Child Welfare Maltreatment-Related Incident Analysis, 2021-2022

Summary

Through the first eight months of calendar year 2022, Child Welfare staff involved in carrying out the DCYF executive (near) fatality reviews observed a higher count of fatalities (14) and near-fatalities (18) being reviewed relative to 2021 levels (nine and nine, respectively). OIAA carried out an analysis of maltreatment-related fatalities and near fatalities with the following aims: 1) to evaluate if the increase in maltreatment-related fatalities and near fatalities in 2022 represents a significant change relative to 2021 levels and 2) to characterize the descriptive factors associated with these fatalities and near fatalities. OIAA found that the number of incidents in 2022 was not above and beyond the number of expected incidents given 2021 levels. While OIAA did not observe an overall change in trend in the number of maltreatment-related fatalities longitudinally, OIAA did observe an increasing trend in the number of maltreatment-related near fatalities beginning in 2019. These findings preliminarily appear to be maintained through October 2023. The largest change in the breakdown of fatalities by medical cause of death was a reduction in the number of safe sleep-related fatalities in 2022 by three while there were no neonatal fatalities in 2022 (relative to two in 2021). OIAA's analysis underscores opportunities for providing greater detail about levels and trends in critical incidents when these data are linked with other data from FamLink and for further examining the extent to which DCYF is leveraging critical incident reviews to inform delivery of services towards preventing critical incidents.

Methods

Data sources

This analysis makes use of two different datasets of fatalities and near fatalities (critical incidents): 1) a dataset maintained by the Child Welfare quality improvement team used for the DCYF executive child fatality and near fatality reviews (hereafter, the DCYF dataset) and 2) the Administrative Incident Reporting System (AIRS). Notably, the criteria for which individuals and incidents are included in these datasets varies (respectively):

DCYF dataset:

a) incidents and cases must be affiliated with DCYF/Child Welfare; and
b) DCYF provided services within 12 months of the (near) fatality to the child (formal involvement with Child Welfare) OR there was an open Child Welfare case on the child at the time of the (near) fatality.

AIRS:

a) incidents and cases must be affiliated with DCYF/Child Welfare;
b) occurred on an open case at the time of the incident or there was a Child Welfare history on the family within 12 months of the incident including intakes screened out for investigation;
c) and/or the incident occurred in a DCYF-licensed, -certified, or state-operated facility.

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Thus, the number of incidents varies between the two datasets with the AIRS dataset reporting higher numbers due to having broader inclusion criteria.[1] Neither of these datasets capture maltreatment-related incidents without current or prior contact with DCYF.[2]

Analysis

We compared the count of fatalities and near fatalities in 2022 relative to 2021 and using a 1-sided Fisher's exact test. The DCYF dataset includes medical examiner findings and notes compiled from Child Welfare about contributing factors related to the incident.

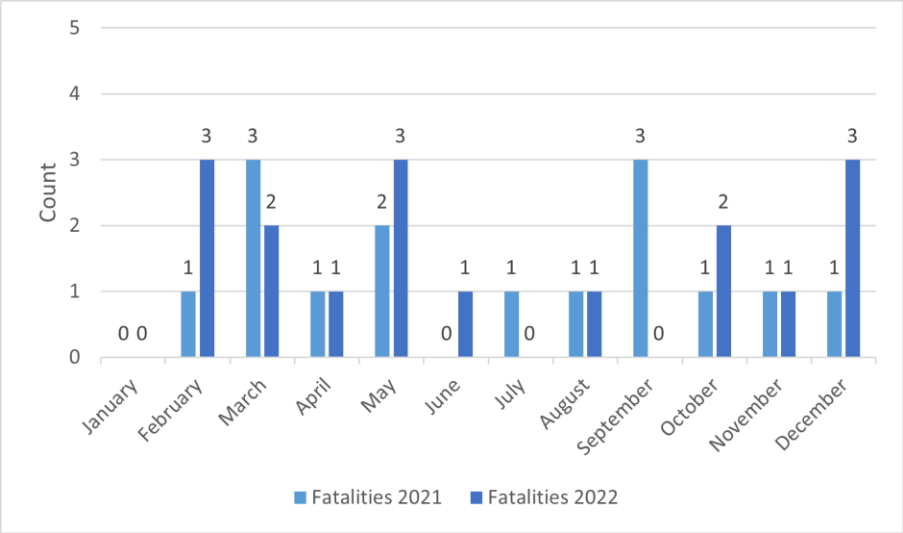
To construct descriptive analytic categories for comparing the medical causes of death associated with these incidents, we created a new variable classifying incidents according to the US National Library of Medicine's Medical Subject Heading Disease Categories. For example, gunshot wounds are categorized as wounds and injuries>wounds, penetrating>wounds, gunshot while drowning is categorized as wounds and injuries>drowning. These categories have been analyzed and presented in this report at the highest level among disease categories (i.e., the wounds and injuries category include both gunshot wounds, drownings, and other causes that fall under the respective Medical Subject Heading Disease category).

