

Child Fatality Review #08-37
Region 5
Pierce County

This five-month-old African American female died from an unspecified medical condition.

Case Overview

On June 19, 2008, Tacoma Police Department and the Pierce County Medical Examiner were called to the home of the aunt of the deceased child. The child's aunt woke around 7:30 a.m. and found the child not breathing. Law enforcement did not document any concerns regarding the condition of the home. The death was not medically unexpected due to issues relating to severe pre-term delivery at 23 weeks gestation. The cause of death was determined to be due to complications of prematurity, and the manner of death is listed as "natural."

The deceased child and her twin sister were born on January 23, 2008 at 23 weeks gestation. Their 18-year-old mother moved to Washington from Sacramento, California one week prior to their birth. She had no prenatal care. The children were not expected to live after delivery.

The mother returned to Sacramento in April 2008 as she could no longer stay with her sister. She was arrested shortly after her return to Sacramento. Prior to leaving, the mother signed a letter giving her sister custody of the twins until they were healthy enough to go to Sacramento. The infants were released to their aunt's care on April 29. Both were still considered medically fragile. Both were on oxygen, medications for reflux, and in the care of an ophthalmologist.

A Public Health Nurse (PHN) working with the aunt went to the home on the morning of the child's fatality. She observed that all oxygen tanks were empty. The Medical Examiner and law enforcement were aware that the infant's travel oxygen tanks were empty at the time of the child's death, but both said this had no direct connection to the child's death.

The Child Protective Services (CPS) social worker did not identify the death as directly related to child maltreatment. However, the CPS investigation resulted in a founded finding for negligent treatment by the aunt for failing to ensure the oxygen dependent infants had a sufficient oxygen supply. The surviving twin was placed in protective custody on June 20. She was placed in foster care and the department filed a dependency petition.

Referral History

On January 23, 2008, Child Protective Services (CPS) intake took a report from a hospital social worker reporting the mother of the deceased child gave birth to her and

her twin sister on January 22. Both infants were born premature at 23 weeks gestation. The mother received no prenatal care. She came to Washington State on January 14, 2008 from California. The doctor estimated the children's survival rate at less than ten percent. The mother was offered resources to assist with her pregnancy, but she never followed through. This referral was screened as information only.

On May 8, 2008, hospital staff reported to CPS intake concerns about the well being of the deceased child and her twin sister in their aunt's care. Hospital staff were concerned about lack of bonding and attachment between the deceased child's twin sister and her aunt. In April, the biological mother left for California. Hospital staff had no contact with her after she left. The maternal grandmother reported the mother was arrested and spent some time in jail in Sacramento. The mother gave custody of the twins to her sister until they were healthy enough to go to Sacramento. The deceased child was released to the aunt's care on April 29, 2008 and was doing well. There were concerns that the hospital was unable to provide resources to the aunt because she is not custodial parent. There were skilled nurse visits for the first two weeks, but those had ended. This referral was screened as information only.

On May 20, 2008, a nurse at Tacoma General Hospital reported to CPS intake allegations of medical neglect by the deceased child's aunt. The aunt had an informal agreement to care for the twins until the mother finished her community service in California. The referrer reported the doctor told the aunt he wanted to see the deceased child two to three days after the discharge from the hospital. The aunt had an initial appointment but canceled it. She did reschedule for four days later. The next appointment was to see an eye specialist due to high risk of blindness from medications the infant was taking while at the hospital. The aunt failed to bring the child in for two scheduled appointments. The infant's eyes were not checked for three weeks; this was concerning to the hospital staff. Hospital staff were concerned that the aunt was unable to meet the high needs of the twins as she was unable to meet medical needs of the one twin. This referral was screened in for investigation by Child Protective Services and closed with a founded finding for negligent treatment or maltreatment. This finding was made after the child's death.

On June 19, 2008, a Public Health Nurse working with the deceased child's aunt reported to CPS intake that the child died. Police and the medical examiner found nothing of concern at the aunt's home. This referral was screened in for investigation by Child Protective Services and closed with an unfounded finding for negligent treatment or maltreatment. The twin sister of the deceased child was placed in foster care after this referral.

Issues and Recommendations

Issue: There were no substantive practice, policy, or system issues identified during the child fatality review.

There was agreement among panel members that all intake decisions, including those made prior to the fatality incident, were supportable. Overall the documented investigative activities appeared to meet or exceed expected practice. Medical and support services were in place in the home at the time of the child's demise, including a Public Health Nurse (PHN) who had made five home visits within a 30-day period. The deceased child was seen by physicians three times between March 23 and June 6, 2008, with no reported concerns.

The investigative finding of "Founded" appears reasonable in the context of the aunt failing to ensure sufficient oxygen supplies were on hand in the home. Without supportive evidence from either the Medical Examiner or law enforcement regarding negligence on the part of the child's caretaker, the CPS investigator did not identify the death as being directly related to child maltreatment. However, the CPS investigation resulted in a finding of founded for negligent treatment by the aunt for having presented a clear and present danger to the deceased child's health and welfare when she failed to ensure the oxygen dependent infant had a sufficient oxygen supply on hand at the residence.

Some missed opportunities for best practice were noted during the review. The CPS worker might have inquired more in depth as to the aunt's history of abuse/neglect as a child and the self-reported parentification at an early age. Such inquiry may have led to an understanding of the aunt's motivation to care for her nieces which may have exceeded her ability to care for the twins. The CPS worker had few documented observations of the aunt's biological children as they were not all present in the home during social worker home visits. Understanding the parent-child relationships between the aunt and her own children may have benefited any assessment of risk and protective factors. The caregiver (aunt) presented well to both the CPS worker and to the PHN. It is conceivable that the way the aunt presented to those involved may have influenced how information was interpreted, filtered, and assessed.

Recommendation: None

Actions Taken: Both the CPS investigator and supervisor participated in the review and received feedback regarding suggestions for improved practice.