Report to the Legislature

Quarterly Child Fatality Report

RCW 74.13.640

July – September 2013

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TABLE OF CONTENTS

Executive Summary

This is the Quarterly Child Fatality Report for July through September 2013 provided by the Department of Social and Health Services (DSHS) to the Washington State Legislature. RCW 74.13.640 requires DSHS to report on each child fatality review conducted by the department and provide a copy to the appropriate committees of the legislature:

> ***Child Fatality Review — Report***
>
> *(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 a supervising agency or receiving services described in this chapter or who has been in the care of the department or a supervising agency 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 ombudsman 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 a supervising agency or who has been in the care of or received services described in this chapter from the department or a supervising agency within one year preceding the near fatality, the department shall promptly notify the office of the family and children's ombudsman. 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 ombudsman.

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 July 22, 2011 and requires the department to conduct fatality reviews in cases where a child 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.

This report summarizes information from completed reviews of eight (8) near-fatalities that occurred in the third quarter of 2013. There were no child fatalities that required a review during the third quarter. All of the near-fatality reviews were conducted as executive child fatality reviews. All prior child fatality review reports can be found on the DSHS website: http://www.dshs.wa.gov/ca/pubs/fatalityreports.asp.

The reviews in this quarterly report include near-fatalities from all three regions.[1]

Region	Number of Reports
1	2
2	2
3	4
Near-Fatalities Reviewed During 3rd Quarter, 2013	8

This report includes near-fatality reviews conducted following a near-fatal incident that was suspicious for abuse and neglect and the child had an open case or received services from the Children's Administration (CA) within 12 months of his/her death or injury. A critical incident review consists of a review of the case

[1] DSHS implemented a reconfiguration of the regional boundaries in May 2011. The existing six regions were consolidated into three.

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 multi-disciplinary committee including community members whose professional expertise is relevant to the family history. The review committee members may include legislators and representatives from the Office of the Family and Children's Ombuds.

The chart below provides the number of fatalities and near-fatalities reported to CA and the number of reviews completed and those that are pending for calendar year 2013. The number of pending reviews is subject to change if CA discovers new information through reviewing the case. For example, CA may discover that the fatality or near-fatality was anticipated rather than unexpected, or there is additional CA history regarding the family under a different name or spelling.

Child Fatality Reviews for Calendar Year 2013			
Year	Total Fatalities Reported to Date Requiring a Review	Completed Fatality Reviews	Pending Fatality Reviews
2013	11	0	11

Child Near-Fatality Reviews for Calendar Year 2013			
Year	Total Near Fatalities Reported to Date Requiring a Review	Completed Near-Fatality Reviews	Pending Near-Fatality Reviews
2013	11	7	4

The fatality reviews are posted on the DSHS website.

http://www.dshs.wa.gov/ca/pubs/fatalityreports.asp

All of the reviews referenced in this report are of near fatalities. Near fatality reports are not subject to public disclosure and are not included in this quarterly report.

Notable Third Quarter Findings

Based on the data collected and analyzed from the 8 near-fatalities reviewed between July and September 2013, the following were notable findings:

- Six (6) of the eight (8) cases involved children under three years of age.
- In six (6) of the near-fatalities, the children sustained serious inflicted injuries to the head and/or abdomen.
- Five (5) of the near-fatalities occurred while the family had an open case with CA.
- Two (2) children were Native American and six (6) were Caucasian.
- Seven (7) of the eight (8) near-fatalities were suspicious for abuse or neglect and all resulted in a founded finding for abuse or neglect by Child Protective Services.
- Of the six (6) near-fatalities resulting from inflicted injuries, three of the children had suffered serious (but not life threatening) injuries prior to the near-fatal injury.
- Of the six (6) near-fatalities resulting from inflicted injuries, four (4) of the children were male. In three (3) cases, the injuries were caused by the mother's boyfriend; in the other two cases, the children's fathers inflicted the injuries.
- Two near-fatalities occurred while the children were in out-of-home placement (one in relative placement the other in a licensed foster home) and both involved near-overdose of prescription medications.
- Due to the small sample of cases reviewed, no statistical analysis was conducted to determine relationships between variables.