Results and Discussion

In the DCYF dataset, there were 17 fatalities observed in 2022 relative to 15 fatalities in 2021 as shown in Figure 1, while there were 26 near fatalities observed in 2022 relative to 14 near fatalities in 2021 as shown in Figure 2.

Figure 1

Child maltreatment-related fatalities - 2021 vs. 2022

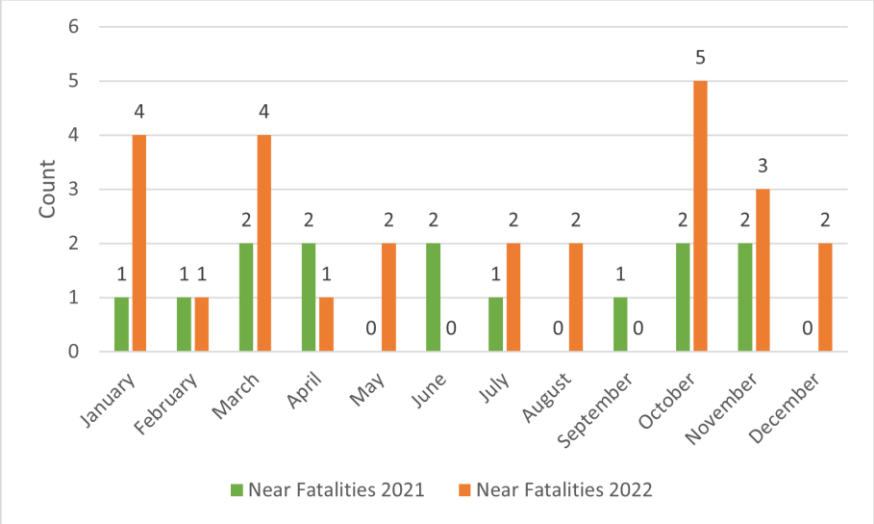


[1]Data from DCYF dataset.

[1] The Office of Family and Children's Ombuds reports on child fatalities and near fatalities utilize AIRS data.
[2] Additional information on monthly trends in child abuse-related injuries are available at https://www.dshs.wa.gov/sites/default/files/rda/reports/DCYFcovid.pdf.

Figure 2

Child maltreatment-related near fatalities – 2021 vs. 2022



[1]Data from DCYF dataset.

We used a 1-sided Fisher's exact test to evaluate if the count of (near) fatalities in 2022 was higher above and beyond what would have been expected, given the count of (near) fatalities in 2021. We found that these counts in 2022 were not higher than what would have been expected given 2021 levels (1-sided Fisher's exact test = 0.218).

