

Child Fatality Review #09-15
Region 3
Island County

This 13-year-old African American male died from a drug overdose.

Case Overview

On March 9, 2009 law enforcement responded to a call at the home of the deceased youth and his mother. The deceased youth collapsed in the kitchen about 4:00 a.m. Police officers began CPR, and he was taken to a local hospital and then to Children's Hospital in Seattle, where he died on March 14, 2009 without regaining consciousness. Initially the death was believed to be from natural causes, but after full autopsy results were received, the cause was determined to be anoxic encephalitis (swelling of the brain due to a lack of oxygen) and "probable acute opiate intoxication." Morphine was found in his system.

On July 1, 2009, law enforcement closed its investigation into this youth's death. The investigation revealed that the deceased youth talked with friends on the phone for several hours the previous evening before his collapse, and the friends reported he appeared to be fine. He told these friends that he had taken some pills. The police report concluded that, "it appears that this death is an accidental overdose of morphine, and it is unknown where the child obtained these pills."

The manner of death is undetermined.

Referral History

On December 4, 1996, a report was made to Child Protective Services (CPS) intake alleging an unrelated infant died of SIDS while in the care of the deceased youth's mother. It was suspected that she operated an unlicensed childcare. The mother was watching children and went to the store for wine, leaving friends to watch the children. When she returned, smelling of alcohol, the child had died. Police reported the mother was known to them as an alcohol and marijuana user with a "short fuse." This intake was investigated by the Division of Licensed Resources.

On June 25, 2002, a neighbor reported to CPS intake that the deceased youth's mother smoked "crack" cocaine in her poorly ventilated home in the presence of her son, then seven-years-old. She also sold prescription drugs openly and drank excessively. The referrer said the child's supervision was inadequate. This intake was accepted for investigation and closed with an unfounded finding.

On March 16, 2003, a neighbor reported to CPS intake getting into a verbal altercation with the deceased youth's mother that escalated to the point where the police were called, and the mother was arrested. Her son, the deceased youth, was present during this

altercation. This intake was accepted for investigation and closed with an unfounded finding.

On October 1, 2003, a neighbor called CPS to report that the deceased youth frequently had to wait up to two hours on the porch for his mother to return home. The referrer often heard the mother screaming at her son late at night. This intake was screened in for investigation, and the case remained opened. The mother agreed to a safety plan.

On December 14, 2003, a hospital social worker contacted CPS intake and reported the deceased youth's mother was brought to a hospital by ambulance after being found at her home, incoherent. She tested positive for cocaine, and the diagnosis was possible toxic psychosis from that substance. The youth was at his aunt's house. It was unknown how long he had been there. This intake was screened in for investigation and closed with a founded finding for negligent treatment or maltreatment. The mother agreed to a service plan.

On February 20, 2007, a social service professional reported to CPS intake that the deceased youth (then 11-years-old) and his mother were staying in a motel. It was reported that the mother was spending much time in the bar leaving her son alone in the room. She reportedly frequently had guests that were drug users and dealers. This intake was screened for an Alternate Response System (ARS) and a letter was sent to the mother.

On April 18, 2007, law enforcement responded to the motel where the mother and the deceased youth were staying. Both she and her boyfriend were drunk and disorderly and it took the officers to calm them down. The deceased youth was there and was also involved in trying to calm down his mother. Police officers did not believe the youth to be in danger. This intake was screened as information only.

On October 16, 2008, school staff called CPS to report they were concerned about the mother's state of mind. She had called the school that morning screaming, claiming someone had given her son (the deceased youth) a black eye. School officials were able to talk to the child who said he was not hit; rather he had just rubbed his eye. This intake was screened as information only.

On March 16, 2009, the King County Medical Examiner reported the death of this 13-year-old youth. The youth collapsed at home and was eventually taken to Children's Hospital, where he died on March 14, 2009. The referrer reported the youth appeared to die from natural causes. This intake was screened as information only.

Issues and Recommendations

Issue: The review team noted deficits in practice in the investigation of the earlier referrals, particularly those in 2002 and 2003. The investigations appeared cursory, with

inadequate child interviews and insufficient use made of collateral contacts to validate parent statements. Safety assessment and safety planning were also identified as issues.

Recommendation: The team recommends additional training for social workers in the region in the best use of the safety assessment tool and best practice in safety planning. This training should also address improving worker skills in validating information learned in the investigation stage.

ACTION TAKEN: The four primary investigations in this case were handled by two social workers, both of whom have left child welfare social work with families.

Issue: The review team saw the chemical dependency evaluation used in this case in 2004 as inadequate. An "expanded assessment" according to contract, should be much more inclusive than this appeared to be and should contain information gathered from collateral contacts.

ACTION TAKEN: Since the time of this evaluation, another provider has been contracted to provide the expanded assessments.