

Child Fatality Review #09-04
Region 4
King County

This three-month-old Caucasian male died from Sudden Infant Death Syndrome (SIDS).

Case Overview

According to the King County Medical Examiner, the mother attempted to wake the deceased child at 8:00 a.m. on January 28, 2009. He was blue and unresponsive. The mother called 911 and medics responded. After attempting CPR, medics transported him to Children's Hospital in Seattle. Medical personnel advised that the deceased child was in very critical condition but did have some heartbeat activity when he left the home. He was taken to Children's Hospital and died there on January 29, 2009. Law enforcement and medical examiner's investigators found no obvious signs of neglect. The home was well kept. Both the bed and crib appeared to have been slept in. The autopsy determined his cause of death to be SIDS (temporarily resuscitated) and the manner of death is natural.

Referral History

On January 2, 2009, a relative called Child Protective Services (CPS) intake with concerns about the deceased child. The referrer expressed concern about attachment issues and felt there was no bond between mother and this baby. The child was approximately three months old and weighed less than nine pounds. The mother did not bathe him and put rice formula in his bottle against medical advice. The mother moved to Washington State three weeks prior. She delayed in taking him to a doctor.

This referral was screened for Alternate Intervention and assigned to a public health nurse. The nurse reported the mother was very attached to her infant and appropriately concerned for his care. She discussed nutrition, growth and development, and sleep safety/SIDS risk factors with the mother. The family did not respond to the nurse's efforts to meet with them for grief support after the death of the child.

On February 4, 2009, law enforcement reported to CPS intake their investigation of the death of this child. This referral was screened in for investigation and closed with an unfounded finding.

Issues and Recommendations

Issue: This report was appropriately screened and assigned for Early Family Support Services. The public health nurse was very thorough in reviewing sleep safety and SIDS risk reduction strategies with this young mother, and yet the infant still died.

Recommendation: Children's Administration should consider collaborating with Public Health and others to find the most effective ways to inform clients about infant death risks and to have the clients comply with that information.

Issue: The decision to screen in for investigation a report of the infant's death. It may not have been necessary since there were no allegations of child abuse or neglect.

Recommendation: The Regional CPS Program Manager should discuss this issue with other CPS Program Managers throughout the state to determine to see how child fatality intakes are screened.

Action Taken: The regional CPS Program Manager discussed this screening decision with the other regional CPS Program Managers and the consensus is that intakes that do not allege abuse or neglect should not screen in for investigation.