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2004 CHILD FATALITY REPORT

REPORT OF THE OFFICE OF THE FAMILY AND CHILDREN'S OMBUDSMAN

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Child Fatalities: Avoidable Tragedies

In 2004, 16 month-old Justice and 6 week-old Raiden Robinson were found dead in their home. In 2005, four year-old Sirita Sotelo was beaten to death by her stepmother. Each of these deaths shocked the conscience. They unmasked our society's inability to protect our most vulnerable. These high profile deaths galvanized advocates, politicians, parents, community members, and other citizens to take action.

Within months of the Robinson children's deaths, the Washington Legislature enacted the Justice and Raiden Act. The Justice and Raiden Act[1] allows Child Protective Services (CPS) greater ability to intervene in cases of chronic neglect. Sirita's death led to Sirita's Law, which called for a state task force to reform the child welfare system in Washington.[2] Both of these laws were inspired by the lessons learned from tragedies. They are a vivid example of positive systemic reform that can arise from a detailed review of a child fatality and a critical examination of the shortcomings in the child protection system. Other states have responded legislatively when they too have been devastated by the death of a child.[3]

The Ombudsman reviewed the fatalities of Justin and Raiden Robinson and Sirita Sotelo and developed recommendations to address:

- ✓ improving procedures for case reviews;
- ✓ implementing caseload standards;
- ✓ modifying statutory provisions governing investigations and interventions;
- ✓ requiring mental health evaluations in certain cases;
- ✓ strengthening case supervision;
- ✓ assuring appropriate services are provided; and
- ✓ improving assessment of other adult caregivers.

[1] ESSB 5922 sets forth the Legislature's intent that DSHS and the justice system intervene in cases of chronic neglect, where the well-being of a child is at risk and specifically includes a parent's substance abuse as an important factor in determining whether negligent treatment or maltreatment exists.

[2] "Sirita's Law" was named after four year-old Sirita Sotelo who was beaten to death by her stepmother in Lake Stevens, Washington. "The bill started as a three-strikes law for parents who abuse or neglect children, but it was modified to call for a task force to study the safety of children in the child welfare system." http://seattlepi.nwsource.com/local/224440_billsign16.html (Seattle PI, May 16, 2005)

[3] For example, in 1994, 7-year-old Megan Kanka was lured away from her home, raped, and killed. Megan's death led to Megan's Law, which increased community knowledge about sex offenders by providing the public with certain information on the whereabouts of sex offenders so that local communities could protect themselves and their children. Megan was a New Jersey girl who was raped and killed by a known child molester who had moved across the street from the family without their knowledge. In the wake of the tragedy, the Kankas sought to have local communities warned about sex offenders in the area. All states now have a form of Megan's Law. http://www.meganslaw.ca.gov/homepage.aspx?lang=ENGLISH. In 1996, 9 year-old Amber Hagerman was abducted and murdered while riding her bicycle in Arlington, Texas. Amber's death led to the creation of the Amber Alert System in 1996. Broadcasters team with local police to develop an early warning system to help find abducted children. AMBER stands for America's Missing: Broadcast Emergency Response. Other states have now implemented their own AMBER plans. http://www.amberalert.gov/faqs.html.

OFCO Reviewed the High Profile Child Fatalities of Justice and Raiden Robinson and Sirita Sotelo[4]

In 2004 and 2005, the Ombudsman reviewed the fatalities of Justice and Raiden Robinson and Sirita Sotelo at the request of the state Legislature. Based on reviews of these child fatalities, the Ombudsman developed several recommendations. The recommendations from the Justice and Raiden Robinson fatality review addressed:

- improving procedures for case reviews by CPS supervisors;
- implementing caseload standards for CPS workers and supervisors;
- modifying the statutory provisions governing CPS investigations and interventions; and
- requiring CPS to attempt to obtain mental health evaluations of a parent when mental health issues contribute to the alleged child abuse or neglect.

The recommendations from the Sirita Sotelo Fatality Review addressed:

- strengthening case supervision following a child's return to a parent's care;
- assuring that appropriate services for successful reunification are provided; and
- improving assessment of other adult care-givers in the parent's home.

JUSTICE AND RAIDEN ROBINSON

On November 14, 2004, 16-month-old Justice Robinson and six-week-old Raiden Robinson were found dead in their home. The children died of malnutrition and dehydration, despite food in the refrigerator and pantry. Police officers had been summoned to conduct a welfare check on the children, and a two-year-old child assisted the officers in opening the front door. Uncooked food was scattered throughout the home, indicating that the two-year-old child had been foraging for food for some time. The responding officers found the children's mother, Marie Robinson, intoxicated and passed out in a bedroom. Police officers also discovered over 300 empty beer cans in the mother's bedroom.

Ms. Robinson's history of alcohol abuse, and the related risk of harm to her children, was well known to Child Protective Services (CPS). Prior to the children's death, CPS received six referrals between 2002 and 2004 reporting chronic alcohol abuse by the mother and related physical neglect of the children. Two referrals were accepted for CPS investigation, two referrals were referred to Alternative Response Services (ARS),[5] and two referrals were screened as "information only" and were not investigated.

The Office of the Family and Children's Ombudsman conducted a case investigation of CPS' involvement with this family and the circumstances leading to Justice and Raiden's death.[6] The Ombudsman

[4] The full text of the Ombudsman's fatality reviews of the Robinson and Sotelo children is available at http://www.governor.wa.gov/ofco/reports.htm.

[5] Alternative Response Systems (ARS) "provide delivery of services in the least intrusive manner reasonably likely to achieve improved family cohesiveness, prevention of re-referrals of the family for alleged abuse or neglect, and improvement in the health and safety of children." These services are voluntary and are not intended to be investigative for purposes of determining whether child abuse or neglect occurred. RCW 74.14D.020

[6] Shortly after deciding to conduct an investigation, several legislators contacted the Ombudsman requesting a case investigation.

reviewed all records and reports from CPS, available treatment reports from service providers, ARS records, as well as applicable Children's Administration (CA) Policy and Procedure, and state law. The Ombudsman also interviewed CA staff. The purpose of the Ombudsman's investigation was to determine whether CPS responded to reports of child neglect secondary to Ms. Robinson's alcohol abuse, in a manner consistent with department policy and state law, and to identify changes in law, policy and procedure that will better protect children from abuse and neglect.

Justice and Raiden Fatality Findings

1. **CPS investigation and case activities were not completed in a timely manner**. For example, CPS failed to complete an investigation within 90 days of a referral received on February 7, 2004.[7] This referral was accepted for a high standard investigation. CA procedures required, at that time, that in a high standard investigation the assigned social worker must "interview child victims face-to-face within 10 working days from the date of referral."[8] On March 1, 2004, 23 calendar days and 15 working days after the referral was received, the CPS worker completed an initial face-to-face interview with the mother, father and two children. The referral remained open at the time of Justice and Raiden's death, nine months later.

2. **CPS investigations were inadequate and insufficient.** In the course of its investigations, CPS did not obtain relevant collateral information from sources such as medical professionals, law enforcement, or service providers.[9] For example, on October 8, 2003 CPS accepted for investigation a referral stating: the mother just completed drug/alcohol treatment 30 days ago and has now relapsed; the children were filthy, had feces all over and had urinated in their pants; and they had not been fed and were starving.

   CPS failed to obtain the children's medical records, or interview medical providers, regarding allegations that the children were filthy and starving. A review of medical records[10] shows that while CPS was conducting its investigations, Justice was seen by a pediatrician on October 29, 2003 for failure to thrive, he had not gained weight in the past month, and in the four months following his birth, he had dropped from the fiftieth to the tenth percentile in weight. Because no inquiries were made, this information was not known to CPS, and the correlation between the mother's binge drinking and the child's failure to thrive was not addressed.

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[7] Children's Administration Practices and Procedures Guide, Section 2520 states: "The social worker shall complete an investigative risk assessment on all investigations of child abuse and neglect upon completion of the investigation and no later than the 90th day after the referral is received unless the requirement is waived by the supervisor . . . ."

[8] Id. Section 2331(D)(2). On August 8, 2005, at the direction of Governor Gregoire, DSHS implemented a requirement that social workers must now interview child victims within 72 hours of moderate to high risk referrals. Interviews must take place within 24 hours in emergent cases.

[9] Id. Section 2331(D)(27) states: "The assigned social worker must: . . . Interview . . . professionals and other persons (physicians, nurse, school personnel, child day care, relatives, etc.) who are reported to have or, the social worker believes, may have first-hand knowledge of the incident, the injury, or the family's circumstances."

[10] The children's medical records were obtained by DSHS CA after repeated requests by the Ombudsman in the course of the Ombudsman's fatality review.

3. **Inadequate factual basis to support CPS' investigative findings.** CPS' conclusion that the referral received on October 8, 2003 was "Unfounded"[11] for child abuse or neglect, was not adequately supported by the information available to the CPS worker. Specifically, the allegation was not refuted that the children were filthy, had feces all over and had urinated in their pants, had not been fed and were starving at the time of the mother's relapse. Additionally, the mother admitted a history of alcohol abuse, treatment and relapse. Moreover, there was no independent information in support of CPS' conclusion that the mother was hospitalized due to low potassium levels, not alcohol consumption, and no independent information regarding the health and welfare of the children.

4. **CPS case records contain several instances of inaccurate or misleading entries.** In each case, these statements minimize the gravity of the mother's history of alcohol abuse or the potential risk to her children. For example, an Investigative Assessment of December 11, 2003 erroneously states "No prior hx [history] with WA CPS." At that time however, the mother had two prior reports to CPS alleging alcohol abuse and related neglect, which were referred to ARS. This Investigative Assessment also stated: "Mother appears to understand addiction process well and sees how she needs to maintain sobriety." The worker failed to record in this assessment that the mother's alcohol evaluation states that Ms. Robinson had not committed to treatment at that time, and that she failed to comply with an agreed Safety Plan. Similarly, a Transfer/Closing Summary dated December 16, 2003 also omitted information that Ms. Robinson did not engage in recommended treatment.

5. **CPS Service Agreements failed to compel the mother to engage in services or reduce the risk to her children.** Twice CPS entered or offered a service agreement, requiring the mother to seek treatment for her alcohol abuse. When these attempts were unsuccessful, CPS did not take additional steps to compel the mother to seek treatment.

6. **Alternative Response Systems (ARS) services failed to adequately assess or address the mother's needs.** In September 2002, CPS received two referrals concerning alcohol abuse, mental health, and child safety issues. Instead of opening these referrals for CPS investigations, they were accepted and referred to the Alternative Response System, which provides services but does not conduct investigations.

