FATALITY/NEAR-FATALITY 2021 ANNUAL REPORT

Washington State Department of CHILDREN, YOUTH & FAMILIES

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QA/CQI Division | Approved for distribution by Doug Savelesky, QA/CQI Administrator

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CONTENTS

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Purpose of a Fatality/Near-Fatality Review

Revised Code of Washington (RCW) 74.13.640 requires Child Fatality Reviews (CFRs) on unexpected child deaths or near deaths when the family has a history with DCYF within the last 12 months, has an open case at the time of the incident, or the child was residing or being cared for in a licensed or state-operated facility at the time of the incident.

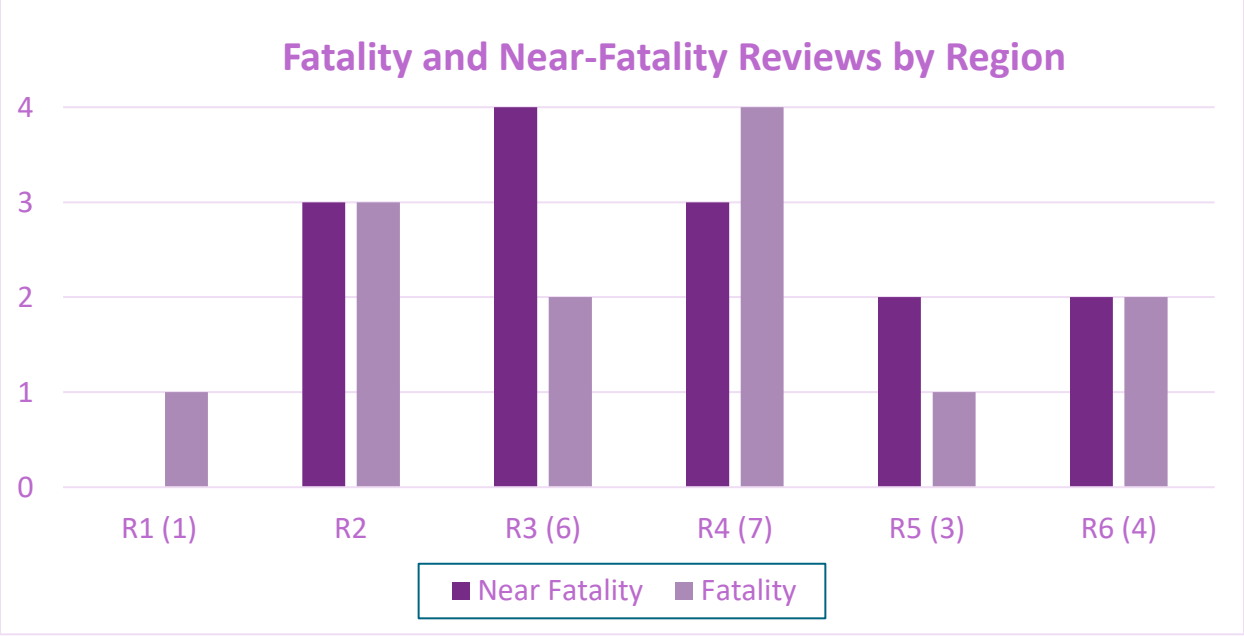
The purpose of the CFRs is to examine all information provided to the department regarding the child and their family. The goals of CFR are to: increase our understanding of the circumstances around the incident and evaluate practice, programs, and systems to improve the health and safety of children.

The 2021 Child Fatality Report is a compilation of information regarding the fatalities and near-fatalities reported to DCYF, which relate to the criteria above. The analysis of this information is vital to the work of DCYF as a mechanism to assist DCYF staff, Tribes, providers, and community partners in improving the outcomes for the children and families we serve. The data presented in this report is based on the reviews completed in the calendar year 2021, which may include incidents that occurred in 2020. The data may not include all incidents which occurred in 2021.

2021 Reviews

By reviewing fatalities and near-fatalities, DCYF receives an overall picture of the serious incidents throughout the state. The analysis of this information is vital to the work of DCYF as a means to assist DCYF staff, Tribes, providers, and community partners in improving the outcomes for the children and families we serve.

