

**Child Fatality Review #09-03**  
**Region 4**  
**King County**

This 12-month-old African American male died from an inflammation of the heart muscle.

**Case Overview**

According to the King County Medical Examiner, on January 25, 2009, this one-year-old was pronounced dead at Children's Hospital, following unsuccessful attempts to resuscitate him. He was visiting his father at the father's home, and had a cold at the time of his death. He was sitting on his father's lap when he gasped and stopped breathing. Paramedics were called and performed CPR. The child was later transported to Children's Hospital. The autopsy revealed that the cause of death was lymphocytic myocarditis. This is an inflammation of the heart muscle, typically associated with a virus, and is an auto-immune response. It prevents the heart from beating. The manner of death is natural.

**Referral History**

On July 1, 2005, a relative called Child Protective Services (CPS) intake to report the police responded to a domestic dispute call on the night of June 30, 2005. The deceased child's mother and maternal grandmother argued, when the mother got a kitchen knife and attempted to leave with her baby (the older sister of the deceased child). Police responded and placed the child with the grandmother. This referral screened in for investigation by CPS and closed with an unfounded finding.

On May 13, 2006, a hospital social worker reported the then 13-month-old sister of the deceased child was admitted to the hospital for a skin infection around her eye. The parents had not cared for or attended to this child. They would not change her diapers or comfort her while she was in the hospital. The case was opened and remained so during the next three months. This referral screened in for investigation by CPS and closed with an unfounded finding.

On June 5, 2006, a relative called CPS intake and reported the parents had separated. The mother was evicted from transitional housing and left her daughter with questionable caretakers. This referral was screened as Information Only.

On June 29, 2006, a relative reported the parents left their daughter with her maternal grandmother after being evicted from a shelter. The parents were homeless. This referral was screened as Information Only.

On July 7, 2006, law enforcement reported to CPS intake a domestic violence incident that occurred between the parents in front of their 15-month-old daughter. The father assaulted the mother. He was intoxicated at the time of his arrest. The child was placed

with her maternal grandmother on an informal basis. The referral was screened in for investigation by CPS and completed with an inconclusive finding. On November 28, 2006, the parents signed a Voluntary Placement Agreement (VPA) formalizing the placement with the grandmother. On January 18, 2007, the parents separated again after another domestic violence incident.

The assigned social worker arranged for a Family Team Decision Meeting (FTDM) and decided to file a dependency petition. The petition was filed January 24, 2007. The daughter became dependent and remained with the grandmother. She was returned to her mother on November 5, 2007. Her dependency continued until June 4, 2009, when it was dismissed.

On January 4, 2009 a relative reported the mother left her infant son (the deceased child) with his grandmother for two weeks and did not provide supplies, money or other support. The referrer reported the mother had been parenting him adequately and there were no allegations of child maltreatment. The assigned Child and Family Welfare Services (CFWS) worker arranged for an in-home FTDM, and the team found that the mother's home was a safe environment for the children. This referral was screened as Information Only.

On January 25, 2009, the King County Medical Examiner reported this child died during the night. This referral was screened in for investigation by CPS since the circumstances were unclear. However, it was determined this child died of an illness and the investigation was closed with an unfounded finding for negligent treatment or maltreatment.

### **Issues and Recommendations**

**Issue:** The decision to screen in for investigation the report of this child's death. The death was sudden and unexpected, but there was no allegation of child maltreatment. A CPS investigation may not have been necessary.

**Recommendation:** The Regional CPS Program Manager should discuss this issue with other CPS Program Managers throughout the state to determine if there is a general consensus on how to screen child fatality intakes that do not allege abuse or neglect.

**Action Taken:** The regional CPS Program Manager discussed this screening decision with the other regional CPS Program Managers and the consensus is that these intakes should not screen in for investigation.