are met.

Issue: The team believed the DLR WAC regarding medication usage by foster parents needs to be strengthened. The DLR worker didn't appear to have assessed the mother's functioning ability while she took prescription pain medication for her chronic back pain issue.

Recommendation: The team recommended that headquarters' DLR Program Manager review the DLR WAC regarding medication usage by foster parents. The region 2 DLR Licensing Supervisor will follow up and remind DLR staff to follow the set guidelines for medication usage by foster parents.

Child Fatality Review #11-20
Region 3
Clark County

This 13-month-old Caucasian male died from unknown causes. Children's Administration (CA) did not have an open case on the family at the time of his death.

Case Overview
On May 30, 2011, Washougal Police and Fire departments responded to a 911 call made by the mother of this 13-month-old. The child was found to be not very responsive when they arrived but was breathing on his own. While being treated by medics the child went into cardiac arrest. He was transported to a local hospital via ambulance. Bruising near his right temple/eye was noticed by fire personnel.

The mother reported to law enforcement that she, the 13-month-old, his father, and his eight-year-old sister were home at the time of the incident. The child and his sister were in a bedroom playing when he came out of the room "whiny" which was uncommon for him. His mother said she did not think much of it at the time. He continued to be fussy and was sweating. She gave him Tylenol and he lay down on the couch with his father. The father noticed his son's head lolled to the side and his breathing became shallow. The child's lips turned blue at which time the mother called 911.

The child's mother said that he was fine just prior to the incident but he fell approximately one week prior striking his right eye on the edge of the bath tub.

The post mortem examination showed no evidence of internal trauma. Evidence of injury was noted on the outer corner of the right eye. No other injuries were noted. The Clark County Medical Examiner determined the official cause of death to be undetermined.

Children's Administration did not have an open case on this family at the time of the child's death. A report was made to Child Protective Services (CPS) intake approximately three months prior to the child's death. The intake suggested possible physical abuse of the older sister and was screened out for investigation.

Intake History
On August 11, 2007, law enforcement reported to CPS intake the arrest of the mother of the 13-month-old following an assault on a relative. The mother was intoxicated at the time. The mother's older children, age 13 years and 6 years old at the time, were placed in protective custody. These children lived primarily with their father and were with their mother on a visit when she was arrested. The intake was screened in for investigation by CPS. The investigation was closed with a founded finding for negligent treatment or maltreatment.

On February 4, 2011, a teacher reported to CPS intake that the then eight year old sister of the 13-month-old told a teacher that she is hit with a spoon when she doesn't do her chores. The child reported no current injury, though said she had old scars from being hit with a spoon. The intake was screened out for investigation as there was no current allegation of abuse or neglect.

On May 11, 2011, CPS intake received a report of this child's death. Washougal Police reported this 13-month-old child died from unknown causes. His mother reported earlier that day the child was playing with his six-year-old sister and acted sick and felt hot. His father gave him some Tylenol. Later, his lips turned blue and the parent called 911.

Paramedics arrived at the family home and the child was partially unresponsive. The medic team attempted to revive him but he did not recover and was pronounced at the hospital. The intake was screened as Risk Only. An autopsy was completed by the Clark County Medical Examiner and no cause of death was determined. A bruise near the child's eye from an earlier fall was identified but did not factor into his death.

Investigations by law enforcement did not find any evidence of neglect or abuse by the mother or the father and closed the criminal investigation. Law enforcement was aware of the mother's alcohol issues but does not believe that it played a role in the death of her son. The CPS Risk Only case was closed.

Issues and Recommendations

Issue: Regarding an intake dated August 21, 2007:
Upon review of the intake the review team felt that this intake should have screened in for investigation. The case was open at the time this intake was received. The intake was received from a medical professional; the allegations were that of the mother hitting her five-year-old daughter with a wooden spoon and her hand on the legs. The medical professional reporting this noted small bruises on the child's legs but was unsure how she got them.

In addition this intake was not attached to the mother's case file; it was attached to the father's case file. It appears that the assigned social worker never reviewed this information. He did speak with the father of this child the day before the August 21, 2007 intake and was informed by the father that he had pending paperwork filed in court for a restraining order against the mother and temporary custody of the child. The child is also listed as a subject in this intake rather than a victim. This intake was converted from CAMIS to FamLink in 2009.

Action Taken: Since this intake was received a statewide intake review was conducted as well as an intake review of the Vancouver office. The Vancouver office intake supervisor reviews all intakes more closely and reviews questionable intakes with the area administrator or regional intake lead. The intake supervisor and area administrator met with intake staff in the Vancouver office and reviewed their practice and intake

decision making. Since this review, intake screening decisions have improved in this office. In addition a policy change has occurred within CA since 2007 that mandates CA intake staff to screen in intake reports meeting the following criteria: A child (birth to 5 years old), reported by a licensed physician or medical professional on "the physician's behalf." In an effort to create more consistent decision making at intake, Region 3 is in the process of moving intake supervision under one area administrator. It is hoped that this move will occur by the end of 2011.

Recommendation: None

Child Fatality Review #11-21
Region 3
Pierce County

This two-year-old African-American male died from carbon monoxide poisoning in a house fire. Children's Administration (CA) did not have an open case on the family at the time of his death.

Case Overview
On May 30, 2011, around midnight, an emergency call to 911 was made regarding a smoke detector sounding inside a home. Tacoma Fire Department (TFD) responded and found the home to be smoke-filled with a small containable fire on the first floor of the home. Upon search of the residence the first responders found a mother and her two-year-old child on the second floor covered with soot. They both were transported to local hospitals with CPR in route. All attempts to resuscitate the child and his mother were unsuccessful. The fire investigation revealed that the fire appeared accidental, with the ignition source likely being a space heater left too close to a dog bed and a couch.

The manner of death was classified by the Pierce County Medical Examiner as a fire related accident, with the cause of death attributed to carbon monoxide poisoning.

CA did not have an open case on this family at the time of the child's death. A report was made to Child Protective Services (CPS) intake approximately eight months prior to the child's death alleging a suspicious injury to this child. This intake was investigated by CPS.

Intake History
In late October 2001, the mother gave birth to her second child, a daughter. The newborn tested positive for cocaine and methadone and experienced significant withdrawal symptoms. The mother was in a methadone treatment program at the time. The child was placed into protective custody and admitted into a Pediatric Interim Care Center (PICC). The mother was founded for neglect and a dependency petition was filed. The mother did not engage in services and her parental rights were terminated. The child was adopted by relatives. The mother's oldest child was already in the care and custody of relatives.

In August 2008, the mother gave birth to her son, the now deceased child. The hospital reported that the baby had prenatal drug exposure as the mother was in a methadone program. The mother engaged in community services (e.g., the Parent-Child Assistance Program [PCAP], Parenting Partnership) and maintained compliance in her methadone program. The CPS investigation was closed late September 2008 with the allegation of neglect having been determined to be unfounded.

On July 29, 2009, CPS intake received information that the now deceased child, then 12 months old, may have been left alone for many hours or with strangers. The intake was screened in for investigation. Law enforcement also investigated the allegation. Neither CPS nor law enforcement found sufficient evidence to conclude that the alleged incident occurred. The CPS investigation closed with a finding of unfounded for negligent treatment or maltreatment.

On October 31, 2009, a hospital social worker reported to CPS intake a domestic violence incident between the mother and her boyfriend. The mother's son was injured (bruising and scrapes). It was also reported that the mother left him home alone without direct supervision prior to the domestic violence incident and appeared to be incapacitated by drugs and/or alcohol. The child was placed into protective custody and discharged from the hospital into foster care under a Voluntary Placement Agreement and Voluntary Service Plan. The CPS investigation resulted in a founded finding as to the mother for negligent treatment and services to the mother and the child were initiated and continued until the child was returned home in April 2010.

On May 23, 2010, a neighbor reported concern regarding the two-year-old playing in the backyard near bags of garbage. The intake was accepted as an alternate intervention response on an open Family Voluntary Services (FVS) case. The FVS worker and the Family Preservation Services (FPS) therapist failed to confirm any significant health hazards upon visiting the home.

On July 16, 2010, a child care provider called CPS intake and reported that the two-year-old showed up at child care with a minor injury (a circle shaped healing injury below his bottom lip). His mother told the child care staff her son fell and may have bitten his lip. The referrer stated that the mother's story did not appear to be consistent with the injury. The report was screened in for investigation by CPS. The CPS investigator was unable to determine if the injury was the result of maltreatment and services continued through FVS with active FPS involvement until services closed out in September, 2010. The CPS investigation was closed with an unfounded finding.

On May 31, 2011, CPS intake received a report of the death of this two-year-old child in a house fire. The fatality notification was taken as information only.

Issues and Recommendations

Issue: Intakes:

All intakes related to this family (2001-2011) were reviewed. While all screening decisions (screen in or screen out) were found to be reasonable and supportable, the review panel did not reach full consensus as to more equivocal aspects of some of the intakes. This included screening in for allegations rather than imminent harm-no allegations (2008), a 24-hour response designation as opposed to a 72-hour response (July 2009), and the possible addition of physical abuse as an allegation against the parent's newly estranged partner (October 2009). Also limited discussion occurred

during the review as to the fact that the screening decision tab does not print out from the State Automated Child Welfare Information System (SACWIS) called FamLink. That section of the intake contains narrative explanation by both the intake worker and the intake supervisor as to additional considerations regarding screening decisions, and sometimes can be beneficial information.

Comment: Independent of any intake issues identified for this Child Fatality Review (CFR), continuing efforts have been made by Children's Administration (CA) to review and improve intake practice. In March 2011, the results from the CA Child Protective Services (CPS) Intake Review were released. The review was a proactive step to identify intake practice trends regarding the quality of information gathered at intake and the accuracy of screening decisions. Results showed that sufficient gathering of general information at intake, accuracy of final intake screening decisions, and accuracy of response times all reached expected practice 90% or more of the time. Areas of needed improvement were also noted (e.g., gathering information regarding child vulnerability), and were consistent with intake issues noted by The Office of the Family & Children's Ombudsman (OFCO) in its August 2011 Implementation of Status of Child Fatality Recommendations report available at http://www.governor.wa.gov/ofco/reports/2011/ofco_2011_annual.pdf.

Discussion was initiated at the October 18, 2011 statewide CPS Coordinators and Intake leads meeting as to developing an action plan for ongoing Quality Assurance for intake screening decisions, which is consistent with the OFCO recommendation that the department continue to examine ways to improve CPS intake decisions. Additionally, efforts were underway in October 2011 to make improvements in FamLink with regard to intake report formatting. Given these ongoing efforts by CA, no recommendations emerged from the CFR with regard to intake.

Recommendation: None

Issue: Quality Social Work - CPS Investigations 2001, 2008, October 2009; FVS April 2010-Sept 2010:

Overall practice appeared to have met department expectations in terms of expected social work activities. Of particular note was the excellent CPS work from the October 2009 investigation and the social work activities of the FVS worker involved from April to September 2010.

Action Taken: The CPS worker from the October 2009 investigation was able to participate in the review and received direct feedback regarding the noted good work. The FVS worker also participated in the review and received feedback regarding noted good work.

Recommendation: None

Issue: CPS Investigation - July 2009:
Many of the investigative activities occurring in 2009 appeared to have met or exceeded practice expectations. There was timely contact with the child and the parents, the subject interview was well documented, and collateral contacts were made and documented (e.g., primary care physician, mother's treatment provider, father's parole officer, and relatives). Overall the documentation met expectations in terms of content and timely entry. The investigation was completed in a timely manner and the case was closed in September 2009.

There were a number of identified areas for where practice could have been improved, although none were found to have any significance to the circumstances surrounding the death of this child nearly two years later in 2011. The most notable of the identified practice concerns were: (1) No documentation that the worker contacted or attempted to contact the referent. Such contact may have helped the investigator come to a more supportable finding than was documented (unfounded) and which appeared to be largely based on the mother's denial that her child had ever been left alone. (2) Although DV was not part of the allegations in the 2009 intake, the social worker did not reconcile the mother's self-report of no DV involving her and the child's father with information provided by an outside source indicating there had been intimate partner violence in the home. The CPS worker could have checked with local law enforcement jurisdictions as to any DV related reports or responses to the residence and could have searched available online local court data bases as to any criminal or civil matters related to DV. It is now known that the mother did file for a Protection Order against the child's father 2 weeks prior to the CPS case closure in September 2009.

Action Taken: The CPS worker from the July 2009 investigation was unable to participate in the review. Feedback was provided post-fatality regarding noted good work as well as the identified areas where practice could have been improved. The worker, currently a supervisor, acknowledged the feedback from the review and was in agreement as to where practice could have been better.

Comment: It is noted that practice expectations regarding contact with referents is already in place. As found in the CA Practice and Procedures Guide (Section 2331 Investigative Standards), the assigned social worker must "contact the referrer if the intake information is insufficient or unclear."

Comment: It is noted that the Domestic Violence and Co-Occurring Child Maltreatment Intake and CPS Investigative Policies became effective late July 2009, and the DSHS/CA Social Workers Practice Guide to Domestic Violence was not finalized until February 2010, which was after the 2009 CPS investigation was completed.

Recommendation: None

Issue: CPS Investigation - July 2010:

In review of the July 2010 CPS investigation regarding a possible non-accidental injury to the now deceased child, the panel found the investigative activities were minimal and the caseworker's documentation was not of good quality in terms of thoroughness, clarity, or timeliness. While the injury may have been relatively minor and healing at the time of the report to CPS, the worker might have considered seeking a medical opinion. The worker missed an opportunity to obtain a photo of the concerning injury taken at the daycare even if the photo as reported was not very clear or revealing. The completion of the investigation at around 90 days from assignment exceeded the current CA expectation of 45 days. The worker stated the delay in completing the investigation was due to awaiting the completion of the law enforcement investigation, the results of which remained unknown at the time of the review. The basis for the CPS unfounded finding was not clearly documented and may have been compromised by the minimal investigative efforts.

During the review, information was presented that suggests workload issues may have played a role in the lower than expected quality of work. During the time of the 2010 investigation the worker's unit had one investigator on maternity leave and also had a vacant position, thus unit members had to assume a higher case load than normal.

Action Taken: The worker is currently employed in another DSHS administration but did participate in the CFR. The worker acknowledged the marginal quality of work. The worker indicated she had at that time a significant backlog of cases that inhibited her ability to complete documentation within expected timeframes.

Action Taken: The CPS supervisor was unable to participate due to a family emergency, but received feedback post-review regarding the identified practice issues and where supervisory oversight could have been improved.

Action Taken: The CPS area administrator did attend the review and participated in the discussions as to the issues identified.

Recommendation: No Recommendations. Policy and practice expectations regarding conducting CPS investigations and completion of work are already in place.

Issue: Monthly supervisor reviews:

Noted during the review was the failure to meet monthly supervisory reviews by the CPS and FVS supervisors from November 2010 through January 2010. Information presented during the review suggested that the situation may have resulted from anomalous circumstances, with the respective CPS and FVS supervisors switching units as part of their master's in social work (MSW) practicum requirements, and then one of the supervisors going on extended family leave. Supervisory reviews did resume early February 2010.

Recommendation: No Recommendation due to the anomalous nature of the situation.

Child Fatality Review #11-22
Region 1
Spokane County

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

Case Overview
On June 7, 2011, the mother of this three-month-old child found him unresponsive in his bassinet around noon. Her fiancé called 911. The mother told first responders the family had gone grocery shopping at 3:30 a.m.; they came home, she fed her son and put him in his bassinet at approximately 4:00 a.m. The mother said her son did not wake up between 4:00 a.m. and noon so she went to check on him and found him unresponsive. The Spokane Medical Examiner determined the death to be sudden infant death syndrome with contributing mild hypoglycemia ketosis (a disorder relating to low blood sugar) consistent with diabetes.