Table 1

Contingency table of incidents 2021-22

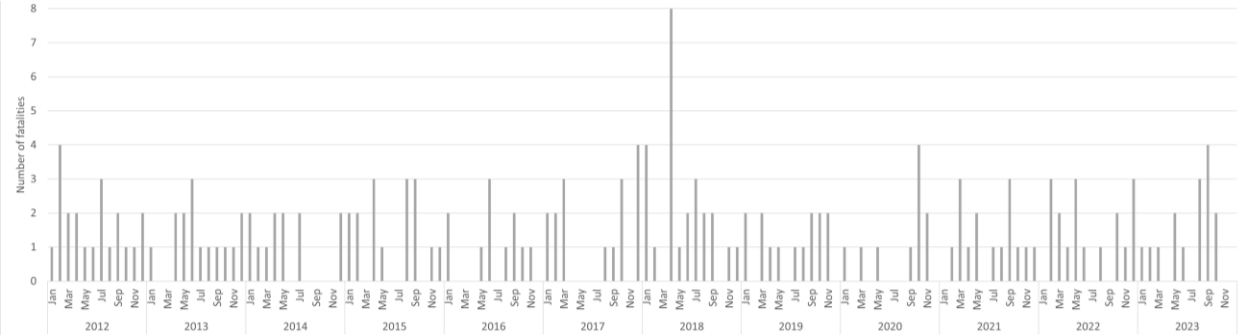
	2022	2021	Total
Fatalities	17	15	32
Near Fatalities	26	14	40
Total	43	29	72
1-sided Fisher's exact =			0.218

[1]Data from DCYF dataset.

Using monthly historical data from both the DCYF administrative dataset and Administrative Incident Reporting System gives a longitudinal picture of the trends in these critical incidents. Figures 3 and 4 show the trends in fatalities and near fatalities, respectively, from the DCYF administrative datasets while Figures 5 and 6 show the trends in fatalities and near fatalities, respectively, from the AIRS datasets. Due to COVID-related restrictions, Child Welfare staff anecdotally shared that there may have been fewer *reported* fatalities in 2020 (due to fewer face-to-face contacts with DCYF staff and school closures), but notably there was no reduction in the trend of reporting near fatalities in 2020. While there does not appear to be a change in trend in fatalities, the increase in near fatalities in 2022 relative to 2021 appears consistent with a rising trend in near fatalities beginning in 2019. These findings – a rising trend in near fatalities but no change in trend in fatalities – appear preliminarily to be consistent into 2023 through October.

Figure 3

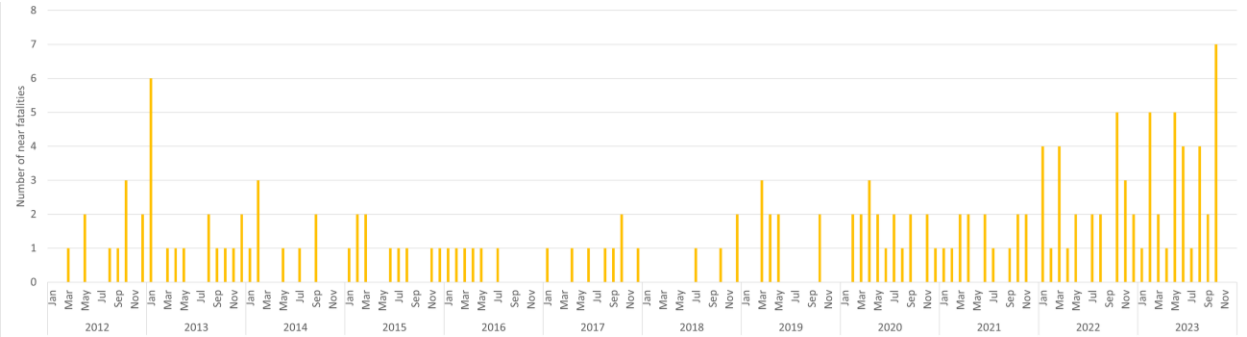
Count of monthly maltreatment-related child fatalities 2012 – Oct 2023 (DCYF)



[1]Data from DCYF dataset.

