

**Child Fatality Review #08-42**  
**Region 3**  
**Whatcom County**

This 17-month-old Caucasian male died from asphyxiation.

**Case Overview**

On August 4, 2008, the child was asleep upstairs in his bedroom in the family home when the ventilator became disconnected and his father, asleep downstairs, failed to hear the alarm. By the time emergency personnel arrived, the child could not be revived. The cause of death was listed in Whatcom County Vital Records as: (a) vacterl syndrome (a series of birth defects affecting multiple parts of the body); (b) tracheostomy and ventilator dependent; (c) dextrocardia with small ventricular septal (birth defect of the heart); (d) defect right hypoplastic lung. The child was medically fragile and only able to live at home with considerable medical assistance. The manner of death is listed as natural.

The deceased child was born with complex medical congenital issues and was hospitalized for the first ten months of his life. He underwent several surgeries and needed several more. He had a tracheotomy and was on a ventilator for his breathing issues. Medical staff instructed the parents that the deceased child was to be on a ventilator at all times.

On the night the deceased child passed away, his father spent the night with his children. The mother was away for the evening. The father fell asleep and failed to hear the ventilator alarm when it became disconnected, even though the alarm sounds frequently. The ventilator tube would often disconnect when the deceased child would reposition himself in bed. The father fell asleep downstairs, but the deceased child's bedroom was upstairs. A neighbor heard the alarm from the open window upstairs and called 911. The father awoke to emergency personnel knocking on the door. The deceased child was unable to be revived.

The Bellingham Division of Children and Family Services (DCFS) office had an open case on this family at the time of this child's death. The department had an extensive service plan with the family that included services to reduce the stress level in the home and to support and assist the mother in coordinating all the activities necessary in caring for the deceased child as well as the two pre-school girls. This plan was in effect until the child died.

**Referral History**

On March 26, 2008, a Children's Hospital social worker reported to Child Protective Services (CPS) intake with concerns about the care given to this medically fragile child who needed to be on a ventilator. Medical staff were concerned after the mother said that

on two occasions she had removed the deceased child from the ventilator for short periods, believing he was happier without it. The mother on two occasions left the home without taking the back-up ventilator with her. This should have been left with the child for emergency use in case the primary one should fail. This referral was screened in for investigation by CPS. The CPS investigator observed the mother was extremely stressed by the needs of her son and two daughters. She was agreeable to a service plan to help her manage the needs of her family. This CPS case was closed with an unfounded finding for negligent treatment or maltreatment.

On April 23, 2008, law enforcement reported to CPS intake that the mother was seen yelling at two small girls while struggling to get them into their car seats. There was no report of injuries. There was no allegation of abuse or neglect and the referral was screened as information only.

On July 29, 2008, a neighbor called CPS intake to report they heard screaming coming from the family's apartment and that one of the girls appeared to have an injury to her nose. This CPS case was closed with an unfounded finding for negligent treatment or maltreatment. The mother was offered Family Preservation Services (FPS) and help with child care to alleviate her stress.

### **Issues and Recommendations**

**Issue:** The documentation in this case reflects the high quality of work done with the family in the Family Voluntary Services (FVS) unit. There was one social worker assigned to the case for the entire time it was open. She assiduously monitored the service plan developed with the family and exceeded performance expectations in her contacts with the family.

**Recommendation:** No specific recommendation was made to the above issue.

**Recommendation:** The safety plan written by the CPS investigator with the family after the initial CPS referral relied on the mother's agreement to follow medical advice regarding the deceased child and to contact certain people if she were feeling stressed. While this plan did not violate standard practice expectations, the methods for monitoring the plan were not specifically addressed. The office had, by the time this review was held, decided that safety planning and its documentation could be further strengthened by additional training and made arrangements for this training.

Supervisory reviews were not consistently documented during the time the case was open. However, the unit supervisor stated to the review team that he and the assigned worker staffed the case frequently and that he was always aware of developments in the case as they occurred.