

Child Fatality Review #08-39
Region 1
Lincoln County

This two-month-old Caucasian female died of Sudden Unexplained Infant Death Syndrome (SUID).

Case Overview

On July 20, 2008, the 19-year-old mother of the deceased child called 911 to report her infant daughter was not breathing. An ambulance was dispatched and took the baby to the hospital. The cause of death is unknown, and there were no signs of abuse. The mother reported she checked on the baby at 6:00 a.m. and changed her diaper. Around noon, she checked on the child and found her not breathing. When the child arrived at the hospital, staff made attempts to revive her. They reported her prognosis was not good. Attempts to revive the child ceased. There were no signs of trauma or abuse evidenced.

The deceased child and her three-year-old sister were on in-home dependencies at the time of the fatality. The mother had a history of being homeless, but had an established residence at the time of her child's death. The mother had left her older daughter, then two-years-old with unsafe persons. The mother voluntarily placed this child with the maternal grandmother. A dependency petition was filed on behalf of this child after the mother was non-compliant with a service plan and was unable to secure permanent safe housing. When the deceased child was born in 2008 a dependency petition was also filed on her behalf. She remained in her mother's care on an in-home dependency. She was left with her mother to promote bonding and attachment. The mother complied with court ordered services including staying clean and sober. She maintained a stable household and consistently visited with her eldest daughter.

Referral History

On July 13, 2007, Child Protective Services (CPS) intake took a report from a probation officer who reported that the deceased child's mother allowed a person with an outstanding DUI to transport her child. It was also alleged the mother allowed a registered sex offender to be with her daughter, then two-years-old. The referrer said the mother left her daughter with anyone for extended periods of time. It was also alleged the mother traded a vehicle for marijuana. This referral was screened in for investigation by CPS and closed with an inconclusive finding. The mother signed a Voluntary Placement Agreement and the child was placed with the maternal grandmother. In October 2007, the department filed a dependency petition on behalf of this child.

On March 13, 2008, a social worker reported to CPS intake that the three-year-old sister of the deceased child was placed with her grandmother on a dependency due to the mother's lifestyle and substance abuse issues. The social worker said the mother was trying to have her daughter placed back with her. The mother was six months pregnant with the deceased child. On March 12, 2008 the mother had a party with underage juveniles involved. The mother was drinking alcohol. The police went to the home and broke up the party. This referral was screened as information only.

On July 20, 2008, a law enforcement officer reported to CPS intake the death of this child, then seven-weeks-old. The child died at approximately 12:00 noon. The mother called 911 and reported her daughter was not breathing. The cause of death is unknown and there was no sign of abuse. Hospital staff attempted to revive the child, but her core temperature was 92.1 degrees indicating that she had been dead for some time. This referral was screened in for investigation by Child Protective Services and closed with a founded finding for negligent treatment or maltreatment. This investigation revealed the mother allowed the deceased child to be alone with unapproved caregivers prior to her death. The mother also slept with the child on her stomach against the instructions of the Public Health Nurse and Home Support Specialist.

Issues and Recommendations

Issue: Child Protective Services currently does not have statutory authority to access autopsy reports through the course of an investigation or on cases that Children's Administration was involved within 12 months of a child's death. This is a barrier for Children's Administration when investigating child abuse and neglect reports as well as facilitating a required child death review.

Recommendation: The review committee recommends an addition to RCW 68.50.105 for release of autopsies and post-mortem reports to Child Protective Services when services were provided to a family within 12 months of a child's death, the case is open at the time of death or when the death is a result of alleged child abuse or neglect.

Issue: Home Support Specialists employed by Children's Administration do not have any particular training requirements or access to position specific trainings.

Recommendation: Children's Administration should develop curriculum and provide standardized trainings to all Home Support Specialists. Curriculum should include at a minimum child development, current public health information such as safe sleep practices and recommended immunization schedules as well as safety and risk assessment.

Issue: Communication and decision making for case planning between the local Attorney General's office and department social workers appears to need improvement.

Recommendation: An Area Administrator in Region 1 will contact the Assistant Attorney General supervisor to initiate a workgroup to discuss the communication and roles of the attorney general and social worker when developing case plans that may need legal interventions.