QUARTERLY CHILD REVIEW RCW 74.13.640
JANUARY – MARCH 2024

Washington State Department of
CHILDREN, YOUTH & FAMILIES

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CONTENTS

Executive Summary

This is the Quarterly Child Fatality Report for January through March 2024, provided by the Department of Children, Youth, and Families (DCYF) to the Washington State Legislature. RCW 74.13.640 requires DCYF to report on each child fatality review conducted by the department and provide a copy to the appropriate committees of the Legislature:

> (1) (a) The department shall conduct a child fatality review in the event of a fatality suspected to be caused by child abuse or neglect of any minor who is in the care of the department or receiving services described in this chapter or who has been in the care of the department or received services described in this chapter within one year preceding the minor's death.
>
> (b) The department shall consult with the Office of the Family and Children's Ombuds (OFCO) to determine if a child fatality review should be conducted in any case in which it cannot be determined whether the child's death is the result of suspected child abuse or neglect.
>
> (c) The department shall ensure that the fatality review team is made up of individuals who had no previous involvement in the case, including individuals whose professional expertise is pertinent to the dynamics of the case.
>
> (d) Upon conclusion of a child fatality review required pursuant to this section, the department shall within 180 days following the fatality issue a report on the results of the review, unless an extension has been granted by the governor. A child fatality review report completed pursuant to this section is subject to public disclosure and must be posted on the public web site, except that confidential information may be redacted by the department consistent with the requirements of RCW 13.50.100, 68.50.105, 74.13.500 through 74.13.525, chapter 42.56 RCW, and other applicable state and federal laws.
>
> (2) In the event of a near fatality of a child who is in the care of or receiving services described in this chapter from the department or who has been in the care of or received services described in this chapter from the department within one year preceding the near fatality, the department shall promptly notify OFCO. The department may conduct a review of the near fatality at its discretion or at the request of OFCO.

Introduction

In April 2011, SHB 1105 was passed by the Legislature and signed into law by Governor Gregoire. The revised child fatality statute (RCW 74.13) became effective July 22, 2011, and requires the department to conduct fatality reviews in cases where a child's death is suspected to be caused by abuse or neglect. This eliminated conducting formal reviews of accidental or natural deaths unrelated to abuse or neglect. The revised statute also stipulates the agency will conduct reviews of near-fatalities or serious injury cases. The revised statute requires the agency to consult with the Office of Family and Children's Ombuds (OFCO) if it is not clear that the fatality or near fatality was caused by abuse or neglect. The statutory revision allows the department access to autopsy and post-mortem reports for the purpose of conducting child fatality reviews.

Quarter One Report

This report summarizes information from completed reviews of six child fatalities and 11 near-fatalities [1] completed in the first quarter of 2024. All child fatality reviews can be found on the Child Fatality & Serious Injury Reports page of the DCYF website.

The data in this quarterly report includes fatalities and near fatalities from five of the six regions (DCYF divides Washington State into six regions).

DCYF Region	Number of Reports
Region 1	3
Region 2	1
Region 3	6
Region 4	5
Region 5	1
Region 6	1
Total Fatalities and Near-Fatalities Reviewed During 1st Quarter 2024	**17**

This report includes Child Fatality Reviews (exhibit A) and Near Fatality Reviews (data only) conducted following a child's death or near-fatal injury that was suspicious for abuse and neglect and the child had an open case or received services from DCYF within the 12 months prior to the child's death or injury. A critical incident review consists of a review of the case file, identification of practice, policy, or system issues, and recommendations to address any identified issues. A review team consists of a larger multidisciplinary committee, including community members whose professional expertise is relevant to the family history. The review committee members may include legislators and representatives from OFCO.

The following charts provide the number of fatalities and near-fatalities reported to DCYF, the number of reviews completed, and those pending for calendar year 2023. The number of pending reviews is subject to change if DCYF discovers new information by reviewing the case. For example, DCYF may discover that the fatality or near-fatality was anticipated rather than unexpected, or there was additional DCYF history regarding the family under a different name or spelling.

Child Fatality Reports for Calendar Year 2024

Year	Total Fatalities Reported to Date Requiring a Review	Completed Fatality Reviews	Pending Fatality Reviews
2024	3	0	3

[1] Near-fatality reviews are not subject to public disclosure and not posted on the public website nor are the reviews included in this report.

Child Fatality Reports for Calendar Year 2024

Year	Total Near-Fatalities Reported to Date Requiring a Review	Completed Near-Fatality Reviews	Pending Near-Fatality Reviews
2024	6	1	6

The child fatality reviews referenced in this Quarterly Child Fatality Report are subject to public disclosure and are posted on the DCYF website.

Near-fatality reports are not subject to public disclosure and are not posted on the public website, nor are the near-fatality reviews included in this report.

Notable First Quarter Findings

Based on the data collected and analyzed from two child fatalities and the five near-fatalities reviewed during the second quarter, the following were notable findings:

Based on the data collected and analyzed from three child fatalities and the eight near-fatalities reviewed during the first quarter, the following were notable findings:

- Nine of the eleven cases referenced in this report were open at the time of the child's death or near-fatal injury.
- Seven of the 17 cases this quarter were either open or recently closed Family Assessment Response (FAR) cases. Two of the seven FAR cases involved siblings who died in during the same incident. Three cases had recent Child Protective Services (CPS) activity and three were open Child Family Welfare Cases (CFWS) cases. In four cases the most recent child welfare program was Family Voluntary Services (FVS).
- One child fatality occurred while the child was in licensed care. This child died of hyperthermia after being left in a car for an extended period of time on a hot day.
- There were 10 critical incidents this quarter where children ingested fentanyl or other opioids. Only one of these was a fatality. All 10 of these children were under the age of 2 years. Fentanyl/opioid ingestion continues to be the leading cause of near fatal injury in cases reviewed by DCYF.
- The other fatality cases reported this quarter include two siblings dying in a house fire intentionally set by a parent; an infant dying from medical neglect; a toddler dying from hyperthermia and a seven-month-old dying from fentanyl poisoning.
- Eight of the children referenced in this report identified as White. Three children identified as Native American. Five children identified as Black/African American. One child was Asian.
- Substance abuse was a significant risk factor in 13 of the 17 critical incident cases this quarter.
- Prenatal drug exposure was present in 8 of the 17 critical incident cases. Pre-natal exposure occurred in 8 of the 10 fentanyl/opioid ingestion cases.
- Lack of safe permanent housing was an issue in five cases.
- Domestic violence was a risk factor in seven cases.

- DCYF received intake reports of abuse or neglect in most of the cases referenced in this report prior to the death or near-fatal injury of the child. The incident of the child dying while in licensed care, the licensed provider did not have any prior CPS intakes before the incident. In 9 cases DCYF intake received between one to six intake reports prior to the fatality or near fatality. DCYF intake received between 7 to 10 prior reports on families in three cases documented in this report. 4 cases had between 11 and 17 reports prior to the fatality or near fatality.

Due to the small sample of cases reviewed, no statistical analysis was conducted to determine relationships between variables.

Exhibit A

Child Fatality Reviews

There were six child fatality reviews completed during this quarter. Child fatality reviews are subject to public disclosure and are posted on the DCYF website.

Exhibit A contains the following child fatality reviews from the first quarter of 2024:

B.B.

V.R.

S.R.

R.C.

A.S.

S.K.