

**Child Fatality Review #09-01**  
**Region 4**  
**King County**

This 4-month-old African American female died of Sudden Infant Death Syndrome (SIDS).

**Case Overview**

The mother of this child went to work on the evening of December 31, 2008. Her fiancé, who is the father of the deceased child, remained at the Auburn home with the child until 9:00 p.m. At that time he went out for the evening leaving the four-month-old in the care of her grandmother who resided in the home. The father returned home around 12:30 a.m., got the infant from grandmother, and went to the basement area of the home where he, mother, and the children slept.

The father placed the infant to sleep in the older sibling's bed with a comforter, stomach down, with her head tilted to the side. He then went to sleep on the couch. The deceased child's mother returned home from work sometime after 7:00 the morning of January 1, 2009. The mother discovered the baby was not in the bassinet, the usual sleeping location, but rather on a bed. She found her daughter unresponsive. Emergency response was called to the home.

A death scene investigation was conducted (including doll re-enactment and use of the Sudden Unexpected Death Investigation form). The King County Medical Examiner was dispatched to the home and found nothing suspicious, and no visible trauma. Auburn Police Department detectives also investigated. Although the room was found to be hot, there were no noted hazards or environmental concerns. The living conditions were described as neat and well kept.

The cause and manner of death was eventually determined to be Sudden Infant Death Syndrome (SIDS) with bed-sharing as a risk factor. The child's death is listed as natural.

**Referral History**

The referrals identified relate to Children's Administration's (CA) involvement with the deceased child's father and his two other children from another relationship. Until the fatality notification there had been no prior CA involvement with the deceased child's mother or her two other children.

On July 22, 2008, it was reported to Child Protective Services (CPS) intake that a family practitioner found two fractures on the right arm of the father's two-year-old son. This child's mother said she did not know how her son got hurt, but admitted that there had been significant delay before she brought him in to be examined. She further admitted that he was not using his right arm. In addition to the mother being identified as an

alleged subject of physical abuse and negligent treatment, the non-custodial father (the deceased child's father) was also identified as a potential subject given that the child had been in his care during the weekend prior to the discovery of the fractures. There was also a suggestion that the child may have been hurt at his child care center.

A referral was also generated to Division of Licensing Resources/Child Protective Services (DLR/CPS) and notification given to Department of Early Learning (DEL). The medical findings supported the likelihood that the arm fracture was most likely the result of a fall (accidental trauma). The CPS investigation on the parents was closed with an unfounded finding for negligent treatment or maltreatment and an inconclusive finding for physical abuse. The DLR/CPS investigation of the child care facility care resulted in an unfounded finding. DEL found no licensing violations as to the child care facility.

On February 22, 2008, a hospital social worker reported to CPS intake that the two-year-old identified in the referral above pulled a pot of boiling water off the stove and suffered a water burn to his elbow. This occurred while the boy and his brother were being watched by their father (the father of deceased child). The father treated the burn but did not take the boy to a doctor. The child's mother took him to the hospital emergency room for additional treatment of the burn. The CPS investigation on the parents was closed with an inconclusive finding for negligent treatment.

### **Issues and Recommendations**

**Issue:** The Child Fatality Review was held at the Tacoma West Division of Children and Family Services (DCFS) office on June 8, 2009. The entire family history of involvement with Children's Administration (CA) was reviewed. The CA history prior to the deceased child's death on January 1, 2009 in Auburn, was limited to two recent CPS investigations (neither founded) involving the father and his two other children and another partner. The deceased child's mother had no prior CA involvement.

The issues emerging during the review are included below for the limited purpose of documenting the discussions occurring during the child fatality review. There were no recommendations emerging from the Child Fatality Review.

**Recommendation:** None

**Issue:** The CPS investigation of the referral dated February 22, 2008.

A hospital social worker reported that the mother of the child victim brought her toddler in for a hot water burn that had occurred earlier in the day when the child was being watched by the non-custodial parent. The concern was to the delay in seeking medical attention. The decisions at intake appear appropriate.

