

**Child Fatality Review #08-40**  
**Region 5**  
**Pierce County**

This two-month-old African American male died of Sudden Infant Death Syndrome (SIDS).

**Case Overview**

On July 27, 2008, the teen mother of twin infants, including the deceased child, spent the night at the home of the children's father. At the time of his son's death, the father was a teen dependent youth living with his grandmother. The father had an open case in the Tacoma Division of Children and Family Services (DCFS) office.

The mother reported that around 3:00 a.m. the morning of July 27, 2008, she cradled the deceased infant while both were sleeping on the floor. The mother placed the child on a couch cushion. She awoke about five hours later to find her son cold, stiff, and not breathing. When emergency responders arrived, the baby was intubated and taken to the hospital where he was pronounced dead at 9:14 that morning. The death of this infant did not appear to be the result of child abuse or neglect. There was no referral on this family prior to the death of this child. Both parents were minors.

The investigating detective from Pierce County Sheriff's Office stated there were seven adults living in the home. The teen parents were staying in one room and slept on the floor with their two babies on couch cushions. The detective stated there was a crib in the home that the mother could put the deceased child or his surviving twin in to sleep. She was advised that the twin should sleep in the crib with tighter fitting sheets, no stuffed animals, or thick bedding. The detective did not put the twin brother in protective custody. The detective considered this as an option if the autopsy indicated abuse or neglect as the cause of death. The detective noted that the infant appeared to have died from positional asphyxiation or SIDS.

The father was offered services for grief and loss issues. The parents declined. The father requested help with finishing his education. The assigned social worker identified various programs in which he could enroll to complete his high school education.

**Referral History**

On July 28, 2008, Child Protective Services (CPS) intake took a report from the Pierce County Medical Examiner's office reporting the death of this child. No cause of death was identified. The child's mother reported sleeping with him cradled in her arm, both lying a cushion on the floor. She found him cold and stiff shortly before 8:00 in the morning. This referral was screened out for investigation.

## **Issues and Recommendations**

**Issue:** The teen mother of the deceased twin had no prior involvement with Children's Administration, either as a child or as a caretaker. The mother and her twin infants appear to have been residing with her parents, and occasionally visiting the home of the teen father.

The teen father was dependent and living in the home of his maternal grandmother. The teen mother and the twins were staying the night at the teen father's residence when the fatality incident occurred. The death of the infant does not appear to be the result of child abuse or neglect.

The assigned worker for the teen father's dependency case had in-person contacts with the teen in January, April, May and June 2008. At no time did the teen or anyone else indicate that the father had a pregnant girlfriend. It was not until the death of the infant in late July 2008 that the worker became aware of the situation. The father told the DCFS social worker and supervisor during the first post-fatality home visit that he had kept the information a secret. It is unknown when exactly family members knew of the pregnancy or the eventual birth of the twins. The teen father's Court Appointed Special Advocate (CASA) stated during a pre-review interview that he had no knowledge the teen had fathered twins until notification of the fatality incident. The CASA stated that based on his many years working with the family, such lack of forthcoming information was consistent with the family's customary behavior.

The father aged-out of care upon reaching the age of majority in December 2008.

In reviewing the available DCFS case file documentation and post-fatality information gathered from other sources, no issues relating to policy, procedures, or practices were identified that had any direct connection to the circumstances of the sudden unexpected death of the infant on July 27, 2008.

**Recommendations:** None

**Issue:** Several practice issues were noted and discussed during the child fatality review which had no apparent direct connection to the circumstances of the child death. These ancillary issues relate to casework activities for the teen father's dependency case and have no relationship to either the teen mother or the twins. These are included in this report solely as documentation of discussion occurring during the child fatality review.

(1) There was a period of time covering several months in 2007 when neither the Guardian Ad Litem (GAL) nor the assigned social worker could locate the teen father or his relative care provider. While the inability to meet the Health and Safety Monitoring Visit requirements was documented by the assigned social worker, efforts to locate the child appeared to be minimal. Best practice would suggest the need to be more active in

contacting relatives and others involved in trying to find the whereabouts of a missing dependent child, and to document such efforts. Procedures for responding to children missing in care are outlined in the Practices and Procedures Guide (Chapter 4000) and a revised Children Missing from Care Policy was made effective October 1, 2007.

(2) When the teen father went to live with his maternal grandmother, the placement change was not entered into CAMIS/GUI. At the time of dependency dismissal when the father turned 18 years old, the CA database still showed placement with a maternal aunt. It is clear in case documentation, confirmed by interview with the father's CASA, that the court was aware that the teen had moved to the residence of his grandmother, but this was not reflected in the CAMIS Placement Module.

(3) It is known that various extended family members either lived or had intermittent stays at the grandmother's residence while the father was residing there. The assigned worker did conduct visits to the home, but admittedly never inquired with either the teen or the grandmother as to who else might be living in the home.

(4) A review of case documentation showed that an intern conducted a Health and Safety Monitoring Visit in June 2008 a month prior to the death of the father's infant son at the home. The use of interns for such visits appears to have been a common practice in the Tacoma DCFS Indian Child Welfare/Child Welfare Family Services (ICW/CWFS) unit despite being clearly in violation of CA practice expectations (Practice and Procedures Guide Chapter 4000). This practice appears to have been contained to the particular unit and not pervasive to other child welfare units in the Tacoma DCFS office. Soon after an interim supervisor had assumed duties for the ICW unit in mid-2008, the use of interns for Health and Safety visits was discontinued and only the assigned social worker conducted such visits.

**Recommendations:** There are no recommendations. As indicated, none of the discussed policy and practice issues related to the circumstances of the death of the dependent teen father's infant. Policies and procedures are in place regarding the identified issues, and the deficits noted do not appear to be pervasive in the Tacoma DCFS office.

**Action Taken:** The Area Administrator whose duties include oversight of the ICW/CWFS unit in Tacoma has agreed to talk to the newly appointed supervisor for the unit to confirm that the Health and Safety Monitoring Visit policy is being followed, and that only assigned social workers are conducting the required visits.

**Action Taken:** The assigned social worker participated in the review and received feedback regarding practice deficits and areas for improved practice. The worker acknowledged that in the future she will inquire more in depth as to current household members and household visitors in relative (non-licensed) placement cases. Additionally

the worker indicated that in the future she would more fully document efforts to locate a child or family that has disappeared.

**Recommendation:** None