CA did not have an open case on this family at the time of the child's death. A Child Protective Services (CPS) investigation was closed eleven months prior to the child's death.

Intake History
On July 9, 2009, CPS intake accepted an intake for investigation that alleged physical abuse and negligent treatment of the sister of the three-months-old. A nurse at a Spokane area hospital called to report the mother frequently brought her infant daughter to the hospital due to reflux. On this day the mother brought her infant to the emergency room with a quarter size abrasion on her forehead. The child had fallen out of a car seat. The mother was frustrated with the baby's crying. A CT scan was done and no further injuries were identified. The emergency room nurse identified the abrasion to be consistent with the explanation.

The nurse had further concerns that the mother did not appear to know how to comfort or interact with her infant. The nurse reported that the mother brought her daughter to the hospital just about every other day since birth.

The mother was working with a Public Health Nurse (PHN) when she was pregnant. The mother and child's father were offered Family Preservation Services (FPS) and they accepted a voluntary case plan with CA. The social worker identified goals of the service to increase parenting skills and provide the parents with direction for basic safety of the infant.

The FPS provider recommended a parenting assessment and possibly a psychological evaluation for the child's father The provider expressed strong concerns for the infant's safety while in the care of the parents.

The social worker made a referral for a parenting assessment and the parents completed an attachment assessment. The attachment assessment had a favorable conclusion of healthy attachments between the infant and the parents.

FPS ended in December 2009 at which time the parents moved in with maternal relatives. They continued to reside in that home at the time of the case closure in June 2010.

On June 8, 2011, the Spokane County Medical Examiner called CPS intake and reported the death of this three-month-old infant. The child was found by his mother unresponsive around noon. He was taken to a local hospital where he was pronounced deceased. The Medical Examiner reporter the cause of death is sudden infant death syndrome (SIDS). There was no allegation of abuse or neglect related to this child's death and the intake was not screened in for investigation.

Issues and Recommendations
Issue: There was not a Child Protection Team (CPT) meeting at anytime for this family although the Structured Decision Making (SDM) tool, used as part of the investigative assessment indicated a moderately high risk for the child in this family.

Recommendation: Policy (2562) currently exists regarding the requirement for a CPT.

Issue: The case was open for a total of eleven months with the last six months as inactive status for paperwork. There were a total of three supervisory reviews completed.

Recommendation: Policy currently exists with requirements for monthly staffings between social workers and their supervisors for monthly supervisor reviews.

Issue: The FPS provider's exit summary and report does not include narrative explanations or examples on the North Carolina Family Assessment scale (NCFAS). Directions on the exit summary tool state that narrative description should include any significant strengths and problem areas indentified in the NCFAS.

Recommendation: Contracted providers should use the assessment tools as instructed by the instrument directions.

Issue: Case note documentation for the months of November and December 2009 as well as January 2010 were all entered on the same day of June 2010 when the case was closed in the electronic system.

Recommendation: Policy currently exists with requirements for the case note documentation timeframes.

Child Fatality Review #11-23
Region 1
Grant County

This eight-year-old Native American female died from injuries sustained in a car accident. Children's Administration (CA) had an open case on the family at the time of her death.

Case Overview
On June 15, 2011, this eight-year-old child died as a result of an automobile accident near Ephrata. She and her 11-year-old sister were passengers in the car driven by their aunt. According to Grant County Sheriff's Deputies, the aunt lost control of the car while taking a curve in the road. The car slammed into a telephone pole and rolled on its roof. Police reported that a rate of high speed was a factor in the crash.

CA had an open case on this family at the time of the child's death. A Child Protective Services (CPS) investigation was opened in March 2011 and was still open at the time of this child's death.

Intake History
The parents of this eight-year-old girl first came to the attention of CA on February 1, 2000. The family included the parents and five children, the eight-year-old, her older sister, and two older brothers. The mother also had a younger son from another marriage. Between February 2000 and March 2008, there were 10 reports made to CPS on this family. These reports included allegations of medical neglect, unsanitary conditions in the home, poor supervision of small children, and substance abuse by the parents. Six of the 10 reports were screened in for investigation. Other intakes were screened for Alternate Intervention or screened out for investigation. All of the screened in CPS investigations were closed with unfounded or inconclusive findings. Services were offered to the family during earlier investigations including Family Preservation Services and public health nurse services.

In December 2003, the parents divorced and the two older boys went to live with their father, the girls lived with their mother.

In 2004, the mother remarried and later had another child, a son, with her new husband. They separated in 2007.

On May 16, 2008, CPS intake received a report that the mother left her children in the care of a relative who was incapable of providing care for them. It was also alleged the mother had a new boyfriend; he was a registered sex offender and involved with drug activity. The report screened as an information only report.

On July 6, 2009, CPS intake received another report that the mother left her children in the care of a relative who was incapable of providing care for them. This intake report

was screened in for investigation and closed with an unfounded finding for negligent treatment or maltreatment.

On April 29, 2010, CPS intake received a report from school personnel regarding the poor hygiene of the older sister of the now deceased child. She was six-years-old at the time of this report. She reported that her grandfather helped her out of the shower and that he “hits” on her. This information was screened as information only.

On October 22, 2010, school personnel reported the mother and her children moved in with the children’s aunt. The aunt’s roommate was reported to be a registered sex offender. A social worker went to the home and observed that the sex offender was being arrested. Law Enforcement did not place the children into protective custody. The intake report was screened in for investigation and closed with an unfounded finding for negligent treatment or maltreatment.

On March 24, 2011, a school nurse called CPS intake with concerns that the older sister had a medical condition that was not being properly managed. There were also concerns for poor hygiene of the children and unstable living conditions. This report screened in for an investigation. During the course of the investigation another report was made on April 12, 2011, with similar concerns in the March 2011 report. Both of these intake reports were screened in for investigation. The April 12, 2011 investigation was closed with a founded finding for negligent treatment or maltreatment.

The mother did not adequately monitor her daughter’s medical condition and did not share important medical information with the school. The mother and stepfather agreed to voluntary services. An action plan was developed that would provide education to the mother to help her manage her daughter’s medical condition. At a Family Team Decision Meeting, the social worker made a point of telling the mother that she could not leave her children in the care of her sister. There was an ongoing CPS involvement with this sister and she was known to abuse drugs.

On June 11, 2011, the assigned social worker made a report that the older sister of the eight-year-old was left home alone overnight on June 9, 2011, and there was no adult there to monitor her blood sugar.

On June 15, 2011, the eight-year-old and her older sister were left in the care of their aunt, in violation of the social worker’s verbal instructions. The girls were passengers in a car involved in a rollover accident; their aunt was the driver. The eight-year-old was killed in the accident; her older sister was seriously injured. This incident was also investigated by CPS and closed with a founded finding. A dependency petition was filed on the older surviving sister. The brothers were living with their father at the time of this accident.

Issues and Recommendations

Issue: There was no investigation or case activity found associated with the June 29, 2000 intake.

Recommendation: None.

Issue: The investigation of the September 20, 2000 allegations lacked case activity documentation to determine what was done during the investigation. There was documentation the family may have moved to Alaska. The investigative assessment was completed a year and a half later.

Recommendation: None.

Issue: The review committee had consensus that the August 6, 2003 and the November 5, 2003 intakes were inaccurately assessed as low risk/alternate intervention intakes. The Alternate Intervention provider was the source of these continued and escalating concerns.

Recommendation: When contracted providers are repeatedly reporting the same concerns and allegations the department should increase the level of intervention with the family.

Issue: The investigation of the October 15, 2003 allegations appeared to be closed prematurely 12 days later. There was also a gap in the conclusion of the investigation and the closing of the case which occurred in May 2004. In April 2004, there is documentation the family reportedly moved to the Moses Lake area.

Recommendation: When families move from one area of the state to another with an open case consider case transfer or notification to the field office in the family's new residence location.

Issue: The intake screening decision of information only for the May 16, 2008 was determined to be inaccurate by the review committee.

Recommendation: None

Child Fatality Review #11-24
Region 1
Kittitas County

This 16-year-old Caucasian female died from injuries sustained in a car accident. Children's Administration (CA) did not have an open case on the family at the time of her death.

Case Overview
On June 15, 2011, this 16-year-old youth was driving a car around midnight when she was involved in a single car rollover accident. Two other teens were passengers in the car; one of the passengers was also killed in this accident. Police reported that speed and alcohol may have been factors in the crash.

CA did not have an open case on this family at the time of the youth's death. A Child Protective Services (CPS) investigation was opened in June 2010 and was closed in August 2010.

Intake History
In November 1998, CPS intake received a report of possible sexual abuse of a younger sibling (who was eight-years-old at the time of this report) by her father. The child was interviewed and examined by a doctor at Harborview Sexual Assault center in December 1998. The doctor believed the child made a credible disclosure of abuse. Her parents were separated and the father had regular visitation.

CPS made founded findings for sex abuse against the father. However, he was never prosecuted for any crime. He moved from the area and did not have contact with his daughter for several years. The case was closed in April 2000.

On August 4, 2007, the father contacted CPS intake to report the child was living with a relative who was too ill to care for her. He denied that she was abused or neglected in the relative's care. This report was screened out and not investigated.

On October 27, 2008, a school counselor reported to CPS intake that the 16-year-old (then 12 years old) reported that her younger sister was sexually assaulted by her father. The report was sent to law enforcement. Upon further investigation by Kittitas County Sheriff it appeared that the youth was reporting allegations of abuse of when she was much younger (from November 1998). The counselor indicated a report was made to law enforcement on October 14, 2008. This report was screened out as it was previously investigated.

On March 19, 2009, CPS intake received information from a domestic violence victim advocate reporting the older sister of the now deceased child disclosed physical abuse by her mother. The youth had a mark on the side of her forehead and tenderness on the back of her head with no marks visible. The Kittitas County Sherriff's Office responded.

The CPS report was screened out and not investigated. The intake supervisor documented that law enforcement telephoned a CPS supervisor to report that following their investigation they did not believe there was physical abuse committed by the mother although mother and teen daughter did have a physical altercation.

On September 12, 2009, CPS intake received a report from police of physical abuse of the 16-year-old (then 14 years old). The youth said she and her mother argued about clothing when her mother slapped her. The youth's mother later grabbed her by her hair, threw her down and punched her. The mother then choked her daughter by putting her knee on her throat. She also put her in a headlock. The officer said the youth had a neck brace on at the hospital so he did not see marks on her neck. The officer said there was dried blood on her clothing and there were scratches and bruises on her arms.

The CPS investigation was completed with a founded finding for physical abuse. The case remained opened and the family agreed to a safety plan. The youth stayed with a relative and the family agreed to participate in Family Preservation Services (FPS). The mother refused a drug/alcohol assessment.

The mother was later arrested for the September 2009 assault of her daughter. She was required to participate with services due to the arrest, to include domestic violence counseling.

On December 8, 2009, a report came from the CPS social worker with information regarding the assault of the older sister by her mother in March 2009. New information clearly describing physical abuse was disclosed to the CPS social worker. The youth described being punched five to six times by her mother and kicked in the side and pelvic area. The youth said her mother had been drinking that day as well and believes that contributed to the problem. The intake was accepted for investigation which was completed with a founded finding for physical abuse against the mother. The case remained open for voluntary services to the family.

The FPS services continued up to February 18, 2010. The FPS provider identified areas where family functioning had improved. There was less chaos in the home and more rules and structure. The teens, however, rebelled against the new structure in the home. The case was staffed with a Child Protection Team (CPT) on March 25, 2010 with the recommendation for case closure.

On June 24, 2010, the father of the 16-year-old reported to CPS intake that his daughter was afraid to be at home with her mother and feared her mother might hurt her again. The father reported he believed there was drug use in the home by his ex-wife's boyfriend. The father indicated he was willing to be a placement option for his daughter. The CPS report was screened in for investigation and determined to be unfounded for negligent treatment. While the investigation was open the father petitioned the court

for custody of his daughter. The youth's mother agreed to the custody change and the case was closed on August 8, 2010.

On June 16, 2011, CPS intake received a report of the death of the 16-year-old in a car accident involving two other teens. The 16-year-old had returned to live with her mother sometime in 2011 following the death of her father. This information was unknown to the department at the time of the accident.

Issues and Recommendations

Issue: The November 1998 investigative finding of founded against the father was not sent to him until April 13, 2000. This delay in notification resulted in the father never receiving the certified mailing at his last known address. The delay in notification and case closure appeared to be from the social worker waiting for a decision from the prosecutor's office regarding criminal charges. The prosecutor's office chose not bring this case to trial.

Recommendation: Policy exists identifying the timeframe for findings notifications to alleged subjects as well as case closure timeframes when no ongoing services are being offered.

Issue: Related to the December 8, 2009 intake, the assigned social worker made a report of suspected child abuse almost six weeks after learning of the alleged abuse.

Recommendation: The timeframes required by law for mandated reporting of child abuse is no later than 48 hours from learning of the alleged abuse or neglect. The area administrator will review this requirement with the social worker.

Issue: The Global Appraisal of Individual Needs-Short Screener (GAIN SS) was not completed with the adolescents living in the home.

Recommendation: Current policy exists which directs cases that are kept open for voluntary services require the completion of the GAIN SS with youth 13-years-old and older. The area administrator will review the policy requirement with the social worker.

Child Fatality Review #11-25
Region 3
Pierce County

This two-month-old Pacific Islander male died from asphyxiation. Children's Administration (CA) had an open case on the family at the time of his death.

Case Overview
On June 22, 2011, the father of this two-month-old child fed formula to his infant son and then put him down to sleep in a supine position on a thin pillow with cushions positioned to keep the child from rolling off the sleep surface. The baby was wrapped in a fleece baby blanket. The father and his children all slept on the floor of the apartment. The father was sleeping in the middle with the infant on one side and the other children on the other side. The mother was working a graveyard shift.

The father woke to find blankets on top of the baby's face and when he removed the blankets he saw the baby was purple, cold, and not breathing. The father called 911 and started CPR via dispatcher guidance. Emergency medical technicians arrived at approximately 6:50 a.m. and took over resuscitation efforts. The infant was in cardiac arrest and around 7:10 a.m. medics were advised to discontinue lifesaving measures. The child was pronounced dead at the scene.

The Medical Examiner's determination, following death scene investigation, autopsy, and ancillary studies, was that the infant death was most likely due to asphyxiation related to bed sharing. The manner of death was identified as accidental.

CA had an open case on this family at the time of the youth's death. A Child Protective Services (CPS) investigation was opened in June 2011 and the case was transferring to Family Voluntary Services (FVS) when the child died on June 22.

Intake History
The first CA contact with the family occurred in early August 2006. CPS intake received a report that a 20-month-old was found wandering outside the home unsupervised. It was further alleged that the home was unsanitary. The intake was assigned for investigation and was closed in October 2006 with an unfounded finding for negligent treatment or maltreatment. The home conditions were not found to be unsanitary or of substantive health risks as reported, and the lack of supervision allegation was not substantiated.

In May 2010, a relative called CPS intake and reported that the father punched his three-year-old son on the leg and slapped his five-year-old daughter on the face. The referrer also reported witnessing the father tossing his nearly one-year-old son onto a bed. The referrer reported the home was always very dirty. The CPS intake was screened in for investigation of physical abuse and neglect. The assigned social worker made two unannounced home visits and found the home to be relatively clean and free of safety hazards. The social worker found no evidence of physical abuse. The social

worker contacted the referrer who said she had been angry that the parents wouldn't allow her to see the children and that the alleged incidents had actually occurred years prior. The social worker provided guidance to the family as to how to locate local child care and how to connect with Women, Infant, and Children (WIC) services. The social worker discussed the state law on reasonable discipline (Use of Force on Children - RCW 9A.16.100) and the parents acknowledged they understood the law. The CPS investigation was closed in June 2010 with unfounded findings as to both the neglect and the physical abuse allegations.