7. **Inappropriate Screening Decision by CPS Intake.** Two CPS referrals received in September 2002 were referred to ARS, and were not investigated by CPS. The second referral, received on September 17, 2002, stated that the mother had been hospitalized for suicidal ideation, that she was discharged on that date (9/17/02) and was still expressing concerns about hurting herself. The referral also stated that the mother reported there was no food in the home, and that the mother lived alone with her six month-old baby.

   This referral was initially accepted for CPS investigation, with a risk tag of 5. After reviewing the referral, the CPS intake supervisor reduced the risk tag from 5 to 2 stating: "ARS Wkr [worker] is

[11] Children's Administration Practices and Procedures Guide, Section 2540(A) provides: at the conclusion of a CPS investigation, "the worker must complete a CAMIS Investigative Risk Assessment (IRA) which includes: . . . a record of case findings regarding alleged abuse or neglect. [Findings are based on the following definitions:] (a) **Founded** means: Based on the CPS investigation, available information indicates that, more likely than not, child abuse or neglect as defined in WAC 388-15-130 did occur. (b) **Unfounded** means: Based on the CPS investigation, available information indicates that, more likely than not, child abuse or neglect as defined in WAC 388-15-130 did not occur. (c) **Inconclusive** means: Following the CPS investigation, based upon available information, the social worker cannot make a determination that, more likely than not, child abuse or neglect did or did not occur."

involved with services and client is receptive to services." CA Practices and Procedures permit the intake supervisor to change the risk tag and screening decisions when "additional information supports the change."[12] Here however, there is no documentation, either by the intake supervisor, or the ARS worker, that the supervisor obtained information from ARS regarding specific services provided to Ms. Robinson or the level of her compliance.

Justice and Raiden Fatality Recommendations

Recommendations Regarding Children's Administration Policy

- **Improve Supervisory Reviews of CPS Investigations.**

  High quality and timely supervisory reviews are essential to ensuring that investigations are conducted in a manner consistent with best practices and agency policy and procedure.

- **Case referral to Alternative Response Systems should not preclude investigation by CPS.**

  CA Policy should be amended to provide that in addition to providing ARS services, CPS may conduct investigations into allegations of child abuse or neglect.

- **Implement Caseload Standards.**

  In order for CPS workers to conduct thorough and timely investigations, assess risk and child safety, engage families in essential services, and monitor case progress, CA must establish and implement reasonable caseload standards. While computing caseloads is an inexact science, the Child Welfare League of America (CWLA) recommends that CPS workers be limited to 12 active investigations per month.[13] CA should use this as a guide in determining and implementing caseload standards.

State Law Recommendations

- **Modify the statutory definition of child abuse and neglect and allow CPS to intervene earlier in an investigation to protect children at risk of abuse or neglect.[14]**

  The Legislature should consider amending the definition of child neglect, to recognize the harm that may result from an act or omission, or pattern of conduct, that constitutes a substantial danger to the child's health, welfare or safety, and allow earlier CPS intervention. The Legislature should consider changes to statutory provisions regarding child abuse and neglect, permitting the court to establish an in-home dependency for the purpose of implementing appropriate service and safety plans. A parent's failure to comply with a service plan or safety plan is a relevant factor which should be considered when determining whether conditions present a substantial threat of harm to the child.

- **Require CPS to attempt to obtain an evaluation when it is determined that mental health issues are a contributing factor to the alleged child abuse or neglect.**

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[12] Id. Section 2220(F)(2).

[13] CWLA Guidelines for Computing Caseload Standards, http://www.cwla.org/programs/standards/caseloadstandards.htm.

[14] The Ombudsman previously made this recommendation in the Office of the Family & Children's Ombudsman 2000 Annual Report. The Legislature modified the definition of abuse and neglect by passing ESSB 5922.

When substance abuse is a contributing factor to alleged child abuse or neglect, state law requires CPS to cause a comprehensive chemical dependency evaluation to be made.[15] Similar statutory requirements should exist to identify and treat mental health issues contributing to the neglect or abuse of a child.

SIRITA SOTELO

Three weeks before she was born, Sirita[16] Sotelo was the subject of a CPS referral, alleging prenatal substance abuse by her mother. After she tested positive for cocaine at birth on February 12, 2000, CPS filed for dependency and placed Sirita in foster care.

Over the next three years, the department made numerous attempts to reunite Sirita with her mother. Services were provided to address the mother's substance abuse and mental health issues. Four times Sirita was placed with her mother, only to again be removed due to allegations of abuse or neglect. During this period, Sirita experienced seven different placement episodes, alternating between foster care and placement with her mother. She spent over 25 months in foster care, in eight different foster homes,[17] and 19 months placed with her mother. Significant periods of placement with the mother lasted four months, five months and ten months. While efforts were being made to reunite Sirita with her mother, the child's father, Mr. Ewell, who was notified of the dependency action, did not involve himself in the dependency process, or seek placement of Sirita.

In May 2003, the department filed for termination of parental rights, based on the length of time Sirita had been in state care, the failed reunification attempts with the mother, and the father's lack of participation in the dependency action or reunification efforts. However, after learning that the department was seeking to terminate parental rights, Sirita's father stepped forward and requested that she be placed with him and his wife. The department then conducted a home study and developed a service plan for the father, which included a drug/alcohol assessment, parenting classes, weekly visits with Sirita, and a psychological evaluation. The father successfully completed these services, and in November 2003, Sirita was placed with her father, stepmother and their four children.

Over the following 12 months, the department continued to supervise Sirita's placement with her father and provide case management services. Monthly visits to check on Sirita's health and safety occurred in December 2003, January 2004, February 2004, and the last visit occurred in May 2004. Although caseworkers identified a need for counseling, this service was not implemented. In November 2004, the dependency was dismissed, as the father had established a parenting plan gaining custody of Sirita.

On January 22, 2005, only two months after the dependency case was closed, CPS received a referral from law enforcement reporting a suspicious death of four-year-old Sirita. The stepmother and another relative had been with Sirita the night of her death and reportedly called poison control stating that Sirita had gotten sick eating glue. Later that evening, the relative checked on Sirita and found her dead, and then called 911. According to law enforcement, the child appeared gaunt, malnourished and pale. Medical examiners later determined she died as a result of blows to the head and body causing a fractured skull and severed liver. The stepmother later stated that she couldn't handle Sirita's fits and tantrums and admitted she threw her in a cold shower and beat her after the child wet her pants.

[15] RCW 26.44.170.

[16] Case records list various spellings of the child's name, including Sereta, Sireta, and Serita.

[17] Length of placement in any one foster home ranged from one night to 13 months.

The Ombudsman conducted a case investigation of the Division of Children and Family Services' (DCFS) involvement with Sirita and her parents. The Ombudsman reviewed all records and reports from DCFS, treatment reports, professional evaluations, as well as applicable CA Policy and Procedure and state law. The purpose of the Ombudsman's investigation was to determine DCFS' compliance with department policy and procedure, and state law, and to identify changes in law, policy and procedure that will better protect children from abuse and neglect.

The Ombudsman identified the following areas of concern:

- Lack of services provided to Sirita, her father and stepmother, following her placement in their care.
- Delay in establishing permanency for Sirita.
- Frequency of health and safety checks did not comply with CA policy.
- The father's and stepmother's CPS referral history may not have been fully considered prior to placing Sirita in their home.
- Although the father completed both a psychological evaluation and drug/alcohol assessment prior to Sirita's placement, there was no similar evaluation of the stepmother.

Sirita Fatality Findings

1. **DCFS delayed establishing permanency for Sirita.** Ideally, a safe, stable and permanent home for a dependent child should be achieved before the child has been in out-of-home care for 15 months.[18] In this case, Sirita was the subject of a dependency action for over three and a half years before a permanent placement with her father was established. Before she was placed with her father, Sirita experienced seven different placement episodes, alternating between foster care and placement with her mother. During this time, Sirita spent a total of over 25 months in foster care, and 19 months placed with her mother.
2. **The father's and stepmother's CPS history may not have been considered.** The screening decision not to investigate the CPS referral received in March 2001, regarding one of the Ewell's children was not clearly inappropriate or unreasonable under the circumstances according to existing CA policy.[19] As a result of this screening decision, however, concerns regarding substance abuse and criminal conduct in the home were never investigated. Additionally, the department's consideration of Mr. Ewell as a potential caregiver for Sirita, erroneously concluded he had a clean slate with CPS. Although the CPT presentation summary briefly mentioned the March 2003 CPS referral stating that the father allowed Ms. Sotelo unsupervised access to his child, the summary states that there was a minimum level of risk in placing Sirita with her father,

[18] RCW 13.34.145(1)(c).

[19] Children's Administration Case Services Policy Manual, Section 2131(C) states:
"The department shall investigate complaints of any recent act or failure to act on the part of a parent or caretaker that results in death, serious physical or emotional harm, or sexual abuse or exploitation, or that presents imminent risk of serious harm, and on the basis of the findings of such investigation, offer child welfare services in relation to the problem to such parents, legal custodians, or persons serving in loco parentis, and/or bring the situation to the attention of an appropriate court, or another community agency: Provided, that an investigation is not required of non-accidental injuries which are clearly not the result of a lack of care or supervision by the child's parents, legal custodians, or persons serving in loco parentis." See also RCW 74.13.031.

in part because he had "no apparent involvement with CPS concerning his own children." Although a CPT presentation summary was prepared by the caseworker, the CPT did not occur. Consequently, a CPT did not review this case prior to the child being placed with the father.

3. **DCFS did not fail to evaluate Mrs. Ewell pre-placement.** The department did not fail to evaluate Mrs. Ewell and her capacity to provide adequate care for Sirita prior to placing her in the Ewell's home. Mrs. Ewell participated in the home study, and complied with a criminal background check. But the department did not seek further assessment or evaluation of her ability to care for Sirita. This was not clearly unreasonable under the circumstances, as the department lacked specific information or concerns that would have warranted further evaluation. However, information presented during Mrs. Ewell's criminal proceedings described events from her personal history that clearly would have justified further assessment regarding her ability to care for Sirita.
4. **Frequency of health and safety checks did not comply with existing policy.** Although both CCS and CWS caseworkers conducted home visits after Sirita was returned home, these visits did not occur with the frequency or consistency required by then existing department policy. Children's Administration Policy, in effect in 2003 - 2004, required that during the first 120 days of a child being placed back in the home, contact with the child must occur at least twice a month for children age birth through five. Sirita was placed in her father's and stepmother's home in November 2003. The CCS caseworker visited the home in December 2003, January 2004 and February 2004, in order to check on Sirita's health and safety. The CWS caseworker visited the home in May 2004. No further health and safety checks occurred after May 2004, even though the department was responsible for supervising this case for an additional 6 months.
5. **Lack of services provided to Sirita and her father and stepmother.** The predominate area of concern was the lack of services to Sirita, her father, and her stepmother following Sirita's placement in the Ewell's care. Caseworkers noted that support services were needed to assist the father and stepmother to address Sirita's behavior issues. These services, however, were not provided.

