

Child Fatality Review #08-66
Region 5
Pierce County

This 17-year-old Caucasian male died from coronary artery disease.

Case Overview

On December 14, 2008, this 17-year-old youth returned home after being out with friends. He said he was not feeling well and went to lie down. Within the hour he was found unresponsive in his room by a friend who alerted the youth's father. The father gave CPR until Emergency Medical Services arrived. The boy died later that day. Pierce County Sheriff's Deputies reported no signs of trauma were found and there was no evidence to suggest suspicious circumstances regarding the death. The Medical Examiner determined this youth died a natural death caused by coronary artery disease. While coronary artery disease is the leading cause of death worldwide and in America, heart attacks are very rare in children including teens.

Referral History

On December 4, 2007, a family friend reported to Child Protective Services (CPS) intake that there was no food in the home and that the home was unsafe and dirty. The children were said to be dirty, had head lice, and did not get their basic needs met. The referrer said the home was overrun with animals. It was also reported that the deceased youth's father was selling or abusing drugs. This referral was assigned for Alternate Intervention and sent to the local Alternative Response System (ARS) provider. A Family Support Worker made an unannounced home visit and found the home to be somewhat cluttered but not in the condition described by the referent. The family reportedly was receptive to the ARS worker, but declined any further services.

On December 30, 2008, a report was made to CPS intake that this youth had died. There were no allegations of abuse or neglect. An autopsy revealed the youth died from coronary artery disease. This referral was screened as Information Only.

Issues and Recommendations

Issue: The Child Fatality Review was held at the Tacoma East DCFS office on April 23, 2009. The family history of Children's Administration (CA) involvement prior to the fatality was limited to a single alternate intervention intake in December 2007. Several issues were discussed during the review but none appeared to have any obvious impact with regard to the circumstances of the child death which involved a medical cause (Coronary Artery Disease).

The issues emerging during the review are included below for the limited purpose of documenting the discussions occurring during the child fatality review.

Issue: Regarding the referral dated December 4, 2007: an acquaintance of the family reported having observed the living conditions in the family home to be unsafe and unsanitary. The referrer also reported that the children had head lice, were dirty, and their

basic needs were not being met. There was speculation on the part of the referent as to substance abuse in the home and possible drug dealing. The initial report was taken by Central Intake (CI) and accepted for CPS investigation.

The intake was reviewed at a Region 5 intake consensus team meeting the following day. The consensus team that day included participation by two Area Administrators. Following discussion of the intake, the report was downgraded to Alternate Intervention (AI) and sent to Alternative Response System (ARS), which is now called Early Family Support Service (EFSS). The reason for the intake decision change was based on the low risk levels associated with the reported health hazards, the lack of any prior history involving the family, and the ages of the children (no young children in the home).

In review of this intake, fatality review panel members agreed that the decision to downgrade to alternate intervention appeared reasonable and supportable.

Recommendation: None

Issue: Regarding the ARS intervention: Timelines were met per CA policy and current EFSS contract. Initiation of engagement was within ten calendar days from date of referral. The home visit was unannounced which is consistent with best practice. Face-to-face contact was made with the mother and the oldest child (now deceased). The other two children were in school at the time of the home visit which would suggest they did not have head lice. The assigned Family Support Worker (FSW) did not observe the home to be in the conditions described by the referent. The FSW recalled that the deceased youth appeared to be healthy (not obese or overweight) although the worker admittedly only had limited contact with the boy. Offered services were declined by the mother and a follow-up letter was sent to the parents with (1) a list of services available at the nearby Family Support Center, (2) resources available in Pierce County, and (3) a client satisfaction survey. The ARS Termination Summary was received in a timely manner by DCFS. The ARS documentation as reviewed appeared sufficient and overall the intervention met expected standards of practice for alternate intervention.

Recommendation: None

Action Taken: The Family Support Worker who conducted the ARS intervention was present during the review and received the feedback as to meeting expected practice standards for EFSS.

Issue: As part of an agreement with Tacoma CPS, the Tacoma-Pierce County Medical Examiner's Office provided a courtesy notification to CPS intake on December 16, 2008, of the death of this 17-year-old youth. There were no suspicions for child abuse or neglect at the time of the notification. An update was documented by intake on December 23, 2008, following contact with the assigned Pierce County Sheriff's Detective who confirmed there were no suspicions regarding the circumstances of the child death. The information was initially documented in a Fatality Log (no referral) as there were no

suspicions for child abuse or neglect and the last referral to CPS (alternate intervention) was over 12 months prior.

The Region 5 Fatality Program Manager reviewed the family case history and found that while the referral date for the prior referral was over a year before the youth's death, the ARS intervention had actually closed only 11 months earlier. Due to the family having received "CA services within 12 months prior" [see CA Administrative Incident Reporting Policy January 2005] an intake was created as well as an incident report generated. In review of the intake, the review panel agreed that the screen out decision (no assignment) appeared to be appropriate, especially given later confirmation that the death was due to a medical cause (coronary artery disease).