QUARTERLY CHILD REVIEW RCW 74.13.640 JANUARY – MARCH 2022

Washington State Department of
CHILDREN, YOUTH & FAMILIES

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Executive Summary

This is the Quarterly Child Fatality Report for January through March 2022, provided by the Department of Children, Youth, and Families (DCYF) to the Washington State Legislature. RCW 74.13.640 requires DCYF to report on each child fatality review conducted by the department and provide a copy to the appropriate committees of the Legislature:

> (1) (a) The department shall conduct a child fatality review in the event of a fatality suspected to be caused by child abuse or neglect of any minor who is in the care of the department or receiving services described in this chapter or who has been in the care of the department or received services described in this chapter within one year preceding the minor's death.
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> (b) The department shall consult with the office of the family and children's ombuds to determine if a child fatality review should be conducted in any case in which it cannot be determined whether the child's death is the result of suspected child abuse or neglect.
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> (c) The department shall ensure that the fatality review team is made up of individuals who had no previous involvement in the case, including individuals whose professional expertise is pertinent to the dynamics of the case.
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> (d) Upon conclusion of a child fatality review required pursuant to this section, the department shall within one hundred eighty days following the fatality issue a report on the results of the review, unless an extension has been granted by the governor. A child fatality review report completed pursuant to this section is subject to public disclosure and must be posted on the public web site, except that confidential information may be redacted by the department consistent with the requirements of RCW 13.50.100, 68.50.105, 74.13.500 through 74.13.525, chapter 42.56 RCW, and other applicable state and federal laws.
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> (2) In the event of a near fatality of a child who is in the care of or receiving services described in this chapter from the department or who has been in the care of or received services described in this chapter from the department within one year preceding the near fatality, the department shall promptly notify the office of the family and children's ombuds. The department may conduct a review of the near fatality at its discretion or at the request of the office of the family and children's ombuds.

Introduction

In January 2011, SHB 1105 was passed by the Legislature and signed into law by Gov. Christine Gregoire. The revised child fatality statute (RCW 74.13) became effective Jan. 22, 2011, and requires the agency to conduct fatality reviews in cases where a child's death is suspected to be caused by abuse or neglect. This eliminated conducting formal reviews of accidental or natural deaths unrelated to abuse or neglect. The revised statute requires the agency to consult with the Office of Family and Children's Ombuds (OFCO) if it is not clear that the fatality was caused by abuse or neglect. The agency can conduct reviews of near-fatalities or serious injury cases at the discretion of the agency or by recommendation of OFCO. The statutory revision allows the department access to autopsy and post mortem reports for the purpose of conducting child fatality reviews.

Quarter Four Report

This report summarizes information from completed reviews of five child fatalities and three near-fatalities [1] that occurred in the first quarter of 2022. All child fatality reviews can be found on the Child Fatality & Serious Injury Reports page of the DCYF website.

The data in this quarterly report includes near fatalities from five of the six regions (DCYF divides Washington State into six regions). There were no reports in Region 1.

DCYF Region	Number of Reports
Region 1	0
Region 2	1
Region 3	1
Region 4	2
Region 5	2
Region 6	2
Total Fatalities and Near Fatalities Reviewed During First Quarter 2022	**8**

This report includes Child Fatality Reviews (exhibit A) and Near Fatality Reviews (data only) conducted following a child's death or near-fatal injury that was suspicious for abuse and neglect and the child had an open case or received services from DCYF within the 12 months prior to the child's death or injury. A critical incident review consists of a review of the case file, identification of practice, policy or system issues, and recommendations to address any identified issues. A review team consists of a larger multidisciplinary committee including community members whose professional expertise is relevant to the family history. The review committee members may include legislators and representatives from OFCO.

The following charts provide the number of fatalities and near-fatalities reported to DCYF and the number of reviews completed and those that are pending for calendar year 2022. The number of pending reviews is subject to change if DCYF discovers new information by reviewing the case. For example, DCYF may discover that the fatality or near-fatality was anticipated rather than unexpected, or there was additional DCYF history regarding the family under a different name or spelling.

Child Fatality Reports for Calendar Year 2022			
Year	**Total Fatalities Reported to Date Requiring a Review**	**Completed Fatality Reviews**	**Pending Fatality Reviews**
2022	7	3	4

[1] Near-fatality reviews are not subject to public disclosure and not posted on the public website nor are the reviews included in this report.

Child Near-Fatality Reports for Calendar Year 2022			
Year	**Total Near-Fatalities Reported to Date Requiring a Review**	**Completed Near Fatality Reviews**	**Pending Near Fatality Reviews**
2022	10	5	5

The child fatality reviews referenced in this Quarterly Child Fatality Report are subject to public disclosure and are posted on the DCYF website.

Near-fatality reports are not subject to public disclosure and are not posted on the public website, nor are the near-fatality reviews included in this report.

Notable First Quarter Findings

Based on the data collected and analyzed from five child fatalities and the three near-fatalities reviewed during the first quarter, the following were notable findings:

- Six of the eight cases referenced in this report were open at the time of the child's death or near fatal injury.
- There were three fatalities involving infants dying in an unsafe sleep environment.
- There was a fatality that occurred in a car accident.
- Two children under the age of 12 months, overdosed on ingested narcotics. Both cases were reviewed as near-fatalities.
- One teen overdosed on fentanyl; the drug was provided to the teen by her mother.
- One child died from inflicted head and bodily injuries. This case was not open at the time of the critical incident.
- One child referenced in this report is of Hispanic ethnicity, two are Native American, one is Black/African American, one is Pacific Islander, and three children are White non-Hispanic.
- Prior founded allegations of abuse and/or neglect by the caregivers was identified in two of the cases.
- Substance abuse was a significant risk factor in seven of the eight critical incident cases.
- Domestic violence was alleged in four of the cases.
- DCYF received intake reports of abuse or neglect in each of the cases referenced in this report prior to the death or near-fatal injury of the child. In three cases, there were three intake reports made regarding the family prior to the critical incident. In a near-fatality case, there were six prior reports called to DCYF intake. One fatality case had nine reports to DCYF intake prior to the critical incident. In a near fatality case in which a teen almost died from an overdose, the family had 44 prior intakes alleging substance abuse by the caregivers. One fatality case had one prior intake; another fatality case had nine prior reports to DCYF.
- Due to the small sample of cases reviewed, no statistical analysis was conducted to determine relationships between variables.

Exhibit A

Child Fatality Reviews

There were three child fatality reviews completed during this quarter. Child fatality reviews are subject to public disclosure and are posted on the DCYF website.

Exhibit A contains the following child fatality reviews from the first quarter of 2022:

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