When reviewing fatalities and near-fatalities, we look at the manner of death along with age, gender, and race. Through the analysis of this data, we hope to identify children most at risk to inform and support a system that can improve the protection of children and reduce child fatalities related to abuse and neglect.



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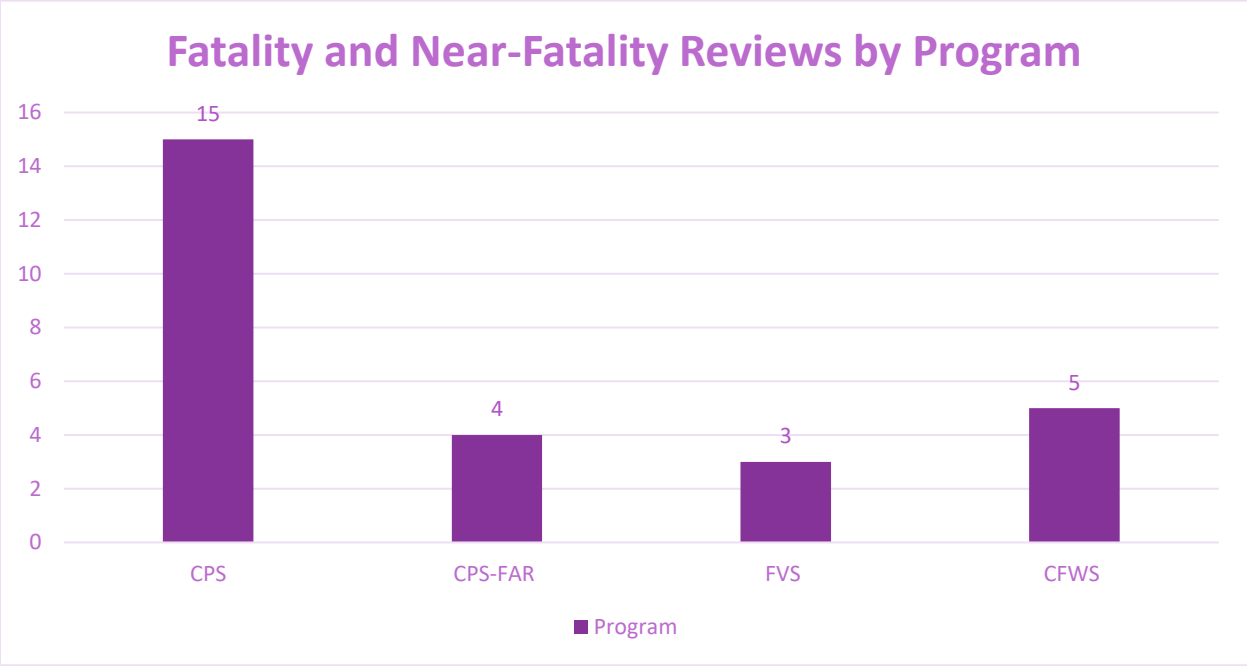
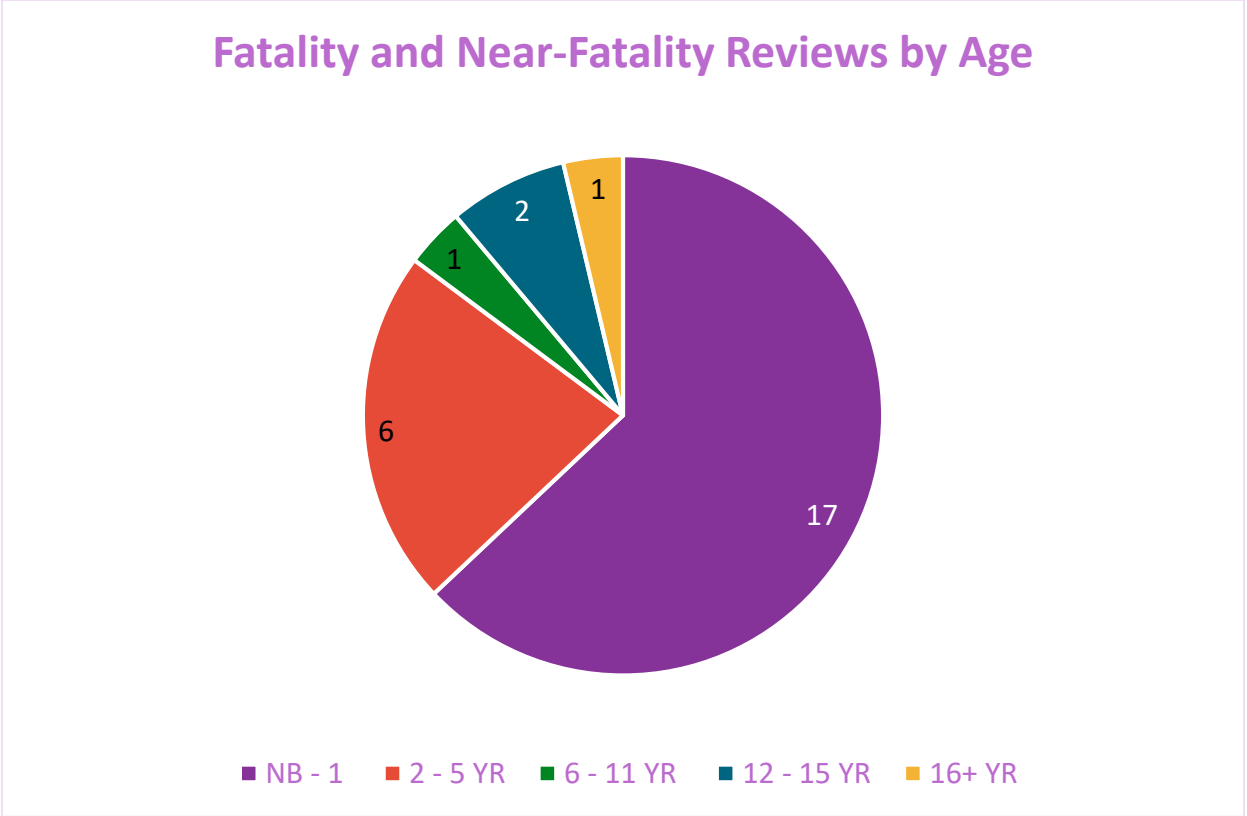
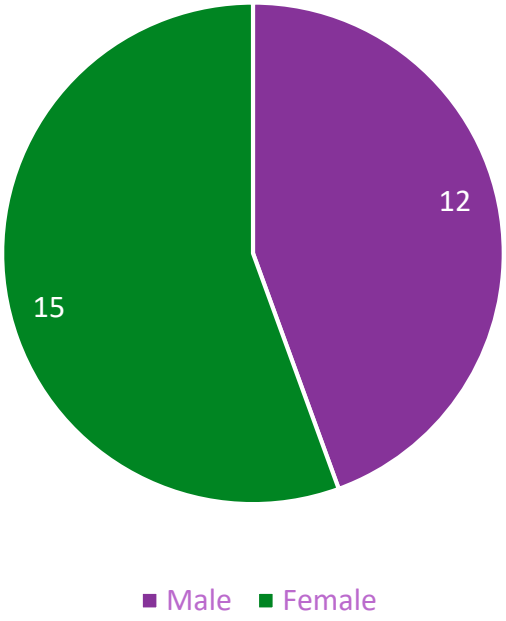
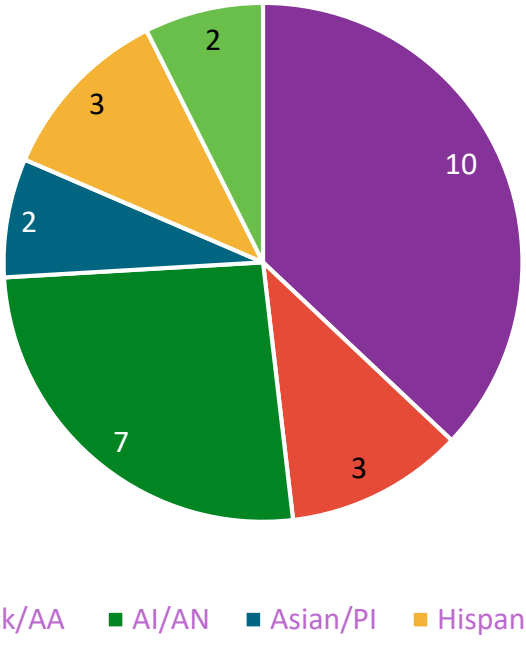