Sirita Fatality Recommendations

- **Heightened assessment of non-parent adult caregivers in the home.**

  Policymakers should require greater assessment of other adults in a parent's home, if it is likely that such person will be providing care for a dependent child on a regular basis. Stepparents or partners of a parent may be thrust into a position of providing daily care for a child with whom they are neither bonded nor related.[20] Their ability to care for a child and their family background is relevant to assessing the child's safety and welfare in the home. A criminal background check of other adult caregivers and a general home study are not sufficient to fully address these issues. At the very least, current home studies should specifically address in detail the extent and nature of care provided by other adults in the home, examine bonding/attachment issues between the child and such adults, and explore whether further evaluation/assessments of an adult caregiver is warranted.

[20] Lack of attachment between child and caregiver, and a caregiver's ambivalence towards the child, are factors identified in previous fatality reviews. See, ZyNia Nobles Fatality Review, Rafael Gomez Fatality Review and Justice and Raiden Robinson Fatalities Review.

- **Revise and implement policy requiring regular health and safety checks for children returned to a parent's care.**

  In 2001, Children's Administration implemented policy[21] requiring in-home contact with the child, twice a month, during the first 120 days of in-home placement, for children age birth to five. After the first 120 days, visits must occur at least monthly. Although this policy has remained in effect since 2001, these requirements have not been incorporated into either the Practices and Procedure Guide, or the Case Services Policy Manual. The absence of these requirements creates confusion as to whether health and safety checks for dependent children placed in a parent's home are required.

- **Increase efforts to provide services once a child is returned to a parent's care.**

  In addition to requiring regular and consistent in-home contact between the caseworker and the child and parent, the department should increase efforts to provide services to a child and family once a child is returned home. Existing tools, such as safety plans and service contracts, should be utilized to assure that families engage in appropriate services. The case record should specifically document steps taken to provide services.

[21] Children's Administration Policy 01-02,"Case Management Requirements for In-Home Dependencies" (Effective May1, 2001; revised November 1, 2002).

Child Fatalities: Opportunities for Reform

The Ombudsman monitors and recommends changes in DSHS procedures with an eye toward ensuring the health and safety of children.[1] In its capacity as a watchdog of the child protection and welfare system, OFCO routinely reviews child fatalities across the state.

In 2005, the Ombudsman dedicated additional resources to compiling and analyzing data[2] on all unexpected child fatalities in 2004 of children who were in the care of, or receiving child welfare services from, DSHS CA[3] within one year of their death, or who died while in state licensed care.[4] This sobering number totaled 87 children. The victims in these less visible cases were no less sympathetic, and the circumstances of their death were often no less egregious, than the high profile deaths of the Robinson and Sotelo children.

A thorough review of the Robinson and Sotelo child fatalities yielded valuable information about the shortcomings of the child protection system and how the system can be improved to safeguard children. We believed that a review of these lesser known cases presented a similar opportunity for reform. Our purpose was to identify critical factors and patterns so as to inform policy makers about developing better strategies to avoid these tragedies, and more simply, to show that taking the time to review fatalities yields significant information that can make a difference.

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[1] RCW 43.06A.030.

[2] OFCO receives notice of child deaths known to DSHS from an automated critical incident notifier via e-mail from the CA Administrative Incident Reporting System (AIRS). This provides the date of the critical incident and sufficient identifying information so that the Ombudsman is able to conduct further research on the child via DSHS records, law enforcement reports, medical records, and autopsy reports to create a profile of the fatality. OFCO records this profile in its data base. It includes information such as the circumstances of the death; age, gender, and race of the child; family history; child abuse and neglect concerns; and legal status of the child at the time of death.

[3] These are services provided by the Division of Children and Family Services (DCFS) within DSHS CA. "[D]CFS is the largest provider of direct client services. Children and families enter [D]CFS through three primary program areas, Child Protective Services (CPS), Child Welfare Services (CWS) and Family Reconciliation Services (FRS). These programs are responsible for the investigation of child abuse and neglect complaints, child protection, family preservation, family reconciliation, foster care, group care, in-home services, independent living, and adoption services for children age 0 to 18 years." http://www1.dshs.wa.gov/ca/about/abServices.asp

[4] OFCO's review criteria are the same factors that trigger a fatality review by DSHS CA under the law, RCW 74.13.640.

Summary and Discussion of 2004 Child Fatalities Examined by OFCO

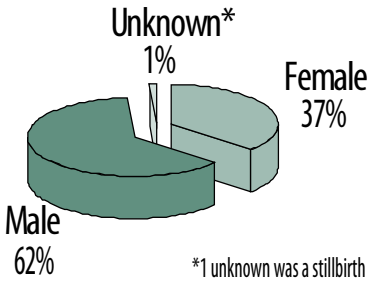
Among the 87 fatalities reviewed, just over half (44) were children who had an open case with DCFS at the time of their death. Four of these children were dependents of the State of Washington when they died.

2004 Child Fatalities by Age

Age at Time of Death	# of Fatalities	Percentage
0 (<age 1)	46	52.87%
1	3	3.45%
2	4	4.60%
3	0	0.00%
4	1	1.15%
5	2	2.30%
6	1	1.15%
7	1	1.15%
8	1	1.15%
9	1	1.15%
10	0	0.00%
11	1	1.15%
12	3	3.45%
13	2	2.30%
14	1	1.15%
15	8	9.20%
16	5	5.75%
17	7	8.05%

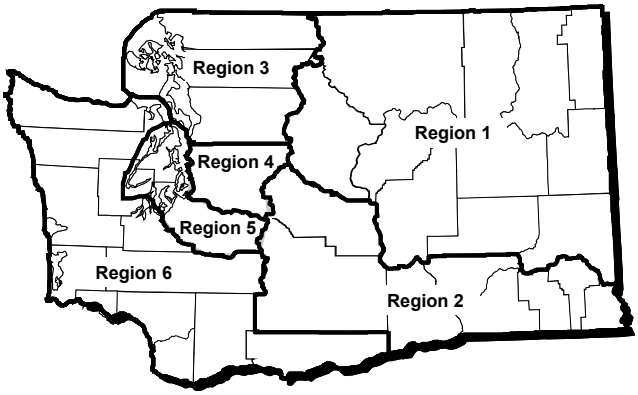
Source: Office of the Family and Children's Ombudsman, February 2006, based on analysis of DSHS CA data

2004 Child Fatalities by Gender



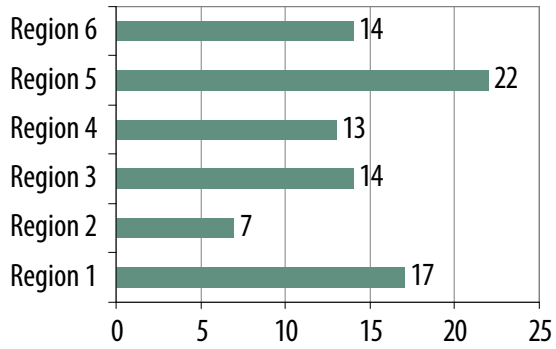
Source: Office of the Family and Children's Ombudsman, February 2006, based on analysis of DSHS CA data

DSHS Regions



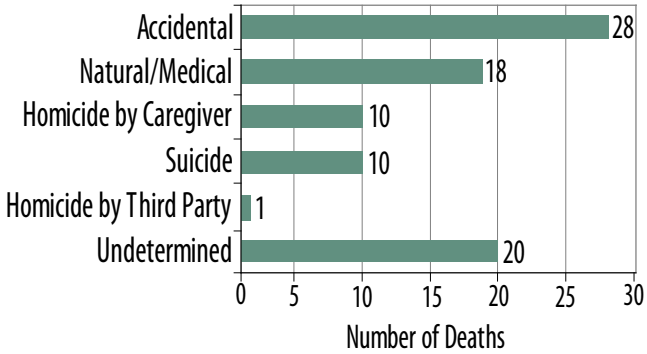
Regional Offices: Region 1—Spokane; Region 2—Yakima; Region 3—Everett; Region 4—Seattle; Region 5—Tacoma; Region 6—Vancouver

Number of Child Deaths by Region



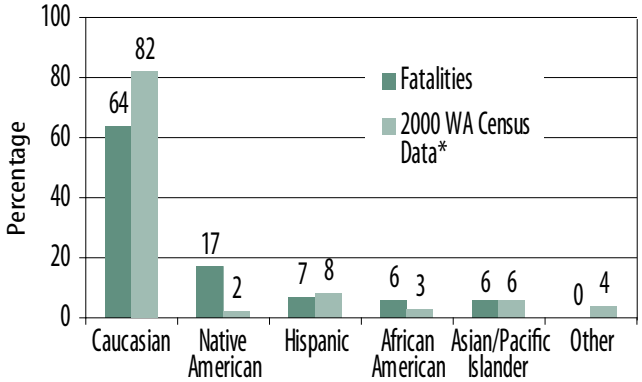
Source: Office of the Family and Children's Ombudsman, February 2006, based on analysis of DSHS CA data

Type of Death (as determined by a medical examiner or coroner)



Source: Office of the Family and Children's Ombudsman, February 2006, based on analysis of DSHS CA data

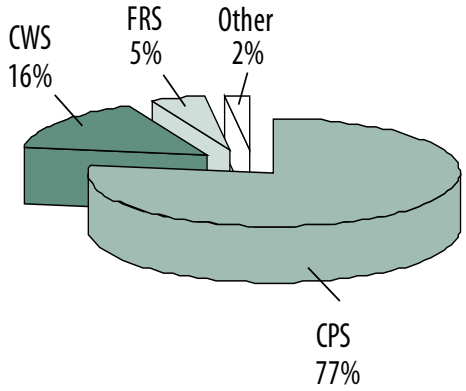
Race of Child Victims Compared to Race of State Population



*Census data adds up to over 100% because it allows people to self-identify with multiple races.

