2005 Annual Child Fatality Report

Children's Administration
P.O. Box 45040
Olympia WA 98504-5040

Table of Contents

Executive Summary

The 2005 Annual Child Fatality report by Children's Administration (CA) is a comprehensive assessment of 87 child fatalities reported to CA during 2005. Sixty-two of those fatalities (71%) met the criteria for a child fatality review. This report evaluates data from the 87 reported child fatalities and the 62 child fatalities that required a case review.

Whenever a child dies and there are suspicions of abuse or neglect or a family is a current or recent client of CA, the fatality is reported to CA. The administration is also notified whenever a child dies in licensed care. Assessment of these fatalities provides valuable information about service delivery, trends and issues facing families served in the State of Washington.

2005 Findings Include:

- The number of reported and reviewed fatalities has consistently dropped since 2001.

- Natural/medical and accidental deaths continue to account for the most frequent manner of death finding (82%).

- The number of fatalities that met the criteria for a child fatality review has steadily dropped from 108 in 2001 to 62 in 2005.

- The most frequently noted practice recommendations (by child fatality review teams) were associated with risk assessment, documentation and interagency collaboration.

- There were 25 maltreatment related fatalities in 2005. Nineteen of those had CPS findings of neglect, 10 had medical examiner's or coroner's findings of homicide and nine had Child Protective Services findings of abuse.

- There were 17 reported near-fatalities that either involved allegations of child abuse or neglect or the incident occurred in licensed care. Near-fatalities are incidents that cause a child to be hospitalized in serious or critical condition. Nine near-fatalities resulted in findings that abuse or neglect more likely than not occurred.

Introduction

The 2005 Children's Administration (CA) Annual Child Fatality Report is a comprehensive assessment of 87 child fatalities reported to CA during 2005. Of them, 62 (71%) met the criteria for a child fatality review. This report evaluates data from the 87 reported child fatalities and the 62 child fatalities that required a case review.

The goal of the Child Fatality Review (CFR) is to increase understanding of the circumstances surrounding a child's death in order to evaluate CA practice, programs and policies, and to evaluate other service systems involved with the child and their family. The Revised Code of Washington (RCW) 74.13.640 states:

> *Child Fatality Review - Report*
> *(1) The department of social and health services shall conduct a child fatality review in the event of an unexpected death of a minor in the state who is in the care of or receiving services described in chapter 74.13 RCW from the department or who has been in the care of or received services described in chapter 74.13 RCW from the department within one year preceding the minor's death.*
>
> *(2) Upon conclusion of a child fatality review required pursuant to subsection (1) of this section, the department shall issue a report on the results of the review to the appropriate committees of the legislature and shall make copies of the report available to the public upon request.*

Child fatality review teams examine the following:

- Nature and preventability of the fatality
- Manner of death (as determined by medical examiners or coroners)
- Prior CA involvement with the family
- CPS or law enforcement findings

After examining the information, the child review team identifies issues and makes policy and practice improvement recommendations. The team makes some recommendations to the local office or community in which a fatality occurred while others relate to statewide practice and policy. The administration summarizes all child fatality reviews for the legislature and CA staff in Quarterly Child Fatality Review Reports.[1]

The Washington State Department of Health (DOH) also conducted community child death reviews on all unexpected child fatalities until 2003 when funding ended and most health districts discontinued the reviews while others continued to meet and provide data. Child Death Reviews (CDR) by DOH are now completed at the discretion of local health districts.[2]

[1] http://www1.dshs.wa.gov/legrel/LR/CIYA.shtm; http://www.dshs.wa.gov/ca/pubs/fatalityreports.asp
[2] Beth Siemon and Diane Pilkey, "Child Death Review (CDR) Surveillance," Washington State Department of Health, January 2007, p. 1.

The administration collects child fatality information from several sources. These include the CA Case and Management Information System (CAMIS), the Administrative Incident Reporting System (AIRS), the Office of the Attorney General Homicide Investigation Tracking System (HITS) and the Department of Health (DOH).

A section of this report examines the number of deaths attributed to maltreatment by a caregiver who acted in loco parentis.[3] Previously, CA calculated this number by counting homicides as determined by a medical examiner or coroner. The 2004 Annual Child Fatality Report by CA included a section on fatalities with neglect factors in which CPS allegations and findings were examined. This 2005 report merges CPS and medical examiners/coroners' findings into a single section on maltreatment-related fatalities. Many states now incorporate CPS findings when calculating the number of deaths related to child maltreatment and it is a statistic reported annually to the National Child Abuse and Neglect Data Systems (NCANDS).[4]

A chapter on near-fatalities is included in this report. Through a review of fatalities and some near-fatalities, CA is able to evaluate demographics, practice or systemic issues regarding incidents of maltreatment of children.

[3] CA only investigates maltreatment by persons acting in loco parentis per RCW 74.13.031(3).
[4] US Department of Health and Human Services, Administration on Children, Youth, and Families, "Child Maltreatment 2005," March 30, 2007, <http://www.acf.hhs.gov/programs/cb/pubs/cm05/cm05.pdf>, accessed on June 6, 2007.

Child Fatalities Reported to CA

In 2005, the Office of Financial Management estimated the child population in Washington State to be 1,710,430. Among this population, there were 719 recorded child fatalities that occurred in 2005.[5] Eighty-seven (12%) of the 719 fatalities were reported to Children's Administration (CA). Reports are made to CA when a person suspects that abuse or neglect was involved in the fatality.[6] The referent contacts CA if he/she is aware that the fatality involves a current or recent client or when the child died in a CA or state licensed facility such as foster home, daycare home or group home.

This section briefly reviews the 87 fatalities reported to CA.[7]

Manner of Death

A Medical Examiner or Coroner must determine manner of death. There are five primary categories for the manner of death. These include natural, accidental or unintentional, homicidal, suicidal and undetermined. The charts below categorize the manner of death for 719 child fatalities in the state and the 87 child fatalities reported to CA.[8] In the charts below, the manner of death is followed by total fatalities and percentage in that category. Homicides in the CA table are divided into homicide by abuse and 3rd party homicides (deaths inflicted by persons not responsible for the care of the child).

Chart 1

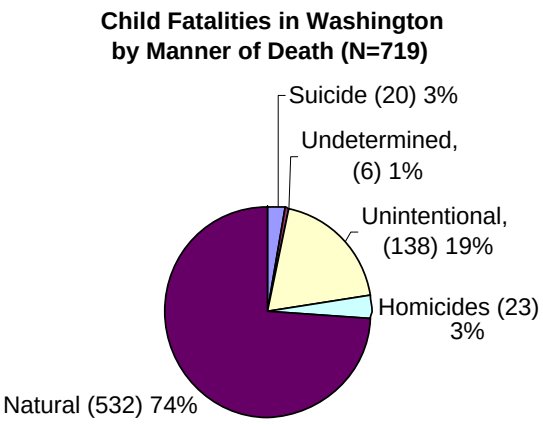
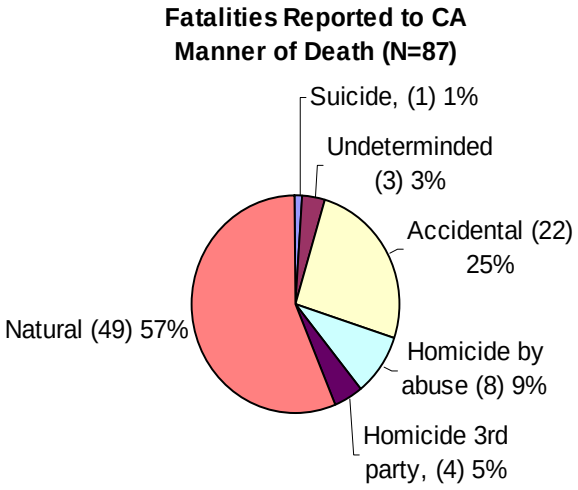


Chart 2



[5] Ann Lima (Department of Health), "RE: 2004 data: Child Deaths – Reported Manner of death.xls," email message, June 1, 2007. Child population in Washington is found on the OFM website: http://www.ofm.wa.gov/pop/coagemf/state.pdf

[6] Some professionals are required by RCW 26.44.030 to contact CA if abuse or neglect is suspected.

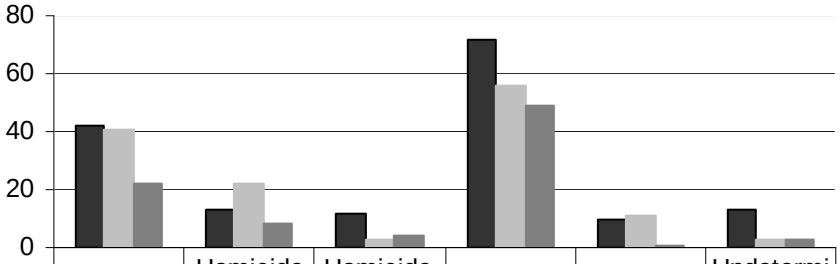
[7] Some reports to CA do not include an allegation of abuse or neglect, nor do they meet criteria for a child fatality review by CA (see introduction). Those are entered into the Automated Incident Reports System (AIRS) in the child fatality log but are not considered CA "reported fatalities."

[8] One homicide by abuse (in both charts) did not have a medical examiner or coroner's report since a body was never recovered. The convicted mother admitted to disposing of the child's body in a river.

The total number of fatalities reported to CA declined 46% from 162 in 2003 to 87 in 2005. The difference can be seen in fewer deaths in all categories. Accidents and homicides (all homicides) have declined by more than 50% since 2003. Suicides have dropped from 10 to 1 during this same time period. Natural/medical and accidents continue to be the most common manner of death reported to CA.

Chart 3

Manner of Death 2003-2005



	Accident	Homicide by Abuse	Homicide by 3rd	Natural	Suicide	Undetermined
2003 (162 fatalities)	42	13	12	72	10	13
2004 (136 fatalities)	41	22	3	56	11	3
2005 (87 fatalities)	22	8	4	49	1	3

The data in Chart 3 represents corrections in the data from 2003 and 2004.[9]

The overall decrease may be attributed to how fatalities are documented in CA's Administrative Incident Reporting System (AIRS). Fatalities in which the family has no prior or recent involvement with CA, and abuse or neglect is not alleged are documented in the AIRS fatality log. Child fatalities that occur within families with recent CA history or alleged abuse or neglect are documented in a completed Incident Report. Incident Reports contain considerable more information on the child's family and the nature of the fatality. Fatality log entries (see footnote seven on page five) have increased, however the number of fatalities reported to CA intake has decreased. This is likely due to standardization of documentation practices. Table 1 shows the shift.

[9] Manner of death data differences from the 2003 and 2004 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 2003, 14 unknown/undetermined were changed to natural, one to accident, and two to homicide. In 2004, five unknown/undetermined were changed to Natural; two to Accidental. *One reason for the inaccuracy was that AIRS did not pull manner of death from the correct field*. 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, and 2005 come directly from the death certificate findings.

