

Child Fatality Review #08-78
Region 6
Mason County

This 11-year-old Caucasian male died from Methadone Intoxication.

Case Overview

On November 25, 2008, the mother of this deceased youth was unable to wake him. He was unresponsive, so she called 911 and performed CPR until medics arrived and took over. CPR was stopped at 8:55 a.m. at which time the youth was declared dead. There were no unusual marks noticed on the youth's body except for the obvious marks from the CPR that had been performed. The family was in the process of moving to Pacific County three days prior. The home was overall clean with moving boxes in the living room.

The toxicology report was received by law enforcement which showed the child had a blood Methadone level of .72. Law enforcement found that the Methadone was a prescribed medication for the youth's mother and was kept in a child friendly pack which looked like a stuffed reindeer. The medication was easily accessible to the children in the home. This youth was known to wander in the night. He would get into the kitchen and refrigerator and eat things and take some things to hoard in his room. His mother had a security device at a previous residence which was described as a motion detector because of this youth's habits. The mother also had a lock box in which she kept her medicines. At the new home where they had just moved, the medication was not in the lock box nor was a door alarm or motion detector installed. The medication was not put in a safe location and was in a child friendly container.

The manner of death has been ruled Undetermined, cause of death is Methadone Intoxication.

Referral History

On January 8, 2007, a neighbor contacted Child Protective Service (CPS) intake to report the family home was filthy. There were used diapers at least a week old, old rotting food and no fresh food. The referrer said the mother had mental health issues and was unable to care for her children. She slept most of the day and the children had to fend for themselves. The older boys, including the deceased youth, were said to be developmentally delayed. All the children were always sick, but when they visit other homes, they are not sick. The children's stepfather had just moved out of the family home. The mother threatened to kill herself and her children if her husband did not return home. This referral was investigated by CPS and closed with an unfounded finding for negligent treatment or maltreatment.

On February 8, 2007, a relative reported to CPS intake the deceased youth's mother was taking a lot of medications which altered her personality to extremes. The referrer said the deceased youth and his 12-year-old brother were slapped a lot. They had no privileges and their mother favored their sisters. The referrer said their parents were aware that both boys needed glasses, but did not get them. The referrer added the boys have a hard time seeing the blackboard at school. The boys told the referrer that at times their mother deliberately withheld food from them, but would feed the girls. The home was alleged to smell like dog and cat urine. There was clothing and clutter all over the home. The deceased youth's older brother told the referrer that he believed his then two-year-old sister was taken to the hospital because she got into their mother's medications. The mother reported it was her husband who took her medications. He entered drug/alcohol treatment for his addictions. The mother also reported her boys had glasses but needed new glasses based on the result of their last eye exams. This referral was screened in for Alternate Response System (ARS) and forwarded to the CPS investigator who was investigating the previous referral.

On April 2, 2007, a relative reported to CPS intake that the deceased youth's two-year-old sister was taken to a Mason County hospital because her mother thought she ate some of the mother's medications. The referrer reported the hospital tested the child and found no evidence that she ingested medications. The referrer also reported she saw the same two-year-old eating dog feces in February 2007. This referral was screened as Information Only.

On April 2, 2007, a relative reported to CPS intake that the deceased youth had injuries caused by his mother. The youth alleged his mother choked him with such force that he couldn't breathe. The deceased youth told the referrer he had mucus running down his face, which his mother smeared into his hair. The referrer said the youth had a scratch on his Adam's apple one-half inch in length. The youth had a bruise on his left arm that was palm sized and oval shaped allegedly caused by the mother grabbing him. A CPS investigation was opened. The deceased youth was interviewed and denied he was hurt and that he could not breathe. No marks were seen on his neck. This referral was closed with an unfounded finding of physical abuse.

On April 19, 2007, a social service professional reported to CPS intake that the deceased youth's mother sought assistance with a local domestic violence victim agency to file a Protection Order against her husband. She also planned to file for divorce. The referrer reported the father/stepfather made inappropriate comments to the mother about her sons' genitalia. The father/stepfather had no contact with the children because of the Protection Order. This referral was screened as Information Only.

On June 18, 2007, a social service professional reported to CPS intake that the mother confided to the referrer that her estranged husband was sexually inappropriate with the deceased youth and his older brother, then ages 12 and 10-years-old. The mother reported

that in the past he attempted to instruct the boys how to masturbate, threatening to masturbate them himself if they did it incorrectly. The mother said she believed he never touched her sons' genitalia, but had possibly exposed himself to them and had forced each to touch their own genitals. It was believed such incident or incidents had occurred before March 2007. The mother stated her husband said he was diagnosed as bipolar and had further issues with alcohol and misuse of both prescription and non-prescribed medications. The referrer said all four children in the home have disabilities of varying severity. The mother also said her husband was verbally abusive to the children. He called the boys "faggots" and "retards." This referral was screened as Low Risk CPS. The case was still open on a prior CPS investigation. The investigating CPS social worker addressed these allegations with the mother. Law enforcement was notified and interviewed the deceased youth and his brother regarding the allegations of sexual abuse. Neither boy disclosed being sexually abused by their stepfather.

