

**Child Fatality Review #08-41**  
**Region 1**  
**Spokane County**

This four-month-old African American male died from unknown causes.

**Case Overview**

On July 27, 2008, the mother of the deceased child put him on his back to sleep on her bed. He was placed on top of the sheets and a blanket. He had a baby blanket placed over him. The child's mother reported that she checked on him shortly after midnight. At that time she noticed her son was on his stomach. She attempted to reposition him and noticed he was limp and not breathing. She called 911 and started resuscitation efforts until the ambulance arrived. The infant was transported to the hospital where he was pronounced deceased.

This child was born at home and later transported to a hospital. At the hospital, he tested positive for cocaine. During his brief life, the deceased child was diagnosed with thrush, influenza, and an ear infection. Medical records show he was within adequate growth parameters for weight and length.

The Spokane Division of Children and Family Services (DCFS) office had an open Child Protective Services (CPS) case at the time of the child's death. The assigned social worker observed the infant's sleep area. The social worker informed the deceased child's father to remove the clothes and stuffed animals in the crib.

The parents denied drug and alcohol abuse. Submitted urine samples for both parents were negative. Both parents agreed to complete drug/alcohol assessments and participate with Public Health Nursing services. The social worker monitored the parents' compliance with these requests. The child's mother followed through with the plan.

The assigned social worker was informed of the child's death on July 28, 2008. The Spokane Medical Examiner determined the cause of death to be undetermined. There were trace amounts of cocaine in the infant's blood stream. The manner of death was undetermined. The Medical Examiner explained the amount of cocaine to be a trace and was less than 0.01 mg per liter. This did not directly cause the child's death.

**Referral History**

On May 13, 2008, a hospital social worker reported to CPS intake that the deceased child was born at the family home on March 11, 2008. He was brought to the hospital after the birth and was in overall good health. The infant tested positive for cocaine while in the hospital. The referrer was told the mother tested positive for cocaine earlier in her pregnancy. This referral was screened as information only.

On July 7, 2008, a pediatric nurse reported to CPS intake that the mother brought the deceased child in for a well child exam and she fell asleep on the table. The doctor had no concerns about the child. The mother did not keep a follow up appointment to treat the infant for thrush. The mother was in non-compliance with her welfare benefits as she did not show for a drug and alcohol assessment. The social worker had a telephone call with Maternity Services at Holy Family where a referral was made for the mother. They stated there was no active case and no record of seeing her. This referral was screened in for investigation by CPS. The investigation was closed with a founded finding for negligent treatment or maltreatment.

On July 28, 2008, CPS intake received a report of the death of this infant. There was no allegation of abuse or neglect and the referral was screened as information only.

### **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 the 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:** There is no documented shared decision making process reflected in the case file regarding the accepted high risk, emergent referral from July 7, 2008.

**Recommendation:** Social workers and supervisors should utilize some form of a shared decision making process when a high risk, emergent referral is received with extremely vulnerable victims. Examples are Family Team Decision making meetings, Child Protection Team meetings and supervisory review staffings.

**Issue:** Family case files are not automatically requested and consolidated when files and records exist in a different field office or in records retention.

**Recommendation:** Each office or region should have a process for automatically consolidating case files when more than one exists for a family.