Table 1

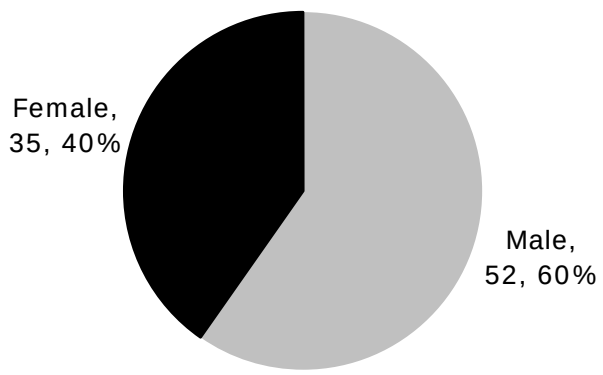
Fatality Log Entries and Fatalities Requiring Completed Incident Report by Year

Year	Fatality Log Entries	Fatalities Requiring Completed Incident Report	Total
2003	44	162	206
2004	92	136	228
2005	124	87	211

Child Fatalities by Gender

The distribution of fatalities reported to CA by gender are similar in percentage to all child fatalities in Washington. According to data from the Department of Health, 65.5 percent of all children in Washington State who died in 2005 were male, 37.5 were female. These percentages are consistent with the child fatalities reported to CA.[10] Chart 4 illustrates child fatalities by gender.

Chart 4



[10] Percentages quoted are for general comparison only. DOH statistics here are for children aged 0 to 19. CA statistics pertain to children age 0-17.

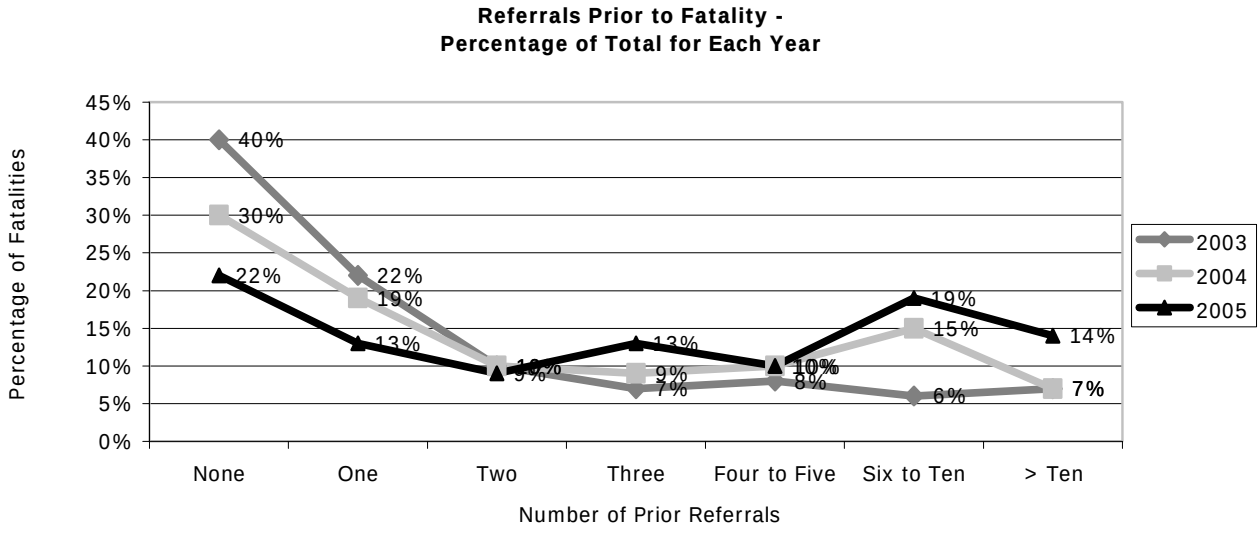
Table 2

Referrals Prior to Fatality

	2003		2004		2005	
# of Prior Referrals	**# of Fatalities**	**Percentage**	**# of Fatalities**	**Percentage**	**# of Fatalities**	**Percentage**
None	64	40%	42	30%	19	22%
One	35	22%	26	19%	11	13%
Two	16	10%	13	10%	8	9%
Three	12	7%	12	9%	11	13%
Four to Five	13	8%	13	10%	9	10%
Six to Ten	10	6%	21	15%	17	19%
> Ten	12	7%	9	7%	12	14%
Total	162	100	136	100%	87	100%

Table 2 above displays the number of referrals on the family prior to the death of the child. Referrals are made to CA for various reasons. Some are assigned and investigated by child protective services because abuse or neglect is alleged. Other referrals are requests for services, licensing complaints or “information only” CPS reports that are not investigated. Prior referrals do not necessarily represent founded allegations of abuse or neglect.

Chart 5



The percentage of fatalities with no prior referrals has decreased substantially while the percentage with six or more prior referrals has increased. The differences may be due to documentation changes discussed on page 6.

Child Fatality Reviews

Sixty-two of the 87 (71%) reported fatalities met criteria for a child fatality review (CFR). Child fatality review teams are comprised of CA professionals and community professionals and other stakeholders. These teams examine the information available to the department prior to the child's death. The goals of the review are to increase understanding of the circumstances surrounding a child fatality and to identify practices, programs and systems in need of improvement.

Fatalities meeting criteria for a CFR have declined since 2001 when there were 108. The 62 CFRs in 2005 marks the fewest CA reviews since program implementation in 1996.

Chart 6

Child Fatality Trends
2003 through 2005

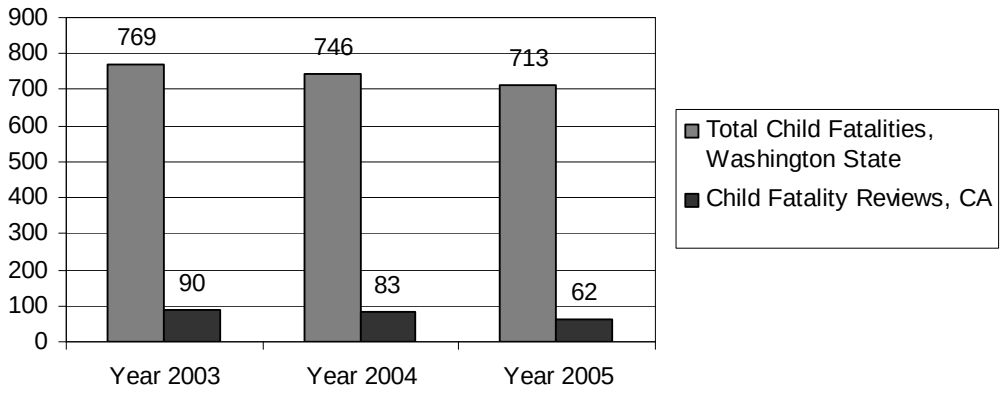
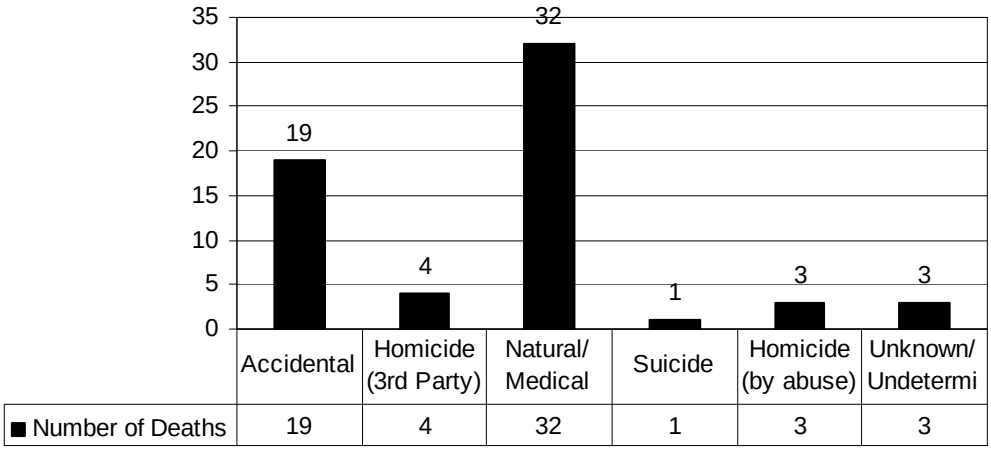


Chart 7

Manner of Death - Fatality Reviews

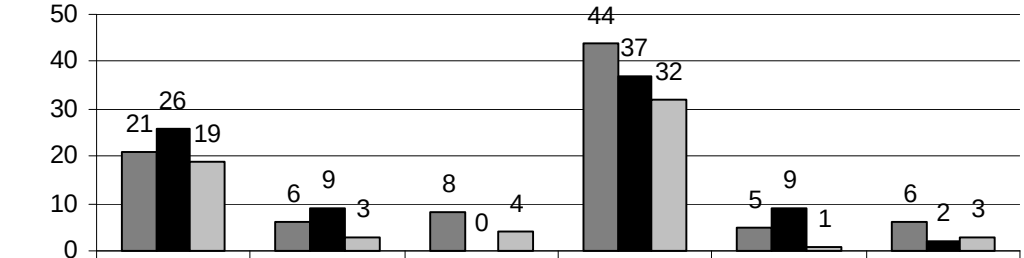


Medical examiners and coroners determine manner of death findings.

Chart 8

Yearly Manner of Death Comparison for CA Reviewed Fatalities

2003 - 2005



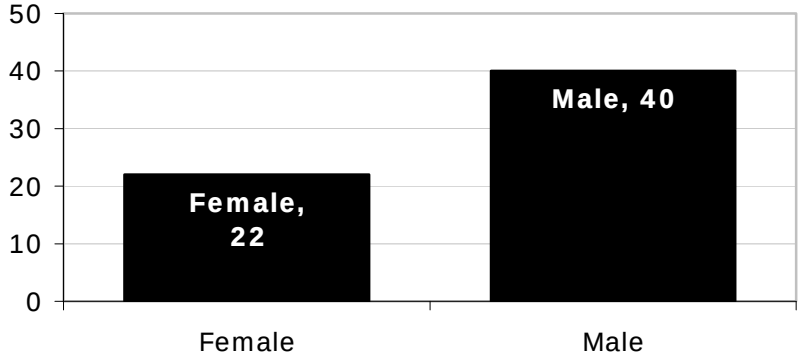
	Accident	Homicide by Abuse	Homicide by 3rd Party	Natural/ Medical	Suicide	Unknown/ Undetermine
2003	21	6	8	44	5	6
2004	26	9	0	37	9	2
2005	19	3	4	32	1	3

Natural and accidental deaths continue to represent the most common manner of death of reviewed fatalities. Suicides have declined from nine in 2004 to one in 2005.[11]

Reviewed Fatalities by Gender

Chart 9

Reviewed Fatalities by Gender



[11] Manner of death statistics in the 2003 and 2004 are different than seen here. See footnote number nine on page six of this report.