Source: U.S. Census Bureau, 2000 Census; Office of the Family and Children's Ombudsman, February 2006, based on analysis of DSHS CA data

Type of Open Case at Time of Death Total=44

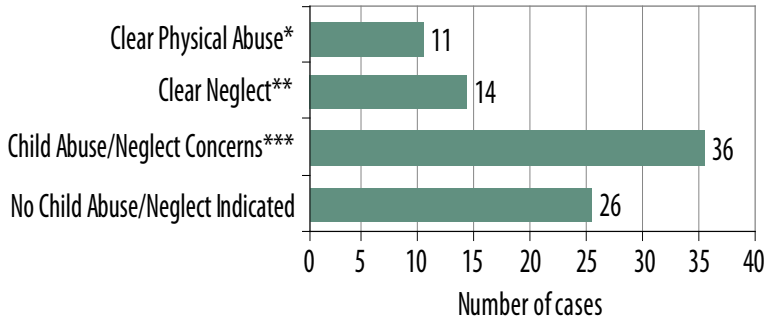


Source: Office of the Family and Children's Ombudsman, February 2006, based on analysis of DSHS CA data

Child Abuse and Neglect Concerns

The Ombudsman reviewed cases to determine if child abuse and/or neglect contributed to the fatalities, and if so, how. We found that in 11 cases (13%[5]), clear physical abuse contributed to the child's death. Clear neglect contributed to the child's death in 14 cases (16%). In 36 deaths (41%), the Ombudsman noted significant concerns about child abuse or neglect in the family's recent history, but there was no conclusive proof that the abuse or neglect was a factor leading directly to the children's deaths. In 26 cases (30%), there were no indications of abuse or neglect having contributed to the fatalities.

Child Abuse/Neglect Types
(as determined by OFCO review)



Source: Office of the Family and Children's Ombudsman, February 2006, baed on analyis of DSHS CA data

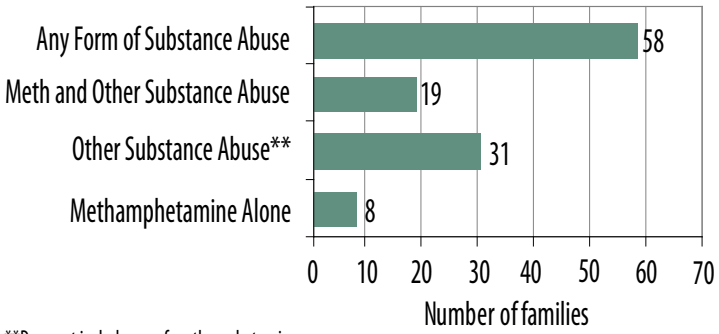
CPS Referral History

In 55 cases (63%), the child's family had been the subject of 3 or more prior CPS referrals alleging child abuse or neglect. The referrals spanned the case history of the family.

Substance Abuse

Among the children who died, 58 (67%) came from families in which one or more forms of substance abuse were noted in their CPS records. Methamphetamine abuse along with other forms of substance abuse existed in 19 case histories, and methamphetamine abuse alone in 8 cases. Other substance abuse, e.g., alcohol, cocaine, marijuana, etc. (without an indication of methamphetamine abuse) was present in 31 cases.

Substance Abuse



**Does not include use of methamphetamine

Source: Office of the Family and Children's Ombudsman, February 2006, based on analysis of DSHS CA data

Clear Physical Abuse: Case and Management Information Systems (CAMIS)† records or references from law enforcement reports noted that physical injuries, intentionally inflicted, caused the child's death.

**_Clear Neglect:_* Circumstances in the family's case history documented that neglect (e.g. leaving an infant unattended for 12 hours) clearly contributed to the child's death.

***_Child Abuse/Neglect Concerns:_* The Ombudsman found the presence of factors in the family's case history associated with abuse and neglect of children. These included factors such as substance abuse, domestic violence by the parent in the presence of children, mental health issues that impair a parent's ability to appropriately care for a child, and prior substantiated abuse of other children in the family. OFCO staff reviewed and reached a consensus to determine if child abuse or neglect contributed to the fatality in those cases where one or more of these factors were present. OFCO did not find it necessary to have a clear association between the concerns as the direct cause of the child fatality (e.g. child died from an impact injury to the head, inflicted by the parent), only that it was a contributing factor (e.g. the parent was under the influence of methamphetamine and alcohol and rolled over in bed, suffocating an infant).

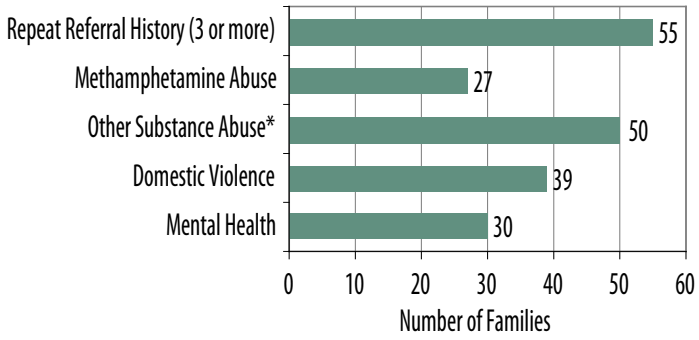
†CAMIS was developed in 1989. It is a computerized database and is the primary system used by CA to document the services it delivers to children and families statewide. OFCO has access to CAMIS.

[5] In the data presented from OFCO's analysis of 2004 fatalities, percentages have been rounded up or down for ease of interpretation.

Summary of Family Characteristics

The majority of the children who died came from families with drug or alcohol abuse and the majority had a CPS history of 3 or more referrals. Forty-one of the child victims (47%) came from families who exhibited 3 out of the 4 family characteristics typically associated with families where abuse or neglect occurs: a repeat referral history (3 or more referrals to CPS); substance abuse; a history of domestic violence; and mental health issues.

Family Characteristics



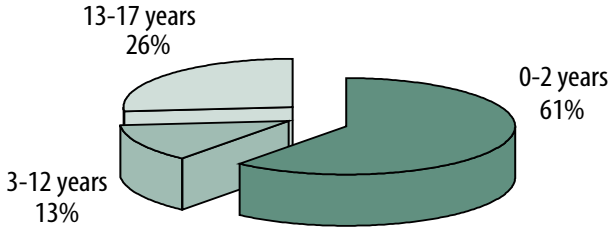
*Other Substance Abuse: Alcohol, cocaine, marijuana, etc.

Source: Office of the Family and Children's Ombudsman, February 2006, based on analysis of DSHS CA data

Vulnerability of Children by Age

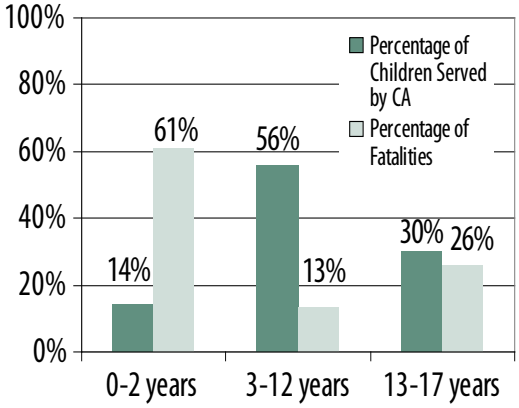
The data provides clear evidence that young children and teens comprise the largest proportion of those who died while in the care of, or who had received services from, DSHS CA in recent history—86%. Young children comprised only 14% of the children served by DSHS CA (in 2002 to 2003),[6] but were approximately 61 % of the children who died in 2004. While teens represented approximately 30 % of the children served by DSHS CA in 2002 to 2003, they were 26% of the dead children in 2004.

Age at Time of Death



Source: Office of the Family and Children's Ombudsman, February 2006, based on analysis of DSHS CA data

Fatalities Compared to Children Served by CA



Source: Office of the Family and Children's Ombudsman, February 2006, based on analysis of DSHS CA data

[6] This is based on data submitted to OFCO by DSHS CA and reflects children served between July 2002 and June 2003. Data on children served by DSHS CA in 2004, the year of deaths reviewed by OFCO, were not available. OFCO recognizes that the data provided by DSHS is for a different year than the year of deaths we reviewed, however we still believe that these numbers provide an interesting context in which to review the deaths of children in various age groups.

Ages 0-2

Summary:

Fifty-three (61%) of the children who died were age 2 or younger, with the large majority of these (46 children) being less than one year old. Thirty-four (34) of the fatalities were infants age 3 months or younger. **Sixty-eight** (68) **percent of the children were male.** OFCO found that the deaths of 8 children were clearly caused by physical abuse, 11 were clearly caused by neglect, and in 25 cases there were serious concerns of abuse or neglect in the history that could have contributed to the fatalities, but could not be clearly proven. There was an absence of child abuse and neglect indicators in 9 of the histories of these youngest children.

Children Less than One Year of Age:

More than half (46 children or 53%) of the 2004 child fatalities reviewed involved children less than one year old. Five infants—a 6-week-old, a 2-month-old, a 2 ½-month-old, a 3-month-old and an 8-month-old--died as a result of clear physical abuse, i.e. homicide by their caregivers. In eight cases, the Ombudsman found that neglect clearly contributed to the infants' deaths--two stillborn infants, a 1 month-old, a 6-week-old (Raiden Robinson), a 3-month-old, a 4-month-old, a 5-month-old, and an 11-month-old. In 25 of the fatalities in this age group, there were child abuse or neglect concerns. For 8 of the 46 fatalities of children less than age 1, OFCO could find no indications of child abuse or neglect having contributed to the deaths. **At the time of these 46 infant deaths, 25 cases were open with DCFS:** 20 within CPS, 4 within CWS, and 1 within the Division of Licensed Resources (DLR), which was investigating the facility where the child died.

Children Age One at Time of Death:

Among the three 1-year-olds who died in 2004, the Ombudsman found that serious neglect contributed to each of these deaths. Two died by drowning and the third was the fatality of 1-year-old Justice Robinson.

Children Age Two at Time of Death:

Of the 4 children who were **age 2** at the time of their deaths, OFCO found that 1 was an accidental death with no child abuse or neglect indicated. However, the other 3 deaths of 2-year-olds were the direct result of homicide by their caregivers.

