

Child Fatality Review #08-51
Region 6
Cowlitz County

This 12-year-old Caucasian male died from acute internal bleeding.

Case Overview

On September 7, 2008, the mother of the deceased child called the police to report he died at approximately 2:30 pm. The deceased child was a hemophiliac and had been sick for 24 hours with diarrhea and vomiting. Hemophilia is a rare bleeding disorder that prevents the blood from clotting properly. Law Enforcement investigated the death and did not report abuse or neglect at the end of their investigation. The Coroner's report indicates the cause of death was acute intra-abdominal hemorrhage. The Coroner found no evidence of lethal injury.

The deceased child was autistic. He was non-verbal and in his mother's care his entire life. His older brother is also a hemophiliac and developmentally delayed. He lives with his biological father. The deceased child's mother has a history of addiction to pain killers. At the time of the child's death the department did not have an open case on the family. The mother had no other children in her care.

Referral History

On November 22, 1996, law enforcement called Child Protective Services (CPS) intake to report an altercation between the deceased child's mother and father. They reportedly drank too much and a domestic violence (DV) incident occurred. The mother had a black eye; the father admitted he hit his wife. The referrer said there was a prior DV incident between these parents in which the deceased child, then five-months-old, was between them. The deceased child's father was on probation for assault at the time. This referral was screened in for investigation by CPS and closed with a founded finding.

On June 22, 1998, a pediatrician called CPS intake to report bruising on the arm of the deceased child, then two-years-old. The mother said another child caused the injury, the doctor suspected the father. The doctor stated the mother was caring for this child appropriately and the injury was not serious, but the mother's story was not consistent with the injury. This case was screened in as a CPS low-risk case. A letter was sent to the child's mother addressing these concerns and an offer of services.

On June 30, 2001, a doctor called CPS intake and reported the deceased child, then five-years-old, was treated for a cut on his thumb while opening a pop can. The mother became belligerent with hospital staff and left the hospital prior to her son being treated for his injury. The mother complained she waited for over two hours and got frustrated. The child was later observed and appeared fine. This referral was screened in for investigation and closed with an unfounded finding for negligent treatment or maltreatment.

On December 29, 2003, a doctor called CPS intake and reported that the deceased child's mother used her son's medical and physical diagnoses to illegally obtain pain medications for herself. The mother called the doctor's office to report her 17-year-old son broke his leg and needed pain medication. The doctor knew she did not have a 17-year-old son. The doctor was concerned that the mother did not follow up with medical care that was essential for the deceased child's well being. This referral was screened in for investigation and closed with an unfounded finding for negligent treatment or maltreatment.

On April 19, 2004, medical professionals called CPS intake to report the deceased child's mother failed to keep medical appointments for him regarding his hemophilia condition. The hospital did not see or evaluate the deceased child in over one year. The mother continually tried to obtain pain medication for the deceased child for her own personal use. Several doctors and pharmacies refused to write or fill prescriptions for the mother. This referral was screened in for investigation and closed with an unfounded finding for negligent treatment or maltreatment.

On June 21, 2005, a doctor called CPS intake to report the deceased child's mother tried to solicit medication through a clinic. The doctor also expressed concern that the deceased child was not seen by a doctor for over one year. This referral was screened in for investigation and closed with an unfounded finding for negligent treatment or maltreatment.

On December 15, 2005, a doctor called CPS intake to report the deceased child's was treated on December 13, 2005 for a swollen right ankle. The doctor determined the child needed care at a hospital emergency room and told the mother to take him immediately. The doctor followed up with the hospital and found the mother never took her son for follow up treatment. The doctor said the child had a serious medical problem leading to an infection. The investigation revealed the child did not have an infection and the mother called and consulted with the child's hemophilia clinic. This referral was screened in for investigation and closed with an unfounded finding for negligent treatment or maltreatment.

On May 11, 2006, school staff called CPS intake to report the deceased child's mother was not at the bus stop to get him when the bus dropped him off. School staff called the police. This referral was screened out for investigation.