A year later on June 6, 2011, a school counselor reported that the oldest child (then six years old) had a red slap mark on the side of her face that had been caused by the father. The child said that she and her siblings were regularly hit by their parents. The intake was forwarded to the Lakewood Police Department who upon interviewing the child at school placed her into Protective Custody. Police did not place the other children into protective custody. The CPS worker met with the other children and none had any bruises, marks or injuries. The six-year-old was returned to the care of her parents on June 8, 2011.

The case was in process of being transferred to Family Voluntary Services (FVS) when on June 22 the family's two-month-old died. The Medical Examiner's determination, following death scene investigation, autopsy, and ancillary studies, was that the infant death was most likely due to asphyxiation related to bed sharing. The manner of death was identified as accidental.

The family engaged in FVS while the CPS investigation continued. The CPS investigation regarding the reported slap to the face of the oldest child did result in a founded finding for physical abuse by the father. The CPS investigation regarding the circumstances surrounding the infant death resulted in unfounded findings regarding child maltreatment.

The case was in process of closure at the time of the Child Fatality Review.

Issues and Recommendations

Issue: CPS Investigation of the June 6, 2011 intake:

Many of the investigative activities regarding the alleged physical abuse of the oldest child appeared to have met practice expectations. There was timely contact with the alleged victim, siblings, and the parents. A request for a child abuse medical consultation was sought regarding the slap mark on the school-aged child's face. The worker made contact with relatives and law enforcement. The Structured Decision Making (SDM) assessment appeared to accurately reflect the family history and current situation and was completed in a timely manner. The decision to initiate transfer of the case to FVS was supported by the case documentation.

There were a number of identified areas where practice could have been improved. Although none were found to have any significance to the circumstances surrounding

the accidental death of the youngest child two weeks after CPS became involved, these practice issues were discussed during the child fatality review. (1) The case worker's documentation was generally not entered into FamLink in a timely manner. (2) Child safety was not assessed when the alleged victim was returned to her parent's care from protective custody. Per policy and practice expectation at that time, a safety assessment/safety plan or transition and safety plan is required prior to the reunification of the child in placement for 60 days or less when the placement was due to child abuse or neglect [Department of Social and Health Services Children's Administration Practice Guide to Intake and Investigative Assessment]. (3) Within a week of the child returning home the CPS worker received secondhand information about an incident involving the mother accidentally hitting the oldest with a jump rope (no injuries). The panel did not reach full consensus as to whether the vague information should have required a new intake. However, there was full consensus that the CPS worker clearly missed the opportunity to inquire with the child and with the parent as to the reported incident.

Action Taken: The CPS worker participated in the review and acknowledged where her practice could have been better, particularly in not checking out the reported jump rope incident.

Action Taken: The CPS supervisor was unable to participate due to a prior obligation, but received feedback post-review regarding the identified practice issues and where supervisory oversight could have been improved.

Action Taken: The Pierce East Area Administrator did attend the review and participated in the discussions regarding practice improvement.

Recommendation: None

Issue: Quality Social Work CPS Investigations 2006 and 2010; FVS 2011:
Overall practice appeared to have met or exceeded department expectations in terms of social work activities and practice standards for the first two CPS investigations and for the post-fatality involvement with Family Voluntary Services (FVS). Noted during the review was the excellent quality of the investigative activities and substantive documentation by the May 2010 CPS worker. Also noted were the well documented social work activities by the FVS worker who made frequent home visits each month, had consistent collaborations with the Early Intervention Program (EIP) public health nurse, and who continually encouraged the parents to engage in available services through the department and via community resources.

Action Taken: The CPS worker for the May 2006 investigation was not available to participate in the child fatality review as she left state service several years ago. The CPS worker for the May 2010 investigation was able to participate in the review and received direct feedback regarding the noted good work. Her supervisor was not

available to participate in the review but was briefed post-fatality on the panel's feedback.

Action Taken: The FVS worker, her direct supervisor, and the Pierce East Area Administrator participated in the review and received feedback regarding noted good work.

Recommendation: None

Issue: CPS Investigation of the June 6, 2011 intake:
Many of the investigative activities regarding the alleged physical abuse of the oldest child appeared to have met practice expectations. There was timely contact with the alleged victim, siblings, and the parents. A request for child abuse medical consultation was sought regarding the slap mark on the school-aged child's face. The worker made contact with relatives and law enforcement. The Structured Decision Making (SDM) assessment appeared to accurately reflect the family history and current situation and was completed in a timely manner. The decision to initiate transfer of the case to FVS was supported by the case documentation.

There were a number of identified areas for where practice could have been improved. Although none were found to have any significance to the circumstances surrounding the accidental death of the youngest child two weeks after CPS became involved, these practice issues were discussed during the child fatality review. (1) The caseworker's documentation was generally not entered into FamLink in a timely manner. (2) Child safety was not assessed when the alleged victim was returned to her parent's care from protective custody. Per policy and practice expectation at that time, a safety assessment/safety plan or transition and safety plan is required prior to the reunification of the child in placement for 60 days or less when the placement was due to child abuse or neglect [Department of Social and Health Services Children's Administration Practice Guide to Intake and Investigative Assessment]. (3) Within a week of the child returning home the CPS worker received secondhand information about an incident involving the mother accidentally hitting the oldest with a jump rope (no injuries). The panel did not reach full consensus as to whether the vague information should have required a new intake. However, there was full consensus that the CPS worker clearly missed the opportunity to inquire with the child and with the parent as to the reported incident.

Action Taken: The CPS worker participated in the review and acknowledged where her practice could have been better, particularly in not checking out the reported jump rope incident.

Action Taken: The CPS supervisor was unable to participate due to a prior obligation, but received feedback post-review regarding the identified practice issues and where supervisory oversight could have been improved.

Action Taken: The Pierce East Area Administrator did attend the review and participated in the discussions regarding practice improvement.

Recommendation: No Recommendations. Policy and practice expectations regarding conducting CPS investigations and completion of work are already in place. A new Safety Framework was implemented in November 2011 following a 3-Phase mandatory training schedule for all case carrying social workers and supervisors. Additionally, the CA Practices and Procedures Guide has been revised and now contains a specific section on Child Safety that incorporates the new Safety Framework.

Child Fatality Review #11-26
Region 3
Grays Harbor County

This 15-year-old Native American female committed suicide. Children's Administration (CA) did not have an open case on the family at the time of her death.

Case Overview
On July 3, 2011, Aberdeen Police responded to a 911 call to the family home after the father reported finding the youth deceased in her bedroom. Police and emergency medics found the youth on the floor of her bedroom and her death appeared to be consistent with a suicide by strangulation. The police report and statements from family members present in the home suggested that the youth had committed suicide.

CA did not have an open case on this family at the time of the youth's death. Family Reconciliation Services (FRS) was requested by and offered to the family in January 2011. The FRS case was closed in March 2011.

Intake History
On January 31, 2011, the department received a call from the mother of the 15-year-old requesting FRS services. The youth's mother requested help filing an At-Risk Youth Petition (ARYP) for her daughter. The 15-year-old was smoking marijuana and cigarettes and skipping school. The school filed a truancy petition. It was reported that the youth was spending time with a 17-year-old boy who had been accused of a sex offense. The parents obtained a restraining order against this 17-year-old boy.

The case was assigned for FRS. The assigned FRS worker met with the youth at school. She reported that she had passed most of her classes during fall semester. She reported to the worker that she believed everything was fine at home and she felt safe there. On February 18, 2011, the ARYP was ordered in juvenile court. The parents had obtained mental health services in the community for this youth. On March 31, 2011, the FRS case was closed as no further services were requested.

Issues and Recommendations
Issue: No issues of concern with Children's Administration practice were noted in this case.

Recommendation: None

Child Fatality Review #11-27
Region 1
Grant County

This two-month-old Native American male died from unknown causes. Children's Administration (CA) did not have an open case on the family at the time of his death.

Case Overview
On July 8, 2011, the father if this two-month-old reported he was napping with his son on a couch when he woke and found his son was cold and not breathing. The father called 911 and emergency medical technicians responded. The child was transported to an area hospital and later flown to Sacred Heart Hospital in Spokane. He was alive in critical condition when he arrived at the hospital. Doctors initially assessed that he would be suffer from extensive brain damage if he survived. He was kept on life support and subsequently died on July 15, 2011.

The Spokane County Medical Examiner's office completed an autopsy. The cause and manner of death are undetermined. The child was previously seen in a Moses Lake area hospital for cardiac testing; problems with the child's heart were ruled out.

The family had another child, a half-sibling to this two-month-old, who died in November 2010. She was put to sleep face down on a pillow. The medical examiner determined that this child died from natural causes. Following the death of the two-year-old, the medical examiner made a recommendation to Moses Lake Police to have microscopic slides from the previous deceased sibling sent to a consultant for a second opinion related to her cause of death.

CA did not have an open case on this family at the time of the death of the two-month-old. A Child Protective Services (CPS) investigation opened in April 2011 was closed just prior to his death.

Intake History
On January 1, 2007, a hospital nurse reported to Child Protective Service (CPS) intake that the mother of the two-month-old just gave birth to her first child and the hospital nurse expressed concerns that the mother appeared overwhelmed. The intake social worker contacted the mother and she confirmed that she was overwhelmed and wasn't getting any help from the baby's father. The intake worker offered services but she declined. The intake was screened in for investigation.

On January 17, 2007, an intake was received from hospital staff. The mother brought her oldest daughter to the hospital where she was diagnosed with Respiratory Syncytial Virus (RSV) and was admitted. The mother told hospital staff that the child's maternal grandmother smoked in the house. The mother was 17-years-old at the time and living with her mother. The referrer expressed concern that the grandmother was putting the child at medical risk. The intake was accepted for investigation.

A shared planning meeting occurred on January 22, 2007. The family declined all services. The investigative assessment was completed as unfounded for neglect on both intakes. The CPS case was closed.

On March 26, 2007, CPS intake received a report from a former neighbor stating the mother may be evicted from her apartment due to disruptive behavior. The mother was described as loud and verbally abusive to her neighbors. The mother and maternal grandmother argued frequently. The intake was screened as Information Only.

On June 14, 2007, an anonymous reporter contacted CPS intake to report the mother was seen hitting her then six month old infant in the face with a cell phone. The baby didn't respond when hit. The mother was also heard calling the baby "stupid" and "ugly." The referrer saw the baby on June 14 but did not see any bruising to the baby. The intake was screened in for investigation of physical abuse.

The assigned social worker notified law enforcement of the intake report. The social worker made contact with the family and saw a bruise under the child's eye. The mother agreed to take her daughter to a pediatrician to be medically evaluated which she did on June 18, 2007. The investigation concluded unfounded finding for physical abuse.

On July 9, 2007, CPS intake received an anonymous report alleging the mother was using drugs and that the maternal grandmother provided most of the care for her baby. The intake was screened as Information Only.

On July 24, 2007, a relative reported to CPS intake that the mother and her boyfriend took the mother's oldest child and moved to the Mount Vernon area. The intake was screened as Information Only.

On August 27, 2007, a family member called CPS intake to report the mother and a friend were seen smoking methamphetamine from a pipe in the presence of the mother's oldest child, who was eight months old at the time. The referrer reported that the infant did not show any effects of being exposed to this drug use. The intake was screened as Information Only.

On October 25, 2007, CPS intake received a call that the mother and maternal grandmother allowed a registered sex offender to move into their home. The intake was screened as Information Only.

On March 1, 2008, an anonymous reporter contacted CPS intake and said she observed a milk bottle that was moldy and had mildew around the top. The mother's oldest child was 15 months old at this time. The intake was initially accepted for investigation and later changed to an alternate response intervention.

On November 19, 2008, a friend of the mother called CPS intake to report she witnessed the mother smoke methamphetamine. The mother had custody of two children at the

time, a two-year-old and a two-month-old, though neither child witnessed her smoking methamphetamine. The intake was screened as Information Only.

On August 12, 2009, CPS intake received a police report of an incident in which the mother's oldest child, then two years old, was found playing in the neighborhood unsupervised. Her mother was four houses away and the grandmother was inside the residence. The child was wearing only a diaper and was covered in dirt. The intake was accepted for an investigation. The mother reported that several people were outside. She denied a lack of supervision. The social worker observed both children who appeared healthy and adequately cared for.

A supervisory case note was entered for September 22, 2009, indicating that collateral contacts were made, there was no need for a Child Protection Team (CPT) meeting, and the children appeared healthy. The case was closed with an unfounded finding of neglect.

On November 16, 2009, CPS intake received a report that the mother's home was described as unsanitary including the presence of several dogs that used potty pads throughout the home. The children walked over the soiled pads. The mother allegedly yelled at the children. The intake was accepted for investigation.

The assigned social worker made contact with the mother and her children on November 19, 2009. The home environment was not as described in the intake. The mother told the social worker she was pregnant and seeing a physician. An investigative assessment was completed with unfounded finding for neglect.

On February 1, 2010, police contacted CPS intake to report the mother's two oldest children were briefly placed in protective custody due to allegations of sexual abuse by the mother's boyfriend. The children were immediately seen by a medical professional who determined the children had diaper rashes and that there was no evidence of abuse. Law enforcement returned the children to the care of the mother and requested CPS follow up on the situation. The intake was assigned for investigation.

The assigned social worker made contact with the two children at the mother's home. She denied her daughters had been sexually abused. The children were regularly seen by their doctor. Contact was made with the doctor's office and no concerns were noted.

On February 8, 2010, CPS intake received a report from hospital staff that the mother had given birth to her third child, a daughter. The hospital nurse had concerns that the infant would be at risk in the mother's care. The intake was screened as Information Only.

On July 28, 2010, CPS intake received a report from a mental health professional (MHP) that the mother sought medications for her then three year old daughter to help

manage her behavior. The MHP denied medications. The intake was screened Information Only.

On October 12, 2010, CA received an intake from a parent alleging her 16-month old child ingested methamphetamine while visiting the family home of the now deceased child. A ten-year-old child reported seeing the 16-month-old put what appeared to be crystals in her mouth. The crystals came from a back room. The intake was screened as Alternate Intervention.

On April 1, 2011, a report was made to CPS intake alleging physical abuse of the three-year-old sibling by her father. The child was observed with two bruises and scratches on her right forearm. The mother told Head Start staff that she fell out of a car and the bruise on her ear was from running into a table. This intake was changed from an Alternate Response screening to accepting it for an investigation. The mother was pregnant and had counseling services as well as Head Start involved with her family.

A social worker made an unannounced home visit with police. There were no apparent injuries to the two-year-old. It was suspected that the father had smoked marijuana just prior to the social worker home visit.

The social worker confirmed that the child was seen at the emergency room on March 26, 2011 after reportedly falling from a van. The physician thought the report was plausible and did not have concerns of child abuse.

A Child Protection Team meeting was held in April 2011 and a recommendation was made for the children to remain in their mother's care. She was participating in mental health services that included home visits at least once per month, Head Start for the children and WIC. The father had initiated services with a substance abuse program.

On July 8, 2011, CPS intake was contacted with information that this two-month-old infant was taken to a local hospital in critical care on July 7, 2011. The child's father reported he was napping with him on the couch when he awoke to find his son was not breathing. The child earlier underwent testing for possible cardiac issues, which were ruled out and cardiac concerns were ruled out. The child never recovered and died on July 15, 2011. The CPS intake was screened in for investigation and closed with a founded finding for negligent treatment or maltreatment. The basis for the finding was the father was instructed by Head Start staff to not place infants on their stomach to sleep.

Issues and Recommendations
Issue: The intake reported on April 1, 2011 was reported by someone other than the first hand source of the information.

Recommendation: Social workers should consider contacting the original source of the allegations of abuse and neglect as additional details and information may affect the investigation and assessments.

