

Child Fatality Review #08-72
Region 5
Pierce County

This three-month-old Caucasian female died from interstitial pneumonitis (a form of pneumonia).

Case Overview

On November 28, 2008, the deceased child's mother and her three children were at the home of the mother's boyfriend, who is the presumed father of this three-month-old infant. The mother reported to law enforcement that she had gone to bed with her infant sometime around 10:30 the evening of November 27, 2008. The infant, mother, and her boyfriend were all sleeping in the same bed. The boyfriend awoke around 4:30 a.m. and went to back to sleep in another room in the house. The mother fed the infant at around 6:30 a.m., burped her, and then laid her across the mother's stomach in the prone position (on stomach with face turned towards mother). They both went back to sleep. The mother said she later awoke with the infant in the same position as when they fell asleep, but the child was blue and cold to the touch. She notified her boyfriend who called 911. Fire and Rescue was dispatched to the scene as the parents attempted to revive their daughter. The child was pronounced dead at 9:44 a.m. Law enforcement was notified and arrived on scene around 10:00 a.m.

There is a reported discrepancy in the events. A responding fireman told police that the mother went back to sleep with the boyfriend around 6:30 that morning and both adults were in same bed when the baby was found not breathing and blue in color. This information conflicts with the mother's later statement to law enforcement that the baby's father was sleeping elsewhere at the time the baby was discovered unresponsive.

Following autopsy and toxicology studies, the cause of death was determined to be medical in nature (interstitial pneumonitis) and the manner of death natural. Interstitial pneumonitis is a form of pneumonia that involves the connective tissues of the lung, and can be caused by an infection, toxic inhalation, or a virus.

Referral History

On May 14, 2007, a neighbor reported to Child Protective Services (CPS) intake that the deceased child's nine-year-old sister had a black left eye. The referrer asked this child about the bruise and she said her mother hit her. The nine-year-old said her mother hit her all the time as did the mother's boyfriend. Another neighbor said this child had a bloody nose from being hit a month prior. This referral was investigated by CPS and closed with an unfounded finding.

On November 6, 2008, a teacher called CPS intake and reported that the deceased child's mother had relapsed on methamphetamine. The mother told the referrer she and her

children had lost their housing and were going to live in a car. The family moved around to various friends' homes. The deceased child's eight-year-old brother has Attention Deficit Hyperactivity Disorder (ADHD) and is developmentally delayed. The referrer reported he was not in school for three weeks. This referral was screened as Information Only.

On December 10, 2008, law enforcement called CPS intake and reported the death of this three-month-old infant. Neither the medical examiner investigator nor law enforcement found anything unusual or suspicious about this child's death. This referral was screened as Information Only.

On January 1, 2009, CPS intake was contacted by staff at a King County area hospital where the deceased child's mother was admitted to the psychiatric ward for suicidal ideation and extreme depression. It was reported the mother was struggling after the death of her child. An emergency room social worker received information from a relative that the mother's boyfriend (the deceased child's father) was previously abusive to her eight-year-old son. This child disclosed he was punched until he passed out. He also disclosed that the mother's boyfriend placed a pillow or blanket over the now deceased child's face until she would stop crying. The intake was accepted for investigation of physical abuse regarding Tyler. The children were in the care of relatives prior to opening the investigation and remain in their care. The mother's boyfriend left the home and his whereabouts are unknown. The CPS investigation resulted in a founded finding for physical abuse of the eight-year-old by the mother's boyfriend. Law enforcement still had an open case regarding the child fatality.

Issues and Recommendations

Issue: In May 2007, CPS received a report alleging physical abuse of the then nine-year-old sister of the deceased child. The allegations did not involve the now deceased child who was not born until September 2008. The CPS investigator appears to have met most policy and practice expectations for conducting an investigation, including timely interviews with the alleged victim and subject. However, in review there were some noted practice deficits from the 2007 CPS investigation, none of which were found to have any significant implication to the child fatality 18 months later.

