

**Child Fatality Review #09-14**  
**Region 1**  
**Whitman County**

This three-month-old Caucasian female died from asphyxiation.

**Case Overview**

On the morning of March 15, 2009, the mother of this three-month-old infant and her two children, a two-year-old year old and the deceased child were co-sleeping in one bed. The mother awoke at approximately 10:00 a.m. and noticed her daughter was not breathing. She picked up the infant and went out on her apartment balcony screaming for someone to help her. The apartment manager contacted 911 and came in the apartment to initiate CPR. First responders to the scene continued CPR although it was clear that the infant was deceased. The County Coroner estimated the time of death to be approximately between 5 a.m. and 6 a.m.

**Referral History**

On August 30, 2006, a report was made to Child Protective Services (CPS) intake alleging the deceased child's mother would not allow the father of her oldest child to have contact with their son. The referrer reported that the mother is bi-polar, off her medications, drinks and drives with the baby in the car. It was further alleged that she becomes violent when she drinks.

The intake was screened as low risk and referred to the Alternate Response System (ARS). A referral was made to the Early Intervention Program (EIP). The EIP nurse met with the mother. The mother denied being diagnosed bi-polar or taking medications. She also denied drinking with her son in her the car. The mother received information regarding Infant Case Management through Public Health and elected to use that program instead of EIP.

On December 13, 2006, CPS intake received a report that the deceased child's mother was arrested for driving under the influence. Her oldest child, a six-month-old son, was in the back seat of her vehicle. Law enforcement charged her with child injury due to her son being in the car. This intake was accepted for investigation. The investigation was completed with a founded finding for negligent treatment. The case remained open for services.

On January 5, 2007 a Public Health Nurse (PHN) contacted CPS intake with concerns that the deceased child's mother, following her DUI arrest, had her seven-month-old back in her care. The intake was screened Information Only as it was a report of the DUI and no new allegations of child abuse or neglect. The case was still open from the previous intake.

On February 5, 2007, CPS received information that the deceased child's mother was extremely intoxicated and there was an altercation that resulted in a police response.

CPS had spent three months attempting to have the mother engage in a chemical dependency evaluation and other services.

On April 5, 2007, a neighbor reported witnessing the mother use methamphetamine and drinking alcohol with her son present. Law enforcement went to the home on April 6, 2007 at the request of CPS to conduct a welfare check of the child. Police found evidence of marijuana use. The home environment looked good as did the child. The mother had a positive urinalysis for marijuana. The CPS investigation was closed with an inconclusive finding.

On November 15, 2007, CPS intake received a report from law enforcement that the mother's paramour was arrested following a domestic violence incident. Both the mother and her paramour appeared intoxicated. Police left the child in her care. This incident occurred over a weekend, but law enforcement waited to report this incident directly to the local office instead of contacting Central Intake afterhours.

The mother filed a restraining order against her paramour and she agreed with a safety plan. Drug/alcohol and mental health assessments were scheduled for the mother. She did not actively engage in these voluntary services. She later moved in with her parents who have been protective and informative in the past. The case was closed with an unfounded finding.

On December 26, 2008, CPS was notified that the mother gave birth to a baby girl (the deceased child) at her parents' home. The mother was involved with Women, Infants, and Children (WIC) and Public Health. CPS referred this case to Early Family Support Services (EFSS) through Public Health. The EFSS provider closed the case on February 1, 2009 with an exit summary that the mother originally agreed to participate with EFSS then refused. She said she would work with the infant case management through Public Health.

On March 15, 2009, this child died of positional asphyxia while co-sleeping with her mother and brother. CA intake was notified after a social worker read about the death in the newspaper. An intake was created and screened as Information Only. The death was determined to be accidental.

### **Issues and Recommendations**

**Issue:** Law Enforcement in Whitman County reported, while calling in intake dated November 15, 2007, that Central Intake was not contacted during afterhours because police do not know if someone will be dispatched and if so it takes too long for a response.

**Recommendation:** The area administrator and office supervisor will use existing forums to meet and discuss this issue with law enforcement throughout Whitman County.