

Child Fatality Review #09-21
Region 5
Pierce County

This five-month-old Caucasian male died from undetermined causes.

Case Overview

On May 16, 2009, the Pierce County Medical Examiner's Office reported to Child Protective Service (CPS) intake that the father of the deceased child went to check on his five-month-old son and found the infant face down in bedding and unresponsive. The preliminary indications were that the death was not suspicious, noting that the child had had some medical problems since birth. Little is known about the circumstances of death.

In August 2009 the cause and manner of death were finalized. Both cause and manner were undetermined. Contributing factors noted were that the infant had been found face down in soft bedding and also suffered from congenital anoxic encephalopathy.

Referral History

On December 16, 2008, a hospital social worker called CPS intake to report a drug exposed newborn. A urine toxicology test had shown marijuana and mother's prescribed opiate medication present in the newborn's system. It was a term delivery and the newborn was not exhibiting withdrawal symptoms at the time of the report to intake. The intake was screened as Information Only.

On May 16, 2009, CPS intake received a report of this child's death. The Pierce County Medical Examiner Investigator found no suspicions regarding the circumstances of death. The child was born with numerous unspecified medical problems. This intake was screened as Information Only.

Issues and Recommendations

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.

Issue: In regards to the intake dated December 16, 2008, five months prior to fatality, CPS intake was contacted by a hospital social worker reporting a drug exposed newborn (marijuana and prescription opiate) based on urine toxicology (meconium test was pending). It was a full term delivery and the newborn was not exhibiting withdrawal symptoms at the time of intake. The mother's medical records suggested a history of seeking pain medication for a medical condition. It was initially misreported that the mother had very late pre-natal care, but this was later corrected by the referent during

follow-up contact with intake two days later. Also during the follow-up contact with intake the hospital social worker reported that the newborn might be showing signs of being drug affected, stating he would re-contact intake if such were medically confirmed. The hospital social worker did not re-contact intake. It was reported that the mother had recently lived in Arizona. Documentation shows that the intake supervisor directed the intake worker to contact Arizona to check on any prior CPS history involving the mother and an older child. Arizona reported no known involvement.

In review the decision to screen out the intake was consistent with Children's Administration (CA) Prenatal Substance Abuse policy (2007) and deemed reasonable based on the initial information and the additional information obtained collaterally. The inquiry made with Arizona CPS was viewed as excellent practice. Consideration might have been made by intake to confirm the meconium test results as newborn urine toxicology tests are known to have only provisional reliability. Consideration also might have been made to call back the hospital social worker regarding the reported possible development of drug affected symptoms.

The intake area administrator from Region 5 and two regional intake supervisors were present during the review and participated in the discussions.

Recommendation: None

Issue: Regarding the fatality notification in the intake dated May 16, 2009, Central Intake (CI) received notification of the death of this five-month-old infant. Preliminary indications were that the death was not suspicious for child maltreatment. It was reported that the infant had had some medical problems since birth (unspecified/unknown by referent). The intake was screened out and an incident report was generated per policy (family had a recent information only referral). In review the screening decision appears supportable.

The intake contained very limited information, and the incident report indicated that the Medical Investigator (referent) did not have any additional information. However, inquiry with the referent as to whether the infant had been transported to a hospital might have been considered at the time of intake. It would be reasonable to assume additional medical information would be available if a hospital had been involved, such as clarification of the child's medical problems.

Recommendation: Practice Consideration: It is known that CA has convened a work group to review the child fatality reporting and child fatality review process. Consideration could be made to look at developing intake guidelines for taking child fatality reports, to include suggestions for intake workers as to specific questions to ask, depending on the source of the fatality notification. This could provide more consistency across intake units in the state with regard to child fatality intakes.