

February 2024 Board of Health Spotlight

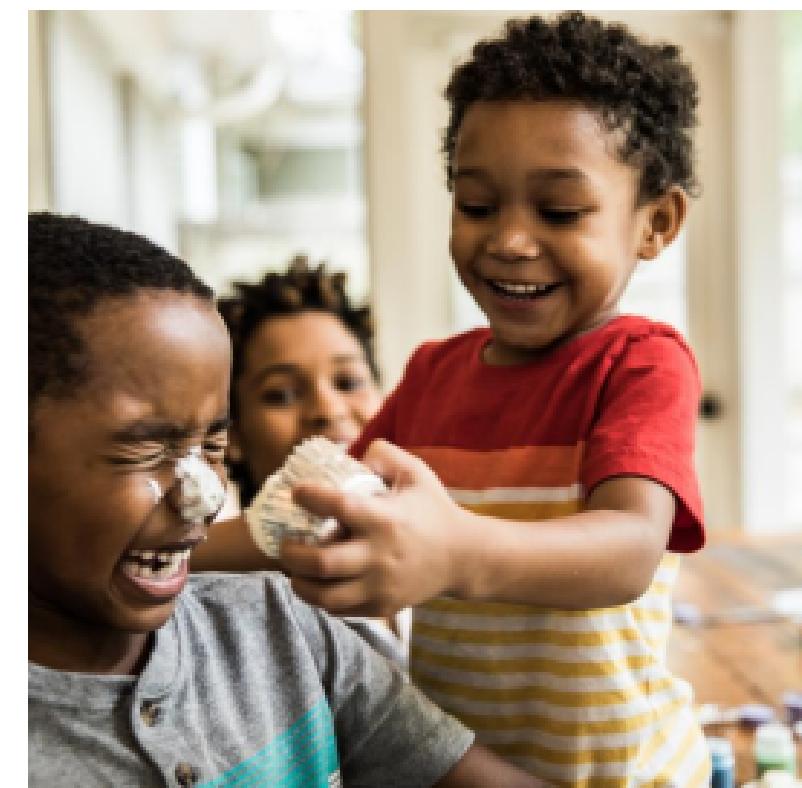
*Child Fatality Review
and Prevention (CFRP)*



Protected Process

*“The legislature finds that the mortality rate in Washington State among infants and children less than eighteen years of age is **unacceptably high**, and that such mortality may be preventable. The legislature further finds that, through the performance of child mortality reviews, preventable causes of child mortality can be identified and addressed, thereby reducing the infant and child mortality in Washington State.”*

- State law (RCW 70.05.170) enacted in 1993 and revised in 2010
- Local Health Jurisdictions (LHJs) can conduct reviews so that “preventable causes of child mortality can be identified and addressed” through evidence-based systems and policy changes
- The CFRP team at the Department of Health (DOH) oversees local CFRP data



What is the CFRP?

Community-oriented process involving professionals from multiple disciplines

Facilitates an **objective review** to outline key circumstances involved with a child's death

Collectively examines how and why children die in our county with the **goal of preventing future deaths and improving safety**

An ongoing, confidential process of data collection, analysis, interpretation, and action

A systemic process guided by **policies and state law**

Intended to move from data collection to prevention activities

What the CFRP is NOT

A mechanism for assigning blame or responsibility for any death

A research study

Institutional review or substitute for existing mortality and morbidity inquiries