The worker did not input the Safety Assessment into the CA Case and Management Information System Graphical User Interface (CAMIS GUI) until well past the prescribed timeline. The Global Appraisal of Individual Needs Short Screener (GAIN-SS), which is designed to be completed with the client, was sent to the parent to fill out and return by mail. The CPS investigator was aware of a male roommate but did not pursue further information. No audio recording was made of the alleged victim interview. Audio recording of physical abuse interviews was expected practice in 2007. The social worker who had been the investigator in 2007 participated in the review and received

feedback regarding the investigation. The worker acknowledged deficits and areas where improved practice, including best practice, might have been conducted.

Recommendation: None

Issue: The decision to screen out the referral taken on November 6, 2008 appears reasonable. There were no specific allegations being reported. While there were identified risk factors, none singularly or cumulatively appear to have represented imminent risk of serious harm at the time of the intake. Just over two weeks later CPS intake received by mail the hardcopy school report from the original call made to intake. The same intake worker who processed the call-in also reviewed the mail-in report. The worker noticed information on the hardcopy school report that had not been originally presented at the time of the call-in, and the worker documented the additional information in a Service Episode Report (SER) case note. The panel was unable to review the hardcopy school report. According to the SER by the intake worker, the school report was discarded due to there being no previous CA case file. This was an error as there had in fact been a CPS investigation conducted in 2007 and a case file for the family existed at the time of the November 2008 intake.

The worker did document in SER that according to the school the mother admitted to drug use. Additionally it was being reported that an unnamed live-in boyfriend was involved with making and selling methamphetamine (not specified if such was occurring at the home or elsewhere). The fact that the intake worker compared the details from the hardcopy school report with what had been documented in CAMIS-GUI reflected good practice. However, the panel review members were in full consensus that the additional information found in the mailed-in school report should have generated at least further discussion with the intake supervisor about a possible screening revision or generating a new referral based on the additional information of the methamphetamine manufacturing and selling. Minimally the intake worker might then have been directed to re-contact the referent to find out who was the primary source of the information being reported.

Recommendation: None

Action Taken: The Region 5 Area Administrator overseeing regional intake has agreed to address with the Tacoma intake supervisor and intake worker for general feedback the specific intake issues discussed during the Child Fatality Review.

Action Taken: Regarding the referral taken on November 6, 2008, it will be used as a training opportunity during the next scheduled Tacoma DCFS intake unit meeting. Primary focus will be on discussing consultation and shared decision making following additional information received on an already completed intake.

Issue: A month following the death of her infant the mother was hospitalized. While the family was visiting at the hospital, a hospital social worker became aware that the eight-year-old brother of the deceased child had disclosed to family members that the mother's boyfriend was physically abusive in the past. The eight-year-old told relatives that the mother's boyfriend punched him and held a pillow over the deceased child's face until she stopped crying. He gave no specified time frame for these incidents. It was noted that the mother's boyfriend no longer had contact with any of the children since the deceased child death in late November 2008.

The intake was screened in by Central Intake (CI) for Alternate Intervention and sent to the appropriate Children's Administration jurisdiction (Tacoma) where the report was reviewed by the Tacoma Intake Supervisor and an Area Administrator. The decision was made to change the CI Alternate Intervention designation to "accepted for CPS investigation." In review, the Child Fatality Review panel was in full consensus that the upgrade to CPS investigation appeared to be more supportable than the original low risk referral decision. This opinion was shared with the CI liaison to Region 5 following the Child Fatality Review.

At intake only the eight-year-old brother was identified as an alleged victim. Information gathered and documented during the CPS investigation appears to have been sufficient to have the older sister added as a victim of abuse by the mother's live-in boyfriend. Less clear was whether there was sufficient information to add the deceased child as a victim of pre-fatality abuse and neglect. Documented statements from the mother suggested that she might have been added as a subject for failing to intervene in the abuse of her eight-year-old son but the review panel was not able to come to any clear consensus as to supportability of such a decision. The CPS investigator for the post-fatality intake and her supervisor were present during Child Fatality Review and acknowledged the reasonableness of adding at least the older sibling to the intake as a victim.

Recommendation: None