On February 9, 2007, school staff called CPS intake to report the deceased child's mother was not home when her son was dropped off. This was a recurrent problem for school staff. This referral was screened out for investigation.

On April 4, 2007, school staff called CPS intake to report the mom of the deceased child was sought by police for theft. The mom and the deceased child lived alone in Longview. This referral was screened out for investigation.

On October 17, 2007, law enforcement called CPS intake and reported a family member said the mother was not taking care of the deceased child and was using drugs. It was alleged the deceased child was locked in his bedroom as a form of supervision. It was further alleged there was inadequate food in the home. Police went to the home and reported the deceased child appeared in good health. It was noted that the home needed to be cleaned and there was minimal food in the refrigerator. Police made contact with the deceased child's teacher who said the child was not a victim of abuse or neglect. He appeared to get enough food. This referral was screened out for investigation.

On February 12, 2008, a neighbor called CPS intake to report an apartment vacated by the deceased child and his mother smelled of feces and urine. The referrer saw the mother remove six bags of garbage from the apartment. The referrer said the deceased child mostly ate cereal. It was alleged that the mother kept the deceased child in his a room. The referrer reported finding a note written by the mother in which she said she wanted to quit doing drugs so she could spend more time with her four children (she only had the deceased child in her custody). School staff were called to verify the allegations reported. School personnel said the deceased child frequently came to school in foul-smelling clothes that had feces and urine on them. School staff believed the deceased child was left home alone a lot. The deceased child was frequently tardy. This referral was screened out for investigation

On May 9, 2008, school personnel reported to CPS intake the deceased child, then 12-years-old, came to school with feces on his body and clothing. The referrer showered him and got him into clean clothes. This was the second time the referrer had to do this. The referrer heard from other school staff that this has been a recurrent problem. This referral was screened out for investigation

On June 23, 2008, CPS intake received a report that the mother of the deceased child, then 12-years-old, would often yell and scream at him. She hit him on his hands when he misbehaved. The referrer did not report any markings or injuries. It was reported that the mother was unstable and moved a lot. She sold his diapers and screamed at him for having accidents in his pants. This referral was screened out for investigation

On July 23, 2008, school personnel reported to CPS intake that the deceased child came to school dirty everyday. School staff had to shower him daily because he still had feces on him from the day before. The referrer said the deceased child was developmentally delayed and wore pull-ups because he was not potty trained. The referent also alleged the child came to school hungry everyday. This referral was screened out for investigation.

On August 29, 2008, school personnel reported to CPS intake that the deceased child arrived at school with urine soaked pants. He had feces on his shirt. He was not wearing a pull up that he needs because he cannot control his bathroom functions. He had a rash around his buttocks and genitals. His mother sent his medications to school in a Ziploc baggy. There were needles poking out of the baggy. The school nurse could not use the syringes because they were dirty. This referral was screened out for investigation by CPS.

On September 7, 2008, law enforcement called CPS intake and reported the deceased child died on this date. Detectives from the Longview Police Department interviewed the mother and reported no abuse or neglect. The mother said her son had been sick for the last 24 hours with diarrhea and vomiting. This referral was screened out for investigation.

Issues and Recommendations

Issue: Screening of new referrals at intake. In reviewing the 10 most recent intakes all were screened out. The review team agreed with eight of the screening decisions made at intake and disagreed with two of the screening decisions made at intake.

Recommendation: The team agreed that based on the information received at intake on July 23, 2008 and August 29, 2008 the intakes should have screened in. Prior to this fatality review a team of four regional staff reviewed 232 Information Only intakes taken by the Kelso office. Of those intakes reviewed the team agreed with 83% (193 intake) of the intake decisions made by the Kelso office. The team also reviewed 26 high standard intakes the team agreed with 96% (25 intakes) of the intake decisions made by the Kelso office. A meeting was held with the intake supervisor and the Area Administrator after the review was conducted to debrief the findings of the review team. The intake supervisor will scrutinize information only screening decision more closely.