

Child Fatality Review #09-02
Region 4
King County

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

Case Overview

On January 16, 2009, the deceased child's mother placed her one-month-old son face-up near the head of her bed. She told investigators she did this around 6:15 a.m. The mother then laid next to him and fell asleep. She woke up around 11:00 a.m. and found her son face up, but unresponsive. She called 911 and was instructed to perform CPR.

Paramedics arrived and pronounced this child dead at 11:44 a.m. No foul play was indicated. The home was noted to be dirty and unkempt. The police said that the parents have an extensive history of domestic violence. There are past reports of the parents using drugs and the child's father in legal trouble. The police reported there was a restraining order on the father to stay away from the child's mother, however he was not in the home at the time of the child's death.

The medical examiner listed the cause of death as SIDS. It was also noted that bed-sharing was a risk factor. The manner of death is natural.

Referral History

The family has a history of ten reports, prior to the death of the deceased child. Nine were screened for Child Protective Services (CPS), and one for Family Reconciliation Services (FRS). Of the nine CPS reports, six were accepted for investigation

The CPS reports are remarkable for domestic violence (DV) and the presence of firearms in the home. On November 15, 2000, CPS intake received a report that the parents smashed out the windows of each other's cars. The case remained open for over a year with services in the home.

On February 21 2003, CPS intake received a report that the deceased child's father had guns in the home. He had already served jail time for possession of cocaine, and weapons charges. The five-year-old brother of the deceased child was interviewed by investigating social workers. He made no disclosures about problems in the home. This investigation was staffed with the community Child Protection Team (CPT). The case was closed after an offer of services was made to the parents. The case was closed with an inconclusive finding for negligent treatment or maltreatment.

On November 17, 2003, school officials reported the deceased child's six-year-old brother had a small bruise on his face. This was assigned for investigation, but the family moved before contact was made. The case was closed with an inconclusive finding.

CPS received no new reports for nearly four years. On January 11 2008, a school counselor reported attendance issues regarding the deceased child's 10-year-old brother. This referral was screened Information Only.

On March 5, 2008, the school counselor reported the 10-year-old brother of the deceased child was sleeping in class. The child said he had difficult sleeping because adults were in and out of his home at night. This referral was screened Information Only.

On May 11, 2008, a hospital social worker reported the 16-year-old brother of the deceased child was found passed out on a city bus. Law enforcement responded to this incident. A referral was made to CPS intake and the mother then asked for Family Reconciliation Services (FRS). The assigned FRS worker made attempts to contact the mother, but she did not respond to repeated requests to meet.

On May 29, 2008, law enforcement reported to CPS intake that the deceased child's parents poured gasoline on each other during a domestic violence incident. Both parents were arrested and police left the children with another family. The children were not placed in protective custody. The parents had separate homes. This referral was closed with a founded finding for investigation for negligent treatment or maltreatment. The worker reviewed the case with the CPT and received approval to close the case. Neither parent would engage in services.

On January 16, 2009, the King County Medical Examiner reported the deceased child's death. This referral was screened Information Only. The death was determined to be SIDS. In the fatality review, it was learned that the mother had some prenatal care, the infant was born full term (seven pounds, ten ounces), and was gaining weight satisfactorily.

Issues and Recommendations

Issue: This family had a history of moving and avoiding CPS as much as they could manage. A more effective response may have been to respond and engage with them as soon as possible in order to offer and provide services.

Recommendation: Maintain emphasis on initial face-to-face contact with victims, and engagement through Solution-Based Casework.

Issue: Infant death with bed-sharing as a risk factor in a family with a history of CPS involvement.

Recommendation: Children's Administration, or at least individual regions, should consider making a referral to the contracted Early Intervention Program (EIP) to provide a public health nurse for every family opened for investigation with an infant under the age of twelve months.