Table 3

2005 Child Fatalities by Age and Gender						
Age	**Number of Males**	**% of Males**	**Number of Females**	**% of Females**	**Age Totals**	**% of Total**
< 1 Year	17	42%	11	50%	28	45%
1-3 Years	4	10%	4	18%	8	13%
4-6 Years	3	7%	2	9%	5	8%
7-12 Years	5	13%	1	4%	6	10%
13-16 Years	4	10%	1	4%	5	8%
17-18 Years	7	18%	3	13%	10	16%
Totals	40	100%	22	100%	62	100%

Chart 10

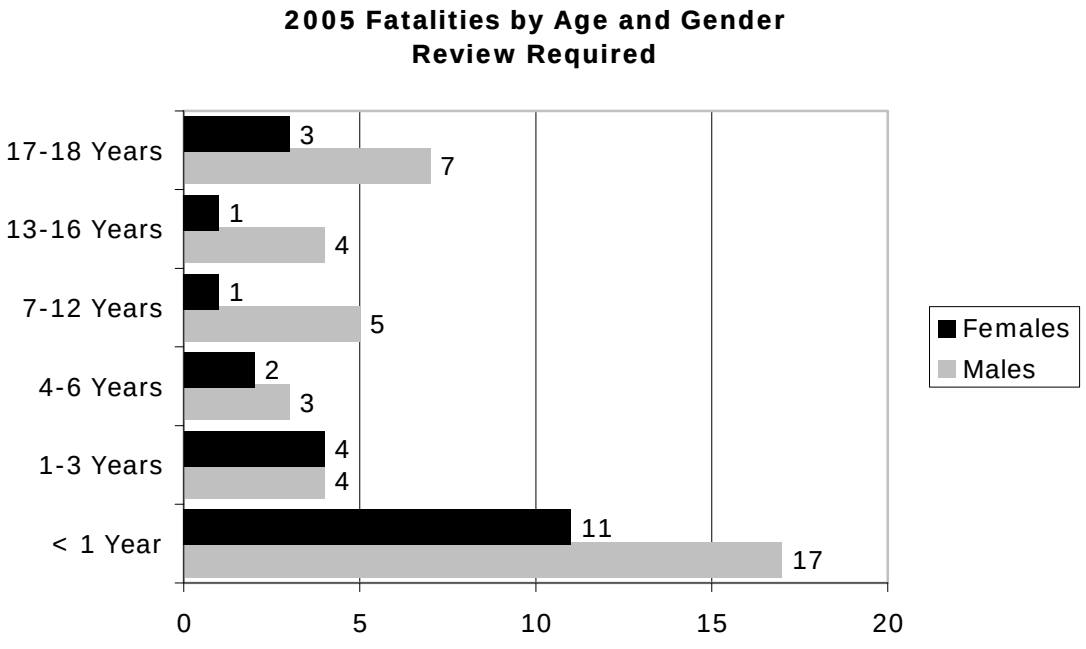
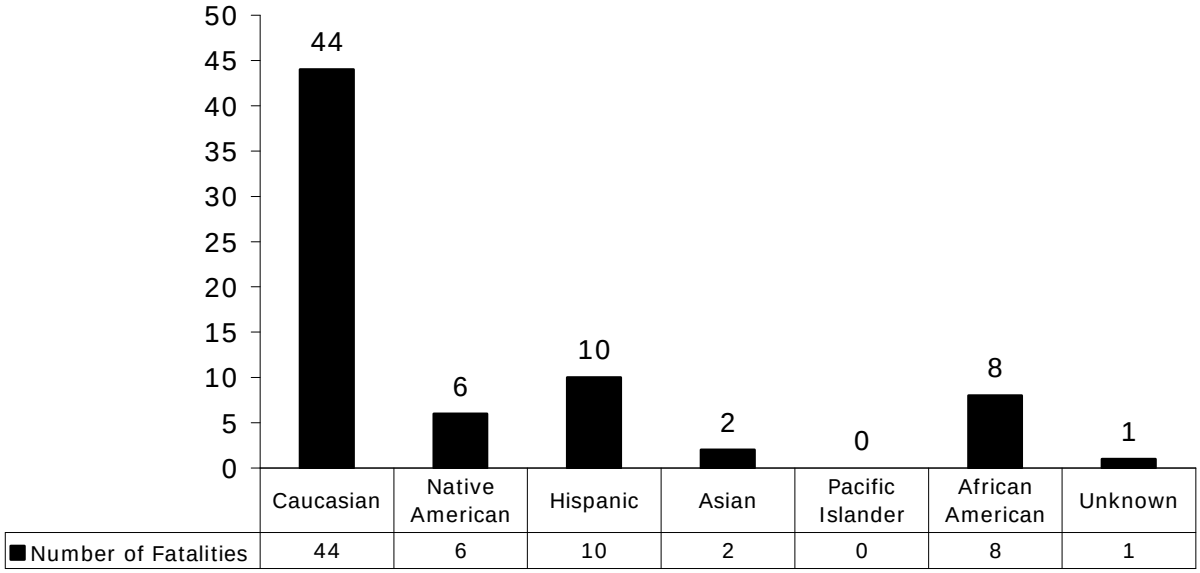


Chart 11

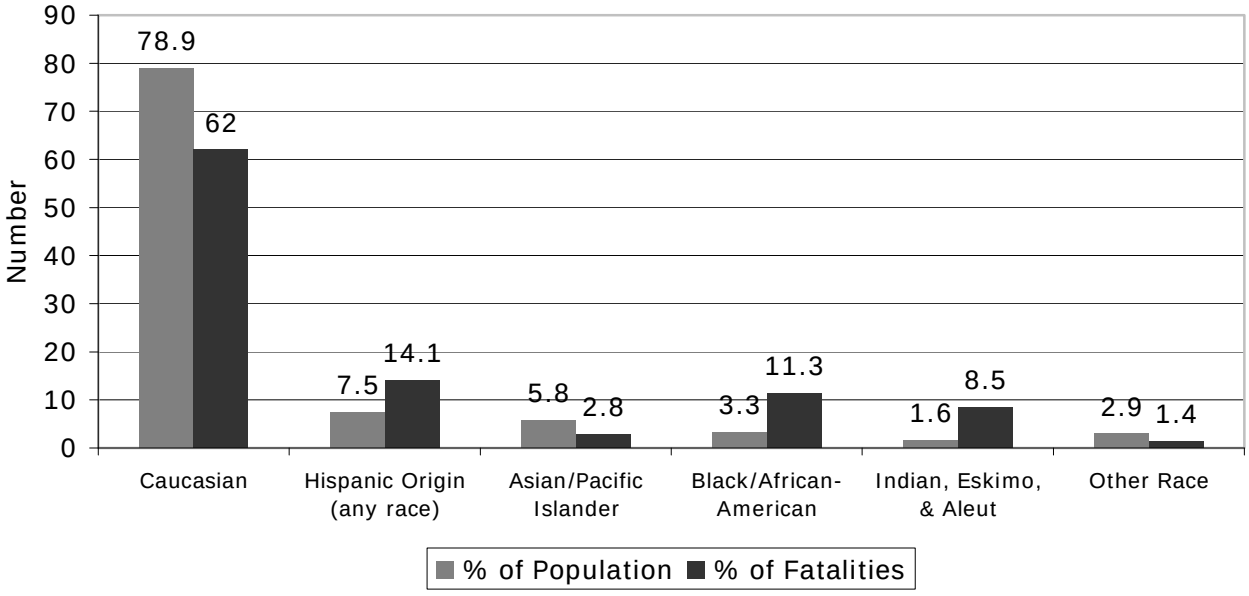
Numbers of Fatalities by Race - Review required



* Total is greater than 62 because some children were designated as more than one race.

Chart 12

Percentage of Fatalities by Race - Review Required



* Total is greater than 62 because some children were designated as more than one race.

Referrals Prior to Fatality - by Manner of Death

The charts below show the average and median number of referrals by manner of death for fatalities reviewed.

Chart 13

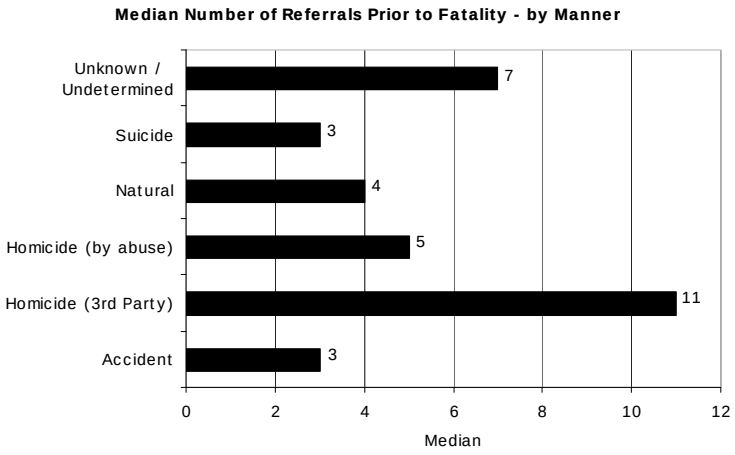


Chart 14

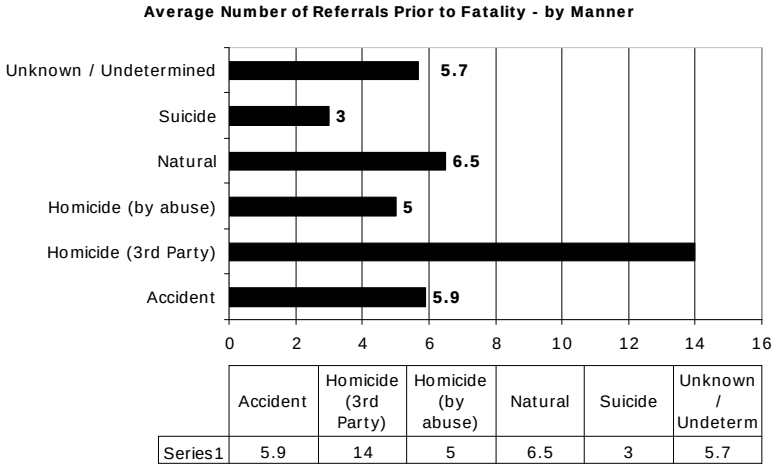


Chart 15 indicates the number and type of fatalities categorized by the number of referrals called in to CA intake prior to the child's death. For example, under category Accidental death, there were four fatalities in which there were five to nine referrals called in to CA intake before to the child's death.