Fatality and Near-Fatality Reviews by Program
16
14
12
10
8
6
4
2
0
15
4
3
5
CPS
CPS-FAR
FVS
CFWS
Program

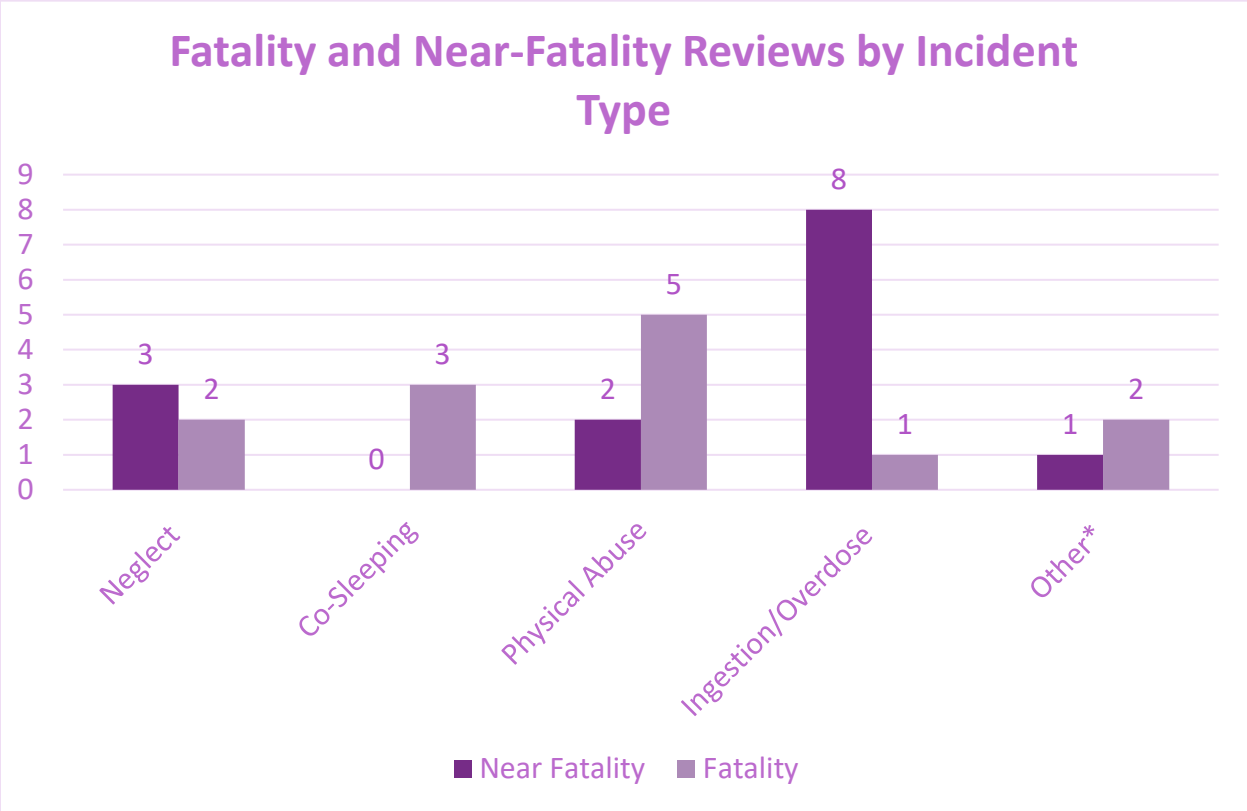

Fatality and Near-Fatality Reviews by Age
1
2
1
6
17
NB - 1
2 - 5 YR
6 - 11 YR
12 - 15 YR
16+ YR