The CPS worker made an unannounced home visit and had initial face to face contact with the alleged child victim within 72 hours of the intake. The mother was interviewed, and a Safety Assessment was done. A Safety Plan was made although it was limited due

to the father not being available for engagement. The Global Assessment of Individual Needs Short Screener (GAIN-SS) was administered to the mother of the child victim (not the mother of the deceased child) and her responses indicated a need for further assessment of mental health. There was no documentation that a referral for an assessment was sent. The father did not make himself available for interview by CPS. In review, the worker might have considered some additional resources to locate the father although how successful additional attempts would have been remains speculative. All case activity ceased for a period of two months before case closure in early June 2008. The length of case inactivity was not consistent with expected practice. The Structured Decision Making (SDM) tool was utilized and indicated low risk for neglect and abuse, supporting the case closure disposition.

The allegation was determined to be inconclusive as to negligent treatment or maltreatment by the father. The lack of a subject interview was a barrier to making a more conclusive finding (founded or unfounded). The hot water burn incident was likely accidental as reported. Although hot water burns can sometimes be an indication of neglect (failure to properly supervise) or abuse (intentional infliction), the review panel agreed that there was no evidence that either condition was involved. Evidence of medical neglect by the father would have relied on a medical opinion that the child had required immediate professional medical intervention treatment and had not gotten it. No medical opinions or medical records were sought. The medical records obtained during a later investigation showed the burn in February was only a mild partial thickness burn and not a serious deep dermis burn. The medical record did not show any exceptional treatment was required when the mother took the child to be seen at the ER.

The worker who conducted the February 2008 investigation did participate in the review along with the CPS supervisor, and received direct feedback for noted good practice as well for noted practice that could have been improved.

**Recommendation:** None

**Issue:** The CPS investigation of the referral dated July 16, 2008.

A family practitioner reported a fractured arm on a toddler. The child's mother had no explanation of how the injury occurred but appeared to have delayed seeking medical assessment. While the mother's statements suggested the injury occurred prior to the visitation with his father, both were identified as subjects for physical abuse and negligent treatment. Due to a remote possibility that the child was injured while attending child care, an additional intake was generated for Division of Licensing Resources/Child Protective Services (DLR/CPS). On review, the screening decisions by Central Intake (CI) appear to be reasonable. The case was assigned for investigation through the local Child Advocacy Center (CAC). Overall the CPS investigation activities met expected practice.

Face to face contact with the victim was within 24 hours, and interviews were conducted in collaboration with medical, law enforcement, CPS, and DLR/CPS. Both of the children were examined (full skeletal). No other injuries were found. The DLR/CPS worker interviewed the child care center staff. The CPS worker completed a Safety Assessment and Safety Plan. Efforts by CPS and law enforcement to speak with the non-custodial father were not successful. In review, the worker might have considered some additional resources to locate the father although how successful additional attempts would have been remains speculative.

Collateral contacts were documented and medical records (current and past) were obtained. The fractures of the toddler's arm were determined by the regional CA Child Abuse Medical Consultant to be more consistent with a fall rather than non-accidental trauma.

An Investigative Assessment was completed. Several SDM questions appear to have been answered incorrectly and this artificially elevated the Neglect, Abuse, and overall Risk Level scores. The mother initially agreed to Family Voluntary Services (FVS) but then later declined. Consultation with the Attorney General's Office did occur and the decision was made to close the case. All allegations against the father were determined to be unfounded and he appears to have had little connection to the incident. The negligent treatment allegation (delay in seeking medical treatment) as to the mother was determined to be inconclusive. The review panel did not reach full consensus as to whether there had been sufficient evidence for a finding of founded rather than inconclusive. The DLR/CPS investigation supported a finding of unfounded as to the child care provider. The Department of Early Learning (DEL) licensor's investigation showed no valid licensing issues.

