

Jacob, an eight-month-old baby boy living with his mother and grandmother, was brought into a local hospital comatose from having ingested Opiates.

Jacob's young mother, Christina, a high school senior, as well as other relatives denied knowing where the Opiates came from. The baby's mom became frightened when the little boy began vomiting and then became increasingly limp and unresponsive. Not knowing the cause of his illness, Christina, her aunt, and the baby's grandmother transported Jacob to the emergency room. The three stated that the little boy was left for a brief time with his grandfather and later he had been playing on a second-hand couch which Christina's aunt had recently purchased.

When hospital staff tested the baby, results showed that he had dangerous levels of Opiates in his bloodstream. The hospital quickly administered Narcan, an antidote for Opiate overdose, and the little boy began to recover. Hospital staff also immediately contacted Child Protective Services.

The baby's mother and her aunt voluntarily submitted to drug screens to confirm that they were not actively using even though Christina openly admitted to having used illicit drugs in the past. The baby's grandmother was taking prescription Opiates but kept them well away from the baby and signed a release of information to her local medical clinic. CPS staff could demonstrate that she was using the medications according to the prescription.

Nobody could determine definitively where Jacob obtained access to the drugs. The family surmised there must have been a pill in the second-hand couch. CPS worked very closely with the family to ensure that the little boy would no longer be at risk.

Together, CPS and the family developed a safety plan. There was reason to believe that the grandfather may not have been able to keep little Jacob safe so he could no longer be left in his care.

A Home Support Specialist worked with Christina on all aspects of baby care. Christina, not only cooperated but often asked for additional information and resources. When Jacob began getting around more on his own, Christina contacted her Home Support Specialist and asked if she could help with baby locks for cupboards and drawers.

Christina submitted to random drug screens throughout the entire time that CPS was involved and every result showed that Christina was drug free.

Children's Administration staff provided a lock box for the grandmother's medication and maintained ongoing communication with the Grandmother's clinic to make certain the medications were appropriately prescribed and not abused.

Christina sought guidance and support from Children's Administration staff and demonstrated caring and a genuine desire to improve her parenting skills and to make sure her son was safe.

Through the responsiveness of family, the quick action of hospital personnel, and a CPS safety plan, a tragedy was averted and a little boy is thriving.



OUR GOAL:

Children will be safe from abuse and neglect.



cut along dotted line

What are **we** doing to improve child safety?

1 We closely review all calls made to CPS regarding allegations of possible abuse or neglect and investigate those that meet the legal criteria for investigation.

2 In those families where it appears there is conflict but low-risk of abuse, we often make referrals to the Alternative Response System in an effort to provide support to families working to avoid having their children placed into out-of home care.

3 We require social workers to meet face-to-face with children who are likely victims of abuse more quickly than ever. Social workers must see children who are in imminent danger within 24 hours and they must see children who are not in imminent danger within 72 hours.

4 We have reduced caseload ratios from about 26 cases per social worker in 2005 to about 22 cases per social worker in 2007. With the support of the legislature, the Administration continues to hire new social workers and is working to further reduce the number of cases per social worker.

5 The legislature re-defined neglect so CA can act more quickly when children experience chronic neglect due to untreated parental substance abuse or mental illness, as well as in situations where children experience inadequate care that is frequent or ongoing.

6 We now require social workers to make visits every 30 days to children who are still in the Department's care but living back at home with their parents. We are working to hire enough social workers so that children in all types of licensed care will be seen at least once every 30 days by their social workers.

7 We require a reunification assessment and a safety plan for all children re-unifying with their families following time in out-of-home care. We continue monitoring those children and families for at least six months following reunification and often longer if needed.

8 We have provided ongoing lessons learned training to direct service staff, supervisors, and managers so we can learn from difficult cases and employ strategies to help us from repeating errors.

9 We continuously evaluate our social worker academy programs to ensure staff training includes the most current best practices.

10 Through the Family to Family Programs we are actively engaging community experts and family members in the process of keeping children safe and families intact.

What can **you** do to improve child safety?

1 Know the signs.

The table below* lists SOME symptoms of the four major types of child maltreatment. The presence of a single sign doesn't prove abuse is happening in a family but when they appear repeatedly or in combination, there is a possibility of maltreatment.

Type of Maltreatment	Possible Symptoms
Neglect	<ul style="list-style-type: none"> • Signs of malnutrition • Poor hygiene • Unattended medical needs
Physical Abuse	<ul style="list-style-type: none"> • Unexplained bruises, burns or welts • Child is afraid of caregiver • Child's stories don't match injuries
Sexual Abuse	<ul style="list-style-type: none"> • Pain, bleeding, redness, or swelling of genital or anal area • Sex play with toys, self, or others that isn't in line with developmental age • Knowledge of sexual activities that isn't in line with developmental age
Exploitation	<ul style="list-style-type: none"> • Extremes in behavior from overly aggressive to overly passive • Delayed physical, emotional, or intellectual development

Excerpted from the National Child Welfare Information Gateway online publication, "Promoting Healthy Families in Your Community: 2007 Resource packet. http://www.childwelfare.gov/pubs/res_packet_2007/ch_five_can.cfm

2 Report the abuse.

In Washington State, you can call **1-866-ENDHARM (1-866-363-4276)**, if you are out of the state and aren't sure where to report, call **1-800.4.A.CHILD (1-800-422-4453)**

Be as specific as possible, provide:

The child's name and location (if you don't have an address but have a license plate number, give that)

- The name and relationship (if known) of the person you think is abusing the child.
- What you specifically have seen or heard regarding the abuse or neglect
- Names of other people who might know about the abuse or neglect
- Your name and phone number (voluntary)
- Make sure you make a separate report each time you have new reason to believe abuse has taken place and never knowingly make a false report of abuse or neglect.