Fatality and Near-Fatality Reviews by Gender



Fatality and Near-Fatality Reviews by Race



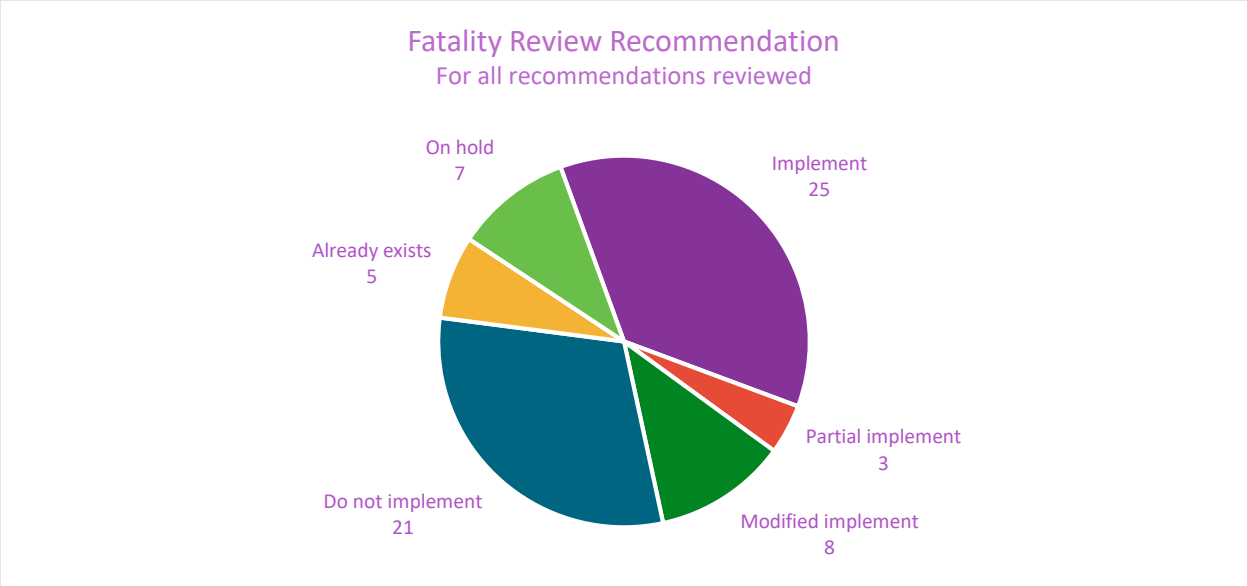

Fatality and Near-Fatality Reviews by Incident Type
9
8
7
6
5
4
3
2
1
0
3
2
0
3
2
5
8
1
1
2
Neglect
Co-Sleeping
Physical Abuse
Ingestion/Overdose
Other*
Near Fatality
Fatality

