

**Child Fatality Review #10-20**  
**Region 6**  
**Clark County**

Two-month-old Caucasian female infant died from asphyxiation.

**Case Overview**

On April 11, 2010, Vancouver Police reported to Child Protective Services (CPS) intake the death of this two-month-old infant. Her mother told police the child had been ill with vomiting and diarrhea earlier in the evening. The mother reported she fell asleep with her daughter on the couch, getting up once at around 1:00 a.m. to change her diaper. The child was fine. When mother awoke in the morning, she found her daughter with a pillow on her face and she was not breathing. The mother took her daughter to a next door neighbor who had medical training. The neighbor called 911 and started CPR. The child was not revived. Law enforcement conducted a forensic interview of the mother's six-year-old son. From all reports, the child's death appeared to be an accident.

Children's Administration (CA) had an open case on the family at the time of the infant's death. This case was open with Child Protective Services (CPS) in response to an intake received on December 18, 2009. This intake alleged the mother's six-year-old son was fed by neighbors nightly because he was hungry. The neighbors also reported the child had poor hygiene. The CPS investigation was completed with an unfounded finding for negligent treatment or maltreatment. However, multiple risk factors for this family resulted in a Family Voluntary Services (FVS) case being opened. The FVS case was still open when the infant passed away.

**Intake History**

On October 9, 2003, a social worker with DSHS contacted CPS intake to express concern that the mother and her boyfriend were unable to care for their newborn son. The mother had a history of drug use and running away as a teenager. The intake was screened in for investigation by CPS. The investigation was completed with an unfounded finding for negligent treatment or maltreatment. The mother reported she was receiving parenting classes through the Women, Infant and Children (WIC) program. She was offered public health nurse (PHN) services, but declined. She was in substance abuse treatment when she learned she was pregnant. The mother was receiving appropriate medical services for her newborn son.

On August 18, 2008, a Head Start teacher contacted CPS intake to report the mother was taking a nap with her boyfriend when her five-year-old son left the apartment and was missing. When the child eventually returned to the apartment complex from the street, the mother was alleged to have spanked him leaving a bruise on his buttocks and his hand. The intake was screened in for investigation by CPS. The investigator determined that it was mother's boyfriend who spanked the child and left the marks. The CPS investigation

was completed with a founded finding for physical abuse on the mother's boyfriend and a founded finding for negligent treatment on the mother. The case was closed after the department arranged for parenting classes for both the mother and her boyfriend. Criminal background checks were completed on mother and boyfriend with no concerns noted.

On June 9, 2009, CPS intake was contacted by an anonymous referrer who reported the mother was using marijuana, methamphetamine and cocaine around her five-year-old son. The referrer also stated there was very little food in the home. The intake was screened as Information Only and was not investigated by CPS.

November 24, 2009, an elementary school counselor contacted CPS intake to report that the six-year-old disclosed that his mother and unnamed boyfriend verbally fight every night, and the boyfriend says things that leads the six-year-old to feel that he might kill the mother. The mother and boyfriend are intoxicated when they fight. The child reported his mother would give him "sleeping pills" when the adults argued. The referrer was unsure what the child was given to help him sleep. The child also disclosed that his mother was pregnant. The intake was screened as Information Only and was not investigated by CPS.

On December 18, 2009, an elementary school staff reported that a neighbor to the family sent information to the school that the six-year-old was frequently fed by neighbors. The child was at the neighbor's home for up to 12 hours without a check-in by his mother. The child was usually hungry, never wore socks, and had poor hygiene. The mother was suspected to be a methamphetamine user. The intake was screened in for investigation by CPS. The investigation was completed with an unfounded finding for negligent treatment or maltreatment. Contact was made with the child's doctor, and he was up to date with well child checks. The case remained opened and transferred to the FVS unit due to multiple risk factors being present during the investigation. Those risk factors included drug use, depression, history of domestic violence in relationships, and parenting deficiencies.

On February 23, 2010, a hospital social worker called CPS intake to report the mother gave birth to a female child. The mother admitted to hospital staff that she smoked marijuana during her pregnancy. The newborn tested positive for marijuana at birth. The mother had prenatal care, though late in her pregnancy. She refused public health nurse services. The child's father was present at the hospital. He and the child's mother had split up prior to the birth of their daughter. Hospital staff reported he appeared to be under the influence of drugs while at the hospital. The intake was accepted for investigation as a Risk Only intake.

The case remained opened and the mother was referred to, or offered, a number of services. The services included a drug and alcohol evaluation, a referral to maternity

support services, a parenting evaluation for the mother, and helping her arrange counseling for her six-year-old son. If the father was to return to the home, he was to also have a drug and alcohol evaluation.

The mother initially engaged in services but had difficulty showing consistent progress. She missed appointments for urinalysis and counseling sessions. Some of the urinalysis samples she submitted were positive for marijuana. The mother completed the drug/alcohol evaluation and agreed to participate in outpatient treatment.