The Fatality Review Process



Tell the Story

Tell each story to identify and understand the risk and protective factors



Collect Data

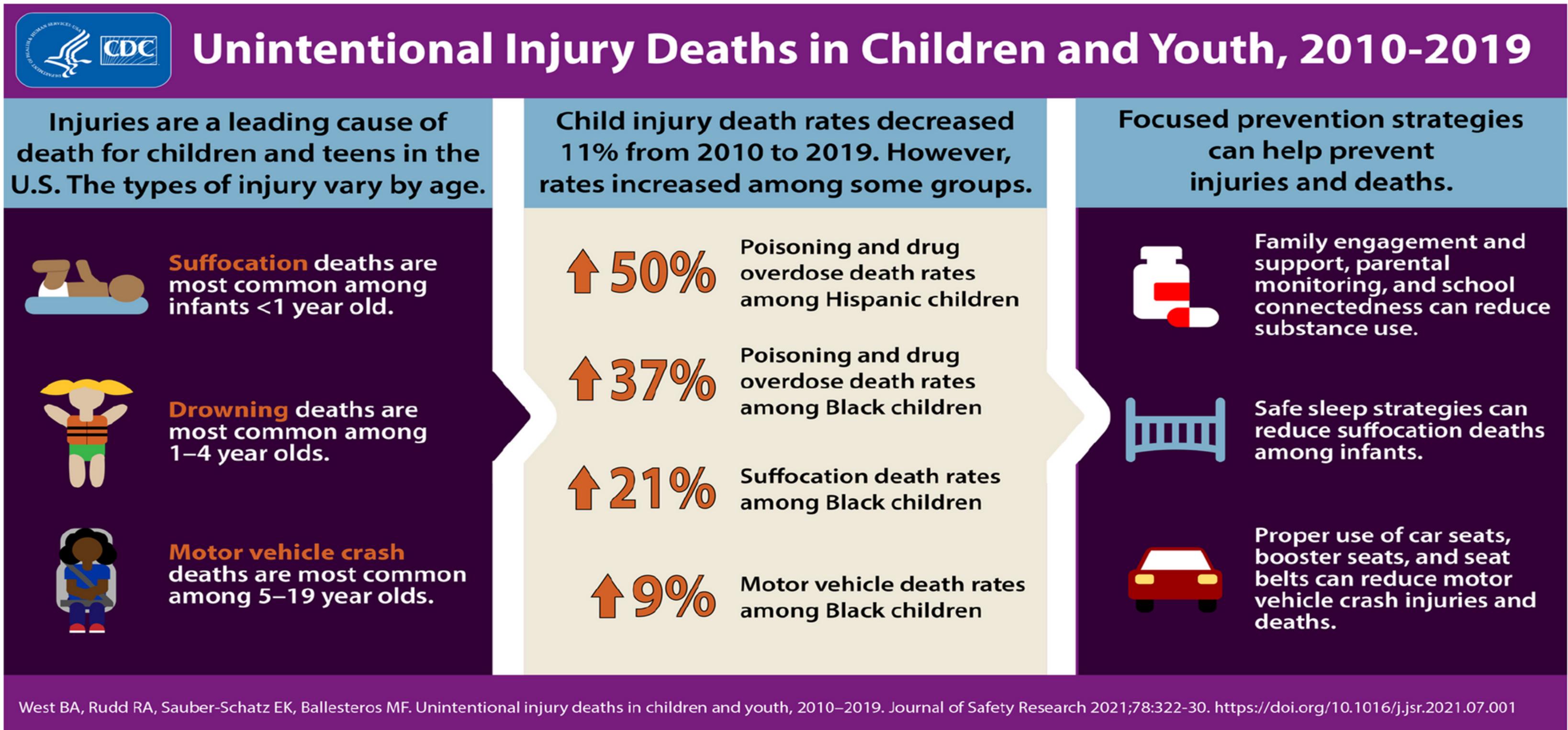
Multidisciplinary data on the context in which the decedent lived should be documented