Figure 4

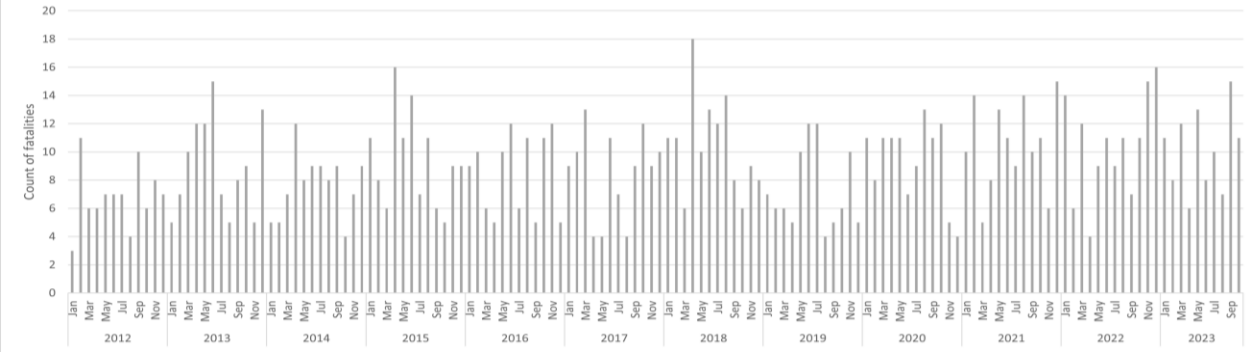
Count of monthly maltreatment-related child near fatalities 2012 – Oct 2023 (DCYF)



[1]Data from DCYF dataset.

Figure 5

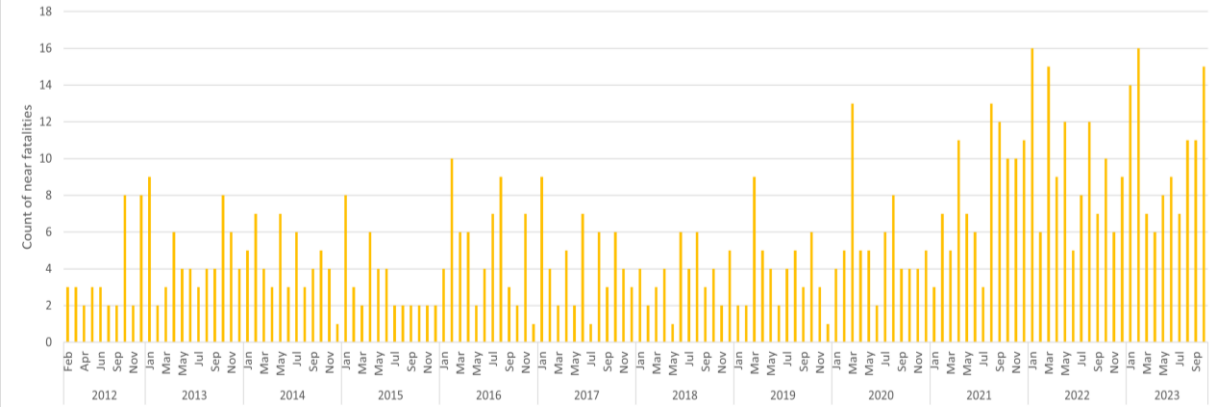
Count of monthly family-involved maltreatment-related child fatalities 2012 – Oct 2023 (AIRS)



[1]Data pulled from AIRS dataset.

Figure 6

Count of monthly family-involved maltreatment-related child near-fatalities 2012 – Oct 2023 (AIRS)