Table 4

Number of Reviewed Fatalities by Prior Referrals						
Manner of Death	0 prior referrals	1-4 prior referrals	5-9 prior referrals	10-15 prior referrals	15-25 prior referrals	25+ prior referrals
Accidental	2	8	4	3	1	1
Homicide 3rd Party	0	1	0	2	0	1
Homicide by Abuse	0	0	3	0	0	0
Natural Medical	5	12	9	3	1	2
Unknown/ Undetermined	0	2	2	1	0	0
Suicide	0	2	0	0	0	0

Regional Comparisons

The Children's Administration in Washington State is divided into six regions and 45 field offices. Regional headquarters offices are located in the following cities:

- Region 1 - Spokane
- Region 2 - Yakima
- Region 3 - Everett
- Region 4 - Seattle
- Region 5 - Tacoma
- Region 6 - Tumwater

Table 5 shows the number of fatalities reported to CA for each region across the state.

Table 5

Regional Comparison

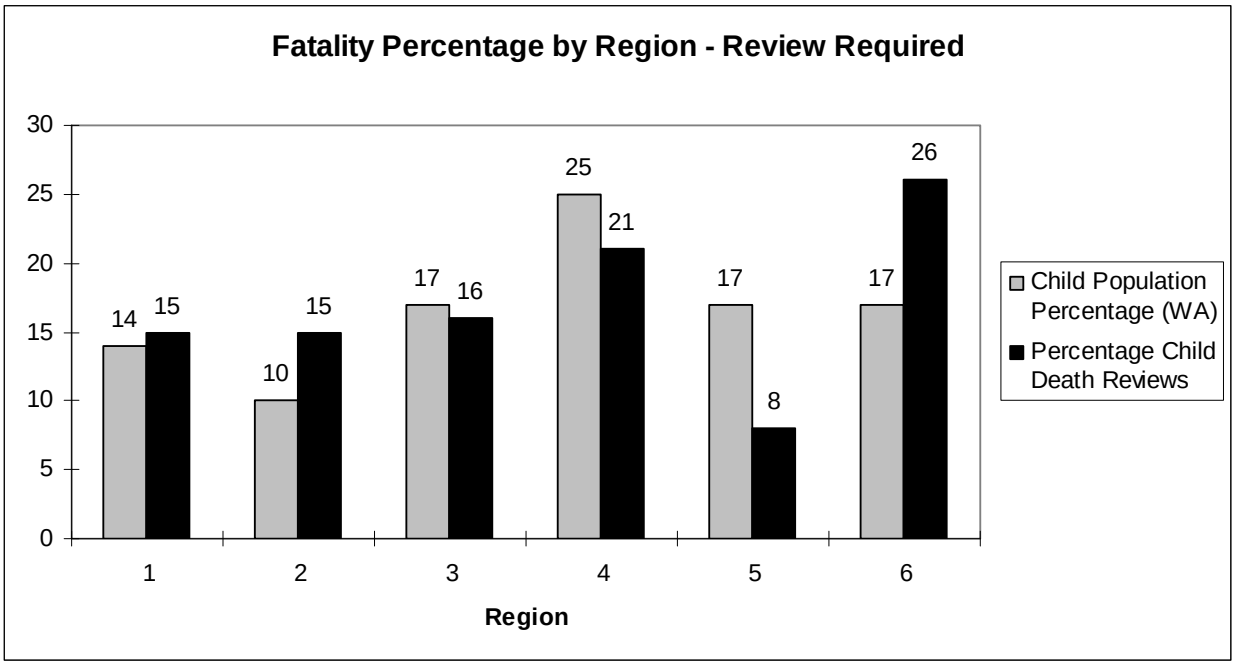
Region	Regional % of Total Population[12]	Regional % of Total Child (0-17) Population[14]	Referrals Received[13]	Referral Victim Count[14]	Total Fatalities Reported to CA	Fatality Review Required	No Fatality Review Required
1	810,128 (13%)	208,016 (14%)	10,294	7,494	14	9 (15%)	5
2	561,674 (9%)	156,336 (10%)	9,526	6,834	11	9 (15%)	2
3	1,029,988 (17%)	253,628 (17%)	13,334	9,745	16	10 (16%)	6
4	1,777,143 (29%)	389,035 (26%)	13,101	9,921	20	13 (21%)	7
5	984,549 (16%)	252,257 (17%)	10,178	7,547	9	5 (8%)	4
6	1,040,306 (17%)	250,508 (17%)	17,523	10,633	17	16 (26%)	1
Total*	6,203,788	1,509,780	73,956	68,756	87	62	25

* Calendar year 2005

[12] "Annual Estimates of the Population of Counties for Washington: April 1, 2000 to July 1, 2004," U.S. Census Bureau, (CO-EST2004-01-53), April 14, 2005.
[13]Includes the following programs: CPS, DLR/CPS, licensing complaints, FRS and CWS (See Key Terms and Acronyms in the Appendix). Data compiled from the Case and Management Information System (CAMIS) Referral File, March 2005.
[14] CAMIS data "Unduplicated alleged victims" for the following programs: CPS, DLR/CPS, FRS & CWS. Maija Morgenweck, Data Support Unit, April 17, 2007. Total includes additional 16,582 referrals received through Central Intake, a statewide intake unit.

Chart 16 displays the regional percentage of Washington State's child population and the regional percentage of CFRs completed.

Chart 16



Maltreatment Fatalities

Some fatalities are related to maltreatment by a caregiver or person acting in loco parentis. Maltreatment is the abuse or neglect of a child as defined by the Washington Administrative Code (WAC).[15] CA has historically used medical examiner's and coroner's findings of homicide to determine the number of fatalities resulting from maltreatment. However, research indicates that nationally less than half of the children who died as a result of maltreatment had death certificates that were coded consistently with maltreatment.[16] Many states, including Washington, now use CPS findings of abuse or neglect when counting maltreatment fatalities.[17]

This chapter divides maltreatment fatalities into two categories:

1. Fatalities with an official finding of maltreatment by a person acting in loco parentis. These include CPS founded findings, criminal convictions and homicides, as determined by a medical examiner or coroner.

2. Fatalities with substantial risk factors present in the family at the time of death, although no official finding or conviction was made.

Determining the number of maltreatment related fatalities requires interagency sharing of information. Law enforcement, medical examiners/coroners and the Department of Health (DOH) have roles in the assessment and evaluation of child deaths. CA received data from the Homicide Investigations Tracking System (HITS) of the Assistant Attorney General's office and DOH vital statistics on death certificates. The Office of the Family and Children's Ombudsman worked with CA in evaluating and categorizing the fatality data and the findings. Each agency has its own set of distinct mandates and responsibilities which often lead to discrepancies in statistics.

An infant who died from positional asphyxiation while co-sleeping with her mother, for example, was classified as an accidental death by the medical examiner but found as a neglect-related death by CPS since the mother had been abusing substances prior the positional asphyxiation. Some states, such as California and Nevada, are reconciling the differences in agency data through interagency participation in child fatality reviews and information sharing.[18]

Currently, medical examiners do not share autopsy information with CA per RCW 68.50.105. A legislative amendment to the RCW adding CA to the list of agencies precluded from confidentiality would be useful for CA reviews and investigations of abuse or neglect fatalities. Sixteen of the 25 fatalities in this section met the criteria for a child fatality review.

---

[15] "What is child abuse or neglect?" WAC 388-15-009.
[16] Tes Crume, Carolyn DiGuiseppi, Tim Byers, Andrew Sirotnak and Carol Garrett. "Underascertainment of child maltreatment fatalities by death certificates." Pediatrics, Vol. 110, April 17, 2002, pp. 479-492.
[17] U.S. Department of Health and Human Services, Administration on Children, Youth and Families, "Child Maltreatment 2005," <http://www.acf.hhs.gov/programs/cb/pubs/cm05/appendd.htm>, accessed on May 17, 2007.
[18] Bill Grimm, "Child Deaths From Abuse and Neglect: Accurate Data, Public Disclosure Needed," *Journal of the National Center for Youth Law*, Vol. 28, No.1, January 2007.

Maltreatment Fatalities by Finding

Table 6

Finding	Total
Homicides	10[19]
CPS Findings of Abuse	9
CPS Findings of Neglect	19
Total Maltreatment Findings*	38

* Some fatalities involved children with multiple findings. For the 25 maltreatment fatalities, there were 38 findings.

Child Protective Services Investigations

Child Protective Services (CPS) investigates all referrals with allegations of child abuse and/or neglect by caregivers or referrals where children are deemed to be at risk of imminent harm. Forty-two child fatality reports included allegations of abuse or neglect.

Table 7

2005 CPS Allegations and Findings on Reported Fatalities		
	Allegations *	**Founded Findings**
Neglect	36	19
Abuse	11	9[20]
Total*	47	28

* Some investigations had allegations and findings of both abuse and neglect as to one child.

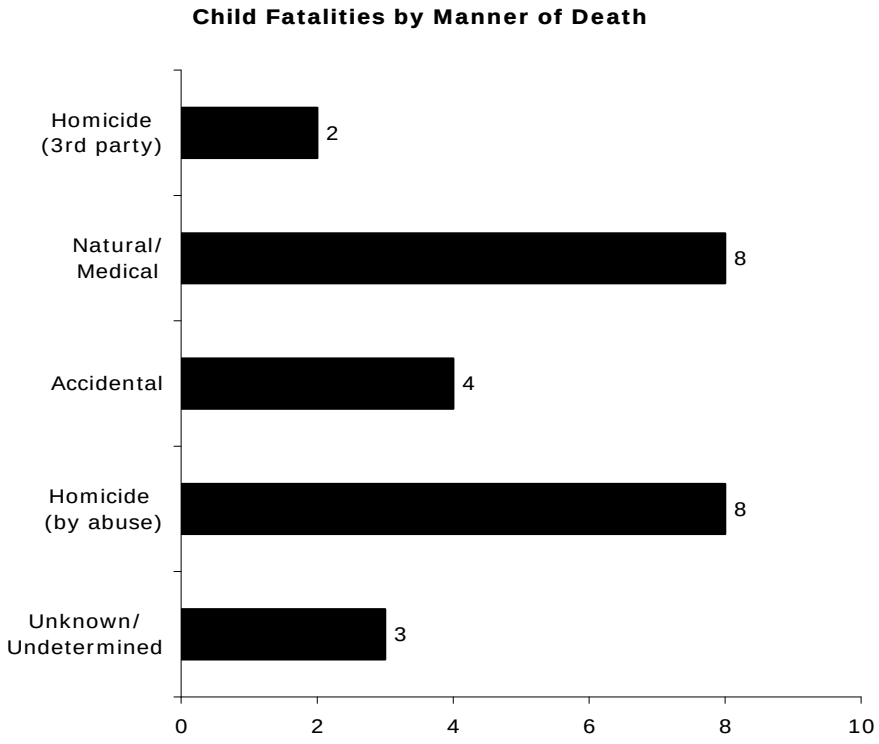
[19] One of these homicides had no autopsy. It resulted in the conviction of a mother who confessed to killing her child, although the body was never recovered. Two of the four 3rd party homicides are excluded from this section because the children were killed by persons not acting in loco parentis. Both were killed by strangers while they were away from home.