3 Get Involved.

Volunteer your time, be a resource for vulnerable children in your community. For ideas about where and how to volunteer, contact www.volunteerwashington.org and enter key words "child abuse."

4 Be Kind.

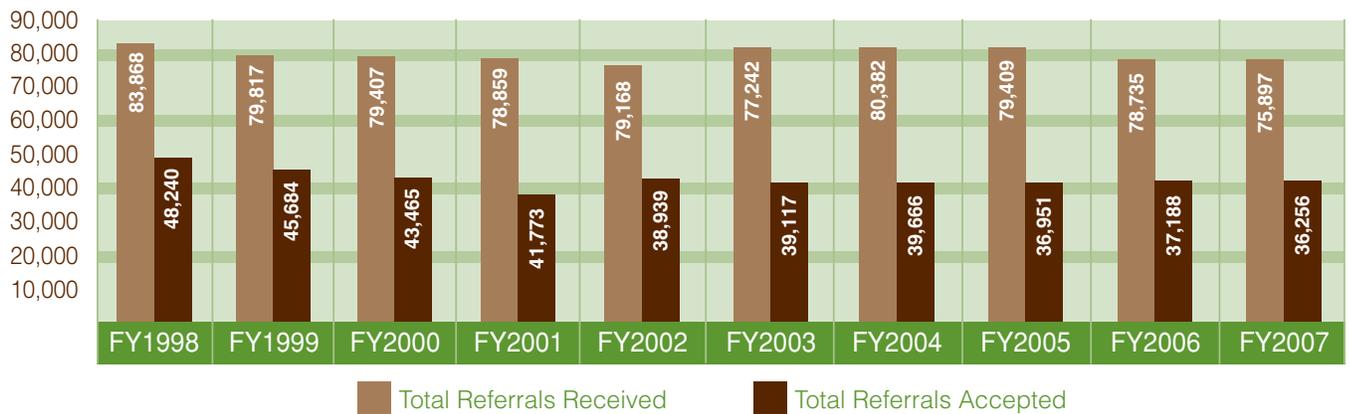
Never discipline your own child in anger and remember it's not just hitting a child that wounds, hurtful words can leave lasting scars as well. Be a model to your own children and others how to solve problems without physical or verbal aggression.

The Children’s Administration’s main priority is ensuring that children are safe from harm. Without the attentiveness and quick action of concerned community members, the Administration cannot intervene on behalf of children who are potentially in harm’s way.

Teachers, doctors, caregivers, neighbors, and relatives can all make the difference in a child’s life by calling Child Protective Services. When a call comes in to CPS, the social worker receiving the report must make a determination about whether or not the referral must be investigated or refer a family for services based upon the information provided and specific legal criteria. In Fiscal Year 2007, the Administration received more than 75,000 referrals of suspected abuse or neglect. Of those, more than 36,000 referrals met the legal definition of abuse or neglect and were investigated by the Administration.

More than 8,500 families with children deemed at low to moderately low risk of harm were offered alternative intervention services in Fiscal Year 2007. Of these, over 2,200 families were referred to the Alternative Response System (ARS). Families directed to the ARS program are typically referred to CPS for neglect issues, and have had little to no contact with CPS in the past. ARS services are delivered by community-based agencies that are contracted to serve families in the least intrusive manner that is reasonably likely to improve family cohesiveness, prevent re-referrals of the family for alleged child maltreatment, and improve the health and safety of children.

Child Protective Services (CPS) Referrals*



*Number of referrals received per fiscal year. Includes Division of Children and Family Services (DCFS) and Division of Licensed Resources (DLR) Child Protective Services referrals. Source: EMIS report.

The Administration monitors the number of referrals for abuse and neglect that it receives annually. In addition, the Administration tracks the number of allegations that were “founded” each year. A founded referral means that an allegation of abuse or neglect was determined more likely than not to have occurred.

Following a significant eight-year increase, the referrals for neglect have decreased since Fiscal Year 2005.

