

**Child Fatality Review #09-17**  
**Region 5**  
**Pierce County**

This two-month-old Caucasian male died from asphyxiation.

**Case Overview**

On April 5, 2009, the Pierce County Medical Examiner's Office notified Child Protective Services (CPS) intake of the death of this two-month-old infant. On the morning of April 5, 2009, the mother reportedly found the infant unresponsive in bed. She and her son were co-sleeping. Emergency responders arrived and determined the infant to be deceased. He was not transported to a hospital. The Medical Examiner's (ME) Medical Investigator and law enforcement were called to the scene. There were no suspicions of child maltreatment with regard to the fatality situation at the time of notification to CPS.

In July 2009, the cause and manner of death were finalized by the Medical Examiner. The manner of death was determined to be accidental. The cause of death has been listed as asphyxia with contributing factors of co-sleeping and possible adult overlay. The ME also noted that at autopsy the child was found to have a rib fracture that was well into the healing stage, noting that such had no consequence to either the cause or manner of death. Consultation with Children's Administration Child Abuse Medical Consultant Dr. Yolanda Duralde was initiated by the assigned CPS worker. The medical opinion was that the rib fracture may well have occurred during the birthing intervention.

**Referral History**

On February 6, 2009, hospital staff reported to CPS intake concerns that the deceased child's mother was not demonstrating bonding or attachment toward her newborn (the deceased child). The child's parents were young and had minimal support and stability. This intake was accepted for investigation by CPS and screened as Risk Only.

On April 6, 2009, CPS intake received notification from the Pierce County Medical Examiner's Office of the death of this two-month-old infant. The infant had been sleeping with his mother who had placed the child on his stomach and later found him not breathing. There were no reported suspicions with regard to child maltreatment and the circumstances of the child's death. The intake was screened as Information Only.

**Issues and Recommendations**

**Issue:** There were no recommendations emerging from the Child Fatality Review. Practice issues were noted and discussed during the Child Fatality Review. None appeared to have any obvious impact with regard to the circumstances of the child's death and are included below for the limited purpose of documenting the discussions occurring during the Child Fatality Review.

**Recommendation:** None

**Issue:** In regard to the intake dated February 8, 2009, two months prior to fatality incident, Central Intake (CI) was contacted by a hospital social worker regarding a young couple that, after a period of indecision, had decided not to put their newborn up for adoption. Noted at intake were concerns by hospital staff that the mother had not shown bonding and attachment behaviors and that the couple's living situation had been tenuous until the paternal grandmother agreed to provide housing for the couple and the infant.

In review, a more reasonable intake decision would have been to defer the report to Early Family Support Services (EFSS) rather than open up a "Risk Only" (72 hour response) case assignment with CPS. While acknowledging the risk factors identified by the referent, it is debatable as to whether the risks posed considerable risk to the newborn. Hospital records later obtained by CPS showed that the referring hospital social worker was of the belief that the report would be sent by CPS for a public health nurse follow-up only. Notes from another hospital social worker did not indicate any substantive concerns about the parents or infant, and when contacted by the assigned CPS worker he indicated surprise that CPS had been assigned the case.

**Recommendation:** None

**Comment:** While the intake decision was found to be questionable it must be viewed in the context of coming at the time of department transition to a new data system (FamLink). At that time there was a mistaken belief statewide that since FamLink screening decisions were "locked" at intake, responding field offices were similarly "locked" into program assignment and unable to change any aspect of a screening decision. This issue was subsequently clarified and currently remedies are available for revising and documenting changes subsequent to initial intake. Also at the time of transition to FamLink, revisions were made as to the sufficiency screen criteria and accepting intakes under "Risk Only" (no allegations). Initially "Risk Only" was broadly interpreted resulting in an increase in questionable intakes being accepted for assignment to CPS. However, this trend has apparently abated through clarifying discussions within Children's Administration (CA).

**Issue:** Overall most practice expectations were met by the CPS worker assigned to the February 8, 2009 intake. This included making timely face-to-face contact with the infant (alleged victim), meeting with both parents, conducting parent-child observations at the family residence, contacting a hospital social worker, and gathering hospital records. The worker administered the Global Appraisal of Individual Needs Short Screener (GAIN-SS) to both parents. Documentation generally met practice expectations as to content and timeframes, the exception being that the Safety Assessment was not documented in a timely manner.

During the review the worker indicated she had planned to contact the Maternity Support Services (MSS) worker when case activity was interrupted by the child fatality incident.

Opportunities for improved practice were identified during the review. Although there is no specified time frame requirement for interviewing caretakers, there was a noticeable delay in the worker conducting a home visit and interviewing the parents. During the review the worker recalled having made phone contact with the parents soon after case assignment but had apparently failed to document the contact. The worker might have considered speaking with the paternal grandmother in whose home the family was residing. Additional consideration might have been made to contacting the maternal grandparents. Best practice would have been to contact the primary care physician as a potential information source.

The CPS supervisor acknowledged during the review that she had not entered any supervisory review notes, indicating that initial problems with the new CA database (FamLink) contributed to lack of required case review documentation.

**Action Taken:** Both the CPS worker and her supervisor participated in the review and received feedback regarding investigative activities and suggestions where practice might be improved.