QUARTERLY CHILD REVIEW RCW 74.13.640
OCTOBER – DECEMBER 2021

Washington State Department of
CHILDREN, YOUTH & FAMILIES

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CHILDREN, YOUTH & FAMILIES

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Executive Summary

Revised Code of Washington (RCW) 74.13.640 requires quarterly Child Fatality Reviews (CFRs) on unexpected deaths or near-deaths when the family has a history with the Department of Children, Youth, and Families (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.

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 conduct a child fatality review in the event of a fatality where child abuse or neglect is suspected of any minor who is currently in the care of the department 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 prior to the minor's death.

   (b) When it cannot be determined whether the child's death is a result of suspected child abuse or neglect, the department consults with the Office of Family and Children's Ombuds (OFCO) to determine if a child fatality review should be conducted.

   (c) The department ensures the fatality review team is made up of individuals who have 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 will issue a fatality report on the results of the review within 180 days, unless the Governor has granted an extension. Reports completed pursuant to this section are subject to public disclosure and must be posted on the public web site. 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 – 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 OFCO. The department may conduct a review of the near fatality at its discretion, or at the request of OFCO.

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 October 22, 2011, requiring the department to conduct fatality reviews in cases where a child's death is suspected of being 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 OFCO if it is not clear that the fatality was caused by abuse or neglect. The department may 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 the autopsy and post mortem reports to conduct child fatality reviews.

Quarter Four Report

This report summarizes information from completed reviews of five child fatalities and four near-fatalities [1] that occurred in the fourth quarter of 2021. All child fatality reviews are 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).

DCYF Region	Number of Reports
Region 1	1
Region 2	3
Region 3	1
Region 4	3
Region 5	1
Region 6	0
Total Fatalities and Near Fatalities Reviewed During Fourth Quarter 2021	9

This report includes Child Fatality Reviews (exhibit A) and Near Fatality Reviews (data only) conducted following a child's death or near-fatal injury where abuse and neglect was suspected and the child had an open case or received services from DCYF within the 12 months prior to their 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. 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 the number of reviews 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 find 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 2021			
Year	Total Fatalities Reported to Date Requiring a Review	Completed Fatality Reviews	Pending Fatality Reviews
2021	16	14	2

[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 2021			
Year	Total Near-Fatalities Reported to Date Requiring a Review	Completed Near-Fatality Reviews	Pending Near-Fatality Reviews
2021	14	12	2

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 five child fatalities and the four near-fatalities reviewed during the fourth quarter, the following findings are notable:

- Six of the nine cases referenced in this report were open at the time of the child's death or the near-fatal injury.
- One fatality case involved a two-month-old infant who died from dehydration. DCYF had an open case on this child at the time of his death.
- One fatality involved an infant who died in an unsafe sleep environment.
- A fatality and near-fatality occurred in a car accident involving two children.
- Two children under the age of 12 months overdosed on ingested narcotics. Both cases were reviewed as near-fatalities.
- One child died from a gunshot wound.
- One child died from a fall from a second-story window.
- One child referenced in this report is of Hispanic ethnicity, three are Native American, one is Black/African American, one is Asian, and three are White non-Hispanic.
- Four of the cases identified prior founded allegations of abuse and/or neglect by the caregivers.
- Substance abuse was a significant risk factor in all of the 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 two cases, there were three intake reports made regarding the family prior to the critical incident. In a fatality case, there were six prior report(s) called to DCYF intake. Two cases had 9 reports to DCYF intake prior to the critical incident. In a fatality case in which an infant died in an unsafe sleep environment, the family had 27 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 fourth quarter of 2021:

J.T-A.

V.S.M.

J.G.

S.M

R.C.