[20] Two fatalities did not include an Investigative Risk Assessment with findings because the children were out of state when the fatalities were reported. Official findings were not made (since the referrals could not be investigated) but both deaths are added here since the care givers were convicted of murder and the medical examiner in that state concluded homicide.

Maltreatment Fatalities by Manner of Death

The chart below shows manner of death findings on the 25 maltreatment fatalities. Forty percent (40%) were classified as homicides.

Chart 17



Nearly half of maltreatment fatalities were classified as accidents or natural/medical by medical examiners and coroners. For example, a positional asphyxiation death coded as an accident by the medical examiner was founded for maltreatment by CPS because the parents had abused substances prior to co-sleeping with the child. Another child's death, deemed natural/medical, was founded by CPS for negligence because the child had been severely ill for nearly one week, and the mother, who had been abusing substances, never took him to the hospital or doctor. Recommendations by school officials to seek medical attention several days prior to the child's death were ignored.

Substance Abuse

Perhaps the most pervasive risk factor found in the maltreatment fatalities was substance abuse by the child's caregiver. Eighteen of 25 fatalities included allegations of substance abuse by the caregiver at or near the time of the fatality that were documented in the case record. Of these eighteen cases, eleven involved methamphetamine or amphetamine use. Substance abuse information was not available for every CFR so this information is most likely underreported.[21]

[21] Some fatalities were not investigated by CA because the parents moved out of state just prior to the death. Moreover, some fatalities were not reviewed because the criteria for a review were not met. See RCW 74.13.640.

Referral History - Maltreatment Fatalities

Table 8

Total Referrals Prior to Fatality	Number of Fatalities
0	6
1 to 3	3
4 to 6	5
7 to 10	5
11 to 20	5
More than 20	1
Total	25

* Approximately 50% of all referrals made to CA are recorded as "information only" and are not investigated.

Table 9

Referrals Accepted For CPS Investigation Prior To Fatality	Number of Fatalities
0	8
1 to 3	7
4 to 6	7
7 to 10	2
11 to 20	1
More than 20	0
Total	25

Race and Gender

Chart 18

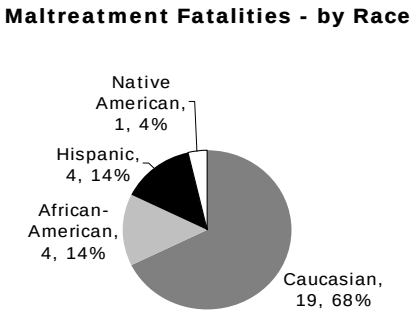


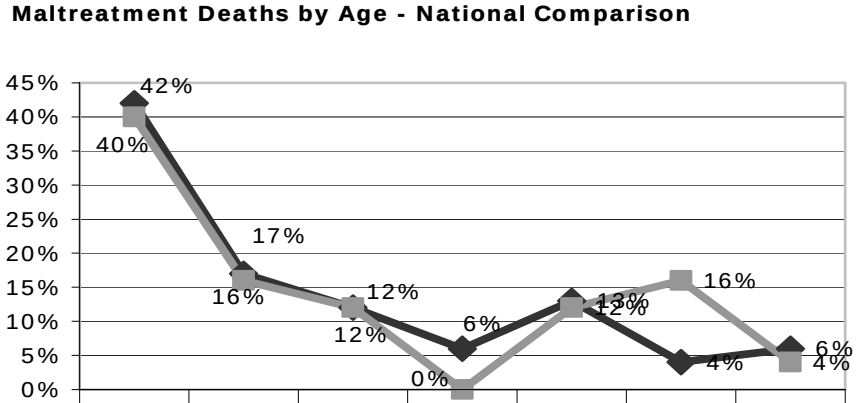
Chart 19

* Some children were categorized with more than 1 race

Age

The chart below compares maltreatment fatalities in Washington with national statistics of the same category.[22] Washington fatalities due to abuse and neglect approximate national trends for most age ranges except in the eight to eleven year old range.

Chart 20



	Infant	1	2	3	4 to 7	8 to 11	12 to 17
NCANDS	42%	17%	12%	6%	13%	4%	6%
Washington	40%	16%	12%	0%	12%	16%	4%

Age Group

[22] US Dept of Health and Human Services, National Child Abuse and Neglect Data System (NCANDS), "Child maltreatment 2005," 2007, <http://www.acf.hhs.gov/programs/cb/pubs/cm05/chapterfour.htm>, accessed on July 5, 2007.

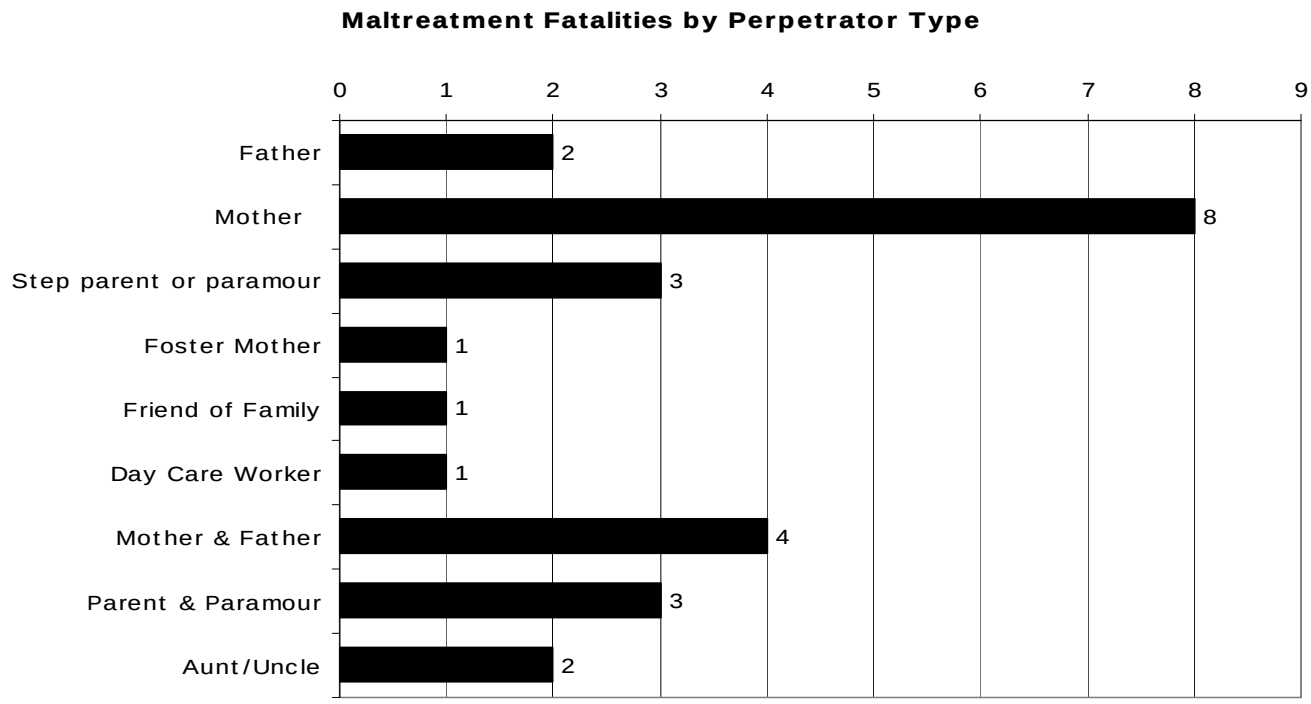
Number of Maltreatment Fatalities by Age

Table 10

Age	Number of children
< 1	10
1	4
2	3
3	0
4 - 7	3
8 - 11	4
12 - 17	1
Total	**25**

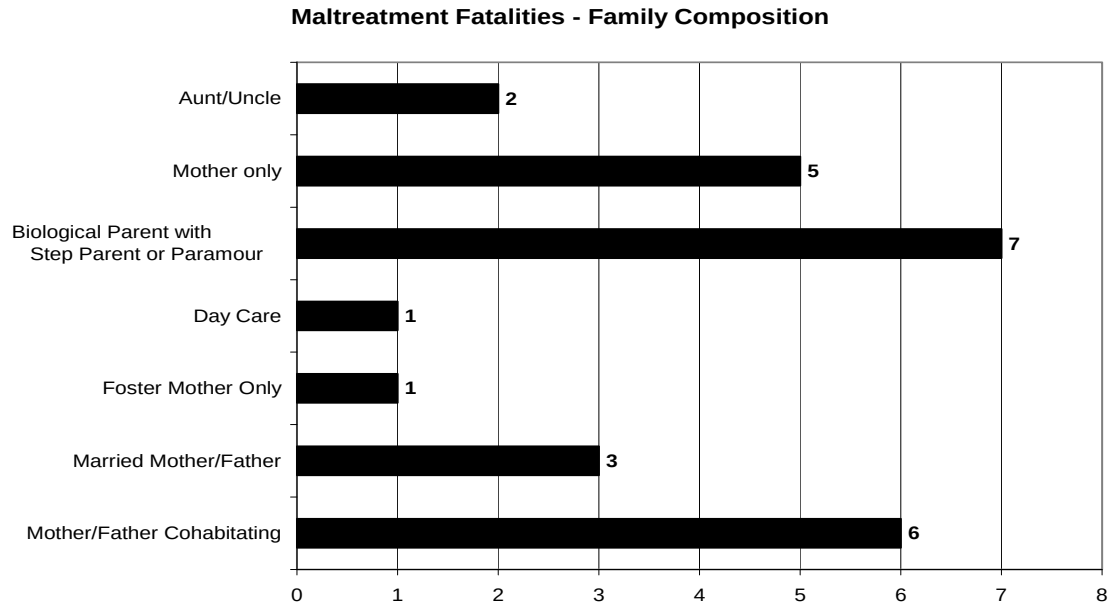
Perpetrators of Maltreatment

Chart 21



Perpetrators of Maltreatment - Family Composition

Chart 22



Cause of Death

Cause of death for each of the 25 maltreatment related deaths are listed below:

Suffocations

1. Overlay
2. Positional asphyxiation
3. Unknown (SIDS or positional asphyxiation)
4. Unknown (possible positional asphyxia)

Homicides

5. Blunt force trauma to head and torso
6. Blunt force trauma to head
7. Blunt force injury to head
8. Blunt force trauma
9. Neglect - deprived of food and water
10. Blunt force trauma to head
11. Drowning
12. Blunt force trauma
13. Blunt force trauma

Medical

14. Dysphasia and encephalopathy
15. Congenital heart malformations
16. Sepsis from ruptured appendix
17. Unattended breech delivery with nuchal cord

Other

18. SIDS
19. Fresh water drowning - fell into lake
20. Firearm
21. Asphyxia due to hanging (by curtain cords)
22. Extreme prematurity from prenatal substance abuse
23. Dehydration
24. Pedestrian / motor vehicle
25. Other - child had severe medical problems stemming from prior neglect and injuries from maltreatment