Issue: The allegations of the April 1, 2011 intake were identified on March 29, 2011. The mandatory reporting law requires notification to law enforcement or DSHS at the earliest opportunity to report but no later than 48 hours.

Additionally, the Head Start employee contacted the child's mother to ask about the injuries. The review committee questioned this practice.

Recommendation: The area administrator will review the Memorandum of Understanding between Children's Administration and Head Start. Head Start requested a refresher training related to mandated reporting and that has been scheduled for May 2012.

Child Fatality Review #11-28
Region 3
Clark County

This 11-year-old Caucasian male drowned. Children's Administration (CA) had an open case on the family at the time of his death.

Case Overview
On July 19, 2011, this 11-year-old and three other children were swimming in the area known as "Potholes" south of Round Lake in Camas. The 11-year-old jumped in the water to retrieve a pop bottle; witnesses saw him come to the surface before sliding down under the water. This occurred around 2:30 p.m. One of the other children present used a cell phone to call 911. Dive teams located the child's body at approximately 4:30 p.m. that afternoon.

CA had an open case on this family at the time of the death of 11-year-old. A Child Protective Services (CPS) investigation opened in May 2011 was still open at the time of this child's death.

Intake History
Two intakes were received by CPS intake in 2004. On November 19, 2004, an intake alleged that the older brother of the now deceased child would come home from school and would be locked out of the house for at least an hour until his mother arrived home. The child was seven years old at the time of this report. On November 23, 2004, it was alleged that this same child was dropped off from school around 4:00 pm and had to wait outside the house until his mother came home from work. These intakes were investigated and determined to be unfounded. The CPS investigation revealed that he was home about 15 minutes before his mother came home from work; he had a plan and knew how to reach his mother as well as calling 911.

On January 10, 2005, a report to CPS intake alleged the mother ran over her one-year-old child with a shopping cart while shopping. She made him walk home. The intake was screened in for investigation and closed with an unfounded finding for negligent treatment or maltreatment.

On April 5, 2006, CPS intake received a report that the mother slapped her children as a form of discipline. It was also alleged that the children were not properly restrained when in the car. The children had no bruises or marks. The intake was screened for an alternate response.

On April 12, 2006, CPS intake received another report that the mother physically abused her children. It was alleged she hit her children on the head with an open hand or newspaper. The referrer stated that a four-year-old in the home had a red mark on his arm where his mother grabbed him. The intake was also screened for an alternate

response. A social worker met with the mother and discussed the allegations in the two intakes received in April 2006. A list of parenting resources was provided to her.

On July 13, 2007, a relative reported that the mother was physically and emotionally abusive of her four children. The mother used foul language and hit her five-year-old child in the face causing a red mark. She also grabbed him by the arm and twisted it. It was also reported that the mother hit the children on their heads, arms, and backs. The referrer said a two-year-old child had a bruise on her face. The intake was screened in for investigation by CPS and closed with an unfounded finding for physical abuse.

On March 26, 2009, a school staff called CPS intake received a report that a seven-year-old sibling in the home reported having inappropriate contact with his older brother, then nine years old. The intake was screened for an alternate response and a letter was sent to the mother advising her to provide appropriate supervision of her children.

On February 17, 2011, CPS intake received a report that the now deceased child, age nine-years-old at the time, being watched by his older brother, age 14, and the nine-year-old had scratch marks and finger marks on his face. He said his older brother inflicted the injuries. The intake was screened for an alternate response and the mother was contacted about the allegations.

On April 13, 2011, a school staff member called CPS intake to report that the now deceased child, then 10 years old, came to school with a bright red mark on his right cheek. He said his mother slapped his face because he took a candy bar without permission. He said the children get slapped on a regular basis. The intake was screened in for investigation by CPS and completed with an unfounded finding for physical abuse.

On May 20, 2011, CPS intake received a report that the nine-year-old sibling of the now deceased child said his father spanks him with a spoon and that he was mean because he was in the military. He said he was spanked earlier this day but had no bruising. The intake was screened out for investigation.

On May 27, 2011, CPS intake received a report that the nine-year-old sibling of the now deceased child was seen with visible scratches on both sides of his face. The child said they were cat scratches. The referrer said the marks appeared to be fingernail scratches. The child also said he scratched himself. There are five cats in the home. The intake was screened in for investigation by CPS and completed with an unfounded finding for physical abuse.

On July 20, 2011, a report was made to CPS intake after this 11-year-old boy jumped into a lake in Clark County and did not surface. His body was recovered approximately two hours later. The incident occurred on July 19, 2011. The intake was screened out for investigation.

Issues and Recommendations

Issue: The assigned social worker did not complete the initial face to face with the child within the required timeframe on the intake dated May 27, 2011. This was on a Friday evening and the Memorial Day weekend. It appears that there was not a field response worker sent out on this intake after hours which resulted in the assigned daytime worker failing to meet the face-to-face contact within the 72-hour timeframe. The area administrator and CPS supervisor in the Vancouver office will review this intake more closely and determine why there was not a CPS field response worker called out after hours in response to this intake. They will report back to the Deputy Regional Administrator by the end of December what they found out and develop a plan to avoid this issue in the future.

Recommendation: None

Issue: The social worker assigned to this case attempted several times to have face-to-face contact with this family prior to closing out the case. He was unsuccessful in meeting with the parents and ended up closing the case out without having face to face contact with the parents. The mother had been reluctant to meet face-to-face with social workers connected to CPS. It was discussed that a strategy for the worker would be to contact the school when closing out a case where the worker had been unsuccessful in making contact with the parents and let the school know that the case was closing at this time and to inquire about how the child was doing and whether there were current concerns. The social worker, supervisor, and area administrator felt that this would be an appropriate response and will incorporate this practice into their work.

Recommendation: None

Children's Administration

Executive Child Fatality Review

N.L.

August 14, 2009
Date of Child's Birth

May 9, 2011
Date of Child's Death

September 12, 2011
Executive Child Fatality Review Date

Committee Members:
Louisa Hall, Licensed Mental Health Counselor/Coordinator, Sound Mental Health
Bradley Graham, Detective, Tacoma Police Department
Bolesha Johnson, Family to Family Supervisor & Court Service Manager, Children's Administration, Region 2 South
Kellie Rogers, Program Manager, The Children's Domestic Violence Program, YWCA
Kat Scheibner, Child Protective Services (CPS) Supervisor, Children's Administration, Region 3 South

Observers:
Edith Hitchings, Deputy Regional Administrator, Children's Administration, Region 3
Patrick Dowd, Office of the Family and Children's Ombudsman
Mary Meinig, Director, Office of the Family and Children's Ombudsman
Amber Osland, Child and Family Welfare Services (CFWS) Supervisor, Children's Administration, Region 3 North

Facilitators:
Cristina Limpens, Central Case Review Specialist, Children's Administration
Marilee Roberts, Practice Consultant, Office of Risk Management, Children's Administration

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Executive Summary

On May 9, 2011, Children's Administration (CA) Central Intake (CI) accepted an intake from Pierce County Sheriff's office reporting the death of 20-month-old, N.L. The referrer stated that they responded to the family home along with Emergency Medical Technicians (EMT) after receiving a 911 call from the child's mother. N.L.'s mother had been at work at a location close to her home when her boyfriend, Charles Mann[2] called her and informed her that N.L. was in distress. Mr. Mann was caring for N.L. and her two-month-old half sister, V.M. Upon returning to the home, the mother found N.L. was not breathing and had vomited. N.L. was brought to Mary Bridge Children's Hospital emergency room by the EMTs who attempted to revive the child however were unsuccessful. Given the condition of N.L. and the unknown origin of her injuries, law enforcement placed V.M., N.L.'s younger sibling into protective custody.

In an interview with investigating officers, Mr. Mann stated N.L. had apparently drowned while he was attending to the infant, V.M. in another room. Mr. Mann stated that he attempted to revive N.L. by pumping her stomach to remove water. Following an autopsy on May 10, 2011, the Pierce County Medical Examiner concluded that the manner of N.L.'s death was homicide, and that blunt force trauma to her abdomen caused fatal bleeding. It was the opinion of the medical examiner that N.L. died within three hours of being struck. No water was found in the child's lungs.

After learning of the autopsy results, Mr. Mann changed his account of the incident and subsequently said he accidentally punched N.L. while pretending to box her. On May 10, 2011, Mr. Mann was arrested and charged with second degree murder. The criminal case is pending.

A review of the family's history with CA notes five intakes prior to N.L.'s death. One intake, dated February 18, 2011, identified N.L., as an alleged victim of child abuse or neglect. The family's history began in 2005 and three intakes received during May 2005, August 2005, and February 2006 respectively, referenced an older sibling of N.L. These intakes were accepted for investigation and involved allegations of neglect associated with ongoing domestic violence perpetrated by N.L.'s father against N.L.'s mother. In 2006, following a third investigation referencing negligent maltreatment and neglect of N.L.'s older brother, a dependency action was initiated. In 2008, third party custody of N.L.'s older sibling with his maternal great grandmother was completed. This child continues to reside with his great grandmother.

A fourth intake was received in April 2009 that was screened as information only. The intake did not meet the sufficiency screen as the alleged victim was the mother's unborn child and the mother had no children in her care. The fifth intake received on February 18, 2011 involved allegations of neglect of N.L. by her mother. This intake was

[2] The full name of Charles Mann is being used in this report as he has been charged in connection to the incident and his name is a part of public record.

assigned for a CPS investigation; however no finding was made prior to N.L.'s death and the CPS case was open at the time of the child's death.

In September 2011, CA convened an Executive Child Fatality Review[3] (ECFR) committee to review the practice and service delivery in the case of 20-month-old N.L. and her family. The fatality review committee members included CA staff and community members representing disciplines relevant to the case. Committee members had no involvement in N.L.'s case. Committee members received the following case documents prior to the review: a chronology of the case prepared for the review, and historical reports relating to the dependency of N.L.'s older sibling including a 2005 police report, and a 2006 parenting and mental health evaluation of N.L.'s mother. Available to committee members at the time of the ECFR were the un-redacted CA case records, and copies of CA policy regarding child protective services (CPS) investigations. During the course of the review, the CPS supervisor overseeing the February 2011 investigation was interviewed by the committee. The CPS social worker assigned to the investigation was available for questions but the committee declined to interview her.

During the course of the review, committee members discussed issues related to CPS investigative practice and procedures, Pierce West CPS workload, supervision, and availability and access to FamLink[4] reports.

Following review of the documents, case history and consultation with the social worker supervisor, the review committee made findings and recommendations which are detailed at the end of this report.

Case Overview

N.L.'s mother and Mr. Mann both have history with the department as children. Department records indicate that as a result of concerns regarding her mother, N.L.'s mother lived much of her childhood with her maternal grandmother. Mr. Mann's family has extensive CPS history dating back to 1989. Department records show reports consistently identified a chaotic family environment due to drug/alcohol abuse, lack of supervision, parental mental health issues, domestic violence, and extensive criminal

[3] Given its limited purpose, a Child Fatality Review by Children's Administration should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. A review is generally limited to documents in the possession of or obtained by DSHS or its contracted service providers and the panel may be precluded from receiving some documents that may be relevant to the issues in a case because of federal or state confidentiality laws and regulations. A review panel has no subpoena power or authority to compel attendance and generally will only hear from DSHS employees and service providers. The panel may not hear the points of view of a child's parents and relatives, or those of other individuals associated with a deceased child's life or fatality. A Child Fatality Review is not intended to be a fact-finding or forensic inquiry or to replace or supersede investigations by courts, law enforcement agencies, medical examiners or other entities with legal responsibility to investigate or review some or all of the circumstances of a child's death. Nor is it the function or purpose of a Child Fatality Review to take personnel action or recommend such action against DSHS employees or other individuals.

[4] FamLink – CA's Case Management Information System

involvement by multiple members of the family. Mr. Mann did not have any prior CPS history as a perpetrator of child abuse and/or neglect.

N.L.'s family's history with CA began in 2005 and included a total of five intakes prior to the report of this child's death in May 2011. Of these five intakes, four screened in for CPS investigation and one was screened as information only. The first three received in May 2005, August 2005, and February 2006 respectively, all involved allegations of negligent treatment of N.L.'s older brother related to ongoing domestic violence between N.L.'s mother and father. The mother sought medical treatment on several occasions due to injuries she incurred as the result of the domestic violence. The investigations related to the 2005 intakes were closed with inconclusive findings of negligent treatment by the mother. The 2006 investigation resulted in a founded finding of negligent treatment by the mother due to the mother's inability to protect N.L.'s older brother and the continuing violence between the parents.

A dependency petition was subsequently filed in February 2006, and the child was placed into foster care. He was later moved to the home of his maternal great grandmother. Over the course of the next 22 months, services were offered to the parents. Services included drug testing, drug/alcohol treatment, parenting classes, domestic violence counseling/treatment, and a mental health and parenting assessment. The mother maintained regular visitation with the child and engaged in services while the father was noncompliant with services and had no contact with the child. There were ongoing concerns regarding the mother continuing her relationship with the father and after it became clear that she was unable to make the necessary changes to parent the child, the permanent plan for that child became third party custody of the child with his maternal great grandmother. A non-parental custody decree was entered during December 2007. The dependency related to N.L.'s older brother was dismissed in January 2008, and the case was subsequently closed.

On February 18, 2011 the department received its first intake referencing N.L. as a victim of child abuse and/or negligent treatment. This intake was received from a child care provider who reported that N.L. presented with a black eye in December 2010 or January 2011. According to the child care provider the mother reported N.L. had fallen in the bathtub. The child care provider identified other concerns including N.L. coming to the day care dirty and with diaper rash, the mother asking others for money to purchase food for the home, and concerns regarding the mother having bipolar disorder and not taking her medication. Additionally, the child care provider said that when she saw N.L.'s older brother in the community, he reported that his mother was "really mean" to him and "beats" him.[5] The intake noted that the mother was currently pregnant with her third child. The intake was assigned for investigation. The CPS investigation into the February 18, 2011 intake began on February 19, 2011 and had not yet been concluded when notification of N.L.'s death was received on May 9, 2011.

[5] N.L.'s older brother was having unsupervised visitation with his mother.

On May 9, 2011 CA was notified of N.L.'s death by the Pierce County Sheriff's office. N.L. died from severe trauma resulting from physical abuse reportedly inflicted by Mr. Mann. He was arrested on May 10, 2011 and charged with second degree murder. In charging documents, Mr. Mann maintained that he had found N.L. under water in the bathtub, but when confronted with the autopsy results, he added that he had accidentally struck the child in the abdomen while pretending to box her. It was the medical examiner's opinion that the bruising found on N.L.'s abdomen was not consistent with a single blow from a closed fist.

As a result of N.L.'s death, her infant sibling V.M. was taken into protective custody by law enforcement and placed in out of home care. A dependency petition was filed in Pierce County Juvenile Court. V.M. had a full skeletal survey and MRI, and no injuries were noted, and she was found to be in good health. N.L.'s older sibling continues to reside with his maternal great grandmother who retains 3rd party custody of him.

Committee Discussion

The review committee discussed at length, the intake history and related investigations regarding this family. Regarding the investigation related to the February 2011 CPS investigation, the committee noted that the initial face to face contact with the alleged victim, N.L., did occur within the 72 hour required time frame and during this contact, the child was assessed to be safe and free from observable injury. However, the committee noted the lack of a thorough and comprehensive investigation as several investigative standards and requirements were missed. During the discussion it was pointed out that there was minimal investigation of all the allegations identified in the intake; specifically the allegation that N.L.'s older brother had reported being beaten by his mother and her boyfriend. There was discussion that an interview with N.L.'s brother was needed and would have added valuable information to support critical decision making on the case. Additionally, the committee identified that the investigation was not completed within 45 days per CA policy. While CA policy does not require children to be seen monthly when a case is open for CPS investigation only, and in this case, there was one home visit and one attempted home visit with N.L. by the social worker, the committee discussed that changing family conditions (i.e. the mother due to give birth) may have warranted an additional home visit for a more comprehensive assessment.

