

Safety

Child Fatality Review Process

A child's death invariably impacts not only the family of which he or she was a part, but entire communities are devastated when a child dies unexpectedly. When any child's death is the result of actions which may have been prevented, the grief and outrage are all the more profound and all the more lasting.

Washington state is committed to identifying ways of reducing unexpected child fatalities regardless of whether those deaths occur as the result of suicide, accidental injury, third party causes or abuse or neglect related causes. Toward that end Washington State employs a thorough retrospective process through Child Fatality Reviews.

The Children's Administration (CA) participates in this process both in collaboration with the Washington State Department of Health (DOH) and through an internal review process.

Since 1998 CA and DOH have worked cooperatively in the development and implementation of a single, statewide child fatality review system. The reviews are conducted by community-based teams facilitated by local health jurisdictions. Children's Administration maintains staff representation on each community team. All unexpected child deaths in the state are reviewed with the ultimate goal of developing preventative measures by looking at aggregate data from which factors and trends may be determined. DOH publishes child fatality review findings based upon aggregate data annually.

The Children's Administration also conducts separate internal child fatality reviews when any of the following criteria is met with reference to the death of a child.

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

Child fatality reviews are not investigations into the manner or cause of death. Such investigations are conducted by law enforcement entities, medical examiners and coroners. Some cases may be reviewed both internally and by community Child Fatality Review teams.

Data collected since 1997 and depicted in the chart on this page reflects all child deaths meeting CA internal review process criteria. This data will vary from the Washington State Department of Health (DOH) aggregate data.

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 ¹	1997	1998	1999	2000	2001	2002
Total number of child fatalities meeting the criteria for internal child fatality reviews	103	79	68	72	108	101
■ Manner of death - Homicide (abuse)	6	9	4	8	3	7
■ Manner of death - Homicide (3rd party ²)	10	5	5	2	8	5
■ Manner of death - Suicide	5	2	2	5	5	3
■ Manner of death - Natural/Medical	45	39	33	33	61	47
■ Manner of death - Accidental	36	20	20	21	26	32
■ Manner of death - Unknown/Undetermined ³	1	4	4	3	5	7

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