

Child Fatality Review #08-67
Region 6
Clark County

This three-month-old African American female died from Sudden Infant Death Syndrome (SIDS).

Case Overview

On November 9, 2008, the deceased child's mother found her unresponsive in her crib. The family reported at 5:30 p.m. the deceased child's father put her in her crib on her back. At midnight, he heard her crying. He got up and gave her a bottle of Enfamil formula. The father reported he left the bottle with the child in the crib. He added that she calmed down and went back to sleep. At approximately 4:30 in the morning, the mother checked on her daughter and found her lying face down, unresponsive in her crib. Police and medics responded after the mother called 911. The child was pronounced dead without treatment at 4:47 a.m. An autopsy was completed and nothing suspicious was found.

Referral History

The deceased child's mother first came to the attention of the department in 2002 on a report that her then four-year-old son was being sexually abused by her and the child's maternal grandfather. In addition, there were allegations of domestic violence between the mother and her partner, the deceased child's father. These allegations came during a heated custody battle. The allegations were investigated and closed with an unfounded finding. Ultimately the father of this child was granted custody.

The mother gave birth to another son in August 2003. Although there were some concerns about the mother using illegal drugs, the department attempted to work with her and the father to provide in-home services to support their care of the infant. The child was placed in foster care when there were concerns about drug use. The family would engage in services and the child would be returned. In June of 2004 the child was placed into foster care where he remained until his adoption.

The mother proceeded to give birth to two more boys in September of 2004 and February 2006. These children were immediately removed from their parents' care. The department offered additional services and attempted to reunify the family. The services offered included: chemical dependency treatment, pregnant/parenting programs for chemical dependency, random urinalysis, relapse programs, transportation services, mental health services, anger management classes, domestic violence classes, visitation, child care, bus passes, Intensive Family Preservation Services (IFPS), and parenting education and support. The deceased child's parents would initially engage in services, but would soon disengage and not follow through. A variety of services and service options were offered to support this family and support the parents being reunified with

their children. Ultimately the department filed for termination of parental rights and it was granted. All three boys were placed in the same home and ultimately adopted by this family.

The case was closed at the time the mother gave birth to the deceased child.

On August 7, 2008, hospital staff reported to Child Protective Services (CPS) intake that the mother recently gave birth to the deceased child. This staff person was aware that the mother had four other children removed by CPS in the past. The mother had a negative urinalysis (UA) at delivery and two negative UAs during her prenatal care. At the time of this child's birth, the mother was living in a homeless shelter. This referral was screened as Information Only.

On November 6, 2008, a report was made to CPS intake by a homeless shelter staff person who reported the deceased child's parents had relapsed and were using methamphetamine in the presence of their three-month-old infant daughter. Another resident in the shelter saw a glass pipe and the methamphetamine near the infant. A shelter staff reported no confirmation that either parent used drugs prior to the death of their daughter on November 9, 2008. This referral was screened in for the Alternate Response System (ARS).

On November 10, 2008, law enforcement reported to CPS intake the death of this child. It was reported the mother checked on the child at 4:30 a.m. and found her unresponsive. An autopsy was completed and nothing suspicious was detected. A toxicology screen was conducted on the child and it came back negative. This referral was screened in for investigation by CPS and closed with an unfounded finding for negligent treatment or maltreatment.

Issues and Recommendations

Issue: Regarding the placement of an older sibling in 2003, there were concerns about the reunifications with the family and then re-entries into foster care. It was unclear what type of risk assessment was used to determine that the child should be reunited, and what criteria was being considered. This child was placed into foster care immediately following his birth on September 2, 2003. He was reunified with his parents on October 7, 2003 and removed from their care again on May 4, 2004. He was back in foster care for seven days and returned to his parents on May 11, 2004 until June 17, 2004, when he returned to foster care for the final time.

Recommendation: The group conducting the review discussed the request by the office for refresher and ongoing safety assessment/risk assessment training for Child and Family Welfare Services (CFWS) workers, in addition to training opportunities for Structured Decision Making.

Action Taken: The Area Administrator has been in contact with Risk Management at Headquarters to schedule this training.

Issue: The review team discussed the screening of the two referrals just prior to the death of the deceased child. During the initial paper review of the file it was unclear as to why the referrals were not screened in for response by CPS. Upon reviewing this with the review team it was discovered that not all of the information was available to the intake workers at the time of the screening due to the case being administratively locked. The intake workers reported a delay in gaining access to information on cases that were marked administrative and at times they needed to proceed with the information they had in front of them in order to meet the time allowed by policy to complete the investigation.

Recommendation: This should no longer pose an issue with the new automation system, FamLink. All intake supervisors have access to view restricted cases and can assist their workers in having this information if needed to make an appropriate screening decision.

Issue: The record clearly showed a pattern of assaultive behavior on the part of the deceased child's father. He was ordered to anger management classes, and had a history of violence with the child's mother. In addition, he followed a DSHS staff to her vehicle and verbally assaulted and threatened her in the parking lot. This required a response from law enforcement. The workers involved in this case felt that the father was loud and inappropriate, but did not feel there was a safety issue.

Recommendation: The Danger to Worker indicator should be marked on this case to ensure staff safety if the case were to return at some point in the future