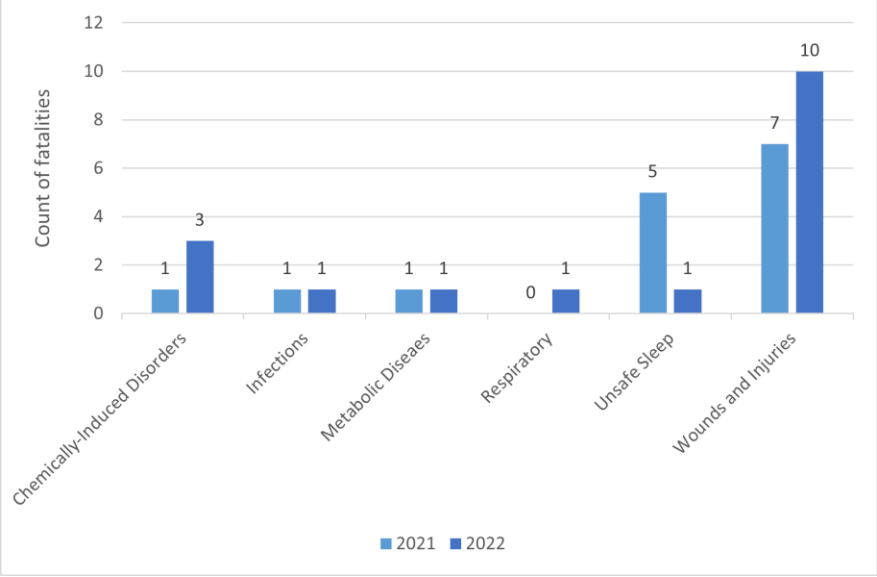


[1]Data pulled from AIRS dataset.

Comparing the medical causes of death from 2021 to 2022 shows that the biggest change was the drop from five unsafe sleep-related fatalities in 2021 to one unsafe sleep-related fatality in 2022 as shown below in Figure 7.

Figure 7

Medical causes of fatalities by category, 2021 - 2022



[1]Data from DCYF dataset.

[2]Categories compiled according to US National Library of Medicine Medical Subject Headings

Figures 9 and 10 below show the regional breakdown of incidents by the six DCYF geographic and Child Welfare Field Operations regions (shown in Figure 8 below). The regions are structured around county lines and are based on former Department of Social and Health Services regions.

