

Child Fatality Review #08-58
Region 3
Skagit County

This two-month-old Caucasian male died from apparent positional asphyxiation.

Case Overview

On November 24, 2008, the mother of this the deceased child was visiting overnight at a friend's house with her three small children. She fell asleep on a bed after feeding her two-month-old infant. When she awoke in the morning she found him unresponsive on the bed beside her. He was unable to be revived. At the time of this report, the County Coroner had not released an official cause and manner of death. The Coroner's official finding is pending the outcome of the police investigation.

This is the third infant to die in this mother's care. A child born in June 2004 died less than one month after being born. The death was officially attributed to Sudden Infant Death Syndrome (SIDS). CPS was not notified of that birth/death at the time and did not become aware of it until three years later.

In October of 2005, the mother gave birth to her third child while Children's Administration had an open case. The social worker closed the case after working with this family for five months. The mother participated in several services. She agreed to frequent urinalysis. During this 5 month timeframe, her initial urinalysis was positive for marijuana, all others were clean.

Her fourth child was born in March of 2007. A referral concerning the death of this child came from the Medical Examiner's office two months later. At that time Child Protective Services (CPS) opened a case and filed dependency petitions on her two surviving children based on the history of substance abuse, continuing issues of domestic violence, and the prior infant death. The children were temporarily removed from the home. When the autopsy report was concluded, the cause of death was officially listed as "undetermined" and the manner as "natural". After two weeks, the court agreed to return the children to the mother's care, based on her clean urinalyses and her quickly accessing the recommended services. The children were made dependents of the court and services were court ordered. The children were placed with their mother.

Between May 2007 and October of 2008, (when the deceased child died) the mother and the children had intensive monitoring and services from the department. She participated in 12 step groups, had clean urinalyses, and participated in counseling. When the department learned the mother was pregnant with the deceased child, the social worker recommended the court continue the dependency with in-home services and monitoring until after the new baby was well established.

It appeared that the mother maintained sobriety after the deceased child's birth. In addition to his scheduled doctor visits, she took him to at least three medical visits when she had concerns. She also received an apnea monitor from Children's Hospital with instructions for use. On the night of the infant's death, the mother, along with the maternal grandmother, and the three small children went to a friend's house where the adults drank and they all spent the night. The deceased child's mother did not have the apnea monitor with her. When she awoke in the morning, her infant was beside her on the bed, unresponsive.

The mother never disclosed the name of the father of this baby. She was adamant it was not the father of her older children, a relationship marked by domestic violence. There were suspicions that she resumed her relationship with him and allowed the children to see him. This was adamantly denied by the mother and the information was not verified.

Referral History

On May 24, 2005, a neighbor reported to Child Protective Services (CPS) intake that the mother's two-year-old child was home alone. This neighbor brought the child into her apartment and kept her overnight. The neighbor reported that the next morning when she returned the child; the mother was unaware the child was gone. CPS and law enforcement arrived and found the father of this child hiding in the house in violation of a domestic violence restraining order. He was arrested. The mother worked with the social worker and participated in a variety of services. After five months and several clean urinalyses, the case was closed about the time. The investigation was closed with an unfounded finding for negligent treatment or maltreatment.

On June 23, 2006, a report was made to Child Protective Services (CPS) intake that the mother's three-year-old child was seen near a busy intersection alone dressed only in a tee shirt. A passer-by returned the child home; the mother was found asleep. She was again asked to submit a urinalyses test and it was positive for marijuana. The case remained open until October when the mother entered inpatient treatment. The investigation was closed with a founded finding for negligent treatment or maltreatment.

On November 16, 2006, a report was made to Child Protective Services (CPS) intake that the mother aborted treatment after only one month against the advice of the treatment agency. This referral was generated as a result of that premature departure from treatment. At that time she was six months pregnant with another child, who later died at two months of age. The case was closed with an unfounded finding for negligent treatment or maltreatment.

On May 14, 2007, a report was made to Child Protective Services (CPS) intake that the two-month-old infant daughter of the deceased child's mother died overnight in a motel room where the mother, her boyfriend (father of her older children) and their two other young children were spending the night. The mother told law enforcement that the infant

had been sleeping in the bed with her and at least one of the other children. She was found non-responsive when she awoke in the morning. A small amount of drugs was found in the room. The boyfriend was arrested for violation of a no-contact order. The cause of the infant's death was not immediately apparent, but was later ruled as "undetermined" cause, and the manner as "natural." The investigation was closed with an inconclusive finding for negligent treatment or maltreatment.

On August 22, 2007, a therapist reported to CPS intake that the deceased child's mother and her long time boyfriend were again having contact around the children despite prohibitions against it in the protection orders and the dependency orders. This referral was screened to the Alternate Response System and a service plan was put in place.

On October 18, 2008, law enforcement reported the death of this child. The two surviving children, ages three and five, were placed in protective custody and remained in foster care until January 2009 at which time they were returned to their mother's care on an in-home dependency.

Issues and Recommendations

Issue: Prior to the birth of this infant, the social work staff identified that the additional stress to the family would be a potential risk factor in the mother's ability to maintain sobriety. It was at precisely this time, however, that the relatively stable team that had been working with the family was disrupted by personnel changes. Although the amount of contact with the family during that time was within policy, the case did have less attention during this time than would have been advisable.

Recommendation: The issue of case transfers within units and from one unit to another should be addressed at a meeting of supervisors. That discussion should include a review of the protocol for transfers, as well as suggestions from the group on the best strategies for ensuring that the supervisor(s) and the newly assigned worker(s) both transmit and understand the most critical pieces of information related to the case that concern the children's safety.