

Child Fatality Review #08-76
Region 6
Jefferson County

This eight-month-old Caucasian male's cause of death is undetermined.

Case Overview

On December 25, 2008, the deceased child and his mother went sleep in the same bed. The mother was on the right side of the bed and the deceased child was in the middle of the bed. The mother was awakened by another resident of the shelter in which they were living. This resident found the mother asleep on the floor near the bed. She did not know how she ended up sleeping on the floor. After the resident left the room, the mother noticed that her son, the deceased child, was blue and not breathing. She screamed for help and another resident called 911. When the medics arrived on the scene a female resident showed them where the deceased child was located. The child was laying on his back his arms out and palms up. He was on the bed with his head towards the center of the bed, unresponsive and not breathing. He was not revived. The child had been sick when his family arrived at the shelter approximately 10 days before his death. The mother was advised by shelter staff to take him to see a doctor, but she did not follow this advice.

Law enforcement opened an investigation into this fatality. Law enforcement also determined that the mother was in no condition to care for her surviving child. The mother was taking medications for depression and anxiety. Following her son's death, the mother took a combination of nine prescribed medications and lost consciousness; she was hospitalized. The police placed the surviving two-year-old sister in protective custody. The Division of Children and Family Services had an open case on this family at the time of this child's death. A referral was screened in alleging general neglect of the children's hygiene needs and level of supervision due to the mother's mental health needs and her use of alcohol.

The death certificate lists cause and manner of death as undetermined.

Referral History

On May 30, 2007, a pediatrician for the deceased child's sister called Child Protective Services (CPS) intake and reported that her parents did not take her in for any well baby checks or immunization updates for four months. The referrer stated there were no medical needs or concerns about the child. This referral was screened as Information Only.

On April 22, 2008, a hospital staff reported to CPS intake that the mother gave birth to the deceased child. He was born seven weeks premature. The mother had a history of alcohol use. The mother's roommate told a nurse that this mother had a serious drinking

problem and binged on a case of beer the previous weekend. The mother denied this. There is a history of domestic violence with the deceased child's father. The deceased child appeared fine at birth. This referral was screened as Information Only.

On December 2, 2008, a report was made to CPS intake that the deceased child's mother neglected him and his older sister. The deceased child was not bathed in days and needed a diaper change. The deceased child's sister fell while climbing out of her crib/play pen. She later climbed up on the bed and wrote all over herself with markers and put them in her mouth. The referrer reported it took a while to wake the mother. The referent stated that the mother had a migraine and took pain medication that made her sleep. The referrer reported this situation has occurred several days in row. The shelter staff addressed this issue with the mother, but there was no change in her behavior. The family's room was dirty and smelled terrible. This referral was screened as Low Risk referral.

On December 11, 2008, a report was made to CPS intake that the deceased child's mother neglected her children because she did not get up and meet their daily needs. The children were not bathed regularly. The referrer indicated that the mother acknowledged she had difficulties in dealing with her situation and caring for the children. The family's room again smelled terrible and was dirty. This referral was screened in for investigation for negligent treatment or maltreatment and closed with an unfounded finding.

On December 25, 2008, law enforcement called CPS intake to report the death of this child. The child was found not breathing and unresponsive. The child was taken to a hospital by ambulance and was later declared dead. The deceased child's two-year-old sister was still in the home. Law enforcement said the mother was unable to parent her as the mother was over-medicated. The family lived in the shelter for approximately 10 days. Staff at the shelter saw the family on December 24, 2008 and everyone appeared healthy. The family's room again smelled terrible and was dirty. This referral was screened in for investigation for negligent treatment or maltreatment and closed with a founded finding. The two-year-old sibling remained in foster care on a Voluntary Placement Agreement.

Issues and Recommendations

Issue: The deceased child was listed as the subject in the December 25, 2008 intake rather than the victim. This intake was entered by Central Intake; unfortunately the CPS investigator and supervisor did not realize this and completed the investigative assessment making it impossible to change the child to a victim in the computer system.

Recommendation: The Deputy Regional Administrator sent an email to Central Intake regarding this issue. Supervisors and social workers will carefully review subject and victims identified in intakes prior to completing tasks in FamLink. This will be discussed at the June 2009 consensus building meeting with all CPS and Intake supervisors.

Issue: During the course of the review it was found that the Structured Decision Making (SDM) tool was completed at the close of the case and had a score of “No” on the question addressing the caregiver’s past or current mental health problem. The review team discussed why this was answered no when the mother admitted to being depressed and on medication. The social worker and supervisor said that SDM manual specifies the Mental Health question should not be indicated on the risk assessment that a parent or child has mental health issues unless this has been documented by a medical or mental health professional. In this case the social worker did not have documentation from a medical or mental health professional.

Recommendation: On a statewide level the SDM manual and definitions should be reviewed with the Children's Research Center to discuss the feasibility of changing the Mental Health definition to more appropriately reflect the issues identified at investigation when a client admits to being depressed both to the social worker and by answering the Global Appraisal of Individual Needs (GAIN SS) in the affirmative to the mental health questions. At the regional level, set up a process to review SDM procedures and practice with supervisors and staff.

Issue: The Investigative Assessment indicated that there were no safety issues identified during the course of the investigation; however the deceased child’s mother indicated to the social worker that she was depressed and also had migraine headaches and was sleeping a lot. There was no documentation in the case file regarding the social worker and the mother discussing the safety needs of the children and how the mother was going to provide a safe environment for her children.

Recommendation: The Regional Administrator and Deputy Regional Administrator will meet to review all of the information on this case. The Deputy Regional Administrator, Area Administrator and Supervisor will meet to review policy and practice regarding assessing the safety needs of children under the age of five.

The issue of assessing the safety needs of children under the age of five will also be discussed at the June 2009 consensus building meeting with all supervisors in Region 6.