On April 7, 2010, CPS intake received a report from a neighbor who reported the mother's seven-year-old son had a large bump/bruise on his forehead. The child has had different accounts of how he got hurt. He has said that he and his mother fell after they tripped on a blanket, that he didn't know how he got hurt, that he fell on a bed post, and that he ran into a wall. A neighbor has told school personnel they smell drugs in the home. The intake was screened as Information Only. The case was still open when this intake was received.

On April 11, 2010, law enforcement called CPS intake to report the death of the two-month-old. Police reported the mother and infant were sleeping on a couch. In the morning the mother woke and found a pillow on her daughter's face and she was not breathing. Police officers interviewed the mother's six-year-old son. The infant's death appeared to be an accident, according to police. An afterhours social worker was sent to the home to assess the safety of the six-year-old. The intake was screened in for investigation by CPS. The CPS investigation was completed with an unfounded finding for negligent treatment or maltreatment.

A Family Team Decision Meeting (FTDM) was held following the death of the infant. The team debated whether to recommend placement of the surviving sibling. The team decided to leave him in the care of his mother. In May 2010, a dependency petition was filed on the six-year-old sibling, though he remained placed in his mother's care. He was removed from her care less than two weeks after the dependency petition was filed after the mother submitted another positive urinalysis sample.

### **Issues and Recommendations**

**Issue:** The mother was advised about safe sleeping by the department when her oldest child was an infant. This discussion was documented in the case record. However, when the department became involved following the birth of her daughter in 2010, there is no record of another discussion with the mother about safe sleeping or a caution about co-sleeping. The mother told law enforcement that sleeping on the futon couch with her infant daughter was a nightly routine, as the mother did not want to sleep in her bed without her boyfriend (the father of the newborn) and felt placing her daughter in a bassinet at night was a danger. No investigative inquiry was made about the newborn's sleeping arrangements because it was believed that this was not the focus of the concern

with this family. Although the mother was instructed about safe sleeping in the past, it was over six years ago and the mother was 16 years old at the time.

**Recommendation:** Recommend that the department remind social workers to routinely educate parents of every newborn with department involvement, about safe sleeping, which includes information about the dangers of co-sleeping. This is especially important for caregivers who have substance abuse issues. Recommend that staff receive information related to concerns with co-sleeping with parents who are using marijuana and opiates, in particular. Recommend that workers are reminded that it is best practice to observe and assess the sleeping arrangements of infants on cases in which the department is involved.

**Issue:** The review team believed that the transfer process in the Vancouver office is not working as efficiently as it might. The CPS social worker forwarded the case for approval to his supervisor on March 16, 2010. The supervisor was unable to review the case until March 26, 2010. The office had an unusually high CPS caseload at the time. The case was not assigned to the FVS social worker until March 31, 2010. At that point, the social worker had a difficult time making contact with the mother, despite trying repeatedly. Because of the transfer process, as well as difficulty making contact with the family, there was no face-to-face contact between the department and the mother from March 15, 2010 until April 12, 2010 which was after the infant's death. This issue generated a discussion on the review team with regard to what was best practice for case transfers for CPS cases. Some believed that the receiving unit should make contact and get involved with the family as soon as possible, despite the fact that the CPS social worker had not completed the investigative assessment and the worker may not have all the information. Others believed that the receiving social worker needed to wait for the investigation to be completed, when they have all the available information in order to best assess and meet the family's needs.

**Recommendation:** DCFS management indicated they have already made some changes in the case transfer process to maximize information sharing in case transfers. The office has meetings weekly to staff cases that are transferring, and there are frequent case staffings between supervisors. There is now an expectation that there is a case staffing between social workers when a case transfers.

The review team recommends that the Vancouver office continue to improve the case transfer process, to minimize the amount of time cases are inactive in the transfer approval process, and maximize information sharing between workers.

The review team recommends that all cases transfer within 24 hours of Area Administrator approval of the transfer.

The review team recommends that, whenever possible, the receiving social worker make a field visit with the social worker transferring the case, in order to facilitate a smoother transition between staff for the family.

**Issue:** The review team discussed the intake that was received and screened out regarding a bruise and bump injury on the six-year-old brother. Information was shared that in other staffings of this case, it was believed that this intake should have screened in for investigation. Through the fatality review process, the fatality review facilitator reviewed another intake that was screened out on this case, and also believed this was an intake that was appropriate to screen in. This was a disclosure by the six-year-old son that his mother and her boyfriend verbally fight, and the six-year-old was afraid the boyfriend would kill his mother. It was also alleged the mother gave her son "sleeping pills." This intake would have been appropriate for an alternate response or a 72-hour investigation.

**Recommendation:** The Vancouver office recently underwent an intake review with a team from outside the office. There were no significant findings regarding screening decisions. The intake supervisor met with his staff and discussed the findings of the review.

Consensus building training occurred with supervisors on July 28, 2010 to strengthen intake screening decision making. Further consensus building training will be scheduled for regional supervisors.