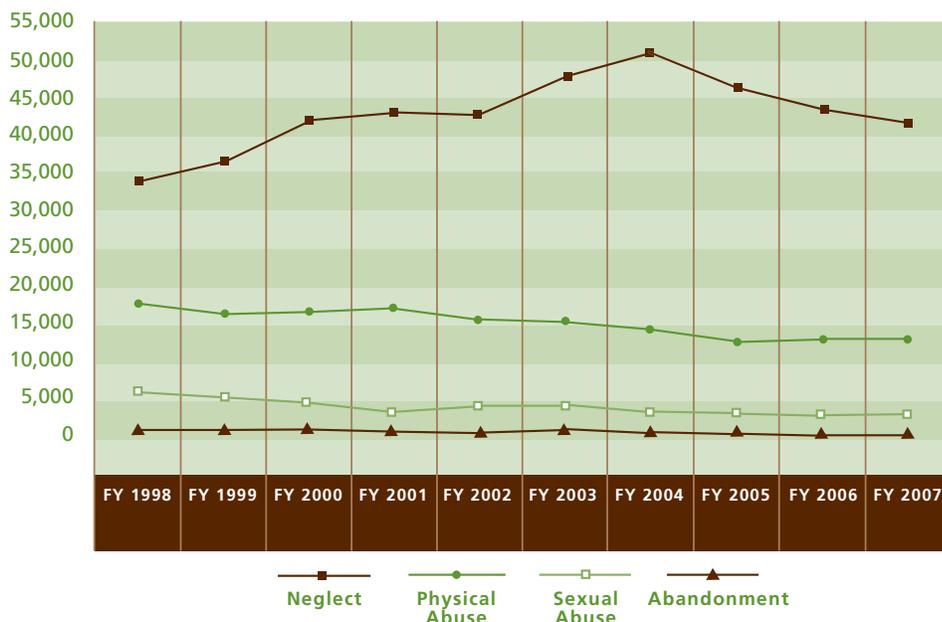
In 2005, the Washington State Legislature passed ESSB 5922, which amends RCW 26.44.020 to expand the definition of neglect effective 2007. This bill gives the Administration the ability to intervene in cases of chronic neglect where the health, welfare or safety of the child is at risk. When chronic neglect has been found to exist in a family, the legal system will reinforce the need for parents’ early engagement in services that may decrease the likelihood of future abuse or neglect.

The Children’s Administration works to improve the likelihood that a child will be safe from abuse or neglect through a series of practice strategies and related performance measures. Social workers are working toward seeing children who are alleged victims of abuse quickly, and the Administration works toward reducing the incidences of re-abuse, keeping children safe when they return home and keeping children safe while in out-of-home care.

Specific measures designed to reflect this work include:

- Children seen face-to-face by a social worker following a referral accepted for investigation.
- Children who are re-abused.
- Children who are placed in out-of-home care due to abuse or neglect with prior placement due to abuse or neglect.
- Children who are abused or neglected in out-of-home care.
- Foster homes receiving health and safety checks.

Alleged Victims in Accepted CPS Referrals by Type of Abuse or Neglect*



*Number of child victims in CPS referrals by type of child abuse or neglect. Victims may be referred for more than one type of abuse. Source: September 2007 CAMIS download.

What is child abuse or neglect? (WAC 388-15-009)

Child abuse or neglect means the injury, sexual abuse, or sexual exploitation of a child by any person under circumstances which indicate that the child's health, welfare, or safety is harmed, or the negligent treatment or maltreatment of a child by a person responsible for or providing care to the child. An abused child is a child who has been subjected to child abuse or neglect as defined in this section.

Physical Abuse means the non-accidental infliction of physical injury or physical mistreatment on a child. Physical abuse includes, but is not limited to, such actions as:

- (a) Throwing, kicking, burning or cutting a child;
- (b) Striking a child with a closed fist;
- (c) Shaking a child under age three;
- (d) Interfering with a child's breathing;
- (e) Threatening a child with a deadly weapon; or
- (f) Doing any other act that is likely to cause and which does cause bodily harm greater than transient pain or minor temporary marks or which is injurious to the child's health, welfare and safety.

Physical discipline of a child, including the reasonable use of corporal punishment, is not considered abuse when it is reasonable and moderate and is inflicted by a parent or guardian for the purposes of restraining or correcting the child. The age, size, and condition of the child, and the location of any inflicted injury shall be considered in determining whether the bodily harm is reasonable or moderate. Other factors may include the developmental level of the child and the nature of the child's misconduct. A parent's belief that it is necessary to punish a child does not justify or permit the use of excessive, immoderate or unreasonable force against the child.

Sexual Abuse means committing or allowing to be committed any sexual offense against a child as defined in the criminal code. The intentional touching, either directly or through the clothing, of the sexual or other intimate parts of a child or allowing, permitting, compelling, encouraging, aiding, or otherwise causing a child to engage in touching the sexual or other intimate parts of another for the purpose of gratifying the sexual desire of the person touching the child, the child, or a third party. A parent or guardian of a child, a person authorized by the parent or guardian to provide childcare for the child, or a person providing medically recognized services for the child, may touch a child in the sexual or other intimate parts for the purposes of providing hygiene, child care, and medical treatment or diagnosis.

Sexual Exploitation includes, but is not limited to, such actions as allowing, permitting, compelling, encouraging, aiding, or otherwise causing a child to engage in:

- (a) Prostitution;
- (b) Sexually explicit, obscene or pornographic activity to be photographed, filmed or electronically reproduced or transmitted; or
- (c) Sexually explicit, obscene or pornographic activity as part of a live performance, or for the benefit or sexual gratification of another person.

Negligent Treatment or maltreatment means an act or a failure to act on the part of the child's parent, legal custodian, guardian or caregiver that shows a serious disregard of the consequences to a child of such magnitude that it creates a clear and present danger to the child's health, welfare, and safety. A child does not have to suffer actual damage or physical or emotional harm to be in circumstances which create a clear and present danger to the child's health, welfare and safety. Negligent treatment or maltreatment includes, but is not limited to:

- (a) Failure to provide adequate food, shelter, clothing, supervision, or health care necessary for a child's health, welfare and safety. Poverty and/or homelessness do not constitute negligent treatment or maltreatment in and of themselves;
- (b) Actions, failures to act, or omissions that result in injury to or which create a substantial risk of injury to the physical, emotional, and/or cognitive development of a child; or
- (c) The cumulative effects of consistent inaction or behavior by a parent or guardian in providing for the physical, emotional and developmental needs of a child, or the effects of chronic failure on the part of the parent or guardian to perform basic parental functions, obligations, and duties, when the result is to cause injury or create a substantial risk of injury to the physical, emotional, and/or cognitive development of the child.