Representative Case Histories:

The following are representative case histories of infant fatalities:[7]

A 3-month-old died without explanation after being left unsupervised by the parents for 12 hours. Marks were found on the infant's neck, leading to a suspicion of strangulation, but the medical examiner ruled the cause of death to be "undetermined." There were 12 prior referrals on the child's family (some of which related to the parents' history as juveniles, indicating a chronic history of intergenerational abuse). The infant's family history included substance abuse and domestic violence, and the family moved frequently between Washington and other states. The most recent referral was made about abuse of older siblings, before this infant was born. The older siblings were placed with grandparents. The CWS case was closed one month prior to the infant's death when the dependencies on the older children were dismissed. **Closed CWS case. Clear Neglect.**

A 4-month-old was found dead in a crib after being put down for a nap in the family's home. The medical examiner determined the cause of death to be "SIDS of a drug affected at birth child." Caseworker records indicate that the father provided two different accounts of his whereabouts at the time of the death—being at home and checking on the infant and gone to the store for 20 minutes. The records also indicate that drug abuse during pregnancy may have contributed to the child's death. Both parents had a history of substance abuse. Methamphetamines, cocaine and heroin were detected in the infant's system at birth. There were four prior referrals regarding allegations of prenatal injury and neglect related to drug use, the last one at the time the infant was born. The infant was placed with the father (after father had spent some time in a drug rehabilitation program) with the stipulation that the mother was to have no contact with the infant. Records indicate that this safety plan was violated when the father left the child with the mother. Father agreed to the safety plan again and the infant remained in his care. There was a report that the mother had moved and the caseworker was monitoring the safety plan. However, later records indicate that the mother had been having continual contact with this infant and her older children. The family's CPS case was open at the time of the death. **Open CPS case. Child Abuse/Neglect Concerns.**

A 3-month-old was found dead on the couch in the family's home. The medical examiner found methamphetamines and nicotine in the infant's urine but not in the infant's blood. The cause of death was determined to be "pneumonia." Both parents were suspected methamphetamine abusers and were the subject of five prior referrals regarding neglect, related drug abuse and possible sexual abuse of an older sibling. At the time of this infant's birth, the parents fled the hospital after refusing urinalyses. A few days later, a social worker made an unannounced home visit and documented possible signs of drug use. The caseworker requested that the parents submit to random urinalyses and work with a public health nurse. The parents denied drug use, refused to be tested and refused public health services. The CPS case remained open at the time of the death. There is documentation by a casework supervisor six weeks prior to the fatality that the department planned to close the case "as the allegations of mother's drug usage appear not provable" and "non-cooperation by parents. Likely that parents are using drugs and refusing all offers of services." **Open CPS case. Child Abuse/Neglect Concerns.**

A 10-month-old was found dead in the family's home, swaddled in a sleeping bag, a usual sleeping place. The medical examiner found a piece of food lodged in the child's throat and methadone in the child's system. The cause of death was determined to be "asphyxiation". In the prior year, there were four referrals on the child's teen parent regarding serious neglect related to drug abuse, domestic violence, and a documented history of the mother's mental health issues including post-partum depression (there were ten other referrals related to the parents' respective families, indicating intergenerational child abuse and neglect). The family was referred to Alternative Response Services (ARS) for counseling. A public health nurse did provide services to the family. Prior to the time of the child's death, the CPS case had been closed "due to family's relocation". The parents were reportedly out of compliance with services at the time of case closure. The social worker's closing documentation indicated that "due to low level concerns, a CPS worker in [the family's new location] would not be assigned." **Closed CPS case. Clear Neglect.**

[7] In order to protect confidentiality we have not noted the sex of the child or date of death.

A 2-month-old was found dead after sleeping in bed with the parents. The coroner determined the cause of death to be "mechanical asphyxiation". As children, the infant's parents had over 20 referrals made to the department on their respective families. As parents of this infant, they were the subject of three referrals alleging neglect and unsanitary living conditions. The most recent referral was made one week prior to the infant's death regarding concerns about the infant's sleeping face down on a waterbed, filthy living conditions and lack of supervision of the infant and toddler sibling. The referral was accepted for non-emergent investigation. Records do not indicate that there was contact between the department from the time this last referral was made and the date of the infant's death. The fatality occurred within the department's required investigative timeframe. **Open CPS case. Child Abuse/Neglect Concerns.**

A 3-month-old was found dead after being placed face down to nap at daycare. There were 12 prior referrals on the daycare facility, eight of which pertained to licensing and four for child safety. There was an open DLR/CPS investigation on the facility at the time of the child's death (alleging neglect for lack of supervision). The child's family had no history with the department. Licensing requirements prohibit daycare providers from placing infants face down and the parents had not signed a waiver stating that the child could be placed face down to sleep. Open DLR/CPS case. **Child Abuse/ Neglect Concerns.**

A 6-week-old infant was found dead after being put down for a nap by the parent. Law enforcement reported the infant was found with bruises, lesions, and a swollen lip. A toxicology report indicated high levels of methamphetamines in the infant's bloodstream. The degree to which methamphetamines contributed to the child's death could not be determined with medical certainty. The possible causes of death as related/not related to methamphetamines were discussed in detail in the autopsy report but the official conclusion was "undetermined". The parents had a documented history of substance abuse and neglect, noted in seven prior referrals made to CPS. Approximately three months before the infant's death, there was a referral alleging mother's use of methamphetamines while pregnant, which was taken as "information only" and not investigated. The latest referral on the parents alleged neglect of an older sibling. The department arranged for daycare for the sibling and then closed the CPS investigation. **Closed CPS case. Clear Physical Abuse.**

A 2-½-month-old infant died from injuries as a result of physical abuse by the teen father. Medical reports indicated that the infant was abused over time. The father admitted to a variety of acts of physical abuse over several weeks time, and he was subsequently charged with homicide by abuse. The family had 12 prior referrals, 11 of which were in regard to the father and his family. The father had a documented history of chronic assaultive and defiant behavior as a juvenile and was himself abused as a child. At the time of the infant's death, there was an open CPS investigation regarding an older sibling, based on a referral made by a community professional. The referent reported a concerning pattern of injuries to the toddler, including bruises and black eyes. Domestic violence services, parenting classes, childcare, medical care and housing assistance services had been offered to the teen parents, but they refused each service. **Open CPS case. Clear Physical Abuse.**

A 2-month-old died in bed while sleeping with the mother who reportedly fell asleep while breast feeding. The medical examiner listed the cause of death as "death during infancy, no identifiable cause". Methamphetamines were found in the child's tissues but not at toxic levels. According to the medical examiner, it is "medically uncertain how the drug exposure contributed to the infant's death". The mother had a documented history of substance abuse, including alcohol, marijuana, and methamphetamines. There was an open CPS investigation at the time of the death. There had been 13 prior referrals on the infant's mother, 12 of which pertained to her as a child. The most recent referral was regarding prenatal methamphetamine use and related neglect of the older siblings, as well as the mother breast feeding while using methamphetamines. Prior to this infant's birth, a Child Protection Team suggested a hospital hold on the new infant and removal of the older siblings. The agency decided against removal when the mother and infant tested negative for drugs at birth. A safety plan was arranged which stipulated that the family live with a designated relative and the mother was not to remove the children without prior approval. Reports indicate that the mother left the relative's home with the children approximately a month later and there was no CPS visit prior to the mother's departure. The relative did not report the mother's departure to the department for several days and the relative reported the mother had lied saying the caseworker had given approval. **Open CPS case. Child Abuse/Neglect Concerns.**

The following is a case history of a 1-year-old who died: [See also complete fatality report on Justice and Raiden for another example.]

A 1-year-old child drowned in a bathtub when left unsupervised by the mother. A CPS investigation was open, but in inactive status, at the time of the child's death. The referral was made alleging prenatal drug abuse by the mother. The child was born drug addicted and had been voluntarily placed with a relative

while the mother received treatment and parenting classes. Family Preservation Services (FPS) were provided and reportedly completed. However, FPS reports indicated that the mother had not been complying with drug treatment and documented an earlier incident where she had left another child unattended in the bathtub; supervision while bathing was addressed with the mother. FPS closed the family's case two days prior to this child's death. The CPS case was slated for closure based on FPS reports of service completion. **Open CPS case. Clear Neglect.**

The following are case histories of 2-year-olds who died:

A 2-year-old child was found under a pillow in bed with two siblings while visiting the non-custodial parent. The parent reported finding the child unresponsive. The parent's explanation was not considered plausible by the medical expert and the death was ruled a homicide by abuse. There was no open CPS case at the time of the child's death but there had been nine prior referrals on the parents alleging physical neglect and substance abuse. The most recent referral was accepted as "low risk" six months prior to the child's death. It was alleged the custodial parent was providing poor supervision of two young children and had allowed them to live in "unsuitable conditions". The custodial parent was referred to Alternative Response System (ARS) but did not engage in services. **Closed CPS case. Clear Physical Abuse.**

A 2-year-old child died from an impact injury to the head resulting from physical abuse by the father. The child was found with multiple bruising. Reports indicate the child was beaten to death. Initially, the parents claimed the child had been in the care of a babysitter. The child's father was an alleged drug dealer with a documented history of perpetrating domestic violence. He had been previously restrained from the biological mother's other children. A dependency was previously filed on one of the child's siblings due to medical neglect but it was dismissed because the parents complied with recommended services. However, in contradictory CAMIS service records there is documentation that both parents were hostile and not complying with services. The family case was closed at the time of this child's death. The child's father and step mother were charged with homicide by abuse. **Closed CPS case. Clear Physical Abuse.**

Ages 3-12:

There were 11 fatalities (13%) of 4- to 12-year-old children and no deaths of 3-year-olds. OFCO identified clear physical abuse as a cause of death in 2 of these cases; clear neglect in 2 cases; and 1 in which there were child abuse or neglect concerns. No abuse or neglect concerns were indicated in 6 of these fatalities. No trends emerged from reviewing the histories of this age group.

A 7-year-old was killed in an auto accident in which the child's father was driving while intoxicated. The father was arrested and investigated for vehicular homicide. This incident occurred one month after the child had been placed with the father by DCFS, after the mother had chronically neglected and abandoned this child and older siblings. The father had previously abandoned the family, had a history of domestic violence, and reported drug abuse and alleged child abuse and neglect. These concerns in the father's history were not adequately addressed before the child was placed with him. There was an open CPS investigation at the time of this death. The most recent referral occurred two months prior to the death, alleging this child and three siblings were living alone without adequate facilities. **Open CPS case. Clear Neglect.**

A 4-year-old died in an auto accident while the parent was driving under the influence of multiple substances.

A 5-year-old was shot to death by a caregiver who had mental health issues.

A 5-year-old with extensive medical problems requiring 24-hour care died of natural causes while living in a licensed facility.

A 6-year-old with developmental delays drowned as a result of neglect by a parent.

An 8-year-old died as a result of cancer but the family had a chronic history of abuse and neglect which may have contributed to the child's suffering.

A 9-year-old died from fatal injuries incurred by a car accident but there were no further details available about the circumstances.

An 11-year-old with severe physical and developmental problems since birth died of natural causes, with no indications of child abuse or neglect contributing to the death.

A 12-year-old with a seizure disorder drowned in the bathtub at home.

A 12-year-old was a passenger in a car and died in an accident when thrown out of the vehicle.

A 12-year-old died from complications following surgery.

Ages 13-17:

Twenty-three (26%) of the victims of fatalities were teenagers: 11 males and 12 females. Nine had open cases at the time of their deaths, 6 with CPS, 1 with CWS and 2 with FRS. One youth's death was related to clear physical abuse, another to clear neglect, and in 10 of these deaths, OFCO had definite concerns that child abuse or neglect contributed to the fatalities. In 11 of the 23 cases, the Ombudsman could not find any child abuse or neglect concerns related to the deaths.