The committee members discussed the lack of supervisory oversight on this case as the case remained open past the 45 day mark without a supervisory review to determine what additional investigative activities or actions may have been needed to complete the investigation. The review committee highlighted the importance of the supervisors in reviewing social worker documentation on an ongoing and systematic basis in addition to meeting with the social worker to analyze and discuss information regarding a family.

At the request of the review committee, the social work supervisor met with them to discuss workload and case assignment issues in the Pierce West office at the time this

family was referred to the department. The social work supervisor stated to the review committee that they have 18 CPS investigator positions assigned to the Pierce West office. The supervisor reported that she supervises six social workers and her unit handles all of the CPS investigations involving military families, although they also investigate civilian cases.[6] There was some discussion regarding the complexities involved with coordinating investigations with the military, and the supervisor stated the military cases increase the workload for this unit. The supervisor indicated that workload was extremely high in her unit, as well as in the other two CPS units. There was a high number of intakes needing assignment; additionally, the area manager had reported prior to the review that there were at least two vacancies in the CPS section between January and March 2011. Additionally CA was unable to assign full caseloads to two other investigators and this impacted workload for the remaining investigators. The investigative social worker assigned to the February 2011 intake received an average of 13.7 new investigations per month between January and May 2011. The new investigations assigned per month were in addition to the worker's ongoing investigations carried over from the previous month. For investigative workers in child protective services, the Council on Accreditation Standards (COA) recommends that caseloads do not exceed 15 investigations or 15-30 open cases. [7]

Further discussion with the supervisor included challenges to completing investigations within the required 45 days and whether this is a realistic time period given the workload in some offices. The supervisor spoke to the difficulties social workers have, in general, finding the time to complete comprehensive investigations within the 45 day time frame particularly when front end case assignment is high.

The social work supervisor spoke at length with the committee regarding her approach and ability to provide clinical supervision and oversight to the social workers in her unit. She indicated that she struggles to complete monthly supervisory reviews with each of her six workers on all of their cases. She stated that she frequently staffs cases with her workers but does not always have time to document the discussion. She described that each of the three CPS supervisors in the office rotate weekly responsibility for assigning intakes and that this additional responsibility significantly impacts the time she has available to provide direct clinical supervision to her workers.

The social work supervisor described a "second level" of screening of intakes she completes which she indicated is often necessary to verify information in the intake. The supervisor reported that in addition to assigning and reviewing intakes, she may also be required to attend Family Team Decision Making (FTDM) meetings, thus further impacting her availability. The committee members agreed that other job duties, specifically the social work supervisor's responsibilities around intake assignment and what appeared to be efforts duplicative of the responsibilities of the intake supervisor, need to be reviewed.

[6] This was not a military case.
[7] http://www.coastandards.org/standards.php?navView=public&core_id=416

In addition to discussing past service delivery to the family and the details of the fatality investigation, the review team also spent some time discussing the issue of domestic violence, including resources and training, as domestic violence was a threat present throughout this case.

Review Committee Findings and Recommendations

The review committee made the following findings and recommendations based on interviews, review of the case records, and department policy and procedure, the Revised Code of Washington (RCW) and Washington Administrative Code (WAC).

Findings

Investigations

The review committee discussed at length the CPS investigations and service recommendations made in this case over the course of the family's involvement with CA. They found the following:

- During February and March 2011, high intake assignments impacted the CPS unit in which the February 2011 intake referencing this family was assigned. Key standards of a CPS investigation required by CA policy[8] did not appear to have occurred. Investigative standards should include:
    - Investigation of all allegations identified in the intake
    - Contact with the referrer to clarify information in the intake
    - Contact with collaterals that were reported to have or may have had firsthand knowledge of the family (e.g., medical providers and other professionals involved with the family, relatives)
    - Completion of the investigation within the required 45 days or an extension of this requirement approved by the supervisor
    - Monthly supervisory review as a means to monitor case progress and to determine if the investigation was not complete and what additional action was necessary
    - Documentation of case activities in a timely manner
- Subsequent to the initial contacts with the alleged victim and mother, there was approximately a 75 day period without any significant investigative follow-up activity or visit by the CPS social worker. During this time, the mother gave birth to another child, which the committee felt may have warranted another visit to the home.
- The review committee confirmed in cases where a child is dependent or a family is receiving voluntary services, CA policy is that each child in the home will be seen monthly. Current CPS investigations policy does not require monthly visits to a home when a case is open 30 or more days for CPS investigation only.

[8] CA Practices and Procedures Guide, Section 2331, Investigative Standards

Supervision

- The review committee found after reviewing FamLink data regarding intake assignment in the Pierce West office and meeting with the social work supervisor that monthly supervisory consultation or staffings were difficult to maintain due to the unit's workload.

Workload

- The committee found after interviewing the social work supervisor, the ability of the CPS social worker to meet practice expectations appeared to be compromised by her caseload. The social worker was experienced. However, due to vacancies in the CPS section and the number of intakes needing to be assigned for investigation, the social worker was getting an average of 13.7 new intakes assigned for investigation between January and May 2011. The social worker had 32 open cases assigned to her at the time of the child's death. The COA standards recommend that a CPS social worker have no more than 30 active cases.
- The supervisor's availability to provide clinical case consultation, monitoring, and feedback to her staff on an ongoing and systematic basis may be impacted by the intake assignment process in the office. CPS supervisors rotate the responsibility of assigning intakes for the section on a weekly basis; much of their time appears to be spent duplicating the efforts of the intake supervisor.
- The supervisor manages a unit that primarily handles military cases, although they do handle civilian cases as well. Coordination with the military can often require additional requirements when conducting investigations, which may increase the investigator's or supervisor's workload.

Recommendations

Practice

- CA may want to consider implementing a monthly visit practice for families who have a CPS case open longer than 30 days. Similar to cases involving dependent children and families receiving voluntary services, children in cases that are open to CPS should be seen monthly.

Supervision

- The review committee recommended that supervisors receive the FamLink report on a monthly basis regarding CPS investigations open for longer than 45 days without an extension as a means to support supervisors in monitoring workload. The committee recommended pulling a statewide report regarding the occurrence of monthly supervisory reviews by office and program area to determine where there may be barriers to completing the reviews.

Workload

- A review of the workflow process from CPS intake to assignment and investigation should occur in the Pierce West and East offices to determine if there are barriers and duplication of job duties.

- A statewide review should occur of the protocols and systemic issues related to coordination of investigations between CPS and the military. Consideration as to whether caseloads involving military cases should be weighted is recommended.

Training/Resources

- The review committee discussed the complexities of cases involving domestic violence. The development of the CA Social Worker's Practice Guide to Domestic Violence in 2010 was identified as a positive step in assisting CA social workers in their work with families experiencing domestic violence. However, the committee recommended that training be developed in collaboration with community partners and implemented for CA staff regarding the Guide. Recommended training methods such as video or web based training can be developed to effectively and efficiently deliver the training.
- Based on funding availability and partnership with community agencies, a domestic violence advocate should be co-located in CA offices for the purpose of consultation, intervention, and planning on cases involving domestic violence. Research shows that domestic violence often co-exists with child maltreatment.

Children's Administration
Executive Child Fatality Review

S.R.

November 29, 2010
Date of Child's Birth

June 18, 2011
Date of Child's Death

September 23, 2011
Executive Review Date

Committee Members
Laurie Alexander, Area Administrator, Children's Administration, Region 2 North
Mary Meinig, Ombudsman, Office of the Family and Children's Ombudsman
Denise Redford, MS, Pathways for Women, YWCA
Deborah Robinson, Infant Death Investigation Specialist
Robert Thornquist, Supervisor, Children's Administration, Region 2 South
Lori Vanderburg, MS, Children's Advocacy Program Manager, Compass Health
Mae West, Volunteer Guardian Ad Litem, Snohomish County

Observer
Yen Lawlor, Deputy Regional Administrator, Children's Administration, Region 2 North

Facilitators
Marilee Roberts, Practice Consultant, Children's Administration
Toni Sebastian, Practice Consultant, Children's Administration

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Executive Summary

On September 23, 2011, the Department of Social and Health Services (DSHS), Children's Administration (CA) convened an Executive Child Fatality Review (ECFR[9]) of a case involving the death of six-month old, S.R. (DOB: 11-29-2010) in her family home. At the time of S.R.'s death the family had an open child protective services (CPS) case and an open child and family welfare services case (CFWS) with CA. A committee that included community professionals and CA staff reviewed the case documents and interviewed staff in an effort to examine child welfare practices, system collaboration, and service delivery regarding this child and her family.

On June 18, 2011 at approximately 2:30 p.m. Snohomish County deputies contacted the department notifying CA of S.R.'s death earlier in the day. The deputy stated neither law enforcement nor first responders noted any concerns in the home upon arrival. Law enforcement reported that the Snohomish County medical examiner was responding to the scene and would provide additional follow-up after completing an examination and autopsy. After completion of an autopsy[10] the Snohomish County medical examiner listed S.R.'s death as '*Unexpected Infant Death of Undetermined Cause and Manner.*' It was also reported at this time that the family had another child. E.R., die in their home in March 2009. This death had already been known to the department with an internal fatality review occurring in August 2009.

S.R.'s family's history with CA began in 2000 and includes allegations concerning chronic neglect, unsafe and unhealthy living conditions, lack of supervision, frequent moves, domestic violence, mental health issues, and drug-seeking behaviors. S.R. was the youngest child born in a family of seven children.

Prior to S.R.'s death in 2011, the fourth child born in the family, E.R, died in March 2009 in the family home. The cause and manner of death was determined as '*probable hyperthermia and the manner classified as undetermined.*' Unsafe and unhealthy living conditions, domestic violence between E.R.'s mother and father, physical abuse, suspicions of drug and alcohol abuse and mental health issues resulted in out-of-home placement of the four surviving children through court action in May 2009. The children were found dependent and remained out of the home until they were returned to their mother's care in February 2010. The dependency for three of the four children was

[9] Given its limited purpose, a Child Fatality Review by Children's Administration should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. A review is generally limited to documents in the possession of or obtained by DSHS or its contracted service providers and the panel may be precluded from receiving some documents that may be relevant to the issues in a case because of federal or state confidentiality laws and regulations. A review panel has no subpoena power or authority to compel attendance and generally will only hear from DSHS employees and service providers. The panel may not hear the points of view of a child's parents and relatives, or those of other individuals associated with a deceased child's life or fatality. A Child Fatality Review is not intended to be a fact-finding or forensic inquiry or to replace or supersede investigations by courts, law enforcement agencies, medical examiners or other entities with legal responsibility to investigate or review some or all of the circumstances of a child's death. Nor is it the function or purpose of a Child Fatality Review to take personnel action or recommend such action against DSHS employees or other individuals.

[10] Complete autopsy includes toxicology results which often take as much as 12-16 weeks to receive post fatality.

dismissed in September 2010. The fourth child's dependency was dismissed in May 2011 after a parenting plan was developed between her father and S.R.'s mother, H.J.

A case summary relating to S.R. was prepared and provided to the ECFR committee. A copy of the family's case file was also available to the committee. During the course of the review the committee discussed issues related to service delivery, the significance of patterns in the case including allegations reported to the department, domestic violence, prescription drug use, and parental avoidance of contact with the department.

Following review of the family's history, case records and discussion, the review committee made findings and recommendations that are detailed at the end of this report.

Case Overview

S.R.'s mother, H.J., has a child welfare history with CA beginning in 2000 that includes child abuse and neglect allegations, and also includes services to address issues related to chronic neglect, unsafe and unhealthy living conditions, lack of supervision, physical abuse, domestic violence with multiple partners, mental illness, drug-seeking behaviors, and abuse of prescription medications. She had three significant relationships throughout her contact with the department; all three men have been named as subjects in reports of abuse and neglect received by CA.

There are 16 reports to CA from June 2000 to June 2011 alleging abuse or neglect of her children by H.J. These reports alleged that she, as the subject of the reports (also known as 'intakes'), abused or neglected her children. Of the eight intakes that were investigated, six resulted in unfounded findings, one resulted in an inconclusive finding, and one investigation was not completed because the family could not be located. Of the remaining eight intakes, seven were screened out as information only[11], and one was accepted for an alternative response.

The first opportunity to offer services to this family occurred in November 2003 following the second intake the department received regarding domestic violence against S.R.'s mother by the father of one of her children. However, S.R.'s mother declined services at that time saying she had already obtained a no contact order (NCO) for herself and her children. H.J. reported that she and the father were involved with the Navy Family Advocacy Center (NFAC) as a result of the father's military service. The mother reported that the domestic violence was being addressed through NFAC. A search of case records could find no verification of the couple's involvement with NFAC. Because the couple stated they were pursuing services through the NFAC, the department agreed that no further CA services were necessary for the family.

[11] Screening decision is based on the absence of allegations of child abuse or neglect as defined by WAC 388-15-009 What is Child Abuse and Neglect?

On March 2, 2009, the department was contacted by law enforcement in regards to the death of E.R. H.J. and D.R. (child's father) were not in the home at the time the child was discovered by an uncle who was caring for the children. They were visiting their newborn child at the University of Washington's Neonatal Intensive Care Unit (UW NICU). Following the child's death, H.J. received psychiatric services for grief and loss through UW NICU. She reported meeting with her clergy and a local Mental Health Clinic. In May 2009 despite efforts made through counseling and other services in place, concerns arose over the mother's mental health, prescription drug seeking behavior, care and supervision of the children, and unsafe/ unhealthy living conditions, CA filed dependency petitions on the four surviving children in the home[12].

The department continued to offer services[13] to the family throughout the dependency and following the birth of the mother's sixth child in January 2010. This sixth child, D.R., remained in the mother's care and was not a subject of the dependency action. The four siblings began returning home in February 2010. After six months in their own home and with supportive services in place the dependency referencing three of the four children was dismissed in September 2010. The final dependency referencing another sibling was dismissed in May 2011 when H.J. and the father of her second child filed an agreed parenting plan.

CA received four intakes[14] regarding this family beginning in December 2010 following the premature birth of S.R. Issues related to possible substance use and unsafe living conditions in the home prompted CA to be diligent in monitoring the living conditions and the parents' ability to ensure their children's safety. Referrers expressed concern that family living conditions and inconsistent parental behavior would place S.R. at risk of harm once she was released from the hospital. Monthly home visits by the CFWS social worker assigned to the case continued. CPS investigations began in December 2010 after an intake was received reporting the birth of S.R. She was premature and the caller, a medical professional, expressed concerns regarding H. J. and her ability to care for the child. An intake received in February 2011 reported similar concerns and in May 2011 another intake was received and assigned for alternative response. [15] The CPS social worker attempted home visits in May and early June to address issues related to possible drug seeking behaviors on behalf of S.R.'s mother and deteriorating conditions in the home. The family was difficult to contact.[16] When contacted by CA, the mother and father were unwilling to engage with the social worker. The CPS and CFWS cases remained open.

[12] The children were placed in relative care during this time.
[13] Services: Family Preservation Services, Public Health Nurse, Homebuilders, grief and loss counseling, psychological evaluation, housing assistance and visitation.
[14] Two intakes screened as CPS Risk Only, one for alternative intervention and one screened out.
[15] The committee found the information in the May 6, 2011 intake screened as an Alternative Response (10-day response time) contained information to support screening in the intake for investigation given the family's history.
[16] Case record documentation notes repeated attempts to contact the family without success.