What is child abandonment? (WAC 388-15-011)

A parent or guardian abandons a child when the parent or guardian is responsible for the care, education or support of a child and:

- (a) Deserts the child in any manner whatever with the intent to abandon the child;
- (b) Leaves a child without the means or ability to obtain one or more of the basic necessities of life such as: food, water, shelter, hygiene, and medically necessary health care; or
- (c) Forgoes for an extended period of time parental rights, functions, duties and obligations despite an ability to exercise such rights, duties, and obligations.

Abandonment of a child by a parent may be established by conduct on the part of a parent or guardian that demonstrates a substantial lack of regard for the rights, duties, and obligations of the parent or guardian or for the health, welfare, and safety of the child. Criminal activity or incarceration of a parent or guardian does not constitute abandonment in and of themselves, but a pattern of criminal activity or repeated or long-term incarceration may constitute abandonment of a child.

OBJECTIVE: Initiate timely investigations
MEASURED BY: Children seen face-to-face by a social worker following a referral accepted for investigation

Social workers are tasked with the difficult work of determining which referrals warrant investigation and which do not based upon the information provided by a referent and specific legal criteria.

If a social worker determines that a child is at moderate to high risk of harm, Child Protective Services (CPS) staff accepts the referral for investigation. Once a referral is accepted, a level of severity and urgency is assessed to determine the time frames within which an investigating social worker must make or attempt to make face-to-face contact with a vulnerable child.

Governor Christine Gregoire mandated in 2005 that Child Protective Services speed up the time in which social workers respond to referrals of suspected child abuse or neglect.

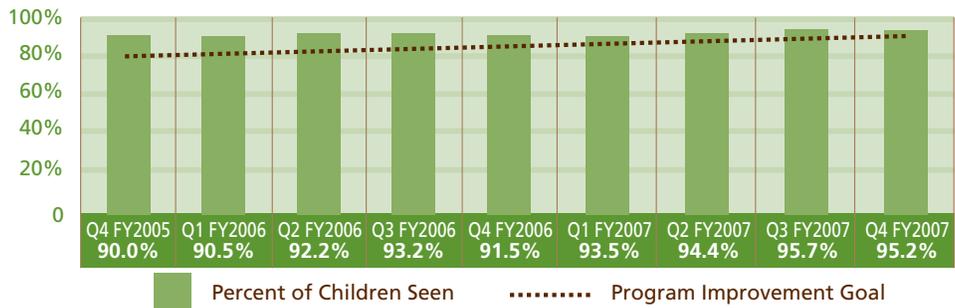
Historically social workers were required to initiate investigations where children were at risk of imminent harm within 24 hours, and make face-to-face contact with children as soon as possible within ten working days of receiving referrals. As of April 29, 2005 social workers must make face-to-face contact within 24 hours of the Administration receiving an emergent referral.

Effective August 8, 2005, the face-to-face contact response time for non-emergent referrals where children are assessed not to be at imminent risk of harm decreased from ten working days to 72 hours of receiving referrals.

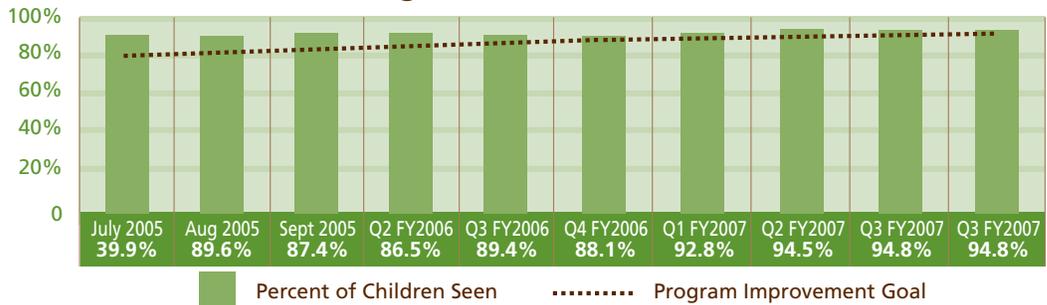
The federal program improvement goal for timely investigations is for social workers to make face-to-face contact with children within required response times at a rate of 90 percent by September 2006.

The Administration surpassed the 2006 goal in every quarter of Fiscal Year 2007 for emergent referrals as well as for non-emergent referrals.

Children in Emergent Referrals Seen Within 24 Hours*



Children in Non-Emergent Referrals Seen Within 72 Hours**



*Percent of children in emergent referrals seen or attempted within 24 hours. Excludes Division of Licensed Resources (DLR) CPS referrals. The federal Program Improvement Plan goal was 90 percent by September 2006. Source: October 2007 CAMIS download.

**Percent of children in non-emergent referrals seen or attempted within 72 hours. Excludes Division of Licensed Resources (DLR) CPS referrals. The federal Program Improvement Plan goal was 90 percent by September 2006. Source: October 2007 CAMIS download.

OBJECTIVE: Reduce recurrence of abuse or neglect
MEASURED BY: Children who do not experience re-abuse

Re-abuse is indicated when any child experiences a founded allegation of abuse within six months of a previous founded allegation of abuse.

