QUARTERLY CHILD REVIEW RCW 74.13.640 APRIL – JUNE 2021

Washington State Department of
CHILDREN, YOUTH & FAMILIES

Washington State Department of
CHILDREN, YOUTH & FAMILIES

Executive Summary

This is the Quarterly Child Fatality Report for April through June 2021, 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.
>
> (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.
>
> (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.
>
> (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.
>
> (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 April 2011, SHB 1105 was passed by the Legislature and signed into law by Governor Gregoire. The revised child fatality statute (RCW 74.13) became effective April 22, 2011, and requires the department 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 department 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 department can conduct reviews of near fatalities or serious injury cases at the discretion of the department 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 Two Report

This report summarizes information from completed reviews of three child fatalities and five near fatalities [1] that occurred in the Second quarter of 2021. 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 four of the six regions (DCYF divides Washington State into six regions).

DCYF Region	Number of Reviews
Region 1	1
Region 2	
Region 3	2
Region 4	2
Region 5	
Region 6	3
Total Fatalities and Near Fatalities Reviewed During Second Quarter 2021	**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, recommendations, and development of a work plan, if applicable, 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 2021. 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 is additional DCYF history regarding the family under a different name or spelling.

[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 Fatality Reviews for Calendar Year 2021			
Year	**Total Fatalities Reported to Date Requiring a Review**	**Completed Fatality Reviews**	**Pending Fatality Reviews**
2021	8	4	4

Child Near Fatality Reviews for Calendar Year 2021			
Year	**Total Near Fatalities Reported to Date Requiring a Review**	**Completed Near Fatality Reviews**	**Pending Near Fatality Reviews**
2021	11	5	6

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 Second Quarter Findings

Based on the data collected and analyzed from three child fatalities and the five near-fatalities reviewed during the Second 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.
- One fatality case involved a 15-year-old youth who died from malnutrition. DCYF opened an investigation six days prior to the youth's death.
- There was one infant fatality of a child dying in an unsafe sleep environment.
- One near fatal incident involved a child in an unsafe sleep environment.
- Two children under the age of 12 months overdosed on narcotics. Both cases were reviewed as near fatalities.
- One child referenced in this report is of Hispanic ethnicity, one is Black African American, and six children are White non-Hispanic.
- Neglect, lack of proper supervision of children, was an identified risk factor in two of the eight cases.
    - Mental health concerns of the caregivers was alleged in three of the cases.
    - Substance abuse was a significant risk factor in five of the critical incident cases.
    - Domestic violence was alleged in three of the cases.
- DCYF received intake reports of abuse or neglect in each of the cases in this report prior to the death or near fatal injury of the child. In four cases, there were six reports made regarding the family prior to the critical incident. Three cases in this report had three prior reports called to DCYF intake. One near fatality case had 4 prior intakes alleging substance abuse by the caregivers.
- 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 Second quarter of 2021:

K. D. and M.D.

T.B.G.

O.T.