Regional Comparison

Chart 23

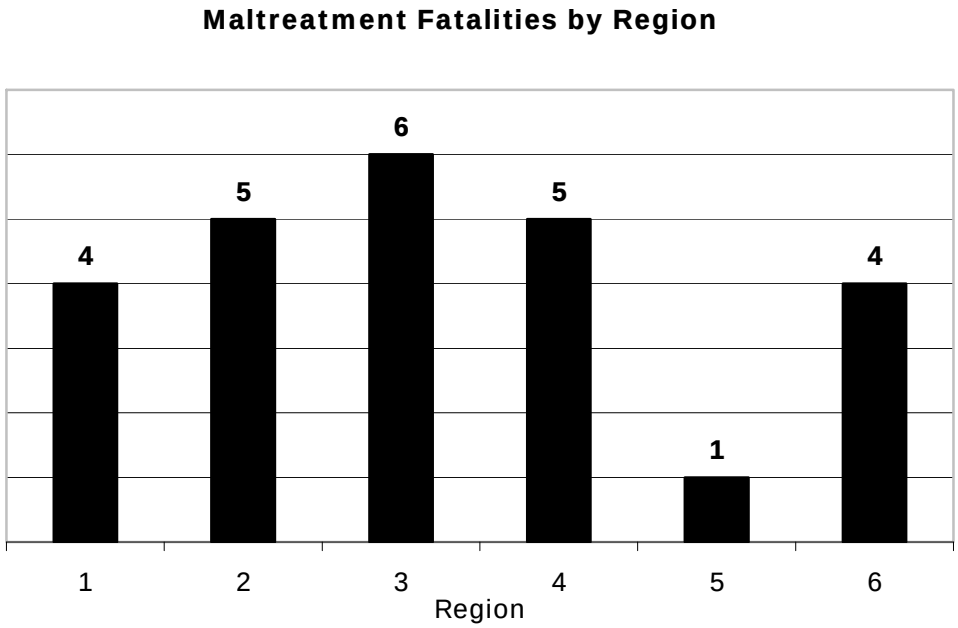


Table 11

Region	Fatality Review Required	No Fatality Review	Total Maltreatment Fatalities
1	3	1	**4**
2	4	1	**5**
3	4	2	**6**
4	2	3	**5**
5	0	1	**1**
6	3	1	**4**
Total	16	9	**25**

Non-Abuse/Neglect Fatalities in Families With CPS History

Some fatalities were not included as maltreatment fatalities because no official finding of maltreatment was made. However, some fatalities occur in circumstances where the family has a history or pattern of alleged abuse or neglect concerns. CPS history, for the purposes of this section, is concluded when two or more of the following exist:

1. The family was investigated by CPS at least three times prior to the fatality.
2. Five or more prior referrals on the family (whether investigated or not).[23]
3. Allegations of substance abuse by the caregiver.
4. CPS findings as to the fatality were "inconclusive."[24]
5. Family had prior CPS investigation for a separate child fatality, near-fatality or Shaken Baby Syndrome.

Table 12

Sex	Race	Age	Cause of Death	Total Prior Referrals	Prior CPS Investigations	Substance abuse	CFR	Other
M	C	5 mo	Positional Asphyxia	4	2	Y (meth)	Y	1 prior near fatality of this child
M	C	1 mo	Positional Asphyxia	5	2	Y	Y	Inconclusive CPS findings
M	C	17	Accidental Drug Overdose	9	6	Y (meth)	Y	
M	C	3	Accidental Drowning @ Hotel	9	4		Y	
M	NA	17	Accidental Drug Overdose	10	6	Y (meth)	Y	
M	C	1 mo	Natural - Pneumonia	5	3	Y	Y	
M	C	3 mo	SIDS	8	4	Y (meth)	Y	
F	C	1 mo	Positional Asphyxia	7	1	Y	Y	Mo refused services
M	AA	2	Long Term Medical Problems	1	1	Y (meth)	Y	Prior near fatality caused the medical problems
M	AA	1	Scalding	12	2	Y	Y	
M	AA	5 mo	Dehydration	3	2	Y (ecstasy)	Y	Inconclusive CPS findings
M	NA	16	Overdose Drug/Alcohol	10	6	Y	Y	Inconclusive CPS findings
F	Hisp/ C	3 mo	Positional Asphyxia	2	1	Y (meth)	Y	Founded

[23] Excluding licensed care facility complaints.
[24] CA policy defines inconclusive as "a determination cannot be made that, more likely than not, child abuse or neglect has or has not occurred."

Drug-Affected Newborns

CA receives CPS referrals from hospitals when birth mothers or newborns test positive for drugs. CA investigates the caregivers of drug affected infants to assess their ability to adequately care for the child. Table 12 details eight fatal drug affected infants where no findings of abuse or neglect were made.[25]

Table 13

Sex	Race	Age	CFR	CPS Finding	Prior Referrals*	In Utero Trauma	Cause of Death**
M	C	7 mo	Y	Inconclusive	2 (both founded)	Methamphetamines/prescriptions	Severe Medical Condition
M	AA	2 mo	Y	Unfounded	5 (4 CPS)	Methadone	SIDS
F	AA	4 mo	Y	Inconclusive	8 (1 CPS)	Barbiturates and marijuana	SIDS
F	AA	stillborn	N	Information only - no CPS investigation	3 (2 other children born testing + for cocaine)	Narcotics	Mother's "Possible ingestion of narcotics"
M	C	1 mo	Y	Inconclusive	3	Amphetamines and marijuana	Medical condition. Premature birth (25 weeks)
F	C	4 mo	Y	Information only - no CPS investigation	6 (3 CPS)	Severe methadone withdrawal followed by "sudden unexpected infant death."	Unknown - Infant stopped breathing
M	AA/C	2 weeks	N	Inconclusive	0	Mother attempted abortion w/ coat hanger. Mother abused substances throughout pregnancy.	Infection
F	AA/C	1 day	N	Inconclusive	0	Mother attempted abortion w/ coat hanger. Mother abused substances throughout pregnancy.	Infection

* CPS investigated referrals in parenthesis
** Cause determined by medical examiner/coroner.

[25] CA has new policies for greater consistency of response on drug exposed and drug affected newborns. See the CA Practices and Procedures Guide, Chapters 2551-2552.

Limitations

The process of classifying a child fatality as resulting from maltreatment can be difficult. Murders committed by caregivers are clear, but making a determination as to the cause of some fatalities can be complex. An accurate assessment of each fatality requires information about how the fatality occurred, who was involved, significant family history, and other facts that are not always available. Some scholars suggest that accurate classification of fatalities requires sharing of information and findings from multiple agencies.[26] [27] This does not always occur. Medical examiners and coroners, for example, may withhold information from child fatality reviewers and investigators citing confidentiality.[28] Aggregate comparisons of data with the Department of Health (DOH), the Homicide Investigation Tracking System (HITS), and the Office of the Ombudsman revealed that some fatalities have never been reported to CA.

The Department of Health documented 22 homicides to children in vital statistics as determined by medical examiners or coroners, yet only 10 were reported to CA. Vital statistics data lack information on whether child maltreatment was a factor. Funding of the community-based child death review process for DOH ended in 2003 and much of that data is no longer available. Theoretically, each of the 22 fatalities should have been reported to CA by a mandatory reporter, though there is no way to know for certain if this occurred since the data cannot be pulled and evaluated.[29]

The incompleteness of the data is compounded in that criminal investigations unknown to CA may have involved a caregiver. The Homicide Investigation Tracking System (HITS) of the Washington Attorney General's office recorded 28 homicide investigations of children in the state of Washington in 2005. Of those, 15 were homicide by abuse (abuse by a caregiver). Eight of the 15 fatalities to children investigated by law enforcement for homicide by abuse were not in CA's database.[30] Necessary information that would have justified the inclusion of those fatalities into this chapter was not available. For example, a father convicted of the murder of his wife and two daughters was not reported to CPS and it is unknown if he was acting in loco parentis at the time of the homicides. Details were also unavailable on three unsolved child murders that may or may not have been the result of maltreatment by a caregiver.

Another limiting factor relates to how maltreatment fatalities are counted. Case findings are made by CPS workers and their supervisors rather than by professional teams, which may create additional inconsistencies. Two maltreatment fatalities in this chapter involved infants who were drug affected at birth. CPS closed these cases as founded for neglect because medical professionals believed the severe medical problems were caused by in-utero substance abuse. Similar cases already mentioned were investigated in other regions but were determined as

[26] Jenny Hasbro, "The relation between child death and child maltreatment," Archives of Disease in Childhood, 2006, < http://adc.bmj.com/cgi/content/abstract/91/3/265>, accessed on August 8, 2007.
[27] Amerian Journal of Public Health, "Public Health Surveillance of Fatal Child Maltreatment: Analysis of 3 State Programs," http://www.ajph.org/cgi/content/abstract/AJPH.2006.087783v1, accessed on September 20, 2007.
[28] RCW 68.50.105 Autopsies, Post Mortems - Reports and Records Confidential - Exceptions.
[29] Diane Pilkey (DOH), "CDR section," email message, May 17, 2007. The text above is in response to a question about the care giver role of 22 perpetrators of child homicide documented in vital statistics.
[30] Information provided by HITS.

inconclusive since legal definitions of "child" were considered preclusive to a substantiated finding of neglect.[31]

Some states have made comprehensive legal changes to reconcile discrepancies between the various agencies. California, for example, has created the State Child Death Review Council of the Attorney General's office to oversee training of child fatality teams, data collection and reconciliation of discrepancies.[32] All suspicious child fatalities are reviewed by child fatality review teams. Each team must choose from one of the following five categories of child abuse/neglect:

1. No Child Abuse or Neglect (in child's life);
2. Child Abuse or Neglect History (not directly related to the death);
3. Suspicious or Questionable Child Abuse or Neglect (as a contributing cause of the death);
4. Definite Child Abuse or Neglect Related Death (present and direct contributing cause); and
5. Definite Child Abuse or Neglect as Primary Cause of Death.

All fatalities in category 4 and 5 are classified as maltreatment and subsequently reported the Children's Bureau, Department of Health and Human Services division of the National Child Abuse and Neglect Data System (NCANDS).

CA only reviews cases where current or recent CA involvement exists. Fatalities not meeting this criteria may not have been examined. Without a formal inquiry by investigation or review, there cannot be a thorough assessment of whether a child's death was related to maltreatment. The issue may not be resolved since professionals are understandably reluctant to further investigate grieving families without adequate cause.

[31] CA has developed new policies to provide consistent definitions when CPS is contacted about the birth of a child that has been prenatally exposed to substances. See Practices and Procedures Guide Chapter 2551-2552.
[32] State Child Death Review Council, "Child Deaths in California," June, 2005, http://www.childdeathreview.org/reports/CA1999-2001report.pdf, accessed on April 12, 2007.