Take Action

Fatality Review Teams should be a catalyst for prevention

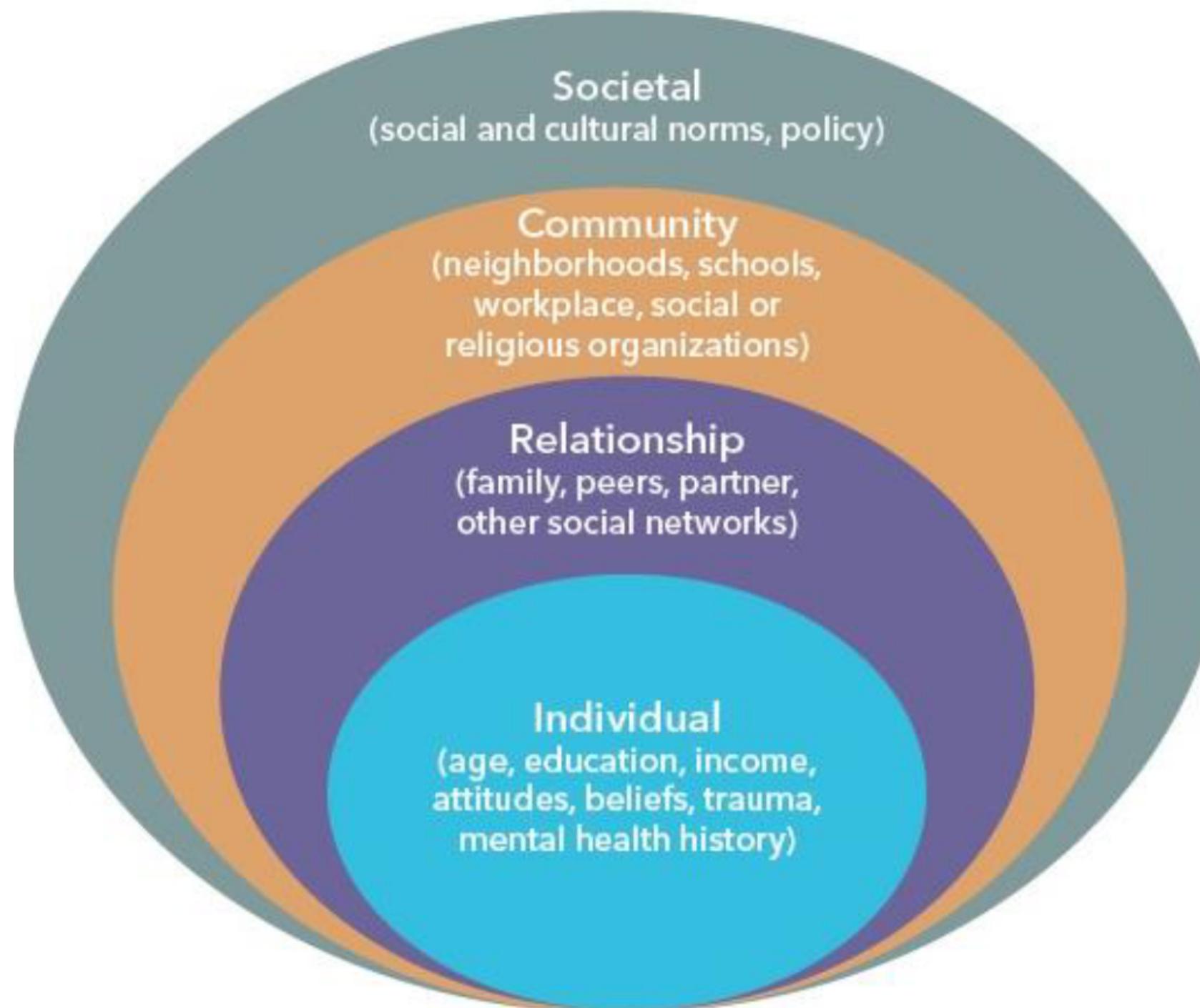
Why We Have Reviews



CFRP Review Meetings

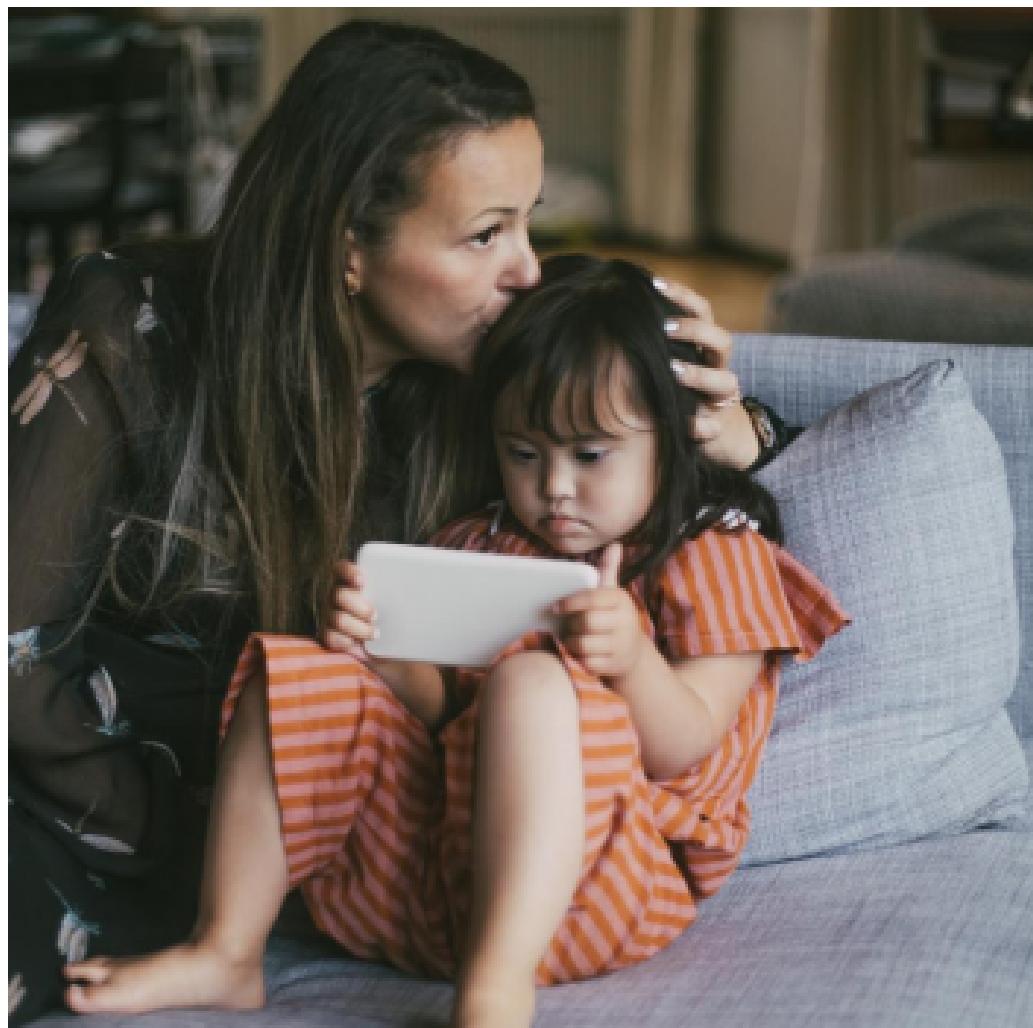
- Reviews follow a systematic, standardized approach
- Cap reviews at 3-4 cases per meeting
- Attendees include core members plus ad-hoc members invited on a case-by-case basis
 - Ad-hoc members will have expertise related to case(s) being reviewed:
 - Examples: Experts in Domestic Violence, Child & Family Therapists, LGBTQ+

Looking Ahead



- Review unexplained and unexpected deaths of 0–18-year-olds who died in Yakima County or who resided in Yakima County but died in another state/county
- Use a social-ecological model and shared risk and protective factors approach to framing prevention work

Purpose of YHD's CFRP Team



- Understand the causes and complexities of a child deaths
- Identify strategies to prevent future tragedies
- Serve as a catalyst for the identified strategies and recommendations
- Prompt a collective community response
- Avoid assigning blame; focus on solutions

First Review Summary

Established Core Members

- Department of Children Youth and Families (DCYF)
- Yakima County Coroners Office
- Yakima Police Department (YPD)
- Yakima County Emergency Medical Services (EMS)
- Educational Service District (ESD) 105
- Yakima Valley Farm Workers Clinic – Childrens Village
- Yakima County Sheriff's Office
- Yakima Health District (YHD)

****Additional experts will be added to reviews on a case-by-case basis****

First Review Summary_Cont.

- Manner of Death – Suicide
 - In 2022-2023, Yakima County had 5 reported youth suicides
- Next steps:
 - Develop recommendations and prevention strategies



Next Meeting

- *April 10, 2024*
- *Manner of Death - Overdose*

YHD Strategic Goals



Deliver mandated services



Develop a network of community partners invested in improving public health



Increase the effectiveness and efficiency of district services

Questions?