Figure 8

DCYF Regional Structure

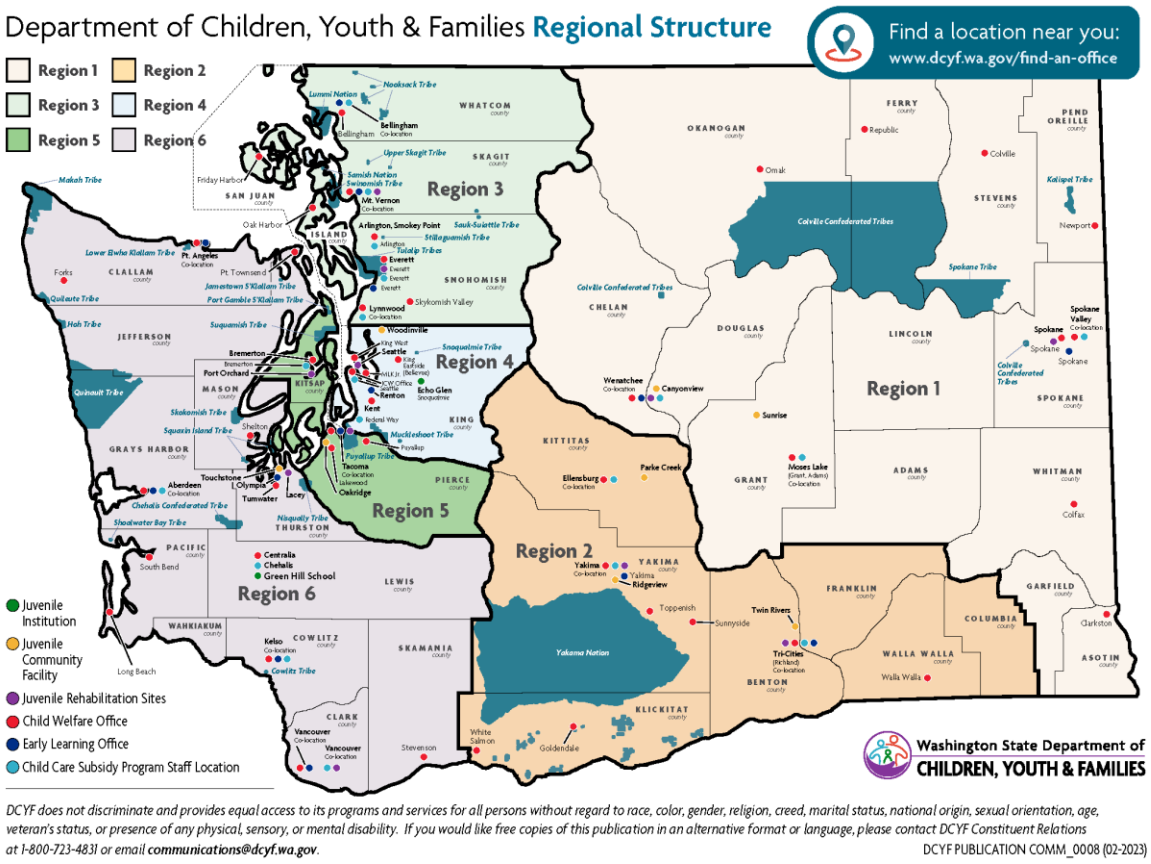
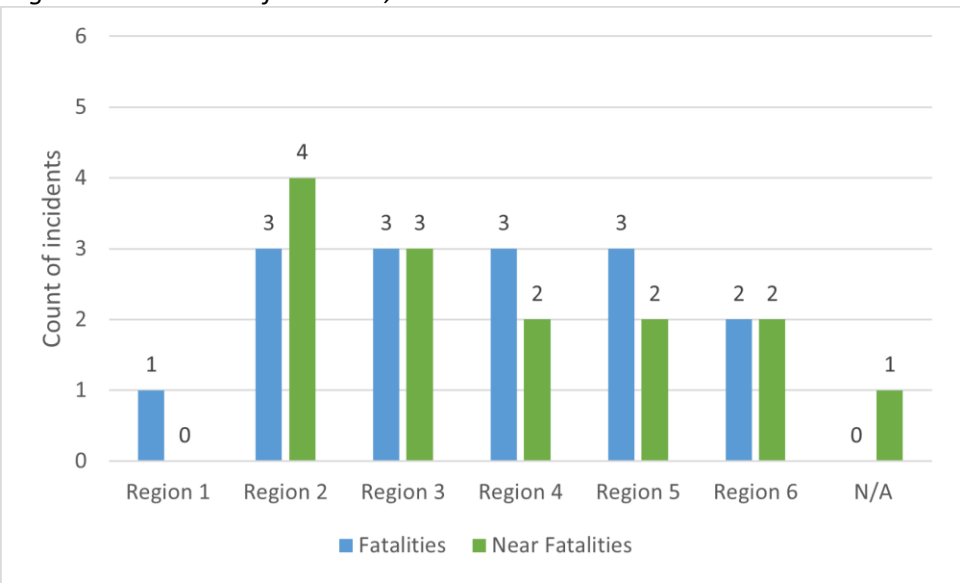


Figure 9

Regional breakdown of incidents, 2021



[1]Data from DCYF dataset.

[2]N/A was indicated as region for 1 individual (unable to track down further information)

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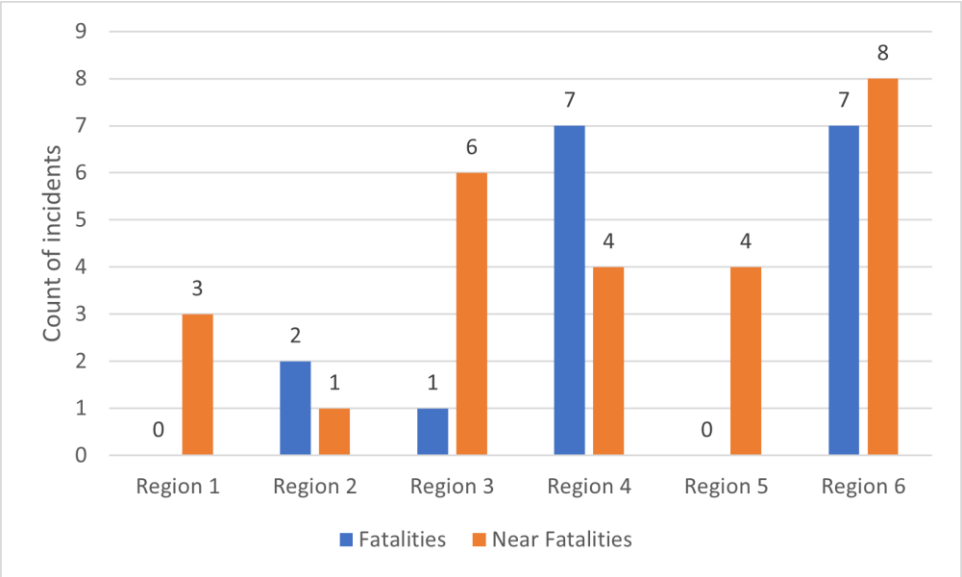
Figure 10