The CPS investigator and her supervisor participated in the review. Both received feedback regarding noted good practice and areas that might be improved.

**Recommendation:** None

**Issue:** The fatality intake dated January 1, 2009.

Central Intake (CI) received what appears to have been a courtesy notification from the King County Medical Examiner's Office (KCMEO) of an infant death in Auburn. Prior to notifying CI, a Medical Examiner conducted a death scene investigation and found nothing suspicious and no visible trauma. The notification was staffed at CI and the decision was made to screen in for investigation of negligent treatment as to the child's death.

There was active debate by review participants as to two key intake considerations. The first was regarding the existence of allegations as to the fatality situation. In review, the majority view was that there were no specific child abuse or neglect allegations as to the

circumstances of the deceased child's death, nor any reported suspicions from anyone responding to the child fatality scene. There were no concerns regarding the deceased child's mother's other children who are older. The second consideration was to the existence of significant risks associated specifically with the deceased child's father that would be a reasonable foundation for assignment to CPS when lacking any allegations.

The basis for screening in the fatality notification for investigation was given by CI as due to the father's recent history. However, in review of that history, the prior July 2008 investigation as to the father's son's arm fractures showed the injury had most likely been from accidental trauma (based on CA Child Abuse Medical Consultant review) and the father (non-custodial parent) was found to have no identifiable involvement in the situation.

The earlier (February 2008) investigation as to the father possibly having failed to seek necessary medical treatment was inconclusive. There is no evidence that medical treatment had been necessary (mild second degree burn on the toddler's elbow), although his ex-partner did have the child seen by a doctor. The majority of child fatality review members did not support the view that the father's history, even if recent, was sufficient to prompt screening in the January 2009 fatality notification for investigation. However, some review participants were more agreeable with the CI decision largely based on a "better to error on the side of the child" argument.

The CPS worker from the Kent DCFS office was not able to attend the child fatality review, but in a pre-review interview (shared with panel members) stated that he had questioned the intake decision at the time of his case assignment. In the investigator's opinion, the CPS response had been an unwarranted and unnecessary intrusion to the family. Prior to the fatality review, Central Intake staff had been notified of the likelihood that discussion would occur regarding the fatality intake and were invited to comment or attend the Child Fatality Review. No response was received.

**Recommendation:** None

**Issue:** The investigation of the referral documenting the fatality dated January 1, 2009. A veteran CPS worker from the Kent DCFS office was assigned to investigate allegations of negligent treatment by the deceased child's father in the death of his daughter. The worker in a pre-review interview indicated confusion as to what exactly he was to investigate given the information provided at intake.

The time frame requirement for face to face contact with the alleged victim was extended due to the fact that the identified victim was deceased. The use of the "extension" code was an error, as the requirement should have been coded as "exception." A home visit was conducted several days after the death and a Safety Assessment completed (no Safety Plan needed). The deceased child's father (the subject) was elsewhere at time of

home visit and the CPS worker only had contact with the child's mother. In a pre-review interview the worker stated that the preliminary information gathered from the KCMEO clearly supported a non child maltreatment death, which later was confirmed by final cause and manner of death determination (SIDS). The worker indicated that he did not see the need for any further intrusion to the family and did not attempt to interview the father. The worker acknowledged that policy and practice dictated interviewing identified subjects. The case was closed within six days of the referral as unfounded. While the investigation appeared to be quickly closed, the disposition was viewed as understandable in terms of minimizing intrusion on the family during an investigation that for some panel members was questionably initiated.

The Kent CPS worker and his supervisor did not attend the Child Fatality Review, but were made aware of possible discussion issues relating to the fatality investigation. As noted elsewhere, the CPS worker was interviewed by the Region 5 Child Fatality Program Manager prior to the review, and the worker's responses were shared with review panel participants.

**Recommendation:** None