Six teens (four 17-year-olds, one 16-year-old and one 15-year-old) died as a result of auto accidents in which there was no indication that child abuse or neglect or substance abuse was involved.

One 17-year-old died in a motorcycle accident while trying to elude police, with evidence of methamphetamines and marijuana involved.

Two 15-year-olds and one 13-year-old died as a result of chronic diseases. In one case the death was most likely hastened by severe and chronic parental neglect, and in another there was a question as to whether medical neglect contributed to the fatality.

A 17-year-old was stabbed to death by an unknown person.

Nearly half (10) of the teen fatalities occurred as a result of suicide (or possible suicide). There were 5 suicides by hanging: a 13-year-old, a 14-year-old, two 15-year-olds and a 16-year-old. There were 3 suicides by shooting: a 15-year-old and two 16-year-olds. There were 3 deaths by drug overdose: 2 were classified as suicides and the other 1 as possible suicide vs. accidental drug overdose.

A 14-year-old committed suicide by hanging in parent's home. Department reports note that the youth had been abusing substances and was exhibiting behavioral problems. The youth's family had two prior CPS referrals, the first alleging physical abuse of the youth by the father (unfounded). The most recent referral (three months before the suicide) was generated as a result of the youth's mother requesting services for her child, one day after the mother reportedly pressed charges against the youth for assault. The youth had run away and was later temporarily detained. Records indicate that the mother was seeking a longer detention period for the youth. There was no documentation in CA service records, including CAMIS, as to whether any services were or were not offered to the family following the mother's request. The case was closed at the time of the youth's death. **Closed CPS Case. Child Abuse/Neglect Concerns.**

A 15-year-old committed suicide by self-inflicted gunshot. The youth used the parent's gun, which was kept unlocked in the home. Reports indicated the youth was upset about losing driving privileges due to poor performance in school. The family had four prior CPS referrals regarding physical abuse of an older sibling. The most recent referral alleged the father beat the youth with a belt, and the family was referred to Alternative Response Systems (ARS). ARS made contact with the family and the father did not admit to the abuse but characterized the beating as physical discipline. The father declined parenting resources offered to him. ARS discussed after school and summer activity programs with the youth and closed the case five months before the suicide occurred. **Closed Case. Child Abuse/Neglect Concerns.**

A 16-year-old dependent youth was shot to death by the foster mother's biological son, a convicted felon. This son was put in charge of the foster youth while the foster mother was out of town. Department reports indicated that the shooting may have been an accident because there had been no apparent problems between the youth and the foster mother's son. The foster mother had been previously instructed to inform the department whenever she would be leaving town, in order for arrangements to be made for an authorized caregiver, but she failed to do so on this occasion. **Open CPS Case. Clear Neglect.**

A 15-year-old youth committed suicide by overdosing on drugs. The youth had made previous suicide attempts and had been hospitalized for related mental health issues. Reports indicated that one prior suicide attempt had been prompted by the child's disclosure of sexual abuse by a sibling, with the mother being very protective of the abusive sibling and not supportive of the abused child. The youth disclosed that the sibling had been abusive for five or six years. There had been two prior referrals to CPS on the family. The latest referral was four months prior to the suicide. The referent reported the youth's suicide attempt and expressed concerns about the mother's unsympathetic response to the child's disclosure of sibling abuse. The first referral was generated when the mother requested help in obtaining an

ARY petition for the older sibling (who was incarcerated soon thereafter). A worker's closing summary was written the day before the suicide, reporting that the youth (the victim) had finished counseling, was no longer in need of services, and would have access to a school counselor if needed. The summary also documented phone contact with the youth's mother who reported the abusive sibling would be released from custody soon and she had nowhere to place the sibling. CPS was to be notified if the abusive sibling was to be released back to the home of the mother and sibling. **Open CPS case. Child Abuse/Neglect Concerns.**

Practice Recommendations

Based on the behavioral patterns of the family as well as the vulnerability of victims, the Ombudsman developed several practice recommendations that could significantly improve outcomes for children:

- Carefully monitor parents with a history of drug abuse who have young infants: require current drug/alcohol evaluation and administer regular, random urinalyses to determine drug usage;
- More closely monitor parents with infants where there is a current referral alleging abuse or neglect of siblings and a pre-existing CPS history of referrals on the siblings;
- Consistently drug test infants after death to detect presence of illegal substances if the parents have a drug history;
- Give greater weight to parents' histories of abuse in their families of origin, particularly in cases of teen parents, in assessing risk and developing a case plan;
- Screen in for investigation all referrals on infants in cases where the parent has had parental rights terminated on other children (this would likely require a change in the law to give CPS broader authority to investigate such referrals, which may in some cases not meet the current statutory definition of abuse or neglect in RCW 26.44);
- Carefully monitor parents' compliance with voluntary service agreements (VSAs) over the course of the VSA and pursue appropriate legal action to safeguard the children if the parents have not complied.[8] In situations where the parents refuse to sign a VSA, or refuse to comply with services, promptly assess the risk to the children and take swift and appropriate legal action;[9]
- Implement a weighted caseload distribution so that cases with a chronic risk of recurring abuse and/or neglect and high risk cases are counted differently, resulting in a more balanced workload among caseworkers; and
- Ensure that parents and teens requesting services to assist families in crisis, such as Family Reconciliation Services (FRS), are provided with sufficient assistance and direction from DCFS on pursuing legal remedies, such as a Child in Need of Services (CHINS)[10] or At-Risk-Youth

[8] The Ombudsman has found numerous instances, brought to our attention in complaints that we have reviewed and investigated, in which DSHS CA has either not monitored parental compliance with VSAs and/or has closed a CPS case due to non-compliance with services by the parents, even when the risk factors that prompted initial agency action appear to still exist.

[9] See changes to the chronic neglect law implemented by the enactment of ESSB 5922 in 2005.

[10] A CHINS petition is a mechanism by which the child, parent, or DSHS may petition the court to place the child outside of the home of the parent in situations where there is serious conflict between the parent and children and reasonable but unsuccessful efforts have been to resolve the situation in the home. RCW 13.32A et seq.

(ARY)[11] petition, to access appropriate services. The State should be as responsive and informative as possible to put requested services in place and to follow through with ensuring that the family received services. DCFS should reexamine and modify existing protocols to determine if they are sufficient to accomplish these goals.

The National Landscape

Child fatalities touch every state across the country. These tragedies underscore the inadequacy of state child protection systems to consistently identify and mitigate factors that make the death of a child more likely to occur, such as a parent's proclivity to abuse or neglect their child. In 2003, the Office on Child Abuse and Neglect,[12] relying on data submitted by individual states to the National Child Abuse and Neglect Data System (NCANDS),[13] concluded that there were 1,500 children who died due to abuse or neglect, with parents being the primary perpetrators.[14] It found in 2002 that 17% of all child abuse and neglect related child deaths are inflicted on children known to the states' child welfare system.[15]

National figures on the number of children who die as a result of abuse or neglect, as reported in NCANDS,[16] are likely to be conservative for several reasons. Not every child death in each state is reviewed and reported on in the same way and some deaths receive a higher level of scrutiny than others.

Causes of Underreporting and Inconsistent Fatality Review

In Washington, the cause of death of a child is not investigated or identified consistently across the state. These regional differences impact record keeping and reporting. Child deaths in certain counties receive a more thorough investigation by medical professionals simply based on the population of the county in which the child died. For example, counties with a population of 250,000 or more may appoint a medical examiner.[17] Less populated counties must use coroners, and in the smallest counties (40,000 people or

[11] ARY petitions may only be filed by the parent of the child and are used to obtain assistance and support from the juvenile court in maintaining the care, custody and control of the child and to assist in the resolution of family conflict, after alternatives to court intervention have been attempted. RCW 13.32A et seq.

[12] The Office of Child Abuse and Neglect originated as the National Center on Child Abuse and Neglect (NCCAN), which was created in 1974 by the federal Child Abuse Prevention and Treatment Act (CAPTA) to serve as an information clearinghouse; Public Law 93-273; 42 U.S.C. 5101.

[13] The National Child Abuse and Neglect Data System (NCANDS) is a federally sponsored data collection effort developed by the Children's Bureau of the U.S. Department of Health and Human Services' National Center on Child Abuse and Neglect (NCCAN) in partnership with the states to collect and present annual statistics on the volume and type of child maltreatment from state child protective services agencies. NCANDS was established in response to the enactment of the Federal Child Abuse Prevention and Treatment Act (CAPTA), Public Law 93-273; 42 U.S.C. § 5101. Available at http://nccanch.acf.hhs.gov/pubs/factsheets/canstats.pdf.

[14] Available at http://nccanch.acf.hhs.gov/pubs/factsheets/canstats.pdf. Consistent with OFCO's findings in Washington state, infant boys had the highest rate of fatalities on a national basis.

[15] This was based on data submitted by individual states to NCANDS. U.S. Department of Health and Human Services. "Child Abuse and Neglect Fatalities: Statistics and Interventions." April 2004. http://www.nccanch.acf.hss.gov/pubs.

[16] NCANDS codes, for purposes of data collection and analysis, a child death as the result of abuse or neglect when either: "(a) an injury resulting from the abuse or neglect was the cause of death; or (b) abuse and/or neglect were contributing factors to the cause of death." See http://www.ndacan.cornell.edu/NDACAN/Datasets/UserGuidePDFs/114user.pdf.

[17] RCW 36.24.190 provides that "[t]o be appointed as a **medical examiner** pursuant to this section, a person must either be: (1) Certified as a forensic pathologist by the American board of pathology; or (2) a qualified physician eligible to take the American board of pathology exam in forensic pathology within one year of being appointed.

less), the local prosecuting attorney serves as the coroner.[18] These individuals often do not have the time, medical training or expertise of a medical examiner/forensic pathologist to thoroughly investigate the cause of death and to make an accurate diagnosis of the cause of death in more nuanced situations, such as Sudden Infant Death Syndrome (SIDS).[19]

These county differences may explain, in part, the lack of standardization in how child deaths are described by medical examiners and coroners.[20] In several of the 2004 cases reviewed by OFCO, the Ombudsman found abuse or neglect clearly contributed to the death of the child, yet the coroner ruled the death resulted from SIDS or as an "unidentified infant death."[21] State law does not currently define sudden infant death syndrome. The range of description used to explain the cause of death may result in misdiagnosis and failure to appropriately designate a death as the result of abuse or neglect. A standard definition of SIDS may result in more accurate diagnoses of child deaths and better record keeping on the incidence of child abuse and neglect as it relates to these deaths.