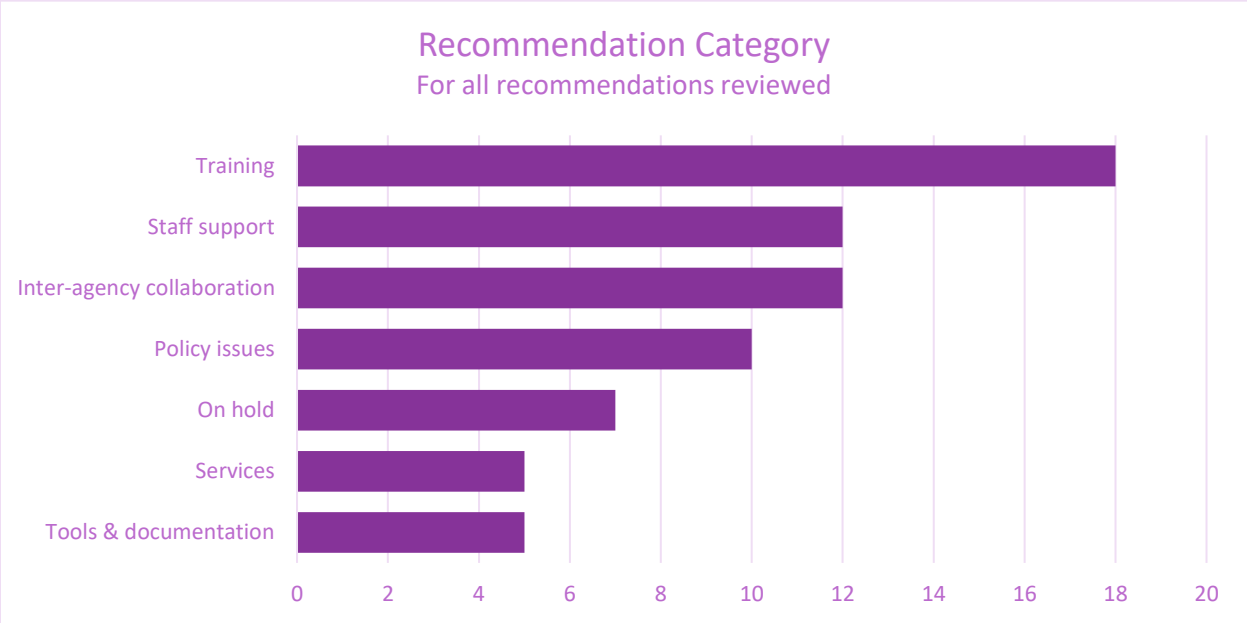
Review Recommendations

The goal of the Child Fatality Review is to increase our understanding of the circumstances surrounding a child's death to evaluate DCYF practice, programs, and policies and to evaluate other systems involved with the child, to improve the health and safety of children.

In 2020 a charter was developed to form a DCYF Recommendations Committee. The purpose of this committee is to establish a standardized process to determine which recommendations made by child near-fatality or fatality review committees across all programs will be implemented by DCYF. The committee is chaired by the Child Welfare Director of Field Operations and co-chaired by the statewide QA/CQI Administrator and Risk Management Office Chief.

Additional committee members include the designated Child Welfare Regional Administrator, Fatality/Near-Fatality review supervisor, a representative from Prevention and Client Services, Indian Child Welfare (ICW) Program Manager, and subject matter experts from DCYF and external organizations to guide the committee on specific topics or areas of practice. The following information is related to the recommendation categories and implementation decisions since the committee's inception in 2020.





A lead for implementation of recommendations is identified for tracking and determination when implementation is complete. The recommendation committee members meet with the DCYF Secretary on a quarterly basis to debrief the fatalities/near-fatalities from the previous quarter and discuss the committee's implementation recommendations.

Opportunities for Growth

DCYF is in the process of joining the National Partnership for Child Safety (NPCS). The NPCS, initially formed in 2018, is a quality improvement collaborative to improve child safety and reduce child maltreatment fatalities through safety science and shared data. Members of the collaborative have a shared goal of strengthening families, promoting innovations, and establishing a public health response to reducing and preventing child maltreatment and fatalities.

Safety science provides a framework and processes for child protection agencies to understand the inherently complex nature of the work and the factors that influence decision-making. It also provides a safe and supportive environment for professionals to process, share and learn from critical incidents to prevent additional tragedies. DCYF is in the process of formalizing a data share agreement with the partnership.

Conversations are forming regarding an agency-wide fatality/near-fatality review committee rather than performing these reviews by division. When a review is required, it is important to be familiar with confidentiality requirements, statutory requirements, and the general process of gathering a review committee and conducting the review.

Currently, each division line has a different mechanism to alert management of the need for a fatality/near fatality review. Child welfare is exploring utilizing a program called ILINX through Image Source to replace its current administrative reporting service. The development of this new reporting system is an opportune time to discuss using one reporting system utilized by all service lines to report when these critical incidents occur.

Having a cross-agency fatality/near fatality review team will provide consistency to the approach of the review, consistent communication, and compile outcomes to inform better practice improvement opportunities which will improve outcomes for children across the state.