Child Fatality Review #08-68
Region 5
Pierce County

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

Case Overview

On December 3, 2008, the deceased child's parents returned to a relative's home where they were staying due to homelessness. According to the couple, it was late in the evening, and they were unable to wake the relative to get inside the house. They decided to spend the night in their car parked in the driveway. They had their three-month-old daughter with them. The relative later told police that the mother and the deceased child were welcome in her home, but the father was not. The mother voluntarily chose to stay the night with the father in the car. The parents put the three-month-old infant in her car seat to sleep. A six-year-old half-sibling was elsewhere at the time. The temperature that evening was in the 40 degree range. The car heater was used several times to heat the vehicle according to the parents.

The parents report having fed the baby around 1:30 a.m. They changed her diaper between 3:00-4:00 a.m. prior to driving to a nearby store for food and returning to the driveway and going back to sleep. When the couple awoke around 6:00 a.m. the infant was unresponsive with bloody mucous from the nose. The parents transported her to a nearby hospital in Pierce County where death was pronounced.

Law enforcement investigated and found no evidence of foul play. In March 2009, the mother was notified by the Medical Examiner's Office that her daughter's death may have been caused by a medical condition involving her heart muscle. The possible connection to a heart condition was confirmed in early April 2009 when the Medical Examiner determined the cause of death to be "Sudden Unexplained Death in Infancy, associated with cardiomegaly; sleeping overnight in motor vehicle in cold weather (undetermined if external factors involved)." The manner of death was designated as Undetermined.

Referral History

On July 23, 2008, it was reported to Child Protective Services (CPS) intake that the deceased child's mother was not meeting the basic needs of her six-year-old daughter (older sibling of the deceased child). It was alleged that the mother used food stamps to buy drugs and left her daughter in a drug house while she went panhandling. This child had head lice and missed a substantial amount of school. This referral was screened in for investigation by CPS. The mother was actively engaged in services including parenting classes, maternity support, housing support, and drug/alcohol evaluations. The case was closed with an unfounded finding for negligent treatment or maltreatment.

On December 3, 2008, a nurse reported to CPS intake that the deceased child was admitted to a Tacoma area hospital at 6:14 a.m. after being found in her car seat not breathing. The child was non-responsive to CPR. The child was declared dead at 6:55 a.m. There were no signs of trauma. This referral was screened in for investigation by CPS. The case remains open at the time of this report. Law enforcement also investigated this child fatality. The mother and her surviving daughter were referred to grief counseling. The mother was also referred to community mental health for other issues. The CPS investigator referred the mother for chemical dependency assessment which resulted in admission into a treatment program. The child's father had moved out of state.

Issues and Recommendations

Issue: The Child Fatality Review was held at the Tacoma West DCFS office on April 29, 2009. The entire family history of involvement with Children's Administration (CA) was reviewed. The CA history was limited to a single CPS investigation prior to the deceased child's birth and her subsequent Sudden Unexplained Death in Infancy (SUDI) associated with cardiomegaly (enlarged heart). During the review several issues were discussed but none appeared to have any obvious impact with regard to the circumstances of the child death.

The issues emerging during the review are included below for the limited purpose of documenting the discussions occurring during the child fatality review.

Issue: Regarding the referral dated July 23, 2008, the overall intake decisions appeared reasonable and supportable. A minor intake issue surfaced during the Child Fatality Review. The live-in boyfriend and father of the then unborn child was not identified as a subject, caretaker, or client although his identity and role within the family was known at the time of the intake. While the review panel did not reach agreement as to whether the deceased child's father should also have been identified as a subject for neglect of the six-year-old sister, full consensus was made that he should have at least been identified as a client and connected to the case.

Recommendation: None

Issue: Regarding the investigation of the CPS referral dated July 23, 2008, the worker met or exceeded policy and practice standards for conducting a CPS investigation. The quality of work appeared exceptional. Interviews with the alleged child victim, the subject, the father of the unborn child, and the referent occurred in a timely manner. A Safety Assessment was conducted and documented in CA Case and Management Information System Graphical User Interface (CAMIS GUI) within the prescribed timeline. The worker conducted the Global Appraisal of Individual Needs Short Screener (GAIN-SS) for substance abuse and mental health issues with the mother, the father of the unborn, and with the relative who was involved in caring for the child. An Ethnic

Identity form was completed for the deceased child’s sister with the mother's participation and signature.

The CPS worker obtained a signed Exchange of Information from the mother permitting the worker to contact service providers. The worker made numerous contacts with professionals involved with the family, including medical (for both the mother and for her oldest daughter), WorkFirst, housing, and a Woman's Empowerment and Employment Program. The worker was never able to connect with the Maternity Support Services worker who had been assigned to work with the mother through the Community Services Office (CSO). However, the medical provider indicated that overall the mother did well with pre-natal care and efforts to involve the mother in a Parent-Child Interactive Program and with a local community mental health agency was in process. Urinalysis testing was done on the mother (positive for marijuana only). A Pierce County Resource Directory was provided to the mother that included sources for drug and alcohol services.

Prior to closing the CPS investigation, the worker appropriately identified both risks and strengths as part of the Investigative Assessment. Although the Structured Decision Making (SDM) tool did not indicate significant risk for neglect or abuse, only the mother was assessed as the deceased child’s father was reportedly no longer a member of the household. It is unknown if the SDM scores would have significantly changed had the father been considered as a secondary caregiver for the purpose of assessment.

Recommendation: None

Action Taken: The CPS worker was unavailable to participate in the Child Fatality Review due to an emergent field response assignment. However, the worker's supervisor and Area Administrator were present and received positive feedback from panel members regarding the excellent work. The worker was made aware of the feedback shortly after the review concluded.

Issue: A Pierce County hospital nurse reported to Central Intake (CI) the death of this child who had been transported by her parents after being found unresponsive. The referent had limited information and the intake was taken for information only purposes. There were no reported concerns that the death was suspicious for child abuse or neglect (CA/N). Given the limited information available to the nurse and provided to CI, the decisions made at initial intake appear to be reasonable. Supervisory reviews by CI were documented and an Administrative Incident Report was appropriately generated by CI due to the family having recently been involved with CPS.

The referral was then reviewed by Tacoma intake. The hospital was re-contacted and additional information gathered. Although there was still no reported evidence of abuse or neglect related to the child death, sufficient concerns were emerging, such as the father's observed behaviors at the hospital and slightly varying details of the

circumstances surrounding the death (e.g., the infant and parents had slept the night in a car). The intake was again reviewed by two Area Administrators in the Tacoma DCFS office and the decision was made to upgrade the referral abuse or neglect allegations the intake was screened in under Imminent Harm. The basis for the revision at intake was documented. The deceased child was identified as a victim of possible imminent harm. It would have been more reasonable to identify the surviving child as being possibly at imminent harm of neglect than the deceased child.

During the review discussion occurred as to whether the fact that the parents slept in a car with their infant on a moderately cold (40 degree) night showed "a serious disregard of the consequences to the child" such that it created "a clear and present to danger to child's health, welfare, and safety" [WAC 388-009: What is child abuse and neglect?]. The panel was unable to reach consensus on that issue. However, the review panel did reach general consensus that the decision to open a case for CA involvement was reasonable given very recent CPS involvement and the high media coverage of the child death incident.

The case was assigned to a CPS worker out-stationed at the Pierce County Child Advocacy Center (CAC) and eventually transferred to Family Voluntary Services (FVS) although the SDM score did not indicate a need for extended services. The mother reportedly declined FVS and the case was transferred back to CPS for case closure.

Recommendation: None