On October 12, 2007, a school staff reported to CPS intake that the deceased youth, then 10-years-old, exhibited what the referrer thought was significant forms of acting out behaviors at school. He tried to choke himself and said he was going to kill himself. The deceased youth told another student he was going to bring a gun to school. This latter comment was forwarded to law enforcement. The deceased youth's mother was contacted. She said he was in treatment with a psychiatrist from Children's Hospital. Because of the gun comment made by the deceased youth, the mother was advised to have him immediately assessed by a county mental health professional at the local county hospital. This referral was screened as Information Only.

On January 23, 2008, a social worker at Children's Hospital called CPS intake and reported the deceased youth's two-year-old sister fell out of a shopping cart while the family was shopping. The mother immediately took her for medical care and she was medically cleared. Days later, the mother noticed a spongy area on the child's head and took her to the emergency department at Children's Hospital. A skeletal survey was performed and the child was admitted to the hospital. The mother's explanation was consistent with the child's injury. The referrer spoke with a relative who reported the mother was on Methadone and Percocet for pain. This relative believed the mother had Munchausen's by Proxy because she regularly took her children to the doctor. The relative did not think the mother would harm her children. This relative was concerned that the mother would drive with children in the car while she was using prescribed drugs. This referral was screened in for investigation by CPS and closed with an unfounded finding for negligent treatment or maltreatment.

On August 30, 2008, the deceased youth's mother contacted CPS intake and requested Family Reconciliation Services (FRS). The mother said her 13-year-old son refused to follow the house rules and he constantly threatened to run away. He bullied the younger children and has a severe hygiene problem. He refuses to change his clothes or bathe. The mother requested family counseling. This referral was accepted for FRS.

On November 26, 2008, a relative called CPS intake to report this youth died in Pacific County. This relative suspected the youth died because of his mother's neglect. The referrer said the youth died in his sleep, was vomiting and was underweight. The referrer expressed concerns for the deceased youth's older brother as it was alleged the mother didn't feed the deceased youth or his older brother. The referrer said the deceased youth's younger sister had the same symptoms as the deceased youth. This referral was staffed with the CPS Intake Supervisor and Area Administrator. Based on the case chronicity and the child fatality, it was decided to screen in this referral for investigation by CPS.

The mother was assessed by a mental health professional as she expressed suicidal ideation after the loss of her son. The CPS case was closed with an unfounded finding though the case remained open under a safety plan. This safety plan required the mother to follow through with all medical recommendations for her surviving children, lock up her medications, and allow for relatives to come to her home and verify compliance with this plan. The surviving children remained in their mother's care.

On January 14, 2009, the Pacific County Coroner reported the results of the toxicology report on this deceased youth's autopsy. The youth died from an overdose of Methadone. The youth had twice the lethal amount in his system. His mother was taking prescribed Methadone for pain management. The mother reported she and all four of her children are diagnosed with neurofibromatosis. Neurofibromatosis is a genetic disorder that affects the development and growth of nerve cell tissues. The county coroner confirmed the child suffered from neurofibromatosis. The CPS investigation into this youth's death was closed with a founded finding as the mother was previously warned about keeping her medications where her children had access to them. The case remained open under the safety plan drafted during the previous CPS investigation.

Issues and Recommendations

Issue: The fatality review team looked at the screening decisions for the referrals/intakes received on this family. The referral dated February 8, 2007 was screened in as a low risk intake. After looking at this intake more closely, the team felt it should have screened in for a high standard of investigation.

Recommendation: None.

Action Taken: Although the referral should have screened in for investigation, this referral was received at a time when Children's Administration had an open case on this family. The social worker had face to face contact with the mother in her home and addressed the methadone issue (alleged in the intake) with her. After the deceased youth's two-year-old sister was taken to the hospital on suspicion of ingesting the methadone, the mother found out through the father's admission that he had taken her methadone. The social worker also found the home clean and did not find it in the condition as described in the referral. The social worker spoke with the mother about

securing her medication away from the reach of the children. The social worker did not document this conversation with the mother. The mother also mentioned that the hospital also spoke with her about securing the medication. There is no documentation in the case file that this was verified with the hospital. The team noted that intakes should not be screened down or out just because the case is open at the time of a new intake. The supervisors involved in the review will discuss this with their staff as well as the importance of reviewing case history when assessing risk.

Issue: The mother had a locked box and at times secured her medication in the box. At some point she stopped securing her medication in the locked box and used a child friendly bag at the time of the deceased youth's death

Recommendation: None

Action Taken: The current social worker has confirmed that the mother is using the locked box for her medications and has it out of the reach of the children.