QUARTERLY CHILD REVIEW

RCW 74.13.640 October – December 2020

Washington State Department of
CHILDREN, YOUTH & FAMILIES

July 2021

Washington State Department of
CHILDREN, YOUTH & FAMILIES

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Executive Summary

This is the Quarterly Child Fatality Report for October through December 2020, provided by the Washington State 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 agency 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 October 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 Oct. 22, 2011, and requires DCYF 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 agency 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 two child fatalities and three near fatalities[1] that occurred in the fourth quarter of 2020. 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 both child fatalities and near fatalities from three of the six regions (DCYF divides Washington State into six regions).

DCYF Region	Number of Reports
Region 1	1
Region 2	0
Region 3	3
Region 4	0
Region 5	1
Region 6	0
Total Fatalities and Near Fatalities Reviewed During Fourth Quarter 2020	**5**

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, the number of reviews completed, and those that are pending for calendar year 2020. 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 Reports for Calendar Year 2020			
Year	**Total Fatalities Reported to Date Requiring a Review**	**Completed Fatality Reviews**	**Pending Fatality Reviews**
2020	9	7	1

Child Near-Fatality Reports for Calendar Year 2020			
Year	**Total Near Fatalities Reported to Date Requiring a Review**	**Completed Near Fatality Reviews**	**Pending Near Fatality Reviews**
2020	19	18	1

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 Fourth Quarter Findings

Based on the data collected and analyzed from the two child fatalities and three near fatalities during the fourth quarter, the following were notable findings:

- Two of the five cases referenced in this report were open at the time of the child's death or near-fatal injury.
- One near fatality case involved a 15-year-old youth who nearly died from diabetic ketoacidosis. The case was reviewed due to the parents' negligence in managing this serious medical condition. This is the third incident in 2020 involving teens nearly dying from diabetic ketoacidosis.
- Three cases involved children suffering from blunt force trauma. Two children died from inflicted injuries. Another suffered near fatal injuries.
- In the three blunt force trauma cases, the three children were 3 years old or younger.
- There were no infant fatalities related to unsafe sleep environments. This had been a prevalent cause of death for infants in prior quarterly reports.
- There was one incident in this quarter involving a child overdosing on narcotics and illegal drugs. This child was 12 months old at the time of his death. This was a near-fatal incident.
    - In the prior two quarters of this year, there were four incidents involving children overdosing on narcotics and illegal drugs.
- Two cases were open to DCYF at the time of the critical incident. One near fatality incident in the fourth quarter involved a CPS case that DCYF closed four months prior to the near fatal injury. Two other near fatality cases were closed three and four months prior to the near fatal injury.

- Two children referenced in this report are White, one is Native American, and two are African American.
- Medical neglect was an identified risk factor in four of the five cases. Pre-natal drug exposure was alleged in one of the cases. Substance abuse was a significant risk factor in three of the critical incident 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 one near fatality case there were 13 reports made regarding the family prior to the near-fatal injury of the youth. Most of the 13 prior intakes alleged medical neglect of a youth who nearly died from mismanagement of their diabetic condition. In two cases in which children suffered inflicted blunt force trauma, there were a total of seven and three reports, respectively, to DCYF intake prior to the critical incident. In one near fatality case, there were 11 prior reports on the family. In two near fatality cases, there were two and one prior reports to DCYF intake on the family, respectively.

Due to the small sample of cases reviewed, no statistical analysis was conducted to determine relationships between variables.

Exhibit A

Child Fatality Reviews

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

Exhibit A contains the following child fatality reviews from the fourth quarter of 2020:

- A.C.G. Child Fatality Review
- H.H. Child Fatality Review