On June 18, 2011, the department received the report of the death of six-month-old S.R. Intake information received stated that S.R. was placed in her bassinet by her mother after being fed. S.R.'s mother reported that she had showered and, afterward, when checking on S.R. she noticed the child had pulled a blanket closer to her and was not breathing. Despite attempts by first responders to revive S.R. she was pronounced dead in the family home at 10:40 a.m. On June 23, 2011 shortly after S.R.'s death[17] and in collaboration with law enforcement, S.R.'s surviving siblings were placed into protective custody due to ongoing concerns of alleged domestic violence, unsanitary living conditions and their mother's untreated mental health issues. Following a brief stay in foster care the children were placed with a relative and dependency was established in August 2011. At the time of this report the children remain out of home in relative placement and the family continues to be involved in services.

Review Committee Discussion and Findings

To develop a thorough understanding of the family and case, the review committee identified dynamics that appeared to influence decision-making by the department, e.g., intake screening decisions, placement decisions, and the 2009 fatality review. The committee requested to meet with the CPS investigator and the CFWS social worker assigned to the case at the time of S.R.'s death. The CPS and CFWS supervisors joined the social workers for their meeting with the ECFR committee.

Patterns: The committee found that a pattern of child abuse and neglect reports to the department had occurred over a significant period of time (2000-2011). While there are gaps in years, 2005-2008, the presence of multiple risk factors[18] and safety threats are found consistently, creating the need to thoroughly assess the family in order to gain an understanding of the parent's ability to safely parent their children. Diligent efforts in locating, accessing and utilizing information from other sources assists in keeping children safe, identifying family patterns, and influences decision making[19] and case planning.

The family experienced significant life events beginning in 2000. These events included reports to the department of chronic neglect and domestic violence,[20] the death of E.R in March 2009, out-of-home placement of the surviving children for nine months, and subsequent premature births (three) in February 2009, January 2010 and November 2010 (S.R.).

Intakes over a ten-year period, consistently included allegations of prescription drug-seeking behavior, domestic violence with three consecutive partners, (one incident resulting in criminal conviction of the perpetrator), unsafe and unhealthy living conditions reported in the family home, and frequent moves. While the mother

[17] Death determined to be Sudden Unexpected Infant Death of Undetermined Cause and Manner.
[18] Mental health, substance abuse, domestic violence
[19] Decisions such as those made on new intakes or the need for out of home placement or services.
[20] One such incident in 2007 led to the conviction of assault/domestic violence of S.R.'s father against her mother.

appeared cooperative with the CFWS social worker, she avoided contact with CPS social workers attempting to complete investigations. Noted in the record were the department's unsuccessful efforts to contact the family through unannounced home visits and phone calls. This pattern of behaviors and events, verifiable through collateral sources, raise questions about the mother's credibility and apparent willingness to work with the department.

Domestic Violence (DV): After closely reviewing the case information and meeting with the assigned social workers the committee identified domestic violence as a reoccurring theme in this family. The committee found that managing the domestic violence in this case was challenging given that H.J. was often the single source of information.

The committee found that by utilizing historical information[21] and accessing collateral information from law enforcement (particularly in cases such as this where there has been a conviction for assault-domestic violence), mental health professionals, and domestic violence agencies, CA can gain insight into the family dynamics to support intervention and planning. Understanding how to identify domestic violence perpetrators, how they think, how other family members respond within the home and how to effectively work with victims and perpetrators can only be gained when employing a collaborative planning effort among experts.

Critical Thinking/Shared-Decision Making: While the committee was convened to review the death of S.R. in 2011, they took note of her sister's (E.R.) death in March 2009. They found complex cases call for a gathering of information from additional sources and is essential in understanding the family's dynamics.

The committee found examples in which gathering additional information and not relying on a single source, such as H.J., would have provided a better understanding of this family's situation. For example, CA received conflicting information from two psychological evaluations on S.R.'s mother in 2010; and continued reports of unsafe and unhealthy living conditions. The committee also noted that the department did not follow-up on critical pieces of information referencing the cause and manner (hyperthermia, undetermined) of E.R.'s death in March 2009; meaning that the child died from external intensive heat and there did not appear to be any inquiry of how the environment became so hot that the child died or if safe sleep issues were discussed with the family following her death. This living condition was noted in several reports to the department. The committee found CA should have confirmed and clarified the information with sources as it was critical in making decisions when case planning to ensure the health and safety of the surviving siblings.

In addition, the committee found following the dismissal of the dependency in September 2010 CA received four intakes beginning in December 2010. The committee noted the referrers making reports were all professionals within the community who

[21] Case history indicated multiple relationships where domestic violence was prevalent.

had insights into this family. The review committee found the family was evasive with CA during this time and when the opportunity to meet with the family occurred CA relied heavily on information from S.R.'s mother and did not always seek corroborating information from second sources (e.g. law enforcement reports, medical examiner, referrer, etc.) regarding allegations or present family circumstances.

The review team found fully understanding a family should result in as complete a picture of a family as possible and will come from a variety of sources.[22] Critical thinking and shared decision making helps to build an understanding of a family and can take into account several areas such as family strengths and respective challenges, which supports developing intervention strategies and case planning.

The committee noted this case could have benefitted from a critical review and analysis of all information received (e.g. clinical supervision, case staffings, child protection teams and multi-disciplinary team staffing). A multi-disciplinary team staffing in particular can provide a comprehensive review and assessment of a complex child abuse and neglect case such as in this family. The collaborative staffing opportunity can support development of case plans that serve individual family members and support child safety.

Given the dynamics in this family the review team found utilizing a multi-disciplinary team decision making approach may have resulted in increased objective recognition and understanding of the family patterns.

Recommendations

Patterns: During the review, the committee learned about CA's implementation of a new Child Safety Framework in November 2011 that supports and assists social workers in assessment, identification, and management of safety threats throughout the life of a case. The patterns of child abuse and neglect reports, domestic violence, and avoidance of department staff would be identified in the new assessment, moving the practice away from incident-focused work to a comprehensive assessment of how this family functioned. The Child Safety Framework also supports the verification of information gathered by contacting collaterals and other child welfare partners working on a case.

Domestic Violence: In February 2010, CA released a Social Worker's Practice Guide to Domestic Violence. The 88 page guide provides social workers with information regarding domestic violence which includes legal considerations, routine screening, domestic violence assessment, case decisions and case planning. The committee commended CA in this effort. However, the committee found that regardless of how valuable the guide, supporting it with a training program that includes direction for supervisor consultation can provide guidance and information to front line staff in assessing and planning around domestic violence.

[22] Sources include medical professionals, law enforcement, schools, community services agencies to include other state agencies, etc.

Given the complexity regarding domestic violence the committee recommended on-going training and regular consultation on domestic violence. A training curriculum that addresses the broad spectrum of domestic violence and includes topics such as perpetrator assessment and accountability, treatment recommendations, understanding patterns and cycles, and safety planning is recommended. Training could be conducted in person or through on-line resources.

Critical Thinking/Shared Decision Making: It is recommended when multiple agencies and service providers over time have worked or are working with a family or have referred them for intervention, CA convene a multi-disciplinary team (MDT). While the primary purpose may typically be to help team members resolve difficult cases, MDT teams may fulfill a variety of additional functions. They can promote coordination between agencies; provide a 'checks and balances' strategy to ensure the interests and rights of all concerned parties are addressed; and identify service gaps and breakdowns in coordination or communication between agencies or individuals. MDTs can enhance the professional skills and knowledge of individual team members by providing a forum for learning more about the strategies, resources, and approaches used by various disciplines.

Children's Administration
Executive Child Fatality Review

Leo Mathis III Case

October 15, 2007
Date of Child's Birth

June 22, 2011
Date of Child's Death

November 16, 2011
Executive Child Fatality Review Date

Committee Members
Jennie Lindberg, Chemical Dependency Professional, Evergreen Manor
Cleveland King, Child Protective Services Supervisor, DCFS, Region 2 South
Megan Sweeney, Domestic Violence Coordinator, Lynnwood Police Department
Bill Barrett, Area Administrator, DCFS, Region 2 South
Paul Smith, Critical Incident Program Manager, Children's Administration Headquarters

Facilitator
Kara Rozeboom, Safety Program Manager, Region 2 North, Children's Administration

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Executive Summary

On June 22, 2011, Leo Mathis Jr. was carrying his then three-year-old son Leo Mathis III across the Prickly Pear Creek near Helena, Montana. Mr. Mathis tripped and fell, dropping Leo III into the creek. The child was swept downstream and was found about 18 minutes later.

Leo III fell into the water at around 7:15 p.m. Witnesses saw him go into the water and immediately called 911. An aid crew with East Helena Fire Department found him about a half mile down the creek. Rescue workers found Leo III at 7:38 p.m. and immediately began administering CPR. He was taken by an ambulance to St. Peter's Hospital in Helena. He was pronounced dead at 8:56 p.m. The Lewis and Clark County Coroner reported that Leo III died from drowning.

On June 24, 2011, Leo Mathis Jr. was arrested on a charge of negligent homicide in connection with his son's death. Police officers reported Mr. Mathis was intoxicated when he attempted to carry his son across the creek eventually dropping him into the water.

Mr. Mathis has pleaded not guilty to negligent homicide. He was still in the Lewis and Clark County Detention facility awaiting trial when this report was written.

Police reported that Leo Mathis Jr. moved to Montana from Oak Harbor just days prior to Leo's death. L.D., Leo's mother, moved with Leo III to Montana in December 2010.

Children's Administration has history on this family from November 2010. At that time, Oak Harbor Police officers stopped Mr. Mathis after he was observed stumbling down the street in Oak Harbor with his young son Leo in his arms. Mr. Mathis was intoxicated at this time. A Child Protective Services (CPS) case was opened on the family. The investigation was completed and the case was closed in December 2010 shortly after L.D and Leo III moved to Helena, Montana.

Leo Mathis Jr. participated in drug/alcohol treatment in September 2010, prior to CPS involvement with this family. His participation in drug/alcohol treatment was a condition of his probation. Mr. Mathis was court ordered into substance abuse treatment because of two DUI arrests and convictions in 2009.

On November 16, 2011, CA convened a multi-disciplinary committee to review adherence to policy and the social work practice in this family's case.[23] The fatality

[23] Given its limited purpose, a Child Fatality Review by Children's Administration should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. A review is generally limited to documents in the possession of or obtained by DSHS or its contracted service providers and the panel may be precluded from receiving some documents that may be relevant to the issues in a case because of federal or state confidentiality laws and regulations. A review panel has no subpoena power or authority to compel attendance and generally will only hear from DSHS employees and service providers. The panel may not hear the points of view of a child's parents and relatives, or those of other individuals associated with a deceased child's life or fatality. A Child Fatality Review is not intended to be a fact-finding or forensic inquiry or to replace or supersede investigations by

review team was represented by disciplines associated with the case and had no involvement or limited involvement with this family. The fatality review team members included a community representative working with victims of domestic violence and a chemical dependency professional. The team also included CA staff who had no direct connection to the case. An invitation was sent to the Office of the Children and Family Ombudsman.

Relevant case documents were made available to the fatality review team. These documents included: law enforcement reports, family history including intake information, a chronology of the case upon assignment of the case on November 20, 2010 and media reports on the tragic death of Leo Mathis III.[24]

Following review of the case history, case records and law enforcement records, the review team discussed the case and any issues and recommendations. The issues and recommendations are detailed at the end of this report. The team also discussed intake screening criteria when cases allege domestic violence between parents.

Case Overview

The CPS history on this family, prior to Leo III's death, consists of one intake received on November 20, 2010. This intake was accepted for investigation by Child Protective Services.

On Saturday, November 20, 2010, the Oak Harbor Police Department called Central Intake looking for assistance in placing three-year-old Leo Mathis III in protective custody. Police officers had decided to place him into protective custody after receiving a call that Leo's father, Leo Mathis Jr., was observed walking down a street in Oak Harbor, very intoxicated and stumbling with his son in his arms. Police responded and made contact with Mr. Mathis. He was belligerent and combative with police officers. Officers initially planned to return Leo III to his mother's care, but Mr. Mathis refused to tell police officers where she was located.

Police reported they transported Mr. Mathis to the police station, but when they arrived, he jumped out of the car and ran.

A police officer contacted an after hours social worker to arrange for a transfer of custody to place Leo III in out of home care. The after hours social worker was

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courts, law enforcement agencies, medical examiners or other entities with legal responsibility to investigate or review some or all of the circumstances of a child's death. Nor is it the function or purpose of a Child Fatality Review to take personnel action or recommend such action against DSHS employees or other individuals.

[24] The criminal case was pending at this time of the fatality review; therefore limited information regarding the criminal investigation is contained in this report to preserve the criminal proceedings of this case. A request for records was made to law enforcement in Montana, but no records were produced. A request was also made for records from Montana Child & Family Services Division. Again, no records were produced as the case was open at the time of the review.

dispatched from Bellingham but was unable to respond in a timely manner due to treacherous road conditions.[25]

Police were later called to the home of a friend of L.D. L.D. and Leo III were staying at this friend's home. After fleeing from the police, Mr. Mathis went to the home of L.D's friend. Oak Harbor Police responded to a call by the mother's friend when Mr. Mathis arrived at her apartment still intoxicated, verbally abusive, and was refusing to leave the apartment. Oak Harbor Police found Leo's mother there and explained that her son was in protective custody. L.D. had a warrant for her arrest for a misdemeanor domestic violence assault. The victim of the assault was not Mr. Mathis or her son. There were no other suitable relatives in the area available to take Leo; Oak Harbor Police agreed to release Leo III to his mother if she agreed to appear in court the following Monday to have the warrant quashed.

Mr. Mathis was unable to walk; due to his state of intoxication, an ambulance was called and he was transported to Whidbey General Hospital. He spent the night at the hospital and had to be physically restrained due to his behavior that included verbally threatening hospital staff and threats of harm. Mr. Mathis was discharged the next morning.

L.D. reported Leo was with his father on a visit during the day. She spoke to Mr. Mathis around 3:00 p.m. and he did not appear intoxicated. L.D. acknowledged there was a No Contact Order barring Leo Mathis Jr. from seeing his son following a domestic violence (DV) dispute. L.D. told the assigned social worker that she had moved in with her friend after Mr. Mathis broke her rib about three weeks prior. She said she did not call the police after Mr. Mathis assaulted her.

L.D. said she planned to move to Helena, Montana where her father, brother, and several aunts and uncles lived.

L.D. went to court and had the warrant quashed. She and Leo III moved in with Leo's paternal grandmother in Marysville. The grandmother had arranged to drive them to Montana just prior to the Christmas holiday where the mother planned to relocate. This occurred around December 17, 2010.

The CPS investigation was closed with a founded finding for negligent treatment or maltreatment against Leo Mathis Jr. The CPS investigation was closed with an unfounded finding for negligent treatment or maltreatment against Leo III's mother, L.D.

There had been considerable domestic violence in the relationship between Leo Mathis Jr. and L.D. There were five different No Contact Orders in place during the course of their relationship. A No Contact Order was in place in November 2010 when

[25] A winter storm resulted in snow and compacted ice on roads.

the CPS investigation was conducted. This information had not been forwarded to Children's Administration staff. L.D. informed the assigned social worker of the No Contact Order during the course of the CPS investigation.

Issues Identified by the Review Team

The review team discussed actions taken by law enforcement and Children's Administration's after hours staff regarding the November 20, 2010 intake. The team acknowledged the excellent social work practice evidenced in the case file after the case was assigned to a local CPS social worker. The findings include the following:

- The team discussed law enforcement's initial contact with Leo Mathis Jr. and questioned why he was not arrested when he was stopped by police.
- Police were aware of Leo Mathis' extensive criminal history and the history of domestic violence and No Contact Orders between Mr. Mathis and L.D. No reports were made to CPS intake.
- According to L.D., there was a No Contact Order barring Leo Mathis Jr. from having contact with his son.
- The review team felt that Leo III should have been placed in care to give the assigned CPS social worker more time to assess his safety with both parents.

Recommendation

- The review team recommended that contact be made with Oak Harbor Police Department by CA staff and offer to provide training regarding Mandated Reporting and provide them with phone numbers to call when a No Contact Order is violated and there is a child in the home.

