

Child Fatality Review #08-62
Region 5
Kitsap County

This two-year-old African American female died from unknown causes.

Case Overview

On the morning of November 2, 2008, a family friend caring for the deceased child went to a bedroom where the deceased child was sleeping and found the child unresponsive and lifeless.

The deceased child was being cared for by a friend of her mother. The mother was unable to properly care for her young children while she recovered from a medical procedure so she arranged for her oldest daughter to visit her father and the deceased child stayed in the home of the mother's long-time friend, the friend's paramour, and his three children. The paramour's fourth child died suddenly of unknown cause and undetermined manner in June 2008.

The mother of the deceased child was aware of the prior child death in the friend's home. She was told the child died from Sudden Infant Death Syndrome (SIDS). The deceased child's mother said she believed the friend's home was a safe place for her daughter. The mother reported that neither the deceased child nor her sister ever showed signs of fear around the mother's friend.

While staying at the home of the family friend, the deceased child was reportedly put to bed by the friend's paramour around 10:30 in the evening of November 1, 2008. He stated that he "swaddled" the two-year-old in a comforter. He checked on the child before he went to bed; the child was alive and breathing. The mother's friend reported getting up during the night and checked on the children, a routine she had been doing since the death of her paramour's son earlier in the year. She reports that all the children were fine.

A preliminary post-mortem report indicated no signs of trauma. Asphyxiation is a possible cause of death; the manner of death is still under investigation. The deceased child's mother is not a suspect in her daughter's death.

Referral History

On May 9, 2008, the mother of the deceased child reported to Child Protective Services (CPS) intake that her oldest daughter was being emotionally abused by her father during court ordered visitation. The mother reported her then two-year-old daughter returned from visitation saying her younger sister (the deceased child) was bad and that she wanted to live with her birth father. The mother made a referral to a therapist. This referral was screened out as Information Only.

On October 22, 2008, an anonymous referrer reported to CPS intake that the three-year-old sister of the deceased child may have been sexually abused. This child had chronic yeast infections and pain in her genital area. It was reported the child's mother had various male visitors in the home. The child had a medical examination for sexual abuse and the result was no evidence of abuse. This referral was investigated by CPS and closed with an unfounded finding for negligent treatment or maltreatment.

On November 5, 2008, a report was made to CPS intake regarding the death of this child. The deceased child's mother allowed a friend to baby sit her child (the deceased child). This friend recently experienced the death of another child in her home. The deceased child was wrapped in a comforter and put to bed. The friend's paramour woke in the morning and heard other children playing and went to a back bedroom and found the deceased child with froth coming from her nose. She appeared deceased. An autopsy was completed; no trauma was found. The coroner raised concerns about this child fatality as he investigated the prior child death in this home. At the writing of this report, the coroner has yet to release the findings of the autopsy. This referral was screened in for investigation by CPS. The finding of the investigation is pending the result of the autopsy.

Issues and Recommendations

Issue: In review of the history of involvement with Children's Administration for the family, no significant practice, policy, or system issues were identified. Two minor practice issues were discussed during the Child Fatality Review held on April 15, 2009. Neither issue appeared to have any implication with regard to the circumstances of the two year old child's death. The noted practice issues (below) are included in this section of the Child Fatality Report for the limited purpose of documenting discussions occurring during the Child Fatality Review.

(1) During the fatality review the social worker investigating the October 2008 referral recalled having spoken to a nurse from the pediatrician's office early into the investigation regarding the alleged victim (oldest child). However, the worker did not document this contact in the case file. (2) A Structured Decision Making (SDM) risk assessment was conducted on the mother (identified subject) for the October investigation regarding the three-year-old sister, the half-sibling of the now deceased child. The biological father and his wife were not identified subjects and therefore completing an SDM on that household would not be required. However, the child did split time evenly between the two households and consideration might have been given to complete a paper version of the SDM on the father's household especially as there were concerns regarding the father's history as a juvenile.

Recommendation: None

Actions Taken: The CPS investigator, the CPS supervisor, and the CPS Program Area Administrator participated in the review and received feedback regarding the two minor practice issues.