

Child Fatality Review #08-75
Region 4
King County

This one-month-old Caucasian female died from Sudden Unexplained Infant Death (SUID).

Case Overview

On December 20, 2008 the King County Medical Examiner's Office called Child Protective Services (CPS) Intake to report the death of this one-month-old infant. She was found dead by her mother at 7:40 a.m. The mother told the death scene investigators that her daughter was possibly ill on the night of December 19, 2008 as she was very fussy and would not sleep. At about 3:00 a.m. the mother was breastfeeding her in bed, with the mother lying on her side. She could not remember if she or the infant fell asleep but when she woke up, her daughter was dead.

According to the scene investigation report, the deceased child was last placed on her side in the mother's bed, with the mother, at 3:45 a.m. She was last known alive at 3:45 a.m. She was found dead at 7:00 a.m., and the mother's bra was entangled with the infant.

The death scene investigators noted the temperature of the room was very hot. The environment was described as clean but cluttered. The King County Medical Examiner ruled the Cause of Death as Sudden Unexplained Infant Death (SUID). It could not be determined if external conditions related to bed sharing contributed to the death. The Manner of Death is Undetermined.

Referral History

On April 22, 2003, it was reported to CPS intake the deceased child's mother was six months pregnant and continued to use methamphetamine, crack, and marijuana. She refused to enter substance abuse treatment and did not have consistent prenatal care. The referrer stated the mother lived with her mother who was dealing drugs from the home. The referrer also reported the mother had a seven-year-old son in her care. The referrer reported she briefly lost custody of her son after she was arrested for child endangerment in California. The mother was briefly incarcerated for felony assault. This referral was screened in for investigation by CPS and closed with an unfounded finding for negligent treatment or maltreatment.

On August 3, 2003, a hospital staff reported to CPS intake that the deceased child's mother tested positive for amphetamines and marijuana while in the hospital to give birth to a baby boy. She had poor prenatal care and tested positive for methamphetamine, marijuana, cocaine, and opiates while pregnant. Doctors placed a medical hold on the newborn infant. This referral was screened in for investigation by CPS and closed with a founded finding for negligent treatment or maltreatment. A dependency petition was filed

on behalf of this child. He was placed in foster care. Eventually the mother's parental rights were terminated.

On September 24, 2003, a report was made to CPS intake that the then seven-year-old sibling of the deceased child was left home alone at 5:45 p.m. The mother had gone to court and said she would not be back until 8:00 p.m. This referral was screened in for investigation by CPS and closed with an inconclusive finding for negligent treatment or maltreatment. A dependency petition was filed on behalf of this child and the mother's parental rights were terminated.

On November 9, 2008, a medical professional reported to CPS intake that the mother gave birth to the deceased child. The referrer reported the mother had little or no prenatal care, tested positive for marijuana upon admission to the hospital, and gave birth to the deceased child prematurely. Hospital staff observed the mother was rough in handling the baby and was inappropriate with the infant. The mother was seen accidentally kicking this newborn on the head. The newborn was examined and found to be fine. Nurses had to coach the mother on proper handling techniques. This was her fourth child. The mother had three other children removed from her care because of substance abuse and neglect issues. The mother briefly lived in Michigan and gave birth to a child there. The child was reportedly removed and placed into CPS custody in Michigan. This referral was screened in for investigation by CPS and closed with an unfounded finding for negligent treatment or maltreatment.

On December 20, 2008, the King County Medical Examiner reported to CPS intake the death of this one-month-old infant. The mother found the infant dead at 7:40 a.m. on December 20, 2008. The mother told the medical examiner that her daughter was fussy and perhaps had picked up an illness by spending time relatives who were ill. The deceased child was unable to sleep on the night of December 19, 2008. At 3:00 a.m., the mother breastfed the infant in bed (co-sleeping). The referrer said the mother was trying to get her life together. There were no outward signs of infection. The child died from Sudden Unexplained Infant Death. This referral was screened in for investigation by CPS. The CPS case remains open at the time of this report.

Issues and Recommendations

Issue: According to the CPS workers, the hospital nurse who made the November 9, 2008 call to CPS Intake thought the report was an inaccurate account of her statement. She told the CPS workers who responded that she did not say the mother tested positive for marijuana. In fact, the mother was not tested while in the hospital. The mother told the referrer that she used marijuana during the third trimester for nausea. The infant was negative for all substances. The nurse did not think the mother was inappropriate with the infant. The nurse was present when the mother's foot accidentally brushed the head of the infant and the infant was not injured. The nurse did think a report was necessary based on the mother's statements about her history.