Near-Fatalities

A near-fatality is defined as "an act that, as certified by a physician, places the child in serious or critical condition" (RCW 74.13.500).

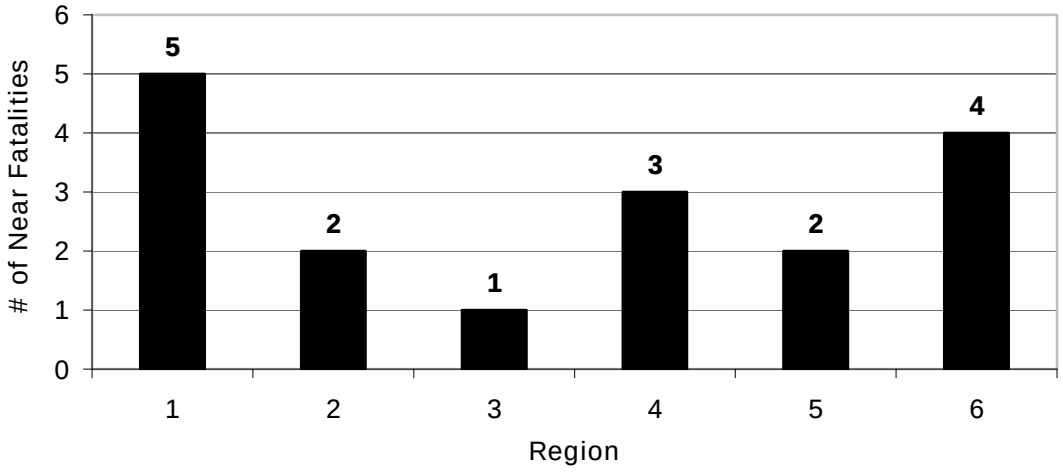
Child near-fatalities must be reported in the Automated Incident Report System (AIRS) if:

A. The near-fatality is a result of alleged child abuse and/or neglect on an open case or on a case with CA history within 12 months.
B. The near-fatality occurred in a CA or DEL licensed facility.

The administration documented 17 near fatalities in AIRS in 2005.[33] A sample of "serious injury"[34] referrals from 2005 revealed that some serious injuries meeting the above criteria for a near fatality weren't reported in AIRS. This may suggest an under-reporting of the data since tracking of near-fatalities only occurs in AIRS. Training on this issue has been provided to staff.

Chart 24

2005 Near Fatalities by Region



[33] This number represents near fatalities that met the policy definition. Twenty-four were removed because the criterion was not met. The total number removed by region (1-6), beginning with Region 1 was: 12, 2, 2, 6, 2, 0.
[34] Some referrals are coded as "serious injury" at the time an allegation or report is made to CA.

Table 14

2005 Near Fatalities

Age	Gender	Race	CPS Findings	Cause of Injury
1 mo	M	C	Unfounded	Failure-to-thrive
5	M	NA	Founded	Fall from upper story window
7 mo	F	C	Inconclusive	Drowned in child's pool
1 mo	F	C	Founded	Multiple bruises and rib fractures
1	M	C	Founded	Skull fracture and head injuries
4	F	NA	Founded	Skull fracture, bruising.
1	M	C	Founded	Drowned in bathtub
2 mo	F	C	Founded	Battered
12	M	AA	No CPS finding; incident involved foster child in licensed care	Choked on food
5 mo	M	NA	Founded	Shaken Baby Syndrome
3	M	C	Founded	Skull fracture
15	F	C	No CPS finding; incident involved foster child in licensed care	Drug overdose
16	F	C	No CPS finding; incident involved foster child in licensed care	Jumped from second story balcony
2	M	C	Unfounded	Severe burns by flammables
1	F	U	No CPS finding; incident involved foster child in licensed care	Infant stopped breathing
16	F	U	No CPS finding; incident involved foster child in licensed care	Suicide attempt from drug overdose
12	M	C	Founded	Auto accident

Recommendations

Child fatality review teams make recommendations for policy, practice and system improvements after reviewing CA case records on fatalities that require a review. These teams identified186 recommendations related to CA practice issues. Each was categorized according to a common area of practice and the corresponding CA program. Some recommendations applied to multiple programs. By quantifying each recommendation in this way, CA is able to evaluate recurring practice issues and programs identified by the child fatality review teams.[35]

Practice Recommendations

Table 15

Practice Category	Number
Risk Assessment*	35
Documentation*	29
Interagency Collaboration*	20
Substance Abuse	16
Chronicity (repeat maltreatment or referrals)	11
Service Delivery (external agencies CA refers clients to)	10
Screening Decisions (an assigned designated response to each referral - by degree and timing)	8
Data Systems (access and input of electronic information)	8
Exceptional Practice	8
Intra-Departmental Communication (CA)	8
External Review (Use of external review teams for feedback)	5
Community Recommendations	4
Mandatory Reporting	4
Background Checks	2
Department of Early Learning (child care recommendations)	2
Licensing (foster homes)	2
Mental Health	2
Cultural Issues	2
Miscellaneous	10
Total	186

** See page 36-37 for further breakdown of these categories*

[35] See a summary of each fatality review online. http://www1.dshs.wa.gov/legrel/LR/CIYA.shtm; http://www.dshs.wa.gov/ca /pubs /fatalityreviews.asp

Practice Recommendations Breakout

Risk Assessment

Risk assessment is the process of collecting and evaluating information about factors known to be predictive of child maltreatment. Issues related to risk assessment were the most common type of practice recommendation made by fatality review teams. Some examples of risk factors are a caregiver's history of abuse to other children, substance abuse, and domestic violence.[36] The 35 risk assessment practice recommendations are divided into five types listed in Table 15 below:

Table 16

Risk Assessment Category	Number of Recommendations
Interview Information	13
Safety Assessment and Plans	6
Confirmatory Bias	4
Reunification	3
General	9
Total	35

- **Interview Information**: Information obtained by interview with children, caregivers, collateral sources, and professionals. In most cases, there was a failure to interview or to gather adequate or appropriate information from persons related to the case.
- **Safety Assessment and Plans**: Safety assessment and planning is the formulation of a short-term plan that is intended to ensure a child's safety when risk of maltreatment has been identified. Effective safety plans depend on comprehensive risk assessments.
- **Confirmatory Bias**: An individual's tendency to give greater weight to information that supports their own beliefs or impressions.
- **Reunification**: Recommendations related to the return of children to caregivers after a child has been removed from the home.
- **General**: Non-specific or miscellaneous risk assessment recommendations.

[36] See "The Practice Guide to Risk Assessment," Children's Administration.

Documentation

Table 16 divides the twenty-nine documentation recommendations into the following types:

Table 17

Documentation Category	Number of Recommendations
Service Episode Report Input	7
Service Episode Report Content	6
Investigative Risk Assessment	7
Inactive	3
Supervisor Case Conference	1
Other	5
Total	29

- **Service Episode Report Input**: Failure to input case narratives in electronic case file
- **Investigative Risk Assessment**: Deficiencies in the CPS findings or investigation report
- **Inactive**: Case was inappropriately inactive for a long period of time.
- **Supervisor Case Conference**: Supervisor/social worker documentation of case staffing.
- **Other**: General documentation recommendations.

Interagency Collaboration

CA collaborates with schools, law enforcement agencies, medical professionals, counselors, contracted service providers and other professionals. These relationships are important for case planning and well informed risk assessments. Collaboration was the third most common type of recommendation made by review teams. Table 17 shows the number of times each organization was referenced in the recommendations.

Table 18

Collaboration Category	Number of Recommendations
Law Enforcement	8
Stakeholders	4
Medical Professionals	4
Other DSHS	3
Courts	1
Total	20

- **Law Enforcement**: Recommendations about communication and collaborative relationships with law enforcement. These generally encouraged better communication and protocols between CA and local law enforcement.
- **Stakeholders**: Professionals in the community who provide services to CA clients. Examples are school personnel, mental health counselors and medical professionals.

- **Other DSHS**: Other DSHS administrations (not Children's Administration).
- **Medical Professionals**: Physicians, hospital staff and medical examiners.
- **Courts**: Juvenile Court staff, Assistant Attorney Generals, commissioners and judges.

Program Recommendations

All recommendations were categorized by a specific program area as well.[37]

Table 19

Program	Number
Child Protective Services (CPS)	65
All Programs	23
Intake (reports made to CA or referrals)	22
Administration (Regional and Statewide)	20
Child Welfare and Service Delivery Social Workers*	15
Division of Licensed Resources (foster and group home licensing)	5
Adoption	3
Contracted Providers	2
Department of Early Learning (day care licensing)	2
Home Support Specialists	2
Family Reconciliation Services (FRS)	1
Total	160

* Social workers that maintain open cases for the delivery of services to children and families.

[37] Some recommendations applied to more than one category which is why the total program recommendations are not the same as the total practice recommendations.

Key Terms and Acronyms

Administrative Incident Reporting System (AIRS): AIRS is a relatively new system for CA. Usage began in 2002 in pilot sites in Region 2 (Yakima and the surrounding areas) and Region 5 (Pierce/Kitsap County area). All regions were instructed to use this system for fatality reports during 2003. After successful results, AIRS was fully implemented statewide on January 1, 2005. This system was designed to track child fatalities, near fatalities, and other critical incidents and has eliminated the need for several different reporting formats. Information from AIRS is used to identify incident patterns, trends, and systems issues to determine what interventions are needed to improve the health, safety, and well-being of the children and families in Washington State.

Accidental Asphyxiation: A cause of death described by a deprivation of oxygen due to accidental overlay of a parent onto an infant while co-sleeping.

Cause of death: "Cause of death is the disease or injury" that was responsible for the death or the death events as defined by the American Family Physician. Examples of cause of death include cancer, pneumonia, blunt trauma, Sudden Infant Death Syndrome (SIDS), and poisoning.

Co-sleeping: A cause of death described as sleeping together with parents or with other children in the same location.

CFR: Child Fatality Review by CA

CDR: Child Death Review by the Department of Health

CWS: Child Welfare Services provides both permanency planning and intensive treatment services to children and families who may need help with chronic problems, such as ongoing abuse, neglect, or intensive medical needs. CWS is provided to children and families when long-term services are needed. Most children served in this program are dependents of the state or are legally free for adoption.

DCFS: The Division of Children and Family Services is a division of the Department of Social and Health Services in Washington State.

DLR: The Division of Licensed Resources is responsible for licensing and monitoring family foster and group homes, training and support of foster parents, and the investigation of complaints concerning the health and safety of children and the quality of care provided in foster care facilities.

FRS: Family Preservation Services, a program of DCFS, helps parents having problems with at-risk adolescent youth. The program helps parents or youths with serious conflicts at home through the courts. FRS also helps families and youths obtain treatment, protection, and other care.

Layover: A cause of death described as a child who is laid on by another person or animal.