Washington law establishes protocols for coroners or medical examiners conducting autopsies of children under the age of three who have a sudden, unexplained death (referred to in this annual report as the SIDS law).[22] The law also provides for special training for law enforcement, emergency medical personnel, and other individuals responding to emergencies and what may become a death scene. Other states have specialized training and protocols as well.[23] Although the law appears to go far in helping to prevent the inappropriate designation of SIDS, there is currently no monitoring to determine the degree of county

[18] RCW 36.16.030.

[19] See Teichroeb, Ruth, "Uniform state system needed for investigating deaths, critics say." Seattle Post Intelligencer (October 31, 2002); According to Deborah Robinson, infant death specialist of the SIDS Foundation of Washington, Washington state is one of the test sites that was selected by the National Center on Disease Control for training to be developed for the certification of child death investigators. This signifies a movement toward increased standardization of procedures used to investigate the deaths of young children.

[20] See chart herein listing different terminology used by medical examiners or coroners to describe sudden, unexplained deaths in 2004 fatalities reviewed by OFCO.

[21] e.g. 5-month-old infant was found dead in his crib. The coroner determined the cause of death to be SIDS. An acute sub-arachnid hemorrhage was found on the infant's brain during autopsy. Two months prior to the death, the infant's mother had pled guilty to a misdemeanor charge of child abuse for inflicting a skull fracture on the infant while the mother was intoxicated.

[22] RCW 43.103.100 directs the Washington state forensic investigations council to research and develop appropriate training on "sudden, unexplained child death, including but not limited to sudden infant death syndrome." The law lists the training components, which include medical information on SIDS for first responders; information on community resources and support groups available to assist families who have lost a child to SIDS; and the value of timely communication between the county coroner or medical examiner and the public health department to achieve a better understanding of these deaths. The law requires the council to work with volunteer groups with expertise in the area of sudden, unexplained child death, including but not limited to the SIDS foundation of Washington and the Washington association of county officials. The law mandates that each county use a protocol developed by the council for death scene investigations of sudden unexplained deaths of children under the age of three and requires the council to develop a protocol for autopsies of such children. The council is authorized to study and recommend cost-efficient improvements to the death investigation system in Washington and report its findings to the Legislature. RCW 43.103.030. Twelve members serve on the council, which includes at least one county coroner, medical examiner, prosecuting attorney, pathologist, members of law enforcement, and legislators. RCW 43.103.040. In amendments to the law in 1991, the Legislature recognized that "sudden and unexplained child deaths are a leading cause of death for children under age three. The public interest is served by research and study of the potential causes and indications of such unexplained child deaths and the prevention of inappropriate designation of . . . SIDS as a cause of death."

[23] The National Conference of State Legislatures provides a summary of state laws on sudden infant death syndrome. Available at http://www.ncsl.org/programs/health/sidsleg.htm.

compliance with the SIDS law, specifically, whether and to what extent deaths are being investigated where the cause and manner of death are unknown.[24]

Moreover, because Washington lacks a statewide system for organizing independent child fatality reviews, not all child deaths in the state receive review.[25] Under the current system, DSHS CA is the only agency currently funded on an ongoing basis to conduct reviews, but these are limited in scope. Only those children who have an open DSHS case at the time of death, were receiving services in the year preceding death, or died while in a state licensed facility are currently required to be reviewed by the agency.[26] Consequently, the death of a child who has not had DSHS CA involvement will not be reviewed; nor will those of children who may have significant prior CPS histories for abuse and neglect, but escape the agency's attention because their case is closed or there have been no recent referrals.[27]

Furthermore, there is inconsistency from county to county as to information that is shared with community professionals investigating a death. Groups of professionals reviewing fatalities should have access to the same types of information, rather than being dependent on local entities to interpret what type of information can be released for review.[28]

[24] Deborah Robinson, infant death specialist of the SIDS Foundation of Washington, reported to the Ombudsman that there are several cases she is aware of in which the death was given an undetermined cause and manner and yet the death scene was not investigated by law enforcement or the medical examiner. This group is in favor of a state audit to determine compliance with the SIDS law. The SIDS Foundation of Washington is one of the groups that RCW 43.103.100 expressly states the state forensics investigations council should work with because of its expertise in sudden and unexplained deaths of young children.

[25] All states, "except Idaho and Washington have child death review programs in place at the state and/or local levels." National Conference of State Legislatures. Available at www.ncsl.org/programs/cyf/childfatal.htm.

[26] "(1) The department of social and health shall conduct a child fatality review in the event of an unexpected death of a minor in the state who is in the care of or receiving services described in chapter 74.13 RCW from the department or who has been in the care of or received services described in chapter 74.13 RCW from the department within one year preceding the minor's death. (2) Upon conclusion of a child fatality review required pursuant to subsection (1) of this section, the department shall issue a report on the results of the review to the appropriate committees of the Legislature and shall make copies of the report available to the public upon request. (3) The department shall develop and implement procedures to carry out the requirements of subsections (1) and (2) of this section." RCW 74.13.640; HB 2984 enacted in 1994.

[27] There are several factors that can influence whether a CPS referral history accurately reflects the living situation in the home. For example, despite Washington's mandatory reporting law, the Ombudsman has found instances in which mandated reporters have not made referrals of suspected abuse or neglect to CPS. The agency also screens out referrals for abuse and neglect if it believes they do not meet sufficiency criteria.

[28] See Washington State Child Death Review Program Progress Report 1998-2000 (May 2001). Available at http://www.doh.wa.gov/Publicat/cdr_program_progress_report.PDF.

Terminology for Sudden, Unexplained Deaths in Young Children

Here are the different terms, used by medical examiners & coroners, referred to in DSHS CA case records to describe unexplained infant deaths in 2004; these are verbatim from specific cases:

- SIDS
- Undetermined
- Unidentified infant death
- SIDS of a drug affected child at birth
- Asphyxiation
- Mechanical asphyxiation
- Natural and caused by SIDS
- SIDS/natural death
- Layover suffocation
- Death during infancy, no identifiable cause
- Undetermined/possible overlay
- Unexplained causes
- Accidental…and caused by positional asphyxiation
- Cardio-pulmonary arrest (SIDS)
- Positional asphyxia, co-sleeping
- Undetermined…voiced concern
- Asphyxia by entrapment
- May be SIDS
- Sleeping with parents, incomplete information

History of Washington's Collection and Review of Child Fatality Data

Initiation of Statewide Department of Health Child Death Review System

In 1993, the state Legislature authorized local health jurisdictions to conduct child death reviews of infants less than one year of age on a voluntary basis.[29] In 1994, the Legislature extended the scope of review to include the unexpected deaths of children from birth through age 17.[30]

This system of review was formalized and expanded in 1997 with the initiation of the Child Death Review (CDR) system. In a 1997 executive directive, Governor Gary Locke established the CDR system and provided funding to the Department of Health (DOH) to develop and implement a comprehensive statewide child death review system to collect and analyze death review data utilizing local community based teams. This gubernatorial action was preceded by legislative action to amend RCW 43.79.45 to provide that funds be appropriated during the 1997-99 biennium for the purpose of statewide DOH child mortality reviews.

DOH compiled aggregate data to identify factors and trends that contributed to the death of children based on reviews of all unexpected child deaths of children aged birth through 17 years of age across the state by the community based teams facilitated by local health jurisdictions, and annually published its

[29] The law provided that the review may include "a systematic review of medical, clinical, and hospital records; home interviews of parents and caretakers of children who have died; analysis of individual case information; and review of this information by a team of professionals in order to identify modifiable medical, socioeconomic, public health, behavioral, administrative, educational, and environmental factors associated with each death. RCW 70.05.170 (2) (1993).

[30] WA bill 5205 revised RCW 70.05.170 to extend comprehensive reviews to deaths of all children from birth to age 17.

child fatality review findings based on this data. In 2003, DOH lost its funding to conduct these reviews, although the law authorizing CDRs is still in effect.[31]

Some local health jurisdictions have continued to conduct these reviews despite the loss of funding, but most are no longer in operation. The importance of a comprehensive, multi-disciplinary review of child deaths was recently articulated in a DOH presentation[32] to the legislative Joint Task Force on Child Safety.[33] The operating principles of such reviews are that:

- The death of a child is a community responsibility.
- A death requires multidisciplinary participation from community professionals.
- A review of case information should be comprehensive and broad.
- A review should lead to understanding of risk factors.
- A review should focus on prevention of other deaths and the health and safety of other children.
- Reviews should lead to action.

Role of DSHS CA in Child Death Review

DSHS CA is required by state law to review all unexpected deaths of children who have been in the care of or receiving child welfare services from the department within one year of the child's death. This includes children who died while in licensed care.[34] Department policy requires either a Child Fatality Review (CFR)[35] or Executive Child Fatality Review (ECFR)[36] of these child deaths, if child abuse or neglect is

[31] According to DOH, at the time funding was eliminated, the 29 local CDR teams were reviewing 92% of all unexpected child deaths across the state and submitting data and recommendations to DOH. Information available at http://www1.leg.wa.gov/documents/joint/cstf/DOH8-23-05.pdf. Presentation and Handout to Child Safety Task Force by Melissa Allen, Washington State Department of Health, Office of Maternal And Child Health. Washington State Department of Health CHILD DEATH REVIEW A Public Health Tool for Injury Prevention. October 2005.

[32] Information available at http://www1.leg.wa.gov/documents/joint/cstf/DOH8-23-05.pdf. Presentation and Handout to Child Safety Task Force by Melissa Allen, Washington State Department of Health, Office of Maternal And Child Health. *Washington State Department of Health CHILD DEATH REVIEW A Public Health Tool for Injury Prevention.* October 2005.

[33] In 2005, HB 2156, also known as "Sirita's law," established a legislative task force to review issues pertaining to the health, safety and welfare of children receiving services from child protective services and child welfare services. OFCO serves on this task force.

[34] RCW 74.13.640; HB 2984 enacted in 1994.

[35] The CFR is participated in "by local/regional staff and/or others appointed by regional administrator (RA). CA may invite community partners who had involvement with and/or provided services to the child's family. [The] CFR [is] prepared and coordinated by regional CPS program manager in Administrative Incident Reporting System (AIRS). Regional CPS program manager completes review within 90 days or RA may authorize extension." Administrative Incident Review Activity. 9-29-05. Provided to OFCO by the Office of Practice Consultation & Risk Management, CA on 2/3/06. Included as an Appendix in this annual report.