Children's Administration
Executive Child Fatality Review

M.S.

September 14, 2009
Date of Child's Birth

July 2, 2011
Date of Child's Death

October 27, 2011
Executive Review Date

Committee Member
Penny Bell, Chemical Dependency Professional, First Step Community Counseling Services
Brent Borg, Area Administrator, Children's Administration, Region 1 North
Sgt. Bob Brockman, Patrol Sergeant, Benton County Sheriff's Office
Erinn Gailey, Shelter Services Director, Domestic Violence Services Benton/Franklin Counties
Mary Meinig, Director, Office of the Family and Children's Ombudsman
Frank Murray, Yakima County Juvenile Court CASA & Diversion Supervisor, Yakima County Superior Court
Sharon Ostheimer, Social Worker 4 Supervisor, Children's Administration, Region 1 North

Facilitator
Marilee Roberts, Practice Consultant, Field Operations, Children's Administration

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Executive Summary

On October 27, 2011, the Department of Social and Health Services (DSHS), Children's Administration (CA) convened an Executive Child Fatality Review (ECFR)[26] of the case involving the death of 21-month old, M.S. (DOB: 09-14-2009; DOD: 7-2-11). M.S. was a dependent of the state at the time of her death. She had recently returned home on trial return home on June 7, 2011. A committee that included community professionals and CA staff reviewed case documents and interviewed CA staff to examine child welfare practices, system collaboration, and service delivery to M.S. and her family.

On July 3, 2011 the Guardian ad Litem (GAL) supervisor assigned to M.S.'s dependency case reported to CA's Central Intake office that she had been notified by the child's family that M.S. drowned in the family's above ground pool on the evening of July 2, 2011. The referrer reported she was told the child's mother was on a cell phone when she saw M.S. go outside the family home. M.S.'s mother, E.S., assumed she was being supervised by her father who was outside with their other child at the time. However, according to the referrer, M.S.'s father (R.A.) was in another part of the yard playing with M.S.'s brother not near the above ground pool and unaware M.S. was outside unsupervised. The referrer reported the family's above ground pool has an attached ladder that the parents report is usually put up when the pool is not in use; however the ladder had been left attached the evening of July 2, 2011 and was accessible to M.S. The referrer reported the family called 911 and law enforcement and emergency medical technicians responded, performed CPR at length, but were unable to revive M.S.

An autopsy was performed at the request of Yakima County Coroner's Office noting *Cause of Death – Probable Fresh Water Drowning – Asphyxia, Manner: Accidental.*

The family's CA history includes 13 intakes of child abuse and neglect. The incident which led to M.S. and her sibling being placed in out-of-home care occurred in May 2010. On May 12, 2010 M.S. was transported to Sacred Heart Hospital in Spokane after being left unsupervised in the bathtub and the victim of a near-drowning. As a result of this incident law enforcement officials placed M.S. and her older sibling into protective custody and upon release from the hospital M.S. was placed in the same foster home as her sibling. A dependency was established in July 2010. Following a year in out-of-home care and services provided by CA, M.S. and her brother were returned home on trial return home in June 2011.

[26] Given its limited purpose, a Child Fatality Review by Children's Administration should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. A review is generally limited to documents in the possession of or obtained by DSHS or its contracted service providers and the panel may be precluded from receiving some documents that may be relevant to the issues in a case because of federal or state confidentiality laws and regulations. A review panel has no subpoena power or authority to compel attendance and generally will only hear from DSHS employees and service providers. The panel may not hear the points of view of a child's parents and relatives, or those of other individuals associated with a deceased child's life or fatality. A Child Fatality Review is not intended to be a fact-finding or forensic inquiry or to replace or supersede investigations by courts, law enforcement agencies, medical examiners or other entities with legal responsibility to investigate or review some or all of the circumstances of a child's death. Nor is it the function or purpose of a Child Fatality Review to take personnel action or recommend such action against DSHS employees or other individuals.

A case summary relating to M.S. and her family was prepared and provided to the ECFR committee. A copy of the family's case file was also available to the committee. During the course of the review the committee discussed issues related to service delivery, the significance of patterns identified in the case regarding allegations reported to the department, domestic violence, and substance abuse. Committee members interviewed the GAL supervisor and the social worker assigned to the case at the time of the death of M.S. The committee's discussion addressed issues related to the coordination of communication between service providers, critical thinking, shared decision making, and case elements.[27] Following a review of the family's history, case records and discussion, the committee made findings and recommendations that are detailed at the end of this report.

Case Overview

Child Protective Services (CPS) history related to M.S.'s mother's family dates back to 2001, when the mother, E.S., was 14-years old. Several intakes identify M.S.'s mother, E.S., as a victim of third party[28] sexual abuse along with repeated requests for services from the family due to family conflict.[29] M.S.'s father's (R.A.) does not present with any history as a child. However, there are several reports to law enforcement referencing R.A.'s family which involve allegations of family conflict and domestic violence.

E.S.'s CPS history as the subject of child abuse and neglect to her own children includes 13 intakes beginning in February 2008. Intakes include allegations related to chronic neglect due to substance abuse and domestic violence. Of the 13 intakes, 7 screened in for CPS investigation, 2 as Low Risk-Alternate Intervention, and 4 screened out (did not meet the Washington Administrative Code[30] [WAC] definition of child abuse and neglect to screen in for investigation). FamLink[31] records note findings regarding the 7 investigations resulted in 4 founded findings referencing neglect and negligent treatment[32] and 3 unfounded. R.A. is associated with 4 intakes (beginning in May 2010) referencing M.S. and her sibling (an older brother)[33]; 2 in which he is identified as a subject of abuse and neglect that resulted in founded findings for neglect and negligent treatment.

In May 2010, CA initiated an investigation in collaboration with law enforcement into allegations of neglect (lack of supervision) after it was reported M.S. had nearly

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[27] Activities conducted according to CA Practice and Procedure Manual and Case Services Manual e.g.) Monthly Social Worker Visits, Documentation, Investigation Criteria, Intake Decisions, etc.

[28] Source: Practice and Procedures Guide - Chapter 2 Section 2210 (H) Third party sexual abuse refers to allegations of sexual abuse of a child by someone other than the child's parent. Third party sexual abuse is generally investigated by law enforcement agencies.

[29] Intakes received were requests for services to address E.S.'s running away, failure to attend school, substance abuse and juvenile delinquency issues.

[30] Source: WAC 388-15-009 What is Child Abuse and Neglect?

[31] FamLink is Children's Administration's management information system.

[32] Allegations in the intakes received detailed issues related to lack of supervision and substance abuse.

[33] M.S. has three brothers; one who lives with his father who is not a dependent, and two others; one older who was part of the May 2010 dependency matter and a younger brother born during the dependency who was not placed in out of home care.

drowned in the family bathtub. It was reported her father had placed M.S. in the bathtub while her mother was outside with their other child. M.S.'s father then left to take the garbage out while seven-month-old M.S. remained in the bath tub. It was reported M.S.'s parents proceeded to argue in the front yard when they realized M.S. was left unattended in the bathtub. Collaterals provided a consistent explanation to the incident and M.S.'s father took responsibility for the incident. As a result of this incident a founded finding was made and a petition to remove M.S. and her brother from the family home was filed in court due to continuing concerns for their safety. Upon release from the hospital, medical staff expressed concern about developmental delays noted during M.S.'s hospitalization that were not related to the drowning incident but more likely to ongoing neglect of M.S. by her caregivers. The shelter care hearing was held on May 17, 2010, and the court ordered the children to remain in out-of-home care until services could be provided to address safety threats and parental protective capacities. Dependency for both children was established in July 2010.

CA provided services during the dependency process which included drug and alcohol assessments, individual counseling, domestic violence, anger management and visitation. Service providers reported although the parents were slow to engage in services, they did begin to comply in their attendance and noted some progress in addressing issues related to parenting, substance use,[34] and relationship issues. Disclosure of domestic violence was made by M.S.'s mother in December 2010, however she recanted shortly thereafter. Follow up regarding possible domestic violence in the home was included in services addressing anger management and relationship issues; however a referral or consultation with a domestic violence program was not noted in the case record.

During the course of the dependency and prior to the return home of the children, CA received three intakes following visits in the parental home. The referrer (foster parent) reported concerns regarding bruises to the children and hygiene issues following visits. Following investigation of the three intakes, unfounded findings were made. In May 2011, as required by policy prior to returning children home, the case was staffed with the local Child Protection Team[35] (CPT). The CPT, after consultation with the assigned social worker and GAL, agreed that return home was an appropriate plan with the condition the case remain open for a minimum of six months and the family continue to participate in any identified services (domestic violence referral was recommended). The children were returned home following court approval on June 7, 2011. The assigned social worker conducted a monthly health and safety visit on June 10, 2011

[34] Case documentation notes both parents participated in random urinalyses during the course of the dependency. Attendance and follow through in recommended treatment was sporadic.

[35] Source: CA Practice and Procedures Manual Chapter 2500 Section 2562 (2) (b) (iii) Child Protection Teams CPT consultation is required: *"In all cases prior to return home or dismissal of dependency, when the child is age six or younger and any risk assessment has resulted in a risk level of moderately high or high risk."*

according to CA Policy[36] noted no concerns, and the children were doing well in the family home. CA policy requires two health and safety visits each month for children returned home on a trial return home for the first 120 days.

On July 3, 2011 CA received the intake noting the death of M.S. CA and Grandview Police Department initiated an investigation into the death and determined M.S., then 17 months old, was outside the family home unsupervised and accidently drowned in the above ground pool located on the family property.[37] The Yakima County Coroner determined cause and manner of death: probable fresh water drowning – asphyxia, accidental. CA's fatality investigation resulted in a founded finding of neglect/negligent treatment against M.S.'s mother. Following CA's intervention and with the assistance of law enforcement based on concerns for child safety and the parents' ability to supervise their children, the surviving siblings[38] were placed in out of home care[39] on July 4, 2011.

Review Committee Discussion and Findings

To develop a thorough understanding of the family and case, the review committee identified dynamics that appeared to influence decision-making by the department, e.g., intake screening decisions and investigations, identification and assessment of family dynamics and how they affected parenting, service delivery and progress, and placement decisions. The committee requested and met with the Child Family Welfare Services (CFWS) social worker assigned to the case at the time of the death of M.S. and the GAL's supervisor.

Casework: The committee discussed at length the CPS investigations and CFWS case management decisions made in this case over the course of the family's involvement with CA. They found the following:

- **Intake screening decisions**: Intakes received on January 28, 2009, March 18, 2009, and August 9, 2009 were screened out recommending no need for intervention by CA. Allegations referenced illicit substance use by M.S.'s mother while pregnant and concern for safety of other children while she was using. The intakes did not note allegations of child abuse or neglect as defined by WAC 388-15-009. However the committee found based on the mother's documented substance abuse history and previous founded findings the intakes merited intervention and recommended they should have screened in as CPS Risk Only.[40]

[36] Source: CA Practice and Procedures Manual Chapter 4420 Social Worker Monthly Health and Safety Visits

[37] The family property included several mobile homes and one fixed dwelling. During the investigation it was noted the above ground pool located on the back of the family property could not be seen from M.S.'s family home.

[38] M.S.'s older brother, already a Washington dependent and a third child born during the course of the dependency (November 2010) were placed in protective custody.

[39] Children were placed in licensed foster care as there were no relatives deemed available at the time for placement.

[40] Source: CA Practice Guide to Intake and Investigative Assessment, Chapter 4, page 25: CPS Risk Only Intakes are defined as intakes that do not allege child abuse and neglect as defined by WAC 388-15-009, but have risk factors that place a child at imminent risk of serious harm.

- **Investigation and case management elements**: The committee found some case elements required by CA policy did not occur. Investigative and case management standards should include:
    - Collaborating with law enforcement when parallel investigations are occurring (especially in cases of a child fatality) as defined by the respective county's established protocol.[41]
    - A review of the family history to gain an understanding of previous interventions and as a means to identify patterns of parental behaviors that affect child safety.
    - Obtain sufficient collateral information which may include a child's medical records, and interviews with sources familiar with the family.
    - Seek and document information obtained from service providers that address behavioral progress in services not just compliance. Committee members found case documentation was minimal which affected decision making.
    - Social worker monthly health and safety visits occurred both in the family home and while the children were in out-of-home placement throughout this case according to policy. Current policy[42] includes observations of the home environment shall be completed at the time of the visit. However, the committee found current policy does not recommend observations of the areas outside the home to check for safety hazards.
    - CA policy requires a Family Team Decision Making (FTDM)[43] meeting to be held when considering reunification. Committee members noted a Child Protection Team (CPT) staffing occurred as required by policy; however a FTDM was not scheduled prior to return home in June 2011.

- **Recommendation for service intervention:** In June 2008 and August 2008 following investigations which resulted in founded findings for neglect/negligent treatment due to substance abuse and lack of supervision the committee found family dynamics supported at minimum offering and referring the Family to Family Voluntary Services.[44] Given the dynamics the committee found the case needed monitoring to ensure parental follow through and child safety. CA closed the case in July 2008 without verifying that M.S.'s mother had entered treatment, offering services, and ensuring family members were providing care and supervision of her children. A subsequent intake was received shortly after case closure in August 2008 referencing that a child belonging to E.S. was found outside in the street without supervision. Relatives once again agreed to care for

[41] Source: RCW 26.44.185 County protocols referencing child fatalities, child physical abuse and chronic neglect cases.
[42] Source: CA Practice and Procedures Manual Chapter 4420 (B) (1) Social worker visits with child
[43] Source: CA Practice and Procedures Manual Chapter 4302 Family Team Decision Making Meetings
[44] Family Voluntary Services are voluntary and the family has no court involvement. CA and the family develop a time-limited agreement based on the family's needs that outlines the services offered to improve their child's health and safety.

the children, however this was not monitored. Case record notes two Family Team Decision Making (FTDM) meetings were held between June and August 2008 in which relatives agreed to care for the children while M.S.'s mother entered substance abuse treatment. The case remained open for two months (closed in October 2008), however the case record does not reflect the case was monitored during this time nor was a safety or service plan developed. The case closed without verifying treatment attendance.

Patterns: The committee observed that a pattern of child abuse and neglect reports to the department had occurred from 2008-2011 (13 intakes in 3 years). The presence of multiple risk factors and safety threats existed throughout the record consistently, creating the need to thoroughly assess the family in order to gain an understanding of the parents' ability to safely parent their children. When assessing for present and impending danger for a child, CA policy directs that staff be aware of the heightened risk to children when the parent shows a pattern of failing to meet the child's physical, medical, educational and emotional needs (e.g. repeated disclosures of domestic violence, supervision issues and illicit substance abuse[45]).

Intakes and inconsistent compliance in services noted in this case demonstrated a pattern in parental behavior directly impacting the health and safety of their children. The committee found recognizing and understanding the pattern of behaviors and events, verified through collateral sources, can support intervention (taking action) and subsequent decision making to increase child safety while assessing a parent's ongoing progress in improving their protective capacities. Diligent efforts in locating, accessing and utilizing information from other sources assists in keeping children safe and identifying family patterns can affect decision making[46], service needs and case plans.

Service Needs and Follow Through: The committee observed that CA staff accurately identified substance abuse and domestic violence issues in this case which directly impacted parenting capacities. Information provided by the social worker and the GAL supervisor indicated that although no significant defining event had occurred in this family following the children's out-of-home placement in May 2010, it appeared the family minimized the impact domestic violence and substance use had in meeting their children's safety needs. Recommendations and referrals for services were appropriately generated to support the family in developing an understanding as to how these issues operated in their home and what safety tasks and services were needed to increase their children's health and safety.