The Administration closely monitors and strives to implement supports and strategies for those families who have multiple founded allegations of abuse so that vulnerable children are protected from further abuse.

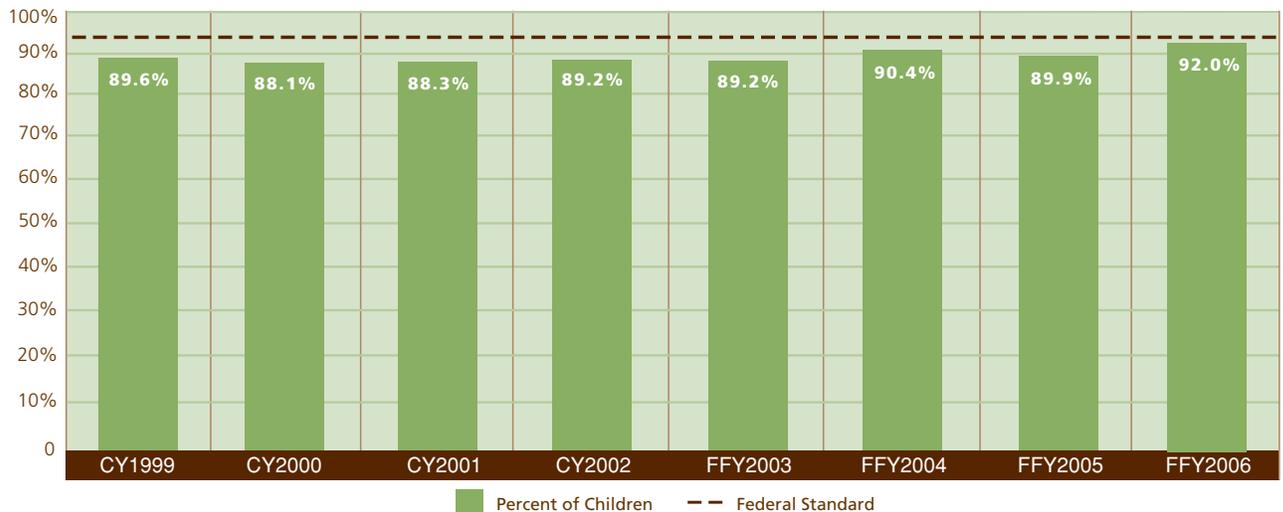
The federal standard requires that, at a minimum, 94.6 percent of children who have been the victims of abuse or neglect will be protected from any additional founded allegations of abuse or neglect. This is an increase from the previous federal standard of 93.9 percent. The rate of children free from additional abuse in Washington State has failed to meet the federal standard throughout the eight-year tracking period shown; however has made improvement since 2001.

The Administration has worked toward improving practice so that fewer children experience additional incidents of abuse or neglect at the hands of their caregivers, while also examining data tracking and reporting methods in an effort to make statistical reporting more congruent with federal methods.

In recent years, the federal government changed the emphasis to children who DO NOT experience incidents of re-abuse. Children’s Administration is reporting this measure accordingly to remain consistent with federal reporting standards.

In Fiscal Year 2007, more children in Washington State were protected from repeat abuse than in any year since data tracking began.

Children Who Did Not Experience Re-Abuse*



*Percent of children with a founded referral of abuse or neglect who were free from an additional founded referral of abuse or neglect within six months of the initial referral. “Founded” means that an investigation concluded that the maltreatment was more likely than not to have occurred. For referrals with multiple allegations, the referral is considered founded if any of the allegations are founded. The federal standard is 93.9 percent or more children will be free from additional founded allegations of abuse. In 2002, the federal government changed the required reporting period from calendar year to federal fiscal year. In 2007, the federal government required that states report the percent of children free from additional allegations of abuse rather than those who were re-abused. Source: federal fiscal year data submitted to the National Child Abuse and Neglect Data System (NCANDS).

OBJECTIVE: Improve safety when returning children home
MEASURED BY: Children who are placed in out-of-home care due to abuse or neglect with prior placement due to abuse or neglect

Families from whose care children have been removed due to abuse or neglect must work with their assigned social worker to implement certain safeguards before children can be returned home.

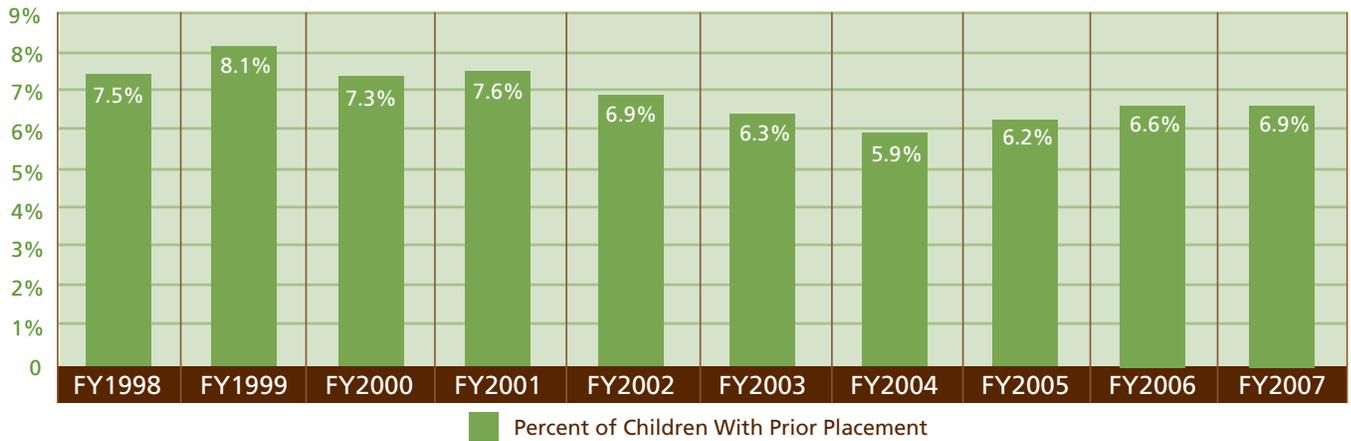
These families must demonstrate an improved ability to safely parent their children. Children’s Administration staff and community experts and child advocates may recommend that a family avail itself of education, training, counseling or other services that may be in the best interest of the child or children returning home. These services may include parental participation in therapy, substance abuse treatment and aftercare, mental health assessments, domestic violence assessments and treatment, parenting classes or other educational or supportive experiences.