[36] According to DSHS, "[a]n Executive Child Fatality Review [ECFR] may be convened by the CA Assistant Secretary **in select** cases when a child dies of apparent abuse by their parent or caretaker and the case was actively receiving services at the time of the child's death. Participants are appointed by the Assistant Secretary and are individuals that had no involvement in the case, but whose professional expertise is pertinent to the dynamics identified in the case. CA convened two such fatality reviews during Calendar Year 2004." Emphasis added. http://www1.dshs.wa.gov/CA/pubs/2004perfrm.asp. See also the Administrative Incident Review Activity for an explanation of the ECFR. Included as an Appendix in this annual report.

alleged.[37] An ECFR provides an independent review by individuals not directly involved in providing services to the family. However, this more independent form of review is never required and is only implemented at the discretion of the Assistant Secretary of CA. Unexpected deaths in which child abuse or neglect is not alleged, do not receive an Executive Fatality Review.[38]

DSHS must issue a report on the results of its fatality review to the appropriate committees of the Legislature and make copies of the report available to the public upon request.[39] Although the current law governing DSHS' review of child fatalities was enacted in 2004, the obligation to review child fatalities in conjunction with other entities such as DOH dates back to at least 1995.[40] DSHS CA collaborated with DOH on the community based review teams until DOH's loss of funding in 2003.[41]

DSHS CA is making significant efforts to improve data collection on child fatalities as well as to fill the void created by DOH's loss of funding for regular use of CDRs. A step in this direction has been the agency's development and implementation of the Administrative Incident Reporting System (AIRS).[42] AIRS establishes uniform requirements for reporting serious and emergent incidents involving DSHS CA, including child fatalities, near fatalities, and other critical incidents known to the department.[43] It is a system which is evolving in complexity and is increasingly designed to analyze policy and practice concerns that come to light in the context of a fatality.[44]

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[37] Fatality Review Matrix (Matrix) provided to OFCO by the Office of Practice Consultation & Risk Management, CA on 2/3/06. This Matrix is included as an Appendix in this annual report.

[38] The practice as set forth in the Matrix and Administrative Incident Review documents referred to in the preceding footnotes varies from the DSHS CA policy and practice set forth in the DSHS Operations Manual and DSHS Practices and Procedures Guide available online at http://ca.dshs.wa.gov/intranet/main/CAMain.asp. DSHS CA needs to update its manuals and guides to incorporate current and accurate practices and procedures.

[39] Enacted during the legislative session, HB 2984 (RCW 74.13.640) requires the department to report annually on each child fatality review conducted by the department and provide a copy to the appropriate committees of the Legislature. Quarterly reports issued between December 2004 and September 2005 are available at http://www1.dshs.wa.gov/legrel/LR/CIYA.shtm.

[40] During the 1995 session, the Washington State Legislature passed Substitute House Bill SHB 1035 mandating that DOH and DSHS develop a consistent process of review of the deaths of children receiving child welfare services. CA Policy 5210 provides that: "Chapter 204, Laws of 1995 required the department, in conjunction with the Department of Health (DOH), local jurisdictions, coroners, medical examiners, and other appropriate entities, to develop a consistent process for review of unexpected deaths of minors in the state of Washington who are in the care of or receiving services described in chapter 74.13 RCW from Children's Administration (CA)."

[41] The Washington State Child Death Review Committee, co-chaired by DOH and the DSHS, directed the activity of the CDR process. It reviewed data gathered by local teams to identify trends and prevention strategies for the entire state. Volunteer experts with a range of expertise served on these teams. DSHS continues to participate on some of the child death review teams convened by local health jurisdictions. Children's Administration Performance Report, p. 20. http://www1.dshs.wa.gov/CA/pubs/2004perfrm.asp.

[42] AIRS Policy DSHS Children's Administration Policy, Administrative Incident Reporting, effective January 1, 2005. Available at http://ca.dshs.wa.gov/intranet/Manuals/AIRSPolicy.pdf.

[43] For a more detailed explanation of what incidents are reported in AIRS, see http://ca.dshs.wa.gov/intranet/Manuals/AIRSCheatSheet.pdf.

[44] "AIRS also maintains specific information about the fatality as well as provides a format and recording document for the fatality review. AIRS also collects aggregate data of child fatalities." Children's Administration Performance Report 2004. Available at http://www1.dshs.wa.gov/CA/pubs/2004perfrm.asp; see also the AIRS Companion Guide for specific information on the type of data entered. Available at http://ca.dshs.wa.gov/intranet/Manuals/AIRSGuide.pdf.

DSHS CA has also reported to the legislative committees on a quarterly basis on its review of some child fatalities.[45] Until March 2006, the department had not prepared an annual report with comprehensive aggregate data on child fatalities, as required by law.[46]

Identified Concerns

Based on OFCO's review of 2004 child fatalities and routine review of other fatalities, the Ombudsman has identified several areas of concern:

- **Lack of a coordinated statewide child fatality review process.**
- **Sole discretion of DSHS CA Assistant Secretary to decide whether to conduct an Executive Child Fatality Review. Need for Ombudsman recommendation to trigger an Executive Child Fatality Review.**
- **Lack of clarity about how cases, once they meet threshold criteria for a possible Executive Child Fatality Review, are then selected by DSHS CA Assistant Secretary for such a review.**
- **Lack of auditing implementation of child fatality review recommendations.** Recommendations that are developed from DSHS CA child fatality reviews have not been made public consistently and consequently there is no procedure to assess their value or to monitor their implementation.
- **Lack of parity in investigative resources among counties. This may affect the thoroughness and accuracy of investigations into child deaths and result in inappropriate designation of SIDS in situations that have not been adequately investigated.** Medical examiners, coroners, and other professionals charged with diagnosing sudden and unexpected death of infants and young children do not appear to have comparable training in each county. Inconsistent terminology is sometimes used to describe unexplained deaths from the same cause.
- **Insufficient research to show how methamphetamine use by a parent affects infants.** Since the effects are uncertain, medical officials' autopsy reports do not indicate how the drug may have contributed to the child's death.
- **Lack of documentation of the caseworker's caseload, at the time of the fatality or near fatality, in the DSHS CA Administrative Incident Reporting System (AIRS).**

Systemic Recommendations:[47]

- **Reinstate a coordinated effort between DOH and DSHS to implement a statewide child fatality review process.[48]**

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[45] Quarterly reports issued between December 2004 and September 2005 are available at http://www1.dshs.wa.gov/legrel/LR/CIYA.shtm.

[46] RCW 74.13.640. On March 6, 2006, OFCO received a copy of DSHS CA's 2003 report.

[47] These are system wide recommendations to address deficiencies in the current fatality review process.

[48] See Missouri law, which is frequently cited by experts as a best practice model: RSMo 210.192 became effective August 28, 1991, and Missouri's Child Fatality Review Program (CFRP) was implemented on January 1, 1992. See http://www.dss.mo.gov/stat/back.htm.

- **Require an Executive Review of both child fatalities and near fatalities upon the recommendation of OFCO.**

- **Require DSHS to establish clear criteria, available to the public, on which cases will receive an Executive Child Fatality Review.**

- **Establish a professional multidisciplinary technical team that will assist DSHS in prioritizing and evaluating the usefulness of implementing recommendations from child fatalities.** Implement an auditing process that requires DSHS to annually report to the Legislature and the Ombudsman on the status of implementation of child fatality review recommendations.

- **Implement consistent methodology in the investigation of child deaths and enactment of a SIDS labeling law[49] so that consistent terminology is used.** Ensure that each child death is investigated by an experienced investigator with specialized training who uses clear and consistent protocol to investigate the death scene and that medical examiners in each county, or their equivalent, employ the same autopsy protocol on sudden unexplained deaths. Consider the viability of making available a medical examiner/forensic pathologist in each county, regardless of its population and/or requiring all unexpected child fatalities to be reviewed by a medical examiner/forensic pathologist. Conduct a review of child fatality notification practices between professional entities (i.e. hospitals, law enforcement, DSHS) to ensure that there is an open exchange of information allowing for timely notification of a child death.[50]

- **Audit counties to ensure that when the manner and cause of unexplained sudden deaths of young children are undetermined, the death is investigated by the county medical examiner or equivalent in that county, and that established death scene and autopsy protocols are followed.**

- **Require DSHS to document caseworker caseloads, at the time of the fatality or near fatality, in AIRS and incorporate in child death review reports for future analysis.**

- **Require DSHS CA to establish a plan and report to the Ombudsman on the implementation of recommendations the Ombudsman makes in its fatality reviews.** In the absence of implementation, require CA to provide OFCO with a reasonable basis for the decision not to implement recommendations and report this to OFCO.

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[49] Several states define "sudden infant death syndrome." While definitions may be similar, the age covered within the definition may vary. A uniform definition may assist with consistent data gathering. For example, Tennessee defines SIDS to mean the death of an infant less than one year of age whose death is unexplained after "thorough case investigation, including performance of a complete autopsy, examination of death scene and review of clinical history." Tenn. Code Ann. § 68-1-1101. Available at http://www.ncsl.org/programs/health/sidsleg.htm.

[50] RCW 74.13.515 provides the Secretary of DSHS with the authority to "make the fullest possible disclosure [of personally identifying information of the child who died] consistent with chapter 42.17 RCW and applicable Federal law in cases of all fatalities of children who were in the care of, or receiving services from, the department at the time of their death or within the twelve month previous to their death." See also 74.13.500. It does not appear that DOH has comparable authority under the law.

Conclusion

OFCO was established in 1996 largely in response to the death of 3-year-old Lauria Grace. The Legislature and the Governor recognized the need for increased oversight of DSHS by a neutral, impartial entity to improve the system. This imperative drives our priorities. For that reason, the Ombudsman's review of fatalities will continue to be a significant part of our day-to-day work.

Our ability to look at a complex set of factors in an impartial manner and to identify the shortcomings in a system is what we do. This is especially critical in the absence of a statewide coordinated system of child death review. In the year ahead, the Ombudsman will continue to monitor DSHS' development of the AIRS system to ensure that critical data is not only collected and recorded, but analyzed in a meaningful way that translates into real, systemic reform.

Child fatalities represent the greatest failure of the child protection system, but also the most meaningful opportunity for reform. For the review of a child's death by DSHS CA to result in improved practice, two conditions must be met. First, the reviews must be based on complete, accurate, and impartial data. Thorough investigations at the front end by law enforcement, medical professionals, and CPS investigative workers and the sharing of investigative findings with the fatality review team is essential. Second, a multidisciplinary group of professionals must evaluate recommendations that arise from these reviews to prioritize them, and determine how they should be implemented. Without a concrete system for considering and implementing such changes, the reviews are an exercise in futility.

The most promising strategy to improve outcomes for children is to involve professionals who use a coordinated, collaborative, and multidisciplinary approach in the investigation of fatalities and critical incidents. This will result in more accurate diagnoses of the manner and cause of child deaths, better record keeping on the incidence of child abuse and neglect as it relates to these deaths, and consistent child death reviews. In turn, these steps can put a halt to avoidable tragedies such as the deaths of Justice, Raiden, and Sirita.