

**Child Fatality Review #09-11**  
**Region 4**  
**King County**

This 17-year-old Caucasian male died from drug overdose.

**Case Overview**

On March 3, 2009, this 17-year-old youth died from an accidental drug overdose. He was found dead, in his bed with his face in a pillow. The family described a normal evening the night before his death. He was last known alive at 10:30 p.m. on March 2, 2009. He was heard in his room, talking on his phone. At 5:00 a.m. on March 3, 2009, his parents heard his phone ringing and his father called to him. His mother found him unresponsive. They called 911, but the youth was pronounced dead at the scene.

The investigators learned that the deceased youth had a history of depression and Attention Deficit Hyperactivity Disorder (ADHD). He was diagnosed at age 15 and had been prescribed an antidepressant. There were also two notes the deceased youth wrote that raised the question of suicide. He had lost a close friend a year ago. He wrote an "Ode" to this friend, as well as a letter. This letter included a line, "I will see you in heaven." His parents were also concerned that he may have taken his mother's prescription medications.

The cause of death was determined to be acute combined methadone and citalopram (an antidepressant) intoxication, with the underlying causes of pulmonary congestion and congestive splenomegaly (engorgement of the spleen with blood). The Medical Examiner determined the manner of death to be accidental.

**Referral History**

On September 7, 2000, a mandated reporter reported to Child Protective Services (CPS) intake that the deceased youth's father was not being protective of his sons by allowing contact with an older cousin. The cousin, age 16, allegedly sexually abused the deceased youth's brother, then six-years-old, several years prior. This intake was accepted for investigation by CPS. This information was forwarded to law enforcement. The assigned worker closed this case with an unfounded finding.

On September 19, 2003, the deceased youth's mother contacted CPS intake to request an At-Risk Youth petition for her oldest son. He was physically assaultive to family members, ran away from home, and did not follow rules. The intake was accepted for Family Reconciliation Services (FRS). The assigned social worker contacted the mother and offered an appointment but she did not follow through and the case was closed.

On July 18 2006, the deceased youth's brother called CPS intake to request FRS in order to file a Child In Need of Services (CHINS) petition. He stated his mother was violent

and hit all three boys. The brother said his mother grabbed him by a necklace he was wearing and punched him in the chest. This was investigated by law enforcement and CPS. The parents have a high level of conflict over child custody. It was determined that the allegations were unfounded, and the case was closed.

On November 27, 2006, a mental health worker reported to CPS intake that police brought the deceased youth to a hospital, due to suicidal ideation. There were additional risk factors, including the mother's mental health issues and lack of compliance, the sons' medication and lack of monitoring. There were on-going child custody issues between the parents. This intake was accepted for investigation and closed with an inconclusive finding for negligent treatment or maltreatment. The youth completed a psychological evaluation and was under the care of a pediatrician.

On May 16, 2007, a relative called CPS intake to report the father's neglect of his three sons. The youngest, age 12, was picked on and hurt by the older two brothers, including the deceased youth. The referrer stated the father was not following through with counseling for the deceased youth. This intake was screened in for investigation of negligent treatment or maltreatment and closed with an unfounded finding. The youth was seeing a mental health counselor and taking antidepressant medications.

On February 27, 2008, a relative called CPS to report that the older brothers, including the deceased youth, were abusive to their 12-year-old brother. The last time the referrer observed this was between July and December 2007. The intake was accepted for investigation. The assigned worker spoke with all three boys; they denied any mistreatment. They spoke about the on-going child custody issues and conflict with their mother. (Note: Despite being divorced, the deceased child's parents were living in the same residence at the time of their son's death). The investigation into this intake was closed with an unfounded finding.

On March 3, 2009, the King County Medical Examiner reported the death of this youth. It appeared the youth died from an overdose, either accidental or suicide. The Medical Examiner noted nothing suspicious about the death. The youth had a history of depression and was seeing a psychiatrist. This intake was screened as Information Only.

### **Issues and Recommendations**

**Issue:** None

**Recommendation:** None