QUARTERLY CHILD REVIEW RCW 74.13.640 APRIL – JUNE 2024

Washington State Department of CHILDREN, YOUTH & FAMILIES

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Executive Summary

This is the Quarterly Child Fatality Report for April through June 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 Two Report

This report summarizes information from completed reviews of two child fatalities and five near-fatalities [1] completed in the second 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	1
Region 2	1
Region 3	2
Region 4	1
Region 5	2
Region 6	0
Total Fatalities and Near-Fatalities Reviewed During 2nd Quarter 2024	**7**

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	9	3	6

[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	14	4	10

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 Second 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:

- The age discrepancy of the children in the DCYF reviewed fatalities and near fatalities is notable that the victims are overwhelmingly young – three years and younger. However, in this report, what is notable is that the child victims were older. Five children in the seven cases documented in this report are 13 years and older.
- Six of the seven cases referenced in this report were open at the time of the child's death or near-fatal injury.
- Six of the seven cases this quarter were either open Child Protective Services (CPS) or recently closed Family Assessment Response (FAR) cases. Two of the seven cases were open Child Family Welfare Cases (CFWS) cases.
- One near fatality occurred while the youth was in licensed care. This teen overdosed on prescription medication that was not to be in his possession.
- Four of the seven critical incident involved children ingesting fentanyl or other opioids. Two of the seven incidents involved overdoses of prescription medications. An infant suffered near fatal injuries in a fall. Fentanyl/opioid ingestion is the leading cause of near-fatal injury in cases reviewed by DCYF.
- Five of the children referenced in this report identified as White. One child identified as Native American, and one child identified as Black/African American.
- Substance abuse was a significant risk factor in five of the seven critical incident cases this quarter.
- Mental health issues were a risk factor in four of the seven critical incident cases.
- Allegations of physical abuse was an issue in five 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/youth. In two cases of the cases, DCYF intake received between one to six intake reports prior to the fatality or near fatality. DCYF intake received between nine to fifteen prior reports on families in three cases of the cases documented in this report. Two of the cases had between 16 and 20 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 five 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 second quarter of 2023:

J.L.

F.C.