CA staff consult with subject matter experts[47] to assist in providing services and effecting behavioral change in families. Consistent communication should not rely exclusively on written reports, but can include telephone contact and providers

[45] Substance abuse and domestic violence was identified as major issues in this case. The committee observed the parents' follow through with these issues was inconsistent throughout involvement with CA staff.
[46] Decisions such as those made on new intakes or the need for out of home placement or services.
[47] In this case domestic violence and substance abuse providers.

inclusion in any identified staffing, which contacts must subsequently be documented according to CA policy.[48] Information shared should focus on a parent's treatment progress rather than just attendance.

Recommendations

Casework: The committee noted CA practice and procedures provide guidance to assist social workers in fulfilling case requirements. The committee confirmed the need to gather and verify information provided by a parent through the use of collateral sources, direct observation and communication, shared planning meetings, supervisor consultation and collaborating with subject matter experts. This collaboration and communication assists in completing a thorough assessment of a family

In referencing social worker monthly health and safety visits the committee recommends enhancement to the existing policy to include an outside perimeter assessment of a home. It was recommended CA could utilize information contained in the C-POD Guidelines[49] (Collaboration, Preservation, Observation and Documentation) used by first responders when responding to child fatalities and serious physical injury cases. The ***observation*** component includes information on how to assess both the outdoor and indoor environment of a home/facility.

Patterns: During the review, the committee learned about CA's implementation of a new Child Safety Framework in November 2011 that supports and assists social workers in assessment, identification, and management of safety threats throughout the life of a case. The patterns in this case of child abuse and neglect reports, domestic violence, and substance abuse would be thoroughly identified in the new assessment, moving the practice away from incident-focused work to a comprehensive assessment of how this family functioned. The Child Safety Framework also stressed the importance of verifying information gathered (from parents) by contacting collaterals and other child welfare partners working on a case.

The framework also suggests critical thinking and shared decision making through clinical supervision and multidisciplinary team staffings assists in understanding family patterns and helps to mitigate bias in casework.

Service Needs and Follow Through: The committee found that given the complexity regarding domestic violence and substance abuse it is recommended on-going training and regular consultation regarding these issues occur for staff. Assessment of parental issues and deficiencies is critical in developing case plans and improving child safety within families. A domestic violence training curriculum that addresses the broad spectrum of domestic violence to include topics such as perpetrator assessment and accountability, treatment recommendations, understanding patterns and cycles, and safety planning is recommended. A substance abuse training curriculum that assists

[48] Shared Planning Meetings, Family Team Decision Making meetings, MDTs, etc.
[49] Source: Washington Criminal Justice Training Commission's C-POD Guidelines for First Responders.

social workers in understanding the progress of addiction as well as recovery would be beneficial. Training could be conducted in person or through on-line resources.

Supervisor Consultation: CA policy[50] supports supervisors conducting monthly case reviews with their staff and documenting in FamLink. The committee found that while thorough guidance is provided in the policy, additional direction and training would be beneficial to frontline supervisors for the purposes of case consultation and supervision. The committee identified the 3 week Academy for supervisors provides an introduction to supervision, however recommended follow up training for supervisors that would address topics such as coaching, mentoring, counseling, interaction, and clinical supervision. It was recommended that CA program managers consider researching the Criminal Justice Training Commission's supervisory course curriculum as a follow up training to Supervisors Academy.

[50] Source: CA Practice and Procedures Manual Chapter 46100(B)(1-3): Monthly Supervisor Case Reviews

Children's Administration
Executive Child Near-Fatality Review

C. H-M.

April 1, 2011
Date of Child's Birth

August 18, 2011
Date of Child's Critical Injury

January 10, 2012
Executive Review Date

Committee Member
Raul Estrada, Housing Manager, Yakima YWCA Domestic Violence Services
Mary Meinig, Director, Office of the Family and Children's Ombudsman
Clayton Myers, Undersheriff, Walla Walla County Sheriff's Office
Berta Norton, Area Administrator, Children's Administration, Region 1 South
Dawn Petre, Mental Health Professional, Central Washington Comprehensive Mental Health
Robin Perches, Advocate, Yakima YWCA Domestic Violence Services
Doug Savelesky, Social Worker 4 Supervisor, Children's Administration, Region 1 South

Facilitator
Marilee Roberts, Practice Consultant, Field Operations, Children's Administration

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Executive Summary

On January 10, 1012, the Department of Social and Health Services (DSHS), Children's Administration (CA) convened an Executive Child Near-Fatality Review (ECNFR)[51] of the case involving the critical injury (non-accidental traumatic head injury) of 6-month old, C.H-M. (DOB 04-01-2011). The family's case was open to child protective services for investigation at the time of C.H-M.'s injury. CA had received an intake on August 1, 2011 referencing allegations of negligent treatment of C.H-M. and her older sibling (age 4). A committee that included community professionals and CA staff reviewed case documents and interviewed CA staff to examine child welfare practices, system collaboration, and service delivery to C.H-M. and her family.

The critical incident which led to CA's involvement with C.H-M. and subsequent out-of-home placement occurred on August 18, 2011. On this date, CA's Central Intake Office was contacted by Kittitas Valley Community Hospital (KVCH) regarding then 4 month old C.H-M. who was reported to have vomited and stopped breathing. Resuscitative efforts were conducted by emergency medical technicians at the family home; when they arrived at KVCH, C.H-M. was breathing. Hospital staff noted C.H-M. presented with seizure activity indicating possible increased pressure on her brain and the need for further evaluation. Emergency room personnel reported the infant had a possible subdural hemorrhage and was being transported to Seattle's Children's Hospital. Upon arrival at Seattle Children's Hospital the child's injury was confirmed by a pediatric radiologist to be a subdural hematoma more likely than not to have been caused by non-accidental trauma. A full skeletal survey conducted at Children's Hospital did not reveal any additional injuries.

While at Seattle Children's Hospital, Jared Mosebar, C.H-M.'s father, met with law enforcement officers and initially provided several explanations as to what had happened to C.H-M. He later admitted to becoming increasingly frustrated with her as she had been throwing up, was difficult to feed, and irritable. He stated he held her face down and shook her excessively. As a result of his admission he was arrested and charged with Assault of a Child in the 2nd Degree, Domestic Violence and transported to Kittitas County Jail. He remains incarcerated at this time pending trial in January/February 2012.

[51] Given its limited purpose, a Child Near Fatality Review by Children's Administration should not be construed to be a final or comprehensive review of all of the circumstances surrounding the critical injury of a child. A review is generally limited to documents in the possession of or obtained by DSHS or its contracted service providers and the panel may be precluded from receiving some documents that may be relevant to the issues in a case because of federal or state confidentiality laws and regulations. A review panel has no subpoena power or authority to compel attendance and generally will only hear from DSHS employees and service providers. The panel may not hear the points of view of a child's parents and relatives, or those of other individuals associated with a deceased child's life or fatality. A Child Near Fatality Review is not intended to be a fact-finding or forensic inquiry or to replace or supersede investigations by courts, law enforcement agencies, medical examiners or other entities with legal responsibility to investigate or review some or all of the circumstances of a child's death or critical injury. Nor is it the function or purpose of a Child Near Fatality Review to take personnel action or recommend such action against DSHS employees or other individuals.

C.H-M's family history with CA consists of eleven intakes between December 2007 and October 2011 and includes allegations of neglect/negligent treatment; primarily issues related to domestic violence, environmental concerns, and supervision. Of the eleven intakes, eight screened in and were assigned for investigation or an alternative intervention and three intakes were screened out noting no allegation of child abuse or neglect was made. C.H-M's mother is noted as a subject in seven of the eight intakes assigned for investigation and her father in four intakes assigned for investigation.

A case summary relating to C.H-M. and her family was prepared and provided to the ECNFR committee. In addition, a copy of the family's case file was also available to the committee. During the course of the review, the committee discussed issues related to CPS interventions (investigations and on-going services), service delivery, shared decision making, and collaboration. Committee members met with the social worker assigned to the case at the time of C.H-M.'s injury. Following a review of the family's history, case records and discussion, the committee made findings and recommendations that are detailed at the end of this report.

Case Overview

Child Protective Services (CPS) history related to C.H-M.'s mother's family dates back several years and includes a period of time in which C.H-M.'s mother was a dependent of the state of Washington for two years. C.H-M's father's history includes several intakes identifying her father as a victim of child abuse and neglect; however he was not removed from his parent's care.

C.H-M.'s mother's CPS history as a subject of child abuse and neglect began in December 2007 referencing C.H-M.'s older sibling. Intakes received include allegations related to poor supervision, domestic violence, unsafe living conditions, and being left in the care of inappropriate caregivers. Investigations into allegations related to the intakes assigned for investigation did not result in any founded findings. The family presented as cooperative and engaged in remedying any safety issues, when identified.

The review committee learned CA received two intakes in May 2009 referencing living conditions in the family home and supervision of C.H-M.'s sibling. As a result of these two intakes and the family's history of involvement with the Children's Administration, CA kept the case opened for five months. However, the case did not formally transfer to Family Voluntary Services (FVS) nor did CA offer or provide any services to the family at this time. The case remained open for monitoring and closed in October 2009 without the benefit of a Child Protection Team[52] staffing despite a moderately high risk assessment score.[53]

[52] Child Protection Team (a committee made up of community representatives) staffing is required at case closure when the risk assessment for the family is identified as moderately high to high and a child in the home is under the age of 3.
[53] CA employs a risk assessment tool to assist social workers in completing a household-based assessment focused on the characteristics of the caregivers and children living in that household. By completing a risk assessment CA can obtain an objective appraisal of the risk to a child. CA Practice and Procedures Chapter 2541 Structured Decision Making

It was not until June 2011 when CA screened in the first intake referencing C.H-M. while in her parents' care. This intake resulted in a low risk response to allegations that C.H-M. and her sibling were being left if the care of an inappropriate caregiver. Following a visit from a CA social worker and several collateral contacts it was determined C.H-M. was not in present danger and the intake was closed.

In August 2011, CA received two intakes referencing C.H-M. and her older sibling (4-years-old). Allegations included lack of supervision, exposure to dangerous animals and possible physical abuse of C.H-M.'s older sibling. CA initiated an investigation which included contact with the children and their parents, local law enforcement, and animal control.[54] In addition, CA obtained the children's medical records. Following the initial contact with the family CA developed a safety plan with the parents regarding the dogs in the home to ensure adequate supervision. However, prior to completing the investigation and obtaining all the collateral information CA received the second intake on August 18, 2011 reporting C.H-M.'s critical injury.

On August 18, 2011, local medical staff reported to CA that C.H-M. had suffered a severe head injury which appeared to be non-accidental in nature. In collaboration with law enforcement, CPS met with and interviewed Jared Mosebar who after attempting to explain her injury numerous times did eventually admit to shaking her several times resulting in her loss of consciousness. C.H-M. was diagnosed with a subdural hematoma the result of non-accidental trauma. Following Mr. Mosebar's admission and his subsequent arrest, CA filed a petition for custody[55] on behalf of C.H-M. and her sibling. C.H-M.'s older sibling was placed in foster care at the time and upon release from the hospital 5 days after the incident, C.H-M. was placed in the same foster home. Jared Mosebar was arrested on 2nd Degree Child Assault, Domestic Violence and remains incarcerated pending criminal trial in January/February 2012.

Discussion and Findings

To develop a thorough understanding of the family and the case, the review committee identified dynamics that appeared to influence decision-making. The committee reviewed decisions and actions taken by CA in regards to investigations, identification and assessment of family dynamics, on-going services needs, and family engagement.

Of note: The review team met with the assigned social worker at the time of the August 2011 intakes. During this interview the review committee learned that following the critical injury to C.H-M., family members came forward with additional information about significant events leading up to the date of the injury they had not disclosed to CA prior to August 18, 2011. The review committee clearly noted the information shared by family and friends post-injury would certainly have raised the level of intervention by CA if it had been known when meeting with the family in early August.

[54] The investigating social worker recognized the pattern between cruelty to animals, domestic violence and child abuse and was seeking information from local animal control regarding the family and its pets when the second intake was received.

[55] Law enforcement did not place either child in protective custody at the time of incident.

Casework: The committee discussed at length the CPS investigation decisions made in this case over the course of the family's involvement with CA. The committee found investigating social workers made active efforts to engage the family on several occasions to discuss allegations and work with the family to ensure child safety. The committee found essential investigative elements were initiated timely by staff and were recorded in the case record. The committee did find the need to strengthen information (fact) gathering during the course of CPS investigations and on-going services. Such areas include:

- Increase the development and collaboration with collateral contacts to assist in understanding family dynamics and patterns in behavior. Utilizing collateral resources[56] supports verification of information shared by family members and assists in identifying family patterns that may be contributing to child neglect.
- CA has successfully provided training to staff on how to interview children. However, the review committee found CA does not offer any training on how to interview adults, particularly those who are the alleged subjects in child abuse and neglect investigations. Assisting staff in developing adult interviewing skills supports gathering facts and supports confronting inconsistent information and behaviors.
- Being cognizant of family history when CA has had multi-generational contact[57] with a family assists in developing an understanding of family dynamics and can affect case planning.
- This case remained open from May 2009-October 2009. The review committee acknowledged given the complexity of this family's case and the identified concerns at the time the case warranted continued monitoring. However, the case was not formally transferred to Family Voluntary Services therefore, CA did not seize the opportunity to case plan thoroughly or implement services.
- CA supports shared decision making throughout the life of a case. Shared decision making supports decision making (i.e. Child Protection Team [CPT], internal staffing, multi-disciplinary staffing, etc.) that assists in understanding family patterns and identifying service needs. In this particular case a CPT meeting should have been held when closing the case[58] in October 2009 to ensure all avenues of service intervention had been explored.

Shared Decision Making: The review team found a family assessment should result in as complete a picture of a family as possible and will come from a variety of sources.[59] Critical thinking and shared decision making helps to build an understanding of a family and can take into account several areas, such as family strengths and respective challenges, which can support developing intervention strategies and case planning.

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[56] Law enforcement, DSHS database systems, National Crime Information Center, community providers, medical records, etc.
[57] The family had a previous dependency action.
[58] CA Practice and Procedures Guide Chapter 2562 Child Protection Teams
[59] Sources include medical professionals, law enforcement, schools, community services agencies to include other state agencies, etc.

The committee noted this case could have benefitted from a critical review and analysis of all information received through any number of methods; clinical supervision, case staffings, child protection teams and multi-disciplinary team staffings. The absence of a Child Protection Team staffing, when required by policy, could have assisted CA in developing a comprehensive assessment of this family. The collaborative staffing opportunity can support development of case plans that serve individual family members and support child safety.

Recommendations

- **Interviewing**: The committee acknowledged that CA provides extensive training to social workers on interviewing techniques for children, however limited training is provided on how to interview adults. CA is encouraged to explore training opportunities for frontline staff that provides direction and insight into interviewing adults. A training curriculum that can provide insights as to how to address inconsistencies in information that is critical to quality family assessments, particularly when it is contradicted by collateral information, is strongly recommended. Facilitation of such training may be available through the Criminal Justice Training Center or in partnership with local law enforcement agencies.
- **Verifying Information**: In addition to adult interviewing training, the review committee recommends CA may want to consider providing additional training on how to verify information while a case is open. Training could include identifying what information needs verification based on its significance to the investigation and how to most accurately obtain verification; for example, what resources to access and appropriate collaterals to seek confirmation.
- **Shared Decision Making**: The review committee identified the various shared decision making methods employed by CA; clinical supervision, internal staffings, multi-disciplinary staffings, shared planning meetings and Family Team Decision Making meetings. Clinical supervision based in solution based casework provides the supervisor and the social worker a common conceptual base that guides casework and supports a holistic approach to case management. The supervisor must take the lead in guiding this discussion. It is recommended CA consider providing additional training for supervisors in clinical supervision that enhances the current practice model, Solution Based Casework, and promotes continued shared decision making.