

Child Fatality Review #09-23
Region 4
King County

This 16-year-old Caucasian female committed suicide.

Case Overview

On April 20, 2009, this 16-year-old youth was found dead in her bed at her family home. She was found by her mother in her basement bedroom around 10:00 p.m. The estimated time of death was around 3:00 a.m. She was last seen alive at about 10:00 p.m. on April 19, 2009 when she returned home and told her mother she was going to bed.

The mother left for work very early the next day and returned home about 5:30 p.m. She and the younger siblings thought the deceased youth was not home. At around 10:00 p.m. a friend of the deceased youth came to the home to show the mother a copy of the deceased youth's blog on My Space, which read, "This is my last blog. I'm sorry. I thought about this for 7 years. I shall remain 17 forever. But I love you guys okay. Bye."

The mother then checked her daughter's room and found her unresponsive and cool to the touch. King County Medical Examiner investigators found several very explicit notes written by the youth clearly stating her intention to commit suicide. They also found a Ziploc bag of miscellaneous pills (imipramine, ibuprofen and acetaminophen).

The autopsy determined that the cause of death was a drug overdose. The manner of death is suicide. It was also noted that she had numerous scarring marks on her arms consistent with self-cutting.

Referral History

On January 25, 2005, a relative called Child Protective Services (CPS) intake alleging the deceased youth's mother was supposed to be home schooling her, but the child was receiving no school at all. The referrer cited similar concerns regarding the three other children in the home. This intake was screened for Alternate Response System (ARS). The matter was sent to a contracted ARS provider in Pierce County and later closed in March 2005.

On April 28, 2006, an acquaintance of the family called to report a statement made to her by the deceased youth's mother concerning possible sexual touching of the deceased youth's younger sister, then age six, by her father. There was a coordinated investigation that involved law enforcement, the Pierce County Child Advocacy Center, and CPS. This intake was accepted for investigation of sexual abuse. There was no evidence found that the father abused the child, and the investigation was closed with an unfounded finding.

On January 30, 2008, a relative called CPS intake and reported the deceased youth's stepfather filed for divorce, and the mother was neglecting the medical needs of the children. The referrer cited a recent visit with the children. The children were sick with colds, and the mother did not provide any medication. The referrer also complained that the deceased youth used physical discipline when she cared for her younger siblings and the mother did not use booster seats for them when she drives. This intake was screened as Information Only.

On March 26, 2008, a social worker who was helping the parents through their divorce reported to CPS intake that the mother accused the deceased youth's stepfather of bruising their younger daughter's leg. She also accused him of observing the deceased youth while showering and exposing himself to her. The deceased youth's stepfather accused her mother of bruising the younger daughter's hands and striking the children with a metal spoon or wooden paddle. During the investigation, the deceased youth confirmed she made statements about wanting to commit suicide. However, she said it was more a sense of being overwhelmed and that she had people at school and church to talk to. This intake was accepted for investigation of physical abuse and sexual abuse. This investigation was closed with an unfounded finding.

On November 26, 2008, a social worker made a report to CPS intake after speaking with the deceased youth's nine-year-old sister and eight-year-old brother. They each made statements about the sister being bruised by the parents in separate incidents. The screening decision was initially Information Only, but based on the family history, it was screened in for investigation. This report was assigned to the contracted Early Family Support Services (EFSS) program. The exit summary received from the contractor stated that the family declined to participate in services. The mother and children were interviewed in the home. The mother explained the on-going family court issues and said they were working with the family court services social worker. The intake was screened for ARS.

On January 8, 2009, the deceased youth's mother called CPS intake to request Family Preservation Services (FPS). This is a contracted service, and the threshold for eligibility is that the children must be at substantial risk for out-of-home placement absent the service. The assigned worker attempted several times to reach the mother, without success. The worker was informed about the family's recent decision to decline services. She informed the family court worker that she was unable to reach the mother. The intake was accepted for Child Welfare Services.

On January 9, 2009, a relative reported to CPS the parents were in a custody dispute and the father received court documentation revealing a long history of abuse of their children by the mother. Most of the allegations were previously reported, except that the referrer also reported the mother had threatened to kill herself and the children in the past. She said she was going to kill them all and would swerve toward the cliffs while she was

driving. The intake was screened for ARS. The ARS social worker made several attempts to contact the mother without success.

On April 21, 2009, CPS intake received notification of the death of this 16-year-old. The Medical Examiner reported the initial cause of death was a drug overdose. The intake was screened for ARS.

Issues and Recommendations

Issue: The deceased child had ten years of exposure to Domestic Violence (DV) and her three surviving siblings have experienced it their entire lives. Witnessing Domestic Violence is a known Adverse Childhood Experience (ACE) that increases the risk of teen suicide.

Recommendation: Communities should increase the capacity of mental health services to address the treatment needs of children who witness DV. In King County, Seattle Mental Health has received grant funds to increase services to this population.

Issue: The social worker assigned to the March 26, 2008 intake did a thorough job of documenting his contacts with the family and collateral professionals. Through his efforts, Children's Administration received a lengthy DV Assessment from the King County Family Court that provided a great deal of information about the batterer's pattern of abuse and the effects on the victim. He was careful to consult before contacting the batterer about the CPS investigation. His interview with the now deceased child revealed that she did have protective factors at that time and that her suicide was not imminent.

Recommendation: Reinforce the need for social workers to obtain collateral information when DV is an issue.

Issue: Children's Administration social workers should receive specific training on assessing teens for the risk of suicide, as well as other mental health crises.

Recommendation: The Program Manager and the Area Administrator will look for training resources that could be offered at no cost to the agency.