Regional breakdown of incidents, 2022

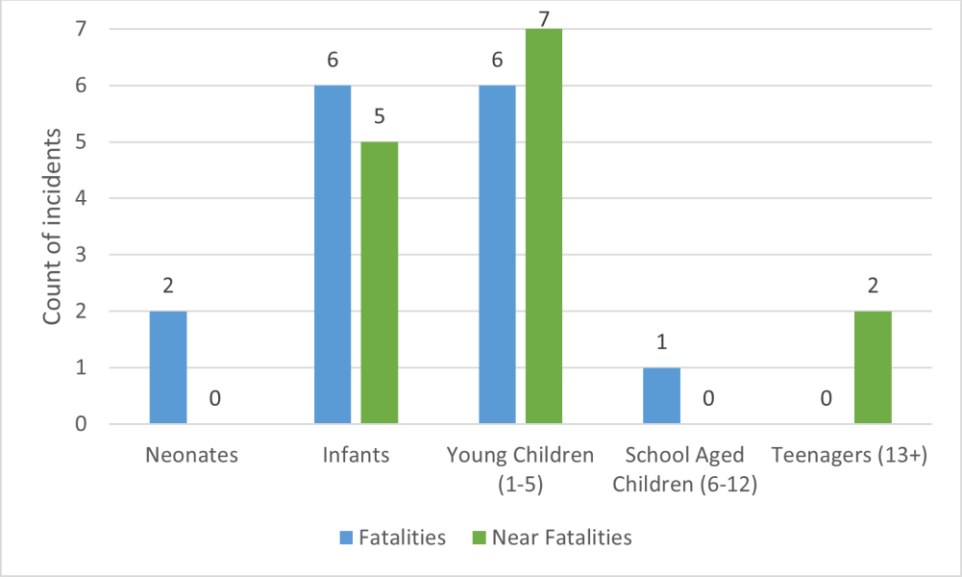


[1]Data from DCYF dataset.

Figures 11 and 12 below show the breakdown of incidents by age categories: neonates (0-30 days), infants (31 days-1 year), young children (1+year-5 years), school-aged children (6-12 years), and teenagers (13+ years). Fatalities are more tightly clustered in general in the neonate through young children age groups while near fatalities account for a higher proportion of incidents in the school-aged children and teenager age groups in both 2021 and 2022. While there were 2 neonatal fatalities in 2021, there were no neonatal fatalities in 2022.

Figure 11

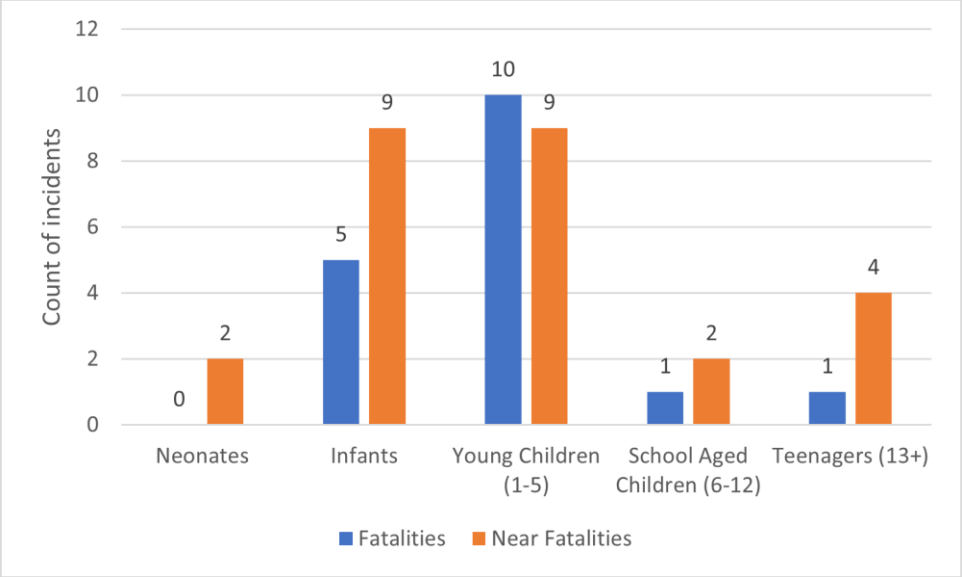
Categorical age breakdown of incidents, 2021



