

Child Fatality Review #09-18
Region 5
Pierce County

This five-month-old African American female died from hypoxic encephalopathy (a lack of oxygen to the brain).

Case Overview

On March 26, 2009, Child Protective Services (CPS) intake was notified that this five-month-old was admitted to Mary Bridge Hospital Emergency Department and was not expected to live. The referrer reported that medical professionals did not have any suspicions about child abuse or neglect (CA/N) and were looking at a possible SIDS type situation. Reportedly the infant was found unresponsive that morning and Emergency Medical Services (EMS) responded to the home and initiated resuscitation efforts. The child arrived at the hospital with very little chance of survival having minimal brain activity. The infant died two days later on March 28, 2009.

It is known that the infant had been born prematurely and had Turner Syndrome, a genetic (chromosomal) disorder found only in females. Approximately 98% of all fetuses with Turner Syndrome result in miscarriage. The incidence of Turner Syndrome in live female births is believed to be 1 in 2500. There can be significant medical problems associated with the syndrome, including heart defects and high blood pressure, both of which can cause hypoxic encephalopathy (lack of oxygen to the brain).

In July 2009, the Pierce County Medical Examiner determined that the infant died of hypoxic encephalopathy from an unknown cause or origin. Noted was that the child suffered Turner Syndrome with congenital cardiac anomalies and was found in a prone position in a crib, with abundant soft bedding. The Medical Examiner reported the manner of death was undetermined.

Referral History

On November 15, 2008, hospital staff reported to CPS intake that the deceased child's mother brought her to the hospital emergency room saying the infant's feeding tube was causing distress to the child. Medical staff told the mother she needed to keep the feeding tube in for another week. A nurse contacted CPS intake as she was not sure the mother understood or would comply with the medical advice. This intake was accepted for investigation by CPS and closed with an unfounded finding for negligent treatment or maltreatment.

On March 26, 2009, a hospital social worker reported to CPS intake that the deceased child was admitted to the ER and was not expected to survive. There were no suspicions about child abuse and initial indications suggested a SIDS type event. 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 death and are included below for the limited purpose of documenting the discussions occurring during the Child Fatality Review.

Recommendation: None

Issue: Regarding the intake reported on November 15, 2008, four months prior to fatality incident, Central Intake (CI) was contacted by a hospital ER nurse. The nurse requested that CPS check on the family because she was not sure if the mother would comply with medical advice regarding keeping a feeding tube attached on the infant who had begun to be bottle fed. Although accepted for investigation of negligent treatment it was not apparent to the review panel as to what parental actions, failures to act, or omissions [WAC 388-15-009] had occurred at the time of the intake, only that the referent speculated the parent might commit a negligent act. The intake was unclear as to how compromised the child's health status would be if the parent were to remove the feeding tube from her child, although neither imminent harm nor emergent response were indicated by the intake worker.

An argument could be made that lacking any allegation or identified imminent risk of serious harm, the referral could have screened out as information only. However, the review panel was in general agreement with the intake decision to accept the case for CPS involvement, and concluded that designating the intake as imminent harm (no allegations) would have been more supportable than screening in the report under allegation (no imminent harm) since the parent had not actually acted or failed to act in a negligent way.

Recommendation: None

Issue: In regard to the investigation of intake reported on November 15, 2008, it was noted that overall most practice expectations were met by the CPS worker. This included conducting a home visit, interviewing the alleged subject, making face-to-face contact with the infant (alleged victim), and making collateral contact with one of the medical practitioners involved with the child. Documentation met practice expectations as to both content and timeframes. The CPS worker referred the family to the Alternative Response System and provided the family with a community resources list prior to closing out the investigation.

Opportunities for improved practice were identified during the review. Although the father was not identified as a subject of the allegations, an effort could have been made to interview him. The worker might have considered interviewing at least one of the older

siblings to assess the home environment, daily routine, and the general care being provided by the parents. Although the worker made contact with the gastrointestinal specialist nurse, inquiry with the primary care physician (PCP) may have also been beneficial.

The CPS worker was aware of a scheduled dietician appointment that was to occur two days after the home visit was conducted, but did not follow up to see if the child was seen. The worker might have inquired more about family resources as mother had expressed being overwhelmed in caring for the children and being isolated from her family. Although no requirement to do so, the worker might have considered conducting a second home visit as an opportunity to engage the mother in additional conversation regarding her admitted chronic depression (she stopped taking her medication) and domestic violence history.

The mother was born in Mexico and although the worker recalled that the mother spoke English well, no inquiry was made as the client's language preference.

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