The objective in cases where it is determined a child may return home if parents make necessary safety improvements is to provide parents with knowledge and supports to help prevent any additional incidences of abuse or neglect.



The Administration has shown Prior Placement rates between 5.9 percent and 8.1 percent since tracking began with an average prior placement rate of 6.93 percent.

Children in Placement Due to Abuse or Neglect With Prior Placement Due to Abuse or Neglect*



*Percent of children placed in out-of-home care for abuse or neglect who had returned home from a prior placement for abuse or neglect within 12 months of being placed again. Both placements must have lasted for more than three days in order to exclude 72-hour emergency placements due to temporary incapacitation of parents. Source: September 2007 CAMIS download.

OBJECTIVE: Improve safety for children placed in out-of-home care
MEASURED BY: Children who are free from abuse or neglect in out-of-home care

Those interested in becoming caregivers for children who have been abused or neglected must demonstrate the ability to provide a safe and stable environment and to meet the physical, mental, and emotional needs of vulnerable children. The process of becoming a foster parent is neither easy, nor meant to be taken lightly. Those pursuing the role of substitute caregiver must invest tremendous thought, energy, and time into attending training and readying themselves for a life-changing experience. The experience is life-changing not only for the foster children but for the parents and families who are forever touched by the courage, resilience, and love of children who are placed in their homes.

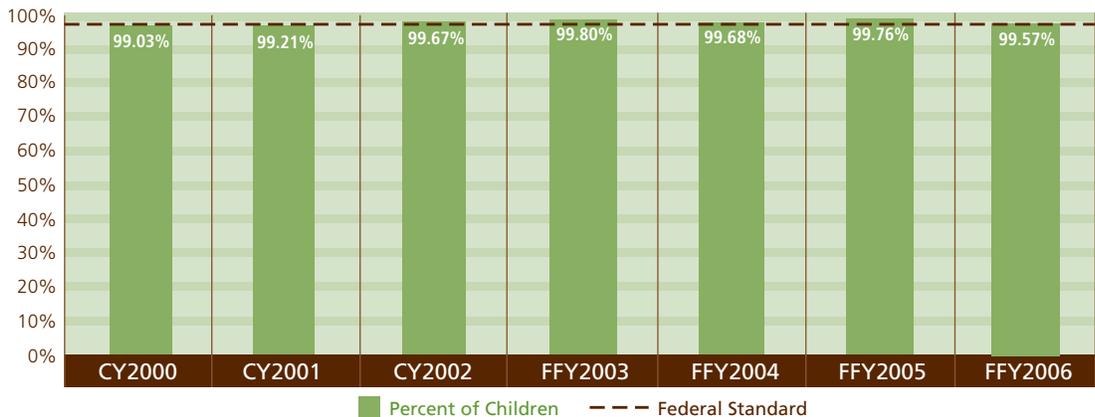
Not only must families be prepared but the homes, facilities, and properties where children in state care live must meet strict licensing standards. The buildings and surrounding grounds must be free of health and safety hazards and must offer children sufficient personal space and privacy. The Administration takes great care to prevent children who have been harmed in their own homes from being harmed in out-of-home care.

The Washington state Children’s Administration embraces the notion that if even one child is abused in licensed care, it is one too many. A new federal standard requires that a minimum of 99.68 percent of children in out-of-home care will be free from founded allegations of abuse or neglect. This is an increase from the previous federal standard of 99.43 percent.

Washington State’s performance was significantly better than the federal standard from 2003 until 2005. In the most recent reporting period, however the Administration showed a slight decrease in the percent of children in out-of-home care who were free from abuse or neglect, failing to meet the federal standard.

The Administration continues to explore ways to evaluate potential foster homes, closely monitor licensed homes, support foster families, and maintain contact with children in out-of-home care in an effort to increase the number of children who are safe and stable in foster care.

Children Who Are Free from Abuse or Neglect While in Out-of-Home Care*



*Percent of children in out-of-home care with a founded referral of abuse or neglect. The new federal standard is 99.68 percent or more. Source: federal fiscal year data submitted to the National Child Abuse and Neglect Data System (NCANDS) and the Adoption and Foster Care Analysis and Reporting System (AFCARS).

