

Child Fatality Review #09-10
Region 3
Snohomish County

This 11-month-old Caucasian female died from hyperthermia.

Case Overview

On March 2, 2009, this 11-month-old infant was found non-responsive by her nine-year-old sister when the sister went to get her from the crib. Emergency medical personnel were called but they were unable to revive her. The officers who came to the home said the room temperature was 100 degrees. The child's internal temperature was 106 degrees when she arrived at the hospital.

The investigating detective said the deceased child's parents left the home that morning around 9:00 a.m. to visit their newborn daughter who was in the hospital. They left their four children in the care of a relative. At 1:00 p.m., an emergency call came in to 911 saying there was a baby not breathing. The first detectives to the scene said the apartment was in "deplorable" shape with one and a half feet of debris on the floor of the deceased child's bedroom. The room was very hot. There was a thick blanket in the crib.

After autopsy, the cause of death was determined to be hyperthermia and the manner was undetermined.

Referral History

On June 19, 2000, an anonymous call to Child Protective Services (CPS) intake reported on the condition of the mother's apartment where she lived with her then one-year-old daughter. The apartment had dirty diapers and other trash throughout. The child had to sleep in a bedroom with a broken window. This intake was accepted for investigation by CPS and closed with an inconclusive finding for negligent treatment or maltreatment.

On November 10, 2003, a social services worker reported to CPS intake a domestic violence incident between the deceased child's mother and her husband. It was also alleged the husband hit the mother's oldest daughter (not this child's father). The mother obtained a restraining order. They later divorced. The intake was accepted for investigation of physical abuse and negligent treatment or maltreatment. The CPS investigation was closed with a founded finding against the mother's husband and unfounded as to the child's mother.

On June 28, 2004, a neighbor reported to CPS intake that the deceased child's mother left her five-year-old and one-year-old home alone for several hours and that the apartment was dirty with cat feces. The intake was investigated by CPS and closed with an unfounded finding for negligent treatment or maltreatment.

On September 8, 2005, CPS intake was contacted by a neighbor who reported the conditions in the home were unsanitary and that the children, ages 6 and 2, were unkempt. There was also minimal food in the apartment. CPS social workers made an unannounced home visit the next day and found the situation to be within acceptable limits. This intake was accepted for investigation and closed with an unfounded finding for negligent treatment or maltreatment.

On July 31, 2008, law enforcement reported the deceased child's mother was receiving threatening messages on her phone from her ex-husband. She said he had assaulted her in the past. On this day he had left papers indicating he was seeking custody of their daughter. Police advised her to get a restraining order due to the threats and past violence. This intake was screened as Information Only.

On March 2, 2009, a father to one of the mother's four children called CPS to report that his daughter had to live in the same home as a "violent offender." He filed for custody of her and said the family court judge told him to call CPS with his concerns. He reported in 2007 police arrested the deceased child's father for assaulting the child's mother. The referrer believed the deceased child's father pled guilty and spent time in jail for the assault. He later returned to living with the mother and children. He said his daughter had witnessed the 2007 domestic violence incident. This intake was screened as Information Only.

Later on March 2, 2009, police called CPS intake to report a child death. The temperature of the bedroom in home was 100 degrees. The apartment is in deplorable shape. The child had a temperature of 106 degrees. Medics were unable to revive child. CPS began working with the family immediately with intensive services. The child's mother appeared enormously stressed during the first few weeks after the death, but agreeable to the services.

During the provision of services, however, it became increasingly apparent that the mother's mental health had deteriorated to the point that she was unable to safely care for the surviving children. The deceased child's father and her extended family appeared unable to assure the safety of the children. The department consulted with doctors and hospitals who had been involved with the family for the past two years. In consultation with these practitioners, the agency determined that the mother was not able to safely parent her children and filed a dependency petition on the children. They were placed with their maternal grandmother.

Issues and Recommendations

Issue: The June 19, 2000 referral was closed without contact by CPS. The investigative assessment was completed by reliance on the report by law enforcement that documented their contact with the family.

Recommendation: The review team concluded that there may be a pattern among investigators of undue reliance on law enforcement, given the differences in methods and goals of investigation. The team recommended continued training for agency staff in working with law enforcement.

Issue: In the investigation of the referral dated September 8, 2005, the mother disclosed co-sleeping with her children. There was no documentation of discussion of this as a potential SIDS issue. It is the thought of this review panel that this agency may be able to take a more active role on education of families to this issue.

Recommendation: The team recommends that at the next regional CPS supervisors' meeting there be discussion of a regional protocol for education of selected families related to SIDS risks. This could include training by a certified SIDS trainer in "risk management" of SIDS; i.e., a discussion of how to reduce risk of SIDS in co-sleeping situations.

Issue: In the CPS investigations of three of the past referrals in this case, the review team noted that the investigations lacked thoroughness. In particular, there was inadequate use of collateral contacts to validate the statements of the person being interviewed.

Recommendation: It was the thought of this review panel that in order to avoid a pattern of less than complete investigations in this region, this topic should be discussed at the next CPS supervisors' meeting. It is recommended that there be an open discussion of "complete investigations" that include adequate use of collateral contacts to validate family statements.