Recommendation: Intake workers can help ensure the accuracy of reports by reading the text of the allegations back to the caller and making corrections as necessary.

Issue: The mother had a CPS history in the state of Michigan and had been in substance abuse treatment. There were no calls to Michigan to verify this history or request records. According to the mother, she gave birth to a daughter while living in Michigan in 2006-2007. She said CPS took custody of the infant and she relinquished her rights so the paternal grandparents could raise her. She also said she was on probation for possession of cocaine and in intensive out-patient treatment there.

Recommendation: Social workers should always contact other states for information when a client has a case history there. This can provide valuable information to help determine a caregiver's impairment, strengths and risks.

Issue: The assigned CPS social worker read the case files from the Division of Children and Family Services (DCFS) King East office concerning the termination of parental rights of her older children. However, neither she nor her supervisor contacted the Child and Family Welfare Services social worker who had been assigned the case and still works in the King East office.

Recommendation: The best practice would be to contact the previously assigned workers. Had the previously assigned worker been contacted about the birth of the deceased child, he may have been able to provide additional information or case history to better inform the latest worker.

Issue: The need for policy guidance on the response when mothers give birth after their parental rights have been terminated as to other children.

Recommendation: Since February 1, 2009, FamLink (Children's Administration's new electronic case management information system) allows reports of infants born to caregivers with prior termination of parental rights to be opened as "Risk Only," meaning there is imminent risk of serious harm but no current allegation of child maltreatment.

When Children's Administration releases the updated "Practice Guide to Intake and Investigative Assessment" later in 2009, it will provide more guidance on how to respond to such intakes.

Issue: The decision to allow the deceased child to go home with her mother.

The assigned social worker made this decision based on information provided by the first responding social worker and on contact with the mother at the hospital. The mother exhibited early positive signs that she was committed to parenting this child. She made living arrangements that included living with another adult (her mother) to monitor the

baby's safety and provide her additional support. She also demonstrated her commitment by making firm arrangements to seek treatment for mental health and substance abuse issues.

Recommendation: More collateral contacts (as mentioned previously) could have strengthened or altered the decision to have the infant go home with the mother.

Issue: The CPS social worker observed the positive interactions between the mother and infant in the home. The mother was able to breastfeed without difficulty. She saw the sleeping arrangements for the infant and mother. The home was noted to be very clean and neat, the mother had her own bed, and there was a crib for her child. The grandmother, a trained LPN, also lived in the home and provided support.

The worker gave the mother a "Safe Sleep" kit, provided by the Northwest Infant Survival Alliance/SIDS Foundation of Washington. The kits include information for parents on SIDS and risk reduction, safe sleep position, and other prompts to make the sleep environment as safe as possible. The worker carefully went over the contents of the kit with the mother. The mother said she smoked outside.

Recommendation: When writing safety plans with families who have infants, it may be appropriate to list all the safe sleep practices and have the caregivers sign acknowledgement and agreement to adhere to them.

This office has since initiated a safe cribs project for their clients. Children's Administration should consider ways of partnering with communities to emphasize infant safe sleep and risk reduction strategies.

Issue: The CPS worker made a referral to the Early Intervention Project, a contract with Public Health Nursing. The assigned nurse visited with the mother and infant in the home. The mother was exclusively breastfeeding. The deceased child's growth and development was within normal limits. She was enrolled at Women, Infants, and Children (WIC). She had a primary care pediatrician and had had her initial well child check. The nurse noted that the infant lived in a safe and nurturing environment. The nurse was aware of the mother's history concerning mental health and substance abuse, and her current treatment arrangements. The nurse visited the deceased child in the home three days before she died. From the Public Health Nurse (PHN) perspective, it was appropriate for this infant to be living at home with her mother.

Even with specific instruction to the contrary from the CPS worker and the PHN, the mother still decided to bed-share with her infant on at least one occasion. Also, the odor of cigarette smoke was noted to be in the home and the bedroom was very hot at the time of the death investigation.

Recommendation: Children's Administration should consider joining community efforts to find the most effective ways of delivering infant safe sleep information to at-risk families.