OBJECTIVE: Improve safety for children placed in out-of-home care
MEASURED BY: Foster homes receiving health and safety checks

Washington state statute requires that “Monitoring shall be done by the department on a random sample basis of no less than ten percent of the total licensed family foster homes licensed by the Administration on July 1 of each year,” and reported annually. (RCW 74.13.260; RCW 74.13.031(5))

The Children’s Administration works to ensure that children who must be placed into out-of-home care are with caregivers who are able to meet their needs.

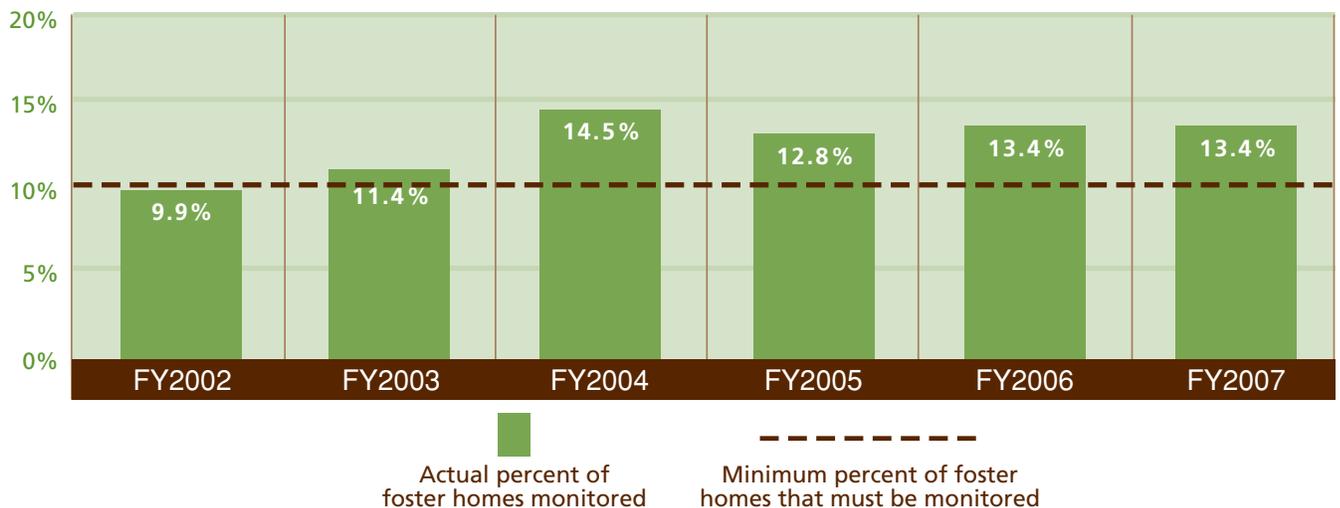
Foster parents must meet licensing standards and so must the physical structures in which children are placed. Often these homes demonstrate safety measures and emergency preparedness beyond what might be found in an average home. Foster homes with fireplaces or wood stoves must have them completely surrounded by safety fences. Two-story houses are required to demonstrate safe methods of exit in case of fire. Medications are locked, first aid kits are well-stocked, and foster parents must be trained in First Aid, CPR and safe response to Blood-borne Pathogens.



Licensors thoroughly inspect and evaluate the condition of homes and facilities to make sure that no hazards have developed since a license was issued or since a previous health and safety check.

The Administration has exceeded the state requirement of ten percent of homes monitored since Fiscal Year 2003.

Division of Licensed Resources (DLR) Foster Homes Monitored Annually*



*Percentage of Division of Licensed Resources (DLR) foster homes with a health and safety check completed by the Division of Licensed Resources annually. Source: September 2007 CAMIS download.

CHILD FATALITY REVIEW PROCESS

The consequences of a child’s death are far reaching. Families and communities are deeply impacted whenever a young life ends too soon. When a child’s death is the result of harm or neglect the tragedy is all the more profound. Through reviewing the many factors which may have contributed to a child’s death, the Children’s Administration attempts to learn from these tragedies.

The Children’s Administration has established the Child Fatality Review (CFR) process to increase our understanding of the circumstances surrounding a child’s death in order to evaluate practice, policies, the Administration’s programs, and the systems involved with a specific child; and to improve the health and safety of all children. From this review, we can identify areas needing improvement and develop a work plan to address any identified deficits in practice, policy, or systems.

Fatality reviews are not investigations into the manner or cause of death. That work is conducted by law enforcement agencies, medical examiners, and coroners.

The Administration conducts a review whenever:

- The child’s family had an open case with the Administration at the time of the child’s death.
- The child’s family received any services from the Administration within twelve months preceding the child’s death, including a referral for services that did not result in an open case.
- The child’s death occurred in a home or facility licensed to care for children.

The Administration’s reviews are conducted by Child Protective Services (CPS) Program Managers, and include staff members who may have had direct involvement with the family. In addition, community professionals whose expertise provides a valuable contribution to the process are asked to participate. CPS Program Managers also work with other agencies to gather information on specific child fatalities.

Data collected since 1997 and depicted in the table and chart on these pages reflects all child deaths meeting the Administration’s criteria for a fatality review. Through the analysis of this data, we hope to identify children most at risk in order to inform and support the Administration in improving the protection of children and improving services to families.

Child Deaths Meeting Children’s Administration Child Fatality Review Criteria*

Based upon child deaths reported to the Children’s Administration (not all child deaths are reported to the Administration).