[1]Data from DCYF dataset.

Figure 12

Categorical age breakdown of incidents, 2022



[1]Data from DCYF dataset.

Future Considerations

These data should be contextualized against the backdrop of the DCYF strategic priority outcome to safely reduce the number of children placed in out-of-home care by 50%. Since 2018, the number of children experiencing an out-of-home placement of 1+ days has been declining. But determining whether these reductions are being done safely remains an important, but challenging assessment. Considering that DCYF conducted 89,154 intakes in 2022, a number that represents an increase over 2021 numbers and a near return to pre-2020 COVID pandemic levels, the trend in reduction in out-of-home placements means that more children are remaining with their biological parents or caregivers. OIAA recognizes that critical incidents are not *singularly* an appropriate outcome for evaluating the safety of placements (nor that any reduction in out-of-home placements has led to any changes in rates of critical incidents). Yet, monitoring levels and trends in critical incidents should be taken as an important contextual piece (among other pieces of evidence) of understanding the agency's broader efforts to more holistically evaluate whether the reduction in out-of-home placements is being done safely.

Missing data, particularly in the AIRS dataset, underscore missed opportunities for further analysis. In the AIRS dataset, for example, 675 individuals are missing race/ethnicity data (21%) and 708 are missing residence type (22%). Based on conversations with the Child Welfare Quality Assurance/Continuous Quality Improvement team, the AIRS is optimized for the staff member recording the incident to notify their supervisor/administrator and the Quality Assurance/Continuous Quality Improvement team often with a minimal amount of information about the incident. Due to technical problems, the system often creates multiple IDs and the AIRS data need extensive cleaning to reconcile information (the data used for this report have already undergone extensive cleaning).

As a result, this report recommends that OIAA consider ingesting the DCYF dataset (not the AIRS data) and link with the individual's FamLink data. Linking data and producing reports will facilitate easier access for further analyses. Given a) the sensitive nature of these critical incidents, b) the small number of incidents (from a statistical point of view), c) the pitfalls of multiple testing on a small dataset, and d)

the risks associated with inaccurate interpretation of these data (particularly around such a sensitive subject), OIAA stresses exercising caution when using these data linked with FamLink data.

If, and once, the DCYF dataset is linked to the individual's FamLink data, we recommend including the following variables/data for reporting:

1) In-home versus out-of-home (whether child was in a placement episode at time of incident)
2) Type of out-of-home placement (foster care vs. kinship care)
3) Most recent intake decision (screen-in, screen-out, pending)
4) Most recent assessment type (risk-only, Family Assessment Response, Investigation)
5) Response time (24 hours, 72 hours, 10 days, Failed, Pending)
6) Any data on re-referrals, re-abuse, and risk factors (e.g., domestic violence and substance use)
7) Results/data from any available Structural Decision-Making Risk Assessments

This report also recommends the following:

8) Augmenting the existing variable of medical examiner findings with a categorical medical cause of death to easily facilitate descriptive analyses (as done here in this analysis)
9) Constructing rates of critical incidents based on population at-risk (denominator as total population at risk and/or sub-rates with critical incidents occurring in-home vs. out-of-home or according to assessment type/intake decision outcome with the corresponding populations)

Citation:

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