

Child Fatality Review #08-64
Region 3
Whatcom County

This two-year-old Native American male died from Sudden Unexplained Toddler Death.

Case Overview

On November 13, 2008, the deceased child's mother called 911 shortly after she woke up at 12:30 in the afternoon and discovered her two-year-old son deceased. She reported that she had found him lying face down wedged between the wall and a cushion on the bed where she put him down to sleep along with his twin brother. The mother reported that her son was cold and appeared to have been dead for some time. The children's father left for work earlier that morning and did not notice his son's condition. The family slept in one room. The three children, the three-year-old daughter and twin sons, all slept in the same bed, a chair that folds into a bed. There were no signs of trauma to the child. The cause of death was certified as "Sudden Unexplained Toddler Death" and the manner of death was "Undetermined."

The parents reported they drank heavily the night before their son died. A report was made to Child Protective Services (CPS) intake of this child's death. The parents entered into a safety plan in which they agreed to address their alcohol abuse. When this failed to happen, the worker and supervisor approached the Tribe and gained support in filing a dependency petition to ensure the safety of the surviving children. The surviving children were placed in relative care.

Referral History

On November 28, 2005, it was reported to CPS intake that the deceased child's parents were so drunk they were unable to properly care for their infant daughter, sister to the deceased child. It was further alleged that the father attempted to make sexual contact with his 17-year-old stepdaughter. This referral was screened in for investigation by CPS and closed with an unfounded finding for negligent treatment or maltreatment and an inconclusive finding for sexual abuse.

On January 28, 2007, an anonymous caller reported to CPS intake that he lived in the family home and reported he was "severely beaten" by the deceased child's parents. He said the parents were often too drunk to care for their 14-month-old child and four-month-old twins. He said the house was usually dirty, smelled like garbage, and there was very little food in the house because the parents spent their money on alcohol and drugs. This referral was screened as information only.

On February 21, 2007, a report was made to CPS intake that the deceased child's parents were extremely intoxicated during a motel stay. The father was arrested for domestic violence. The parents stayed in one room with the three small children. The police

observed many empty beer bottles and broken beer bottles on the floor. The paternal grandmother picked up the children. This referral was screened in for investigation by CPS. However, the assigned social worker was unable to locate the family and the case was eventually closed without a finding.

On November 21, 2007, an anonymous report was made to CPS intake alleging the deceased child's mother was drinking heavily and smoking marijuana in the same room with her children. The caller also stated the father is violent toward the mother and sometimes made her and the children sleep in the van. This referral was screened in for investigation by CPS. Again, the assigned social worker was unable to locate the family and the case was eventually closed without a finding.

On November 14, 2008, police reported to CPS intake the death of this two-year-old child. The child's mother woke around 12:30 in the afternoon and found the child face down wedged between the wall and the cushion on the bed. The surviving children were temporarily placed with relatives. The parents agreed to participate in services to address their alcohol abuse and the children were returned to their care. The parents never fully complied with the service plan and the children were removed from their care. The social worker consulted with the Tribe and a dependency petition was filed on the surviving children.

Issues and Recommendations

Issue: The referral dated February 21, 2007 was closed out after several failed attempts to locate the family. A member of the Lummi Child Protection Team (CPT) offered to supply information about the family's whereabouts, as they were believed to still be on the Lummi Reservation, but there was no documentation of follow-up on that request.

Recommendation: An agreement was reached with the Lummi Children's Services that if a social worker needs information on a case, and a member of CPT offers to assist in providing that information, it will be made available to the worker within a few days of the CPT meeting, or at the very latest, at the next CPT meeting. CPT meetings are held weekly.

Issue: The referral dated November 21, 2007 was closed out without sufficient contact with the family to conduct an investigation. This referral was not staffed with the Lummi CPT.

Recommendation: It appeared that during the time the CPS worker was trying to locate this family, they moved very frequently on and off tribal lands. The team recommended that in this kind of situation, the worker explore the possibility of contacting the office providing the Temporary Assistance for Needs Families (TANF) assistance and attempt to have the benefits held until contact is made.

The team recommends the unit be reminded of the need to staff each referral involving a Lummi child with the CPT.

Issue: The Family Team Decision Making (FTDM) meeting following the death of this child was chaotic and adversarial, with thirty people present from the Tribe, most appearing unexpectedly. The concerns that the CPS worker had about the safety of the surviving children were not addressed at that meeting.

Recommendation: The team recommends that the agency continue its emphasis on adherence to the FTDM model. Additionally, when an FTDM needs to be held following the death of a child, this team recommends that the department explore the possibility of:

- 1) Having a person trained in grief/trauma issues present at an FTDM that is immediately following a child death.
- 2) Having an Area Administrator or two supervisors present at an FTDM that has the potential for bringing forth heated emotions.
- 3) Delaying the FTDM until after the most intense grieving has passed, in cases where the surviving children can remain in a safe situation.

Issue: This case involved the close family member of a Division of Children and Family Services (DCFS) employee. That employee became involved in the case causing some complications.

Recommendation: The team recommends that the department explore the feasibility of an administrative policy requiring self disclosure when an employee becomes aware that a close relative has become involved with DCFS.

Issue: Despite the difficulties the social workers encountered at the FTDM meeting, the supervisor new to that unit was able to reach out and engage the parents in a commitment to address their substance abuse issues. He was able to gain the support of the Tribe in a dependency action when it became apparent that would not be sufficient to keep the surviving children safe.

Recommendation: None

Issue: The second referral on this family was made by an anonymous caller but contained allegations that the parents were frequently too drunk to care for the four-month-old twins. It was taken as information only. The team believed this referral should have been screened in for investigation.

Recommendation: This referral should be discussed for consensus building at the next meeting of Regional Intake Specialists, which includes a representative from Central Intake.

Issue: Two referrals received on this family prior to the fatality were assigned but closed without contact being made with the family. The staff investigating these two referrals did not follow regional protocol that specifies the efforts that should be made in attempting to locate the family before closing out the referral.

Recommendation: The regional protocol should be updated and distributed again to ensure that all CPS staff are reminded of it.