Children’s Administration Statewide Child Fatality Data	CY1997	CY1998	CY1999	CY2000	CY2001	CY2002	CY2003	CY2004	CY2005	CY2006
Total number of child fatalities meeting the criteria for internal child fatality reviews	103	79	68	72	108	101	90	83	62	61
■ Manner of death - Homicide (abuse)	6	9	4	8	3	7	6	9	3	5
■ Manner of death - Homicide (3rd party**)	10	5	5	2	8	5	8	0	4	5
■ Manner of death - Suicide	5	2	2	5	5	3	5	9	1	5
■ Manner of death - Natural/Medical	45	39	33	33	61	47	44	37	32	24
■ Manner of death - Accidental	36	20	20	21	26	32	21	26	19	16
■ Manner of death - Unknown/Undetermined†	1	4	4	3	5	7	6	2	3	6

*Calendar year data is based upon reports as of July 2007, and may change as new reports become available. Source: (AIRS).

**Third party abuse involves the abuse of a child by someone other than that child’s parent or guardian.

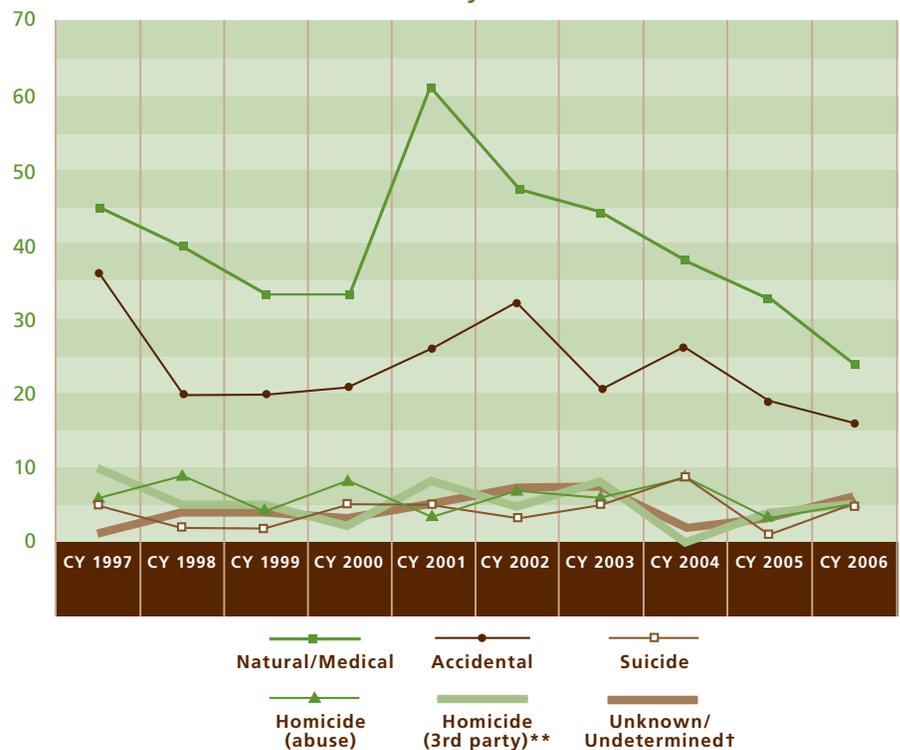
†The manner of death was unknown or undetermined by coroners or medical examiners at the time reports were filed with the Children’s Administration. History may change over time as manner of death determinations are made.

An Executive Child Fatality Review may be convened by the Administration's Assistant Secretary in select cases when a child dies of apparent abuse and/or neglect by their parent or caretaker, and the case was actively receiving services at the time of the child's death. Participants are appointed by the Assistant Secretary and are individuals who had no involvement in the case, but whose professional expertise is relevant to the dynamics identified in the case. The Administration convened one executive review during Calendar Year 2006, and completed the review during Calendar Year 2007.

The Administration has continued to improve systems for tracking child fatalities, both through the Case and Management Information System (CAMIS) and the Administrative Incident Reporting System (AIRS). Both systems provide an electronic alert that notifies appropriate staff in the event of a child's death. The AIRS also maintains specific information about each fatality, collects aggregate data, and provides a format and recording document for fatality review teams. Information from these systems is summarized in the Administration's Annual Child Fatality Report. Beginning with the 2004 Child Fatality Report, information on near fatalities and neglect became available.

The number of child fatalities that require a review by the Administration has decreased over the past five years. Of those fatalities that require review, the number of child deaths resulting from natural/medical or accidental causes has decreased. The number of deaths caused by homicide or suicide has remained relatively constant, with fewer than ten deaths in each category each year. The increase in the number of child fatalities where the cause of death is unknown or undetermined is due in part to ongoing investigations, and in part to an increase in the classification of Sudden Infant Death Syndrome (SIDS) fatalities as undetermined.

Trends of Child Fatalities Meeting Children's Administration Child Fatality Review Criteria*



*Calendar year data is based upon reports as of November 2007, and may change as new reports become available. Source: Administrative Incident Reporting System (AIRS). Manner of death data differences from previous reports were corrected for this report. All unknown/undetermined fatalities from those years were contrasted with death certificates obtained through vital statistics and corrections were made. In other instances, the child fatality review report did not contain the correct manner of death. The two reasons were, 1) medical examiners sometimes offered a preliminary manner that was later changed as new information became available and, 2) several medical examiner's offices in the State of Washington do not share information with CA, citing confidentiality. All manner of death designations in this report for the years 2003, 2004, 2005, and 2006 come directly from the death certificate findings.

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