Manner of death: categorized into the following groups *natural*, *accident*, *suicide*, *homicide*, and *undetermined*. Manner of death does not indicate cause and effect, but is used in conjunction with the cause of death to better describe how the death occurred.[38] The manner of death category is identified by the local medical examiners and coroners.

Manner of death and cause of death relationship: The cause of death describes what physically caused the death while manner of death refers to the intention that led to the death. For example, when a person dies from a cocaine overdose, the manner of death could be listed as an accident and the cause of death listed as an overdose of cocaine. In this case, even though the person was engaging in a dangerous activity, it is classified as an accident because the person did not intend to harm himself or herself.

Neglect: "An act or a failure to act on the part of a child's parent, legal custodian, guardian, or caregiver that shows a serious disregard of the consequences to the 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:

1. 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;
2. 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
3. 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's, or the effects of chronic failure on the part of a 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 a child.

OFM: The Office of Financial Management provides vital information, fiscal services and policy support that the Governor, legislature and state agencies need to serve the people of Washington State.

Positional Asphyxiation: A cause of death described by a deprivation of oxygen due to the position of the child.

[38] American Family Physician, October 1, 1997, Volume 56, Number 5.

Executive Child Fatality Reviews

Executive Child Fatality Reviews (ECRF) are fatality reviews convened by the CA Assistant Secretary and conducted by multi-disciplinary teams comprised of individuals who have no prior involvement with the deceased child's case. In October 2005, Children's Administration (CA) convened an ECFR to review the practice and events that occurred prior to the January 2005 death of 7-year-old Tyler DeLeon. CPS found that the adoptive mother, a licensed foster parent, deprived this 7-year-old child of food and water. He died of dehydration and weighed 28 pounds at the time of his death. (See the complete ECFR report for issues and context to these recommendations).[39] The ECFR team included a pediatrician, an educator, a mental health professional, a representative from the Guardian ad Litem (GAL) program, a police chief, a foster parent, two legislators, and one department representative from the Division of Licensed Resources (DLR) and the Division of Children and Family Services (DCFS).

The committee found the DeLeon case noteworthy because so many professionals were involved with Tyler's physical, emotional and psychological care. Most of these professionals did not recognize that Tyler's life was in jeopardy in his adoptive home. Tyler was frequently seen by doctors, but none expressed concern that he was the victim of abuse or neglect. His history reflects a pattern of injuries and allegations of food and water deprivation. Unlike more "typical" neglect cases, Tyler's foster/adopt mother regularly took him for medical care and interacted with medical providers and school authorities. Carole DeLeon was the primary source of information for the professionals involved in Tyler's life. Most professionals believed Ms. DeLeon was honest and credible in her explanations for his injuries and health problems. This confidence in Ms. DeLeon had a significant impact on the assessment of all the events that occurred in her home. Concerns by DCFS staff were mitigated by the positive comments by doctors and other professionals who worked closely with the family.

Ms. DeLeon told professionals that Tyler's birth history and family of origin caused his reported behaviors. Her accounts of Tyler's history are not supported by the facts. This misinformation led others to minimize or ignore Tyler's declining growth over the last four years of his life. Tyler died on his seventh birthday.

Ms. DeLeon reported that Tyler had severely dysfunctional behaviors, including excessive water and food consumption. Ms. DeLeon told school officials that Tyler's physicians had directed her to monitor and restrict Tyler's food and fluid intake. She directed the school to restrict his food and fluid intake as well.

DLR/CPS social workers who investigated referrals regarding injuries in the DeLeon home prior to Tyler's death consulted with medical professionals about the injuries. They were unable to substantiate any physical abuse by Ms. DeLeon or her adult daughter who also provided child care for the children in Ms. DeLeon's home. Tyler sustained a significant pattern of suspicious injuries throughout his life. He had numerous injuries that were noted by different agencies or providers, but no agency or provider was aware of the cumulative number and nature of his

[39] Department of Social and Health Services, Children's Administration, "Tyler Deleon Fatality Review," January 2006, <http://www.dshs.wa.gov/pdf/ca/CFRDeLeon.pdf>, accessed August 29, 2007.

injuries until after his death. Medical records contained reports of injuries that were not reported to CPS or law enforcement, presumably because abuse was not suspected.

The ECFR committee found that all the systems involved with Tyler, as well as other children in Ms. DeLeon's home, did not detect the pattern of abuse and neglect that became evident in the investigation after Tyler's death.

Annual Trends

1997 - 2005

Table 19 shows the number of fatalities that required a Child Fatality Review from 1997 through 2005 by manner of death.

Table 20

Children's Administration Statewide Child Fatality Data
Child Fatalities Meeting the Criteria for an Internal Child Fatality Review
Calendar Years 1997 - 2005*

Manner of Death	1997	1998	1999	2000	2001	2002	2003	2004	2005
Accident	36	20	20	21	26	32	21	26	**19**
Homicide by Abuse	6	9	4	8	3	7	6	9	**3**
Homicide by Third Party	10	5	5	2	8	5	8	0	**4**
Natural	45	39	33	33	61	47	39	24	**32**
Suicide	5	2	2	5	5	3	5	9	**1**
Undetermined	1	4	4	3	5	7	11	15	**3**
Total	103	79	68	72	108	101	90	83	**62**

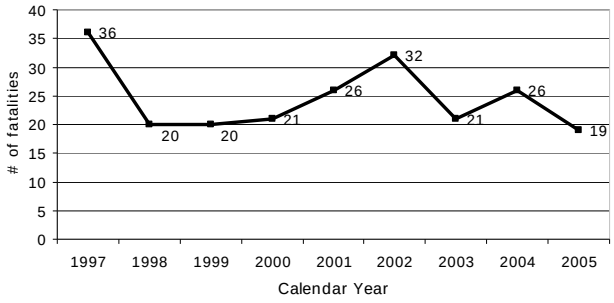
* Data included in this table is based upon information as of April 2007 and may change as new information becomes available.

Chart 25

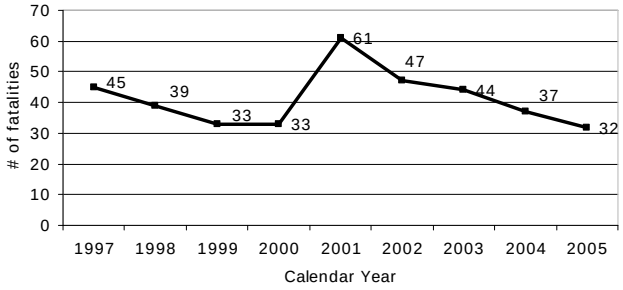
Annual Trends - By Manner[40]

Charts 26-31

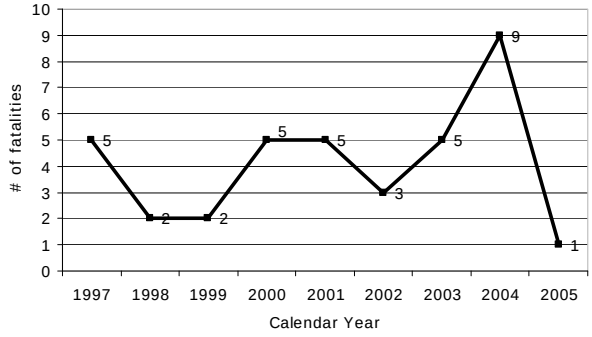
Accidents
1997 - 2005



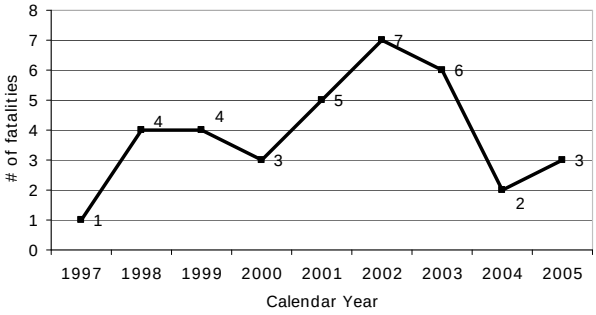
Natural
1997 - 2005



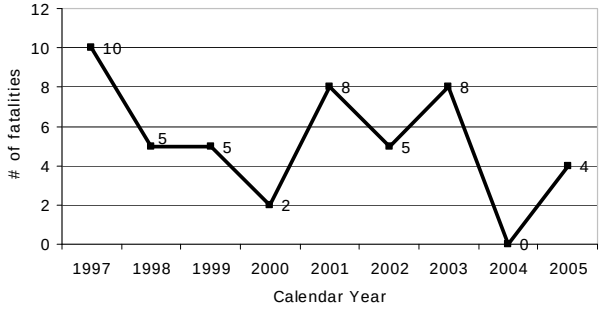
Suicides
1997 - 2005



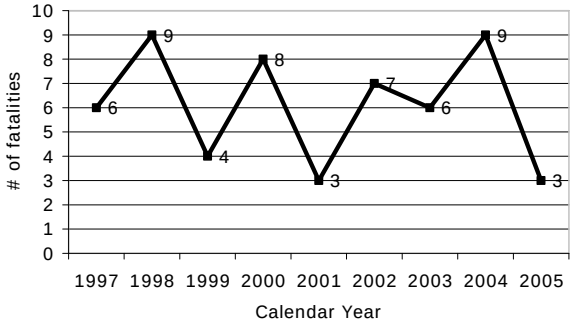
Undetermined / Unexpected
1997 - 2005



Homicide (3rd Party)
1997 - 2005



Homicide by Abuse 1997 - 2005



[40] Unknown/Undetermined manner of death from 2003 and 2004 are different than what appeared in previous annual fatality reports. See footnote nine on page six.

Appendix

Summary of Child Fatalities - 2005

Number of child fatalities in Washington	719
Child fatalities reported to CA	124
Number of fatalities required to be reported to CA (Per RCW 26.44.030)	87
Of the fatalities reported to CA, the number of reports that included CA/N allegations	41
Of the fatalities reported to CA required by RCW 26.44, the number of reports not containing current CA/N allegations, but refer to children in open/recent cases	46
Of fatalities required to be reported to CA, the number of fatalities in licensed facilities	17
Number of fatalities CA was required to conduct a fatality review (per RCW 74.13.640)	62
CA reviewed fatalities attributed to CA/N (Maltreatment)	16
Number of CA reviewed fatalities not attributed to CA/N, but for which CA/N history exists in the family	13
The number of fatalities attributed to CA/N and reported to NCANDS*	9
Of the fatalities reported to NCANDS, the number that received a fatality review	5
Of the fatalities reported to NCANDS, the number not requiring a child fatality review	4

* NCANDS data is pulled from federal fiscal year 10/1/04 - 9/30/05. The criteria for NCANDS fatalities attributed to CA/N includes only those fatalities in which the parent or caretaker was charged with homicide for the death of the child. The NCANDS data is found at: http://www.acf.hhs.gov/programs/cb/pubs/cm05/table4_1.htm